The Hospitals

I can never forget the results to myself of this long hospital service. . . . I learned in it what has done most to render me in any sense useful to those who have given me their confidence.
—Walter Channing to N. I. Bowditch, October 7, 1851

By September 1, 1821, construction of the Massachusetts General Hospital was complete and it was ready to receive patients. Two days later, a thirty-year-old man diagnosed with syphilis was admitted.¹ He was still there a month later, when the attending physician, James Jackson, named Walter Channing to be the assistant physician. “I entered the service of the Hospital almost literally at its opening,” he proudly recalled, “and . . . attended the very first patient who was received within its walls.” Channing remained a member of the staff for more than seventeen years, eventually as attending physician.² His long hospital service was an important part of his career, augmenting his esteem for the medical profession, his “reverence for its character, its objects, its results.”³

Despite the fact that Channing was increasingly associated with midwifery, Jackson’s choice made sense. He was better acquainted with hospital practice than most physicians in Boston, having spent many of his student days at the hospitals in Philadelphia, Edinburgh, and London. The other promising men among his professional generation, including Bigelow and Ware, had not had the advantage of study abroad. It was a well-deserved compliment from Jackson, who remained satisfied with his assistant and annually requested renewal of the appointment. “I nominate Dr. Channing for re-election from a conviction that I shall thereby best promote the real welfare of the hospital,” he wrote to the trustees in 1828.⁴
Hospital physicians were an elite group in American medicine, and Channing benefited from the reflected glory of his chief. Frequent contacts with the trustees and with the consulting physicians who were occasionally asked for advice further enhanced his reputation, “until he was one of the best known physicians of the Boston community.” Hospital duties also increased his sympathy for the poor and reinforced his social concerns. Admission required a visit by the physician or surgeon to the home of the patient, where, it was assumed, he could better judge real need. Channing was thus forced to witness more squalor than private practice or Dispensary patients provided. The tragic experiences of some patients became part of their medical histories. One young woman who spent six weeks in the hospital was diagnosed with amenorrhea (cessation of menstrual periods for abnormal reasons) and an unspecified “affection of the lungs.” Most of her life had been spent sewing straw, “which obliged her to sit a good deal.” Another patient, a domestic servant only thirteen years old, was brought to the hospital with a concussion resulting from a bad fall. She had been abandoned by her parents, did not know if she had brothers or sisters, and had no one to take care of her.

Channing often spent an hour or so at the hospital even on days when Jackson was attending. During the late spring and summer months, when Jackson left town for his country retreat, Channing had complete responsibil-
ity for the medical wards. He listened to the complaints and medical histories of newly admitted patients, made an initial diagnosis, and prescribed whatever drugs, blisters, diet, baths, or other treatment he deemed appropriate. For the men and women already in the hospital, he visited daily to observe their conditions and adjust their therapies. The house physician, appointed annually by Jackson and John Collins Warren from among the recent medical school graduates, followed Channing's instructions and kept records of the medical history and daily care for each patient.

Ideally, the hospital was viewed as a family, and was often referred to as "the house," with the trustees in the role of beneficent but exacting parents, limiting expenditures, enforcing order, and demanding good conduct from the patients and staff. The hospital was meant to replicate the care more fortunate people would receive at home, albeit with fewer luxuries. As an early hospital report explained, "The poor patients under the care of skilful, intelligent, and eminent surgeons and physicians, are watched over by faithful and attentive nurses, and in truth the minor officers and domestics . . . continue to give the sick poor all the comfort and relief with all the chances of restoration, which the kindness of friends or the influence of money can command for those favoured with both."

Two trustees regularly visited the wards each week, preferably when no one from the staff was present, to hear patients' comments and complaints. "The committee cannot but record their satisfaction at the order, neatness and regularity of everything in the house and at the unwearied attention of the Superintendent & all connected with this establishment," was typical of their comments. They also approved admissions, determined the weekly fee assigned to each patient on the basis of his or her ability to pay, and certified that free patients were indeed among the "deserving" poor. Members of the Visiting Committee served two-month staggered terms, which enabled them to become well acquainted with the patients, follow their progress or lack of progress, and approve the physicians' recommendations for discharge. Since patients often remained in the hospital for many weeks or months, the increased intimacy between visiting trustees and the dependent sick promoted the sense of family.

The apothecary, nurses, house physician, and house surgeon were the faithful servants in this house for the sick. Except for the nurses, they were governed by hospital rules that required them, as well as the superintendent, to live within its walls and to seek permission of the superintendent whenever they wished to be away. Although antebellum nurses have been viewed retrospectively as little more than charwomen (and indeed this was often the case), a few who attended the sick at the Massachusetts General had enough under-
standing of disease to receive praise from some of the physicians. According to Oliver Wendell Holmes, "a clinical dialogue between Dr. Jackson and Miss Rebecca Taylor, sometime nurse in the Massachusetts General Hospital, a mistress in her calling, was as good questioning and answering as one would be like to hear outside of the court-room."  

The attending physician and surgeon, together with their assistants, ranked above the rest of the staff. No one was supposed to interfere or dictate to them regarding patient care. Nonetheless, their freedom was limited to the treatment of the patients. In all other matters, the trustees had the ultimate control that any proper Boston father would have in his own house. The physicians could and did offer advice on tangential issues such as arrangement of the wards, ventilation, window shades, assignment of free beds, and patient diet, but the trustees made the final decisions. Indeed, they supervised every aspect of hospital life from purchase of surgical instruments, the cost and quality of food, denial of admission to alcoholics and "colored" people, and rules of conduct. They forbade Sunday visitors who might produce "an unfavorable excitement in the patients" during religious service. They even directed the superintendent "to place a label on the principal doors of the Hospital requiring persons to shut them softly."  

Boston was still sufficiently small and society sufficiently circumscribed for Channing to live among, worship with, and share the same outlook as the bankers, merchants, clergymen, and Harvard professors who served as trustees. He was familiar with many, for at various times the board included Perkins and Higginson relatives and some of his personal friends. Most trustees were Federalists in politics and Unitarians in religion, as was he. Though committed in their daily lives to the accumulation and conservation of wealth, they sincerely felt their responsibilities for the less fortunate. Perhaps some helped the poor as a way to maintain a steady labor force and defuse threats to social stability, as has been asserted by a few historians, but many others, like Channing, were genuinely compassionate.  

Nonetheless, he too believed that careful adherence to rules and regulations promoted the welfare of the patients as well as "the reputation and usefulness of the establishment." When, for example, he unexpectedly arrived at the hospital to find the house physician, the house surgeon, and the apothecary absent from the premises, he quickly sent a lengthy letter to Warren urging that the regulations be revised so that such a travesty would not occur again. He also recommended a small salary of a hundred or a hundred fifty dollars per annum for the house physician and surgeon, thinking it would provide an incentive for better behavior and compensation for obeying house rules. It was the first attempt to remunerate the otherwise unpaid medical
staff. The trustees responded with revised guidelines for conduct and responsibilities of the staff and an annual grant of fifty dollars to house officers upon completion of their appointments.20

The number of patients admitted annually was not large. The second patient, a twenty-five-year-old man with chronic diarrhea and fever, did not enter until September 20. He was discharged on October 13. The first female patient, age twenty-eight, described as suffering “tremors of the whole body though not violent, weakness in knees and some strabismus [a vision problem],” came to the hospital November 7 and was discharged December 2, “at her own request . . . greatly relieved she thinks by the bath at 96 degrees.”21 During the four months from the inception of care through December 31, 1821, only eighteen patients were admitted. In the following year there were 122, and in 1823 the hospital had 207 patients.22 By 1838, Channing’s final year of attendance at the hospital, 380 patients were admitted, males outnumbering females 255 to 125.23 The increase reflected the growing acceptance of a general hospital among the sick poor who began to suppress their fears about medical experimentation and dissection and to recognize the benefits they might enjoy.

The wealthier class showed its support by continuing to make donations and bequests. As the hospital became more respectable there were patients who could pay partial or full board. One, an elderly gentleman who had been an officer during the Revolutionary War and a judge in the Massachusetts courts, not only paid board but was billed by Channing personally for extra services he had rendered. The Visiting Committee had to approve the payment of what was still an uncommon event.24

Nonetheless, charity patients continued to predominate. To provide for the charity cases, free beds had been created by contributions from philanthropic individuals and institutions. Among the male patients in 1838, charity and paying, the greatest number were laborers or mechanics, followed by sailors, clerks, and minors. Domestic servants predominated among the female patients. Most patients were in their twenties and thirties, with only a few teenagers and elderly. By then, the trustee reports had begun to indicate increasing numbers of Irish among the free patients. By strict economy, which greatly pleased the trustees, weekly expenses per patient were $5.38, an amount that had increased only slightly since the early years. Most of the money went for food, supplies, and the wages of the nurses and housekeeping personnel. Expenditures for medicines were less than 8 percent—technology had not yet begun to affect hospital costs. And, to prevent charity patients from succumbing to the immorality of dependence, those who had sufficiently recovered were expected to do some housework on the wards.25

Frequently listed among the patients were members of the hospital staff.
who became ill from close contact with infectious patients. Their children too became patients. The four children of the superintendent, ages ten, eleven, thirteen, and fifteen, were hospitalized during January 1825 with cough, sore throat, chills and fever, sweating, vomiting, and soreness in the chest. Ipecac was prescribed and all four recovered rapidly. Their father was less fortunate and died a few months later. Nurses were especially vulnerable, but even the cook had to be treated for dizziness, swelling of the eyelids and face, trembling, and inability to walk up stairs.

With a weekly average of forty-three men and women in the hospital, some of whom were surgical patients and not his responsibility, Channing was not overly taxed by his daily rounds. Nonetheless, the hospital offered the chance to see a great assortment of diseases, often aggravated by poverty and neglect. Within one seven-week period he encountered patients diagnosed with phthisis, typhus, cachexia, pleurisy, pox, uterine tumor, dyspepsia, catarrh, epilepsy, dysentery, prolapsus uteri, fever and ague, lung fever, and palsy. Private practice might include an equal variety of ailments, but the hospital experience encapsulated what would otherwise require a professional lifetime.

Annual hospital death rates were below 10 percent, in part because most patients suffered from adult chronic diseases, while the often fatal infectious diseases of childhood were still, even among the poor, treated at home. As a rule, smallpox patients were sent to the municipal pesthouse (a house of quarantine), although one case did make its way into the hospital, causing immense concern for patients, especially young patients, who had never been vaccinated. Some of the more adult patients and staff feared their previous vaccinations would no longer be protective. Channing immediately vaccinated "every one who felt the least anxiety," and no one else was infected.

Cholera, another potentially epidemic disease, threatened Boston and the rest of the country in 1832. It had already terrorized large parts of Western Europe and Great Britain and was expected to arrive by some unknown transmissible manner aboard the ships and merchandise that made the Atlantic crossing. Like officials in every other port city, those in Boston expected large numbers of cholera patients, and the Massachusetts General Hospital was advised to expect an overflow from a municipal facility especially created for the emergency. However, these same officials also took effective steps to clean up the city. Though there was no commonly accepted explanation for the spread of cholera, experience had demonstrated an association of epidemic disease with the open sewers and accumulated filth that blighted urban areas. Drains were flushed, streets were swept, garbage and other refuse were disposed of. These measures succeeded so well that despite the alarm, Boston was one of
the few American cities that escaped the cholera epidemic. There were only seventy-eight cholera deaths in Boston in 1832, a marked contrast to about three thousand deaths in New York.31

Erysipelas (an acute infection of the skin and subcutaneous tissues) was always a threat in hospital environments. We now understand that erysipelas is caused by a virulent strain of the streptococcus and can be fatal, especially among the elderly, surgical patients, and puerperal women. In Channing’s time erysipelas was known to be contagious, but no one understood the cause. Prevention was the best defense. When an outbreak occurred in 1826 and five deaths ensued, the medical staff advised the trustees to move the patients to other quarters and close the hospital. Once this had been accomplished, the superintendent and housekeeping staff undertook a “thorough purification by fumigation or otherwise,” washing first with sulphur, then with chlorine, whitewashing and repainting the wards, washing the furniture and airing the mattresses.32 Subsequent outbreaks were treated less strenuously but always with attention to ventilation, cleanliness, and isolation of infected patients. One such, a sailor whom Channing had admitted to the hospital after first examining him on board a ship in the harbor, was isolated in separate quarters with a newly acquired French disinfecting machine for company.33

For most of the patients at the Massachusetts General Hospital, it was the decent food, warm shelter, cleanliness, rest, and escape from the unhealthy environment associated with poverty that allowed patients to leave the hospital “well,” “much relieved,” or “relieved,” as reported in hospital statistics. Their long stays in the hospital abetted that process. Those who fared less successfully were categorized as “not relieved” or “unfit.” The bodies of those who died in the hospital were returned to their families. If there was no family, the city assumed responsibility for burial. Postmortems were not uncommon, as might be expected in a hospital staffed by academic physicians. Channing sometimes performed autopsies and otherwise was a frequent attendant. Here again was an opportunity to learn about disease.

During the years of Channing’s service, a quiet revolution was occurring in medical therapeutics. Though Channing associated Jackson with heroic medical treatments at the time of his apprenticeship, he recognized that his mentor was never as strong an advocate of drastic therapeutics as were Benjamin Rush and other medical men of that generation.34 Over time, careful observation rather than tradition and theory convinced Jackson and his colleagues that the debilitating effects of cathartics and bleeding did not of themselves cure the sick. At the medical school, Jackson taught a theory of “expectant treatment” that held that the course of every disease was fixed and that there was little the physician could do to alter it. Rather than attempt to
interfere in the body's natural struggle against disease, the physician's first task was to make the patient comfortable and encourage recovery with fresh air, sensible clothing, exercise, and cleanliness.35

Thus, the treatments prescribed by Jackson, and Channing as his deputy, were gentler than might be expected. They continued to use cathartics for digestive ailments, but in milder doses and for shorter periods than before. They relied on bloodletting in the beginning stages of pneumonia but not otherwise. Leeches were sometimes ordered for headache and local pain, but discarded if not effective. Opium and guaiac (derived from the resin of a tree native to the West Indies) were prescribed for persistent diarrheas or bloody stools, fevers were treated with quinine, local inflammations with cantharides (or Spanish fly, a dried beetle used as a counter-irritant). But they recognized that the facilities of the hospital did much to relieve people who would otherwise have had to recover while living in filthy surroundings. Digestive ailments responded well to an improved diet; respiratory ailments to "the pure air and clean apartments."36

In the decade of the 1830s Boston began to feel the impact of French medical teaching, especially that of Pierre Louis, whose "numerical method" was based on observation of many cases of the same disease and analysis of the effectiveness of therapies used for them. Recent American medical graduates as well as established physicians, including some from Boston, went to Paris to study with Louis and other eminent French medical professors, much as the previous generation had gone to London and Edinburgh. The Paris hospitals, with their large patient populations, offered the opportunity to corroborate Louis's studies and to observe the benefits of bedside teaching.37 James Jackson, Jr., J. Mason Warren (a son of John Collins Warren), and Oliver Wendell Holmes were among those whose exposure to Louis and the Paris school of medicine confirmed what Jackson and others had long suspected.

Jacob Bigelow, who visited Paris in 1833, enunciated the new teaching two years later at the annual meeting of the Massachusetts Medical Society. "On the Self-limited Diseases," Bigelow's exposition on the ability of nature to cure many diseases, was a straightforward call for therapeutic moderation. He urged his colleagues to refrain from interfering with nature's curative powers, though he also recognized that with some diseases the physician's measures could make a difference. Bigelow's prominence in Boston's medical circles strengthened the impact of his essay.38

The difficulty physicians faced, having begun to doubt the efficacy of bleeding, purging, and dosing with mercurials and other toxic medicines, was that they had nothing with which to replace them. Knowing what does not work does not necessarily mean knowing what will work. Even the greater
understanding of the etiology of infectious diseases that followed the path-breaking work of Pasteur, Koch, and Lister at the end of the nineteenth century would not significantly reduce morbidity and mortality until the development of antimicrobial agents in the middle of the twentieth century. Nor do we yet know how to cure some of the infectious diseases that have recently appeared and many noninfectious diseases such as cancer. Channing and the other hospital physicians thus continued to rely on the customary therapeutics, using moderation and caution; but they were forced by the necessity of “doing something” to prescribe treatments we look back upon with horror.

Hospital practice did not add much to Channing’s expertise in obstetrics and the diseases of women. Some of the female patients were diagnosed with various menstrual disorders that may well have been symptoms of underlying disease that could not be explained. For example, the headaches, dizziness, abscesses on the side of the neck, chest pain following meals, confused vision, and hearing loss of one patient were attributed to amenorrhea, though she subsequently developed a cough, swollen tonsils, and abdominal pain. Even more mysterious, for no obvious reason she gradually recovered. Other women were treated for postpartum hemorrhage, prolapsed uterus, ovarian tumors, and other all-too-common female disorders. Obstetric cases were rare. When a nineteen-year-old woman entered the hospital on November 15, 1823, the house physician noted that she “looks daily to be confined.” She had developed complications during the previous four weeks, including syncope (fainting) and repeated threats of convulsions, for which she was bled. On the 29th she delivered a nine-pound daughter “with relative ease.” The house physician attended the birth. The following day another paroxysm occurred, but by December 14 she had recovered and was discharged.

It is unclear how the new mother came to be admitted to the Massachusetts General Hospital. The New York Hospital had had a lying-in department since 1801, and the Pennsylvania Hospital since 1803. They also permitted midwifery instruction on the wards. But Boston’s civic leaders and philanthropists were less eager to offer their medical facilities to childbearing women. If it had once been difficult for them to accept their responsibilities toward friendless strangers stranded in their city—widows without families to care for them, or the worthy poor who served as domestic servants and common laborers—it remained difficult for them to assume additional obligations on behalf of poor women seeking a clean, safe place in which to deliver their babies. Nor were they sympathetic to the idea of using the hospital for instruction in midwifery, a serious restraint on Channing’s income. Whereas Warren and Jackson could bring their students to the hospital for clinical teaching,
and could charge additional fees for that instruction, Channing and his students did not have a similar advantage. In the early years of the hospital, clinical midwifery instruction was briefly considered but just as rapidly abandoned.42

NONETHLESS, there were well-intentioned people in Boston who recognized the need for a lying-in facility where homeless or impoverished women would be subjected to less degrading attitudes and receive better medical care than at the House of Industry, the new name for the old Almshouse. The initial impetus came from the Humane Society, which had supported the General Hospital from its inception, contributing five thousand dollars to the original subscription and making subsequent donations for free beds.

The Humane Society, founded in 1786, was originally dedicated to resuscitation of drowning victims and others in danger of asphyxiation or suffocation. It provided equipment to restore breathing and sponsored education aimed at preventing drowning and other accidents. Many physicians were among its early officers, including John Warren and Aaron Dexter. Benjamin Waterhouse had been involved in the initial conversations. Over the years, its assets increased more rapidly than expenditures and the officers began to seek additional purposes for its funds.43

In September 1830 a committee led by the Reverend Charles Lowell and including Dr. George Hayward, then the junior surgeon at the hospital, was asked for recommendations “in aid of some other humane and charitable object.” The committee soon reported back that “they knew of no object more deserving, or more needed in the present condition of the community, than an establishment for Lying-in women.”44 They proposed that five thousand dollars be appropriated by the society on condition that an additional twelve thousand dollars be raised for the same purpose. When Lowell and his associates asked the hospital trustees to collaborate in the enterprise, they were politely but firmly rejected. Though the trustees agreed that a lying-in ward was highly desirable, they excused themselves from contributing to its construction and support because of “the present state of the funds at their disposal.”45

In view of the response of the trustees to a request for an obstetrical department made nearly fifteen years later by John Collins Warren and Jacob Bigelow, it is questionable whether the trustees answered Lowell honestly. In 1845 Warren and Bigelow made a strong plea for clinical instruction in midwifery so that graduating students would not start medical practice without having ever witnessed a delivery.46 The trustees replied by conceding the need for clinical training, but they refused to allow it in their hospital. They did not think it would succeed because respectable married women, even though
impoverished, would not want to deliver in a ward where medical students and unmarried women were present. Nor would "young females in the City who, from being unprotected & exposed to temptation, fall into a situation in which a charity of this sort would be a protection and a boon" further degrade themselves or "proclaim their fall" by using it.

The trustees predicted that only the worst sorts of females, "women of notoriously bad habits . . . and females brought up in the lowest abodes of misery . . . whose inheritance has been sin," would dare to use the facility. If these women were admitted to a maternity ward, the poor but virtuous women for whom "female chastity is considered the highest virtue" would stay away from the medical and surgical wards. In short, only "the lowest class of women" (read prostitutes), who had nothing to lose from public shame, would avail themselves of a lying-in facility, and, by doing so, they would drive away sick women whom the hospital was meant to serve. As for instruction, the trustees assumed that pregnant inmates of the House of Industry and Dispensary patients delivering their babies at home would be suitable subjects.47

The attitudes expressed by the trustees, representative as they were of contemporary views of chastity, marriage, and female virtue, remained so prevalent that no further attempt was made to introduce obstetrics at the Massachusetts General Hospital for the remainder of the century. The argument they did not use, though hindsight renders it more appropriate, is that the patients in a lying-in ward, even if it was in a separate part of the hospital or in a special building, would have been exposed to infection and the possibility of high rates of morbidity and mortality. The Pennsylvania Hospital had experienced several epidemics of puerperal fever and European hospitals were renowned for the dangers on their maternity wards.

Though the offer from the Humane Society was rejected by the Massachusetts General Hospital, it attracted notice from another charity looking for worthy organizations to support. The Massachusetts Charitable Fire Society was founded a few years after the Humane Society to assist people whose homes were damaged or destroyed by fire, a common enough event in an era when buildings were constructed of easily flammable materials and there were no insurance companies to compensate owners for their losses. By judicious management its funds too had grown, especially since improved building materials and fire-fighting equipment and the advent of private insurance companies reduced the need for their help.48 Like the Humane Society, the Charitable Fire Society had made annual contributions toward free beds at the hospital. When asked to join them in the creation of a lying-in hospital for indigent women, the Charitable Fire Society responded affirmatively. Its charter was amended by the legislature to permit expenditure of funds for such a purpose.
Subsequently the two organizations, established forty years previously for very different purposes but faithful to a tradition of civic responsibility and obligation to the less fortunate, contributed five thousand dollars each toward the establishment of the Boston Lying-in Hospital. In return, each organization was entitled to name two trustees. Additional subscriptions brought the assets to more than fifteen thousand dollars.  

The idea of a private lying-in hospital was relatively new in the United States. New York had had a series of small lying-in establishments, of which only the New York Female Asylum for Lying-In Women was extant when the Boston Lying-in Hospital opened its doors. In Philadelphia, the Lying-In Charity had just begun to provide obstetric care and to train women in obstetrical nursing. Thus, despite the recalcitrance of the trustees of the General Hospital, Boston was a leader in the recognition of the need to provide free obstetrical care for poor women. A small brick building, once a private home, on the west side of Washington Street was purchased. To the rear was a garden where the matron raised vegetables to feed the patients and to sell for the benefit of the hospital. The establishment was meant to be homelike, restful, and secluded, though one wonders if the seclusion was entirely for peace and quiet. The hospital was located at the southernmost limit of Boston, where a narrow strip of land connected it to Roxbury and towns to the south. Perhaps the founders and trustees preferred to shelter their clients in a remote part of the city where they would be less offensive to the neighbors.  

And where was Walter Channing while all these plans were hatched? His name does not appear in the official correspondence, act of incorporation, or list of officers. The only reference in his personal correspondence is a casual remark made in a letter to James Jackson, Jr., then a student in Paris, written shortly after the hospital opened. “We have a small Lying in Infirmary established at last and I think this will be useful here.” Yet he is generally considered the founder of the hospital, his name is permanently associated with its origins, and his portrait hangs prominently in the lobby of today’s Brigham and Women’s Hospital, successor to the Boston Lying-in. In October 1940 Frederick Irving, an obstetrician and amateur historian who had a long association with the Boston Lying-in Hospital, established “Walter Channing Day” to commemorate the anniversary of the first patient at the hospital. Channing, he said, should “be venerated because he founded this hospital.”  

Channing was indeed a friend of many members of the Charitable Fire Society. Samuel Perkins, his father-in-law, was one of the earliest members, served on the committee that secured legislation permitting the charter change, and was one of the initial hospital trustees designated to represent the society. Perhaps, as Irving suggested, Channing persuaded him and his
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colleagues to add their funds to those already offered by the Humane Society. He may also have been instrumental in the offer from the Humane Society, for he was equally familiar with the men on its board. George Hayward was on the staff of the Massachusetts General Hospital and had been a frequent contributor to the *New England Journal* while Channing was editor. More than anyone else in Boston, Channing understood the need of poor women for "such comforts and attentions as the necessities of the puerperal state require," and he would have been a powerful influence on the charitable men who decided to help them.  

In most respects the Lying-in Hospital was patterned after the General Hospital. The house physician, appointed from the recent medical school class by the attending physicians, was required to live on the premises, free beds were made available through the income on hospital investments and the charity of benefactors, and visitors were strictly limited. The only significant differences were general supervision from a matron rather than a superintendent and the appointment of twenty-four directresses who visited weekly, much as the Trustee Visiting Committee did at the General Hospital. The participation of directresses was expected to add "delicacy to the benevolent objects of the institution" and assure the public that the hospital did not condone immoral conduct.  

The trustees, all male, also visited regularly to check on the matron and give their approval to the establishment. To make certain the hospital was not seen as a haven for "fallen females," the *Rules and Regulations* specified that "none but married women, or recent widows, known to be of good moral character" were to be admitted. It was important that the hospital not give "the least encouragement to Vice or immorality." In further acceptance of conventional morality, medical students were not permitted at the Boston Lying-in. How much this bothered Channing is not certain. As dean of the medical school faculty in 1845, he informed the trustees of the Massachusetts General that his colleagues "retain their original impressions on the subject," even though they accepted the decision not to create a lying-in department. Thirty years later he continued to deplore the absence of clinical obstetrics in the medical curriculum and urged his colleagues in the Boston Obstetrical Society to remedy the situation. On the other hand, he was enough of a realist in 1832 to know that the new hospital would never have community support if it did not conform to contemporary mores.  

The trustees of the Lying-in Hospital named Channing attending physician, along with Enoch Hale, a close friend and colleague. John Collins Warren, Jacob Bigelow, and George Hayward were designated consulting physicians. Edward Hook, a recent graduate of the medical school, was the
first resident physician, responsible for admitting patients and keeping case records.

Despite the incorporators' claims of urgency, the hospital was never fully occupied. From the admission of the first patient on October 24, 1832, until the hospital closed in 1854 prior to its removal to a different location, there were only 650 patients, an average of twenty-seven per year. In most months only four or five women were in residence. Like the patients at the Massachusetts General, they tended to stay for long periods, often arriving many weeks before term. It was not uncommon for the resident physician to note "reckoning doubtful" when a woman claimed that she did not know when she had had her last menstrual period or when she first felt "quickening." Perhaps many women did not. Or perhaps they feigned ignorance because they wanted early admission.

One woman entered the hospital seven weeks before her labor began. The resident physician noted that she "has been remarkably well. Enters now from anxiety or ignorance." Middle-class women who delivered at home usually enjoyed the luxury of reduced responsibilities before delivery, and poor women would have had similar or perhaps even greater need of respite. Additionally and despite the Rules and Regulations, the hospital provided a haven for unmarried women in the final weeks of pregnancy when they could not hide their condition. Nonetheless, the trustees resented the evidence of patients seeming to convert the hospital into a free boardinghouse, even though they usually worked in the house or garden until the onset of labor. Some patients remained longer after delivery than deemed necessary by the physicians. Susan Brown gave birth on September 17, 1837, and was discharged October 3, but remained three additional days although she had three children already at home. Middle-class women would have expected a lengthy convalescence, yet the trustees were uncomfortable with Susan's apparent malingering. Most patients were charity cases, but those who could afford some minimal payment were charged accordingly.

The requirement that they be either married or recently widowed was honored more in the breach. The number of women claiming widowhood or desertion by unworthy husbands was unusually high, and the management made little or no attempt to verify their stories. The directresses and trustees also meant to demonstrate Christian compassion by placing patients in "good homes," as either domestic servants or wet nurses, if they had no place to go following discharge. What happened to the babies of those women is unknown.

If some of the women did not fulfill the requirement regarding wedlock, all seem to have been poor. "On account of great poverty, has been subject for
a few days to many and great privations," was the notation in one case his-
tory. 65 Abigail Carner, nineteen years old, was admitted eight days after the
birth of her baby "because of her destitute situation." Sophia Yorke had four
other children and was "accustomed to hard work." Margaret Boga, a washer-
woman with three children, "has worked very hard lately." Mercy Sparhawk
Goodenow "is at present in a delicate state of health caused by laborious exer-
tions for the support of her family, has had 5 children, including twins." 66 One
patient, "her mind much excited," had had seven daughters and claimed her
husband had died two weeks before she entered the hospital. Another, age
forty-seven and among the oldest ever admitted, had had eleven children, of
whom only six were still living. She said she had recently been abandoned by
her husband, "an intemperate man." 67 For the women who had so many chil-
dren at home, both the respite from the harsh conditions of their daily lives
and the relative cleanliness and peacefulness of the Lying-in must have been
particularly welcome.

Hospital records also reveal women who had been beaten by their hus-
bands. One young woman, a recent immigrant, fearful and frequently deliri-
ous, had been told by "an old hag" that she would die in childbirth and her
baby would be given to strangers to be raised. Neither event occurred. 68
Enough women returned to the hospital for a subsequent confinement to indi-
cate that they had been satisfied by their experiences there. On the other hand,
Sarah Currier was "anxious to go out" two weeks after the birth of her baby,
complaining that she had not regained her strength, apparently thinking "she
wont [sic] get it here." 69 Several others left without permission from the at-
tending physician as required by the bylaws of the institution. Despite general
satisfaction, some patients clearly resented the strict regulations. 70

Women who went to the Lying-in Hospital must have wondered what
awaited them, for there was nothing comparable to it in New England. On
the whole, despite the rules and regulations and occasional complaints about
cleanliness, they found good care and sympathetic attendants who provided
shelter and decent food during the weeks of waiting, encouraged them
through labor, and gave advice and medical care as needed to mother and child
during the postpartum weeks. The physicians usually agreed to their desires
for special foods, particularly if they were ill following delivery. Thus, there
were orders such as "Desires salt fish, may have it," "wishes meat or broth,
may have weak mutton broth," and "may have lemonade to drink." 71 Of course,
we do not know how many requests may have been denied.

The first patient was Mary Connor, age twenty-one. Her marital status was
not indicated in the hospital records, which did note that she had been in
domestic service. The physicians ordered her "to exercise as usual and have
for diet plain, nutritious food.” Mary lived in the hospital for seven and a half weeks until her baby, a seven-pound girl, was born on December 8. Four days later she was allowed to sit up for an hour, and she gradually increased her activity until discharge on the 19th. She had the hospital to herself until December 1, when Maria Gregg, “domestic, age 19, has had one child,” doubled the patient load.

Mary Connor was relatively healthy during the weeks she awaited the birth of her child, but other women required treatment for problems ranging from the usual aches and pains of pregnancy to severe coughs, delirium, and

Boston Lying-in Hospital case report, 1832 (courtesy of the Boston Medical Library, Francis A. Countway Library of Medicine)
convulsions. Their hospital records reveal daily attention to their complaints and disorders, with particular regard for proper diet and prevention of constipation.

Although most were already resident in the hospital when labor began, a few arrived when they were experiencing frequent pains. “Sarah Oakes, age 29, domestic, has done housework to last evening. This morning in bed the waters came away after which [she] walked from her residence to the Hospital—a distance of three-fourths of a mile... baby born quarter past eight A.M.” Another “has walked today about eight miles and feeling some pain thought best to enter.” Two and a half hours later, her daughter was born.72

Poor women could be as modest as rich women. Roxanna Frost, age thirty-two, refused an examination until well into labor “when the parts were found somewhat dilated and membranes protruding.” She delivered an hour later.73 To avoid embarrassment to physician or patient, the nurse examined the women following delivery and reported her observations to Channing or Hale for his prescriptions. Thus, on March 8, 1838, “patient has (by report of nurse) a swelling on inside of thigh about the size of a dollar which is very painful”; on March 1, 1838, “nurse reports that there is an excoriation of the perineum, extending around the anus and vulva and downwards between the thighs.” The latter wound, caused by pressure of the child’s head, which had to be perforated in order to terminate the labor, was dressed with a cloth dipped in a dilute solution of sodium chloride and a bread-and-water poultice.74 Some domestic medical treatments, reminiscent of female midwifery, remained popular and were prescribed by medical men.

The procedures during labor and delivery at the Lying-in did not vary from those noted in Channing’s private practice or from those of other contemporary obstetricians.75 Patients usually delivered on the left side, but there were exceptions and some delivered on their knees. In most cases, neither Channing nor Hale examined vaginally until labor had been under way long enough for dilation to have occurred. If the amniotic sac was protruding but had not broken, they ruptured it with a fingernail, as was common practice. Ergot was administered for long labors, especially when contractions were not forcing the child through the birth canal. If convulsions threatened or occurred, the usual treatments were attempted: bleeding, blisters, sinapisms (mustard plasters), ice to the head, or antispasmodic drugs such as valerian and asafetida.

Instruments were used much less frequently at the Lying-in than in Channing’s private practice, however. In 173 cases from 1832 to the end of 1838, the years when Channing was on the staff, instruments were noted only five times.76 Poor women might be expected to have increased rates of nutritional
deficiencies and pelvic deformities and thus to require more instrumental deliveries. In several cases, labor continued for many days yet instruments were not used. Perhaps there was insufficient dilation to permit the safe application of forceps. Perhaps the physicians imputed greater forbearance to the women at the hospital. But Channing's private practice included poor women in complicated cases requiring obstetrical instruments, so it is difficult to compare the hospital patients with other patients in a meaningful way. In any case, none of the noninstrumented hospital patients died.

Rates of maternal morbidity and mortality at the Lying-in Hospital during Channing's tenure were lower than those he noted during his early years of practice, the only period for which there are consistent records. There were four maternal fatalities among the 173 deliveries at the Lying-in, one attributable to preexisting disease, the others to puerperal fever. In at least ten other cases, symptoms of infection were noted and the women recovered. Some instances of puerperal fever were extremely severe. One woman was clearly identified as Channing's patient and the records of her case did not flatter him. Her fast pulse, abdominal tympany, and extreme diarrhea could have been caused by infection or by physician error, for the placental membrane had not been entirely removed. A creosote solution, which caused much irritation, was injected into her vagina to reduce the offensive odors caused by rotting tissue. She also had a urethral fistula, which led to catheterization and subsequent vaginal infection. As if all this was not enough, the poor woman developed a severe infection of the parotid gland—mumps. Yet she recovered fully and was discharged from the hospital four and a half months after entering, nearly ten weeks following delivery of a stillborn baby.

This relatively successful record regarding puerperal fever is an important aspect of the early history of the hospital, since other maternity hospitals experienced serious epidemics and their reputations for high mortality rates were well known. It may be that the Boston Lying-in took more precautions. One thing that clearly favored it was the small number of patients present at any one time. For example, when Isabelle Johnson was diagnosed with peritonitis on February 19, 1837, there were no other patients in the hospital. She had already begun to recover by the 25th, although she was not discharged until March 18. Meanwhile, Anne Taylor entered the hospital on March 6 and Mary Tully on the 18th. Neither delivered until long after Isabelle Johnson had gone. Neither they nor the next patient developed disease, but Serena Dunnell, who entered on April 5 and delivered on June 9, was diagnosed with peritonitis on June 13. She too recovered. The next two entrants did not get sick. Thus, there were three cases following Isabelle Johnson with no sign of infection, then one moderately infected, and two that were not. Perhaps neither Johnson nor
Dunnell was infected by a virulent strain of the streptococcus, or perhaps each had sufficient stamina to withstand the disease.

A year previously, when the hospital was more crowded and seven women entered in a one-month period, there were four cases of and two deaths from puerperal fever. It was episodes and contradictions like these that added to physicians' inability to understand the infectious nature of puerperal fever or to decide how best to cure it. Channing addressed the Boston Society for Medical Improvement on the quandary, pointing out that "some bore bleeding well and were benefitted by it, one, which did not bear venesection was treated with sedatives and did well; fatal case was bled."

Infant mortality also was significantly lower at the Lying-in than in Channing's beginning practice, when 23 percent died, mostly at the Almshouse. At the Lying-in Hospital fewer than 11 percent either were stillborn or died shortly after birth. These statistics more than justified the founders' intentions, since their clientele was composed primarily of poor and destitute women similar to the Almshouse and Dispensary patients. The prolonged care received at the Lying-in, especially during the month prior to delivery, the relative cleanliness during and after delivery, and decent food and shelter during convalescence contributed to the successful record.

This does not mean that the hospital did not have its share of mistakes and tragedies. Some stillborn babies died because there was no way to foresee that the umbilical cord was too tightly wound around their necks. Others suffered trauma that might have been avoided if instruments had been used or used more promptly. But there were also stillborns successfully revived when cold spirits were "dashed" on them or they received artificial respiration. Three premature babies died, although the staff had covered them with flannel blankets and kept them in warm rooms. Each weighed less than four pounds.

What may have been an egregious error involved three babies born in the autumn of 1838. In each instance, the mother was not able to nurse and the infants were fed milk mixed with sweetened water. Within a few hours each began to show signs of great distress: twitching, fits, and paroxysms of pain. They also had unusually dark green stools. By the third case the house physician began to note the similarities with the two previous babies. The babies were treated with various compounds of ipecac, opium, and magnesium intended to relieve intestinal disturbance, as well as by frictions over the chest, cold cloths at the head, flannel coverings at the feet, and soap and oil enemas. Despite such apparently heroic efforts, two died. The autopsy of one revealed a full bladder distended with bile, stomach lined with thick, dark-colored mucus, the small intestine filled with meconium. Could contaminated milk or impure water have been the cause of death? It seems more than likely.
Many babies were diagnosed with ophthalmia (an eye inflammation), for which they were treated with silver nitrate and mild mercurial ointments. Many also had aphthea (or thrush, a fungal infection of the mouth and tongue), which was thought to be caused by poor digestion. These newborns received small doses of magnesia to purge the bowels. The increased incidence of these neonatal infections may have been due to infection of the birth canal or poor hygiene postpartum.

Hospital staff did everything they could to facilitate breast-feeding. Leeches were applied to painful and abscessed breasts. If a mother’s nipples were inverted, several methods were used: a breast glass, a breast pump, or, if neither was effective, an older, stronger infant was placed on the breast to suckle and stimulate the flow of milk. In almost all these cases, the physicians “discharged mother and child well.”

In the summer of 1838, Channing terminated his formal association with the Lying-in Hospital but remained many years longer as a consulting physician. He also decided to give up his appointment at the Massachusetts General Hospital, where he had been serving as one of three attending physicians, a post to which he was elevated in 1836. Late in the autumn, he sent a letter of resignation to the trustees. We do not know whether the letter was a formal statement or whether it contained some regrettable remarks. In January 1839 he wrote a second letter requesting that the prior one be destroyed and that he not be considered for the next annual appointment. It was a strange way of ending his association with the hospital.

We can only speculate about the reason for these almost simultaneous withdrawals from hospital service. Channing was over fifty years old and may well have found himself too widely committed or less willing to exert himself so strenuously. Perhaps he was experiencing another period of depression or was angry about something. In any case, he needed to pay careful attention to his income. There were extra expenses for Lucy, the daughter who was always sickly, and there was continuous concern about Ellery’s future. The two older daughters were still unmarried and he was responsible for them too.

Despite the mystery of his resignation from the Massachusetts General, Channing expected to be named one of the consulting physicians, since it was the custom to make those appointments from among the men once on the staff. To his surprise, his expectations were not realized. Instead, John Homans filled the next vacancy, though he had no previous association with “the house.” The episode was an embarrassment to some of the trustees who seem not to have realized what had happened. Two stopped Channing on the street to explain that he had simply been forgotten. Channing did not admit his
chagrin though he was keenly disappointed. Instead, he praised Homans as “an excellent physician and a personal friend,” which indeed he was. Equally inexplicable, the trustees’ minutes for February 10, 1839, included an expression of appreciation of Channing for his “long and faithful services,” which was never transmitted. Channing remained unaware of the recognition until a history of the hospital published in 1845 referred to the matter. It seems unlikely that, after being at the hospital from the very beginning, a fixture since its opening days, Channing should have been forgotten. A more plausible explanation is that he no longer had a champion in Jackson, who had retired two years previously. Or it may be that his tendency toward self-deprecation prevented his name from being considered, whereas the other physicians were more aggressive. Another possibility is that Channing’s increased association with obstetrics made him less desirable as a general physician.

In any case, he took the news philosophically, noting in his memoirs, “little a man does is remembered after he is dead.” This included his important service to the Massachusetts General Hospital. On the other hand, he continues to be remembered, long after death, as the founder and guiding personality during the early years of the Boston Lying-in Hospital.