The Stadsziekenhuis and its patients: Patterns in patient admission and mortality between 1867 and 1915 in Hoorn

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Image 1. The Stadsziekenhuis around 1900.[1]

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[1] Beeldbank Oud Hoorn, image number 0011797, https://www.beeldbank-oudhoorn.nl/cgi-bin/beeldbank.pl?ident=0011797&search=0011797&sort=14&veld=all&inword=1&display=gallery&istart=1 (seen on 12-04-2024).

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Introduction

Today, all sorts of people are admitted to hospitals and all sorts of people die in hospitals. Hospitals are seen as hubs of medical knowledge and expertise. They are places where a wide variety of treatments are offered for all sorts of diseases and other physical discomforts, and thus the locus for people from all walks of life to go to when they need medical attention. While Dutch hospitals enjoy a high level of trust today, this was not always the case, even in historical research.[2] Historically, hospitals have been depicted as institutions for the indigent, and as social institutions that one would only visit as a last resort, with limited or no therapeutic options available to patients.[3] Many historians have argued that European hospitals turned into medical institutions through a century-long process of medicalisation before the twentieth century.[4]

This thesis focuses on one hospital from the past, the Stadsziekenhuis in Hoorn and the function of this hospital as an institute. This hospital was established in 1867 and was in function until 1954, when it merged with another local hospital. During this time, thousands of patients were admitted. This thesis resolves around a part of those patients, namely the patients that were cared for in the Stadsziekenhuis between 1867 and 1915. A 37-year period between 1867 and 1915 is analysed in detail, with an 11-year gap between 1890 and 1900. The periodisation stems from the available source material, which are patient registers.

The central question is: 'Who was admitted into the Stadsziekenhuis and who died there, and how can patterns in patient admission and mortality throughout time be explained, also through the institutional lens of the hospital?'. By studying the characteristics of the patients, I examine the practice of a local hospital in the Netherlands at the end of the nineteenth and beginning of the twentieth century. By performing this study, this thesis also wants to shed light on the function of the hospital and whether or not a transition from a place of death to a place of health was visible in the Stadsziekenhuis. Was it a social institution meant as a shelter for the poor or was it a medical institution whose main aim was the successful treatment of its patients?

[2] F.J.P. van der Hulst, A.E.M. Brabers and J.D. de Jong, Barometer Vertrouwen in de Gezondheidszorg, https://www.nivel.nl/nl/zorg-en-ziekte-in-cijfers/cijfers-burgers-over-gezondheidszorg/barometer-vertrouwen (seen on 16-06-2024).
[3] Lindsay Granshaw, 'Introduction' in: Lindsay Granshaw and Roy Porter (eds.), *The Hospital in History* (London; New York 1989a) 1-18, there 1-2.
[4] Guenter B. Risse, Medicalization: Hospitals Become Sites of Medical Care and Learning (Conference paper, 2004) 1-25, there 2, 14.

Historiography

General trends

Three topics in the historiography are important for this research. The first includes debates regarding the hospital as an institution, the second debate is about what type of patients were admitted into hospitals in the past, and the third debate focuses on mortality rates and more specifically on the impact of hospitals on mortality rates. I will start by discussing hospital historiography in general, both in international and Dutch research.

The history of institutions, such as hospitals, prisons and asylums has been majorly influenced by the French philosopher Michel Foucault. In his *The Birth of the Clinic* from 1963, he argued that French hospitals can be pinpointed as the birthplace of modern hospitals. After the French revolution these hospitals went through a process of medicalisation which resulted in hospitals becoming sites of medical progress and teaching.[5] In the Netherlands, a substantial number of institutional histories have also been published in the medical history field. Many studies focused on the history of a particular institution, often the ones in larger cities such as Amsterdam, Rotterdam and Utrecht. They were mostly commissioned by the board of the hospital to commemorate a milestone in their existence, which led them to have a rather celebratory viewpoint, focused on the progress of the institution and the staff – mostly physicians – throughout their existence.[6] This tendency is also visible in international research. The rise of the social history of medicine meant a rejection of this older scholarship, which was characterised as 'written largely by doctors about doctors for doctors, and explicitly or implicitly it sang the praises of medical progress.'[7]

From the 1970s and 1980s onwards, the rise of social medical history resulted in a new wave of publications on the history of medicine, that challenged the idea of constant progress in the medical field. In both international and Dutch historiography, new actors and topics and previously overlooked aspects have come to light.[8] One of those new aspects in research is the

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[5] Michel Foucault, *The Birth of the Clinic. An Archaeology of Medical Perception*, transl. A.M. Sheridan (London 1973); Guenter B. Risse, 'Before the Clinic Was ''Born''. Methodological perspectives in Hospital History' in: Norbert Finzsch and Robert Jütte (eds.), *Institutions of Confinement. Hospitals, Asylums and Prisons in Western Europe and North America, 1500-1950* (Cambridge 1997) 75-96, there 75; Renzo Derosas and Cristina Munno, 'The Place to Heal and the Place to Die. Patients and Causes of Death in Nineteenth-Century Venice', *Social History of Medicine* 35:4 (2020) 1140-1161, there 1142.

[6] See for example A.F.G.V.M. Ypma, *Beter in Deventer. Gezondheidszorg en Deventer ziekenhuizen* (Deventer 2008); Annemieke Klijn, *Verlangen naar verbetering. 375 jaar academische geneeskunde in Utrecht* (Amsterdam 2010).

[7] Roy Porter and Andrew Wear, 'Introduction' in: Roy Porter and Andrew Wear (eds.), *Problems and Methods in the History of Medicine* (London 1987) 1-13, there 1.

[8] Benoît Majerus and Joris Vandendriessche, 'Introduction' in: Benoît Majerus and Joris Vandendriessche (eds.), *Medical histories of Belgium. New narratives on health, care and citizenship in the nineteenth and twentieth*

'nature of people's experience with the hospital and the role it played in their lives'.[9] Sociomedical historian David Rosner has also argued in favour of studying small community institutions in favour of large medical centres to truly understand how both patients and the majority of physicians experienced healthcare in the nineteenth and twentieth century, since many did not work in or were admitted to the large hospitals in capitals and other large cities.[10] The Stadsziekenhuis in Hoorn is one of those smaller institutions that could be exemplary for many healthcare facilities in Dutch towns and smaller cities and thus provide another perspective than the often researched hospitals of Amsterdam and Rotterdam.

Hospitals as institutions

Several historians have engaged with the topic of medicalisation and the shift from hospitals as social towards medical institutions. Several eras have been pointed out as the turning point in this transition or as accelerations or decelerations of medicalisation. Hillen, Houwaart and Huisman argue in their overview of medical history that the eighteenth century was the time when a 'new form of institutional healthcare' sprouted, where surgical and non-surgical patients were separated and chronic and uncurable patients were not admitted anymore. Yet, this was mostly the case in the larger European cities. Outside of those cities the hospitals remained institutions aimed at providing care for the poor. The situation changed in the 1830s, when hospitals became part of 'a system of urban public facilities', where local regents, architects, and physicians became more involved with healthcare.[11] Large and middle large cities started to build hospitals and increased the number of hospital beds. All these developments led hospitals to become medical institutions.[12]

Other historians pointed to the second half of the nineteenth and the beginning of the twentieth century as the turning point for hospitals. Historian Allison Nuttall found that in the Edinburgh Royal Maternity Hospital the change from 'a social purpose to a medical function' occurred only at the beginning of the twentieth century and for a different reason than had often been argued.[13] While the shifting role of hospitals was mostly explained by 'the development

centuries (Manchester 2021) 1-26, there 3; David Rosner, *A Once Charitable Enterprise. Hospitals and Health Care in Brooklyn and New York, 1885-1915* (Princeton 1986) 6.

[9] Rosner, *A Once Charitable Enterprise*, 6.

[10] Ibidem.

[11] H.F.P. Hillen, E.S. Houwaart and F.G. Huisman, *Medische geschiedenis: ziekte, kennis, dokter en patiënt, gezondheidszorg en maatschappij* (Houten 2018) 198-199.

[12] Ibidem, 100, 196-199.

[13] Alison Nutall, ''Because of Poverty brought into Hospital: . . .' A Casenote-Based Analysis of the Changing Role of the Edinburgh Royal Maternity Hospital, 1850-1912', *Social History of Medicine* 20:2 (2007) 263-280, there 277.

of antisepsis, professional nursing and surgery', this was not the case for the Maternity Hospital. There, Nuttall identified the 'changes in attitudes to child health and maternity care' as the explanation for the shift.[14]

Rosner also placed the transformation at the beginning of the twentieth century. When examining hospitals and healthcare in Brooklyn and New York, he found that 'the new system of hospital-based community healthcare was largely in place by 1910.' He characterized this new hospital model as 'a place where fear had been supplanted by hope, passive care by active treatment, diagnostic empiricism by medical technology and laboratory science, social homogeneity by social exclusiveness, and, not least of all, public charity by personal choice and responsibility for the quality of care received.'[15]

The Italian historical demographers Renzo Derosas and Cristina Munno looked at hospitals in Venice in the second half of the nineteenth century and found that the hospitals showed a 'dual nature, as places of shelter and centres for medical treatment'.[16] They also stress that the nature of hospitals differed, depending on the time and place.[17] These diverging findings show that the function of hospitals differed between time and place, and that there is a need to perform case-studies of particular institutions to show how these changes might have occurred in a city or town in the Netherlands.

Patient admission

In twentieth-century scholarship, the idea that nineteenth-century hospitals were places where people mostly died and where proper medical care could not be provided was dominant. Hospitals are depicted as filthy places where infectious diseases ran rampant, where uneducated staff was in charge and where the poor received charity, while others preferred to stay as far away as possible.[18]

Historians from the 1970s have argued that hospitals in the past had strict and selective admission policies, to in- and exclude certain groups. S. Cherry researched two hospitals in Norfolk and Norwich and argued that not social status and income were decisive for admission, but the hazard that the patient brought with them for the hospital. Hospitals wanted to prevent the spread of infectious diseases and prevent the admission of incurable cases. He found that

[14] Nutall, ''Because of Poverty brought into Hospital: . . .'', 277.
[15] Rosner, *A Once Charitable Enterprise*, 40.
[16] Derosas and Munno, 'The Place to Heal and the Place to Die', 1159.
[17] Ibidem, 1159-1160.
[18] Nadeche Diepgrond, Een poort naar de dood en verblijfplaats van 'ongelukkigen'? Een onderzoek naar de patiënten en sterfte in het Amsterdamse Binnengasthuis in de tweede helft van de negentiende eeuw (Masterscriptie Geschiedenis & Actualiteit, Radboud Universiteit, Nijmegen 2021) 10-11.

the hospitals wanted to prevent the admission of pregnant women, those suffering from infectious diseases and venereal diseases and children under the age of six.[19] Thomas McKeown argued the same for charity hospitals from the eighteenth century onward. Hospitals wanted to admit patients who they deemed curable, and especially preferred patients suffering from short-term illnesses.[20]

Recent research has to some extent revised the gloomy image that existed of eighteenth- and nineteenth-century hospitals, but still holds on to the assumption that the poor were hospitalised the most. Renzo Derosas and Cristina Munno have argued that there was no 'pivotal period in which charity gives way to medicine, care to cure, stigma to pride, the mortuary to the recovery room, the poor to the middle classes.'[21] There was no linear development of the hospital from a place where the poor died to a place where the whole of society was healed. However, they argued that in the nineteenth century many people were still afraid to go to hospital because of its reputation as a place where the chances of contracting disease were high and there was little hope of recovery.[22] Lindsay Granshaw also mentioned in *The Hospital in History* that many people were reluctant to go to the hospital because it was 'associated with pauperism and death.'[23] People who could be treated at home preferred this to hospitalisation.[24]

In contrast to these findings, Anders Brändström and Göran Broström, who studied Swedish hospitals, found that not only the poor found their way to the hospital by the end of the nineteenth century, but that there was also a sizable portion of patients from higher social classes. In fact, everybody except noblemen were represented in the patient population.[25] Nadeche Diepgrond, in her research on the Binnengasthuis in Amsterdam, also concluded that the patient population was more diverse than often assumed and that not only the sick poor were admitted to the hospital in Amsterdam, but that the patients were 'a reflection of the diversity of nineteenth-century society in Amsterdam'[26] In the last quarter of the nineteenth century, all kinds of people were admitted to the hospital, and they became even more diverse

[19] S. Cherry, 'The Role of a Provincial Hospital: The Norfolk and Norwich Hospital, 1771- 1880', *Population Studies* 26:2 (1972) 291-306, there 295.
[20] Thomas McKeown, 'A Sociological Approach to the History of Medicine', *Medical History* 14 (1970) 342-353, there 350.
[21] Derosas and Munno, 'The Place to Heal and the Place to Die', 1142-1143.
[22] Ibidem.
[23] Granshaw, 'Introduction', 1.
[24] Ibidem.
[25] Anders Brändström and Göran Broström, 'Life-Histories for Nineteenth-Century Swedish Hospital Patients: Chances of Survival', *Journal of Family History* 14:3 (1989) 195-209, there 198-199.
[26] Diepgrond, Een poort naar de dood en verblijfplaats van 'ongelukkigen'?, 49.

with time.[27] Derosas and Munno came to a similar conclusion, but with an important nuance in their research on nineteenth-century Venetian hospitals. They found that the patients were mostly 'elderly, poor and those who had little or no support at home.'[28] But they did emphasise that 'hospitals were not just shelters providing undiversified relief to the destitute.'[29]

Mortality and hospitals

In the historiography of demographic patterns, the epidemiological transition theory proposed by Abdel R. Omran in 1971 has been extremely influential.[30] This health transition entailed that mortality rates in Western countries were declining between 1775 and 1940 for all age groups. The most important cause of death shifted from infectious diseases towards degenerative and man-made diseases such as cancer. This resulted in a gradual shift from very high infant mortality rates towards a larger group dying at an older age.[31]

In his classic – or western – model, Omran argued that during the late eighteenth and nineteenth century mortality rates were gradually declining. The beginning of the twentieth century was a turning point. From then on mortality rates showed a steadier decline, while the morbidity also changed significantly. The fertility rates also gradually declined in these centuries.[32] Omran distinguished three phases in the mortality dynamics. The first was 'the Age of Pestilence and Famine', exemplary for the premodern period.[33] During this period, the mortality rates showed considerable fluctuations and were generally high, mostly due to wars, famines and pestilence. People mostly died between the age of 20 and 40. This was followed up by 'the Age of Receding Pandemics'.[34] During this period less people succumbed to infectious diseases, which led to an acceleration of the declining mortality rate. Life expectancy rose to 50 years. During the 1920s and 1930s, the decline stabilised during 'the Age of Degenerative and Man-Made Diseases'.[35] Diseases such as cancer and cardiovascular diseases

[27] Diepgrond, Een poort naar de dood en verblijfplaats van 'ongelukkigen'?, 38.
[28] Derosas and Munno, 'The Place to Heal and the Place to Die', 1142.
[29] Ibidem.
[30] Abdel R. Omran, 'The Epidemiologic Transition: A Theory of the Epidemiology of Population Change', *The Milbank Memorial Fund Quarterly* 49:4 (1971) 509-538.
[31] Evelien Walhout and Frans van Poppel, ''Eene statistiek naar de geloofsbelijdenis'. Onderzoek naar de samenhang tussen godsdienst en mortaliteit in Nederland, 1775-1940' in: Tom-Eric Krijger and Paul van Trigt (eds.), *Pandemieën en protestanten. De omgang met infectieziekten in protestants Nederland sinds 1800* (Utrecht 2022) 97-120, there 97-98.
[32] Omran, 'The Epidemiologic Transition', 534-535.
[33] Ibidem, 516.
[34] Ibidem.
[35] Ibidem, 517.

became the most important cause of mortality. The higher mortality of women and children that was exemplary in the past vanished during this period.[36]

Since then, other historians have pointed to national and regional differences which do not always support this health transition. For example, the decline in mortality from airborne diseases did not happen as fast as the decline of mortality due to infectious diseases spread by water, food and insufficient hygiene practices.[37] What exactly caused the declining mortality rates in the nineteenth and twentieth century has also been debated. One point of contention is the impact that hospitals and healthcare had on declining mortality rates. Several historians and demographers have developed theories and tested them with the help of case studies, resulting in different views on how these patterns of the health transition occurred and thus how mortality rates declined in the nineteenth and twentieth century and on how the life expectancy increased. Epidemics and endemic diseases caused fewer deaths during this period. A common argument, both in international and Dutch literature, is that people became wealthier and thus better nourished, which improved their health and therefore their susceptibility to these diseases. Others have pointed to medicalisation and public health measures that reduced the opportunities for epidemics to arise and for endemic diseases to spread.[38]

The most important spokesman for the explanation of the improvement of living conditions instead of the impact of medical interventions as the explanation for declining mortality rates is the British epidemiologist Thomas McKeown. Together with R.G. Record he studied hospitals in England and Wales in the nineteenth century and found that hospitals were mostly places where patients died. They argued that declining mortality in the second half of the nineteenth century was due to the improving standard of living, which resulted in better diets, and which led to a decline in deaths from tuberculosis and typhus. Of less importance were sanitary reforms and the changing relationship between infective organisms and humans. Improved medical therapies had 'a trivial effect' on the declining death rates.[39] In a publication together with R.G. Brown from 1955, they argued that well into the nineteenth century,

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[36] Omran, 'The Epidemiologic Transition', 517, 527; Theo Engelen and Marloes Schoonheim, 'Mortality in the Netherlands: general development and regional differences' in: Theo Engelen, John R. Shephard and Yang Wen-shan (eds), *Death at the Opposite Ends of the Eurasian Continent Mortality Trends in Taiwan and the Netherlands 1850-1945* (Amsterdam 2021) 82-97, there 82.

[37] Theo Engelen, *Van 2 naar 16 miljoen mensen. Demografie in Nederland, 1800-nu* (Amsterdam 2009) 120.

[38] Roy Porter, *The Greatest Benefit to Mankind: a medical history of humanity from antiquity to the present* (London 1999), 246; Theo Engelen and Marloes Schoonheim, 'Mortality in the Netherlands: general development and regional differences' in: Theo Engelen, John R. Shephard and Yang Wen-shan (eds), *Death at the Opposite Ends of the Eurasian Continent Mortality Trends in Taiwan and the Netherlands 1850-1945* (Amsterdam 2021) 82-97, there 82.

[39] Thomas McKeown and R.G. Record, 'Reasons for the Decline of Mortality in England and Wales during the Nineteenth Century', *Population Studies* 16:2 (1962) 94-122, there 121.

hospitals did not help to reduce mortality rates and improve public health. Instead, they were places that contributed to the spread of diseases through overcrowding and unhygienic working practices and thus actually harmed their patients.[40]

Several historians tested their theory. Anders Brändström and Göran Broström examined nineteenth-century Swedish hospitals. They found that patients with incurable diseases were also admitted. These patients often died in the hospital, but it is likely that they would have died with or without hospitalisation. In this account, they agree with McKeown that nineteenth-century hospitals can be regarded as gateways to death. Nevertheless, an important finding was that the majority of the patients were cured and left the hospital alive and lived for many years afterwards.[41]

Carolyn Pennington conducted further research into hospital care provided in Glasgow during the nineteenth century in order to test McKeown's conclusions once more. She supports McKeown's view that mortality did not decline due to hospital care. She argued that respiratory diseases contributed substantially to mortality decline, yet it was unlikely that this was caused by improvements in hospital care. The three infirmaries in Glasgow focused on surgical care, while the Poor Law sick wards 'were the place of last resort for those unable to gain admission to an infirmary ward or to pay for medical care at home.'[42] Pennington notes that the sick wards in poorhouses, where the poor resorted to for care before Poor Law sick wards were established, were unlikely to have played a significant role in the decline in mortality caused by respiratory diseases. The sick wards treated patients who were often in advanced stages of sickness and the nursing care was not of good quality yet. The lack of effective drugs and the failure to segregate patients facilitated the spread of disease. Furthermore, mortality caused by respiratory diseases was declining since 1870, prior to the improvements in the quality of the treatment in poorhouses. While significant technological advancements were made, the majority of these were surgical in nature and were primarily beneficial for the treatment of non-life-threatening conditions. Despite these surgical developments, diseases such as tuberculosis continued to claim many lives.[43]

Diepgrond found that in the second half on the nineteenth century mortality rates in the Binnengasthuis in Amsterdam were rising, thus substantiating the findings of McKeown that

[40] Thomas McKeown and R. G. Brown, 'Medical Evidence Related to English Population Changes in the Eighteenth Century', *Population Studies* 9:2 (1955) 119-141, there 125, 140.
[41] Brändström and Broström, 'Life-Histories for Nineteenth-Century Swedish Hospital Patients', 207.
[42] Carolyn I. Pennington, 'Mortality and Medical Care in Nineteenth-Century Glasgow', *Medical History* 23 (1979) 442-450, there 449.
[43] Ibidem, 444-448.

hospitals and new medical knowledge and treatments were not beneficial for mortality rates once more. She observed an increase in mortality rates between 1870 and 1890 in comparison to the previous decades in the Binnengasthuis, which could be attributed to the expansion of the city population, which resulted in a corresponding increase in the number of patients. The hospital was not ready for thousands of extra patients, which led to overcrowding. This caused the medical care to deteriorate in comparison to previous years.[44] The high rates were also due to the welcoming nature of the admission policy of the hospital.[45] Already in the 1970s, Cherry had also argued that mortality rates were rising in the second half of the nineteenth century in hospitals in England, and that this was also due to the fact that a growing population relied on the hospital for medical care.[46]

Diepgrond found that after 1890, a 'rather spectacular decline' set in.[47] Diepgrond attributes this decline to the medicalisation of the hospital and the improvement of institutional healthcare. Treatments were improved and new medical knowledge was implemented. In addition, the hospital was renovated and the new Buitengasthuis was built to treat patients suffering from infectious diseases. These developments led to the sharp decline in mortality rates. This is in line with McKeown's findings, who argued that it took a long time for medicalisation to have a positive effect on mortality rates.[48] She also supports this by pointing to the large decline in mortality in the surgical ward, where due to new methods and knowledge such as anaesthesia, asepsis, and antisepsis mortality was reduced. The surgical ward was also less likely to benefit from the decline in infectious diseases, strengthening the argument that medicalisation was the cause of the decline in mortality.[49]

Sources and method

By combining different sources and methods, I want to paint a rich picture of the patients and practices of the Stadsziekenhuis in Hoorn at the end of the nineteenth and the start of the twentieth century. The Stadsziekenhuis in Hoorn as a case study is relevant because even though the city was relatively small, it did host various social and religious groups. In size and characteristics, it does also not particularly stand out from other Dutch cities and towns, which makes the results fitting for comparative research in the future.

[44] Diepgrond, Een poort naar de dood en verblijfplaats van 'ongelukkigen'?, 22.
[45] Ibidem, 22, 50.
[46] Cherry, 'The Role of a Provincial Hospital', 305; Brändström and Broström, 'Life-Histories for Nineteenth-Century Swedish Hospital Patients', 202.
[47] Diepgrond, Een poort naar de dood en verblijfplaats van 'ongelukkigen'?, 21.
[48] Ibidem, 22.
[49] Ibidem, 25.

The most important source used for this thesis consists of the patient registers of the Stadsziekenhuis.[50] These span from 1867 to 1919, with an 11-year gap between 1890 and 1900. The patient registers contain several thousands of patients who were hospitalised in this period in the Stadsziekenhuis, spread over four book volumes, which all contained identical categories which were filled in by the hospital staff. The left pages of the registers include the name of the patient and the names of their parents and whether they were deceased or not, in addition to the birthplace of the patient. On the right page they recorded the religious denomination, marital status and if applicable the name of the spouse. In addition, the date of hospitalisation and the date they either left the hospital or passed away was written down, followed by the number of days they were admitted. The last column was reserved for comments, e.g. whether a patient had paid for their admission and how much, or their patient numbers from previous visits were noted, signifying that a patient had been admitted before.

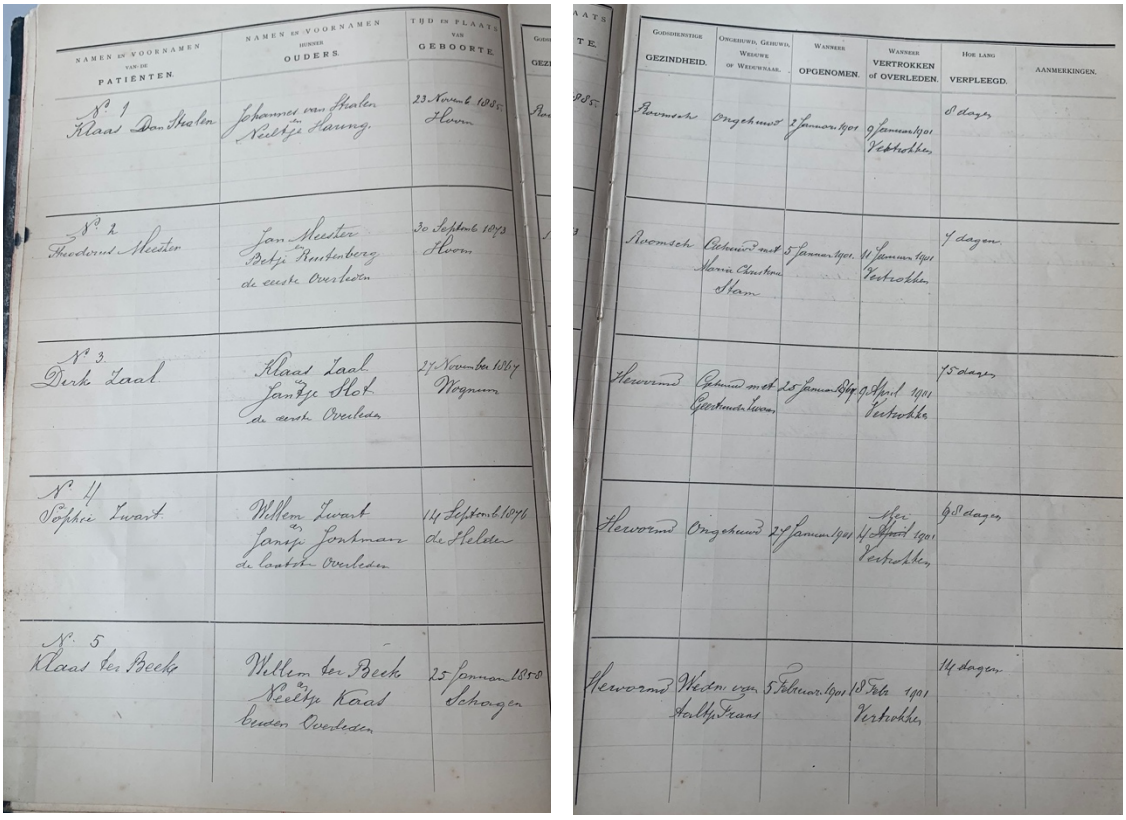

Image 2 and 3. A left and right page from the patient registers.[51]

All the aforementioned information has been collected for a total of 4,091 patients into a database by transcribing all the information that is provided in the patients registers about them into an Excel Spreadsheet. The database thus consists of all patients that were admitted

[50] Westfries Archief (WA), Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.
[51] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 399, patient register.

according to the patient registers between 1867 and 1915.[52] This database is used to find patterns in patient admission and mortality. By examining the data in Excel and by drawing up tables and graphs, the characteristics of the patients are visualised, analysed, and explained. These findings are compared to existing historical research on hospitals and mortality, to examine the similarities and differences.

Other archival sources that I used consist of ordinances, instructions, cover letters and notes of board meetings of the Stadsziekenhuis, to examine both the theoretical aims of the board and the practical implementation of these aims, for example in the recruitment of personnel and the admission of patients. This allows for the investigation of questions such as: what type of people worked in the hospital and were they educated or not? Or: What type of instructions and regulations did the staff have to follow and what were those instructions and regulations based on?

The source material offers valuable information, but also has limitations. A significant limitation is that the reason for admission, the diagnosis or cause of death were not noted, which makes it impossible to analyse what kind of diseases were treated and what caused the most deaths. Another difficulty is that not every column was filled in for every patient. When information was unknown, the columns were blank. Also, when a patient has already been hospitalised before, the columns related to the personalia of the patient were not filled in. On top of this, the staff was not always consistent in their methods of filling in the registers, which leads to incomplete results. At times all the information was noted for returning patients, which makes them not identifiable as returning patients. Additionally, it was not always mentioned when someone had been hospitalised before, which makes it difficult to ascertain how many patients had been hospitalised before. Despite of these limitations, the registers still offer a large amount of information about the patients. Additionally, because the entire patient population has been examined instead of a sample, it is possible to offer a complete overview of the patient population.

This thesis is divided into three sub-questions. The first question is mainly based on a qualitative analysis that resolves around the question whether the Stadsziekenhuis was a medical or a social institution. I focus on the organisation of the hospital and its goals, rules, activities, staff, and reputation, to sketch both the theoretical foundation and the practical workings of the Stadsziekenhuis as an institution. The second and third chapter offer a quantitative analysis of the patient registers of the Stadsziekenhuis between 1867 and 1915.

[52] Referred to as: Database Patient Registers Stadsziekenhuis Hoorn.

The second chapter focuses on the actual practice of patient admission, to show what type of patients were hospitalised. Patient characteristics in terms of gender, age, religion, birthplace, marital status and social class are studied, to uncover patterns in patient admission and explain them. The third chapter offers a similar approach. In this chapter, the mortality patterns of the patients are studied, to uncover who was most likely to die in the hospital and to explain these patterns. The findings in the second and third chapter are also used to analyse what type of institution the Stadsziekenhuis was at the end of the nineteenth and the beginning of the twentieth century and how this evolved over time.

1. The Stadsziekenhuis as an institution

1.1 Introduction

The first chapter focuses on the hospital itself instead of the patients. Using a variety of archival sources such as letters, minutes and ordinances as well as application letters, the foundation principles of the hospital are examined to analyse what type of institution the Stadsziekenhuis was and who it was aimed to be for. The theoretical policies, rules and goals are examined and when possible compared to their practical implementation. The daily practice is also investigated by examining the staff, board and physicians.

1.2 The establishment of the Stadsziekenhuis

Hoorn was the sixth city of North-Holland in size during this period. While the sixteenth and seventeenth century were periods of prosperity, the eighteenth century became a period of decline, when the role of Hoorn in international trade and local governance diminished. During the nineteenth century, the stature of the city had diminished, but it was slowly recovering and became a local trading centre for dairy products – especially cheese – and agricultural seeds. Especially the last quarter of the nineteenth century was a period when Hoorn gained significance as a regional centre.[53] Around 1867, Hoorn counted around 9000 inhabitants. In terms of religion, there were six church congregations, from which the Dutch reformed was the largest, followed by the catholic community. Hoorn also included a significant Jewish community during this period.[54]

Already in the fourteenth century, the first hospital was established in Hoorn, the Sint Jans Gasthuis. In the nineteenth century, it faced large financial difficulties. It served as a shelter for the poor and was permanently inhabited by seventeen *proveniers*, who had bought a lifelong board and lodging arrangement in the Gasthuis. The municipality was asked by the board to take over the responsibility.[55] This implied that Hoorn did not have a place for the treatment of the poor when they were in need of medical attention and was thus in need of a new facility.[56] The municipality managed the remaining capital of the Sint Jans Gasthuis until it provided them

[53] Geschiedenis van Hoorn, https://www.inhoorn.nl/over-hoorn/over-hoorn/historie/#:~:text=Hoorn%20werd%20een%20stad%20van,in%20het%2019e%20eeuwse%20Hoorn (seen on 24-03-2024).
[54] Josephus Martinus Maria Leenders, *Benauwde verdraagzaamheid, hachelijk fatsoen. Families, standen en kerken te Hoorn in het midden van de negentiende eeuw* (Amsterdam 1991) 6-8, 122.
[55] Piet Boon and Henk Saaltink, *Van Stad tot Streek. De geschiedenis van vier Westfriese ziekenhuizen* (Hoorn 1986) 7-8.
[56] Oud Hoorn, Ach Lieve Tijd 2: Zeven eeuwen Hoorn, zijn bewoners en hun zieken en armen, https://www.oudhoorn.nl/archivering/ach_lieve_tijd_hoorn/ach_lieve_tijd_hoorn_025.php (seen on 04-03-2024).

with sufficient funds to establish a new hospital. That moment arrived in 1862. The Stadsziekenhuis was officially opened in 1868, but one patient was also admitted in 1867.[57]

The hospital consisted of a women's and a men's ward, a smaller room for maternity, women suffering from venereal diseases and a room for the treatment of patients suffering from infectious diseases. The room for the treatment of patients suffering from infectious disease was very small and only provided room for three patients. Additionally, there were two separate rooms for patients who were paying for their own treatment.[58] Around 1900 the number of beds had increased to 50. There were four wards equipped for ten patients, and rooms that were set up for two, three and four patients. At that time, room was made for the treatment of eleven patients afflicted by infectious diseases through the establishment of a *Buitengasthuis*.[59]

1.3 Hospital organisation and admission

Hospitals were often upkept by the elites. They were charitable institutions and gave their rich benefactors a way to fulfil their Christian duty of sharing their wealth with the poor.[60] Thus, the lay influence was large in hospitals. Because of this, Granshaw has argued that only looking at patients and medical personnel is also not enough, since the founders were fundamental in shaping a hospital.[61] This is also clearly the case in Hoorn. The Stadsziekenhuis was run by five regents, who were appointed by the municipal council. The regents were in charge of 'the management and supervision over the medical care of the sick … and what else relates to that.'[62] The ordinance of the hospital listed that the regents should 'supervise the treatment and the nursing of those admitted in the hospital and all that concerns the medical and domestic services in the hospital.'[63] They also hired the majority of the employees. Their range of tasks was thus substantial and mostly consisted of running the institution in a proper manner.[64]

Every year, one of the regents was forced to resign. He was then immediately eligible for re-election. The regents themselves could propose two candidates to the municipality, who chose the board. The regents were free to hold as many meetings as needed, but were required

[57] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 16, minutes from the meeting of the municipal council from 20 July 1841; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 16, minutes from the meeting of the municipal council from 27 December 1866.
[58] Boon and Saaltink, *Van Stad tot Streek*, 9-11.
[59] Ibidem, 13.
[60] Granshaw, 'Introduction', 6-7.
[61] Ibidem, 4.
[62] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 13, ordinance of the Stadsziekenhuis of Hoorn, 1867, '*het beheer en toezigt over de verzorging en geneeskundige verpleging der zieken … en wat daarmede verder in betrekking staat.*'
[63] Ibidem.
[64] Ibidem.

to hold at least one meeting per month. Regents were also forced to resign when they missed four consecutive meetings. The decisions were taken by approval of the majority.[65]

Many historians have argued that until the twentieth century, hospitals were mostly aimed at helping the poor.[66] In the ordinance of the Stadsziekenhuis, written in 1867, the focus on the poor was also very clear: it was a charity institution. Admission was meant for 'the sick, wounded, maternity women and other poor people in need of medical and surgical care.'[67] It was also a local institution: only people who lived in the municipality of Hoorn for longer than three months were to be admitted. Additionally, all people suffering from infectious diseases and who were cared for in a *Godshuis*, a charity run by a religious organisation of any denomination, were also allowed to be admitted.[68]

While the aim of the hospital was to help the poor, they were not the only group that was allowed admission. People who were willing to pay for their own hospital stay were also admitted. When they were able to keep paying fourteen days in advance during their stay or otherwise provided another form of deposit that guaranteed that the costs for their hospitalisation would be paid, they were allowed to be admitted. There was a fixed rate for every day spent in the hospital. For impoverished patients, the costs were one guilder per day, which excluded medicine. Other patients had to pay 2.50 guilders each day.[69] Dutch labourers earned around 7 or 8 guilders per week in 1900, so this was a substantial sum.[70] The regents preferred the treatment of the poor over the ones who could pay for themselves. They ordered the physicians to treat as little paying patients as possible, since their treatment was not lucrative, and the hospital was meant for treatment of the poor who could not afford healthcare otherwise.[71]

Another category of people who was always allowed admission were people that had to be hospitalised by order of the chief of the police, when he deemed that the public order and safety was at stake when someone was not hospitalised. This occurred sporadically. In 1885, 22-year-old and unwed Henderina Mandemaker was also admitted by order of the police. She was admitted for 66 days and gave birth to a lifeless child.[72] It also seems that this did not

[65] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 13, ordinance of the Stadsziekenhuis of Hoorn, 1867.
[66] Granshaw, ''Fame and Fortune by means of bricks and mortar': the medical profession and specialist hospitals in Britain, 1800-1948' in: Lindsay Granshaw and Roy Porter (eds.), *The Hospital in History* (London; New York 1989b) 199-220, there 201.
[67] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 13, ordinance of the Stadsziekenhuis of Hoorn, 1867, '*zieken, gewonden, kraamvrouwen en andere genees of heelkundige verpleging behoevende armen*'.
[68] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 13, ordinance of the Stadsziekenhuis of Hoorn, 1867.
[69] Boon and Saaltink, *Van Stad tot Streek*, 13.
[70] Henriëtte Roland-Holst-van der Schalk, *Kapitaal en arbeid in Nederland* (Nijmegen 1977) 35.
[71] Boon and Saaltink, *Van Stad tot Streek*, 13.
[72] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, patient register.

always happen purely out of medical necessity. In August 1891, the chief of the police constrained the hospital to take in a man called Karel Westerman. He was 37 years old and born in Alkmaar, but at the time, he had no permanent residence. He was barely able to walk and used crutches. According to the chief, his presence on the public road caused a disturbance of the public order. Because of his disability he was not able to keep up with the pace of the rest of the traffic with resulted in him being surrounded by a large crowd of people. This was enough for the chief to deem the man eligible for hospitalisation.[73]

When people were able to provide the funding for their hospitalisation, the mayor and councillors authorized their hospitalisation. The physicians and the midwives were also allowed to recommend patients to the regents, who oversaw the admissions. Image 4 depicts an admission note written out for Willem Mantel from 1888, who had been allowed admission by the regents after being nominated by the city's physician. He had been hospitalised three years prior, and he was hospitalised again two times more within a year.[74]

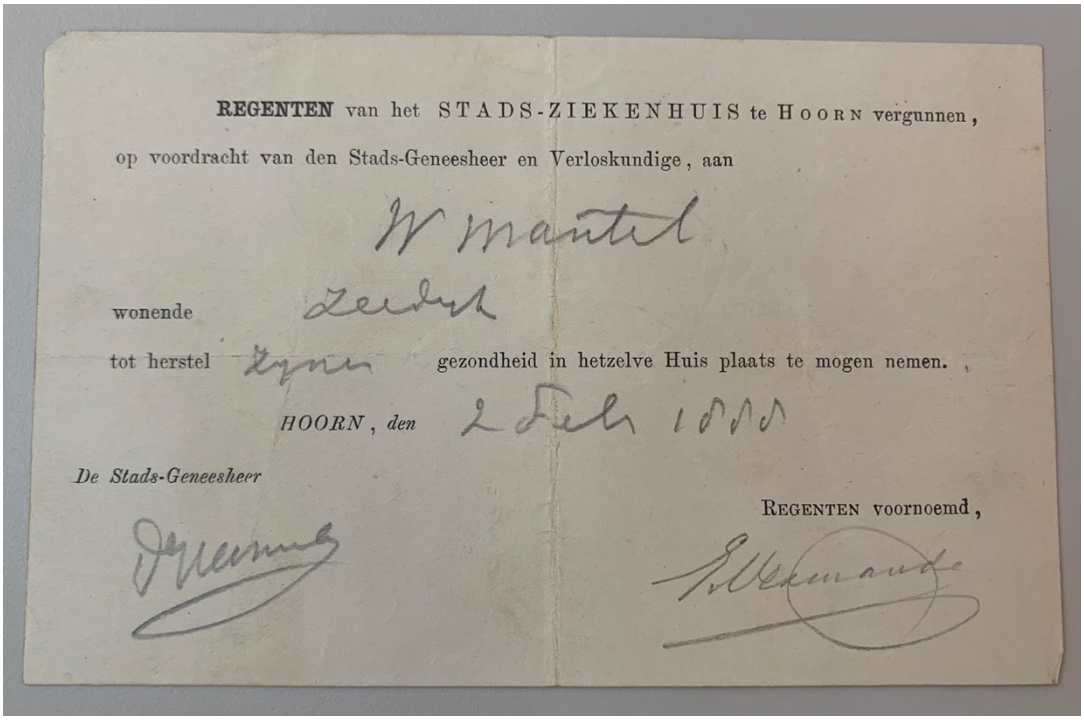
REGENTEN van het STADS-ZIEKENHUIS te HOORN vergunnen,
op voordracht van den Stads-Geneesheer en Verloskundige, aan
W Mantel
wonende Leiden
tot herstel Zijner gezondheid in hetzelve Huis plaats te mogen nemen.
HOORN, den 2 Feb 1888
De Stads-Geneesheer
REGENTEN voornoemd,

Image 4. The admission note for Willem Mantel.[75]

The regents did not allow everybody to be hospitalised, even when they were recommended by the physicians. This happened to a woman who suffered from the incurable consequences of a stroke. The regents refused to admit her to the hospital. They explained their

[73] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 185, letter from the chief of police Terpstra to the board of the hospital, 4 August 1891.
[74] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 398.
[75] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 398, nomination note, 3 February 1888.

decision under the pretext that this would be a violation of the ordinance, but they did not specify this any further.[76] In another case, a man who was also brought forward by the physician was not admitted, because his hospitalisation was not seen as urgent enough.[77] It is very likely that the incurable and chronic nature of their complaints was to blame for their rejection. The ordinance did not explicitly state that it was forbidden to allow incurable and chronic patients admission, but they are also not mentioned as the group for who the hospital was meant.

Patients were forced to leave the hospital when the physicians or midwives informed the regents that their hospitalisation was no longer necessary for their healing process. When people passed away in the hospital, they also had to be buried at the cost of the hospital when the family did not arrange a funeral.[78]

Around 1900 the patient population still mostly consisted of the poor according to one of the physicians, since the wealthy citizens and the growing number of people who were part of health insurance funds were treated at home.[79] It took until the 1920s for the Stadsziekenhuis to let go of their main focus on the poor as patients. In 1920, the ordinance was changed to the 'entire or partly free of charge nursing of impecunious or insolvent sick and maternity women'[80] instead of 'poor people in need of medical and surgical care'[81], which had been the basis of admission in the preceding decades. It was also added that hospitalisation was at most times only for patients 'suffering from presumably rapidly progressing (acute) diseases or deficiencies' and only when it was not possible to treat them in their own homes.[82] This change of focus visible in the ordinances is an indicator that the social purpose had redirected towards a medical one.

1.4 Modernisation

It appears the shift from a social towards a medical institution can be pinpointed to the beginning of the twentieth century in the Stadsziekenhuis. A possible explanation for this rather late shift is the slow pace of modernisation that took place in Hoorn. A part of the physicians in Europe had a hard time coming to terms with new inventions. It was e.g. only in the twentieth

[76] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 17, board meeting of 7 December 1868.
[77] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 17, board meeting of 7 September 1869.
[78] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 13, ordinance of the Stadsziekenhuis of Hoorn, 1867.
[79] Hans Moolenbel, 'Het Witte Kruis Afd. Hoorn', *Oud Hoorn* 39:2 (2017) 95-97, there 95.
[80] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 13, ordinance on het Stadsziekenhuis, 27 April 1920, '*geheel of gedeeltelijk kostelooze verpleging van onvermogende of minvermogende zieken en kraamvrouwen*'.
[81] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 13, ordinance of the Stadsziekenhuis, 1867, '*genees of heelkundige verpleging behoevende armen*'.
[82] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 13, ordinance on het Stadsziekenhuis, 27 April 1920, '*lijdende aan vermoedelijk snel verloopende (acute) ziekten of gebreken*'.

century that the use of instruments became a daily practice for most physicians. In the previous century, instruments such as the stethoscope had been introduced, but it took several decades for it to be accepted into the daily routine of most physicians. The benefit and use of instruments was oftentimes not clear and had to be proved through a collective learning process, which could take decades. The physicians were used to perform their trade mainly by classical anamnesis and physical examination, and some had a hard time coming to term with new discoveries and changing attitudes towards health and disease.[83]

Developments in hospital organisation and healthcare systems first bloomed in large European cities such as London and Paris. Hospitals turned into places of science and research. Effective healthcare was seen as a potential opportunity for large cities for economic development, to assure a healthy workforce.[84] This did not happen in the same way in different parts of Europe, since 'healthcare systems were connected to path-dependent political, economic and ideological national conditions.'[85] Yet, many European hospitals were still philanthropic or municipal institutions that were aimed at helping the poor and thus were not too keen on incorporating pioneering innovations. When changes occurred in the mid-nineteenth century in large Western European cities, they were mostly influenced by mass migration to industrialized centres, an increasing number of sick and wounded people caused by wars, and the revolutionary discoveries in medicine.[86]

Hoorn was not a large city and not an industrialized centre, so there was no mass migration that gave an incentive to organize more healthcare or the need to provide the labour force with healthcare to make sure there was a reliable workforce to boost the economy. Neither was the Netherlands in this period involved in wars that were driving forces for the development of hospitals.

The discoveries in the field of medicine were only slowly incorporated in the Stadsziekenhuis. An example is the practice of surgeries in the Stadsziekenhuis. The physicians and regents visited hospitals in Amsterdam and Rotterdam in 1891 to learn from them. Thus, there was clearly some willingness to improve. After their visit, the regents saw the necessity of an operating theatre. However, it took until 1900 before the construction of an operating theatre was started. Even after it was realised, the physicians kept performing operations in the sick wards instead of the operating room. The regents then decided to obligate the physicians

[83] Hillen, Houwaart and Huisman, *Medische geschiedenis*, 147-148.
[84] Paloma Fernández Pérez, *The Emergence of Modern Hospital Management and Organisation in the World 1880s–1930s* (Bingley 2021) 20.
[85] Ibidem, 20.
[86] Ibidem, 20-23.

to perform operations in the designated room.[87] This shows that while there was some willingness to modernise, the incorporation of new techniques and practices took time.

The treatment of infectious diseases was another field in which the Stadsziekenhuis was not as equipped as other hospitals. The hospital lacked the newest standards in relation to the treatment of these diseases. The state got more involved only around 1880, when the idea grew that state intervention was necessary to change and enhance the social order, which could be done by implementing new social legislation.[88] State intervention in relation to hospitals was mostly focused on containing infectious diseases. This was influenced by new knowledge regarding microbiology, which advanced the knowledge about the curing of infectious diseases. These new discoveries led to the implementation of preventive policies for infectious diseases all over Europe. Especially in large cities new hospitals were set up that met the new standards in healthcare, such as proper ventilation and lighting and the possibility to separate and isolate people suffering from infectious diseases from other patients.[89]

Hoorn did not live up to the new standards in relation to the treatment of infectious diseases. Medical inspectors, who worked for the provincial medical council, tried to intervene. A medical inspector from the province of North-Holland wrote in 1876 to the physician of the Stadsziekenhuis about his concerns regarding the way people suffering from infectious diseases were treated. He pointed to the necessity to set up separate rooms for sufferers of infectious diseases. He wrote that while the hospital in Hoorn was 'very good', there was no appropriate place for the treatment of infectious diseases. Although they were treated in a different room from the rest of the patients, this was supposed to be done in an entirely different building to avoid infecting other patients.[90] To battle this, the physician was tasked with persuading the regents to convince them of the necessity to set up a room for the treatment of infectious diseases away from the main building of the hospital.[91] Only in 1881 a new room was built for these patients outside of the main building.[92] This also shows that the regents were still very much in charge instead of physicians, and that their attitude towards modernisation was also substantial for the pace of progress.

There were more people from outside the hospital who tried to improve the modus operandi. G.J. de Boer, a general practitioner who had worked as a physician in the

[87] Boon and Saaltink, *Van Stad tot Streek*, 13; H.J. Roon, *Kroniek van Hoorn, 1850-1931* (Hoorn 1931) 16.
[88] Hillen, Houwaart and Huisman, *Medische geschiedenis*, 30.
[89] Pérez, *The Emergence of Modern Hospital Management and Organisation in the World*, 23.
[90] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 243, letter from the medical inspector of North-Holland A.J. de Bordes, 10 July 1876, '*zeer goed*'.
[91] Ibidem.
[92] Boon and Saaltink, *Van Stad tot Streek*, 10-11.

Stadsziekenhuis between 1902 and 1906, also tried to modernise the hospital but he was faced with little cooperation. He took seat in the municipal council and wanted to change the regulations to modernise the hospital. He argued that the fact that the *huismeester* and *huismeesteres* managed the nursing staff was problematic, especially when the nurses were medically educated. He argued that the organisation of the hospital was too old-fashioned and functioned more like an orphanage than a hospital. However, his suggestions were not taken into consideration by the other council members or the regents.[93]

The first two decades of the twentieth century were thus characterized by mostly failed or slowly realized attempts to modernise. This is a possible explanation for the late shift from a social towards a medical institution. The fact that there were no circumstances such as a vastly growing population or the experiences from the treatment of victims of war also caused there to be less incentives for changes. This was enhanced by the fact that the regents seemed not too adamant to modernise the hospital.

1.5 The staff

The staff of the Stadsziekenhuis consisted of two physicians. They were appointed as the city's physician and surgeon by the city council. They were in charge of taking care of the sick patients. The pregnant women were aided by the city's appointed midwives, under supervision and with the help of the city's obstetrician. They did not only have medical tasks, but were also charged with taking care of 'the interior, the use and the heating and lighting of the rooms, the daily schedule and all that belongs to the good order and cleanliness in the institution' in mutual agreement with the regents.[94]

The regents hired all the other staff. This consisted of a *huismeester* and *huismeesteres*, who oversaw the domestic service, the daily bookkeeping, and the nursing of the patients. They were often a married couple, but a father and daughter performed the task at the beginning of the twentieth century. They lived at the site of the hospital and were provided with free housing, fire, lighting, and healthcare, just like the other nursing staff. They had to take orders from both the regents and the physicians.[95]

The nursing staff of the Stadsziekenhuis was not medically trained during the second half of the nineteenth century. They consisted of domestic servants or other occupations that

[93] Boon and Saaltink, *Van Stad tot Streek*, 17.
[94] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 13, ordinance of the Stadsziekenhuis of Hoorn, 1867, '*de inrigting, het gebruik en de verwarming en verlichting der lokalen, de dagverdeeling en al wat tot de goede orde en zindelijkheid in het Gesticht behoort*'.
[95] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 13, ordinance of the Stadsziekenhuis of Hoorn, 1867.

had no medical background. Part of their work also included tasks related to that of domestic servants, since they were responsible for cleaning the building and doing the laundry. The nurses worked from nine in the morning until ten in the evening. After their shift, their job was overseen by *oppassers*, who acted more as guards during the night than caregivers.[96]

When the hospital opened in 1868, the position for male nurse had not been filled. Three men wrote an application to the board. The first was a 56-year-old unemployed man from the nearby city Enkhuizen, who had been a soldier and had worked in a hospital in the East Indies. A second applicant was a baker's assistant from Alkmaar. The third applicant was a 45-year-old man, also from Alkmaar, who was unemployed. The first man who had some medical experience was hired. Yet, this also shows that there was no abundance of educated and suitable applicants.

There were also no female applicants for positions in the kitchen and the domestic service, so another vacancy was placed in local newspapers, together with a vacancy for the role of nurse.[97] This led to a few applicants for the position of nurse, but only unemployed and uneducated women and mostly domestic servants applied. The only woman that brought in a reference from a former employer was hired for the position. She was a widow from Arnhem, so she had to move to the other side of the country for her new job. It is noteworthy that there were also women from Haarlem, Delft and Zwolle who applied for the job, but only one woman that lived in the region applied.[98]

Educated nurses were hard to come by.[99] Still in 1898 no trained nurses were employed in the Stadsziekenhuis. Yet, some did bring nursing experience with them. For one of the positions, two uneducated women sent in an application. One of them had worked as a nurse in a children's hospital for three years and had also worked in the municipal hospital in The Hague for over two years. The second applicant had worked for a period of five years in the Academic Hospital in Amsterdam, again without being trained as a nurse. The third woman was a domestic servant. She mentioned that while she was uneducated, she was still able to offer 'the best references, from several distinguished families.'[100]

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[96] Oud Hoorn, Ach Lieve Tijd 2: Zeven eeuwen Hoorn, zijn bewoners en hun zieken en armen, https://www.oudhoorn.nl/archivering/ach_lieve_tijd_hoorn/ach_lieve_tijd_hoorn_027.php (seen on 07-03-2024).
[97] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 17, board meeting of 3 March 1868; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 17, board meeting of 4 February 1868.
[98] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 17, board meeting of 17 March 1868.
[99] Boon and Saaltink, *Van Stad tot Streek*, 14-15.
[100] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 358, Application letter, 9 February 1898; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 358, Application letter, 7 February 1898.

The staff turnover was very high in the Stadsziekenhuis. Even recovering patients were sometimes asked to perform nursing duties. A woman called Aaltje Tros was hospitalised on 3 January 1868 at the age of 27. She was the third patient to be hospitalised after the hospital's establishment. After 45 days she was discharged from the hospital. She was again hospitalised on 1 May 1868 and treated for another 46 days. In the meantime, she had become a nurse at the women's ward. Another woman, Alida van Duin, who was hospitalised between 26 June and 1 August 1876 because she suffered from epilepsy, started working in the hospital's kitchen.[101] Sometimes even relatives were paid to care for their family. A girl suffering from smallpox was cared for by her mother, who was paid two guilders for her help.[102]

An explanation for the high turnover were conflicts with the *huismeester* and *huismeesteres*, who were a married couple. They were often accused of being too strict and unkind. The regents tried to intervene, but without much success. Even the surgeon did not come to the hospital in 1879 for a few days after a conflict with the couple. The *huismeester* passed away in 1889, which led the turnover to decrease. Yet, because so many job vacancies had been placed in local newspapers over the decades, the hospital lacked a good reputation as employer.[103]

These difficulties regarding the staff continued in the first decades of the twentieth century. There were constantly conflicts between the regents during hiring processes, since different regents oftentimes supported different candidates. There was also dissatisfaction among the staff. A male nurse submitted a piece of writing to a local newspaper in 1912, where he complained about the regents, the *huismeester*, and the food that was provided for the patients. His plea was partly effective because the food given to the patients was improved.[104]

The minutes from a meeting of the board of regents also shows that the uneducated nature of the staff led to difficulties. One of the physicians wrote them a letter to complain that a man suffering from smallpox was sent away by one of the nurses from the hospital, since he did not have a permission note from the regents for his hospitalisation. The man then left Hoorn, which meant that he could spread the disease to other places. The physician criticized the nursing staff for sending away a man potentially suffering from an infectious disease. The physician pointed towards an earlier case when people suffering from smallpox were sent from Amsterdam and Alkmaar to Hoorn. Hoorn had then complained to the inspector of the medical

[101] Boon and Saaltink, *Van Stad tot Streek*, 11; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, patient register.
[102] Boon and Saaltink, *Van Stad tot Streek*, 11.
[103] Ibidem.
[104] Ibidem, 17.

service, who sent the mayor of Alkmaar a letter to stop this practice. To battle this situation, he wanted the regents to allow the physicians to decide about hospitalisation in these cases, instead of having to wait for approval of the regents. The regents responded by stating that it was already allowed to take in people suffering from infectious diseases without explicit approval of the regents. Yet, the fact that the staff were not aware of or did not follow the existing policies shows that the ordinances were not always implemented.[105]

In 1915, the Stadsziekenhuis was allowed to train nurses. The physicians served as teachers.[106] This was the beginning of the presence of a properly trained staff in the Stadsziekenhuis, in contrast to the previous decades, when the staff consisted of untrained men and women, who were not able to help to modernise the hospital. This also possibly contributed to the slow progress from a social towards a medical institution.

1.6 Attitudes towards healthcare

According to Rutten, 'medical care was a commodity that, especially in the country regions, did belong to the normal consumption pattern.'[107] Yet, people tended to wait as long as possible before consulting a medic. He also stressed that medicalisation was largely influenced by economic and social circumstances and that people from poorer regions were less likely to consult a physician in case of health problems. This did not automatically mean that they were indifferent towards medical knowledge and healthcare, but that they had a different outlook on how to respond when health problems emerged. People from the Western provinces, including Hoorn, were more likely to be open to medical help from professionals according to Rutten.[108]

Yet, it seems that the culture regarding healthcare initiatives from the public was also not very alive in Hoorn. In 1875 a provincial branch of the Witte Kruis was founded in Noord-Holland, which was aimed at warding off infectious diseases and provide relief during epidemics. The goal was to establish a branch of the Witte Kruis in each municipality. In Hoorn, this did not happen until 1901. The goal of the department in Hoorn was also different from the initial goal of the Witte Kruis. It was aimed at better treatment of patients who were treated at home, instead of those suffering from infectious diseases. The initiative for the establishment of the branch was taken by one of the physicians of the Stadsziekenhuis. Before that time, there was also a branch of the Red Cross, which was eliminated because there was a shortage of

[105] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 17, board meeting of 7 November 1871.
[106] Boon and Saaltink, *Van Stad tot Streek*, 17-18.
[107] W.J.M.J. Rutten, 'Mortaliteit en medicalisering. Een regionaal-differentiële analyse van de sterfte zonder geneeskundige behandeling in Nederland (ca 1870-1900)', *Hollandse Studien* 17 (1985) 131-160, there 157.
[108] Ibidem, 157-158.

members.[109] Thus, it took some time for new initiatives coming from citizens in Hoorn regarding healthcare to emerge. Additionally, in 1877, only 3,4 of the population of Hoorn was insured for medical healthcare.[110]

Whether this lack of private initiatives also proves an aversion against hospitals cannot be substantiated. As Van Lieburg has stressed, it is hard to investigate the attitudes of patients towards hospitals. Newspapers can offer a glimpse of these attitudes. Van Lieburg found a newspaper article from 1858, where the author argued that after the Coolsingelziekenhuis in Rotterdam was operating five years, the common 'deep-rooted judgement of the people' against municipal hospitals had completely vanished.[111] Yet, other sources offer a different perspective. The physicians in the Coolsingelziekenhuis in Rotterdam were still complaining in the 1890s that the therapeutic effect of their treatment greatly diminished because patients tended to visit the hospital only in an advanced stage of their disease.[112] Fifteen years before that, another physician had suggested that their 'desire for freedom' led many people to prefer to stay home in case of sickness over being hospitalised. Only after much persuasion would they change their minds. Van Lieburg argued that medical advancements in the 1890s drove people to the hospital after all.[113]

The attitude of patients from Hoorn is also difficult to decipher. The large number of vacancies that were published and the dissatisfaction shown about the organisation of the hospital by a nurse in a local paper might have had a deterring effect on people. Patients also took it upon themselves to complain sometimes. Two people submitted an article to a local newspaper after the hospitalisation and death of their mother. The article was meant to explicitly notify other citizens from Hoorn about the 'unchristian treatment' that their mother had gotten in the Stadsziekenhuis by a 'Christian Love sister'. However, they ended their plea by thanking the *huismeester* for the care and love that he gave their mother during her stay.[114]

There is also evidence about the attitude of patients in the correspondence between physicians from Hoorn and the board. The lacking conditions regarding the treatment of infectious diseases in the hospital were known to the public. When there was an outbreak of

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[109] Moolenbel, 'Het Witte Kruis', 95.
[110] Bert van der Saag, streekarchivaris West-Friesland, Een mazelen-epidemie – Ziekenverpleging (vervolg), aflevering 10 (1977), https://www.beeldbank-oudhoorn.nl/pdfjs3/web/viewer.html?file=/publicaties/large/000335.pdf#search=Hoorn%20honderd%20jaar%20geleden&phrase=true
[111] M.J. van Lieburg, *Het Coolsingelziekenhuis te Rotterdam, (1839-1900): de ontwikkeling van een stedelijk ziekenhuis in de 19e eeuw* (Amsterdam 1986) 295.
[112] Ibidem, 325.
[113] Ibidem.
[114] Boon and Saaltink, *Van Stad tot Streek*, 15.

scarlet fever in December 1868, some people refused to go to the hospital, even though all people suffering from an infectious disease were allowed to be hospitalised free of charge. One of the physicians turned to the board of regents to suggest improving the rooms. The physician remarked how 'for example proper housemaids' refused to be hospitalised, since they would have to lay there 'so open and naked and so cold'.[115] To battle this, the physician suggested that curtains would be installed around all beds. The regents agreed and curtains were installed.[116] Decades later in 1900, one of the physicians again shared his frustration that there were still people who preferred not to visit the hospital because of prejudices against hospitals. This prejudice seems to have diminished in the following twenty years, because around 1920 the physicians from Hoorn noted that prejudices regarding the hospital were started to disappear.[117]

1.7 Conclusion

The Stadsziekenhuis in Hoorn was led by a lay group of regents. Together with two physicians and several untrained nurses and other untrained staff they worked to provide healthcare, predominantly for the poor. Changes in the modus operandi were implicated slowly. The utilisation of new knowledge and techniques was often a process that took up several years. This can be explained by the fact that there were no incentives to change their working methods, the staff was uneducated and therefore also mostly unable to modernise, and the regents showed not that much ambition to incorporate changes. The hospital also seems to have had a negative reputation, based on the large number of vacancies and the negative articles posted in local newspapers, and the statements made by the physicians. Only in the second decade of the twentieth century there was a clearer shift from a social towards a medical institution. What this meant for the population of patients in the hospital, is investigated in the second chapter.

[115] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 17, board meeting of 7 December 1868, '*b.v. fatsoenlijke dienstmeisjes … zoo open en bloot en zoo koud*'.
[116] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 17, board meeting of 7 December 1868.
[117] Boon and Saaltink, *Van Stad tot Streek*, 14, 18.

2. Patterns in the patient admission

2.1 Introduction

This chapter focuses on the patients who were admitted to the Stadsziekenhuis. The previous chapter implied that the ordinances and regulations, together with the slow modernisation and untrained staff led to a late shift from a social towards a medical institution. The actual practice and implementation of the regulations and whether the implied late transition can also be substantiated by evidence from the patient registers is examined in this chapter. Additionally, this chapter shows what kind of people were admitted in the Stadsziekenhuis between 1867 and 1889, and between 1901 and 1915 and how changes and patterns in the patient population can be explained.

2.2 The number of patients

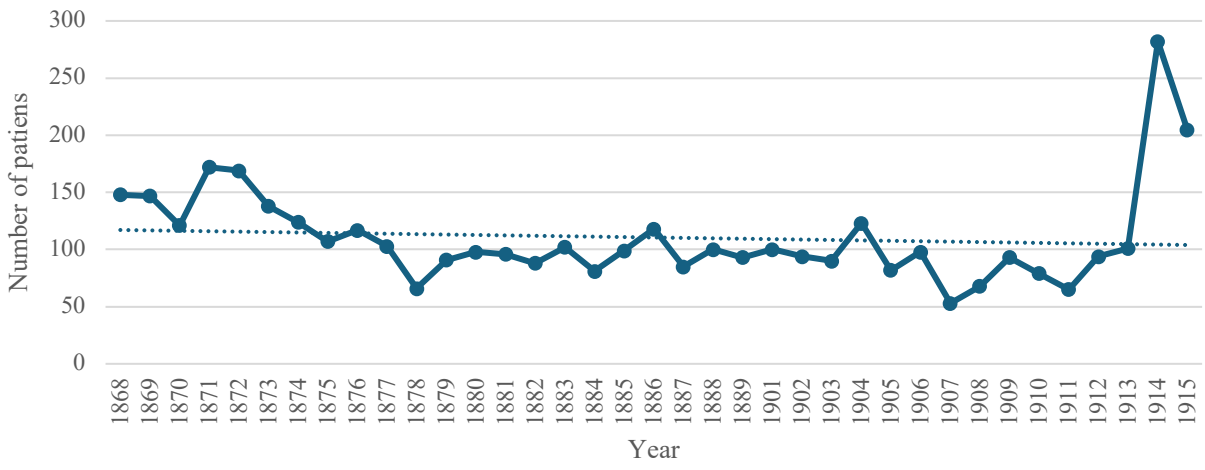
Over the course of the 37-year study period, the hospital admitted 4,089 patients. Figure 1, which depicts the number of patients per year, shows that there has been a slight downward trend in the annual patient admission. However, the number of patients was rather fluctuating. It is notable that the number of patients mostly decreased over time, as is visualized by the trend line in Figure 1. While the inaugural years of the hospital saw an average of approximately 150 patients per year, there was a notable decline in the number of patients admitted from 1872 to 1878, with only 66 patients being hospitalised during that last year. The number of patients admitted remained relatively stable at around 100 until 1889, before declining to a range of approximately 50 patients per year until 1900. In 1904, there was a brief increase in the number of patients admitted, but this was followed by a larger decline in the following years. Only in 1913 did the number of patients rise to 101. There was a sharp increase in 1914, but the number declined rapidly in 1915.[118]

The number of annually treated patients was very small compared to large hospitals such as the Coolsingelziekenhuis in Rotterdam, which was the second largest hospital in the Netherlands. There, between 2,186 and 5,238 patients were treated annually between 1870 and 1900, but those numbers also showed many fluctuations. However, a significant rise in the number of patients was visible in Rotterdam, in contrast to Hoorn, where this number declined.[119] It is difficult to compare the number of patients in Hoorn to the number of patients in other hospitals in Dutch cities of similar sizes, since the research on those hospitals often did

[118] Database Patient Registers Hoorn WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.
[119] Van Lieburg, *Het Coolsingelziekenhuis te Rotterdam*, 320.

not focus on the patients but instead on the physicians and the medical advancements that were made and therefore does not include these numbers.

Figure 1. The number of admitted patients each year between 1868-1889 and 1901-1915



Source: Database Patient Registers Stadsziekenhuis Hoorn

Some trends in the number of admitted patients can be easily explained, while others are more difficult to grasp. Even hospital boards did not always understand why the number of patients dropped or spiked in particular years.[120] One of the easy to explain spikes is the pronounced increase observed in 1914. This increase of patients was the result of the treatment of soldiers and Belgian refugees during the First World War. In 1914, 128 soldiers were admitted to the hospital, and 38 Belgian refugees. Upon exclusion of these cases from the total number, the number of patients would have been 116, which is consistent with the gradual but persistent increase that had commenced in 1912. In 1915, twenty soldiers and eighteen Belgian refugees were admitted. The number of patients would have been 167 in the absence of these so-called outlier groups and thus in line with the increase after 1912.[121]

The spike in 1904 can be explained by the influx of patients who were hospitalised in the Buitengasthuis, which was designated for patients suffering from infectious diseases. A total of 17 patients were admitted there, resulting in a 13.8% increase in the number of hospitalised patients during that year. Unfortunately, no information is available regarding the

[120] Van Lieburg, *Het Coolsingelziekenhuis te Rotterdam*, 320, 325.
[121] Database Patient Registers Hoorn WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.

specific infectious diseases from which the patients were suffering. The only exceptions are two comments in October 1883, indicating that two individuals were afflicted with smallpox.[122]

On occasion, there were instances when patients were not admitted throughout the whole year. One such period was in January 1906, when two physicians ceased their duties due to a conflict with the mayor of Hoorn regarding the implementation of new instructions. On 6 February 1906, patients were once again admitted to the facility. No patients were admitted for more than a month, which resulted in a smaller number of patients than in previous years.[123]

While the spikes in the data can be attributed to the influx of new patients, such as Belgian refugees, or the increase of patients suffering from infectious diseases, this is not so straightforward for certain drops in the number of patients. For example, in 1907 only 53 patients were admitted. This increased to only 68 patients in 1908 and 93 in 1909, only to decrease again to 79 and 65 patients in the subsequent years.[124]

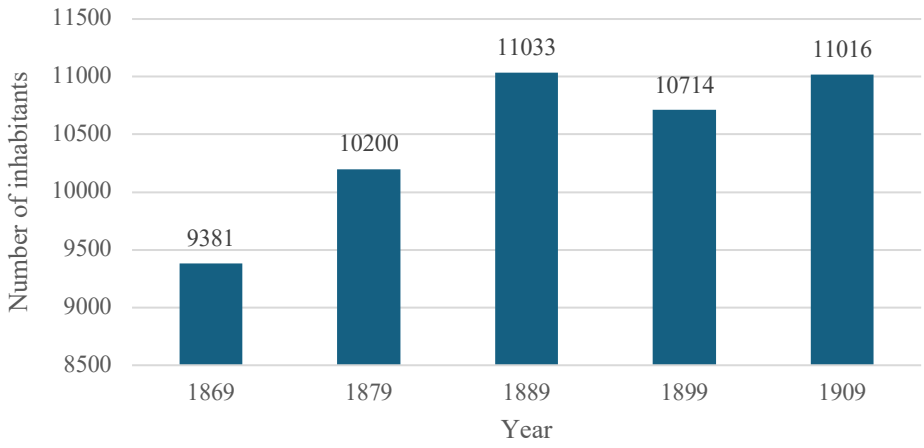
One possible explanation for the observed overall decline in the number of patients up to 1912 is the established of a new hospital in 1907, a private hospital with a liberal protestant character, called De Villa. The hospital catered to the higher classes, but was also open to less wealthy patients. While hospitalisation was 1 guilder per day in the Stadsziekenhuis, De Villa asked 1.50 guilders per day for people who could not afford to pay more.[125] Additionally, a catholic hospital was established in 1913.[126] However, this is not substantiated by the relative number of protestants patients in the Stadsziekenhuis. In 1907, 26% of the patients were protestant, while this had been 17% in 1905 and 21% in 1906. However, the fact that the hospital catered to the higher classes makes it less likely that patients from the Stadsziekenhuis chose to replace the Stadsziekenhuis where they could stay free of charge with a hospital where they did have to pay for hospitalisation.[127]

Another possible explanation for this phenomenon is the decline in the incidence of major epidemics following 1875, as described in the epidemiological transition theory.[128] This

[122] Database Patient Registers Hoorn; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.
[123] Boon and Saaltink, *Van Stad tot Streek*, 13; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.
[124] Database Patient Registers Hoorn WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.
[125] Ordinance of De Villa, https://geschiedenislokaalwestfriesland.nl/bronnen/verpleging-in-de-villa (seen on 17-06-2024).
[126] Oud Hoorn, Ach Lieve Tijd 2: Zeven eeuwen Hoorn, zijn bewoners en hun zieken en armen, https://www.oudhoorn.nl/archivering/ach_lieve_tijd_hoorn/ach_lieve_tijd_hoorn_028.php (seen on 12-03-2024).
[127] Database Patient Registers Hoorn WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.
[128] Hillen, Houwaart and Huisman, *Medische geschiedenis*, 11.

may have resulted in a reduction in the number of patients admitted to hospitals. Nevertheless, during the inaugural years of the hospital, only three beds were designated for patients afflicted with infectious diseases. This gradual increase continued until 1900, when there were eleven beds available.[129] It is therefore unlikely that the number of people hospitalised with infectious diseases has significantly declined over the years. It is challenging to corroborate the number of individuals admitted to the Stadsziekenhuis with infectious disease using the primary source material. The first mentioning of two individuals being hospitalised due to an infectious disease, namely smallpox, occurred in 1883. This is also the only instance in which the specific disease the patient suffered from is provided. The third patient register book, spanning the period from January 1901 to May 1914, is the only source that records the admission of patients to the Buitengasthuis.[130] It is impossible to determine the number of admissions of patients suffering from infectious diseases for the other years and thus to determine how this has changed over time and how this influenced the admission numbers.

Figure 2. Total number of inhabitants of Hoorn between 1869-1909



Source: Population Census

The number of individuals requiring hospitalisation at the Stadsziekenhuis declined over time. Nevertheless, the population of Hoorn increased from 9,381 in 1869 to 11,016 in 1909, as illustrated in Figure 2.[131] Although there was a slight decrease in the population in 1899, it

[129] Boon and Saaltink, *Van Stad tot Streek*, 10-11; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.
[130] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 399, patient register.
[131] Population Census 1869, population of Hoorn, http://www.volkstellingen.nl/nl/volkstelling/imageview/VT186901H4A/index.html (seen on 12-02-2024); Population Census 1879, population of Hoorn, http://www.volkstellingen.nl/nl/volkstelling/imageview/VT187909H4/index.html (seen on 12-02-2024); Population Census 1889, population of Hoorn, http://www.volkstellingen.nl/nl/volkstelling/imageview/VT188908H4/index.html (seen on 12-02-2024); Population Census 1899, population of Hoorn, http://www.volkstellingen.nl/nl/volkstelling/imageview/VT189904H4/index.html (seen on 12-02-2024);

is unlikely that this decline can account for the fluctuations in the number of admitted patients. Therefore, it is unlikely that the population size is a factor in the trends in the number of patients.

Another factor in the pattern of the number of patients might have been the attitude towards hospital care. The construction of additional hospitals in Hoorn is likely indicative of an increasing demand for hospital care. This also does not indicate that the inhabitants of Hoorn were reluctant to visit a hospital. This is in line with the findings of Willibrord Rutten. By examining the percentage of people who died without receiving medical attention, Rutten has argued that the cities in the Dutch coastal provinces were more open towards medical help from professionals, which included Hoorn.[132] The level of medical consumption were also high at the end of the nineteenth century in the Netherlands. Around 1870, 95% of the deceased had consulted a physician before their passing.[133]

Yet, Chapter 1 has shown that the slow modernisation, the gradual incorporation of new medical techniques, the persistent lack of trained staff, and the likeliness that the Stadsziekenhuis did not have a very good reputation may have prompted individuals to seek care at alternative facilities or in their own howes. The lack of modernisation may have resulted in the Stadsziekenhuis retaining its status as a hospital for the indigent, while the middle class, who was able to afford private hospitals, opted for these facilities instead of the Stadsziekenhuis. According to Van Lieburg medical advancements were important factors that convinced people to be hospitalised after 1890.[134] The lack of improvements in medical care might have been an incentive for people to seek medical help outside of the hospital. In addition, new hospitals emerged throughout the country that focused on specific patient populations, such as children or specific diseases or body parts. This specialised care may have also prompted people to visit other institutions than the Stadsziekenhuis.[135]

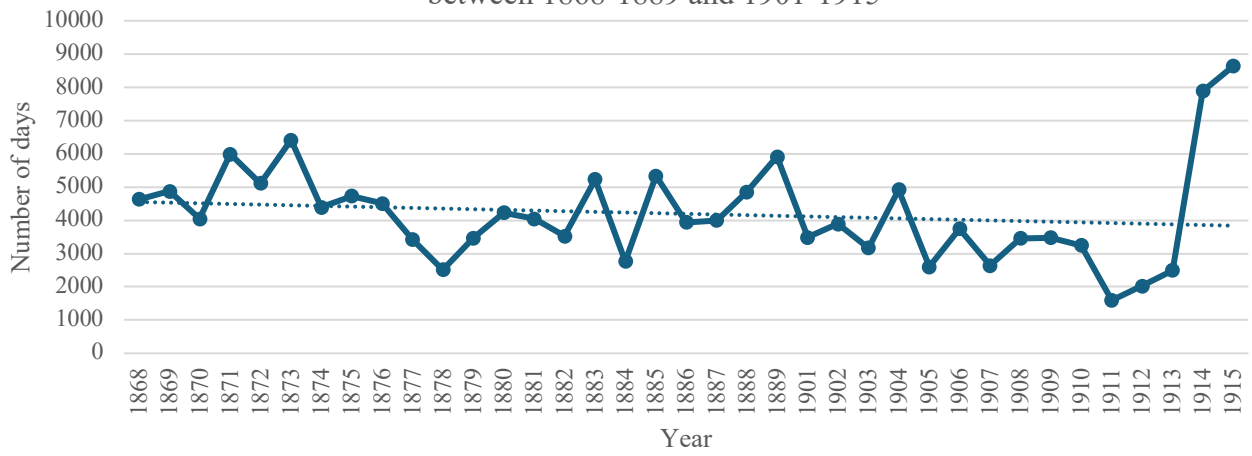
2.3 The hospital as a home

The total number of days spent by patients in the Stadsziekenhuis is presented in Figure 3. This closely aligns with the trend observed in Figure 1. Figure 4 presents the average number of days a patient spent in the Stadsziekenhuis. The trend lines added to Figure 3 and Figure 4 demonstrate that both the total number of days and the average number of days spent in the

Population Census 1909, population of Hoorn, http://www.volkstellingen.nl/nl/volkstelling/imageview/VT190902T1/index.html (seen on 12-02-2024).
[132] Rutten, 'Mortaliteit en medicalisering', 158.
[133] W.J.M.J. Rutten, 'Ongelijke behandeling binnen het gezin. Een onderzoek naar de leeftijdsverschillen in de kans op geneeskundige hulp in Nederland (ca. 1870-1900)', *A.A.G. Bijdragen* 28 (1986a) 245-265, there 259.
[134] Van Lieburg, *Het Coolsingelziekenhuis te Rotterdam*, 325.
[135] Hillen, Houwaart and Huisman, *Medische geschiedenis*, 202-205.

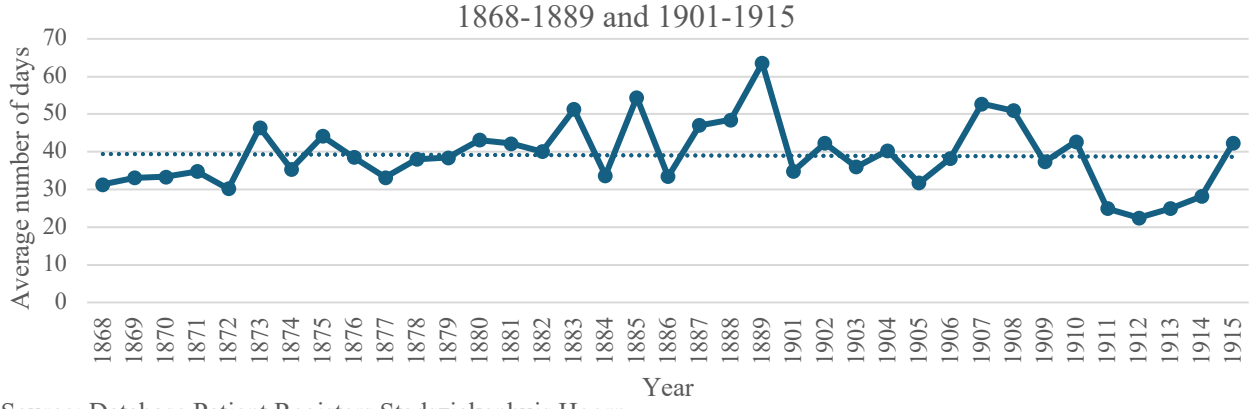
hospital were declining. Given the minimal change in the average number of days that these patients stayed, as illustrated in Figure 4, it is not surprising that the total number of days these patients stayed, as depicted in Figure 3, exhibited a more pronounced decline, given that the total number of patients also declined, as shown in Figure 1.

Figure 3. Total number of days patients were admitted in the Stadsziekenhuis between 1868-1889 and 1901-1915



Source: Database Patient Registers Stadsziekenhuis Hoorn

Figure 4. The average number of days spent in the Stadsziekenhuis between 1868-1889 and 1901-1915



Source: Database Patient Registers Stadsziekenhuis Hoorn

When comparing these numbers with the Coolsingelziekenhuis in Rotterdam, an opposite pattern is visible. In Rotterdam the number of patients increased, which also resulted in a larger number of total admission days.[136] A similar pattern between the Stadsziekenhuis and the Coolsingelziekenhuis is visible in the average days patients were hospitalised. In both the hospitals this number was declining. Yet, in Rotterdam it was declining in a much faster pace. The average days patients were hospitalised declined from 45.6 days in 1852 to 33.8 days

[136] Hillen, Houwaart and Huisman, *Medische geschiedenis*, 202.

in 1899.[137] When comparing these averages, the numbers in the Stadsziekenhuis do not seem extremely high or low.

One potential explanation for the observed decline in the average length of hospitalisation is the limited modernisation of the Stadsziekenhuis, as discussed in Chapter 1. New medical techniques and treatments were incorporated late and at a slow pace, which might have resulted in a limited decline in the number of days patients were hospitalised. Is has also been argued that new techniques and treatments were pull-factors for hospitals, so the lack of these techniques and treatments might have caused that the Stadsziekenhuis did not draw in new patients, which led to a decline in the total number of hospitalisation days.[138] Modernisation could also lead to longer hospitalisations, as was the case in the Coolsingelziekenhuis, where the average admission on the surgical ward become longer due to more impactful operations, from which patients had to recover for a longer time.[139] Because the operating theatre came into use later in the Stadsziekenhuis, it is possible that this effect of longer recovery after impactful operation did not happen in the Stadsziekenhuis and therefore the average days of admission also continued to decline.

Another explanation for the lower averages in Figure 4 in the first ten years compared to the high spikes in the 1880s is the fact that less patients were admitted that were suffering from infectious diseases. Those patients often deceased after being hospitalised for a shorter time than other patients, which could have lowered the average in the first decade. This would be in line with the health transition, that argues that the number of people dying due to infectious diseases declined in the last quarter of the nineteenth century.[140]

On occasion, individuals remained in the hospital for extended periods. David Rosner goes as far as to argue that patients 'often used the hospital as a home'.[141] He found that patients often stayed for over three months.[142] In Hoorn, 8% of the patients was hospitalised for more than 90 days. It thus seems that while a significant number of patients did stay for several months on end, this was not the standard. The division between men and women was fairly equal and there were more adults than children who stayed for extended periods of time.[143]

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[137] Van Lieburg, *Het Coolsingelziekenhuis te Rotterdam*, 326.
[138] Hillen, Houwaart and Huisman, *Medische geschiedenis*, 202.
[139] Van Lieburg, *Het Coolsingelziekenhuis te Rotterdam*, 326.
[140] Ibidem.
[141] Rosner, *A Once Charitable Enterprise*, 19.
[142] Ibidem.
[143] Database Patient Registers Hoorn; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.

The fact that 8% was hospitalised for more than 90 days implies that the Stadsziekenhuis was not merely a medical institution but also served as a place of refuge for individuals who had no alternative accommodation. The lack of intensive treatments might also have led to longer admissions. An example is the hospitalisation of Homme Raijer, who spent almost three decades in the hospital. He was born in Hoorn in 1844 and was unmarried. He was first hospitalised in March 1874 at the age of thirty. He was admitted to the hospital due to a wound on his leg. He remained in the institution for a period of 401 days before his departure. When the wound failed to heal, the physician sought the assistance of a professor working in Amsterdam. He was hospitalised in Amsterdam for four months in 1877. The Stadsziekenhuis paid a sum of 250.31 guilders for his stay there. Upon his return to Hoorn, he was admitted for an additional 58 days. In July 1879, he was readmitted to the hospital for another 5 years and 168 days. The regents wanted to dismiss him, but the lack of suitable accommodation available for Homme after his departure precluded them from doing so. In 1902, he was still hospitalised. This time, the regents were unwavering in their decision. He was compelled to leave the hospital. In consultation with the general poor relief, Homme was admitted to a diaconate house in 1901.[144]

There were more patients who were hospitalised for long periods of time in the Stadsziekenhuis. The 18-year-old, unmarried Anna van Kleef was admitted to the hospital in September 1880 and remained there for a period of 214 days. Subsequently, she was readmitted to the hospital in December 1885, where she stayed for a further 113 days. In February of 1889, at the age of 25, she was hospitalised again, this time for 1,461 days. She was discharged from the hospital in February 1893. Even in the twentieth century, patients occasionally remained in the Stadsziekenhuis for more than a year. An 85-year-old man named Hendrik Franciscus Vingerhoed was hospitalised for 1,174 consecutive days between August 1915 and November 1918.

More hospitals struggled with the admission of chronic patients who had no other accommodation. Hospitals relied on local charities to house the patients when they had no other place to go, so when they refused to cooperate, the hospital often had no other choice but to keep nursing the patient.[145] This is an exemplary struggle for hospitals during the time when their function was shifting from providing sanctuary for the poor – among them chronic patients – towards providing the entire community with medical care for acute health problems. Chapter

[144] Boon and Saaltink, *Van Stad tot Streek*, 11; Database Patient Registers Hoorn; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.
[145] Van Lieburg, *Het Coolsingelziekenhuis te Rotterdam*, 453-455.

1 has shown that on the one hand, patients were not admitted in the Stadsziekenhuis when they wanted to be treated for chronic health problems, such as the consequences of a stroke. However, some patients were admitted for years on end. It is likely that patients were not admitted for the treatment of chronic health problems, but when patients did not heal or displayed chronic complaints after their admission, they were not discharged when they had no access to other forms of healthcare, and thus that the hospital in that regard functioned as a shelter for these patients.

2.4 The characteristics of the patients

2.4.1 Sex

Looking at all the patients of the Stadsziekenhuis between 1868 and 1915, men make up 51.4% of the total number of patients, while women make up the remaining 48.6%.[146] Table 1 shows the distribution of men and women in the population of Hoorn, which shows that there was no clear and lasting surplus of men or women.

Table 1. Inhabitants in Hoorn according to the Population Census.[147]

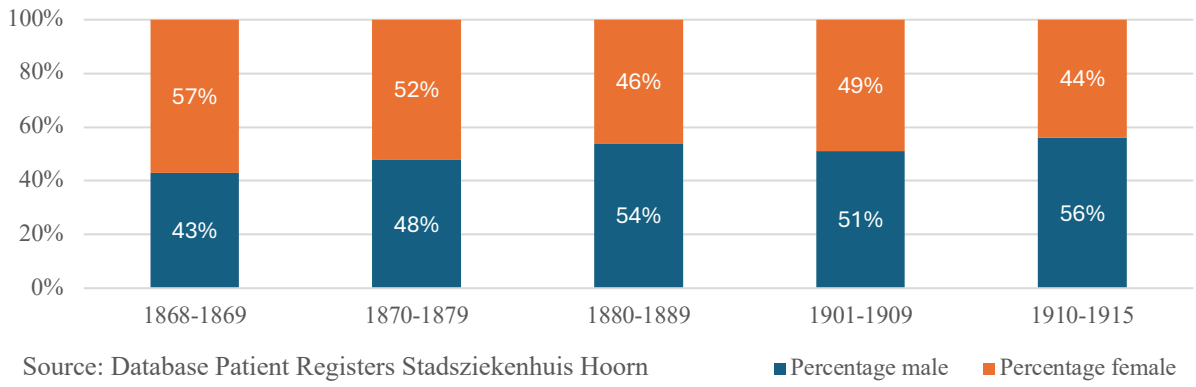
Year	Total number of inhabitants	Percentage male	Percentage female
1869	9381	50.25%	49.75%
1879	10.200	49.99%	50.01%
1889	11.033	50.91%	49.09%
1899	10.714	50.49%	49.51%
1909	11.016	49.39%	50.61%

However, if we look at the distribution between men and women in different decades, we see that the division changed over time. Figure 5 shows that when the hospital first opened, more women than men were admitted. The percentage of men grew rapidly in the next decades and more men than women were admitted by the 1880s. At the beginning of the twentieth

[146] Database Patient Registers Hoorn; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.
[147] Population Census 1869, population of Hoorn, http://www.volkstellingen.nl/nl/volkstelling/imageview/VT186901H4A/index.html (seen on 12-02-2024); Population Census 1879, population of Hoorn, http://www.volkstellingen.nl/nl/volkstelling/imageview/VT187909H4/index.html (seen on 12-02-2024); Population Census 1889, population of Hoorn, http://www.volkstellingen.nl/nl/volkstelling/imageview/VT188908H4/index.html (seen on 12-02-2024); Population Census 1899, population of Hoorn, http://www.volkstellingen.nl/nl/volkstelling/imageview/VT189904H4/index.html (seen on 12-02-2024); Population Census 1909, population of Hoorn, http://www.volkstellingen.nl/nl/volkstelling/imageview/VT190902T1/index.html (seen on 12-02-2024).

century the division was almost equal, but in the last few years, men were again the majority of patients.[148]

Figure 5. Percentile distribution of sex in the Stadsziekenhuis between 1868-1889 and 1901-1915



Source: Database Patient Registers Stadsziekenhuis Hoorn

If we compare the sex ratio of the Stadsziekenhuis to other hospitals, it becomes clear that the ratios between hospitals differed. The ratio in Amsterdam at the end of the nineteenth century showed an almost equal distribution between men and women, and so did the ratio of the Stadsziekenhuis during that time. However, when examining the ratio over different decades, the differences become visible. The data from the Stadsziekenhuis shows that in the 1870s more women were admitted, while more men were admitted after 1800. Whereas in Amsterdam the ratio was almost equal, in Hoorn from 1880 onwards men were more likely to be admitted to hospital than women.[149]

In the Coolsingelziekenhuis in Rotterdam, yet another distribution is visible. There was a clear surplus of men before 1890. Between 60 and 70% of all patients were male, even though children were also counted under women regardless of their sex. Then in the 1890s the division equalised. Especially the surgical ward showed a large surplus of men before 1890, which might have been caused by the fact that men were more likely to sustain injuries through their occupation.[150]

David Gagan and Rosemary Gagan studied charity hospitals in Canada, suggest a possible explanation for the male surplus they found in Canadian hospitals. They argued that there was a 'dominant culture of ward life' of young men, together with the fact that men were

[148] Database Patient Registers Hoorn; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.
[149] Diepgrond, Een poort naar de dood en verblijfplaats van 'ongelukkigen'?, 30-31.
[150] Van Lieburg, *Het Coolsingelziekenhuis te Rotterdam*, 322-323.

more likely to be indigent and thus receive healthcare in hospitals.[151] In addition, medical treatment may have been more male-oriented, and negative stereotypes about hospitals and the proximity of infectious diseases may have discouraged women from entering them. The number of women did not increase until gynaecological surgery improved, and hospital births became the preferred option. It was not until around 1914 that a parity between men and women was reached.[152] Willibrord Rutten, who researched who was most likely to receive medical care in the nineteenth century, came up with another explanation for the male surplus. He found that being a breadwinner was an important factor in the decision to seek out professional medical help. It was important to cure breadwinners as soon as possible to guarantee an income.[153]

It is unlikely that the hospital in Hoorn was aimed more towards men, as women had been the majority of patients in the first two decades of the hospital's existence. This also makes it unlikely that there were negative stereotypes that prevented women from going to the hospital. The fact that men were often the breadwinners is a possible explanation for the surplus of male patients. In certain years, for example in 1914 and 1915 when many soldiers were admitted, the surplus of men could also be expected.

2.4.2 Age

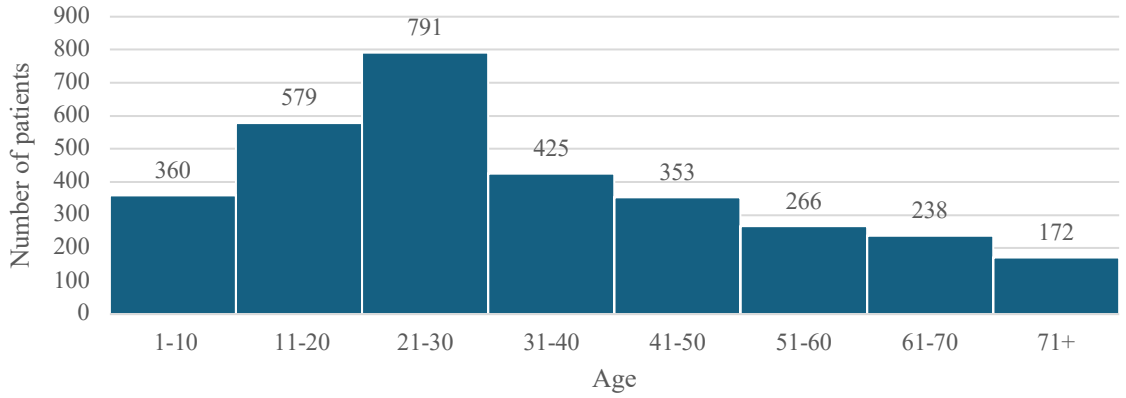
The age of the patients admitted to the Stadsziekenhuis is shown in Figure 6. This shows that the largest group of patients were those aged between 20 and 30 years, followed by the group of patients aged between 10 and 20 years. A total of 3,184 patients are included in Figure 6. For the missing 914 patients, the date of birth was not recorded, mainly because they were admitted to the Stadsziekenhuis before.[154]

It is noteworthy that the majority of patients admitted to the Stadsziekenhuis were under 30 years of age, namely 1,730 patients, in contrast to 1,454 patients above the age of 30. The results shown in Figure 6 are also consistent with the findings of Nadeche Diepgrond in her research regarding the Binnengasthuis in Amsterdam. The largest group of patients at the Binnengasthuis in Amsterdam was between 21 and 30 years old, which was also the largest group of inhabitants in Amsterdam. The number of patients aged over 30 gradually decreased

[151] David Gagan and Rosemary R. Gagan, *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada* (Montreal 2002) 17-18.
[152] Ibidem.
[153] W.J.M.J. Rutten, 'Volksgeneeskunde in sociaal-historisch perspectief. Limburg in het laatste kwart van de 19e eeuw', D*e Sociaaleconomische Geschiedenis Van Limburg/Jaarboek Van Het Sociaal Historisch Centrum Voor Limburg* 33 (1986b) 100-113, there 107-111; Rutten, 'Ongelijke behandeling binnen het gezin', 252.
[154] Database Patient Registers Hoorn; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.

in the Binnengasthuis, which also corresponded to the population of Amsterdam.[155] This decline in the number of patients over the age of 30 can also be seen in Figure 6. In each subsequent age group, the number of admitted patients becomes smaller. One possible explanation is that there were simply fewer people of old age in both Hoorn and Amsterdam.

Figure 6. The age of admission in the Stadsziekenhuis between between 1867-1889 and 1901-1915



Source: Database Patient Registers Stadsziekenhuis Hoorn

Rutten argued that children and elderly were least likely to be treated by a physician. Infants were the largest group to die without receiving medical attention. People between 15 and 65 were most likely to consult a physician. He found that adults were mostly involved in the medicalisation process and from an earlier period, followed by young adults. This medicalisation process meant that people relied on professional help instead of traditional medicine.[156] Elderly and infants continued to rely on folk medicine. These findings are consistent with the findings of Rutten that adults and young adults were most likely to receive medical care. Yet, the considerable number of children under ten does suggest that his argument that while children did receive less medical care, they were hospitalised and thus not only relied on folk medicine.

Rutten explains that physicians were not able to cure most diseases, which led people to have little faith in the medical profession. The idea that medical attention for elderly and children was mostly fruitless was particularly persistent in the countryside and among the lower social classes. Disappointing previous experiences with physicians attributed to this idea that it was useless to call for a physician when a child was sick. Adults were also more likely to survive their treatment than children, which again led people to believe that physicians were primarily

[155] Diepgrond, Een poort naar de dood en verblijfplaats van 'ongelukkigen'?, 32-33.
[156] Rutten, 'Ongelijke behandeling binnen het gezin', 245.

able to cure adults.[157] Additionally, Rutten made the previously mentioned argument that breadwinners were more frequently hospitalised. Social and economic factors were also important. The poorest in society were eligible for free medical help. Those who earned just above the limit for this help were less likely to consult physicians, since they had to pay for it.[158] Thus, in a city like Hoorn medicalisation was possibly more advanced which led people to have more faith in the medical profession and the fact that the Stadsziekenhuis catered to the poor for free might have also removed a barrier to hospitalise children.

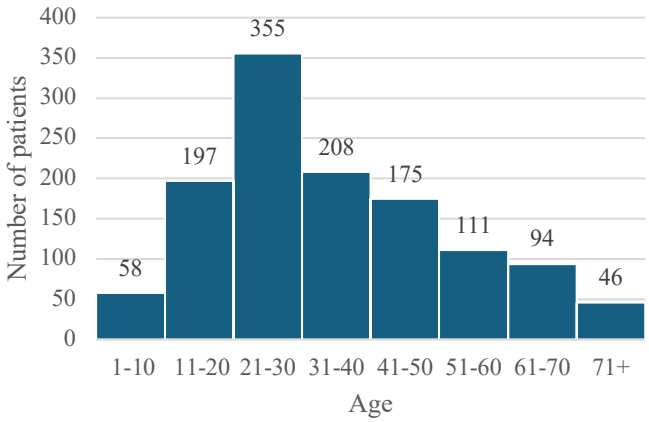
Figures 7a to 7d illustrate the changes in age composition over the decades. This shows that the number of children under 10 increased with time. The group between 11 and 30 declined in the 1880s, then showed a small increase between 1901 and 1909, only to display a small decrease again in the next six years. The patients between 31 and 40 also decreased significantly after 1880, but showed a small increase again between 1910-1915. The number of patients above the age of 50 displayed a large decrease in the 1880s, but then increased again. The number of patients between 51 and 60 decreased, while the number between 61 and 70 stayed the same and the number of patients older than 71 increased. Overall, during the first years there were more patients older than 30 than those under 30, but the numbers were close, as can be seen in Figure 8. This changed in the next decades, when those aged under 30 became the majority of people that were admitted to the Stadsziekenhuis.

The number of children and infants aged 0 to 10 in the Binnengasthuis in Amsterdam rose rapidly in the last quarter of the nineteenth century. Diepgrond points to the decline in infant and child mortality as an explanation for their increasing presence in the hospital. But there was also more attention being paid to the care of children in the Binnengasthuis, which was an important incentive for the admission of children.[159] A similar trend can be seen in the Stadsziekenhuis in Hoorn at the end of the nineteenth century. Figure 9 shows that the number of children at the turn of the twentieth century doubled in relation to the previous decades. It is therefore likely that without a large population increase in Hoorn, which is not the case in Hoorn as can be seen in Table 1, the explanation given by Diepgrond could also be valid for the Stadsziekenhuis in Hoorn.[160] The argument made by Rutten that with time more faith was put

[157] Rutten, 'Volksgeneeskunde in sociaal-historisch perspectief', 107-111; Rutten, 'Ongelijke behandeling binnen het gezin', 252.
[158] Rutten, 'Ongelijke behandeling binnen het gezin', 254-255, 258.
[159] Diepgrond, Een poort naar de dood en verblijfplaats van 'ongelukkigen'?, 33.
[160] Diepgrond, Een poort naar de dood en verblijfplaats van 'ongelukkigen'?, 33; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.

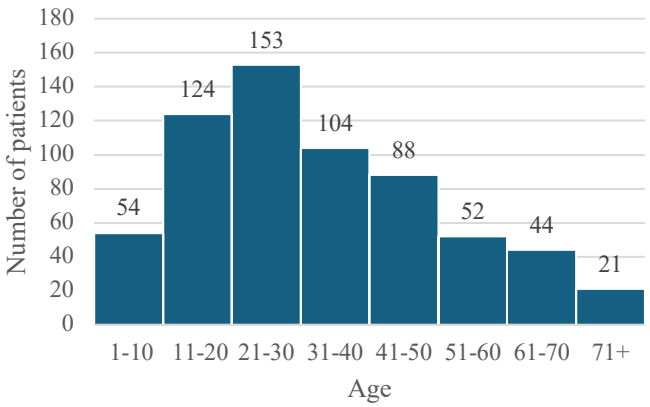
in the usefulness of providing medical attention for children might have also persuaded parents to bring their children to the hospital.[161]

Figure 7a. Age of patients admitted between 1868-1879



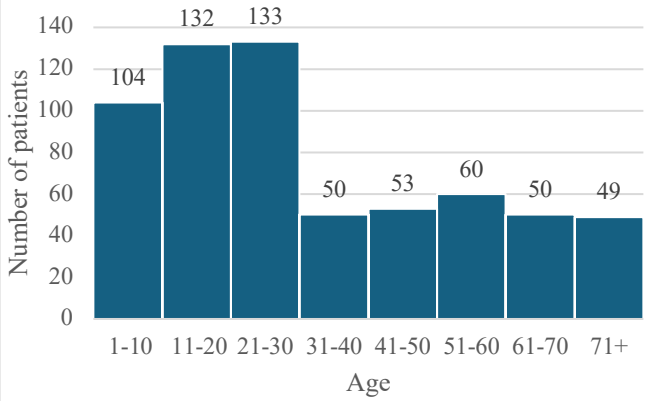
Source: Database Patient Registers Stadsziekenhuis Hoorn

Figure 7b. Age of patients admitted between 1880-1889



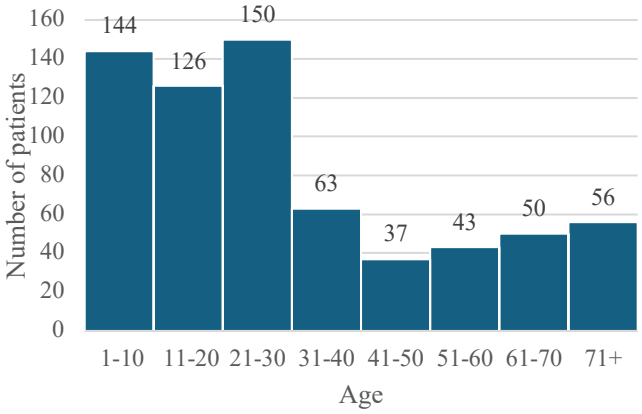
Source: Database Patient Registers Stadsziekenhuis Hoorn

Figure 7c. Age of patients admitted between 1901-1910



Source: Database Patient Registers Stadsziekenhuis Hoorn

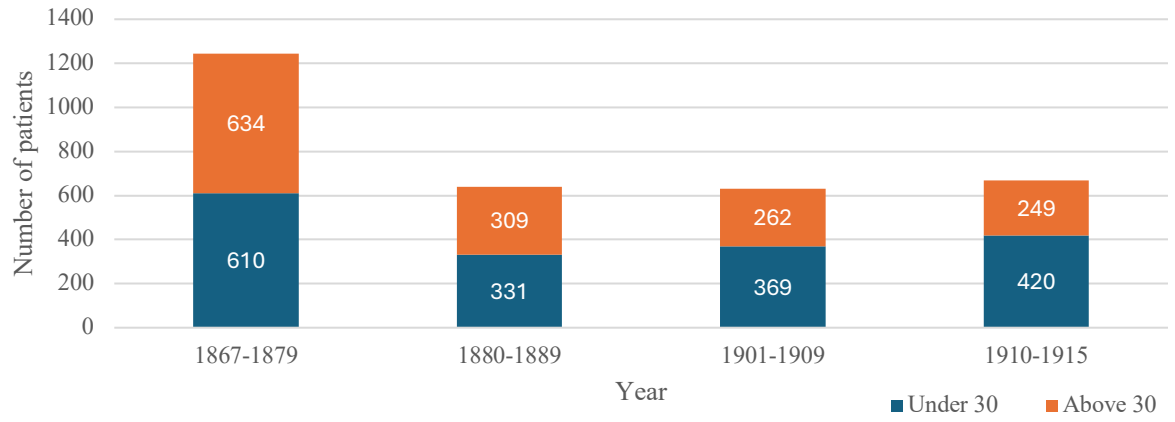
7d. Age of patients admitted between 1910-1915



Source: Database Patients Registers Stadsziekenhuis Hoorn

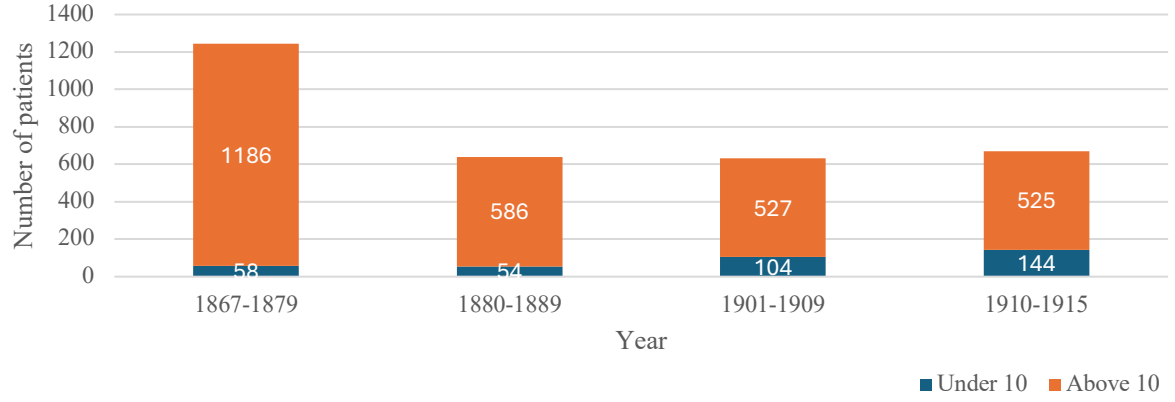
[161] Rutten, 'Volksgeneeskunde in sociaal-historisch perspectief', 107-111; Rutten, 'Ongelijke behandeling binnen het gezin', 252.

Figure 8. Number of patients below or above the age of 30 between 1867-1889 and 1901-1915



Source: Database Patient Registers Stadsziekenhuis Hoorn

Figure 9. Number of patients below or above the age of 10 between 1867-1899 and 1901-1915



Source: Database Patient Registers Stadsziekenhuis Hoorn

When it comes to the division between men and women, Table 2 shows that the admitted children were mostly boys, but the surplus of males disappeared between 1910 and 1915. This is in line with the findings of Levene, Reinarz and Williams of English hospitals in the eighteenth century, where around 60% of child patients were male.[162] They argue that this might have been due to the fact boys worked in more dangerous workplaces which could result in injury, were valued more because they brought in money or due to a cultural bias towards boys, while it might also have been true that girls were protected more and therefore cared for in the home.[163] The opposite is visible in the age group between 11 and 20 and those aged 21-30, where women were the majority between 1868 and 1901 and were then surpassed by men. The

[162] Alysa Levene, Jonathan Reinarz and Andrew Williams, 'Child Patients, Hospitals and the Home in Eighteenth-Century England', *Family & Community History* 15:1 (2012) 15-33, there 20.
[163] Ibidem, 26.

division between those ages 31-40 fluctuated throughout the decades, as was the case for the people aged above 71. The ages between 41 and 70 show a surplus of men throughout the period.

Table 2. The division of men and women in different age groups in the Stadsziekenhuis between 1868-1889 and 1901-1915.[164]

Period	**1868-1879**		**1880-1889**		**1901-1909**		**1910-1915**	
Age	**Men**	**Women**	**Men**	**Women**	**Men**	**Women**	**Men**	**Women**
0-10	33	25	32	22	61	43	70	74
%	*57%*	*43%*	*59%*	*41%*	*59%*	*41%*	*49%*	*51%*
11-20:	70	127	56	68	60	72	78	48
%	*36%*	*64%*	*45%*	*55%*	*45%*	*55%*	*62%*	*38%*
21-30:	120	235	72	81	52	81	97	53
%	*34%*	*66%*	*47%*	*53%*	*39%*	*61%*	*65%*	*35%*
31-40:	100	108	68	36	26	24	28	35
%	*48%*	*52%*	*65%*	*35%*	*52%*	*48%*	*44%*	*56%*
41-50:	106	69	53	30	34	19	20	17
%	*61%*	*39%*	*64%*	*34%*	*64%*	*36%*	*54%*	*46%*
51-60:	76	35	30	22	43	17	28	15
%	*68%*	*32%*	*58%*	*42%*	*72%*	*28%*	*65%*	*35%*
61-70:	59	35	22	22	29	21	32	18
%	*63%*	*37%*	*50%*	*50%*	*58%*	*42%*	*64%*	*36%*
71+:	17	29	5	16	23	26	24	32
%	*37%*	*63%*	*24%*	*76%*	*47%*	*53%*	*43%*	*57%*

2.4.3 Religion

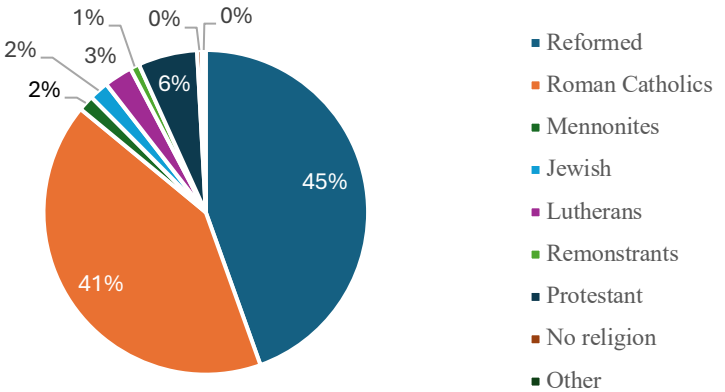
The Stadsziekenhuis was open to all religions and both protestants, catholics and Jews were admitted. As shown in Figure 10, the majority of patients were of reformed denomination, followed by catholics. Only 2% of patients were Jewish, while the remaining 12% were of other denominations, were not filled in or had no denomination. The remaining denominations were mainly protestant minorities.

The distribution of religious denominations in Hoorn in the census years 1869 and 1909 can be seen in Table 3. The largest part of the population thus consisted of people with reformed beliefs. Both the majority of patients and the majority of inhabitants of Hoorn were reformed. Throughout the period, approximately half of the inhabitants of Hoorn were reformed. The catholics were the second largest group with about one third of the population. The lutherans were the third largest denomination, but much smaller. The Jewish community in Hoorn was

[164] Database Patient Registers Hoorn; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.

the thirteenth largest in the Netherlands in 1860, but its numbers declined rapidly towards the twentieth century. The number of people whose religion was unknown or who did not belong to any denomination rose rapidly from 0.1% in 1869 to 6.3% in 1909.

Figure 10. Ratio of denomination of the patients between 1868-1889 and 1901-1915



Source: Database Patient Registers Stadsziekenhuis Hoorn

Table 3. The religious composition of Hoorn in 1869 and 1909 according to the Population Census data.[165]

Religion in Hoorn	1869	1909
Reformed	54.7%	50.3%
Roman Catholic	31.5%	34.4%
Lutheran	5.3%	3.6%
Jewish	4.1%	1.1%
Remonstrant	1.4%	1.4%
Other Convictions	2.9%	3.0%
Not filled in or none	0.1%	6.3%

In Diepgronds research on the Binnengasthuis in Amsterdam, she concluded that the religious division was also similar to the actual religious division of the city, as was the case in the Stadsziekenhuis. However, most Jews did not go to the Binnengasthuis in Amsterdam when they were ill. This is not surprising, as there was a Jewish hospital in the city. Diepgrond

[165] Population Census 1869, religious division in Hoorn, http://www.volkstellingen.nl/nl/volkstelling/imageview/VT186901H4B/index.html (seen on 12-02-2024); Population Census 1879, religious division in Hoorn, http://www.volkstellingen.nl/nl/volkstelling/imageview/VT187909H5/index.html (seen on 12-02-2024); Population Census 1889, religious division in Hoorn, http://www.volkstellingen.nl/nl/volkstelling/imageview/VT188908H5/index.html (seen on 12-02-2024); Population Census 1899, religious division in Hoorn, http://www.volkstellingen.nl/nl/volkstelling/imageview/VT189904H5/index.html (seen on 12-02-2024); Population Census 1909, religious division in Hoorn, http://www.volkstellingen.nl/nl/volkstelling/imageview/VT190903T1/index.html (seen on 12-02-2024).

mentions that although the Binnengasthuis was open to everyone, Jews might have preferred a Jewish hospital to ensure that they could follow their religious practices.[166] Jews in Hoorn did not have this opportunity because there was no Jewish hospital. There were two Jewish societies that supported the sick and helped pregnant and postpartum women, but Jews still visited the hospital. The decline in their number after 1880 can be explained by the decrease of the number of Jewish inhabitants in Hoorn.[167]

Table 4. The division of religion between men and women in the Stadsziekenhuis between 1868-1889 and 1901-1915.[168]

Decade	**1869-1879**		**1880-1889**		**1901-1909**		**1910-1915**	
Sex	**Men**	**Women**	**Men**	**Women**	**Men**	**Women**	**Men**	**Women**
Reformed	274	356	158	149	168	179	133	121
Roman Catholic	244	253	161	141	154	111	152	132
Lutheran	27	25	8	9	3	3	10	7
Jewish	22	20	3	3	3	4	4	4
Remonstrant	8	6	5	3	0	5	1	2
Other Convictions	13	20	8	4	1	3	7	8
Not filled in or none	115	119	175	132	81	84	77	68

Little has been written about the relationship between religion and willingness to seek hospital treatment. However, each denomination has specific views on health, wellbeing and how to deal with illness.[169] The fact that people of all religions attended the hospital, and that the religious breakdown of the patients did not differ significantly from the religious breakdown of the inhabitants of Hoorn, makes it likely that there were no people who avoided the hospital on religious grounds.

This is substantiated by the gender division of different denominations, which shows that throughout the decades, both men and women of different denominations were hospitalised, as can be seen in Table 4. In the period between 1869 and 1879 there was clear difference between reformed men and women, when 91 more women than men with a reformed

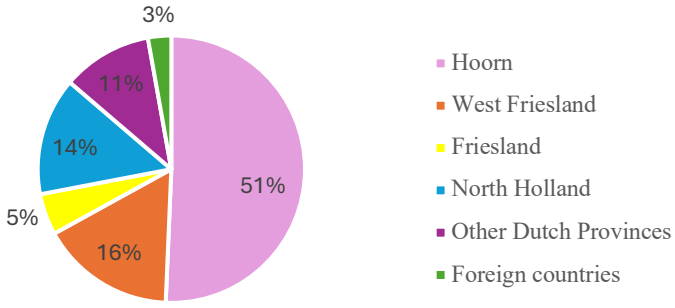
[166] Diepgrond, Een poort naar de dood en verblijfplaats van 'ongelukkigen'?, 33.
[167] Hoorn, https://jck.nl/joodse-gemeenten/hoorn (seen on 14-03-2024).
[168] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.
[169] Tom-Eric Krijger and Paul van Trigt, ''Opdat Ik u en uw volk met de pestilentie zou slaan…'. Het Nederlandse protestantisme in de context van epidemische ziekten' in: Tom-Eric Krijger and Paul van Trigt (eds.), *Pandemieën en protestanten. De omgang met infectieziekten in protestants Nederland sinds 1800* (Utrecht 2022) 7-18, there 9, 11.

denomination were hospitalised. Yet, this is the only substantial difference between men and women from one denomination in the entire period. The difference also disappeared in the following decades. Especially the lutherans, Jews and remonstrants showed very equal numbers between men and women. Catholic men were more likely to visit the hospital than catholic women from the 1880s onward, but the difference was not substantial.

2.4.4 Place of birth

The patients in the Stadsziekenhuis were born from many different places. It was possible to admit patients who did not live in Hoorn, but only if there could not receive medical help anywhere else. Requests for admission from neighbouring villages were therefore only accepted if admission was deemed necessary.[170] The focus of the hospital was to serve its own inhabitants, so the regulations of the Stadsziekenhuis determined that only patients who had lived in Hoorn for more than three months could be admitted. This is reflected in the distribution of the place of birth of the patients admitted to the Stadsziekenhuis. Figure 11 shows that 51% came from Hoorn and another 16% from other places in the region of West Friesland. Only 11% came from provinces outside North Holland and Friesland. It is important to note that these statistics refer to the place of birth, so it is not clear whether the patients were actually residents of Hoorn at the time of admission.

Figure 11. Place of birth of the patient population between 1868-1899 and 1901-1915



Source: Database Patient Registers Stadsziekenhuis Hoorn

The Binnengasthuis in Amsterdam had a similar rule that the hospital was meant for its own inhabitants. The majority of the patients lived in Amsterdam and a large proportion was born there at the end of the nineteenth century. Diepgrond mentions the possibility that the construction of new hospitals meant that people from the hinterland no longer had to travel to

[170] Boon and Saaltink, *Van Stad tot Streek*, 10; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 13, ordinance of the Stadsziekenhuis.

Amsterdam for medical care.[171] It is unlikely that the construction of new hospitals in the surrounding areas before 1889 led to fewer admissions from the neighbouring towns, as the number of patients born in West Friesland did not decline until that time. After 1889 it may have contributed to the decline in patients from the surrounding towns.

2.4.5 Social class

When it comes to the social class of hospital patients, hospitals have long been associated with the poor and thus the lowest social classes.[172] As early as the 1980s, studies began to challenge this view. David Rosner argued that in the last three decades of the nineteenth century, patients in hospitals in Brooklyn and New York were mostly skilled and unskilled labourers.[173] Gagan and Gagan have also noted that hospitals in Ontario, Canada, were treating wealthier classes as early as the 1890s.[174] In addition, the study of Swedish hospitals by Brändström and Broström showed that it was not only the 'industrious poor' who were admitted to hospitals, but also a large proportion of relatively well-off patients. The majority still came from the lower classes, but people from higher classes were also admitted.[175] They also found that the social make-up of many Swedish towns matched the social composition of patients in Swedish hospitals. This contrasts with the long-held belief that hospitals were mainly populated by the poor.[176] In the Binnengasthuis in Amsterdam, too, the end of the nineteenth century ushered in a time when not only the poor, but also the wealthier part of society wanted to be hospitalised when they needed medical attention.[177]

It is difficult to ascertain the social class of the patients in the Stadsziekenhuis, because the occupations of the patients are not mentioned. Only in the personalia of the first 176 patients is the occupation of 29 patients recorded. The largest groups were 'labourers' and domestic servants, both consisting of nine people. There are also clear indications that higher classes were also hospitalised in Hoorn. An apothecary clerk is mentioned, a tailor, two merchants and a trustee. The rest consists of a sailor, a cooper, a fisherman, two carpenters, a sailmaker, a tobacconist and a broom-maker.[178] In some hospitals, different classes were also nursed in different room, for example in Rotterdam and Groningen. It is not clear whether this also

[171] Nadeche Diepgrond, Een poort naar de dood en verblijfplaats van 'ongelukkigen'?, 28.
[172] Rosner, *A Once Charitable Enterprise*, 22.
[173] Ibidem, 3.
[174] Gagan and Gagan, *For Patients of Moderate Means*, 14.
[175] Brändström and Broström, 'Life-Histories for Nineteenth-Century Swedish Hospital Patients', 195.
[176] Ibidem.
[177] Diepgrond, Een poort naar de dood en verblijfplaats van 'ongelukkigen'?, 2.
[178] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.

happened in the Stadsziekenhuis, but the existence of several rooms meant for two, three or four patients makes this likely.[179] Thus, the different occupation and the existence of smaller rooms corroborated with the findings of other authors who have pointed to the diversity of social classes in hospitals.

People who could often not be treated in their place of residence were domestic servants who lived in the houses of the upper classes. According to Rosner, when domestic servants were ill, they were a burden to their employers, who would rather see them treated in hospital. Some domestic servants also felt that they were seen as a burden, which led them to agree to hospitalisation. It was also likely that they had no other place to stay apart from their employer, which also made hospitalisation necessary.[180] It is possible that this also happened in Hoorn, as nine domestic servants were hospitalised, and for five of them the hospitalisation was paid for. One unmarried domestic servant even gave birth in the hospital. Her hospitalisation had also been paid for.

2.4.6 Marital status

The marital status of most patients was known at the time of admission. Table 5 shows the distribution of marital status of all patients aged eighteen and older. The majority of the patients in the Stadsziekenhuis consisted of unmarried men and women, but there was also a large group of married men and women. 36% of the men and 31% of the women aged 18 and older were married. A smaller group was widowed, and very few were divorced.

Table 5. The marital status of patients above the age of 18 between 1867-1889 and 1901-1915.[181]

Marital Status	Men	Average number of days hospitalised	Hospitalised for 20 days or less	Women	Average number of days hospitalised	Hospitalised for 20 days or less
Married	322	36.6	50%	290	36	53%
Unmarried	424	39.2	45%	530	39.1	50%
Widowed	84	47.5	39%	91	38.6	51%
Divorced	2	19.5	50%	1	11	100%
Not recorded	53	27.3	51%	25	30.8	56%

[179] Boon and Saaltink, *Van Stad tot Streek*, 13; B.P. Tammeling, *Honderd vijfenzeventig jaar AZG: geschiedenis en voorgeschiedenis van het Academisch ziekenhuis Groningen* (Groningen 1978) 256; Van Lieburg, *Het Coolsingelziekenhuis te Rotterdam*, 329.
[180] Rosner, *A Once Charitable Enterprise*, 17-18.
[181] Database Patient Registers Hoorn; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.

Diepgrond found that more than 40% of the adult patients at the Binnengasthuis in Amsterdam were married. A smaller proportion were widowed or divorced. We may conclude that people did not go to the hospital simply because they had no family to rely on for care. For unmarried people in difficult situations, for example because they were pregnant with an illegitimate child or because they had contracted a venereal disease, the hospital was a place where they could receive care when they could not receive it from their own familial or social network.[182]

Dupree found that the marital status influenced the length of someone's stay in Glasgow during the nineteenth century. Married men and women stayed in the hospital for shorter periods of time. She argued that responsibilities towards their families might have encouraged married patients to return home as soon as possible.[183] As can be seen in Table 5, this pattern is also visible in Hoorn, but not as clear as it is in the sample of Dupree, where married patients were almost twice as likely to spent 20 days or less in the hospital. When looking at the married, unmarried and widowed patients, it becomes clear that married people in Hoorn stayed in the hospital for the shortest amount of time. Yet, the differences between the groups were minimal. The average number of days spent in the hospital and the percentages of patients who spent 20 days or less hospitalised was lower for married men than for unmarried and widow men. While this is also the case for women, the differences between married women in contrast to unmarried and widowed women are minimal. This might be explained by the fact that men felt more pressured to provide for their families than women did.

The divorced and unknown groups displayed the lowest averages in hospital stay and the highest percentages of a stay of 20 days or less. However, there were only two divorced cases, and the unknown group does not differ too much from the other groups.

2.5 Childbirth and children in the hospital

The hospital was not only a place of death and sickness, but also a place where children were born. The patient registers include a total of 155 children born in the Stadsziekenhuis. The average length of stay at the hospital for woman who gave birth was 21 days. 20 women gave birth to more than one child in the Stadsziekenhuis and a total of 38 women had been hospitalised before within the window of observation. Most of the women who gave birth to more than one child had two or three children born in the hospital. One woman, Catharina

[182] Diepgrond, Een poort naar de dood en verblijfplaats van 'ongelukkigen'?, 37-38.
[183] Marguerite W. Dupree, 'Family Care and Hospital Care: the 'Sick Poor' in Nineteenth-Century Glasgow', *Society for the Social History of Medicine* 6:2 (1993) 195-211, there 209.

Veenstra from Hoorn, gave birth to six children in the Stadsziekenhuis between 1874 and 1883.[184]

The marital status of the women who gave birth in the Stadsziekenhuis is remarkable. 52% of the women who gave birth were unmarried. Only 42% was married and 6% was widowed. In the Binnengasthuis in Amsterdam, 60% of the women who gave birth there was unmarried. Diepgrond offers a possible explanation for this. She argues that the overrepresentation of unmarried men and women in the maternity and the venereal disease ward probably went to the hospital for care because of a lack of understanding and support from their own relatives and friends.[185] It is likely that this was also the case in Hoorn. In Hoorn, between 1 and 2% of the children that were born were born out of wedlock in 1880, which was lower than the national average. This meant that there was likely a relatively strict sexual morale.[186] This strict morality might have led unwed pregnant women to experience less support from their immediate environment, thereby increasing the likelihood of them seeking assistance from the hospital for the delivery of their child. The average stay of women delivering a child was also relatively short in comparison to the average days other patients spent in the hospital, which makes it unlikely that all these women were admitted because of complications during their pregnancy and delivery.

Some women were also taken to the hospital together with their child.[187] Children were allowed to stay with their mothers if they were also hospitalised. In practice, this sometimes led to confusion. A boy named Pieter Hollander was admitted to the Stadsziekenhuis at the age of five. His mother had been admitted six days before him, and his father was no longer alive. The physician allowed the boy to be put in the women's ward with his mother, but the *ziekenvader* refused, saying that all men had to be put in the men's ward. The boy cried and screamed so much that the *ziekenvader* allowed him to be with his mother. Both mother and child were released from the hospital after the boy had been there for 28 days. However, Pieter died the day after they were discharged. After the incident, the physicians wrote to the regents asking them to change their policy and allow male children to be placed with their mothers. The regents replied that there had never been any objection to children under the age of six being placed with their mothers.[188]

[184] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.
[185] Diepgrond, Een poort naar de dood en verblijfplaats van 'ongelukkigen'?, 37-38.
[186] NIDI, *Bevolkingsatlas van Nederland. Demografische ontwikkelingen van 1850 tot heden* (Rijswijk 2003) 68.
[187] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.
[188] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 17, meeting of the regents, 7 November 1871.

As well as being born, children were also admitted as patients in their own right. Is has been argued that hospitals were not always seen as appropriate places for children and that children were excluded from admission since they were 'difficult to treat, potentially disruptive, often contagious, and required intensive nursing'.[189] Seidler also argued that only 'the unwanted, the abandoned, the orphaned, but hardly any truly sick children' were hospitalised.[190] Additionally, Kappelhof argued that physicians played 'no role at all' in the care of infants and toddlers during most of the nineteenth century.[191] He argued, like Rutten, that little was known about the common causes of death of infants and there was no trust in physicians in relation to the treatment of infants and children.[192]

Levene, Reinarz and Williams analysed hospitals in eighteenth-century England and have argued that this view is incorrect and that children were often admitted as patients, even though they were often out-patients instead of hospitalised in the hospital, which they argue was due to the prevailing sentiment at the time that children should be cared for in the home.[193] In the Stadsziekenhuis in Hoorn, children under 10 years made up 4.7% of all patients between 1868 and 1879. This increased to 8.4% between 1880 and 1889, to 16.5% between 1901 and 1909 and to 21.5% between 1910 and 1915. However, they are unsure whether children were hospitalised as a last resort or not. They do note that there were no children suffering from chronic diseases in the hospital, so those children were likely cared for in the home.[194]

It is not easy to determine the social class of the children who were admitted to the Stadsziekenhuis. However, it is unlikely that most of them were unwanted orphans, because they were quite often admitted together with a parent or a sibling. More than a hundred cases can be found in the patient registers of children being admitted together with a relative. The admission of family groups has had little attention in other research on hospital patients, but can be an important explanation for the presence of children in the hospital. Levene, Reinarz and Williams are some of the few authors who have considered the admission of family groups. They argued that when another family member needed medical attention, children were admitted at the same time out of convenience. They suggest that parents did not want to

[189] Levene, Reinarz and Williams, 'Child Patients, Hospitals and the Home in Eighteenth-Century England', 17.
[190] Eduard Seidler, 'An historical survey of children's hospitals' in: Lindsay Granshaw and Roy Porter (eds.), *The Hospital in History* (London; New York 1989) 181-198, there 182.
[191] A.C.M. Kappelhof, *Een groot hart voor kleine mensen. Kindergeneeskunde in 's-Hertogenbosch 1383-2000* (digitized version 2018) 15.
[192] Kappelhof, *Een groot hart voor kleine mensen*, 59; Rutten, 'Ongelijke behandeling binnen het gezin', 254-255, 258.
[193] Levene, Reinarz and Williams, 'Child Patients, Hospitals and the Home in Eighteenth-Century England', 24.
[194] Ibidem, 23.

hospitalise children without the supervision of another family member or that they did not want to face the burden of arranging the admission for a child on its own.[195]

In the Stadsziekenhuis, children were often admitted together with siblings or with their parents. Sometimes, whole families were admitted together. This occurred mostly in the 1870s, but it continued to happen in the following decades. Sometimes mother and child were registered together under the mother's name. The addition of 'and child' was then noted behind her name. This happened eighteen times. The child was not registered individually, so it is possible that they were not seen as patients themselves. In two occasions, the reason why an adult was admitted together with a child was clear from the notes in the register. In 1869, a 5-year-old orphan girl was admitted 'under supervision of the grandmother' for five days.[196] Her grandmother also paid for the hospitalisation. In the same year, another 4-month-old girl was admitted 'with and under supervision of the mother.'[197] Thus, it appears that children were indeed admitted under the auspice of a relative when they needed medical attention. It also seems that it was approved for children to be admitted together with their mother when they did not require medical help themselves. The child might have come along with their mother in the absence of care for the child in the case the mother was hospitalised.

Sometimes, both parents and their child were hospitalised together. On other occasions, siblings were admitted together and in other occasions one parent together with one or more relatives were hospitalised at the same time. It also happened several times that children were admitted more than once with a relative and then at other times alone. It is difficult to ascertain whether these children were hospitalised because they were also sick or because there was no place else to house them during the hospitalisation of their parents or because parents did not want to hospitalise a child alone, especially since no reason for admission is incorporated into the patient registers. An example is the case of the mother Aagje bon and her child Willem. They were hospitalised for thirteen days together with his brother Jan in 1868. Willem was two years old and Jan only five months. They father was also still alive. In 1871, Aagje and Willem are hospitalised again for eleven days, both this time without Jan. Seven months later Willem is hospitalised again, but this time on his own. This example shows that it was possible that children were deemed fit for hospitalisation on their own and were only admitted together when other family members were also sick.

[195] Levene, Reinarz and Williams, 'Child Patients, Hospitals and the Home in Eighteenth-Century England', 26-27.
[196] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, patient register.
[197] Ibidem.

2.6 The question of payment

While the hospital was mainly intended for the poorer sections of the population, there were also people who were admitted who had to pay for their admission. A total of 336 admissions were paid for by the patients or by someone else. Sometimes it is mentioned that the person, the family or another person paid for the treatment, but oftentimes only the word 'paid' was added. In the first decades, it was usually the municipality where the patient resided that paid for their hospital stay. 147 of the paying patients were soldiers that were treated at the Stadsziekenhuis in 1914 and 1915. They all paid 1.50 guilders per day.[198] All other paying patients were charged between 0.50 and 1.50 guilders per day. In the first year, it was also recorded when someone used a *sleepkoetsje*. This was a sledge that was used to transport patients from their homes to the hospital. Patients had to pay between 0.30 and 1 guilder for its use. After 1868, the sledge is no longer mentioned in the registers.

The number of patients who paid for their visit fluctuated. In the first two years after the hospital opened in 1868, 42.4% of patients were recorded as paying patients. Many of these were living in poverty in another town, so it is likely that their attendance was paid for by another municipality. Between 1870 and 1879, only 1.7% paid for their visit. In the next decade this declined to 0.8% and between 1901 and 1909 2.8% of patients paid for their visit. The last years between 1910 and 1915 were profitable for the hospital, as 21% paid. This can be explained by the fact that many soldiers were admitted then. The difference between the first few years and the following decades is difficult to explain. A possible explanation is that the hospital staff stopped writing down information about payments in the patient register. It seems unlikely that an institution set up for the poor would go from 42.4% paying patients to 1.7% paying patients in a few years, even when the regents preferred the admission of the poor over that of paying patients, as discussed in Chapter 1.[199]

A very different process took place in the United States. In Brooklyn and New York, rising costs were tackled by trying to get patients to pay for their stay. In 1899, 19% of patients at Brooklyn Hospital paid (part of) their stay. A year later this had risen to 35%. By 1910, more than half of all patients paid for hospitalisation.[200]The preferred admission of paying patients was also visible in Ontario, Canada. One inspector feared that the focus on paying patients was causing the hospital to lose sight of its original foundation of caring for the sick poor. The

[198] WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.
[199] Boon and Saaltink, *Van Stad tot Streek*, 13.
[200] Rosner, *A Once Charitable Enterprise*, 82-83.

paying patients were given the best rooms, while the poor were placed in less desirable parts of the hospital, which did not improve the quality of their care.[201]

In the Venetian hospitals studied by Derosas and Munno, the number of paying patients was unknown, but they believed that the number was likely small. A contemporary source, a Venetian nobleman, wrote in 1859 that many people who could afford it preferred to be treated in their own homes over being hospitalised. Conditions in the hospital were worse than in the homes of the upper classes, and they relied on their own familial or social network to look after them when they were ill.[202]

After 1880, not only the indigent poor, but also the working class and bourgeoisie came to the hospital for medical care according to most authors.[203] More and more people saw hospitalisation as a right. This was reinforced by the introduction of health insurance. According to Porter, this also led to the transformation of the hospital from a charity towards a medical institution.[204] The slow and late industrialisation of the Netherlands and the autonomy of cities and religious communities made social reform slow. There was not so much social inequality and unrest that the upper classes feared revolution if they did not guarantee the livelihood of their workers. In addition, medical care was not seen as absolutely essential to keep factories running as it was in other more industrialised countries.[205]

In 1880, however, a debate arose about the accessibility of medical care. In the Netherlands, medical care was not nationalised. Municipalities were charged with arranging medical care in their territory. Social insurance for workers was introduced in 1900.[206] The first social insurance scheme was the *Ongevallenwet* in 1901, which was financed by insurance contributions paid for by employers and administered by the *Rijksverzekeringsbank*.[207] Only in 1904 was the *Rijksverzekeringsbank* and the *Ongevallenwet* first mentioned in the patient registers as their means of payment. In the following years, they are also mentioned only sixteen times, so it appears that the social reforms did not result in the admission of a large groups of patients.

[201] Gagan and Gagan, *For Patients of Moderate Means*, 24.
[202] Derosas and Munno, 'The Place to Heal and the Place to Die', 1142-1146.
[203] Hillen, Houwaart and Huisman, *Medische geschiedenis*, 202.
[204] Porter, *The Greatest Benefit to Mankind*, 380.
[205] Hillen, Houwaart and Huisman, *Medische geschiedenis*, 261.
[206] Ibidem, 263.
[207] Henk van der Velden, *financiële toegankelijkheid tot gezondheidszorg in Nederland, 1850-1941* (Rotterdam 1993) 38.

2.7 Conclusion

The population of the Stadsziekenhuis was diverse. It included young and old people, men and women, followers of a variety of religions, and people from different social classes. This diversity does not always come forward in the historiography, that has often characterised hospital patients as paupers. The patterns in the patient admission show no clear transition from a social towards a medical institution. There were no dramatic changes in the type of patients that were admitted.

What points towards the sustaining of the social function of the hospital is the minimal decline in the average days patients spent in the hospital and the extensive periods some patients were hospitalised, and the admission of family groups. What point in favour of the process towards a medical institution is the variety of patients that sought medical assistance in the Stadsziekenhuis and the paying patients, but also the fact that married people were admitted for a shorter period, probably to return to their families, which indicates that it was not merely a shelter for the poor.

3. Patterns in the patient mortality

3.1 Introduction

This final chapter examines mortality in the Stadsziekenhuis and focuses on those who did not survive their hospital stay and were listed as 'deceased'. As the reason for hospitalisation, the diagnosis and the cause of death are not recorded, the focus will be on the characteristics that the deceased patients displayed and what possible explanations there are for the observed patterns. By studying the information from the patient registers, this chapter shows which patients died in the Stadsziekenhuis between 1868-1889 and 1901-1915 and how change and continuity might be explained.

3.2 Mortality rates in the Stadsziekenhuis

Of the 4,091 patients that were admitted to the Stadsziekenhuis in a period of 37 years, a total of 595 patients were reported as deceased. Thus, 14.6% of the patients who were admitted in the Stadsziekenhuis died there. The annual percentages of the number of patients that died while still being in the hospital are represented in Figure 12. Naturally, it is possible that a patient was admitted in 1868 but died in a different year. In Figure 12, that patient is still counted under the year 1868. This makes it possible to compare the number of deceased patients to the number of admitted patients and to calculate how many of the patients that were admitted in one year died in the hospital.

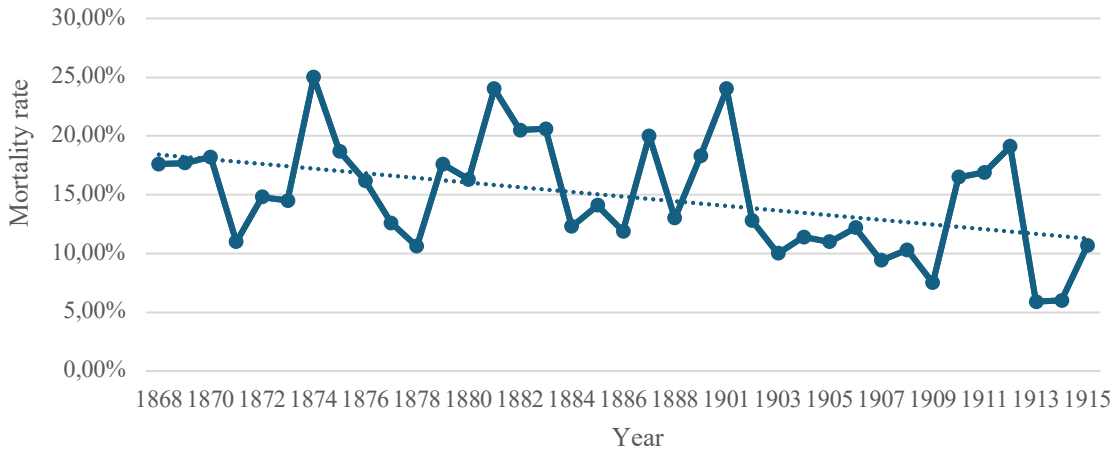
The mortality rates in the Stadsziekenhuis were between 9.4% and 25%, but showed a lot of fluctuation. The trend line in Figure 12 does show that the mortality rate was declining over time. This is in line with general patterns of declining mortality from 1880 onwards, when infectious diseases resulted in less deaths.[208] What is important to note regarding the mortality rates of the Stadsziekenhuis is that the annual number of patients was rather low, and therefore coincidence also played a part and thus not every increase or decline in the graph is explainable.[209] The highest number of patients that died in one year was 26, while 5 was the

[208] Frans van Poppel and Erik Beekink, 'De 'gezondheid' van Nederland. Sterftetrends en sterfteverschillen in de negentiende en twintigste eeuw' in: Erik Beekink, Onno Boonstra, Theo Engelen en Hans Knippenberg (eds), *Nederland in verandering. Maatschappelijke ontwikkelingen in kaart gebracht, 1800-2000* (Amsterdam 2003) 71-94, there 72-73.

[209] Frans van Poppel and Peter Ekamper, 'Zuigelingensterfte per gemeente in Nederland, 1841–1939', *Bevolkingstrends* 1 (2008) 23-29, there 24.

lowest annual number. E.g. in 1878, only 7 patients died, but that still amounted to 10.6% of the total patients. So, high mortality rates do not mean that a large number of patients died.

Figure 12. Mortality rates in the Stadsziekenhuis between 1868-1889 and 1901-1915



Source: Database Patient Registers Stadsziekenhuis Hoorn

Over the period of 1844-1900, Brändström and Broström found a total deathrate of 10,7% in Swedish hospitals, while the morality rate in the Coolsingelziekenhuis in Rotterdam was around 12% during this period.[210] In the Binnengasthuis in Amsterdam, the mortality rates were between 10 and 15% and increased in the last quarter of the nineteenth century. Cherry found that mortality rates were low in the hospital in Norfolk and Norwich, but that the rates were also rising at the end of the nineteenth century.[211] Cherry argued that the medical standards deteriorated at the end of the nineteenth century. The mortality rates increased due to a large patient influx that grew faster than the success of treatments.[212] The mortality rates were relatively high, also due to a rising number of patients in Amsterdam, which was also visible in the Cherry's analysis.

On average, the mortality rates in the Stadsziekenhuis were higher than in other European hospitals. A possible explanation is that the Stadsziekenhuis did not benefit from the health transition. There is an indication that children were not sent to the hospital when they suffered from infectious diseases. In 1876, there was a croup epidemic, which led to the death of 25 children in Hoorn. In 1877, there was also a measle epidemic, and 30 children consequently died. Yet, in 1876 only one child below the age of six was admitted and in 1877 this number amounted to only four children.[213] It appears that either the Stadsziekenhuis did

[210] Van Lieburg, *Het Coolsingelziekenhuis te Rotterdam*, 320.
[211] Cherry, 'The Role of a Provincial Hospital', 297-299.
[212] Ibidem, 302.
[213] Bert van der Saag, streekarchivaris West-Friesland, Een mazelen-epidemie, aflevering 7 (1977), https://www.beeldbank-

not admit children suffering from infectious diseases or that parents did not seek out medical help in this case. This could mean that the health transition did not affect the mortality rates in the hospital as it did in other hospitals that did admit many children suffering from infectious diseases. The decline of infant mortality and the decline of mortality from infectious diseases had the largest effect on declining mortality rates in the second quarter of the nineteenth century. However, both these groups were likely not admitted in great quantities in the Stadsziekenhuis. Consequently, the impact of these developments on the mortality rates of the Stadsziekenhuis is unlikely to have been significant, and thus the decline in mortality rates at the Stadsziekenhuis was not as rapid as it was in other hospitals.

The Dutch government ordered municipalities from 1875 onward to track the cause of death of all their deceased inhabitants, which were published every four years. When comparing these general mortality numbers to the mortality in the hospital, it seems that only a small portion of the inhabitants of Hoorn died in the hospital. Between 1875 and 1880, 1,428 of the inhabitants of Hoorn died. 91 people died in the hospital during that period, equal to 6.4%. Between 1880 and 1885, 102 patients died in the Stadsziekenhuis, while a total of 1,383 of the inhabitants of Hoorn died, thus a maximum of 7.4% died in the hospital. It appears that both the relative and absolute number of inhabitants from Hoorn that died in the Stadsziekenhuis increased.[214] However, these percentages were significantly lower than they were in other European cities. In Venice in these years, 40% of all deaths occurred in hospitals, while this ranged from 20 to 40% in several Spanish cities.[215]

3.3 The average admission length of deceased patients

The average number of days patients were admitted as presented in Figure 4 of Chapter 2 already showed that throughout this period the average number of days a patient was hospitalised fluctuated mostly between 30 and 50 days. When comparing this to the average length of stay of deceased patients given in Figure 13, it is observed that there was a greater variety in the annual average and that there were far more years that experienced either an average of more than 60 days or an average of less than 30 days.

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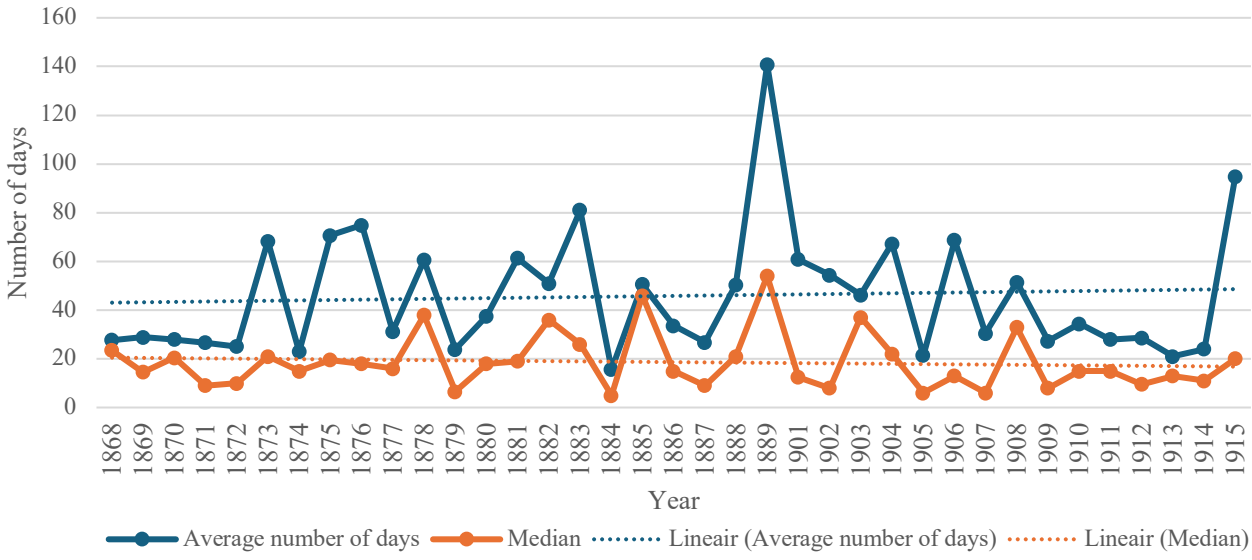
oudhoorn.nl/pdfjs3/web/viewer.html?file=/publicaties/large/000332.pdf#search=&phrase=true (seen on 15-06-2024); Database Patient Registers Hoorn; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.

[214] Database Patient Registers Hoorn; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers; Departement of Binnenlandsche Zaken, *Vijfjarig overzicht van de sterfte naar den leeftijd en de oorzaken van den dood in elke gemeente van Nederland gedurende 1875-1880* (The Hague 1882); Departement van Binnenlandsche Zaken, *Vijfjarig overzicht van de sterfte naar den leeftijd en de oorzaken van den dood in elke gemeente van Nederland gedurende 1880-1885* (The Hague 1888).

[215] Derosas and Munno, 'The Place to Heal and the Place to Die', 1141.

Figure 13. The average en median number of days patients spent in the Stadsziekenhuis before their death between 1868-1889 and 1901-1915



Source: Database Patient Registers Stadsziekenhuis Hoorn

Of the 595 patients who died, 234 were hospitalised for less than 10 days. Of these 234 patients, 97 died on the first or second day after arrival in the hospital. This provides an argument in favour of the idea that the Stadsziekenhuis was predominantly a social institution. It is also in line with the theory that hospitals were not places of medical care, but places where people came to die. Yet, it might also mean that people went to the GP when it was already too late or that the physicians oftentimes had no remedy, since no effective cures existed, or patients were in advanced stages of their disease or injury. The absence of causes of death records for the patients makes this harder to substantiate. The fact that there were also 65 people who were admitted for more than 100 days before they died could also be a manifestation of the fact that people viewed hospitals as places where they could turn to when they needed care for a longer period or when they had no other place to turn to for care.[216]

There were patients that passed away in the hospital after an extensive stay all throughout the nineteenth century. In 1873, 1876, 1881, 1889 and 1901 there were four or more patients who had been in the hospital for more than a hundred days when they died. Thus, during the nineteenth century, it seems that the social function of the hospital was still withstanding, as supported by the fact that people remained in the hospital for a long time before they eventually died. Their stay might have been this long because they were incurably ill, but

[216] Database Patient Registers Hoorn; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.

had no place else to go or had no family to take care of them and thus were allowed to stay in the hospital.[217]

Of the 65 long-staying patients who were hospitalised for more than 100 days, 16 are also listed as returning patients. This suggests that they had relied on the hospital as a place to receive care more than once. This might mean that in the case of illness, they saw the hospital as the right place to go to for medical help and thus not only as a place where one went to die. The 65 long-staying patients consisted of both men and women. However, there were more adults than children who stayed for more than 100 days, since only 5 of these 65 patients were under the age of 18. Additionally, 45 patients were aged between 18 and 60, and 12 patients were older than 60.

The Binnengasthuis in Amsterdam showed similar patterns of either very short or very long admission periods of deceased patients. Half of the deceased patients had died within ten days and one in three patients died within five days. Additionally, 73 patients passed away after being hospitalised for more than 90 days. According to Diepgrond, the patients staying for several months probably faced physical problems that were difficult to cure, which thus led to a bigger likelihood to die.[218] The percentage of people that died after being hospitalised for less than ten days declined at the end of the nineteenth century from 30,1% in 1876 and 22,1% in 1896. This leads Diepgrond to conclude that the fear for hospitalisation was declining. People started to trust hospitals more, which led them to choose admission sooner and thus increased their change of survival.[219]

The average days patients spent in the Stadsziekenhuis before their deaths increases somewhat over time, as shown by the trend line in Figure 13. This could mean that with time, less people viewed the hospital as a last resort. There were less people who died shortly after arrival and thus it is likely that the hospital became more of a place of medical attention than of social care as time progressed. While before 1881, there were oftentimes more than ten patients who died within nine days of hospitalisation, this number decreased after 1881.

Large peaks in the average and smaller peaks in the median are visible in Figure 13. This can be explained by the fact that in the years in which these numbers peaked, more patients died who had been staying in the hospital for a long time. For example, the mortality rate in 1889 is not higher than expected, but the median and average were very high in 1889. This is

[217] Database Patient Registers Hoorn; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.
[218] Diepgrond, Een poort naar de dood en verblijfplaats van 'ongelukkigen'?, 44-45.
[219] Ibidem.

the result of the fact that there were 5 patients who stayed for longer than 100 days, including a patient who had been admitted for 1,461 days. While it appears that the median and the average show a rather similar course, the trend lines in Figure 13 show opposite developments. While the median shows a small decline in the period, the average number of days a patient spent in the hospital increased.

3.4 The characteristics of the deceased patients

3.4.1 Sex and age

While Chapter 2 has shown that women were the majority of admitted patients between 1868 and 1879. Table 6 shows that when it comes to the division between the sex of deceased patients, man had been the majority of deceased patients since the establishment of the hospital. The years between 1910 and 1915 are the only years when more women than men died. Diepgrond also found that men died more often than women during the second half of the nineteenth century in the Binnengasthuis. This was visible in both the hospital and in the general mortality rates of Amsterdam.[220]

Table 6. The gender division of the deceased in the Stadsziekenhuis between 1868-1889 and 1901-1915.[221]

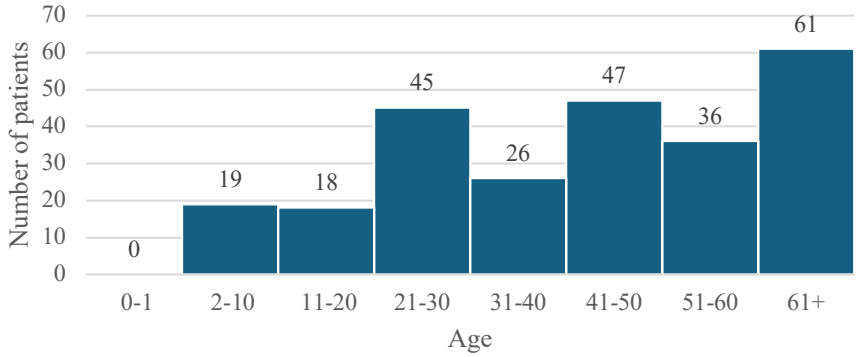
Year	Men	Women
1868-1869	51,9%	49,9%
1870-1879	52,6%	47,4%
1880-1889	55,9%	44,1%
1901-1909	58,6%	40,4%
1910-1915	49,4%	50,6%

Between 1868-1889 and 1901-1915, men constituted the majority of the deceased in 22 years, while women were the majority in only 8 years. The division was equal for 7 years. However, it is important to note that in most years, the absolute numbers of deaths were very close. 1870 was the year with the biggest gap, when 10 more men than women died, which resulted in a division where 73% of the deceased were male and 26% female. In 1905, 100% of the deceased patients were male, because nine men died in contrast to zero women.

[220] Diepgrond, Een poort naar de dood en verblijfplaats van 'ongelukkigen'?, 42-43.
[221] Database Patient Registers Hoorn; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.

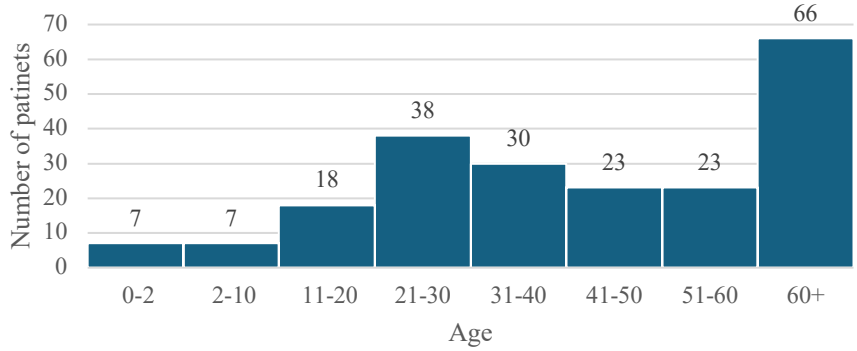
The limited excess mortality of men is in line with general mortality patterns. Men were more likely to die from the majority of diseases.[222] Life expectancy was also around two years shorter for men than for women between 1850 and 1900. From 1865 onward the surplus of male mortality increased. The opposite happened after 1903, when the life expectancy of men and women came closer together.[223] According to Van Poppel, male excess mortality was very low or non-existing before 1930 and was not visible for people aged between 5 and 20. Only from the 1880s onward did men instead of women show an excess of mortality among adults. The difference was mostly caused by infant mortality, since male surplus mortality was highest among infants.[224]

Figure 14a. The age of deceased women between 1868-1889 and 1901-1915



Source: Database Patient Registers Stadsziekenhuis Hoorn

Figure 14b. The age of deceased men between 1868-1889 and 1901-1915



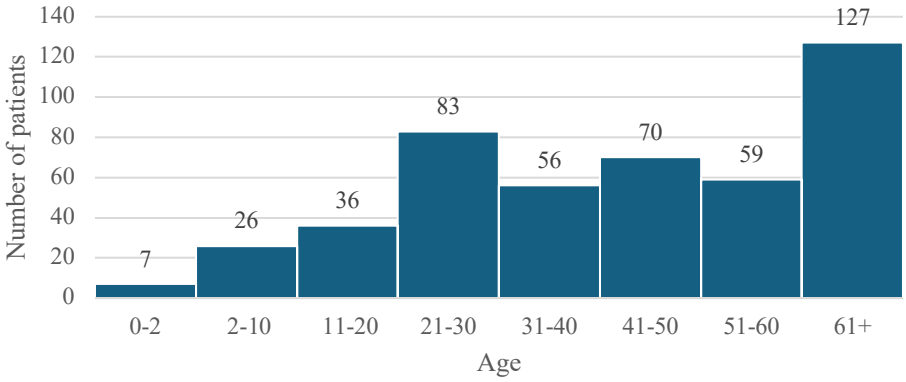
Source: Database Patient Registers Stadsziekenhuis Hoorn

[222] Hilde L. Sommerseth and Evelien C. Walhout, 'The Gendering of Infectious Disease: Classifying Male and Female Causes of Death in the Netherlands and Norway, 1880-1910', *Social History of Medicine* 35:4 (2021) 1088-1115, there 1089.
[223] Frans van Poppel, 'Trends in mortality and the evolution of the cause-of-death pattern in the Netherlands: 1850-2000' in: Theo Engelen, John R. Shephard, Yang Wen-shan (eds), *Death at the Opposite Ends of the Eurasian Continent Mortality Trends in Taiwan and the Netherlands 1850–1945* (Amsterdam 2021) 17-43, there 30.
[224] Ibidem, 30-31.

These findings are not completely in line with the findings from the Stadsziekenhuis. While the excess male mortality was not extremely high, the excess infant mortality among males was non-existent. As Figure 14a and 14b show, males did not make up the mortality of deceased patients for all age groups. More female infants, and women aged between 31 and 40 and aged over 60 died in the Stadsziekenhuis. The excess male mortality is also not visible for the patients aged between 2-10.

While Rutten has argued that breadwinners were more likely to be hospitalised and thus to survive diseases and health problems, Diepgrond suggested the opposite to explain the higher mortality rates of men. She argued that breadwinners might have delayed seeking medical help since hospitalisation would mean that they could not provide an income for their family. During that time, the disease could move to an advanced stage which made treatments less effective.[225]

Figure 15. The age of all deceased patients between 1868-1889 and 1901-1915



Source: Database Patient Registers Stadsziekenhuis Hoorn

Table 7. The mortality rates of the different age groups of the Stadsziekenhuis between 1868-1889 and 1901-1915.[226]

Age Groups	Mortality Rates
0-10	9,20%
11-20	6,20%
21-30	10,50%
31-40	13,20%
41-50	19,80%
51-60	24,80%
61+	31,00%

[225] Diepgrond, Een poort naar de dood en verblijfplaats van 'ongelukkigen'?, 42-43; Rutten, 'Volksgeneeskunde in sociaal-historisch perspectief', 107-111; Rutten, 'Ongelijke behandeling binnen het gezin', 252.
[226] Database Patient Registers Hoorn; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.

Diepgrond found that mortality was especially high among the youngest and the oldest patients in the Binnengasthuis.[227] In 1876, the mortality rates of infants and children amounted to 21%. One in three children under the age of one died, while the chance for children to survive hospitalisation between 5 and 10 years old was one in thirteen. Children under the age of one consisted of two percent of the total patient population, but made up 5,4% of the mortality cases.[228]

When examining Figure 15, it is clear that the elderly were also a significant group in the hospital, but that the number of infants and children was very low. Table 7 shows the mortality rates of the different age groups, by dividing the outcome of Figure 6 in Chapter 2 – the total number of admitted patients for different age groups – with the outcome of Figure 15, to calculate the mortality rate of the different age groups. The outcome is visualized in Table 7. This Table shows that the child and infant mortality was low in comparison to the mortality rate in the Binnengasthuis and in comparison to the other age groups of the Stadsziekenhuis. The patients aged between 11 and 20 showed the lowest mortality rates of all patients. From all the patients over 20 years old, the mortality rate became higher. The mortality rate for people that were older than 50 was especially high. Thus, this indicated that for the elderly, the hospital was a place where many of them died.

3.4.2 Religion

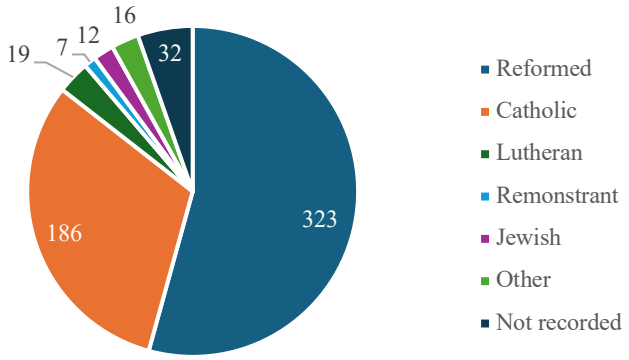
Various contemporary as well as modern scholars found that religion influenced mortality rates. In particular Jews were found to have lower mortality rates than other religious groups. Several explanations have been put forward. The first was their relatively isolated way of living, which shielded them from coming into contact with infectious diseases. Their awareness regarding hygiene and the strict rules regarding food and bathing were also pinpointed as a possible explanation for the fact that Jewish mortality rates were lower. Another explanation was the fact that Jewish mothers took better care of their children.[229]

The mortality rates in the Stadsziekenhuis did not show a significant lower mortality rate for Jews, as can be seen in Figure 16. A total of 63 Jews were hospitalised in the Stadsziekenhuis, of which 12 died, equal to almost 20%. Both Jewish men and women were hospitalised, and their ages varied, but most of them were elderly. The majority was between 60 and 80 years old. There was only one Jewish child hospitalised, who was thirteen years old.

[227] Diepgrond, Een poort naar de dood en verblijfplaats van ‘ongelukkigen’?, 42.
[228] Ibidem, 40-41.
[229] Walhout and Van Poppel, ‘‘Eene statistiek naar de geloofsbelijdenis’’, 97, 104-110.

Thus, it seems that Jewish children were less often in need of medical attention, thus substantiating the idea that Jewish families took better care of their children. Yet, it is also important to note that Jewish parents might have preferred to have their children cared for by Jewish caregivers. This was possible, since there were two societies established for Jewish healthcare in Hoorn, one of which was focused on supporting pregnant and postpartum women.[230] Thus, it is probable that children were brought there when they were sick instead of the hospital.

Figure 16. The number of deceased patients from each denomination



Source: Database Patient Registers Stadsziekenhuis Hoorn

Table 7. The mortality rate in relation to the denomination of the patients.[231]

Denomination	Mortality rate
Reformed	22,3%
Roman Catholic	13,8%
Lutheran	20,7%
Jewish	19,0%
Remonstrant	23,0%

Most Jewish patients that eventually died did so within a month and almost half of them died within a week. There was only one man who stayed for a considerable period of time: 390 days. There were Jewish patients throughout the entire researched period. Thus, in these regards there are no specific patterns visible when it comes to Jewish patients in relation to patients from other faiths. It is noticeable that there were mostly widows and widowers and unwed Jews who were hospitalised, which might mean they had no support system unlike married Jews. All

[230] Hoorn, https://jck.nl/joodse-gemeenten/hoorn (seen on 14-03-2024).
[231] Database Patient Registers Hoorn; WA, Archive Stadsziekenhuis Hoorn (0415), inv. nr. 397, 398, 399 and 400, patient registers.

but one patient did not have to pay for their stay, so they were likely part of the indigent poor of the city. Four patients had also been hospitalised earlier, thus it seems that there was no taboo on hospitalisation in the local hospital among the Jewish community.

Researchers have also been puzzled by the fact that in some parts of the Netherlands catholic mortality rates were higher at the end of the nineteenth century than those of protestants. This was in line with the change from high mortality rates in the Western part of the Netherlands towards higher mortality rates among infants and children in the Catholic provinces of Limburg and Noord Brabant that occurred during the second half of the nineteenth century.[232]

The outcome of the number of deceased patients of different denominations in the Stadsziekenhuis in Figure 16 provides an opposite picture. More than half of the deceased patients were reformed, while just over 30% were catholic. Another important finding is visualized in Table 7. There, the mortality rates of different denominations are presented. While most religions show a mortality rate of around 20%, the mortality rate of the catholic patients was the lowest of all denominations.

Many suggestions have been made for the reason why catholics and especially catholic infants died in higher rates in the catholic provinces of the Netherland. The fact that catholics were less likely to embrace new medical insights, the fact that they often kept to themselves and the emergence of a culture of shame which prevented them from breastfeeding their children have been named as significant factors in these developments.

Only in the second half of the nineteenth century did catholicism turn into a negative factor in relation to mortality. The interference of catholic priests on the cultural behaviour and norms in the second half of the nineteenth century might have contributed to higher mortality rates among catholics, since breastfeeding declined due to a culture of shame surrounding breasts, which had to be always covered up with accordance to the new culture of bodily shame after 1850. Developments in the medical field were also scrutinized by some catholics when they came from outside their social environment.[233]

This is in line with the findings of Hofstee, who argued that culture and mentality were very important in the choices that people made regarding health. He did not mention religion in his argument, but he argued that a modern and an opposite traditional viewpoint existed in regard to healthcare. He characterized the tradition viewpoint by a negative stance towards

[232] Walhout and Van Poppel, ‘‘Eene statistiek naar de geloofsbelijdenis’’, 110-111.
[233] Frans van Poppel, ‘Regionale sterfteverschillen in Nederland 1850-1930. Continuïteit en verandering’, *Amsterdams Sociologisch Tijdschrift* 18:1 (1991) 34-72, there 64-65.

medical and healthcare. The modern 'culture pattern', where people trusted science and medicine and they were awareness of the importance of hygiene was important in the declining mortality rates according to Hofstee. He argued that this traditional pattern was mostly visible in the countryside in the East and South of the Netherlands.[234]

However, it was not always the case that protestant and catholic mortality rates in each municipality diverged, as can be seen in the case of the Stadsziekenhuis.[235] Other research has also shown that in places were both catholics and protestants lived together, the excess catholic mortality was not too pronounced.[236] There are several possible explanations for this phenomenon. One explanation is the contact between protestants and catholics in regions where they lived in close proximity to each other, such as in Hoorn. Catholics in Hoorn probably encountered people from different denominations more often than the catholics from the Southern provinces due to the fact that Hoorn housed several other religious groups. This contact might have taught women about practices that were common among women from different denominations, such as the practice of breastfeeding. The lack of a powerful clergy and the presence of a local culture were women of different denominations lived together might have reduced the influence of this culture of shame on the lives of catholic women in Hoorn and thus might have caused that the mortality rates, both of adults and infants and children, was not as high as in other provinces.[237]

3.5 Conclusion

The mortality rates in the Stadsziekenhuis declined very slow and were high in comparison to other hospitals. While increasing mortality rates in hospitals were not uncommon due to population increases, this is not the explanation for the high mortality rates in Hoorn. The primarily social nature of the hospital and the slow modernisation and progress likely attributed to the high mortality rates and their slow decline. Additionally, the characteristics of the patients that had the highest chance to die while in the hospital differ from the findings from other hospitals in the nineteenth century. Especially the low mortality rates of children and catholic patients are remarkable.

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[234] E.W. Hofstee, 'Regionale sterfte-verschillen', *Tijdschrift voor Sociale Geneeskunde* 36:20 (1958) 499-511, there 509-511.
[235] Walhout and Van Poppel, ''Eene statistiek naar de geloofsbelijdenis'', 112.
[236] Evelien Walhout, *An infants' graveyard? Region, religion, and infant mortality in North Brabant, 1840-1940*, (Ede 2019) 110.
[237] Walhout, *An infants' graveyard?*, 110, 124; Van Engelen, *Van 2 naar 16 miljoen mensen*, 119.

Conclusion

With the incorporation of several aspects, namely the institutional, the admission and the mortality aspect, this research has tried to provide an in-dept analysis of the Stadsziekenhuis in Hoorn between 1867 and 1915 to answer the question of who was admitted, who died and what sort of institution the Stadsziekenhuis was.

The transition from hospitals being primarily social shelters for the poor to a medical institution for everybody has been a significant topic of debate in the field of medical history, and has led to different conclusions. We concluded that the findings of the Stadsziekenhuis are largely consistent with the results of Derosas and Munno, who argued that hospitals in Venice during the late nineteenth and early twentieth centuries were not solely social shelters or medical centres, but rather a combination of the two.[238] A similar argument can be made regarding the Stadsziekenhuis. It focused on the admission of the poor, which also led the hospital to be responsibility of proving relief for chronic patients and for extended periods of time. The pace of modernisation of the hospital was slow. Throughout the period, the most important caregivers were untrained nurses, and new modus operandi such as performing operations in a designated operating theatre were introduced slowly. Nevertheless, the installation of an operating room and the admission of paying patients indicated that the Stadsziekenhuis was also a medical institution. Only after 1920 did the Stadsziekenhuis cease to prioritise the provision of medical care for the poor. Thus, during the previous decades, the Stadsziekenhuis was primarily an institution with a social purpose, but by way of providing medical help and was thus also a medical institution.

While hospitals in the nineteenth century were often portrayed as places where people only went as a last resort, research by Diepgrond and Brändström and Broström has shown that different social groups were admitted in these hospitals.[239] This is also visible in the Stadsziekenhuis. We conclude that, while it aimed at proving medical help for the poor, a variety of patients were admitted. Like the Binnengasthuis in Amsterdam, the Stadsziekenhuis also did not have a restrictive admission policy.[240] Therefore, the explicit exclusion of groups such as pregnant women and young children was not observed in the Stadsziekenhuis, as Cherry and McKeown have argued to be characteristic features of British hospitals in the past.[241]

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[238] Derosas and Munno, 'The Place to Heal and the Place to Die', 1159.
[239] Diepgrond, Een poort naar de dood en verblijfplaats van 'ongelukkigen'?, 49; Brändström and Broström, 'Life-Histories for Nineteenth-Century Swedish Hospital Patients', 198-199.
[240] Diepgrond, Een poort naar de dood en verblijfplaats van 'ongelukkigen'?, 49.
[241] Cherry, 'The Role of a Provincial Hospital', 295; McKeown, 'A Sociological Approach to the History of Medicine', 350.

The predominance of the social function of the Stadsziekenhuis is also visible in the admission patterns. Unwed mothers and family groups were admitted, only a minority paid for hospitalisation and 8% of the patients were hospitalised for more than 3 months. The number of patients also declined over time and the average days those patients spent in the hospital declined only marginally. Yet, the variety of patients does show that it not only served as a shelter for the poor, but was also a place that drew in people who required medical attention.

The declining mortality rates that are exemplary for the end of the nineteenth and beginning of the twentieth century, the so-called health transition, are also visible in the mortality rates in the Stadsziekenhuis. Yet, the mortality rates were rather high in Hoorn in comparison to other hospitals and was fluctuating. This leads to the conclusion that the impact of a local hospital such as the Stadsziekenhuis in Hoorn possibly did not have an important impact on the declining mortality rates in the nineteenth century, as findings from McKeown, Pennington, Brändström and Broström, and Diepgrond have also shown.[242] A clear transition from a place of death towards a place of medical healing is not visible, based on our data.

There is no evidence that the Stadsziekenhuis did more wrong than good for its patients, as Brown and McKeown have argued for British hospitals.[243] Even though the mortality rates were higher than that rater other scholars have found for hospitals in this period, the absolute number of patients that died in the hospital were not very high. Additionally, the findings of the Stadsziekenhuis also show that regional case studies remain interesting, since the low mortality rate for both catholic patients and for children are surprising in relation to previous debates regarding mortality patterns in the past. Both the high catholic mortality during the second part of the nineteenth century and the high child mortality have been an important topic of debate, but both the mortality rates were in fact low in the Stadsziekenhuis.

An important insight that is missing from this research is knowing how long people lived after leaving the hospital. When a significant part of the patient population died shortly after their hospitalisation, then the conclusion that the Stadsziekenhuis also became more of a medical institution does not hold. Brändström and Broström did incorporate this aspect in their research, and they found that most of the patients that were hospitalised in Swedish hospitals did not die shortly after they were discharged from the hospital.[244] In the Stadsziekenhuis, a

[242] McKeown and Brown, 'Medical Evidence Related to English Population Changes in the Eighteenth Century', 125, 140; Diepgrond, Een poort naar de dood en verblijfplaats van 'ongelukkigen'?, 22; Pennington, 'Mortality and medical care in nineteenth-century Glasgow', 444; Brändström and Broström, 'Life-Histories for Nineteenth-Century Swedish Hospital Patients', 207.
[243] McKeown and Brown, 'Medical Evidence Related to English Population Changes in the Eighteenth Century', 125, 140.
[244] Brändström and Broström, 'Life-Histories for Nineteenth-Century Swedish Hospital Patients', 207.

proportion of the patients was also admitted several times, which meant they did not shortly die after hospitalisation. The phenomenon of returning patients is in itself also a majorly understudied topic, which could shed light on the function of hospitals as either shelters or medical institutions.

However, it would be a very valuable addition to research vital records and population registers, to find out how long after hospitalisation patients died, to see whether their treatment had any success. This could be done for example through a website like wiewaswie.nl, where more than 240 million persons and their vital records are incorporated in a database. Also, these vital records could provide more information on the social class of the patients, because they often include the occupation of individuals.

Another important contribution to research on hospitals would be the incorporation of similar sources as those used in this research, but that also includes the medical cause for admission, diagnosis or cause of death. When the reason for admission is known, more can be said about the function of the hospital, since it could make clear whether patients – for example children – were admitted for medical reasons or not, as well as indicate the predominance of certain types of (infectious) diseases. Additionally, it could show which diseases were the most lethal for patients, which is especially significant since several authors have already concluded that the chance of survival after hospitalisation was influenced by the disease patients were suffering from.[245] Finally, the effectiveness of medical therapies could be studied.

The study of other hospitals and their patients would also be relevant in general, since the results from this study in comparison to other studies has shown that there was a lot of variety between different hospitals. The incorporation of studies on hospitals in university cities, hospitals in the countryside and in predominantly catholic or protestant areas would enrich the debate and bring differences and similarities between different hospitals to light.

A final suggestion for further research would be to include the presence of family groups in hospitals. This is an understudied topic, which is of great importance in the explanation of the epidemiological transition theory, because the decline of infant and child mortality is an important part of the explanation of the declining mortality rates in the nineteenth and twentieth century. Their presence in hospitals has been debated, but often only in the margin of research on hospitals. The research on children and family groups in hospitals and the reason for their stay is still relatively unclear, but could provide new evidence of the role of hospitals in the debate regarding the substantial decline of infant mortality at the end of the nineteenth century.

[245] Diepgrond, Een poort naar de dood en verblijfplaats van ‘ongelukkigen’?, 45-46.

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