‘Family-Centred Care’
in American Hospitals in Late-Qing China

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Today, patients’ families in the West are regaining the access to hospitals that they lost when hospitals emerged as the primary site for medical treatment, research and training at the beginning of the twentieth century. In China, however, families were never excluded from American mission-run hospitals, in fact, they were indispensable. Families were in the waiting rooms, consulting rooms, wards and operating theatres. They provided more than reassurance and comfort: they fed and nursed their sick relatives, acted as advocates and middlemen and may even have lowered the incidence of cross-infection, the scourge of the contemporary hospital in the West.

Inspired by the consumer-led movements of the 1960s, and encouraged by research from psychologists who wrote about ‘maternal deprivation’ of institutionalised children, American parents had started to campaign against restrictions on visiting their children in hospitals.\(^1\) In Massachusetts they formed ‘Children in Hospitals’, an organisation which, in 1973, started to conduct and publish bi-annual surveys of visiting hours in the state’s hospitals. It is unlikely they could have foreseen their activism leading to the widespread adoption of an entirely new approach to patient care that pertains in American hospitals today.\(^2\)

This new policy approach goes by the name of ‘family-centred’ care. Developed originally with children in mind, one of the first concrete moves in its direction was legislation passed in Massachusetts in 1980 requiring hospitals to institute twenty-four-hour family access to paediatric wards.\(^3\) Today it is a well-developed system with an agreed set of principles and protocols.\(^4\) Over the years it has extended its reach and is increasingly being adopted by hospitals for the aged as well as for adults in acute care hospitals.\(^5\) Like fathers wanting to be present at the birth of their child – including those carried out by caesarean section – family members are expecting to be present even during invasive and emergency procedures.\(^6\)
The cornerstone of the family-centred policy – emphasised in many hospital advertisements – is a belief that ‘health care providers and the family are partners, working together to best meet the needs of the child.’ Of course, neither the idea nor the practice of families caring for their sick is new and, before the advent of hospitals for other than the very poorest of them, patients were routinely cared for at home with occasional visits from a physician. What is new in America is the idea that the family should take on a significant, if not central, role in patient care within the hospital setting. But, there have been manifestations of the American hospital from which the family was never excluded – those established by Protestant missionaries in nineteenth-century China, for example. There, the presence of family and friends was commonplace well into the twentieth century and continues in the Chinese successors of these hospitals today.

So, the questions addressed in this chapter include: what economic, political and cultural factors operated in China to distinguish the American hospital in China from its counterpart at home, particularly in relation to the presence of patients’ family and friends? To what extent and in what capacities were these ‘visitors’ involved in the actual operation of mission hospitals? What were the possible consequences of the families’ involvement, so far as outcomes were concerned, for the Chinese patients, their families and for hospital staff? Lacking first-hand contemporary accounts by either Chinese patients or their families, this chapter relies upon annual reports published by a wide range of hospitals operated by various missionary societies and articles in missionary journals, particularly those written for and by medical missionaries. For the history of hospitals and present-day practices in America, secondary sources are used.

Background: medical missions

When the first of the Protestant medical missionaries arrived in China in the mid-1830s what few public hospitals there were in America had been established primarily to serve the poor. Those who could afford it were still treated at home by a physician and cared for by family members. The state of medical knowledge, practice and technology – before anaesthesia and the germ theory – meant that specialised equipment and nursing were not deemed to be necessary; the middle or upper-class home was thought to provide a perfectly adequate environment in which to care for the sick. So it would have been considered unremarkable when the first American medical missionary, Peter Parker, arrived in Canton, the warehouse he chose for his hospital, in 1835. Equally unremarkable was the fact that he had no nurse; caring for the forty in-patients he could accommodate was undertaken by their relatives, friends or servants.