The History of Geriatric Medicine and Hospital Care of
the Elderly in England between 1929 and the 1970s

by

M. J. Denham

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Abstract

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Before the 1930s chronic sick, elderly hospital patients were often medically neglected: they were not properly examined or treated but received 'benign guardianship' and expected a 'bed for life'.

The first doctors interested in geriatric medicine showed that many such patients, previously considered untreatable, could be treated and remobilised. These doctors had to contend with considerable ignorance: 'not only is the problem of the treatment of the chronic sick not being met, but also most people do not realise there is a problem' (p.617).¹

Post-war consultant geriatricians faced huge numbers of in-patients, substantial waiting lists, poor quality ward accommodation, inadequate investigative facilities and insufficient staffing. However by diligent application of diagnosis, treatment, home visiting, development of day hospitals together with improving social service support, patient throughput slowly increased and length of stay decreased.

Many obstacles to progress remained. General physicians continued to be generally hostile, viewing consultant geriatricians as inferior physicians. Geriatric medicine was disparaged as 'a second-rate speciality, looking after

third-rate patients in fourth-rate facilities' (p.129). Health authorities were not always supportive and some failed to establish geriatric units even when firmly encouraged by the Ministry of Health and the Department of Health. Universities were slow to introduce teaching of geriatric medicine. Arguments about 'bed blocking' by elderly patients continued. Geriatricians and local authorities were blamed. However as Sir George Godber maintained, the Ministry, although supportive of geriatric medicine, could not enforce change, it could only persuade or encourage. 

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3 Sir George Godber was Chief Medical Officer for England and Wales between 1961 and 1972. Godber Sir George, Geriatrics as a speciality. London: The British Library, National Sound Archive. 1991
<table>
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<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>BGS</td>
<td>British Geriatrics Society</td>
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<td>BMA</td>
<td>British Medical Association</td>
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<td>CMO</td>
<td>Chief Medical Officer</td>
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<td>DHSS</td>
<td>Department of Health and Social Security</td>
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<td>EBS</td>
<td>Emergency Bed Service</td>
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<tr>
<td>FRCP</td>
<td>Fellow of the Royal College of Physicians of London</td>
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<tr>
<td>FRCP (Ed)</td>
<td>Fellow of the Royal College of Physicians of Edinburgh</td>
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<tr>
<td>FRCS</td>
<td>Fellow of the Royal College of Surgeons</td>
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<tr>
<td>HAS</td>
<td>Hospital (later Health) Advisory Service</td>
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<td>HIPE</td>
<td>Hospital In-patient Enquiry</td>
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<tr>
<td>HMC</td>
<td>Hospital Management Committee</td>
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<tr>
<td>HMSO</td>
<td>His/Her Majesty's Stationery Office</td>
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<td>IAG</td>
<td>International Association of Gerontology</td>
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<tr>
<td>MRC</td>
<td>Medical Research Council</td>
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<td>MSCE</td>
<td>Medical Society for the Care of the Elderly</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NCCOP</td>
<td>National Council for the Care of Old People</td>
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<tr>
<td>OHE</td>
<td>Office of Health Economics</td>
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<tr>
<td>PPC</td>
<td>Progressive Patient Care</td>
</tr>
<tr>
<td>Part III</td>
<td>Refers to Residential Homes administered by Local Authorities</td>
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<tr>
<td>Accommodation</td>
<td></td>
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<tr>
<td>RHB</td>
<td>Regional Health Board</td>
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<td>SRN</td>
<td>State Registered Nurse</td>
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Acknowledgements

I would like to acknowledge the tutorials, guidance, and advice given to me by many members of the staff of the Wellcome Trust Centre for the History of Medicine at University College London. In particular I thank my supervisors Professor Lawrence and Professor Bynum for their patience, tolerance, understanding and help. The members of the Centre’s Information Technology unit, Gwyn Griffiths in particular, have been exceedingly helpful in teaching me more about the intricacies of Windows, given me much encouragement and considerable assistance, particularly in getting me out of several deep computer holes.

The library staffs at the Wellcome Trust, the Royal Society of Medicine, Mount Vernon Hospital, the King’s Fund, the Royal College of Physicians and the NHS Library have been most supportive and accommodating. The Chief Executive Officers of the British Geriatrics Society helped me with access to the Society’s archive. I also thank Dr. John Wedgwood for talking to me about his early days in geriatric medicine and Dr. James Andrews for the loan of personal papers. My wife has been most understanding and undertook much of the burden of proof reading.
The History of Geriatric Medicine and Hospital Care of the Elderly in England between 1929 and the 1970s

Before the Innovative Work of Marjory Warren and Colleagues

'The buildings are old, dark, devoid of modern sanitary conveniences...and unfit for the nursing of the chronic sick' (para 72).¹

'Not only is the problem of the treatment of the chronic sick not being met, but most people do not realise that there is a problem' (p.617).²

After

'It [geriatric medicine] has established its expertise and has had notable success in developing and raising the standards of services for the old' (p.46).³


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Chapter One

Literature Review: Attitudes towards Old Age and the Care of Sick Elderly People

Introduction

Within the broad subject of old age are three interrelated topics: theories of ageing, how to increase longevity and the medical management of sick, elderly people. Initially the first two topics have received most attention, but even so the range of historical and historiographical literature is limited. Old age was seen as part of life but whether it was pathological or a natural event was not agreed. The medical management of older people in England, which is the subject of this thesis, was widely neglected until the 1930s, when the early reformers founded, by default, the speciality of geriatric medicine.

Primary Sources: Early and Later Writers on Old Age

Early writers such as Cicero, Galen, Roger Bacon, and Francis Bacon discussed old age in general terms pointing to features such as skin changes, deteriorating memory, sight and hearing, reduction in physical strength and loss of employment. None were sure of the cause(s) of old age. Theories ranged from loss of heat to loss of moisture. Several took a positive attitude to becoming

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old, emphasising the experience and knowledge of elderly people, and the value of keeping active and taking exercise to maintain strength.

British writers of the 18th and 19th centuries, such as Sir John Floyer, Sir John Hill, Sir Anthony Carlisle, Professor George Day and Sir John Sinclair, wrote about old age and how to prolong life, but devoted little attention to medical management of disease. They generally thought it impossible to turn an elderly man into a young person. However, much could be done to make later life as healthy as possible. Lifestyle was important, with sensible eating of easily digestible foods taken at regular intervals, taking exercise, ensuring good sleep, keeping clean, wearing warm clothing and avoiding constipation. Several writers described the diseases of old age such as gout and arthritis, leavening their accounts with descriptions of their patients. Sir John Carlisle cautioned against operations in older people because the results were usually fatal. In 1863 Dr. Daniel Maclachlan, medical superintendent at the Royal Hospital Chelsea, found little in English literature about old age that contained useful information on hygiene and diseases. He realised that precise diagnosis could be difficult in older people because several diseases could exist simultaneously.


3 Sir John was surgeon extra ordinary to HRH The Prince Regent.

Literature Review: Attitudes towards Old Age and the Care of Sick Elderly People

The major event in the 19th century in England was the 1882 translation into English of Jean Martin Charcot's *Clinical Lectures on the Diseases of Old Age.* These described an extensive range of subjects including the overt signs of old age, rheumatism, gout, arthritis, fever and its feeble response in older people, respiratory infections, cerebral haemorrhage and cerebral softening but contributed little to treatment or management.

The early 20th century English writers continued to describe old age. In the early 1900s Sir Henry Weber and Dr. Robert Saundby restated the principles of prolonging active life. G. Stanley Hall in 1922 reviewed previous publications on old age and offered further advice on good health in old age. In 1928 Sir Humphry Rolleston published an overview of old age, where he examined the duration of life and the diseases of old age including stroke, Parkinsonism, and pneumonia. Maurice Ernest writing in 1938 pointed out that until the 19th century only superficial knowledge existed of how the body worked and regretted communication between thinkers and scientists was difficult, which limited the

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exchange of ideas. In 1941 Dr. Arthur Todd, who was an honorary physician at Bristol Royal Infirmary, published a study of medical aspects of old age.

Publications about the management of illness in old age began in the mid 20th century, stimulated by the realisation that many 'chronic sick' patients were treatable. In 1943 Dr. Marjory Warren published the first of her many articles on the modern treatment of the chronic sick (see chapter four). Dr. Trevor Howell, a geriatrician, in his short book on geriatrics in 1944 concentrated on salient areas of old age such as temperature control, blood pressure, chronic bronchitis and treatment. He commented 'time and again they [the older patient] will surprise everyone by their power of recovery, so that a little optimism in prognosis is often justifiable' (p.47). He extended the scope of the subject in his enlarged edition of 1950. In 1948 Dr. Joseph Sheldon, a general physician, published his research into the health of the elderly living in the community in Wolverhampton. Professor Norman Exton-Smith published Medical Problems of Old Age in 1955. In his preface he confidently wrote, 'It is encouraging to observe that the


application of modern knowledge is achieving success in the treatment of elderly patents. This approach was particularly important because the numbers of elderly people were increasing.

Modern geriatric medicine commenced in the United States of America before the United Kingdom. Although this thesis relates to geriatric medicine in England it is fitting perhaps to mention some early American publications. Dr. Ignatz Nascher, the ‘father of geriatric medicine’, produced his major work in 1916. Dr. Malford Thewlis, a disciple of Nascher’s, published the first edition of his book in 1919. He considered diseases of the kidney accounted for many of the illnesses of old people. The Americans established two societies concerned with the elderly: the Gerontological Society of America and the American Geriatrics Society. Each published its own journal, which first appeared in January 1946. Dr. Nathaniel Shock, in 1951, published the first edition of his classification of geriatrics and gerontology but pointed to the scarcity of material. Dr. Edmund Cowdry’s textbook followed in 1958.15

These later writers were reversing the years of neglect of the ‘chronic sick’ by the medical profession. They had the advantage, over earlier doctors, of improved rehabilitation techniques and medications. They took a vigorous, optimistic approach to medical care. They realised many infirm patients could be

maintained in the community with adequate domiciliary support: life was being added to years.

My thesis concentrates on this new style of medical management of the elderly and chronic sick practised by Warren, colleagues and successors in England, the immense tasks they faced and how this affected thinking within the Ministry of Health. I view their work with the eyes of a later geriatrician. This detailed approach reveals defects in some arguments of the secondary sources, which sometimes accepted an overall picture without realising it masked significant underlying variations.

**Primary Sources: Ministry of Health and Chief Medical Officers’ Annual Reports**

Between 1928 and the late 1930s the annual reports of the Ministry of Health and the Chief Medical Officers had implications for chronic sick elderly patients. Initially these reports devoted considerable attention to the reasons for, and results of, the Local Government Act of 1929.\(^{16}\) This legislation aimed to unify medical services; to appropriate Poor Law infirmaries where possible, and to improve medical and nursing care for sick people in better equipped hospitals. This was important for the chronic sick because they occupied many infirmary beds.

By the late 1930s the Ministry of Health had to concentrate its attention on preparations for war and the expected large numbers of military and civilian

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casualties. The Emergency Medical Service (EMS) was set up. Arrangements were made to discharge vast numbers of hospital patients, and evacuate chronic sick patients away from the expected areas of severe air attack in the South East of England. 190,000 hospital beds were emptied during the first week of the war and a steady average of 140,000-150,000 empty beds was maintained during the summer of 1940. By 1944 about 40,000 beds were kept vacant for casualties.

During the war the Ministry learnt the value of rehabilitation for casualties and, most importantly, started the foundation work for the future NHS with countrywide hospital surveys. These reported in 1945 and were generally critical of services for the chronic sick, a conclusion supported by the Nuffield Provincial Hospitals Trust.17

After the war the Ministry concentrated on the establishment of the NHS. Doubtless views on the elderly were coloured by the Beveridge report, which placed their services low in the list of priorities.18 The 1948 Ministry of Health’s Annual Report noted the Nuffield Foundation Report on Old People, the valuable work of Warren and colleagues, and the presentation by two of its medical officers to the Parliamentary Medical Committee on the subject of the care of the chronic sick.19 In 1950 the Chief Medical Officer, Sir John Charles, reported an increased demand for beds by the elderly chronic sick and development of

domiciliary support services.\textsuperscript{20} By 1952 he noted nearly 57,000 beds were occupied by the chronic sick with a waiting list of 8,800.\textsuperscript{21} However he quoted one unnamed area where 60\% of such patients were discharged from hospital within one month. From 1953 onwards many annual reports of the Chief Medical Officer contained a section on the elderly chronic sick.

The Ministry was therefore aware of the problems presented by the chronic sick, many of whom could be rehabilitated with enlightened treatment and discharged from hospital, which could in turn relieve the pressure of the waiting list.

**Primary Sources: Ministry of Health Circulars**

After the war the Ministry published a series of official circulars, memoranda and documents highlighting the Ministry's firm interest in modern management of elderly patients and the drive to establish a geriatric unit in every health district.

In 1948 the Ministry of Health produced a classification of the 'sick' and 'infirm'.\textsuperscript{22} In 1950 the Ministry issued two circulars about the treatment of the elderly mentally infirm and the chronic sick.\textsuperscript{23} The first referred to setting up an


Literature Review: Attitudes towards Old Age and the Care of Sick Elderly People

effective geriatric service. The second supported short-term admission to an assessment unit for diagnosis and treatment. In the same year the Ministry issued the circular on the development of consultant services.24 The section on general medicine reminded the consultant that he 'would be expected in future to undertake care of the chronic sick as part of his normal duties' (p.11). The following year a circular considered difficulties in arranging emergency admissions, and those of elderly people.25 By 1955 Sir John Charles, the Chief Medical Officer, thought: 'there is reason to believe that the difficulty of providing sufficient hospital medical services for old people is being surmounted' (p.198/9).26 The Boucher report, which surveyed the care of older people in England and Wales, was published in 1957.27 It paved the way for two circulars, which reviewed the range of geriatric services provided by the NHS and the local authorities and stated 'the Minister considers that hospital authorities should give high priority in the allocation of their resources to the establishment in every


27 Boucher C. A., *Survey of Services Available to the Chronic Sick and Elderly 1954-1955.* Reports on Public Health and Medical Subjects No 98. London: Ministry of Health, 1957. Dr. Christopher Boucher was a Principal Medical Officer at the Ministry. (See Chapter Eight)
hospital centre of a geriatric department under the charge of a specialist physician’ (para.19).²⁸

The need for hospital geriatric departments was highlighted in the 1962 Hospital Plan and later documents.²⁹ In the mid 1960s the Ministry of Health issued a document, which referred to the care of the elderly in hospital and residential homes.³⁰ ‘It should be the object of the hospital authority to provide as soon as practicable in every area an effective hospital geriatric service’ (para. 6), and laid down the objectives of the local authority and hospital geriatric service.

In the early 1970s the DHSS published further documents, which considered the psychogeriatric patient, the quality of accommodation of those in residential care, and the requirements for a geriatric service and day hospitals.³¹ In 1981 the Department issued guidance about the respective roles of general and geriatric medicine.³² It reported 42 health districts in England still lacked geriatric beds in general hospitals in 1978.


Literature Review: Attitudes towards Old Age and the Care of Sick Elderly People

A comparison of the achievements and articles of the reformers with the publications of the Ministry and its medical officers, suggests the Ministry followed rather than led developments in geriatric services. It had to persuade health authorities to establish proper medical services for older people but could not force change.

Primary Sources: British Medical Association Reports

In 1947, 1948 and 1955 the Association issued reports on the care of the elderly.33 The first recommended a co-ordinated geriatric service and its requirements to the newly created Regional Health Authorities. The second listed further recommendations and referred to the ‘bed blocking’ problem. The last concentrated on the considerable range of domiciliary services needed by the infirm elderly to enable them to stay at home for as long as possible. Several early reformers were on the Association’s committees, which no doubt influenced the contents of the reports.

Primary Sources: the Cost of Care of the Elderly

Government concern about the cost of the NHS and care for the elderly population surfaced in the 1950s. Two committees were set up. The first to report was that chaired by Sir Thomas Phillips.34 Its prime concerns were

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pensions, the inadequacy of contributions, and whether the retirement age should be raised.\textsuperscript{35} The second committee report, chaired by Claude Guillebaud, appeared in 1956.\textsuperscript{36} This committee had commissioned Brian Abel-Smith and Richard Titmuss to study the expenditure.\textsuperscript{37} They concluded that the rising costs were due more to the fall in the value of money rather than a true increase on expenditure. The impression gained from the reports was of government concern with the age of retirement, the cost of pensions and the general costs of the NHS rather than the cost of geriatric services \textit{per se}. In 1976 Dr. Muir Gray, a community physician, raised the financial aspects again, pointing out one quarter of total NHS expenditure was spent on patients over 75 years of age but services for the elderly were not strong competitors for resources.\textsuperscript{38}

**Primary Sources: the National Sound Archive**

In 1989 Professor Margot Jefferys identified those who worked, or had worked, in the field of geriatric medicine and who were still alive.\textsuperscript{39} She and colleagues interviewed 72 people, including doctors, nurses, therapists, a social worker, a senior civil servant and politicians. She accepted their views were not

\textsuperscript{35} The report did indeed recommend an increase of retirement age to 68 years for men and 63 for women; but the government did not accept it.


necessarily representative of the speciality, and memory and hindsight might distort their recollections. However she was ‘impressed...by the general consistency of their accounts of the medical arrangements which existed in the early years of the NHS’ (p.78). Jefferys’ opinion was that many did not enter geriatric medicine by first intent, but did so because there was a greater chance of advancement in a field previously neglected by the medical profession. A frequent theme of these later reformers was the huge clinical workload, very large waiting lists, widespread hospital units with poor facilities and limited staffing.

**Secondary Sources: (a) General Comments**

Commentators have had mixed views of services for older people provided by the new NHS. In 1960 Ruck pointed out the old Poor Law system had given ‘a co-ordinated personal service to its clients’ (p.120), but the tripartite structure of the NHS service led to a lack of cooperation and coordination between the arms of the service.40 Charles Webster contended in 1988 that ‘although the NHS achieved only limited equalisation of services, it provided the less well off with a variety of forms of care to which previously they had only limited access’ (p.397).41 In 1991 he wrote ‘the elderly had much to gain from the new [NHS]. For the first time they had access to consultant services’ (p.175).42 However in some respects the early NHS compared unfavourably with the situation in the pre-


war years. Chronic and mental services received a smaller share of capital and revenue. He also considered ‘the NHS had failed to bring about a revolution in their hospital care’ (p.178). Martin Powell judged the NHS would even out the odds in favour of the unfortunate, but Pat Thane wrote, ‘when the NHS came into being, it offered no clear guidelines for the treatment of old people’ and pointed out that while the care of older people took up the majority of the time of general practitioners, geriatric medicine remained the least valued medical speciality (p.444). David Wilkin and Beverley Hughes similarly argued the NHS had failed to establish clearly defined objectives for a health service for the elderly. However they noted that by the late 1950s priority in resource allocation was being given to the Cinderella services. Paul Bridgen judged ‘the development of health and welfare services for older people in the early post war years has generally been regarded as disappointing’ (p.507). On the other hand Beveridge and the Nuffield Foundation both cautioned the provision of care of the elderly had to take account of the country’s limited wealth, labour and resources. Brian Watkin wrote of the immediate post war period that the country went from ‘one economic crisis after another...Britain had finished the war bankrupt and in debt


Literature Review: Attitudes towards Old Age and the Care of Sick Elderly People

to America’ (p.138). In 1993 Jefferys considered age discrimination was still current in the United Kingdom. Surgeons and general physicians still used age ‘as an overriding blanket criterion to justify excluding older individuals from a variety of clinical procedures, which were likely to be just as efficacious among them as among younger people’ (p.151).

Webster emphasized the important local government role in the community care of the elderly. However he disagreed with official reports, which endeavoured to convey the impression of steady progress towards the aim of enabling them to stay at home. Although the number of home helps had increased considerably there was less change in the number of health visitors and home nurses: see table 1.1. He maintained the Ministry of Health did little to improve the performance of poorly performing local authorities. He realised the importance of chiropody and meals on wheels for older people. Moira Martin in 1995 endorsed the view of the shortage of local authority services, referring to the


48 Webster C., op. cit., note 42.

49 Whereas the home help and the home nurse mostly worked with the elderly, the health visitor mostly worked with infants, and only 10% worked with the elderly.

50 Chiropody could be provided under section 28 of the NHS Act but for economic reasons was excluded from ministerial approval of LHA schemes.
Literature Review: Attitudes towards Old Age and the Care of Sick Elderly People

'failure in the 1950s to develop adequate systems of domiciliary support or to address the housing needs of elderly people' (p.444).51

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<td>2,955</td>
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Table 1.1 The number of personnel employed by local authority in home support of the elderly 1949-1966.52

Limited account was taken of the effect of the environment and poor housing on general health of the elderly, such as was found in the Birmingham surveys and by Amulree in the St. Pancras area. As Martin wrote, 'despite the recognition that poor housing conditions contributed to ill health and disability...there was little government action to remedy this state of affairs' (p.456).53 She also pointed to the vital role of the carers.

Commentators seem to have devoted less attention to matters which were important to the practising geriatrician such as staff shortages, lack of resources,

51 Martin M., "Medical Knowledge and Medical Practice: Geriatric Medicine in the 1950s," Social History of Medicine, 1995, 8: 443-461.

52 Webster C., op. cit., note 42. (p.183) He considered these returns needed to be treated with caution because of difficulty of converting part time staff into whole time equivalents, the need to take account of different levels of qualifications and double counting of the same individual often as a midwife, home nurse and health visitor.

53 Martin op. cit. note 51.
and disputes about the appropriate placement of those elderly people who were neither 'ill' nor completely 'well'.

**Secondary Sources: (b) The Growth of Geriatric Medicine**

Thane argued, rightly, the growth of geriatric medicine partly took place because the 1929 legislation exposed Warren to patients in poor quality Public Assistance Institutions. She thought geriatric medicine 'emerged very largely as a means to protect older people from the exclusion from medical care and treatment they had [previously] experienced' (p.457). Martin argued geriatric medicine 'took off' because the geriatricians were fired by the need to empty beds. Wilkins and Hughes postulated 'the wish to free beds occupied by elderly patients created a powerful force for a separate speciality' (p.171). However Warren’s articles showed her primary aim was to reverse medical neglect. This had the secondary 'knock on' effect of reducing bed requirements, reducing overcrowding in the wards and increasing bed turnover.

Commentators have disagreed about the support, or lack of it, given to geriatric medicine by policy makers. Getwood argued geriatric medicine received consistent support from the Ministry/Department from the mid 1950s onwards and the Boucher report was largely responsible for this. However Webster in

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54 Thane P., "Inventing Geriatric Medicine", op. cit., note 43.

55 Wilkin D. and Hughes B., op. cit. note 44.


1991 contended 'insufficient leadership from above and inertia within the system' inhibited innovation (p.178). In spite of all the reports, enquiries and recommendations there was still 'the absence of a single connected review of services for the elderly [which] seemed unforgivably negligent to the social analysts of the time,' (p.174) and between 1970 and 1991 'the National Health Service has still failed to generate an effective planning document on the care of the elderly' (p.188). However the achievements of the early geriatricians did influence the Ministry and its medical officers. Admittedly the latter had no executive power but they could influence opinions and discuss matters with the political head of the department. Bridgen in 2001 asserted health officials and many in the medical profession hampered the emergent clinical management in geriatric medicine. He reasoned the creation of bed norms for geriatric units meant a reduction in beds where units had over the 'norm'. I will argue he missed the point that high turnover and low waiting list units often operated with fewer beds than the recommended bed norms. Those units with more beds tended to be less efficient. Consequently criticism of Boucher and the Ministry is unfair, since they thought the number of beds was adequate but needed to be used more efficiently. A further vital factor was the 'drive' of the geriatrician to establish a thriving unit. However I agree with Bridgen's argument: 'only slow progress was made...in the incorporation of geriatric medicine in medical training' and thus

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58 Webster C., op. cit., note 42.
59 Bridgen P., op. cit., note 45.
60 Boucher noted this effect. op. cit., note 27.
influence the attitude of doctors in training (p.511). He thought those in authority were aiming to restrain the demands for hospital care for elderly people by restricting the non-acute function of hospitals and increasing the emphasis on rehabilitation and domiciliary care.\textsuperscript{61} He has, I think, not understood geriatricians were trying to cope with an increasing demand for treatment, which meant not only making the most effective use of in-patient services but also having vigorous out-patient and day hospital facilities for those living in the community. Indeed many geriatricians thought the day hospital was an essential component of their service and furthermore patients preferred being a day patient to being an in-patient. I do not think there was a conscious attempt to concentrate on the day hospital service at the expense of in-patient needs. Bridgen also maintained the split between hospital and local authority accommodation could mean infirm older people in these homes could be shut out of the development of geriatric medicine, a view with which I would agree.

Jefferys referred to arguments about the future direction of geriatric medicine:

the pre-1948 legacy, therefore, had resulted in a predominately segregated service where old, frail individuals could at best expect benign guardianship until they died rather than active treatment aimed at their ultimate discharge (p.153). The strategy of the first

\textsuperscript{61} Bridgen P., op. cit., note 45.
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generation of geriatricians was therefore to bring medical care of elderly people into the orbit of the general hospital (p.154).62

Early geriatricians strove for more consultant appointments wholly in geriatric medicine to ensure total commitment to the elderly, which might not happen if the consultant had ‘an interest in geriatric medicine’. This view held sway during the 1960s and early 1970s. About this time some thought the separate status of geriatric medicine denied older people the full benefits of modern medicine and therefore geriatric consultants needed to be integrated into general medicine. The Royal College of Physicians and the Royal Commission on the NHS supported this view.63

Conclusions.

The literature shows that the early reformers began to reverse custodial practice and medical neglect of the chronic sick in England in the 1930/40s. The task was immense. Support, resources and finances were limited. The medical

62 Jefferys M., op. cit., note 47.

officers of the Ministry and Department supported this new approach to care, which aimed to mobilise the chronic sick and return them to the community. Ministry officials tried to persuade health authorities to establish geriatric units in every health district.
Chapter Two

Setting the Scene

Introduction

This chapter reflects on some of the problem areas in geriatric medicine which faced the new breed of consultant geriatricians: indifference of the medical profession to elderly patients; who were/are the ‘chronic sick’; the developments of hospital services; and debates about the word ‘geriatrics’.

Indifference of the medical profession to elderly patients

In recent times general physicians generally ignored chronic sickness in old age. This attitude was noted at the beginning of the twentieth century. The 1909 Minority Report of the Poor Law Commission advocated a need ‘to break up the present unscientific category of the aged and infirm’ and ‘to deal separately with distinct classes according to the age and mental and physical characteristics of the individuals concerned’ (p.361).¹ Reasons for this neglect were many. The care of the aged and infirm lacked the dramatic appeal of acute illness in the young. Physicians questioned why elderly people should be put through extensive rehabilitation when they had only a few years to live. Complete recovery was rarely possible and the result often disproportionate to the effort required. One consultant physician said he ‘switched off’ whenever he found an elderly person

¹ The National Committee to Promote the Break-up of the Poor Law. The Minority Report of the Poor Law Commission. Part I: The Break-up of the Poor Law. 1909.
in one of his beds.\textsuperscript{2} Another visited his long-stay unit, was horrified by what he saw and never went again.\textsuperscript{3} Chronic sick patients were often accommodated in poorly equipped and staffed hospitals.\textsuperscript{4} Physicians appeared uninterested in deciding what was normal or abnormal in this age group, in learning what treatment could achieve, and were displeased at the diversion of resources from general medicine to geriatric medicine. Thane concluded geriatric medicine ‘emerged very largely as a means to protect older people from the exclusion from medical care and treatment they had long experienced’ (p.457).\textsuperscript{5}

Those working with the elderly were aware of the difficulties, including apathy, poor working conditions and social problems. In 1961 Dr. Cyril Bainbridge, a senior administrative medical officer of the Western Regional Hospital Board discussed the problems in setting up a geriatric service. He noted ‘practical difficulties included a general lack of interest, apathy, and even intolerance on the part of the general physicians’ (p.195).\textsuperscript{6} In 1963 Dr. Tom Rudd, a geriatrician, thought the problem was prejudice: Poor Law medicine had been associated with bad conditions of employment, which high-grade

\textsuperscript{2} Personal comment to author.


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professional workers would not accept. Many years later the Director of the Health Advisory Service wrote in 1985 about long term elderly care in hospital, ‘Too often [the patients] are looked after in large units which are in ancient buildings (one hospital seen this year included structures dating from the 12th century) and too far from the communities to which they belong’ (p.14). Others thought the considerable social/non medical component of geriatric medicine put off general physicians. Dr. George Crockett, a geriatrician, wrote:

an enormous mound of strictly non-medical problems...remain to be shovelled laboriously away before the patient can be discharged....Unless the geriatric physician is prepared himself to do the shovelling...nothing will happen [and] the patient will take root in the ward [and] become...a long stay patient. (p.804). Geriatrics is about incontinence, mental confusion, cot-sides, bed sores,...teaching nurses physiotherapy and teaching physiotherapists nursing, cleaning dirty spectacles,...chatting up social service officers,...home help supervisors, meals on wheel organisers.(p.805)


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Professor of Psychiatry, Ian Batchelor, summed up the situation in his report to the Nuffield Provincial Hospital Trust:

despite its successes the speciality of geriatrics has not gained high professional status. Its weaknesses are obvious. It attracts few of the intellectually most gifted members of the medical profession. Its contribution to research has been undistinguished. Far too many of those who man the geriatric services have had their basic medical training overseas; this is not their preferred career, their motivation is uncertain, and they have difficulties with the language and the culture...The snobbery of physicians, who have viewed the geriatrician as, more often than not, a failed physician or at best a physician manqué (p.46/7).11

The Boucher report commented that ‘geriatricians were regarded as medical practitioners of a clinical calibre who could not always claim equality with other consultants’ (p.24).12

Attitudes of medical students towards the elderly changed as they trained and qualified. A survey of their attitudes before qualification showed they had empathy for, and a ‘bedside interest in’, the elderly.13 This disappeared after


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graduation when the doctors considered their career prospects, and they turned against geriatric medicine. Victor Cross, a Birmingham medical student, blamed the change on the prejudice of medical teachers against geriatric medicine, failure of medical students to identify with the elderly, (which contrasts with the above study), and the poor image/role of the geriatrician. These factors resulted in poor recruitment of U.K. medical staff into the speciality. The Royal College of Physicians in 1972 and 1977 listed other possible reasons: drab, overcrowded, smelly institutions deserted by other specialities, isolation from mainstream medicine, inadequate resources, inadequate medical and nursing staff, lack of equipment and having to work with second rate staff in second rate accommodation. The College made recommendations, including integration of geriatric medicine with general medicine, appointment of consultant physicians with a special interest in geriatric medicine, and rotation of junior training posts


16 Report of the Royal College of Physicians of London on Geriatric Medicine. London: Royal College of Physicians of London, 1972. The College found that 60% of senior registrars and 30% of consultant geriatricians were from overseas. Gale and Livesley reported that 85% of geriatric registrars and 90% of senior house officers were also from overseas, op. cit., note 13. Royal College of Physicians of London, "Medical Care of the Elderly: Report of the Working Party of the Royal College of Physicians of London," Lancet, 1977, 1: 1092-1095. The Royal Commission on the NHS supported the concept of a speciality of geriatric medicine but favoured the appointment of physicians with special interest rather than those wholly committed to the care of the elderly. The Commission accepted this was not the view of some leading geriatricians. Sir Alex Merrison Royal Commission on the National Health Service. London: HMSO, 1979.
Setting the Scene

between the two specialities. This latter suggestion did not find favour with the general physicians who considered it would reduce the calibre of those applying for their posts.\textsuperscript{17} Furthermore they were not keen to have the geriatricians 'on take' with them because they considered they were poorly trained in clinical and academic skills.\textsuperscript{18} On the other hand the editorial writer of the \textit{Lancet} in 1977 was generally supportive.\textsuperscript{19} General practitioners took a pragmatic view when wishing to admit an elderly patient with mixed social and medical problems. They referred the patient to the geriatrician rather than the general physician because the former provided quick and easy domiciliary visits, which were helpful to both patient and relatives in planning management.

This negative attitude towards sick elderly people received some support from eminent authorities. William Beveridge in 1942 wrote, while acknowledging 'the nature and extent of the provision to be made for old age is the most important and in some ways the most difficult, of all problems of social security,' (para 233) went on 'It is dangerous to be in any way lavish to old age until adequate provision has been made for all other vital needs such as the prevention of disease and the adequate nutrition of the young' (para 236).\textsuperscript{20} Sixteen years later Shenfield wrote 'the aged had become the new poor of the post

\textsuperscript{17} Dr. Alex Baker, the first Director of the Hospital Advisory Service, also concluded the general physicians were reluctant to rotate their junior doctor posts and were not sympathetic to treating the older patient. Baker A. A., \textit{Hospital Care for the Elderly}. Age Concern: England, 1974.


General physicians have argued that the average age of patients in a large number of acute medical wards was probably not very different from those in geriatric wards and pointed out many elderly patients were admitted to general medical wards. Dr. John Leonard, a general physician in Manchester, argued that the ‘on take’ general physicians acquired experience of medicine in the elderly, and geriatric medicine should become part of general medicine, which would improve recruitment. This aroused fierce correspondence from geriatricians, who disagreed. Dr. Fine, a geriatrician in Liverpool, argued that the general physician failed to diagnose older patients quickly and to motivate the nursing team. Furthermore geriatricians looked after the ‘old elderly’ while the general physician looked after the ‘young elderly’ who were, in general, ‘healthier’ than the older people and often had only one pathology. Dr. Malcolm Hodkinson, a geriatrician, made the age point unambiguously. The average age of his patients at Northwick Park Hospital was 79.5 years, and while his general physician colleagues saw slightly more of those aged 66-75, he saw five times as many of aged over 75 years and fifteen times more of those aged over 85 years.


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Thus the indifference of the general physicians was multifactorial. The lack of dramatic clinical appeal, the slow response to treatment, the fear of bed blocking, poor facilities and the presence of social factors were probably the main considerations. One is left to wonder who they would choose to treat them when they themselves became 'geriatric'. On the other hand the geriatrician could point to the challenge and satisfaction of working with older people, the need for leadership, good clinical skills, and a sense of the ridiculous, much patience and empathy with the older person who could be humorous, mellow and resilient.

The ‘Chronic Sick’

Who were the ‘chronic sick’? No exact definition seems to exist. The term meant/means different things to different people. In 1932 the Chief Medical Officer, Sir George Newman, reported in ‘the sick wards of a mixed institution there are many aged inmates suffering from chronic rheumatism, from hemiplegia, from failing heart action and from mere senescence of body or mind’ (p.133).25 In 1934 he viewed the term ‘chronic sick’ as a loose one, which appeared to be interpreted differently in different areas, and even the designation ‘acute sick’ was capable of varying meanings. Sir George, while extolling the value of classification of in-patients, implied the ‘chronic sick’ were ‘those suffering from chronic or incurable complaints for whom little or no benefit can be expected from remedial treatment, but who do require nursing care and

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medical supervision.' (p.198). In 1943 Dr. Letitia Fairfield, a barrister-at-law and a senior medical officer for the London County Council, commented the diagnosis of 'chronic sick' was a serious matter and, by implication, criticised those who appeared to make the diagnosis too readily. She stated it should be made only after careful examination, preferably in a fully equipped acute hospital, when an estimate could be made of the degree of incapacity, the probable expectation of life and the need for palliative treatment. 'Lack of these obvious precautions has led to deplorable errors in disposal, as for example, patients with minor or improvable defects being cast unnecessarily into the stagnant pool of a workhouse ward' (p.455). In 1945 the hospital survey team of the North Western Area reflected on the term 'chronic sick'. The members considered it excluded those aged and infirm who were not bedridden and did not need nursing. The team visiting London observed the term 'chronic sick' was used in an infinite variety of meanings. 'In its broadest sense it included all who were not acutely sick...It is used to describe those with long standing conditions usually associated with increasing age' (p.19). Amulree and Sturdee found 71% of the 'chronic sick' in the county hospitals and institutions in Surrey in 1943 were aged over 65


years. During the war, voluntary hospitals extended the term ‘chronic sick’ to include babies with pneumonia, acute bronchitis in young men, and women with influenza. They maintained this stance in spite of a large stock of empty beds during this period. Warren accepted ‘there is no accurate or precise definition of the term ‘chronic sick’, in the minds of most people the term referred to patients over 60-65 years’. In 1946 the Nuffield Foundation declared the term covered a multitude of different conditions. A 1947 British Medical Association report stressed the elderly were not a homogeneous group. Abel-Smith observed whenever the question of admission arose, these ‘chronic sick’ patients would be placed at the end of the queue, because they might ‘block beds’.

Others entered the field of definitions. The British Medical Association attempted to clarify the muddy waters in 1947 by categorising the elderly sick into: the acutely ill who needed the same facilities as a younger person and who should be in a district general hospital; the long term sick who are potentially

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34 "Report (1947) of the Committee on the Care and Treatment of the Elderly and Infirm," British Medical Journal: Supplement, 1947, 1: 133-140. The non-homogeneity of elderly people was echoed by Wilkin and Hughes who disagreed with the view that 'old age is...a time of deterioration in health, greater physical and/or mental infirmity and increasing dependency on others' (p 164). Wilkin D. Hughes B., "The Elderly and the Health Services," in, Ageing and Social Policy, ed. Phillipson C. and Walker A. Aldershot (UK) and Brookfield(USA): Gower, 1986.

35 Abel-Smith B., op. cit., note 31.
remediable, and finally the irremediable. In the same year the Ministry of Health divided patients into groups including one for those with chronic complaints with no further expected benefit but who did need nursing care and attention. In 1948 the Ministry of Health defined sickness and infirmity:

Sick – and therefore proper to the [Health] board – patients requiring continued medical attention or supervision and nursing care. This would include very old people who, though not suffering from any particular disease, are confined to bed on account of extreme weakness.

Infirm – and therefore proper to the local authority - persons who are normally able to get up and who could attend meals either in the dining room or in a nearby day room. This class would include those who need a certain amount of help from the staff in dressing, in toileting or in moving from room to room, and also those who, from time to time –e.g. in bad weather - may need to spend a few days in bed (para 2).

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36 *British Medical Journal: Supplement*. op. cit., note 34. Amulree, Cosin, Warren, and Brooke were members of the committee.


These definitions were generally recognised as unrealistic, largely because old people frequently passed from one category to the other and back again.\(^3\) Shenfield agreed – 'the dichotomy of administration of services for the elderly...assumes a convenient dividing line between the healthy and the sick, which in practice is not always easy to determine' (p.159).\(^4\) Sir John Charles, the Chief Medical Officer, also concurred: in 1952 he wrote 'the problem of... the borderline cases [is] particularly difficult to solve' (p.16).\(^5\) In 1957 the Ministry attempted another definition.\(^6\) The chronic sick were those 'patients who cannot benefit from active treatment but who require a higher standard of nursing than can in fact be provided in their own homes or can properly be provided in local authority accommodation - the genuine chronic sick' (para 23).

Reviewing the in-patients in the long-stay wards is another way of deciding who might be considered as 'chronic sick'. In a series of papers starting in 1943 Warren described the 874 patients she found in the local Public Assistance Institution.\(^7\) In the same ward were senile dement, restless and noisy patients, elderly sick patients, elderly destitute people, bedridden patients with a variety of


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degenerative conditions, and unmarried mothers with their infants. She divided chronic sick ward patients into five groups: chronic and mobile; chronic, continent and bed ridden; chronic and incontinent; senile and quiet; and last, those senile people who needed to be segregated from the others. Mr. Lionel Cosin, at Orsett Lodge Hospital, found physically disabled and permanently bedfast people, who needed every nursing care and attention, among his long-stay patients.44

So who were the ‘chronic sick’? The geriatricians, who presumably treated more ‘chronic sick’ patients than anybody else, probably considered them as: those who failed to respond to currently available treatment and rehabilitation even after a prolonged period, required constant skilled nursing care and/or complex drug therapy. The general physician probably considered them as elderly patients with long-term disabilities whom they could not cure.45

The development of hospitals in England

Health care might be considered to start with that provided by the monasteries, which continued until they were dissolved in 1536. According to Amulree ‘a large number of elderly helpless persons benefited from the custom of

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44 Cosin L., "Organising a Geriatric Department," British Medical Journal, 1947, 2: 1044-1046

45 Warren disliked the word chronic, since it implied a negative and disparaging attitude towards the patients concerned. She hoped the term chronic sick would be dropped as old fashioned and long term sick used instead. Warren M. W., "Medical Care of the Aged," The Medical Officer, 1950, 84: 98-99. Banks in 1945 also disliked the term chronic sick as it had become associated with the incurable and 'uninteresting' long-stay case. Banks A. Leslie, "The Care of the Infirm and the Long-Stay Patient," Ministry of Health Monthly Bulletin, 1945, 4: 112-118. Once a label of chronic sick had been attached to a patient all further questioning of the diagnosis ceased and the patient would be 'written off'. Amulree was not enamoured of the term chronic sick since it implied medical failure to recognise a condition as treatable and more importantly as remediable. Lord Amulree, Arnold P. and Polak A., "Length of Stay in Hospital of the Aged Sick," Lancet, 1952, 2: 191.
receiving doles of money and food at the monastery gates’ (p.9).\textsuperscript{46} He noted ‘people in general continued in work until a great age, and only to cease when some real physical infirmity prevented them’ (p.9). Most illnesses were managed at home with the help of family members and only those who could afford it went into hospital.

Hospitals did not become central to health care until the 19\textsuperscript{th}-20\textsuperscript{th} centuries, by which time two different types of hospital were evolving: the voluntary hospitals and the workhouse/municipal infirmaries.\textsuperscript{47} Voluntary hospitals, some of which dated back to the 10\textsuperscript{th} century, could either be general or specialised, such as ENT, maternity and infectious diseases. Their finance came initially from endowments, subscriptions, fees and fund raising, but costs due to salaries, expenses and improvement schemes tended to outstrip income. By 1861 there were some 11,000 patients in voluntary hospitals.\textsuperscript{48} Between 1911 and 1938 in England and Wales the number of voluntary hospitals increased from 783 to 1,255.\textsuperscript{49}

Workhouse infirmaries were funded by local rates. They evolved to cope with the illnesses of the inmates of the workhouse but they lacked operating theatres or out-patient departments. Some admitted elderly people directly from their own home, including those refused admission by the voluntary hospitals.

\textsuperscript{46} Lord Amulree, \textit{Adding Life to Years}. London: The National Council of Social Service (Incorporated), 1951.

\textsuperscript{47} Abel-Smith B., op. cit., note 31.

\textsuperscript{48} Ibid.
They gradually tended to become long-stay institutions for the chronic sick. The relieving officer, an appointee of the Board of Guardians, could force infirmaries to accept patients even if they were full, but had no such powers over voluntary hospitals. Other types of state hospitals also evolved, which included those for infectious diseases, tuberculosis, mental disorders as well as large general hospitals.

Figure 2.1 A typical workhouse institution in the Birmingham region.50

Unsatisfactory conditions and examples of poor care in workhouses and infirmaries in the 1860s caused concern and resulted in visits by the Lancet commissioners and the inspectors of the Poor Law Board. The full report of the Lancet Sanitary Commission was issued in 1869.51 The introduction stated that 'State hospitals are in workhouse wards. They are closed against observation. They contravene the rules of hygiene... The doctor and the patient are alike the


50 Sheldon, J. H. Geriatric Services in Birmingham Regional Hospital Board. Birmingham: Birmingham Regional Hospital Board, 1960.

51 The Lancet Sanitary Commission. London: Lancet, 1869. The commissioners were Mr. Ernest Hart of St. Mary's Hospital, Dr. Anstie of Westminster Hospital and Dr. Carr of Blackheath.
objects of a pinching parsimony' (p.v). 'Multitudes of sufferers from chronic disease...crowd the so-called 'infirm' ward of the house' (p.8). 'The fate of the 'infirm' inmates of crowded workhouses is lamentable in the extreme; they lead a life which would be like that of a vegetable, were it not that it preserves the doubtful privilege of sensibility to pain and mental misery' (p. 8). 'If all the infirm were medically treated there would be a very large percentage of recovery and...an important saving on the rates’ (p.9). 'The medical officers [in workhouse infirmaries] are habitually placed in an entirely false position, by having twice or three times as many persons under their nominal change as they can possibly do justice to.’ (p. 30). The Editor of the Lancet called workhouses 'The Antechambers of the Grave'.

As a result of the 1929 Local Government Act, half the Public Assistance Institutions were taken over by the Public Health Committees of the local authorities. The Public Assistance Committees became responsible for those beds which were not appropriated. However the quality of service provided by the local authorities to the residents was uneven and tended to be of better quality where rate revenue was significantly boosted by income from the Exchequer. By 1939 there were 149,000 residents in beds in England and Wales controlled by Public Assistance Committees with nearly 60,000 classified as sick. The 1941-1945 wartime surveys of hospitals revealed the grim state of services for elderly patients, with severe shortage of medical staff and poor coordination between the various caring services.

52 Webster op. cit., note 49.
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The situation before the inception of the NHS could be summarised as the absence of any central guiding philosophy or driving force behind the development of universal health care services, although the Local Government Act of 1929 had attempted to unify medical care of the chronic sick. Webster described the situation before the NHS as ‘a patchwork of ramshackle and uncoordinated services’ (p.89), hostility between sections of the service and increasingly chaotic funding, with a hospital service which was unevenly distributed and limited in rural areas.53

On the Appointed Day, 5th July 1948, 1,143 voluntary hospitals with some 90,000 beds and 1,545 municipal hospitals with 315,000 beds were taken over and placed under the control of regional hospital boards. This left 66,000 beds under the control of the Public Assistance Committees.54

**The term Geriatrics: origins, meaning and acceptability**

The evolution of the terminology has been the subject of much debate. The word *gerocomy*, attributed to Galen, was used for the medical care of the elderly and was adapted to *geroncology* for their sociological aspects.55 In 1903 Metchnikoff invented the word *gerontology* for the biological study of the ageing process. Dr. Ignatz Nascher, an American, is generally credited with coining the word *geriatrics*.56 ‘The term was…derived from the Greek, *geron*, old man and


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*iatrikos*, medical treatment. The etymological construction is faulty but euphony and mnemonic expediency were considered of more importance than correct grammatical construction' (preface p.ix). He is commonly known as 'The Father of Geriatric Medicine'. Warren maintained *geriatrics* derived from *geros* meaning old age and *iatrikos* pertaining to a physician and had come to mean the medical treatment of elderly people.\(^5\) *Gerontology*, she considered, meant the study of all problems of ageing. Howell added a footnote to the debate by pointing out at least one author had confused *gerontology* (the science of old age) and *geriatrics* (the care of the aged).\(^5\)\(^8\) He thought that *gerocomy* (defined by the Oxford English Dictionary as the science of the treatment of the aged) was a term too good to be abandoned and could be used for non-medical aspects of care of the aged such as accommodation, clothing etc. In 1950 Sir James Ross suggested the word *eugeria*, meaning well-being in old age or healthy old age, was more appropriate.\(^5\)\(^9\) He also pointed out that *hygieia* meant health and *eudaemonia* meant happiness. He did not like the word *geriatrics*.\(^6\)\(^0\) The writer of a *Lancet* editorial in 1963 thought the word ugly and unscholarly but coining it drew attention to this 'essential province of medicine' (p.1037).\(^6\)\(^1\)

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\(^8\) Howell T. H., "New Words About Old Age," *Lancet*, 1946, 2: 214. He considered that both words related to Sir John Floyer’s publication of *Medicina Gerocomica*’ in 1724.


For many years elderly care physicians appeared content with the word *geriatrics* probably because of its parallel with *paediatrics*. Recently in the United Kingdom the elderly and their doctors questioned its appropriateness. The elderly were not a homogeneous group of people: those who were sensible objected strongly to being labelled as *geriatric*, which they viewed as synonymous with *senile*. Boucher, a Senior Medical Officer at the Ministry of Health, thought the word *geriatrician* was unfortunate and unattractive, and ought to be discarded because it meant different things to different people. The title suggested a new speciality and aroused suspicions particularly in those who had ignored their responsibilities in the past. He suggested an alternative to *geriatrician* could be *gerocomist*, but this hardly seems an attractive word. His view was such doctors should be called *physician for the elderly*. Sir Donald Acheson - later a Chief Medical Officer – also considered the word *geriatrics* was derogatory to both patients and staff. Professor Grimley Evans, a geriatrician, attacked the word *gerontology* (the study of old men) as a barbarous misspelling and considered the word should be *geratology*, the study of old age.

The founders of the Medical Society for the Care of the Elderly had exercised great care in choosing the original name of the Society and did not use the word

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Professor Adams, a past president of the British Geriatrics Society, suggested an alternative to geriatrics was *eld health*, citing in support of this view *child health* was more felicitous than *paediatrics* and the early English word for *old* was *eld*.

The British Geriatrics Society echoed the general disquiet and frequently attempted to find a more acceptable name. After much debate, the name was left alone but a sub-title has been added: ‘Specialist Medical Society for Health in Old Age’. Many U.K. hospital geriatric units, also aware of the public’s perception of geriatrics, called themselves ‘Department for the Medical Care of the Elderly’ or ‘Care of the Elderly Department’.

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65 Howell and Warren, founder members of the Medical Society for the Care of the Elderly, commented the word *geriatric* was, in 1940s, almost unknown. Indeed it was treated with some suspicion and had not been widely accepted in the United Kingdom at that time. Howell T. H., "Origins of the British Geriatrics Society," *Age and Ageing*, 1974, 3: 69-72. Warren M. W., "Care of the Chronic Aged Sick," *Lancet*, 1946, 1: 841-843.

Chapter Three

Hospital Services for the Elderly in England 1929-1945

Introduction

This chapter considers the main developments in hospital services after the 1929 Local Government Act up to the end of Second World War and their effect on the 'chronic sick'.

Before World War Two incurable, elderly and chronic patients who could not afford care were admitted to the Poor Law infirmary or its successors.¹ They tried to avoid this because of the stigma and poor conditions in these institutions.² Nonetheless pressure for admission to these institutions was likely to increase because the number of the over 65-year-old population was increasing. In 1841 it was 4.5%, 4.7% by 1901, 7.8% by 1921, 9.6% by 1931 and 10.5% in 1947.³

Three events changed the situation. First, the 1929 Local Government Act transferred control of Poor Law institutions and infirmaries to the local

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¹ The Poor Law Amendment Act of 1834 limited out door relief and was more likely to force chronic patients to enter the workhouse.

² However the Medical Officer of Health for Northants and his county public assistance colleague thought ‘in recent years the attitude of the public towards county institutions had altered, the stigma of the poor law is rapidly disappearing, if not already gone, institutional life has become more pleasant and old people are no longer averse to seeking admission’. They did recommend periodic review of inmates so that those who no longer needed to be there could be discharged – this suggests once persons were admitted they might never be discharged. Abbott W. H. and Smith C. M., "Public Assistance Beds," Lancet, 1938, i: 1247.

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authorities. Doctors, who were used to treating acutely ill patients, now had responsibility for the chronic sick and 'incurable'. Second, the Emergency Medical Service which was created to treat wartime civilian and service casualties resulted in massive discharge of patients at the start of the war and the evacuation of chronic sick and elderly derelicts to hospitals outside the metropolitan areas. Third, the 1941-1945 Hospital Surveys revealed the unsatisfactory state of the hospital service for the chronic sick.

The First Event: Local Government Act (1929)

Prior to the passage of the Local Government Act a bipartite system of health care existed in England and Wales, 'one part for the pauper and the other part for the non-pauper' (p.70). Paupers were admitted to Poor Law infirmaries, which were established alongside workhouses to treat those residents who were infirm and suffered from chronic sickness. The Chief Medical Officer, Sir George Newman considered the new Act would bring this to an end and produce one system for all, which would be made more comprehensive and effective than previously practical. Indeed Thane thought the Act improved conditions in Poor Law institutions.

(a) Transfer of Control to Local Authorities

On April 1st 1930, the 1929 Local Government Act transferred the responsibilities of the old Board of Guardians to the Public Health and Public

\[\text{\footnotesize 4} \text{ Ministry of Health. } \text{Annual Report of Chief Medical Officer 1928. London: HMSO, 1929.} \]

\[\text{\footnotesize 5} \text{ Thane P., "Inventing Geriatric Medicine," in, } \text{Old Age in English History, ed. Thane P., Oxford: Oxford University Press, 2000.} \]
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Assistance Committees of the County Councils and County Borough Councils.

The Act made the development of the hospital service part of an integrated public health service of the local authorities. The latter were encouraged to appropriate from the Public Assistance service those institutions which were suitable, or could be readily made suitable, for use as public health hospitals. This proved easier for the County Borough Councils as compared with the County Councils, though the Chief Medical Officer criticised both Councils for being dilatory.\(^6\) The cost of appropriations of infirmaries was met by grants in aid, to be replaced later by consolidated block grants or by loans.\(^7\)

Sick patients in Poor Law infirmaries became the responsibility of the Medical Officers of Health.\(^8\) However the admission of the destitute sick under the new arrangements still caused problems. In 1932 the Chief Medical Officer, Sir George Newman, put it succinctly, ‘the paramount issue is the healing and benefit of the patient’ (p.132).\(^9\) In 1935 Chief Medical Officer, Sir Arthur MacNulty, wrote ‘Until the needs of destitute persons for hospital treatment are satisfied, the Councils are not entitled to utilise beds in an appropriated hospital

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\(^8\) In 1936 there were 1,045 Medical Officers of Health. Ministry of Health. *Annual Report of Chief Medical Officer 1936*. London: HMSO, 1937.
for other members of the community...The essential test for admission...is the need for some form of treatment’ (p.136).¹⁰

(b) Health Surveys

The Ministry of Health health surveys started in 1930 but were curtailed in 1939 by the civil defence exigencies. Sir George Newman emphasised there was nothing new in these surveys – they dated back to the days of Edwin Chadwick.¹¹ The surveys were designed to satisfy the Minister of Health that the local authorities were achieving and maintaining a reasonable standard of efficiency and progress in the discharge of their function relating to public health services (including hospitals), and that their expenditure was not excessive or unreasonable.¹² Each survey involved a complete review of all the health services of a local authority. By 1931, 44 of the 83 County Boroughs and 27 of the 61 Counties in England and Wales had been investigated.

The Chief Medical Officer reiterated that standards of medical treatment must not be allowed to become perfunctory.¹³ He gave evidence of inadequate care: e.g. a female of 54 admitted 8 years ago with a suspected gastric ulcer, was still

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occasionally vomiting, still without special treatment and still with no diagnosis. He gently admonished the unnamed hospital and suggested the appointment of a consultant could have considerable advantages. He exhorted the medical staff to keep clinical records of the patients in accordance with the Public Assistance Order: 'The keeping of a clinical record of inmates of sick wards...is a duty which is sometimes neglected or perfunctorily carried out' (p.134, Chief Medical Officer 1932).

(c) Hospital and Bed Numbers

The Ministry of Health annual reports for 1931-8 showed a steady increase in the number of hospitals and beds coming under local authority control with a concomitant decrease in Poor Law infirmary beds, see Table 3.1.14 This shows, between 1931-8, the number of Poor Law hospitals fell by 140, with an associated reduction of 25,603 beds. The local authorities acquired 75 hospitals and 30,899 beds. The London County Council became arguably one of the largest hospital authorities in the world. By 1936-7 the Ministry of Health reported local authorities controlled seven-tenths of hospital beds in England and Wales. The value of an out-patient department in providing an improved service to patients was frequently reiterated.

Table 3.1 shows how the number of Poor Law hospitals and beds changed between 1931 and 1938.\textsuperscript{15}

The quality of accommodation in Public Assistance Institutions was criticised. Warren described the pre-1946 wards for the elderly as scrupulously clean, with highly polished floors, dark walls, high windows but with no furniture or flowers, lockers or evidence of personal possessions. The beds were neatly made in perfect line with each other and invariably tidy, but the staff were usually uninterested in their patients. Equipment and ancillary services were lacking. Treatment was limited to nursing care.

(d) The Classification and Clinical Care of Infirmary Patients

The Chief Medical Officer’s annual reports of 1932 and 1934 drew attention to a classification of hospital patients, which he had instigated in 1930, although the principle was contained in his report of 1929.\textsuperscript{16} Its primary function was administrative – to estimate the institutional requirements of an area. However it was found to have a substantial role in identifying neglected patients and those

who should not be in hospital at all. This point was mentioned in virtually every Chief Medical Officer's annual report and was reiterated, yet again, in the Ministry of Health report of 1946.¹⁷ The classification was broadly as follows: first, persons who did not need nursing care and attendance, including infants and nursing mothers; second, persons with some infirmity not needing nursing care; third, patients with chronic complaints with no further expected benefit from treatment but who did need nursing care and attention; fourth, patients with chronic/recurrent afflictions who should improve with treatment and then go home; fifth, patients with afflictions who might get better with improved diagnosis and treatment; sixth, patients with acute/sub acute conditions; seventh, maternity cases; last, mentally ill patients.¹⁸

The Chief Medical Officer's annual reports of 1932, 1933 and 1935 commented on patient care, emphasising the criterion for admission should be sickness not destitution.¹⁹ A study of unidentified hospitals in a large county borough council and a county council showed the largest group of patients was


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the chronic sick. 20% of the acutely ill patients were in institutions doubtfully suited to their needs. These figures could be questioned since, as Sir George Newman realised, the words 'chronic sick' could be interpreted in varying ways.20

The suggested solution was to assess the need for skilled nursing. Sir George recommended prompt treatment on admission to prevent chronicity. Patients should be placed in the correct hospital environment to encourage the prospects of recovery and not transferred to other hospitals until they had received adequate treatment or unless the receiving hospital had better facilities, neither should they be in hospital if they no longer needed treatment.21 A negative attitude towards discharge could develop when large numbers of aged and chronic sick accumulated on a ward, such as patients with chronic rheumatism, hemiplegia, and heart failure as well as younger patients with rheumatoid arthritis, accidents and deformities.22

The Chief Medical Officer noted in 1930 arguments in favour of transferring bed-ridden infirm patients from an acute hospital to an appropriate ward in the poor law 'house'.23 Reasons given included: first, the care and attendance they required was thought to be given more consistently by women skilled in this type of work; second, the routine of the ward was better adjusted to their comfort;


third, should such patients became ill they could be rapidly transferred to an acute hospital ward; and last, the presence of chronic infirm patients in a hospital was calculated to lower medical and nursing standards throughout the hospital.

(e) The Hospital Buildings

Both the Ministry of Health and the Chief Medical Officers reported on the quality of hospital fabric. Transferred hospitals varied in quality of accommodation, size and suitability, and efficiency of plant and machinery. Many dated back to the fourth decade of the previous century while a few were even older. They were built for a purpose that differed from their current use and were used for different types of inmates from those originally admitted. Some buildings did not conform to modern requirements. The wards were ill lighted, poorly ventilated and heated, sanitary and bathing facilities were inadequate; side rooms such as duty areas and kitchens were sometimes insufficient. In general, however, 'local authorities as a whole are maintaining reasonable standard of efficiency and progress' (p.44, Ministry of Health, 1932) but there were examples of imperfect coordination of services, poor control of medical services and poor use of X-ray facilities.

(f) Medical Staffing

Between 1929 and 1934 Sir George Newman reported on medical staffing of appropriated infirmaries, recommending increased consultant input, better junior

staffing and medical quality of care. Some infirmaries had a full staff of consultants, appointed on annual salaries, and who were required to visit weekly or as required. Others occasionally obtained the services of consultants, who could only advise because they were not in charge of the patients. He discussed the need for competent junior staff, particularly in surgery if they were to undertake large numbers of major operations. Competence, he suggested, could be measured by the number of years of surgical experience and possession of a higher qualification e.g. FRCS. He suggested improved salaries and appointment of consulting staff, who would have full charge of, and responsibility for, the patients. Surgical resident staff could carry out emergency work at night provided they were supervised by more experienced staff like the 'First Assistants' in voluntary hospitals. He recommended resident staff be appointed for short periods of time to ensure first, the experience of acute hospital work spread across as many doctors as possible and second, to prevent staff becoming 'fossilised' by retaining them when they had lost their drive and enthusiasm. Sir George criticised Poor Law infirmaries without resident medical staff, leaving a busy private practitioner to provide cover in addition to his many duties in the community. He recommended that the Medical Officer of Health should have at his disposal, when taking over an infirmary, a clinician who would periodically

25 Rudd pointed out Poor Law medicine became what it was because of the bad conditions of employment, which high grade professionals would not accept. Colleagues despaired those who did, even after changes in hospital conditions. He put it succinctly 'to minister to the neglected, the undernourished, those with long term conditions and the dying is no longer considered an adequate role for workers with high standards of clinical experience. (p. 394/5) Rudd T.N., "The Challenge of Chronic Disease in Old Age," Postgraduate Medical Journal, 1963, 39: 394-400.

consult with the Medical Officer and review the patients in institutions. The Medical Officers were expected to cooperate with the local medical practitioners, who were initially fearful that public health services would erode their private practice.27

(g) Nursing Staff

The Ministry and the Chief Medical Officers discussed the quality and quantity of nursing staff in the old Poor Law infirmaries. Sir George acknowledged the comfort and welfare of the sick in Poor Law infirmaries were largely dependent on the adequacy and efficiency of the nursing staff.28 His 1932 report commented on nursing/bed ratios, which varied from 1:6 with 31% bedridden patients to 1:13 with 27% bedridden patients.29 Nurse/bed ratios tended to be worse in the small rural infirmaries, which often had more untrained staff than the voluntary hospitals. Nurses worked excessive hours although this had improved. The disadvantage of such excessive hours included deteriorating efficiency, declining quality of care with the risk of mistakes, and impaired recruitment. The 1934 Ministry of Health report referred to the inadequacy and unsuitability of accommodation for nurses – 'a point of criticism which has recurred quite frequently in the survey reports' (p.62).30 The problem, it said, might have resulted from improvements in ward areas taking priority over

28 Ibid.
29 Ministry of Health. op. cit., note 11.
upgrading the nursing accommodation. Training of probationer nurses in Poor Law Infirmarys could only take place in those institutions approved by the Minister of Health for that purpose. The General Nursing Council kept the situation under review.31

(h) Local authorities' relationship with voluntary hospitals

The Local Government Act directed local authorities to cooperate and consult with voluntary hospitals to ensure that public and voluntary systems were cooperative and complimentary, and not overlapping or competing.32 Local authorities could offer financial support to voluntary hospitals or even use part of their buildings for its own purposes. Hospital staffs were encouraged to work in local authority hospitals, to decide what diseases should be treated, at which hospital and to arrange transfer of patients as necessary. The Chief Medical Officer strongly emphasised the policy of pooling resources for the benefit of patients.33

The Second Event: the Emergency Medical Service (EMS)

The Ministry of Health started planning an emergency medical service as war loomed closer.34 A very large number of civilian and service causalities were expected in the first few days of war – 25,000 casualties per day for the first ten

31 Ibid.
33 Ministry of Health. op. cit., see note 10.
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days of war.\textsuperscript{35} A base line of information was required, so a survey of all ordinary hospitals (excluding mental hospitals, mental deficiency colonies and service hospitals) in England and Wales was carried out – in all about half a million beds were reviewed.\textsuperscript{36} Hospitals were placed under central control and organised into groups – one in each group acting as a centre for casualties, which would triage patients to other suitable hospitals in the suburbs or rural areas. The general policy was to move casualties away from the point of attack e.g. from London to suburban and rural areas.

To provide empty beds for the large number of expected casualties the Ministry of Health arranged, in the first week of September 1939, for patients no longer needing to be in hospital to be discharged, and extra beds put up (known as ‘crowding’), thus creating 190,000 empty beds.\textsuperscript{37} Large numbers of empty, but staffed, beds were kept available throughout the war. In January 1941, there were 187,000 beds for EMS casualties, while on 31\textsuperscript{st} March 1944 there were 40,000. A cadre of whole time salaried medical officers of various grades was created to

\textsuperscript{35} The Air Ministry anticipated that the Luftwaffe would attempt a ‘knock out’ blow in the first few days of the war and considered 300,000 beds would be required in Great Britain – a figure two to three times the size of the whole fighting strength of the British Expeditionary Force. 190,000 beds were made available during the first week of September 1939 although some patients were inappropriately discharged home. In the event 60,854 civilians were killed, 86,159 seriously injured and some 132,000 slightly injured during the whole war period. The number of civilians killed was nearly one quarter of those killed in the Armed Forces of the United Kingdom in all theatres of war, while those wounded was more than three quarters of those wounded in the Armed Forces. Elliot Right Hon. W., "Medicine and the State," British Medical Journal, 1945, 2: 911-914. Ministry of Health. Annual Report of Chief Medical Officer for 1939-1945. London: HMSO, 1946.

\textsuperscript{36} Ibid.

staff these beds. By 31st March 1941, 1,737 doctors were employed whole time and 564 part time.

Eventually the large number of empty beds caused pressure on the Ministry to relax rules for the admission of ordinary sick civilian patients and, as a result, all hospitals were allowed to admit civilian sick up to 75% of their normal capacity. The admission of the chronic sick was well down the list of priorities. Over 7,600 chronic sick and shelter derelicts, found in public shelters and rest centres in London during the air raid period, were evacuated to emergency hospitals in the provinces or coastal areas during 10th October–14th November 1940. Similar transfers took place in Southampton, Plymouth, and Cardiff. Later these chronic patients were transferred to other accommodation. The Ministry considered evacuating aged people from their own homes but due to problems of finding suitable accommodation, only a few were moved.

In 1947 Dr. Edwin Sturdee, a Principal Medical Officer at the Ministry of Health, reported the Ministry undertook an inquiry, during the latter part of the war, into the number and condition of patients who had been evacuated from the chronic wards of hospital in dangerous areas to institutions in safer parts of the country.

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38 Ibid.


It was something of a shock to find that while the patients were being fed and cared for to the extent of being kept clean and free from bedsores, little or nothing was being done in the way of active treatment or rehabilitation. The common view seemed to be that the patients were 'chronic sick', and no treatment would be of any avail. They must therefore be kept in bed until they died, in five, ten or possibly twenty years' time (p.360).

The Third Event: the Hospital Surveys

In 1941, while the country was still standing alone against Nazi Germany, the Ministry of Health commissioned a series of regional hospital surveys, which would form part of the information base for the future National Health Service. The surveyors were chosen from those with past and present experience of hospital work - one was Dr. George Godber, later to become the Chief Medical Officer. The reports, published in 1945, were based on a questionnaire and visits, and varied considerably in style and presentation. Some were more a blueprint for the future; and others were substantial, forthright in their comments before proceeding to make recommendations. Many, in varying degrees, were devastating about the care of the chronic sick. The Sheffield report said, for example, 'there has been widespread failure to treat the problem of the chronic sick as primarily a medical one and as such of the highest importance' (p.59). The West Midlands report stated, ‘the surveyors have been impressed with the

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need of a complete change of outlook in the care of the chronic sick both in the organisation of the professional work involved and in the type of accommodation which should be provided' (p.5). The Nuffield Provincial Hospital Trust summed up the reports 'It is for the provision for the chronic sick that the surveyors reserve their bitterest criticism' (p.15).

The accommodation was often inadequate. The Berkshire report wrote, 'The buildings are old, dark, devoid of modern sanitary conveniences, death traps in the case of 'fire' and unfit for the nursing of chronic sick or any other form of sick person' (para, 72). It continued 'the bulk of the Public Assistance Institutions that they have seen [are] so bad and so ill-adapted for carrying out the duties they are called on to perform that they recommend a complete reorganisation and establishment of a new service in modern buildings' (para 73). The Yorkshire report wrote 'the windows [of the wards] are so high from the floor that patients can see nothing but the sky' (para, 115). It noted wards above the ground floor were not equipped with lifts. 'The sanitary arrangements are in the great majority of cases completely out of date, insufficient numerically and difficult of access' (para, 115). Ideally, according to the West Midlands report, the accommodation

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43 Hunter J. B., Clark R. V. and Hart E., Ministry of Health: Hospital Surveys - The Hospital Services of the West Midlands Area. London: HMSO, 1945


for the chronic sick should be in light airy wards, in single storey buildings, with a pleasant outlook and easy access to gardens.\(^4\) These units should be linked to the nearest general hospital to enable periodic review by specialist staff.\(^4\)\(^8\)

Medical care was frequently criticised. The London report stated, 'the first essential is that every patient should be thoroughly examined and treated with a view to restoring a maximum degree of activity' (p. 19).\(^4\)\(^9\) The North-Western report noted that chronic hospitals found it difficult to provide staff of good quality.\(^5\)\(^0\) Reports suggested increasing the number of resident medical staff and the appointment of consultants to supervise patients. Although some institutions had permanent medical staff, some never requested visits by consulting staff.\(^5\)\(^1\) Six surveys mentioned the value of classification of patients. Three reports supported the admission of chronic sick patients to acute hospitals first, to ensure full investigation and adequate treatment before transfer to a chronic ward was

\(^4\) Hunter J. B., op. cit., note.43.
\(^8\) Although not part of this thesis the South Wales report makes interesting reading. The Welsh surveyors reported several buildings, used for the chronic sick, were erected between 1835 and 1845. 'They were intended 'as penitentiaries, where persons without means could be put to work under unattractive conditions'. 'These buildings were not intended for the chronic sick.' (para, 20). 'The worst and oldest buildings were set aside for the chronic sick' (para, 82). 'In short, they have to admit all the cases rejected by other hospitals and in need of institutional care' (para, 39). Jones A. T., Nixon Professor J. A. and Picken Professor R. M. F., *Welsh Board of Health*: *Hospital Surveys - The Hospital Services of South Wales and Monmouthshire*. London: HMSO, 1945


\(^5\)\(^0\) Carling Sir E. R. and McIntosh T. S., *Ministry of Health: Hospital Survey - The Hospital Services of the North-Western Area*. London: HMSO, 1945

\(^5\)\(^1\) Parsons Professor. L. G., op. cit., note 42.
considered. There was general support for medical students and nurses to be taught on these patients.

Several reports commented on the quality of staff accommodation and bed requirements, e.g. 'The proportion of trained staff is very low' (p. 10). Some reports noted that nurses were hampered by primitive and/or insufficient equipment. Three reports recommended the number of beds needed for the chronic sick – which varied from 1 to 2 per 1000 population.

Conclusions

Between 1929 and 1945 major upheavals occurred in hospital services in England. The Local Government Act of 1929 ended Poor Law control of infirmaries with the transfer of power to the local authorities. The Ministry of Health surveyed health services in the pre war years to ensure the authorities were achieving a reasonable standard of efficiency and progress. Deficiencies in accommodation, classification of patients and quality of care were found. During the Second World War shortage of beds meant the chronic sick had difficulty in gaining admission to hospital. Those who were admitted were frequently placed in poor quality accommodation and did not always get the correct standard of treatment. Their care required a complete and revolutionary change.

52 Parsons et al., op. cit., see note 42.
Chapter Four

The Opening Moves

Introduction

This chapter reviews the work of the first reformers, the conditions they found, the types of patients and the results of treatment.

The development of geriatric medicine in England is a story of endeavour, relatively ineffective at first, to reverse custodial care and medical neglect of elderly people in chronic sick hospitals. It is one of contrasts: apathy and enthusiasm; stagnation and innovation; antipathy and compassion; many indifferent physicians and a few keen reformers. The generally accepted turning point in the development of geriatric medicine in the United Kingdom was the appointment of Dr. Marjory Warren in 1926 to the West Middlesex Hospital, an acute admissions hospital. Initially her interest was surgery, but in 1935 she was given sole charge of 874 residents in a local Public Assistance Institution. Three other doctors, just a few years later, had similar ideas for changing the care of older sick people: a surgeon (Mr. Lionel Cosin), a general practitioner (Dr. Trevor Howell) and a general physician (Dr. Eric Brooke). The enthusiasm of these four put the 'new style' hospital care of the elderly patient firmly 'on the map'. After
the war a further wave of enthusiasts, such as Drs Agate, Davison and Wilson, began to make their mark.\(^1\)

The work of the four medical reformers influenced the Ministry of Health, and other organisations. Two medical officers of the Ministry of Health carried the message to the Houses of Parliament. The British Medical Association, in 1946, set up a committee on the Care of the Elderly and Infirm to provide a template for improved geriatric care for the newly created Regional Health Authorities. The Nuffield Foundation, which had assisted with the 1941-1945 Hospital Surveys, set up the National Council for the Care of Old People (NCCOP), chaired by Seebohm Rowntree.

Dr. Marjory Winsome Warren CBE, MRCS, LRCP, (1897-1960), was the eldest of five daughters of a barrister. She was tall, red haired and freckled. She

\(^1\) Dr. Joseph McMullan listed their achievements. He considered the newly established geriatricians amalgamated the knowledge of the medical specialist with community aspects of medical care of the elderly, and led the rehabilitation team with the aim of returning the patient to his/her own home. McMullan J. J., "The Problem of the Ageing Population," *Postgraduate Medical Journal*, 1963, 39; 382-383
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is generally accepted as the 'Mother of British Geriatric Medicine'. She was educated at the North London Collegiate School and qualified in 1923 at the London Hospital School of Medicine. Subsequently she had appointments at the Royal Free, Elizabeth Garrett Anderson, and Queen's Hospitals. She was appointed assistant medical officer at the West Middlesex Hospital in 1926. Initially her main interests were surgical – she performed over 4,000 major and minor operations and gave some 3,500 anaesthetics. Her appointment to the hospital placed her in a previously exclusive male preserve and she was viewed askance by her new colleagues. Dr. Matthews reported 'she endured the disapprobation of one Dr Cook, who told her flatly 'I'll have you know that I in no way approved of your appointment'" (p.253). However, within a few years she became deputy medical superintendent. In 1949 she was recognised as a consultant physician. In 1960 she was appointed CBE. She lectured to nurses and became an examiner for the General Nursing Council. During the post war period she became the Secretary of the International Association of Gerontology (IAG). She did not marry and lived with her sister. She died following a road traffic accident in Metz, France in 1960, when driving across Europe to Baden-Baden to give a lecture at the Medical Women's International Association. Her friends said she tended to pay more attention to her passengers and the exposition of her ideas than to the road conditions.3

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3 Ibid.
The Opening Moves

In 1935 the West Middlesex Hospital took over the adjacent Public Assistance Institution, which had been administered for the previous 5 years by the Middlesex County Council. Prior to that event a Board of Guardians had been in control. Warren was given the task of re-organising the care of the 874 patients. These included 16 maternity patients and about 144 'mental observation' patients, who were subsequently transferred to appropriate departments. This left 714 patients for further assessment. She found the same ward could contain young and old, senile dement, restless and noisy patients who required cot beds, incontinent patients, elderly sick patients who were treatable and patients who were relatively healthy. She described the situation:

Having lost all hope of recovery, with the knowledge that independence has gone, and with a feeling of helplessness and frustration, the patient rapidly loses morale and self respect and develops an apathetic...temperament, which leads to laziness and

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4 Warren's articles reveal slight discrepancies in the number of patients and the time period covered. The figures quoted above were given at a meeting at the Royal Society of Medicine. Warren M. W., "The Evolution of a Geriatric Unit from a Public Assistance Institution, 1935-1947," Proceedings of the Royal Society of Medicine, 1948, XLII: 337-338. In the same year an article in Geriatrics gave different figures. There she reported taking over about 700 patients, 200 of whom were transferred to a residential home after examination. A further 150 patients attached to mental observation wards were transferred to the care of the psychiatric staff. This left 350 really chronic sick patients who she examined and classified over a 7-month period, although a period of 10 months (June 1935-March 1935) given in the RSM paper. Warren M. W. "The Evolution of a Geriatric Unit," Geriatrics, 1948, 3: 42-50. During the next two years Warren was able to reduce her bed numbers from 514 to 200. However Adams, in 1975, mentioned 240 beds, while rather confusingly, Warren in 1950 said she eventually managed on 180 beds having previously had 520. Adams G. F., "Eld Health: Origins and Destiny of British Geriatrics," Age and Ageing, 1975, 4: 65-68. Warren M. W., "Medical Society for the Care of the Elderly," Lancet, 1950, 2: 861.

faulty habits, with or without incontinence. Lack of interest in the surroundings, confinement to bed...soon produces pressure sores...inevitable loss of muscle tone make for a completely bedridden state...[leading to] disuse atrophy of the lower limbs, with postural deformities, stiffness of joints, and contractures [see below]...in this miserable state, dull, apathetic, helpless, and hopeless, life lingers on, sometimes for years (p.841).  

Half of the 714 patients were bedridden: many for long periods of time. Initial assessment identified 200 elderly and destitute able-bodied workers, who did not need hospital care, and who were eventually transferred to a residential home. The remaining 514 patients were examined and classified during the period June 1935 and March 1936. In 1948 she was asked to supervise a further 200 elderly residents in an adjacent public assistance home.

Figure 4.2 Bedfast patient

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She attributed the neglect of elderly patients to many factors: first, lack of continuity of care associated with loss of medical interest, followed by early transfer to a ‘chronic ward’; second, failure to investigate and treat fully by modern methods; third, failure to provide first class equipment for the ‘chronic sick’; fourth, the elderly were usually on a pension and unlikely to be remunerative to private medical practitioners; fifth, the need for time and patience to obtain a history and examination; sixth, the longer time required to recover from illness; seventh, the presence of multiple pathology with a higher death rate; eighth, patient turnover was slow; and last, lack of medical appreciation of rehabilitation and how it should be carried out.\textsuperscript{9} She criticised the medical profession. ‘It is surprising that [it] has been so long awakening to its responsibilities towards the chronic sick and aged, and that the country at large should have been content to do so little for this section of the community’ (p.841).\textsuperscript{10}

Warren’s classification of patients had similarities to that of the Chief Medical Officer: chronic but relatively mobile; chronic, continent but bedridden; chronic and incontinent; senile but quietly restless, and senile dements who required to be segregated from other patients.\textsuperscript{11} The classification of the patients

\textsuperscript{9} Ibid.

\textsuperscript{10} Warren M. W., op. cit note 6.

helped to make a clinical diagnosis and decide on appropriate drug therapy.\textsuperscript{12} Warren's assessments found no previous classification of patients had been undertaken. Trained nurses, physiotherapists and occupational therapists thought it unimportant to work on geriatric wards. The wards were large, overcrowded, dull, inadequately lighted, with old and inadequate ward equipment. The beds were low, black in colour and old fashioned.

Warren placed patients with the same conditions and at the same stage of illness together in one ward, instead of being mixed up with patients with other diseases at differing stages of their illness, as was earlier practice.\textsuperscript{13} The new arrangements allowed some wards to be used for initial assessment, investigation, and treatment, with other wards for those needing restraint, and for female patients whose main or only disability was incontinence of urine and/or faeces. Other wards were needed for mobile patients awaiting discharge, and for those still needing a good deal of nursing and/or medical supervision.

She had strong views regarding elderly patients referred to her for possible transfer to one of her wards. She accepted for transfer only those patients she considered would benefit from further treatment or who needed treatment for other diseases. This could put her at odds with the expectations of the physicians and orthopaedic surgeons who were used to moving their patients, without consultation, to an elderly care ward. She achieved considerable progress with those patients she did accept. A woman of 62 years was sent to her (from an


unnamed well-known London hospital, where she had been in bed for nine months) because the physicians considered they could do nothing for her. Within one month of ordinary routine treatment she was walking in the ward.14 In 1950 she took 50 hand fed, incontinent and bedridden patients, who had been in that state for at least 2 years.15 After three months 20% were ambulant, independent and had returned home and a further 30% were up dressed and partly independent. In 1955 she accepted a 74-year-old woman from another unnamed hospital where she had been bedridden for 20 years. She was discharged from the West Middlesex Hospital after 30 weeks of successful rehabilitation.16 If she thought it appropriate patients should continue to be treated on the original ward, she would refuse to take them.17

Warren realised the importance of the environment in helping the patients make progress. She improved ward lighting by installation of individual indirect lights.18 She arranged the repainting of the wards from the previous dark colour to cream. High nursing beds in light pastel shades with adjustable backrests replaced the low, black coloured, old-fashioned beds. Each bed was provided with a single modern locker, a bed table and a pair of headphones as well as

17 According to Sheridan, who was Warren's social worker between 1948-1958 before becoming the Chief Welfare Officer at the Ministry of Health, this led to tremendous rows, particularly with the orthopaedic surgeons. Sheridan A. M. Geriatrics as a Speciality. London: The British Library, National Sound Archive. 1991.
The Opening Moves

bright red top blankets, light coloured bedspreads and patterned screen curtains. The wards were equipped with modern clinical aids, handrails, and suitable armchairs. Larger quantities of bed linen were provided for the incontinent patients. Framework obstructions in doorways were removed. Patients were given access to mobile libraries.

Warren developed rehabilitation as a team function carried out by medical and nursing staff, physiotherapists, occupational therapists and medical social workers, all of whom had interest, patience and sympathy for old people. Relatives were encouraged to expect the elderly patient would be discharged home with the necessary home support.

She led the rehabilitation team, encouraged patients to take a healthy, optimistic and creative interest in their progress, play a part in their recovery and

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20 They worked together in complete harmony and were loyal to one other. Sheridan op. cit., note 17.

21 Sheridan reported there was a personality cult around Dr. Warren, who was totally loyal to her staff, who were frightened of her while also respecting her. She respected the views of other members of the team and if a member said a patient was not ready to go home, or the home arrangements were not yet satisfactory, that view was accepted and discharge was postponed. Working with her was very exciting. Everyone was young. There was opportunity for international contacts, and close working relationships with relatives and friends. Occupational therapists, after an initial reluctance to work with these patients, saw the results they obtained, and were encouraged to continue. Their department was virtually taken over by the geriatric unit. Matthews quoted a personal comment of Howell who said that since the physiotherapists were primarily under the jurisdiction of the orthopaedic surgery department, Warren decided to utilise the talents of the occupational therapists ‘who were nobody’s babies’. The enthusiasm of the rehabilitation teams with their good results meant recruitment to the geriatric department was not a problem – nurses remained in post and did not leave. This must have been a very unusual event at a time when many medical articles refer to nursing shortages in general medical wards. Sheridan recorded Warren really ‘got going’ in 1945. She would be on the wards at 11pm at night, perhaps carrying out a ward round at that time. She slept in the hospital much of the time since she was on call a great deal. Matthews D. A., op. cit., note 2. Sheridan op. cit. note 17.
help other patients, thus creating a stimulating atmosphere.\textsuperscript{22} A kindly discipline was found to be effective. Where necessary the patients were educated to a slower pace of life but they were expected to take an active role in their own recovery: as she put it 'Nothing a patient can do for himself should be done for him' (p.923).\textsuperscript{23} She tackled the unsatisfactory situation of elderly single and double amputees.\textsuperscript{24} She was particularly keen to provide proper rehabilitation for the stroke patient, who prior to her intervention received no treatment or physiotherapy, which resulted in the paralysed limb contracting.\textsuperscript{25} For general mobilisation, she recommended the patient learnt to stand at the end of the bed holding on to the bed rail, and then learnt to stand on one leg then the other, after which a few steps could be attempted.\textsuperscript{26} Her concepts of the aims of a geriatric unit were encapsulated in a paper in the Ulster Medical Journal.\textsuperscript{27}

The rehabilitation wards were specially adapted. Floors were not highly polished, steps were avoided, lighting improved, hand rails fitted to the side walls

\begin{itemize}
\item \textsuperscript{23} Warren M. W., "Activity in Advancing Years," op. cit., see note 22.
\item \textsuperscript{25} Warren M. W., "Care of the Hemiplegic Patient," op. cit., note 21. She made a film of the rehabilitation programme for the stroke and double amputee patients to emphasise how it could be done. Warren M.W., "Activity in Advancing Years," op. cit., note 22
\item \textsuperscript{27} Warren M. W., "The Role of a Geriatric Unit in a General Hospital," \textit{Ulster Medical Journal}, 1949, 18: 8-17.
\end{itemize}
of the wards, special chairs provided for arthritic and heart patients, as were walking sticks and frames. Some equipment she designed herself is still used today.\textsuperscript{28} She helped chair-ridden patients mobilise themselves by designing a shuffleboard - still used today.\textsuperscript{29} Sensible non-institutional clothing was introduced – loose, light in weight, comfortable and easily cleaned. Where disabilities were present, clothing and shoes were adapted to the patients’ needs. Heating was evenly spread across the ward – cold toilets discouraged use. With good nursing and teamwork, incontinent patients were cured; many were able to return home, leading to a great rise in morale among patients and staff. By 1948 Warren reported the general medical staff acknowledged that their ‘chronic’ elderly patients actually did better on the geriatric unit than on their own wards.\textsuperscript{30}

She visualised the Geriatric Unit as a medical department within the general hospital. She thought it inappropriate elderly sick patients should be treated initially in a separate institution, where facilities for diagnosis, research and treatment were limited. Neither should they be admitted to general acute wards because they would suffer lack of attention and treatment. She considered the geriatric physician should be broadly trained and have an empathy with the


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elderly. Her aim was not to prolong life but to make it easier.\textsuperscript{31} She thought different units for the elderly must be allowed to choose their own ways of working.\textsuperscript{32}

She thought geriatric medicine was a new field of medicine but should remain an integral part of general internal medicine. In 1943 she wrote 'not until the subject [of geriatrics] is recognised, as a special branch of medicine, will it received the sympathy and attention it deserves and ensure early effective treatment'. She was always thankful that great events elsewhere distracted attention from what she was doing, giving her so many years of quiet concentration to achieve her purpose.\textsuperscript{33}

Warren provided statistical information of patient throughput: see table 4.1.


\textsuperscript{33} Professor Adams G. F., op. cit., note 2.
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Male Ward 35 Beds

<table>
<thead>
<tr>
<th>Year</th>
<th>Admitted</th>
<th>Discharged</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home</td>
<td>Residential</td>
<td>Died</td>
</tr>
<tr>
<td>1944</td>
<td>297</td>
<td>90</td>
<td>23</td>
</tr>
<tr>
<td>1945</td>
<td>292</td>
<td>86</td>
<td>25</td>
</tr>
<tr>
<td>1946</td>
<td>191</td>
<td>48</td>
<td>17</td>
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Female Ward 45 Cot Beds

<table>
<thead>
<tr>
<th>Year</th>
<th>Admitted</th>
<th>Discharged</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home</td>
<td>Residential</td>
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<td>1945</td>
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<td>49</td>
<td>30</td>
</tr>
<tr>
<td>1946</td>
<td>222</td>
<td>41</td>
<td>27</td>
</tr>
</tbody>
</table>

Table 4.1 Shows patient admissions and discharges to Warren’s unit 1944-1946.34

By 1950 she had organised an out-patient service, with referrals from general practitioners for assessment, active treatment, or advice.35

The high rate of patient discharge allowed her to vacate three wards – one of 45 beds was made available for TB patients, another of 22 beds was allocated to dermatological patients and a third ward of 18 beds was converted to a small gymnasium and a second X-ray unit. However in another account she refers to

34 Warren op. cit. note 31.
35 Sheridan op. cit., note 17.
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allocating 90 beds to the Tuberculosis Service. Some beds were given to a newly arrived consultant physician who had no beds of his own.36

Her post war recognition was wide spread, although criticism occurred. Her vitality and the results of her work inspired others to apply her methods.37 She was always warm in her hospitality, inspired affection, and respect. To work with her was an experience. She knew her patients and always had a cheerful word for them. She gave freely of her time and knowledge, writing extensively in many journals. She lectured in Australia, Canada and the Americas. She served on some 20 national and international committees. She ‘had a remarkable success in extracting approval (and funds) for improvements from a [Regional] Board usually better known for skinflint attitudes to infirmaries. She owed much of her success in this to personal charm, persuasiveness and an indomitable will to get things done’ (255).38

Criticism came from several sources. Lionel Cosin, who visited her at the West Middlesex Hospital, was shocked to see wards of doubly incontinent patients. He thought she changed her treatment and approach to the care of these

36 Coghill N. F. and Stewart J. S., Development at West Middlesex Hospital Isleworth, Middlesex 1947-1989. Private publication: 2002. (In Wellcome Library) The North West Metropolitan Regional Board noted a number of difficulties regarding care of elderly patients in 1952: the poor quality of doctors applying for consultant posts in geriatric medicine, the problem of those patients who were neither fit nor ill, bed blocking and the need for cooperation between the local authority and the hospitals. It recommended elderly patients should be admitted to a general hospital for investigation before discharge or transfer. North West Metropolitan Regional Hospital Board-Survey of Work July 1947-December 1950, London: North West Metropolitan Regional Hospital Board, p 21-23, 1952.

37 Adams op. cit., note 2.

38 Matthews op. cit., note 2.
patients in view of his comments. He maintained she only discharged 10% of her patients, while he discharged 40%. She asked him 'where are your long-stay patients?' implying she had such patients. He replied he did not have any, which was not strictly accurate, as will be seen later. He thought she was rigid and authoritarian, and learnt little from her. Sheridan, however, considered Cosin was 'an awkward cuss' and was rather out on a limb by himself – he was not in the main stream of geriatric medicine like Lord Amulree or Professor Exton-Smith. Sheridan, Warren's social worker, did admit that Warren never gave an inch in terms of the difficulties in the hospital, whose senior staffs were not well disposed towards her or the unit, although she did get support from the medical superintendent. Sheridan reported criticism of Dr. Warren's lack of qualification in geriatric medicine, 'she wasn't a proper physician - she wasn't fully qualified'. This pointed remark probably related to the fact she had not passed the MRCP examination. Sheridan agreed Warren had a strong personality and could be difficult to get on with, but if 'she did get on with you, she would go a long way out of her way to be helpful'. Sir Ferguson Anderson, a Scottish geriatrician, visited her and found her inspiring, brilliant and a hard working woman. However he thought she was not well regarded in the West Middlesex Hospital, partly because she very forthright and partly because she worked with the elderly.


40 Sheridan op. cit., see note 17.
He did not think the antagonism against her was due to her being a woman, unlike Adams who did.

**Mr. L.Z. Cosin**

Mr. Lionel Zelick Cosin MA, LRCP, FRCS, (1910-1993), came to the care of the elderly chronic sick from a surgical background. He trained at Guy's Hospital, qualified in 1933, and completed junior posts at the Royal Northern and Prince of Wales Hospitals, as he began to follow a surgical career. He passed the FRCS while at the Littlemore Mental Hospital. At the outbreak of War he was drafted to Orsett Lodge Hospital in Essex. This was originally a Public Assistance Institution but was upgraded to an Emergency Medical Service Hospital in 1939. By 1944, at the age of 34, he had become the Medical Superintendent on the retirement of the previous incumbent. He became responsible for 300 chronic sick patients in addition to his surgical commitments. He found they were fed and kept clean but no other treatment was given. When ordinary admissions restarted in 1944 he admitted elderly women with fractured

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femurs, successfully operated on them, gave them rehabilitation and discharged them home. Previously these patients had been considered too old for treatment. His rehabilitation staff consisted of one elderly physiotherapist and four male aides, who were conscientious objectors.

In 1948 he moved to Langthorne Hospital in North London as Senior Medical Officer, where he pioneered day care for confused elderly patients, the ‘floating’ or ‘respite’ bed, and occupational therapy for the mentally confused. In 1950 he was invited to establish a geriatric unit at Cowley Road Hospital in Oxford, where he became its first clinical director and stayed there until he retired in 1976. During his career he wrote many articles describing particularly rehabilitation, progressive patient care, dynamic quadruple assessment, and his day hospital.

Cosin is described as small of stature, but a strong willed character with big ideas and the drive to get them into practice. He was always ready to go to the top to get what he wanted. ‘Camp on the minister’s doorstep’ was his advice to a frustrated colleague. The cartoon, on the previous page, is said to be a good likeness of him and his crusading zeal. Dr. Peter Horrocks, who worked for Cosin, said he was autocratic. He could be difficult to work with, although Horrocks himself had no problems. At times, he said, Cosin treated his fellow consultant like an office boy. According to Horrocks, Cosin had no in-patients

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42 Irvine. op. cit., note 41.

43 Horrocks became a consultant geriatrician at Hull and later Director of the NHS Health Advisory Service,
while in Oxford but spent his clinical time organising rehabilitation and the day hospital.

Cosin considered classification of elderly patients essential. His system was: those bedfast, permanently disabled patients who needed every nursing care and attention, but who could improve with rehabilitation; those disabled bedfast patients who could look after themselves but required limited nursing care; the frail ambulant in need of increased periods of rest but were otherwise self caring; and those who were self caring, but unable to provide their own residential or feeding arrangements, and who did not need to be in hospital. He reorganised patient accommodation: an acute geriatric ward for investigation and treatment; a long-stay annex ward for the permanently bedfast; long-stay wards for the frail ambulant; and ‘residential home’ type of accommodation for the more robust patients.

He had firm views on rehabilitation, having seen its value with injured military personnel. He emphasised patients should be up, dressed, sitting at a table for meals, and taken to the toilet at frequent intervals. It would soon be found that those capable of getting themselves unaided to the toilet would do so. This would solve the incontinence of recumbancy and the need for frequent linen changes. Overall he thought geriatric units, by giving effective treatment and rehabilitation for six months or even a year, could return 50% of patients to their previous accommodation.

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Cosin described results of his treatment and management of 781 elderly patients for a 26-month period from 11th November 1944 to 10th January 1947 at Orsett Lodge Hospital. The patients were a 'mixed bag', consisting of 23 people who had not been evacuated from the hospital, 188 who were transferred to Orsett Hospital from other hospitals, as well as other patients from the local area admitted after a long period on the waiting list, confused patients who could not be admitted to the local mental hospital, and elderly patients from East London and parts of the north bank of the Thames. During the study period 37% of the patients were discharged, 38% died, 4% were transferred and 21% were still resident. Nearly three quarters of deaths occurred within three months of admission.

Cosin continued his statistical analysis for a further 18 months – January 1947 to July 1948, during which time he admitted 301 patients. He found only 3% of the patients were permanently bedfast at 6 months, approximately one third had died, 40% were discharged, and 24% were still in hospital. The statistician, who analysed his results, warned against rigid use of the analysis for far reaching conclusions – rather the data should act as a stimulus for further experiments. Cosin concluded that assessment of the patient’s pathological diagnosis, 'psychologic' needs, social needs, and residual physical disability provided


solutions for the total problems of the old person – his ‘dynamic quadruple assessment’.

In 1956 he reported data showing in 1947 the average length of stay was 286 days but fell to 51 days in 1951. The proportion remaining in hospital longer than 180 days declined from 20% to 7%. In addition 10% of patients were transferred to low cost residential beds within the medical unit. His admissions increased from 200 a year to 1200 through the same number of beds. The average age of the patients increased from 68 to 75 years. Cosin considered 10% of his patients would become permanent bedfast.

Cosin discussed the factors which influenced length of in-patient stay. These included: physical/mental problems causing admission, effectiveness of medical/surgical treatment, amount of rehabilitation and treatment given before admission which, in turn, could depend on the length of the waiting list. The latter was dependent on the size of the local aged population, the attitude of voluntary and/or municipal hospitals to the admission of elderly patients and the patient’s social/medical background. Long waiting lists caused patients to be admitted late in the illness with lengthening recovery time and/or increased risk of death. Relief of pain could be a key factor in rehabilitation. He criticised current medical opinion for two fundamental errors in the care of the disabled elderly: first, the facile acceptance of the inevitability and irreversibility of the

pathological processes and second, failure to recognise the possibility of restoration of physical activity.

Cosin supported a system of ‘holiday admissions’ for patients to allow relatives to go away, and he espoused the ‘floating bed’. This involved patients being admitted to the same bed in the same ward for two nights and three days every three weeks during which time they had the same medical and nursing staffs. He thought the ‘floating bed’ allowed phased investigation, assessment of the mental state, rehabilitation, social relief and terminal care.

In the 1950s Cosin opened the Oxford day hospital – the first of its kind in the country. About 500 patients were admitted to the unit in the first six months of 1953; 53 of them were suffering from confusion and dementia of major severity, while another 70 suffered confusion secondary to respiratory or localised cerebral arteriosclerosis which resolved as the disease abated. Cosin thought intellectual deterioration could follow a fall in systolic blood pressure due to major anaesthesia and postoperative surgical shock.

Cosin described the function of the day hospital. It aimed to maintain patient independence, sharing responsibilities for care with the family and/or the community. His unit was managed by the superintendent occupational therapist because the unit was housed in her department. The unit had rooms where the patient could spend the day receiving occupational therapy, physiotherapy,

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chiropody and bathing. A midday meal was provided. A doctor could examine the patient if required and a social worker was available for advice. Cosin hoped to increase the attendance to 30-40 patients per day.

Admission to the day unit usually followed discharge from hospital, where a case conference of those concerned with the patients’ care would consider the value of admission. The assessment team could include the consultant geriatrician, the psychiatrist, social worker and the occupational therapist. A general practitioner request for admission usually resulted in a home visit or outpatient appointment to assess suitability for the unit. Cosin’s plans for future day hospital developments included a small gymnasium, a dining room for midday meals, a room for physiotherapy and the activities of daily living, and accommodation for Electro-Convulsive Therapy (ECT). He did not explain why he wanted an ECT room but it implied problems with the treatment of elderly depressed patients, perhaps due to a paucity of facilities at the local mental hospital. Dr. Brian Lodge and Suellin Greenaway described the medical care of the elderly in an Oxford community hospital in 1975. They concluded consultants in geriatric medicine needed to be more involved in the hospital to ensure continuity of care within the hospital and community. Lodge B. and Greenaway S., "Geriatric Medicine in a Community Hospital," Gerontologia Clinica, 2003, 17: 109-125.
Dr. Eric Barrington Brooke MB, FRCP, DPH, (1896–1957), was the son of George Brooke, a barrister-at-law of the Middle Temple. He was educated at Bradfield College, Caius College, Cambridge, and at St Bartholomew’s Hospital and qualified in 1922. After house posts he emigrated to South Africa working in Cape Province, Pretoria and the Randfontein mine where he studied phthisis. He returned to the United Kingdom in 1930. He worked at Redhill (Edgware) Hospital, and then became medical superintendent at another Redhill (Surrey) Hospital. After a few years he was appointed as the first medical superintendent to newly built, 800 bedded, St. Helier Hospital in Carshalton, where his nickname was ‘Daddy’ Brooke. The building was hit a number of times by enemy bombs and his superintendent’s house was destroyed by a flying bomb in 1944. Brooke was severely wounded and lost an eye but returned to duty in due course. In 1953 he was invited to assist in the organisation of a geriatric service in the western half of the South-Western Metropolitan Region and was appointed consultant physician to the Southampton group of hospitals. This move was made in part to escape the London ‘smog’, which exacerbated his severe asthma. Brooke was a
modest man with an impish sense of humour and was much addicted to quotations from A. A. Milne's Pooh Bear.53

His approach to his long waiting list was different from others because he had few staffed beds. He tried to manage patients at home by developing domiciliary 'in-patient service' and using the out-patient department. Brooke advocated a rational approach to the use of hospital beds, which would help tackle the problem of nurse shortage.54 He viewed the hospital as a polyclinic with beds rather than as a ward nucleus with ancillary facilities. Greater selection of potential admissions to the beds was necessary and a balance was needed between the numbers of acute, recovery and long-stay beds. In addition other accommodation such as short stay hostels should be available. He set up two committees. One managed domiciliary services and linked with the Hospital Management Committee, Surrey County Council, the Local Executive Council, the National Assistance Board and voluntary organisations.55 The other committee implemented the recommendations of the 1947 British Medical Association report (Brooke was a member of the BMA committee which produced that report).

His domiciliary 'in-patient' service started with a home visit usually made by the hospital based geriatric social worker, who coordinated the necessary


55 Boucher, a Principal Medical Officer of the Ministry of Health, praised the function of this committee. See also Editorial, "Home Care Again," Lancet, 1950, 1: 79.
community services e.g. district nurses, home helps, domiciliary occupational therapists, laundry service and the Red Cross library. The key member of the scheme was the general practitioner as the person who 'steers the ship' aided by the other health and local authority personnel. Often a major reason for requesting admission was the older person's inability to provide meals for him/herself. Consequently a hot 'meals on wheels' service was set up by the Women's Voluntary Service (W.V.S.), which provided meals as often as five days a week. He arranged for volunteers to visit the older people. Thus 'everything was possible short of admission to hospital'.\(^5\)\(^6\) By 1950 home visits carried out by the social worker had been superseded by those make by medical staff because the decision to admit was ultimately medical.\(^5\)\(^7\) By 1950 Brooke had assessed some 400 patients in an eighteen-month period and found only one in three required admission on a short-term basis for investigation and treatment, terminal care or to provide holiday relief for caring relatives. He gave priority to two types of patients - those who might benefit quickly from medical treatment and those who were very ill and living in unsuitable home conditions.

Brooke discussed his admission difficulties. He argued the problem might be avoided by using less highly equipped annexes largely staffed by people who were not qualified nurses, and an out-patient service to provide investigation and treatment, with collaboration with the department of physical medicine, the


\(^{57}\) Brooke E. B., "Home-Hospital," _The Medical Officer_, 1950, 84: 99-100. Dr. Stevenson wanted to develop home visits a stage further where the consultant might carry out a range of investigations at home including X-rays and ECGs. Stevenson F. H., "The Home Consultant," _Lancet_, 1947, 1: 532.
cardiologist, psychiatrist, urologist, orthopaedic surgeon, dietician and the social worker. An adequate transport service for stretcher and sitting cases was necessary.\(^5\)

He argued for a geriatric department to be established in district hospitals but he did not believe geriatric medicine should be regarded as a new clinical speciality.\(^9\)

He attacked the unquestioning approach to care of elderly people who were kept in bed without treatment until bed shortages prompted someone to suggest transfer of the patient to a chronic ward or to get them out of bed. He quoted an example of a 72-year-old woman kept in bed for 18 years, yet she still became able to walk when she was got out of bed.


\(^{59}\) Brooke E. B., op. cit., note 57.
Dr. Trevor Henry Howell, FRCP Ed., (1909-1988), was shy and reserved but with a dry sense of humour and a great concern for others. He was educated at St. Johns College, Cambridge and trained at St. Bartholomew's Hospital. He qualified in 1934. He undertook postgraduate studies in Edinburgh before being appointed tutor at the Royal British Postgraduate Medical School, Hammersmith.

He then entered general practice in Worthing, where many of his patients were elderly and had problems he had not encountered before. At the outbreak of war, he joined the RAMC, and was posted to the Royal Hospital, Chelsea, to replace the regular ‘trained’ RAMC officer, who was posted elsewhere. The hospital was bombed in 1941, so the army pensioners were transferred to St. Luke’s Hospital nearby, but this was bombed a few days later so they were moved to the West Middlesex Hospital. Howell was subsequently posted to India and Burma.

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What puzzled him about elderly people was what represented 'normal' for age and what represented disease. This triggered his book Old Age and many research studies. The Nuffield Foundation heard of Howell's gerontological research from Dr. Leslie Banks, a Senior Medical Officer of the Ministry of Health, and awarded him a research fellowship. A geriatric research unit was created at St. John's Hospital in Battersea, where he became consultant physician and where Dr. Alfred Mitchell was medical superintendent. The latter was anxious to develop geriatric medicine in his hospital. Howell visited Warren, learnt much from her and put it into practice. He was joined at St. John's in 1947 by ex. R.A.F. doctor Dr. Tom Wilson, who later became the first consultant geriatrician in Cornwall: see Chapter Seven p 236. At one time, during his London career, he had responsibility for over 600 patients in two institutions. Eventually Howell became physician superintendent at Queen's Hospital, Croydon.

Howell kept meticulous records of his patients, which formed the basis of the over 300 papers and four books he wrote. He kept a hand written record of every book he read, every patient he saw, and every post-mortem held on his patients carried out by Dr. A.P. Piggot, a former deputy superintendent of St. James'
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Hospital, Balham. Howell lectured at St. Bartholomew's Hospital and taught students from many London medical schools.  

His expertise was both nationally and internationally recognised. The Royal College of Physicians awarded him the prestigious F.E. Williams medal; the American Geriatrics Society gave him the Willard O. Thompson gold medal, while the British Geriatrics Society gave him its first Founders medal. On retirement he worked as a research fellow in the geriatric department at St. George's Hospital.

He considered geriatric medicine was an art based on early admission with prompt, active treatment, and was not merely just another branch of medical knowledge. Like the others he advocated classification of patients – his scheme was very simple: the incurable, those treatable but not curable and those curable. He echoed the cry of the surgeons; 'Why didn’t we get these [patients] sooner?' He thought early referral was the reason for the reduction in the death rate at the Royal Hospital where he admitted army pensioners early in their illnesses. He attacked the problem of bed blocking by elderly patients. He quoted an unnamed former municipal hospital where eight old men were found unfit for a further prostatectomy. They occupied beds for 2 years before transfer elsewhere. During this time, those beds could have been used for 250 acute surgical cases.

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He argued patients should not be allowed to stagnate, but kept as active in body and mind as possible. He wrote in 1946, 'Sympathy for the sorrow of old age is not enough, it is time to translate it into action' (p. 400).

Research and teaching occupied much of his time. As he put it 'the harvest truly is plenteous but the labourers are few' (p.264). A great gulf 'existed between those who research into the problems of senescence and those who look after the aged...research is rarely carried out in hospitals for [the] chronic sick' (p.264). He strongly advocated an Institute of Gerontology, which would research, teach and publish. He firmly supported teaching medical students:

Many doctors get the impression that those diseases which they did not see in their training schools...are somehow outside the pale of regular medicine and surgery. Knowing nothing of the chronic diseases of aged people, they think that such conditions are untreatable and incurable. Worse than this, they feel that the diseases themselves must also be dull and uninteresting to study, since they are not adequately described in their textbooks (p. 167).

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He contrasted the situation in the United Kingdom with the United States of America, where already there were two societies concerned with the elderly (The Gerontological Society of America and The American Geriatrics Society), each with its own journal, which were first published in January 1946. The United Kingdom had neither society nor journal. His determination, with that of Sturdee, led to the creation of the Medical Society for the Care of the Elderly, which was physician based. He thought another society was needed to cater for other disciplines. Consequently he became one of the founders of the multidisciplinary society, the British Association for the Service to the Elderly (BASE), which by 1988 had over 20 branches.\(^7\)

**British Medical Association Reports: Care and Treatment of the Elderly and Infirm**

In 1946 the admission of sick elderly patients was becoming a problem. A *Lancet* editorial in 1947 noted elderly patients were turned away from hospital even when they needed treatment.\(^2\) The Emergency Bed Service had reported that of 247 requests for admission in the first week of January 1947, 44 were declined on the grounds of old age. In the first week of June 1947, 19 out of 182 were refused. The cause was partly lack of nursing staffed beds and partly fears of the elderly being ‘chronic’ and blocking beds.

The British Medical Association thought it appropriate to give advice about care of the elderly to the newly formed Regional Health Authorities. The

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\(^7\) Dr. William Davison, consultant physician in geriatric medicine at Addenbrooke’s Hospital, Cambridge, became its first chairman in 1974. See Chapter Seven p 253.

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Association issued its report in 1947 and in 1948 published its first supplement to that report, 'The Right Patient in the Right Bed'. One of the committee members pointed out in a letter to The Times, and quoted in the 1947 report, that 'Britain lacks a systematic policy for the welfare of the elderly...there is no commensurate awareness of the plight of the infirm, the decrepit, the incapacitated...the permanently incurable...most of these concealed from the public eye in institutions, no services are yet provided which in any way meet their needs or their deserts' (p.133/4). Three members of that committee were Brooke, Cosin and Warren.

The committee gave its classification of the elderly. It considered there were the healthy, who lived at home and who formed 95% of the older population, and the elderly and infirm, who needed suitable home or hostel accommodation. The elderly sick could be subdivided into the acute sick, the long term sick with potential for recovery and the irremediable. Elderly psychiatric patients were considered a special group, as were the elderly blind and deaf. The report deliberated on appropriate housing, pointing out that the number of elderly people in Great Britain was steadily increasing and would continue to do so. It criticised previous medical care for the sick elderly who were given little care and treatment other than recumbancy, which in turn led to 'infirmary decumbency' with contractures and deformities. This engendered an air of defeatism causing patients to become apathetic with loss of hope of recovery. Beds were

unnecessarily blocked when, with proper timely coordinated medical services, the situation could be prevented.

The committee visualised a coordinated medical service. This would accept, in conjunction with other hospital departments, new acute or chronic patients, directly or by transfer; provide facilities for investigation and treatment as necessary, provide observation wards for all elderly psychiatric patients with suitable medical treatment as necessary; resettle patients who could be discharged either to their home, residential home or to a long-stay annex; assist in medical social work; provide general practitioners with advice for elderly at home; provide advice on medical aspects of welfare and housing, and teaching and research. It was accepted that about 20% of geriatric patients would need a long-stay accommodation, where they would be periodically reviewed – without such a facility the prospects of a coordinated service would fail. The report suggested these units should not exceed 30 beds and be situated near relatives. Large independent hospitals or institutions devoted entirely to the chronic sick were not acceptable. It anticipated, if the envisaged service was adopted, the hospital bed shortage/bed blockage would be resolved in two ways: first, early investigation and treatment would prevent patients becoming unnecessarily bedfast and second, the provision of long-stay accommodation (annexes) and residential homes for those no longer requiring hospital care.

The Association's supplementary report of 1948 emphasised the value of short stay hostels for investigation, which could be staffed by a minimum of skilled nurses but supplemented by orderlies and attendants. Acute bed requirements could be reduced by using a geriatric out-patient department and
half way houses (convalescent homes). The former would require an adequate transport system.\textsuperscript{74}

In 1953 the BMA set up another committee to consider the establishment of an integrated service for the treatment and rehabilitation of chronic disablement arising from age or illness.\textsuperscript{75} It noted the first two reports had not been implemented as fully as had been hoped. The membership of the committee had changed. Amulree and Howell were chosen, Brooke and Boucher were observers, but Warren and Cosin, though still active, were not members.

Medical Society for the Care of the Elderly (MSCE) – The Early Days

It can be argued that Howell’s writings, his enthusiasm for geriatric medicine, his drive for research into the causes of old age, and the total lack of any United Kingdom geriatric, gerontological or specialist medical organisation, lead him to the conclusion that those working with the chronic sick should work more closely together. He may be thought of as the driving force behind the creation of the Medical Society for the Care of the Elderly (later to become the British Geriatrics Society).\textsuperscript{76} In the summer of 1947 Howell invited Warren to his home for a discussion about the idea of forming a medical society concerned with old age.

\textsuperscript{74} Just how complex the requirements of a comprehensive district health service for the elderly were to become is well illustrated by Horrocks’ paper of 1986, which was culled from his very extensive experiences as Director of the NHS Health Advisory Service. Horrocks P., "The Components of a Comprehensive District Health Service for Elderly People - A Personal View," \textit{Age and Ageing}, 1986, 15: 321-342.


\textsuperscript{76} A counter argument is the catalyst came from another quarter: Sturdee at the Ministry. See Chapter Eight p 302.
He convened a meeting at St. John's Hospital. Those present included: Amulree, (still at the Ministry of Health at this stage), Edwin Sturdee, (Principal Medical Officer at the Ministry of Health and, interestingly, chairman of the meeting), Warren, Brooke, Cosin, Tom Wilson, and Alfred Mitchell. It was agreed to form a purely medical society called the Medical Society for the Care of the Elderly. Amulree was elected President, an office he held for 25 years and Dr. Joseph Sheldon became vice president. Wilson was elected Treasurer and Howell Secretary. The Society, realising perhaps the importance of continued contact with the Ministry, arranged that the Ministry’s medical officer with responsibility for the elderly was always co-opted on to the Society’s council.

The first clinical meeting was held at the West Middlesex Hospital, where Warren gave a demonstration of her rehabilitation methods for stroke patients. Also present was Dr. (later Professor) George Adams, who had become interested in geriatric medicine after reading Warren’s articles and meeting Wilson. After this informal start the Society recruited members and held meetings every three to four months in different centres, some as far afield as Cornwall and Belfast. For years the society’s ‘office’ was a suitcase carried around by the secretary. In 1959 the Medical Society for the Care of the Elderly, after several months’


discussion, changed its name to the British Geriatrics Society. At that time the Society had about 200 members, by 1975 it had 500 members and by 1997 1,800 worldwide.

Conclusions

These four reforming doctors, who initiated change in the existing custodial, confinement-to-bed, style of care of the elderly and infirm, all came from differing backgrounds, faced different problems and adopted different solutions to solve them. All were either medical or deputy medical superintendents of their hospitals, posts which could either be purely administrative or mixed clinical/administrative. Warren and Cosin were clearly strong-willed characters believing strongly in their policies, which perhaps not surprisingly led to great enthusiasm and inspiration in their admirers, although Warren caused antagonism in those who had to compete with her for limited resources. Brooke seems to have been a quieter, less combative person, perhaps due to his wartime injuries and asthma. He adopted a lower key approach, made fewer presentations and wrote fewer papers. He does not seem to have engendered the antagonism produced by the others. Howell was more interested in research into the causes and results of old age, and did not seem to have engendered any rancour. He was a prolific writer of papers about the pathology of old age. He was a major force in the formation of the Medical Society for the Care of the Elderly.

All wrote or presented papers: the two most quoted were by Marjory Warren: one in the British Medical Journal (1943) and the other in the Lancet (1946) - the
The Opening Moves

two premiere, most widely read, peer reviewed journals in the United Kingdom.81 The others' articles mostly appeared in less prestigious medical journals though the occasional one did appear in the Lancet. Therefore it is likely their views, clinical approach to their problems and their results probably received less attention in the main medical field.

Warren, Howell, Cosin and probably Brooke followed the exhortations of the Chief Medical Officer by classifying patients, which proved helpful in identifying those who needed rehabilitation from those who did not. All agreed a rehabilitation team was needed and departments of geriatric medicine were required in major hospitals.

All four either managed to reduce bed requirements, reduce the length of patient stay or reduce the waiting lists. However their results are difficult to assess. Statistical analysis was in its infancy. The days of Evidence Based Medicine and Randomised Clinical Trials were many years in the future. All appreciated their waiting lists of elderly people for admissions were an inaccurate measure of demand.

Their results influenced the Ministry of Health, and the British Medical Association report on the Care and Treatment of the Elderly and Infirm. Warren's work influenced Banks at the Ministry.82 Amulree and Sturdee mentioned the advances in geriatric medicine in their 1946 presentation to the


82 See Chapter Eight, p 300.
Parliamentary Medical Committee. The Ministry of Health published in 1950, *The Development of Consultant Services*. ‘The general physician will be expected in future to undertake care of the chronic sick as part of his normal duties (p.11).’

Boucher in 1949 praised the enthusiasm, skill, patience and work of these pioneers, and concluded they could discharge half their patients, 20% of the remainder would become bedfast in spite of treatment while the rest would die in the next twelve months. The Ministry of Health took a pragmatic view of geriatric units and did not support any one pattern of treatment/management of elderly people but drew attention to the usual principles of early investigation with suitable treatment, and admission to long-stay wards only being made via acute wards.

All agreed there was a significant problem in admitting the elderly due to lack of empty beds. This resulted from many factors such as problems of discharging those frail, often ambulant, elderly people who did not need to be in hospital but needed hostel accommodation and/or the provision of services, such as meals at home. The authorities disagreed between themselves regarding the criteria for admission to hospital and welfare home. Somerville Hastings, a doctor and MP, reported that an elderly man was found dying in Manchester.

‘He had been refused admission to a hospital because he was not sick enough, and

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to a welfare institution because he was a sick person and in need of hospital treatment' (p.879). This type of argument was to go on for years.
Chapter Five

The Birmingham Story

Introduction

This chapter discusses the surveys of chronic sick hospitals, initially carried out with the agreement, but later at the behest, of the Birmingham Regional Hospital Board. Eventually all chronic sick hospitals in the entire Birmingham region were reviewed. Professors Arthur Thomson and Thomas McKeown with Dr. Charles Lowe led the initial surveys in the late 1940s. Their aim, first, was to identify the proportion of elderly people who needed to be in hospital for investigation and/or treatment. Second, they wished to quantify the number of individuals occupying a hospital bed unnecessarily, the so-called ‘bed blocker’. The last survey, undertaken by Joseph Sheldon, reviewed all chronic sick hospitals in the Birmingham region to assess the quality of the accommodation and care given to elderly patients. The Regional Health Board expected these surveys to assist planning future hospital requirements, facilitate the discharge of the ‘bed blocker’, assist admission of elderly patients to vacated beds in the chronic sick hospitals and generally improve hospital services for the elderly. The surveys now look flawed because they failed to involve the local social services departments in the classification of the patients. This was most important since local authority assistance and agreement would be needed for the appropriate placement of patients or providing them with domiciliary support.
Surveys of ‘Chronic Sick’ Hospitals

The person who triggered the surveys was Professor Sir Arthur Peregrine Thomson, MC, LLD, MD, FRCP, (1890-1977). He was born in British Guiana where his father was a colonial civil servant.1

He was educated at Dulwich College and the University of Birmingham, where he achieved first class honours in medicine, surgery, obstetrics and gynaecology. He graduated in 1915 and served as medical officer with Guards in Flanders 1915-18. He was awarded the Military Cross, the Croix de Guerre with star, and was twice mentioned in dispatches. In 1919 he became assistant physician at the Birmingham General Hospital and later consultant physician. He passed the MRCP examination in 1920, obtained his MD in 1923, and become FRCP in 1930. In 1947 he was appointed to the part-time post of Professor of Therapeutics in the University of Birmingham. At one time he was Dean of the Faculty of Medicine and Vice Principal of the University. He gave major lectures at the Royal College of Physicians including the Lumleian lecture in 1949 and the Harveian oration in 1962. He was knighted in 1959.

He was short in stature, worked very hard, had the behaviour of a gentleman, was courteous, and a charming man who never bore a grudge. He was one of the clinical giants of his generation. Initially his main interest was in diabetes but later he researched into ageing and chronic sickness.

Thomson had a major role in planning services for the Birmingham Regional Hospital Board of which he was chairman in 1962. He was chairman of its Planning Committee between 1947 and 1962. He was aware of two problems: the first would face the general practitioners on the ‘appointed day’, 5th July 1948, when they sought admission for elderly people. After that date there would no statutory obligation on anybody to provide hospital accommodation. The second was bed blocking by elderly people who did not need to be in hospital but could not be discharged.

Thomson, though aware of ‘bed blocking’, did not know its true extent since no data existed, even from the University Department of Medical Statistics. He did know 14,000 patients were on the medical and surgical waiting lists. He therefore planned a survey of the chronic sick hospitals, to find out the true situation. This would assist the Regional Health Board in deciding whether or not to build new hospitals. His main support came from the members of the
University Department of Public Health, with funding from the Birmingham University Students Social Services Fund.

**The Pilot Study**

Before undertaking the full surveys, Thomson carried out a pilot study based on the largest hospital in Birmingham, the Western Road Infirmary (WRI), and supplemented by occasional visits to other unnamed hospitals.\(^5\) It had no defined aim but was more of a general survey to find out what was 'going on'. The results formed the basis of his two Lumleian lectures given on the 5\(^{th}\) and 7\(^{th}\) April 1949.\(^6\)

An initial cross-sectional survey reviewed the records and medical examinations by Thomson’s registrars of 714 patients, (318 males and 396 females), the results of which he discussed with the hospital’s resident medical

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\(^5\) Birmingham New Workhouse with its Infirmary opened in 1852 to accommodate 1600 inmates. The Infirmary, which admitted the sick, infirm and aged, proved inadequate and was extended in 1869, but by 1883 it contained over 1000 people and so in 1887 a new workhouse Infirmary was built. By 1914 the Infirmary was called Dudley Road Infirmary and in 1920 was renamed as Dudley Road Hospital (DRH). The old workhouse was renamed Birmingham Infirmary, but this was considered confusing and so it was renamed the Western Road Infirmary (WRI). Gradually the Dudley Road Hospital began to take most of the acute cases while the Western Road Infirmary admitted the chronic sick and infirm. In 1948 the WRI was taken over by the Regional Hospital Board, and was renamed as the Summerfield Hospital. The story was completed in 1975 when the hospital was integrated into the DRH as part of the Department of Geriatric Medicine. This information fits with hospital nomenclature used by Sheldon in his 1959/60 surveys of the Birmingham Regional Hospitals. Hearn G. W., "The Geriatric Department," in, *Dudley Road Hospital 1887-1987*. ed. Hearn G. W. Birmingham Postgraduate Centre: Dudley Road Hospital, 1987. Nagley L., "A History of Summerfield Hospital," *Midland Medical Review*, 1975, 10: 10-17. May K., "Notes on Birmingham and Dudley Road Hospital," *Birmingham Medical Review*. 1953, 18: 109-114.

staff. The majority of the patients were between 70-79 years old and were mostly widows/widowers. The mean duration of stay was 34 months for males and 37 months for females. Over one quarter of the patients had been in hospital for more than 3 years. He found 49% of males and 60% of females were bedridden but about 10% of inmates were able to move out of doors. One third of all admissions had died within 4 months and nearly one half had been discharged. The quality of medical care and treatment was surprisingly good even though there were only 5 whole time doctors, including the medical superintendent, looking after 1,000 bed-ridden patients, 300 inmates of a local social welfare home and a large venereal diseases clinic. He judged only about 5% of the bedridden had prospects of rehabilitation.

Thomson was struck by the patients' profound apathy and their apparent sole interest in meal times. They were well nourished and stout, seldom moved, read a paper or spoke to one another. He reported a conspicuous absence of emotional overtones as they told their personal histories. The workhouse system of segregation of the sexes, even husband and wife, persisted at meal times.

7 Similar high death rates in acute admissions of the aged sick were to be found by other geriatricians, as will be evidenced in later chapters.

8 This contrasted with the Ministry of Health Annual Report of 1948, which stated between 30%-40% of patients in chronic wards could be successfully rehabilitated and quoted the work of Warren and Cosin as examples. The explanation of this discrepancy might be due to different types of patients or the responsible consultant taking a more sanguine view of the rehabilitation prospects than Thomson. Ministry of Health. Report of the Ministry of Health for the Year Ended 31st March 1948. London: HMSO, 1949.
Patients, who were fit enough, were allowed to visit the city, and some would return quite drunk.\(^9\)

Thomson compared the results of admissions to the WRI, under the care of Dr. Lawrence Nagley, whose work is discussed later in this chapter, with those of Cosin, while he was at Orsett Lodge Hospital. (See table 5.1). The time period, during which the admissions were studied, was not given. More elderly patients were admitted to Birmingham and more were discharged.

<table>
<thead>
<tr>
<th></th>
<th>Western Road Infirmary (Nagley)</th>
<th>Orsett Lodge (Cosin)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total admissions over 60 years</td>
<td>1820</td>
<td>780</td>
</tr>
<tr>
<td>Died</td>
<td>902 (49%)</td>
<td>296 (38%)</td>
</tr>
<tr>
<td>Discharged</td>
<td>807 (44%)</td>
<td>284 (37%)</td>
</tr>
</tbody>
</table>

Table 5.1 Compares the number of admissions to Western Road Infirmary and Orsett Lodge Hospitals.\(^{10}\)

He reviewed the 'prelude' to admission of the patients. Six out of seven patients were admitted directly without adequate preliminary investigation or treatment.\(^{11}\) Thomson found less than one fifth had been admitted via a general hospital and some of these had been seen only in the casualty or out-patient department. Only half the patients over 60 years of age had had some form of

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\(^9\) Sixteen years later Green and Lodge found similar features: some patients were so fit that they could have lived in a home without supervision. Green M. and Lodge B., "The Needs of the Elderly in the Hospitals and Welfare Homes of Barrow-in-Furness," *Gerontologia Clinica*, 1965, 7: 20-43.


laboratory investigation. At least one third of the Birmingham patients were admitted solely because of domestic/social problems e.g. death of spouse, friend or illness in those who looked after them.

Thomson thought illness in the old should not be removed from the common stream of medicine, and elderly people should be investigated and treated in a general hospital, and also medical students should be taught about the diseases of old age. The results of the survey suggested the fallacy of the then current medical dogma that all signs and symptoms must be due to a single disease. It did not apply to sick elderly people, because they usually had multiple pathologies each producing its own signs and symptoms. The survey also found a high proportion of patients with mental problems in the chronic sick hospitals. Thomson classified over one third of the patients as mentally abnormal and believed that a quarter of all patients could be certified as insane, and compared his findings with those of Dr. James Affleck, who found over one third of the

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12 This contrasted poorly with Affleck’s study where the great majority of patients had been thoroughly examined in an acute hospital before admission to the chronic hospitals. See Annex One in this chapter.


14 Dr. Wilson and colleagues, writing in 1962 reiterated the same point: ‘the doctrine of the single diagnosis found no place in the interpretation of diseases, characterised as they were, by their multiplicity and frequent lack of predicable relations to one another’. Wilson L. A., Lister W. A. and Brass W., "Multiple Disorders in the Elderly," Lancet, 1962, 2: 841-843.
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chronic sick hospital patients had mental disorders; see Annex One at end of this chapter.15

Thomson considered medical students should be taught about elderly and infirm patients – his registrar thought the patients had so much pathology that they presented a Censor’s paradise. Sheldon put it in a different way: the elderly ‘are a mine of interest to the observer with the merest tincture of curiosity’ (p.398).16

Thomson was impressed by the standard of nursing care – the wards were clean, free of smell and beds impeccably made with sheets well tucked in. Indeed the beds were almost too well made, since tightly tucked in sheets could prevent leg and foot movement leading to contractures and foot deformities. Only nine bedsores were found in the entire institution. However ‘the equipment on the wards was lamentable...the sluice rooms archaic...the baths were of the ordinary domestic type’ (p.245). Thomson found only two nurses looking after 70 patients, nearly half of whom were incontinent. At night one nurse assistant was in charge of 70 beds. The nurses had a disproportionate heavy workload, never seemed to stop working and recalled ‘in their quiet endurance and their

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15 An MP, Mr. W. F. Yates, raised the matter of the admission of chronically sick elderly people to mental hospitals in Birmingham and questioned the adequacy of existing facilities for the care of this group of patients, particularly since a number had died shortly after admission. Aneurin Bevan, the then Minister of Health, reported two groups of experts were investigating the problem and said the local health authority was making arrangements for home nursing. Yates W. F., "Care of Aged Sick," Lancet, 1949, 1: 983. Mr. George Thomas, MP, thought non-mentally ill elderly patients were being admitted to mental hospitals in Wales because there was no other accommodation, but Mr. Bevan denied this was happening. Thomas G., "Care of the Aged," Lancet, 1947, 1: 502.

efficiency...the virtues of their fathers in the rank and file of the county regiments
who held the trenches in Flanders...in 1914-1918’ (p.245).

Thomson reviewed discharge difficulties and the attitude of patients to leaving
the infirmary. A return home for many patients was unlikely for several reasons.
First, the patients’ clinical condition had progressed too far and/or had not
responded to treatment; second, prolonged bed rest had resulted in contractures
and incontinence; third, the patients had become ‘institutionalised’, and last many
patients no longer had their homes or lacked home support. While Thomson
agreed ‘freedom from tyranny, from poverty and want...and from the hopeless
despair of unattended and persistent sickness is, no doubt, desirable’, he
questioned whether these freedoms could be achieved ‘without effort on the part
of the individual or his family’ (p.250). He noted the frequency of relatives
visiting patients tended to reduce with duration of in-patient stay, suggesting a
weakening of the sense of family unity.

In his second Lumleian lecture Thomson noted the four main physical
conditions he considered characterised chronic sick patients; first, contractures,
where patients could be found in a state of extreme flexion – the foetal position.
Attempts to straighten the limbs caused pain. Second, onychogryphosis, gross

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17 Abel-Smith and Titmuss noted two thirds of all hospital beds in the country, which were
occupied by those aged over 65 years, were taken by single, widowed or divorced people. They
reasoned the married state appeared to be a ‘powerful safeguard against admission’ to any type of
hospital. Abel-Smith B. and Titmuss R. M., The Cost of The National Health Service in England
and Wales. Cambridge: Cambridge University Press, 1956. Somerville Hastings, one time
consultant surgeon to the Middlesex Hospital, and Member of Parliament for Reading and later
Barking, noted elderly people in hospital received free treatment and accommodation, while those
in local authority homes had to pay out a proportion of their pension. Thus there was a positive
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overgrowth of the nails especially toe nails, was often found on admission and
associated with deformities of feet and toes. Third, he noted hemiplegic limbs
developed flexion contractures. Last, incontinence, which in some cases he
thought might be due to institutional regimes and which sometimes improved
with mobility.

The subsequent surveys

The aims of the subsequent surveys, led by Professors Sir Arthur Thomson,
Thomas McKeown and Dr. Charles Reginald Lowe, of Birmingham University
Department of Public Health, were to ascertain: first, what proportions of the
chronic sick required medical and/or nursing attention provided in hospital;
second, what facilities were needed for patients who could more satisfactorily or
more economically be cared for outside hospitals. In effect the purpose was to
estimate the numbers of ‘bed blockers’.18

18 Hall and Bytheway in 1982 deemed ‘bed blockers’ a derogatory term and thought
‘misplacement’ more appropriate. In their postal enquiry of 127 Area and Regional Health
Authorities they were given the shortest, simplest definition of a ‘blocked bed’, i.e. one ‘occupied
by a patient who does not require hospital facilities’, a term which could apply equally to acute
and chronic hospitals. The consultant was the key figure in the decision regarding who was, or
was not, blocking a bed. Some consultants were pleased to have blocked beds since it reduced
their workload and increased their leverage in local bargaining for resources. Hall D. and
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Thomas McKeown PhD, DPhil, MD, FRCP, (1913-1988), was born in Northern Ireland, the son of a building contractor. He obtained his first doctorate at McGill University. He became an Oxford Rhodes Scholar and worked for Sir Solly Zuckerman during the Second World War on the effects of enemy bombing, which provided part of the basis for later allied bombing strategy. He qualified in medicine in 1942, and was appointed Professor of Social Medicine at the age of 32. He was a consultant in Public Health Medicine for the World Health Organisation. His initial interest was the epidemiology of foetal growth and malformation. Later he studied design of hospitals and population dynamics. He was well known for aphorisms e.g. 'To be happy one does not need to be doing anything, but one does need to have something one ought to be doing'.

Charles Roland Lowe, CBE, PhD, MD, FRCP, FFCM, (1912-1993), was born in Staffordshire and educated at Dudley Grammar School. He qualified at

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Birmingham Medical School in 1936 and served in the RAMC in the Middle East and Yugoslavia from 1941-1945. He later worked as a general practitioner before turning to public health. He became Lecturer and later Reader in Social Medicine at Birmingham University Medical School from 1948-1961. In 1962 he was appointed Professor of Social and Occupational Medicine at the University Of Wales College Of Medicine. His early studies included stillbirths, tuberculosis, and the accommodation needs of elderly people. He wrote many papers and was co-author, with McKeown, of a standard textbook on Public Health: *An Introduction to Social Medicine*. He was a cultured man with a dry sense of humour.

McKeown and Lowe reported on their findings in 1949 and 1950 on 1,005 chronic sick patients in the WRI.\(^{22}\) They used the classification of chronic patients suggested by the Chief Medical Officer, but strengthened it by clarifying the meaning of 'nursing' requirements of the patients.\(^{23}\) They defined skilled nursing as necessary in the care of acutely ill people, for those requiring injections, dressings, and administration of dangerous drugs. Simple nursing, on the other hand, was considered appropriate where patients only needed help with washing, feeding, dressing and mobilising in/out of bed. They classified those patients without gross mental change into three categories: first, those needing skilled nursing/medical attention once or more a week, (approx. one fifth);


second, those needing simple nursing care in home or institution (just over one half) and third, those not requiring simple nursing in home or institution (approx. one tenth).

There was a fourth group of approximately one in five patients with gross mental changes. The researchers thought they were potentially certifiable and suitable for mental hospital care, although the relatives were not keen. Since no psychiatrists were involved directly in the study, these conclusions are questionable. McKeown and Lowe thought patients with gross mental changes were inappropriately placed in general medical wards. The psychiatrists claimed their hospitals were for acutely mentally ill people, not for custodial care of long-stay mental patients.

McKeown and Lowe argued chronic sick patients who needed hospital care should be in the wards of a general hospital. They gave three reasons: first, medical and nursing care would be better; second, the greater availability of investigations and treatments; and last, the medical and nursing staff would gain experience in caring for these patients. However they counselled caution in the application of their results across the population as a whole because of lack of reliable demographic data.

24 Amulree in 1971 agreed these difficulties still persisted and pointed out prior to the enactment of the Mental Health Act of 1959, some mental hospitals would admit elderly mentally impaired patients with great reluctance and then often only on an exchange basis. Lord Amulree, "Twenty Five Years of Geriatrics," British Journal of Clinical Practice, 1971, 25: 97-104. Dr. Smith and colleagues thought their institutional geriatric patients, with little or no evidence of psychiatric disease, should be moved from psychiatric hospitals to other hospitals concerned with organic or structural medicine. Smith S., Gibb G. M. and Martin A. A., "Metamorphosis of a Mental Hospital," Lancet, 1960, 2: 592-593.
In their next papers McKeown and Lowe reported their findings on WRI and Stoke-on-Trent patients.\textsuperscript{25} 90\% of the former were over 60 years, some of whom had been in hospital for over 3 years. Three quarters were admitted directly from their homes and approximately two thirds had no pre-admission investigations. Only half of the patients were willing to leave hospital, over one half were bedfast, about one third were mentally abnormal and one third were incontinent.

Lowe and McKeown compared their Birmingham results with medical examinations and record reviews of hospital patients in the Stoke on Trent area. The patients were surveyed in the same manner as before. They were a little younger, more had been in hospital for less than one year, and the proportion of unmarried patients was higher. The proportion needing frequent medical attention/skilled nursing was slightly higher in Stoke but the proportion of those needing simple nursing was similar. The authors thought more patients in Stoke were admitted directly from home and fewer were inappropriately placed in hospital.

Thomson and Lowe concluded the earlier surveys had limited value for planning policies for the aged and infirm because they did not assess the medical/social condition of the patients at the time of admission.\textsuperscript{26} A further


survey was therefore commissioned which involved a review of 393 consecutive requests for admissions to the WRI (now renamed the Summerfield Hospital) made between 10th October and 22nd December 1949, see table 5.2. Those who refused admission to hospital did so because they considered the Infirmary to be a workhouse. Those who died before assessment, or were admitted elsewhere, did so within 48 hours of the receipt of the request.

<table>
<thead>
<tr>
<th>Total number of requests for admission 393</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessed</td>
</tr>
<tr>
<td>Refused admission</td>
</tr>
<tr>
<td>Died before assessment</td>
</tr>
<tr>
<td>Admitted elsewhere</td>
</tr>
</tbody>
</table>

Table 5.2. Results of 393 consecutive requests for admission.\(^{27}\)

The 335 patients were examined by one of five consultant physicians who assessed the home situation and arranged for a social history taken by an almoner. With this information to hand the consultant decided on appropriate ‘disposal’ - see table 5.3. To check consistency of the first medical assessment a second opinion was obtained by reappraisal of the details by one of the other physicians, who was unaware of the original decision. There was virtual complete agreement of the ‘disposal’ assessment for groups one and two but there was considerable divergence of opinion for groups three and four.

\(^{27}\) Lowe op. cit. note 26.
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Total number of patients assessed 335

<table>
<thead>
<tr>
<th>Group</th>
<th>Suitable for admission to a</th>
<th>136 (40%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>general hospital</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Suitable for admission to a</td>
<td>34 (10%)</td>
</tr>
<tr>
<td>3</td>
<td>mental hospital</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Long-stay annex</td>
<td>79 (24%)</td>
</tr>
<tr>
<td></td>
<td>Suitable for return home</td>
<td>86 (26%)</td>
</tr>
</tbody>
</table>

Table 5.3. ‘Disposal’ of 335 patients referred for admission.28

Thomson found the survey very depressing, particularly when he considered
the patients’ social/domestic background. One third lived alone and were
dependent on neighbours or fellow lodgers for help.29 Of the 306 dwellings
assessed 7% had no internal water supply, 72% had no bath, and 80% had no
indoor sanitation. Those living in the latter accommodation had to share outdoor
sanitation with neighbours. Overcrowding in the patients’ homes was evident e.g.
in 205 of the houses visited, the sick had separate bedrooms but in 35 cases this
was a euphemism for exclusive use of the living room at night.30 The
maintenance of patients in their own homes would require improvements in
community domestic services.

Conclusions from the surveys of chronic sick hospitals

McKeown and Lowe found about half the patients in the chronic sick
hospitals were appropriately placed, but the other half were not. This conclusion
was weakened by failure to involve local authorities in the surveys. McKeown

28 Ibid.

29 Sheldon, a general physician, reported only 17% lived alone in his Wolverhampton community

30 Matters had not improved much since 1936 when a Ministry of Health housing survey showed
marked overcrowding, particularly in the Metropolitan areas. Ministry of Health, Report on the
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and Lowe thought misplacement could be resolved if first, their classification of patients could be agreed and used; second, if domiciliary services were improved; third, if nursing home facilities were established in association with welfare homes; and last, if there was a more precise definition of the responsibility of the local and health authorities. They concluded if community measures were implemented, the Regional Planning Committee would not need to build more hospital beds.

Thomson thought sick elderly patients should be admitted first to a general hospital, which had full investigative and treatment facilities, and medical students should be taught about them. The infirmaries themselves needed better staffing and equipment although the standard of medical and nursing care was good. Amulree in his F. E. Williams lecture at the Royal College of Physicians in 1955 paid tribute to Thomson, in particular for his demonstration of the lack of

31 Thomson and colleagues' classification of patients was: Group One - patients who required frequent medical attention or skilled nursing; Group Two - patients who did not require frequent medical attention or skilled nursing but who were confined to bed; Group Three - ambulant patients who needed a little simple nursing and occasional medical supervision and Group Four - ambulant old persons not in need of medical or nursing care. The North West Metropolitan RHB also acknowledged there was misplacement of chronic sick patients in hospitals, private and welfare homes, and at home. The Board hoped half way homes, financial assistance for patients and improved cooperation between all authorities concerned would assist the situation. North West Metropolitan Regional Hospital Board. Chronic Sick Patients. London: unpublished, 1949. Unfortunately misplacement of patients/residents persisted, which led to 'people swapping' between hospital and welfare homes. Langley G. E. and Simpson J. H., "Misplacement of the Elderly in Geriatric and Psychiatric Hospitals," Gerontologia Clinica, 1970, 12: 149-163. Boucher C. A., Survey of Services Available to the Chronic Sick and Elderly 1954-1955. Ministry of Health. Reports on Public Health and Medical Subjects No 98. 1957.

32 Norris found 8% of hospital beds (types not specified) in the Birmingham region were closed due to shortage of nurses, a problem she insisted needed to be solved before further buildings plans were made. Norris V., "Role of Statistics in Regional Hospital Planning," British Medical Journal, 1952, 1: 129-133.
any thorough assessment or diagnosis in many patients who were in old-fashioned institutions.\(^3\)

Responsibility for the 'bed blockers' is discussed in Annex Two at the end of the chapter.

The Later Work of McKeown and Lowe

McKeown and Lowe continued to apply their classification system to patients in general hospitals, to those with tuberculosis and to the mentally ill.\(^4\) A further reassessment of chronic hospitals was also made because of changes over the previous ten years.\(^5\) The studies showed a high proportion of elderly patients in chronic hospitals needed full hospital facilities but almost all the elderly patients in a general hospital were appropriately placed there. However 1.8% and 11.8% of admissions to the acute and chronic sick hospitals respectively could have been cared for at home. In 1961 McKeown and colleagues found the distribution of patients between mental, chronic and general hospitals was now largely determined by the age of the patient, whereas before the common feature of patients in chronic hospitals was destitution.\(^6\) Thus, in this later study, if the

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\(^6\) McKeown T., Mackintosh J. M. and Lowe C. R., ibid
patient was young and ill, he/she would be admitted to a general hospital, but if he/she was aged and ill then admission was usually arranged to a chronic hospital.37 His concern for the best interests of the patient led him to the concept of a balanced hospital community.38 This had four features: the care of all types of patients on a common site; a centre consisting of multiple buildings of varied design; a common staff; and an intimate relation between hospital and domiciliary medical services. The editorial writer of the Lancet enthusiastically supported the idea pointing out McKeown was involved in the planning of such a centre in Birmingham. 39

The culmination of the Birmingham story requires mention of two other doctors: Drs. Lawrence Nagley and Joseph Sheldon.

37 Seven years later Green and Lodge found similar uneven distribution between acute and chronic wards of hospitals. Green M. and Lodge B., op. cit., note 33.


Dr. Lawrence Nagley, MD, FRCP, (1911-1992), was born in Goole, Yorkshire, the son of a woollen merchant. He was educated at Harrogate and qualified at Leeds University in 1934. After house posts at Staffordshire General Hospital he joined the staff of Dudley Royal Infirmary in 1934 and was seconded in 1937, by Dr. Frederick Ellis, the then medical superintendent, to be Resident Medical Officer to the WRI. He intended to remain only for one month to cover the sickness of the usual resident but stayed for more than 40 years. He had a genial courteous manner and was a lover of literature, exemplified by his use of apt quotations.

He was the first consultant physician to be appointed by the Birmingham RHB on 5th July 1948. Together with one full time and two part time medical officers he had care of 1,200 chronic sick patients, 300 able bodied destitute people, 50-60 vagrants, 30-40 young chronic sick and 39-40 venereal and skin patients. He found no written medical records. He later claimed he had spent more years looking after more sick old people in a greater concentration than any other physician.

Nagley described the situation on the wards. Gross over crowding existed: ‘it was not possible for a nurse with a trolley to pass another nurse with a trolley unless the beds were pushed aside and...the distance between bed centres was less than 4 feet 6 inches’ (p.16). The day rooms were so over crowded with beds there was no place for patients to sit. The floors were highly polished

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resulting in at least one case of a fractured neck of femur: it required the help of the coroner to ensure the floor surface was changed. There was a system of giving numbers to mixtures of stock medicines e.g. Mist. Expect. Stim. was known as mixture Number 22. Nagley postulated this arrangement was because the pauper nurses could not read. He noted all the dermatological patients had been in hospital for over a year and had been treated with all sorts of ointments and creams to a point that the original rashes were impossible to diagnose. He claimed he cured 18 of the 60 patients by stopping all their treatments. Though the hospital was overcrowded, Nagley had, on several occasions, to cope with 1,000 people made homeless by air raids and who stayed for one night for shelter and sorting out before they were moved on to other accommodation. He reported the hospital boasted a very fine orchestra and a top class cricket team. When a male nurse or a porter applied for a post, more attention was paid to his musical or cricket skills than his skills pertinent to the post.

Nagley and Thomson visited both Warren and Brooke, and in particular Nagley adopted the latter's practice of home assessment visiting to manage the extensive waiting list for admission to the WRI. In 1957 Dr. Ronald Cape joined him, followed by Drs Ian Kellock and Richard Parnell. In 1975 a new


42 Between 1953–4 a waiting list of 1,091 patients was eventually reduced to 19 by admitting nearly 60%, referring 15% to other hospital or welfare services, while the remaining 25% refused admission or had died. Shenfield B. E, *Social Policies for Old Age.* London: Routledge and Kegan Paul, 1957 (p.184). However problems occurred later according to Parnell, who was based at Highcroft and Summerfield Hospitals. Between 1961 and 1967 the accommodation for the geriatric service decreased with a resulting fall in admissions and turnover. In 1972 he reported turnover had nose dived, a fact which he attributed in part to the increasing domination of general medicine due to Cogwheel reorganisation of hospital management. Parnell R. W., "Geriatric Plans," *British Medical Journal, 1972, 2: 760.*
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wing of 196 beds was opened as well as a 50-bed day hospital. By 1982 the bed compliment had fallen to 600 and by 1985 to 475.

Dr. J.H. Sheldon and his surveys.

In spite of the results of the surveys of 'bed blockers' and the development of geriatric services, the Birmingham Regional Health Authority remained concerned about its services for the aged and infirm. It therefore commissioned Dr. J.H. Sheldon in 1959 to survey all its chronic sick hospitals, but not those caring for the 'psychogeriatric' patients.

Dr. Joseph Harold Sheldon CBE, MD, FRCP, (1893-1972), was a general physician based in Wolverhampton. He was the eldest son of a bank clerk and a widely read mother. His other brothers became doctors. He trained at King’s College London and served in the Royal Navy for a short time before qualification. He obtained his MD and MRCP and was appointed to the Royal Hospital, Wolverhampton in 1921. He was renowned as a clinician and teacher. He arranged his out-patient department appointments to coincide with local market days. In his later years he studied elderly people, which culminated in his publication in 1948 of Social Medicine of Old Age, a study of the health of the
elderly in the community.\textsuperscript{43} Two years later he gave the F.E. Williams lecture of the Royal College of Physicians.\textsuperscript{44} In 1964 he was elected President of the International Association of Gerontology.\textsuperscript{45} In 1966 he was awarded the Moxon medal of the Royal College of Physicians. He was said to be a humble, unselfish and lovable man, who refused more chairs in medicine than anyone else.

Sheldon's Wolverhampton community survey of elderly people was the first of its kind after the War. He used the ration card register to locate his sample of 583 old people (186 men over 65 and 397 women over 60 years).\textsuperscript{46} He found that of the 450 people who replied to questions about health, their general practitioner was currently treating 29%, and 44% had had treatment in the past 3 years. Two thirds of his sample could still get about, one third had some limitation of mobility and 2.5% were bed ridden. 98% of old people lived in their own homes. The majority of illnesses in the family were managed within its own resources – spouse, children or neighbours - which could be a heavy burden on younger members of the family.

Sheldon emphasised the positive contribution made by older people and backed efforts to help them to be independent for as long as possible.\textsuperscript{47} He


\textsuperscript{44} Sheldon, J. H., "The Role of the Aged in Modern Society," \textit{British Medical Journal}. 1950, \textit{1}: 319-23.


\textsuperscript{46} Sheldon, J. H., op. cit., note 43.

\textsuperscript{47} Ibid
supported attempts to provide elderly people with meals on wheels, chiropody and other services: a view upheld by the later Guillebaud report. He distinguished between ‘chronological’ age and ‘biological’ age. Chronological old age officially started when a pension is paid but biological old age would begin when there is definite limitation of activity, which could be after the age of 70 or even 75 years. Thus a 5 to 10 year age gap could exist between official and natural onset of old age. He noted the increasing proportions of older people in the general wards in Wolverhampton: 3.9% in 1948, 10.4% in 1957, and 12% in 1959.

Sheldon’s survey of regional hospital geriatric services took place in 1959/60 and the report appeared in 1960. It was initially confidential and consequently Sheldon wrote, in the preface, ‘in many places...the phraseology has not been emasculated to such a level of neutrality as might be thought more apt for general publication’. It revealed a highly unsatisfactory state of affairs, which echoed comments made some 15 years earlier in the 1945 Hospital Survey Reports. The editorial writer of the Lancet expressed horror at the description of the hospitals.

Sheldon reminded the Regional Board that illness in old people consisted of two hazards: first, degenerative disease which could leave a residue of incapacity;

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49 Sheldon, ibid.

50 Sheldon, J. H., Geriatric Services in Birmingham Regional Hospital Board. Birmingham: Birmingham Regional Hospital Board, 1960.

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and second, support from relatives in the patient's home might be limited. He stressed hospital services were interdependent on services supplied by the general practitioner, voluntary bodies and the local authorities – i.e. hospital and community services were linked. He found some areas appeared to be over bedded although this masked considerable overcrowding. Other areas were seriously under bedded. In parts of the Region, for example, only one seventh of the chronic beds were provided, although that area contained one quarter of the population. Norris, a regional statistician, reviewed bed requirements statistics in regional hospital planning.\textsuperscript{52} She found that independent workers and government committees produced considerable variation in the estimates of required hospital beds, see table 5.4, and also that nurse ratios for chronic sick and acute beds varied even after standardisation across the region.

\begin{tabular}{|l|c|c|}
\hline
Estimate & Type of Beds: & \multicolumn{2}{c|}{Numbers required/1000 total population} \\
 & & General & Chronic Sick \\
\hline
Surrey Plan & & 6.0 & 6.0 \\
Berk's, Bucks, and Oxon, scheme & & 5.5 & 2.5 \\
Scottish survey & & 4.8 & 1.5 \\
Consultant Services (Ministry of Health) & & Approx. 6.5 & 1.5 \\
Birmingham region & Total Bed Complement & 2.85 & 1.4 \\
 & Available Bed Complement & 2.53 & 1.34 \\
\hline
\end{tabular}

\textbf{Table 5.4 Estimates of hospital beds required for each 1,000 population.}\textsuperscript{53}

\textsuperscript{52} Norris V., "Role of Statistics in Regional Hospital Planning," \textit{British Medical Journal}, 1952, \textit{1}: 129-133.

\textsuperscript{53} Ibid
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Sheldon found inappropriate use of buildings, some of which were over 200 years old and one was nearly 800 years old. They had originally been designed as ‘human warehouses’ and were not intended for their present use, although attempts at improvements had been made. The quality of some of the buildings was such he recommended six should be either partially or totally demolished. He reported only one-sixteenth of the expenditure on capital works had been allotted to hospitals for the chronic sick, although they contained one-seventh of the total beds – 6,000 out of 44,000. 54

Sheldon itemised the inadequacies he found. In many hospitals the upper floors had no lift and could only be reached by narrow external stairs, and therefore constituted a fire hazard.55 Patients had to be carried up and down stairs,

Figure 5.6 Bedpans stored in bath 56

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54 This was not just a regional problem. Abel-Smith and Titmuss reported ‘as the prices of building work and other capital assets have risen substantially [between 1948-1954], the rate of capital expenditure in real terms has progressively declined’(p.170). The rate of fixed capital expenditure had averaged one third of pre-war rate in real terms and therefore it would take 200 years to replace all the present day hospitals. They noted 45% of all hospitals had been built before 1891. Abel-Smith B. and Titmuss R. M., The Cost of The National Health Service in England and Wales. Cambridge: Cambridge University Press, 1956.

55 The problem of ward access to upper floors was still present in Brighton in 1971. See Chapter Seven and photographs (p.286). South East Metropolitan Regional Hospital Board. Development of Services for the Elderly and Elderly Confused. South East Metropolitan Regional Hospital Board. 1971.
as did all food (either hot or cold), linen and perhaps coal. Space for rehabilitation facilities was often cramped. He found it quite an experience to see bedpans stored for the night in the bath, to find the same room being used for washing bedpans and domestic crockery and being told of nurses having to queue up for the same toilet as the male patients, (see figures 5.6 and 5.7). The work of the nursing staff was commended. He still found patients inappropriately placed in hospital e.g. 300 patients in Summerfield Hospital (previously the WRI) required only supervision with occasional nursing care and needed alternative accommodation. The photographic appendix to his report emphasised the points he was making.

Sheldon thought three types of accommodation were required for the chronic sick: acute assessment units with rehabilitation, long-stay units, and small chronic sick facilities associated with the local cottage hospital. He recommended the appointment of more geriatric physicians in the Region and emphasised the need

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for postgraduate medical education in the modern treatment of the chronic sick.\(^5^8\) He advocated adequate staffing of all sections of the rehabilitation team. However because so little was known about illness/diseases of old age, he suggested it was premature to consider having a speciality of geriatrics. The report drew a strong supportive editorial response from the *British Medical Journal*.\(^5^9\) Perhaps the results of his survey added impetus to the British Medical Association because, two years after his report, the Association published *A Guide to Geriatric Services*.\(^6^0\) This affirmed over 100 geriatric departments had been established in Britain and the services they provided including rehabilitation, long term care, relief admissions, domiciliary visits, and day hospitals.

**Conclusions**

The Birmingham story is one of surveys and classification of elderly patients in 'chronic sick hospitals'. The first studies clarified the strategic planning for the future bed/hospital requirements of the Region, since only about one half of the patients needed hospital care and therefore, it was concluded, no more hospitals were needed at that time. The surveys found inadequate investigation of patients before admission to hospital, poor quality housing and lack of domestic and social

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\(^{5^8}\) About 9-10 years earlier Hastings had thought there should be such physicians in every general hospital. Hastings S., "Old People," *Lancet*, 1951, 2: 879-880.

\(^{5^9}\) Editorial, "Human Warehouses," *British Medical Journal*, 1961, 2: 100. A history of Birmingham RHB published in 1966 reported accommodation for geriatric services was deficient in quality and quantity, lacked modern amenities and in places constituted a fire hazard. op. cit., note 2.

service support in the patient's home. However these surveys lacked active participation and collaboration of the local authorities.61

The Regional Board remained dissatisfied with its geriatric services and in 1959 commissioned a region wide survey by Sheldon. His report showed good nursing care but was highly critical of the accommodation, with overcrowding and shortage of beds, inadequate facilities for staff and poor hygienic arrangements.

All involved in the surveys were unanimous that medical students should be taught about the chronic sick. They would have been pleased to note the first appointment to the Charles Hayward Chair of Geriatric Medicine in Birmingham, Dr. Bernard Isaacs, was made in 1974.

Annex One

James Whigham Affleck, (MB, FRFPS, DPM), who was deputy medical superintendent of the Municipal General Hospital, Leeds, discussed the management of chronic sick patients with mixed physical and psychiatric disease in a study published in 1947.62 He examined 788 patients admitted to five hospitals in Leeds, three of which were for the chronic sick. Patients with 'pure' psychiatric symptoms were not admitted to these hospitals, although elderly patients were not refused admission if mental problems were included in their

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61 A 1975 study in Liverpool of bed blocking did include a member of the social service department. Their problem was considered to be due to lack of local authority beds and poor mobility in those going home. Rubin S. G. and Davies G. H., "Bed Blocking by Elderly Patients in General Hospital Wards," *Age and Ageing*, 1975, 4: 142-147.

symptoms. Three quarters of the total admissions were chronic sick patients and over one third had evidence of mental disease. Nearly two thirds of them were suffering from senile dementia, while over 14% suffered from paranoia or depression. Affleck thought chronic sick hospitals had a greater mixture of mental disorders than a well-arranged mental hospital. Those in charge of the former were blind to the patients' psychiatric problems and the medical and nursing staff were not trained or interested in such patients. The best solution would be to admit these patients to a special ward in a geriatric hospital, which had ready access to medical, surgical, orthopaedic and psychiatric opinion. The Ministry supported Affleck's view of a short stay assessment unit for the elderly mentally infirm sited within the geriatric department with transfer to a long-stay annex for those patients without marked behavioural disorder. This annex might be sited within a mental hospital complex but if this was not possible, a strong link with a psychiatric medical and nursing staff should be retained.

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64 This perception was supported by Cook and colleagues who also advocated greater use of services such as psychiatric social workers, health visitors, district visitors, home helps and domiciliary visits. Cook L. C., Cunningham Dax E. and Maclay W. S., "The Geriatric Problem in Mental Hospitals," *Lancet*, 1952, 1: 377-382. A later development was the joint assessment unit where patients with mixed medical, psychiatric and/or social problems could be admitted for investigation and treatment, and decisions made about their ultimate discharge and accommodation. Morton E. V. B., Barker M. E. and MacMillan D., "The Joint Assessment and Early Treatment Unit in Psychogeriatric Care," *Gerontologia Clinica*, 1968, 10: 65-73. The subject of psychogeriatric assessment was again raised by those who believed the key to success was clarification of the patients' needs with good collaboration and trust between the geriatrician, the psychiatrists and the local authority. Exton-Smith and Robinson thought those with behavioural disorders were the prime responsibility of the psychiatrist, while the geriatrician should care for those with predominantly medical problems although these patients might have some mental symptoms. Exton-Smith A.N. and Robinson K.V., "Psychogeriatric Assessment Units," *Lancet*, 1970, 1: 1292.
Misplacement of chronic sick/psychiatrically ill elderly in-patients found by Affleck and Thomson continued. Smith and colleagues, using the Thomson classification, found such evidence in a very large psychiatric hospital in Lancaster and because there were geriatric patients in their hospital, the psychiatrists had created a geriatric service, ready for a consultant geriatrician if one was appointed. Although the following study is outside the area of this thesis the findings are important. A Belfast study in 1962 showed 24% of elderly patients were misplaced in mental hospitals and 34% were misplaced in geriatric units. Kidd also found that 'the mortality of misplaced patients is significantly higher wherever they are sent. Further, by comparing the figures for the medical and psychiatric cases in the two hospitals it can be shown that medical cases in the mental hospitals have a higher mortality than correctly placed medical cases and that psychiatric cases in the geriatric units have a higher mortality than psychiatric cases correctly placed' (p.1492). As Kidd put it, 'It is difficult to imagine any more dramatic consequences from admitting old people to the wrong hospital than so high a proportion of them should die, and that of those who survive so few should be discharged' (p.1493).

Annex Two: Whose responsibility was the care of the 'Bed Blockers'?

'Bed blockers', those patients whom the clinicians considered no longer needed to be in hospital, presented a problem to the hospital service. The

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National Corporation for the Care of Old People put the problem succinctly: 'there are old people in hospital who are not in need of skilled nursing, only of care and attention; but there is nowhere for them to go. There are others who live in their own homes who are in dire need of hospital treatment yet there is no room for them in hospital' (p.7)\(^6\)\(^7\) The following year Dr. Joseph Greenwood, medical superintendent at the Withington Hospital, agreed, 'one great difficulty in treating these [aged sick] patients is to find suitable quarters for them when they no longer need continuous medical and nursing care' (p.1048).\(^6\)\(^8\)

McKeown and Lowe postulated three reasons for the 'bed blocker' situation. First, after the Second World War, the care of the aged and infirm was split between the National Health Service and the local authorities. Second, there was a lack of clarity and/or definition regarding which authority should look after which type of patient/client. Third, the costs of the health service were rising: both health and local social services were short of resources while the number of elderly people in the population was increasing. Data produced by one government committee (Phillips) showed a steady level percentage in the elderly population from 1851 to the early 1900s after which it began to increase, see table 5.5.\(^6\)\(^9\) Dr. Joseph McMullan, formerly senior administrative Medical Officer at the South East Metropolitan Regional Hospital Board, argued the increasing numbers of elderly was due to a reduction in mortality, which meant many more


people survived to middle and older ages. Family size had decreased from 5-6 in mid-nineteenth century to 3-4 at the turn of the century and even fewer at the time of writing, which meant fewer people were available to look after ageing relatives. It was important to remember elderly people did not constitute a homogeneous group. Some were fit, some were ill, some were neither one nor the other but were ‘in the middle’, and some changed from being ill to being well and back again. Then there was the difficulty of deciding who the ‘chronic sick’ were.

<table>
<thead>
<tr>
<th>Year</th>
<th>0-14 years</th>
<th>15-64 years</th>
<th>65 years and over</th>
<th>All Ages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Millions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percentages</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>7.4 (35)</td>
<td>12.4 (60)</td>
<td>1.0 (5)</td>
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<td>8.2 (36)</td>
<td>13.8 (59)</td>
<td>1.1 (5)</td>
<td>23.1</td>
</tr>
<tr>
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<td>9.4 (36)</td>
<td>15.4 (59)</td>
<td>1.3 (5)</td>
<td>26.1</td>
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<tr>
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<td>10.8 (36)</td>
<td>17.5 (59)</td>
<td>1.4 (5)</td>
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</tr>
<tr>
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<td>28.2 (66)</td>
<td>2.6 (6)</td>
<td>42.8</td>
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<td>10.8 (24)</td>
<td>30.7 (69)</td>
<td>3.3 (7)</td>
<td>44.8</td>
</tr>
<tr>
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<td>11.0 (22)</td>
<td>32.5 (67)</td>
<td>5.3 (11)</td>
<td>48.8</td>
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</tbody>
</table>

Table 5.5 Shows changes in the population of Great Britain 1851-1951.  
Both hospital and local authorities argued over responsibility for ‘bed blockers’. Both sides could quote from official documents to support their point

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71 Ibid.
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of view. The hospital authorities thought they were not responsible. They could quote Section 21 of Part III of the National Assistance Act 1948, which stated ‘it shall be the duty of every local authority...to provide residential accommodation for persons who by reason of age, infirmity, or any other circumstances are in need of care and attention which is not otherwise available to them’ (para 21 (1) a) and ‘a local authority may provide...on the premises in which accommodation is being provided such health services, not being specialist services or services of a kind normally provided only on admission to hospital, as appear to the authority requisite and as may be specified in the scheme under this section’ (para 21 (7) b). However there is a degree of ambiguity in the interpretation of the phrase ‘services of a kind normally provided only on admission to hospital’. Furthermore many requests for admission to hospital were precipitated by a social/domestic crisis.

The local authorities in their turn could argue this was a very one-sided view of the situation. Section 79 of Part VI of the National Health Service Act 1946 defined a hospital as ‘any institution for the reception and treatment of persons suffering illness’ (para 79 (1)) and defined illness as ‘including mental illness and any injury or disability requiring medical or dental treatment or nursing’ (para 79 (1)). The local authorities could argue they might not agree with the doctors’ classification of their patients. Certainly the Boucher survey report found


evidence that welfare officers did not always agree with the clinicians regarding who was fit for welfare accommodation. The Ministry fudged the issue in 1950, when it suggested those not fit to be discharged to their own homes or to homes provided by the local authority should be transferred to a long-stay annex and not retained in the acute hospital. The nub of the comment lies in the interpretation of "fit".

The resolution of the problem was not going to be easy. There were several options: some were politically impracticable, some were possible, others would require considerable resources with implications for the local authorities, but much might be achieved by simple good will and understanding without costly intervention. McKeown and Lowe thought the ideal solution would be to place the care of elderly people within one authority but accepted this radical view was politically impractical. Bridgen argued the transfer of the care of elderly persons needing long-stay care to the local authorities was politically unacceptable for three reasons. First, there could be accusations of a return to the Poor Law 'dump hospitals'; second, local authorities would demand considerable increase in resources; and third, the elderly would be forced to pay for their care.


If transfer of care of the chronic sick was not possible, then far better understanding and cooperation between the various parts of the NHS was required. Hospital services would need to understand the role and problems of the local authority in providing welfare homes and care in the community and to realise their limitations in resources and services. Unfortunately the lack of cooperation within the National Health Service was notorious. Boucher wrote in his 1957 report, 'There is frequent reference to the absence of coordination of the services and to the lack of cooperation between them...only too often [the services] exist in isolation instead of assisting and supporting each other...in a few places the hospital and the local health authority appeared to ignore each other's existence' (p.48) The Central Health Services Council (CHSC) produced a specific report on the subject in 1952. The problems were so 'well known', it said, that no amplification was given. The hospital services were tempted to develop their services without regard to the other two, which induced a feeling of inferiority in the latter. The problem was aggravated in three ways. First, only the local health authorities had a unitary structure, the other two did not. For example, in the hospital service the Board of Governors were independent of the Regional Boards, and there was a division of function between the Boards and the


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Hospital Management Committees. Second, two of the three branches of the Service were associated in their work with authorities, which were not created by the Act but were closely concerned with its operation. In the hospital service, the Universities had a special relationship created by the Act to both the Boards of Governors and the Regional Boards. Third, the local health authority and the executive council for general practitioner services were usually coterminous while the hospitals were not.

Lack of cooperation persisted. Ruck reported the same problem between housing and welfare departments concerned with the care of the elderly. He quoted one welfare officer talking about his housing department, 'You wouldn’t think we belonged to the same firm' (p.125). The same story was reported from the Barrow-in-Furness study. Green and Lodge wrote that while the three Fates (Clotho, Lachesis and Atropos) worked together, the three authorities of hospital, welfare and housing manifestly failed to do so.

An important feature in the resolution of the 'bed blockers' was improved housing and support services. Thomson suggested better housing with the provision of nursing and domestic help in them, but also the creation of simple hostels, improved staffing and facilities in the infirmaries and appropriate accommodation for the mildly demented patient. McKeown and Shenfield recommended adequate home domestic services, such as nurses, home helps,

83 Green M. and Lodge B., op. cit., note 33.
laundry, and meals, but thought the demand for these services would exceed supply. The need was supported in an editorial in the British Medical Journal. Some areas still lacked adequate meals on wheels, special laundry services, home nurses, welfare beds and special appliances for the disabled. However the writer praised the comprehensive geriatric services and agreed modern geriatric practice made effective use of resources and beds even in inconvenient and old hospitals. Shortages were noted in the London area generally and in particular its boroughs of Lewisham, Camberwell and Hampstead. Wright and Roberts considered that standards of training and pay of home helps needed improving. Mrs. Barbara Castle asked the then Minister of Health, Aneurin Bevan, whether he was aware that surveys had shown hundreds of old people living alone required visiting and someone to do their shopping. The provision of meals on wheels was another important domiciliary service. Brooke and Wetenhall set up such a service with the WVS. In Salford meals on wheels were made in the Civic Restaurant, and


their delivery gave the older person the opportunity for a chat with someone friendly.91

Support for maintaining people at home came from financial data of Shenfield.92 She showed keeping old people at home could be less costly than being in a hospital bed or residential home, table 5.6.

| Cost of being in a hospital bed, residential home or living at home; £ per year |
|-----------------------------------|------------------|
| Chronic hospital bed              | £400             |
| Residential/local authority home  | £200             |
| Stay in a half way home           | £320-350         |
| Living at home with some social service support e.g. home help, meals on wheels | £80-100 |

Table 5.6 Shows the costs of keeping elderly people in various accommodations in 1957.93

She concluded it was worth spending £100 per year to help maintain old people at home rather than in a home or in hospital, and if family help were available the cost would be even less. This view was disputed by Dr. Louis Opit in 1977 who found, in a study of 139 elderly sick patients living at home in Central Birmingham Health District under the home nursing service, the revenue cost of domiciliary care was equal to or greater than the average residential or hospital custodial care.94 He thought some cost reduction could occur if there

93 Ibid.
were 'appreciable changes in the organisation of the health and social services' (p.33).

The 'blocked bed' situation in hospital was not one sided. Some residents in welfare homes were inappropriately placed there. Townsend's surveys of welfare homes carried out in 1958/9 showed one third of residents were frail and a few were bedfast, but nearly half could care for themselves or were little incapacitated.\(^{95}\) Green and Lodge in 1965 reported on assessments of residents of welfare homes in Barrow-in-Furness.\(^{96}\) This showed two residents out of 145 were medically ill but 65 had social problems, most of whom were too fit for their present accommodation, indeed many took a bus or walked into the town. In 1977 the Royal College of Physicians reported, 'there is much misplacement of old people into part III and other special accommodation.' (p.1094).\(^{97}\)

The arguments about 'blocked beds' continue to this day with elderly patients and local authorities often being blamed. The pressure for admission to acute hospital beds has not abated. The difficulties have been exacerbated by a

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\(^{96}\) Green M. and Lodge B., op. cit., note 33.

decrease in the number of long-stay beds in the NHS, private and voluntary sectors.
Chapter Six

The Amulree Years

Introduction

This chapter is about Lord Amulree, the second major influential figure in British geriatric medicine. Basil William Sholto Mackenzie, 2nd Baron Amulree, KBE, MD, FRCP, (1900-1983), took centre stage shortly after the Second World War. I argue that he was unique amongst U.K. geriatricians in having a ‘wide angled’ view of the care of elderly people, which resulted from his administrative duties at the Ministry of Health and, later, his clinical work at University College Hospital (UCH) and St. Pancras Hospital. Furthermore his position in the House of Lords enabled him to bring the problems of old age and infirmity before a wider audience.

His appointment to UCH was the first, and for a long time, the only London teaching hospital appointment in geriatric medicine. He and his registrars classified, diagnosed and treated elderly in-patients, as well as making assessment visits to old people at home, which ensured appropriate placement of patients in hospital or home with necessary extra support. Application of these methods resulted in a considerable shortening in the average length of stay of his in-patients, increased patient/bed turnover and a reduced waiting list. He deprecated the poor housing conditions of some elderly people living at home and espoused the great need for, and value of, domiciliary support services, which he said could not only prevent unnecessary admission but also help maintain frail elderly people at home.
Sholto Mackenzie was the son of a lawyer, who was a Member of Parliament in Ramsay MacDonald's first Labour government and who later became the first Lord Amulree.\(^1\) His uncle was Sir James Mackenzie, (1854-1925), an outstanding cardiologist at the London Hospital and physician to the King in Scotland. He was educated at Lancing, and Gonville and Caius College, Cambridge. After qualification from University College Hospital (UCH) Medical School in 1925, he completed his house posts and then worked as an assistant pathologist at UCH and the Royal Northern Hospital. He passed the MRCP examination in 1928, obtained his MD in 1936 and joined the Ministry of Health in the same year. As war approached, Amulree was directed towards the care of the chronic sick, which brought him into contact with Marjory Warren, Lionel Cosin and Trevor Howell. Eventually, according to Sir George Godber, Amulree became their most trusted ally in the Ministry. He acquired firm views of the working of the official civil servant mind, because in 1946 he commented the care of the elderly was 'a

matter from which the hand of the bureaucrat should be kept as far as possible’ (p.801).²

In 1949 he was appointed physician in charge of the newly established geriatric department at UCH based at St. Pancras Hospital. This action, Godber considered, was a refreshing approach to the otherwise ‘blinkinged fashion adopted by most teaching hospitals of the time’ (Munk’s Roll p. 13). However Dr. Maurice Pappworth reported Amulree applied for several other posts before this appointment.³ He succeeded to the peerage in 1942 when he became Lord Amulree. He became FRCP in 1946, and was made KBE in 1977 for a lifetime of public service to health and welfare.

He was a Liberal Peer and whip for 22 years between 1955 and 1977. He did not play a leading role in politics, according to Godber, and was transparently without personal ambition. As a member of that Party he was appointed a member of a three-man team, which produced in 1948 a report, ‘The Aged and the Nation’. This discussed deficiencies in the care of older people, much of which was familiar, according to the Lancet.⁴ The report also advocated elderly people continued to stay at work and made suitable pension arrangements. The Chief Medical Officer, Sir John Charles, who drew attention to the decline in

employment in those over 65 years, supported this conclusion.⁵ He reported that
the number of elderly people still in work had fallen steadily since the turn of the
century: in 1901 61% of men over 65 years were still working, a figure which fell
to 48% in 1931 and to 32% in 1951. In 1968 Amulree served on one of the series
of official NHS enquiries into allegations of abuse in the care of elderly people, in
his case at Banstead Hospital.⁶

Amulree was a modest, agreeable man, good with people even though he had
a severe stammer. He had a wide circle of friends and lived in his flat in Chelsea,
where he had a magnificent collection of pictures and ceramics. He was a
governor and president of many organisations including the British Geriatrics
Society, which he headed for 25 years; the Society for the Study of Medical
Ethics; the London County Division of the British Red Cross Society; the
Association of Occupational Therapists, and the Association of Welfare Officers.
He was chairman of the Attendance Allowance Board from its inception. In 1972
he helped to establish the Chair of Geriatric Medicine at UCH, which was

⁵ Support for employment for the elderly continued to arouse comment. Ministry of Health.
1955. The value of continued employment of older people, if they wished it, was supported in a
of services for the elderly in Bristol also supported continued employment amongst the old. A
Report on the Treatment and Care of the Elderly Chronic Sick in Bristol. Bristol Local Medical
Committee, 7 The Dell, Westbury-on-Trym, Bristol. 1955. Dr Robert Logan, Reader in Social
Medicine at the University of Manchester and Director of Medical Care, reported in 1965 that 27%
of men over the age of 65 years were still in employment. Logan R. F., "The Burden of the Aged
in Society and on Medical Care," in Medicine in Old Age, ed. Agate J. N., London: Pitman

⁶ Ministry of Health. Findings and Recommendations Following Enquiries into Allegations
awarded to Dr. Norman Exton-Smith, his first assistant medical registrar. He never married.

The Post War Period to the ‘Appointed Day’ – 5th July 1948

About three years elapsed after the end of the Second World War before Amulree took up clinical duties and therefore I set the scene that would face him in his clinical work. The new Chief Medical Officer, Sir Wilson Jameson, pointed out that 1948, the year the new NHS came into being, was a period of great difficulty for the general health of the population and one of upheaval for the hospital service. He made it plain there was an economic crisis as well as an ever-increasing dollar crisis facing the country. There was an unprecedented shortage of fuel, a winter of exceptional severity, followed by the heaviest floods for 53 years. Food rationing, which perhaps might have been expected to improve after the War, got worse. Bread was rationed for the first time in late 1946, meat in September 1947, the bacon ration was halved in October and potatoes were rationed in November. The Standing Committee on Medical and Nutritional Problems was concerned about those who had to live on their rations without recourse to canteen or restaurant meals. Accordingly the Ministry of Health convened a conference on how best to plan to feed such aged people and concluded they should have help with shopping, cooking and meals on wheels.

Jameson was anxious about many aspects of hospital care. Demand for

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8 Ibid.
hospital treatment was increasing. Diagnostic and therapeutic techniques were becoming more complicated and required more space. The proven value of wartime rehabilitation techniques could now be applied to civilian cases but accommodation was limited. There was a nursing shortage. Building restrictions on new hospitals severely limited a national building programme and many facilities, originally described as temporary, might have to last 25-30 years. The situation was assuaged to some extent by the release of 28 hospitals and 4,574 beds from the Emergency Medical Service, which compared with the release in 1946 of 149 hospitals and 16,000 beds. The EMS still retained 329 hospitals and 18,000 beds at the end of the year. The lack of chronic beds prevented the return of all those patients who had been evacuated from London during the War. Although 560 patients had returned during 1947, 400 were still in other parts of the country.

Jameson discussed hospital design and the more efficient use of beds. He considered the optimal size of a hospital was about 500-600 beds. These beds could be used more effectively by expanding out-patient departments, providing hostel accommodation, planning the layout of wards to make observation by nurses easier, encouraging patients to help themselves and employing ward assistants to relieve nurses of some duties. He extolled the work of Eric Brooke in his use of the out-patient department and home care service at St. Helier Hospital, but he reported abuse of the car [ambulance] service for 'sitting cases'. Jameson noted Regional Health Boards (RHBs) were grouping hospitals into

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9 Ministry of Health. op. cit., note 7.
suitable local admission units with a balanced professional team to look after the patients. However they needed to review waiting lists and improve admission procedures. This supported the aims of the Ministry of Health for an efficient and effective hospital specialist service as signalled by *The Development of Consultant Services*.\textsuperscript{10}

The limitations on hospital building programmes were put in perspective by cogent arguments in a 1960 study, supported by Nuffield Provincial Hospitals Trust.\textsuperscript{11} It compared hospital building costs with those of house building: ‘at present costs (at £5,000 per bed in new hospital construction and £1,500 for a new council house) even to provide a 1 bed per 1,000 population in England and Wales, a total of 45,000 beds, would have meant building 150,000 fewer houses. The cost of these beds would represent about one third of the annual running costs of the National Health Service’ (p.109). The nettle for a new major hospital building programme was not grasped until 1962, when the Hospital Plan for England and Wales noted that half the hospitals inherited by the NHS were built before 1891, and 1 in 5 before 1861.\textsuperscript{12}

The pressure on hospital admissions was much debated. A 1947 editorial in the *Lancet* suggested the bed and nurse shortage could be partly alleviated by better use of the out-patient department and proper classification of patients.


admitted for treatment. 13 Eric Brooke supported this opinion. 14 Jameson agreed and pointed to the value of rehabilitation. 15

Dr Edwin Sturdee, Principal Medical Officer at the Ministry of Health, writing in 1948 pointed to other unsatisfactory situations. 16 Doctors and nurses who went to work in the community would find they had no experience of the diseases of old age, because they had been taught exclusively on ‘acute cases’. He extolled the active teaching measures taken by two London teaching hospitals to enable students to be taught in local ‘chronic sick’ hospitals. 17 He supported the concept of preventive medicine and old people’s clubs, and, like Amulree, he promoted an easy ‘two way passage’ between hospital and home as the patients’ condition required.

Amulree, with Sturdee, fired his opening salvo on behalf of the chronic sick and aged in the Parliamentary Presentation in 1946.\textsuperscript{18} In this very general paper he and Sturdee underscored the fact that the vast majority of the chronic sick were elderly people. They acknowledged the tendency to give priority to the acutely ill patient at the expense of the older patient, who was feared as a potential 'bed blocker', but they reiterated proper classification of patients was needed for correct diagnosis and treatment. The concept of hostels or small houses for the aged chronic sick with problems with self-caring was supported but institutionalisation had to be avoided. Amulree and Sturdee defined four groups of patients who were inappropriately occupying hospital beds – those with diseases which had become chronic because they had not been treated soon enough; those with disabilities who could not be sent home; those admitted with preventable diseases; and those who could go home but no longer had a home to go to and therefore needed some other form of accommodation. They referred to the work of Dr E. M. Bluestone, Director of the Montefiore Hospital, New York.\textsuperscript{19}

Amulree cited Hill Homes in Highgate, as a good example of hostel/home accommodation for the elderly, which in 1947 comprised four homes with a fifth just about to open.\textsuperscript{20} Alderman Margaret Neville Hill, CBE, (wife of the

\textsuperscript{18} Lord Amulree and Sturdee E. L., "Care of the Chronic Sick and of the Aged," \textit{British Medical Journal}, 1946, \textit{1}: 617-618.


physiologist A.V. Hill), who was chairman of Hill Homes Ltd., described her homes in detail in the 1952 F. E. Williams lecture given at the Royal College of Physicians.\textsuperscript{21} She strongly supported the prevention of unnecessary illness and encouraging elderly people to remain as physically active as possible in retirement: 'the will to live is the strongest of all instincts and persists in old age'. Her 20-year-old housing trust had admitted some 320 people most of whom were old. When the residents became unwell, nursing care and home help was provided, so that of the 48 deaths, which had occurred, only 2 had taken place in hospital while all the others happened in the home itself. She considered individuals had the right to independence and privacy, either in a small flat or single room. Bed rest should be kept to a minimum otherwise 'the desire for the adventure of living is easily lost' (p.448), and will power for recovery might be lost. She deprecated years of lying in a ward bed, which could amount to actual cruelty with life regularised, dressing limited to being attired in a dressing gown, and possessions almost non-existent. She quoted one lady who 'had most successfully learned to do absolutely nothing and unfortunately had lost power or incentive to help her' (p.448). She realised bed rest was used to overcome the fear of falls and possible criticism for accidents but this would be at the expense of liberty and happiness. She considered nursing should be reserved for those in real need. Further, nurses should be given advice about the correct way of lifting patients to avoid injury to their backs. She, too, supported the easy transference

\textsuperscript{21} Hill Mrs A. V., "The Dangers of Chronic Inactivity in the Aged," \textit{Lancet,} 1952, 2: 447-449. She wrote about the care of older people with deteriorating memory in a pamphlet, \textit{An Experiment in the Care of the Mentally Ageing:} date of publication not known.
of patients between hospital and welfare home for elderly people. She divided older people into four groups: those with senile dementia, persons with weak intellect who had grown old, the aged ‘crank’ and those with simple senility.\textsuperscript{22} In 1961 she published ‘\textit{An Approach to Old Age and its Problems}’, in which the following dedication appeared:

\begin{quote}
As you are now so once were we
As we are now so shall you be.\textsuperscript{23}
\end{quote}

The problem of appropriate accommodation for the elderly people, which Sturdee and Amulree highlighted, received support from a 1946 survey of 350 hospital almoners, on the care of the chronic sick and patients with malignant disease.\textsuperscript{24} This quoted examples of lack of apposite accommodation for the chronic sick, of patients dying at home who should have been in hospital, while still others lingered in hospital who should have been at home. The Public Assistance Institutions were too often in ‘old workhouses’ which were grim, depressing, out of date buildings quite unsuitable for their present use and which represented the stigma of the old Poor Law in the mind of elderly people. The chronic sick often lacked domestic help, convalescent homes, accommodation in semi-invalid nursing homes, and occupational therapy. The Institute made many recommendations, suggesting each general hospital should have a special


\textsuperscript{24} Institute of Almoners. \textit{Memorandum on the Care of the Chronic Sick}. London: Institute of Almoners, 1946.
department for long-term cases with doctors and nurses trained in the care of such patients. Wards should be made less institutional with comfortable day rooms, more light and good decoration. The enlarged 1935 edition of The Hospital Almoner, which described the work of these professionals, had no specific section devoted to the aged and infirm although the chronically and incurably ill did merit a single page out of a total of 166 pages.25

Amulree returned to the attack later in the same year with an article in the Lancet.26 ‘We have already made great strides with the improvements of conditions for infants and young children...let us now turn our attention to the old, who having worked all their lives, can pay no dividend: in fact it is we who owe them much. Their plight is desperate’ (p.802). He noted those over 60 years had increased in number from 2.4 million in 1901, to 6.3 million in 1944. If this trend continued it would result in the unsatisfactory economic situation of 40% of the population aged less than 60 years, looking after the 60% over that age. Poor health in the working population would only compound the disparity.27


27 He reiterated the problem of the growing number of the elderly in the House of Lords. Lord Amulree, "Plight of Old People," Lancet, 1947, 1: 652-653. Dr John Pemberton and Dr John Smith in a 1949 study based in Sheffield found only one third of male medical in-patients, aged 50-64 years returned to their previous work although a further 8% returned to lighter work. Much depended on the nature of the illness e.g. chronic pulmonary disease, which was likely to preclude return to work. Pemberton J. and Smith J. C., "The Return to Work of Elderly Male Hospital In-patients," British Medical Journal, 1949, 2: 306-308. Logan in 1966 commented that there was a steady increase in chronic sickness leading to a withdrawal from work of men under 65 years. Two million people in the country needed help but did not get it due to poorly coordinated social service support. One third of a million had no indoor toilet or exclusive use of a bathroom. Logan R. F. L., "The Burden of the Aged in Society and on Medical Care," in Medicine in Old Age, ed. Agate J.N. London: Pitman Medical Publishing Company Ltd, 1966, p. 69-92.
Amulree reviewed the possible types and quality of accommodation for older people. Homes, hostels and other accommodation for the elderly should be sensibly designed and furnished but old people should not be collected together in self-contained communities unless they were in the middle of towns. Stair carpets should be in good condition and not loose. Floors should be made of a non-slip material. Fires should be adequately protected and the coal store should open into the house. He quoted the Royal Hospital for Army Pensioners in Chelsea as an example of good practice. Other types of contemporary accommodation were described in a series of articles in the *Lancet*, for example bungalows, municipal institutions, small group dwellings and almshouses. In the same year, 1947, Mr. George Thomas MP asked the Minister of Health whether hostels were to be made available for bedridden old aged pensioners, but the latter replied the care of the aged sick was a matter for the new health service. Care of those who were not sick would be dealt with in new legislation. The *Lancet* editorial writer of 'Life for the Long Lived' supported provision of alternative accommodation for the frail elderly people.

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In 1947 the Nuffield Foundation, of which Seebohm Rowntree was chairman, reported on the care of old people. The report took a pragmatic stance and commented that although sympathy for the problems of ageing and the hardships for old people was widespread, it realised the country’s wealth and labour resources were limited. Although about 95% of older people lived at home, many of them were physically or mentally unfit to do so. They continued to live in this unsatisfactory way due to lack of appropriate alternative accommodation with domestic and/or nursing support. The report suggested a national house building programme in which 5% of homes would be set aside, and made especially suitable for the aged and placed close to shops and bus stops. The report recommended senile patients should have homes, which specifically catered for them, but they should be moved out if their condition improved. It considered elderly patients should be admitted to a general hospital first for examination and treatment before being moved elsewhere.

After the ‘Appointed Day’ of 5th July 1948

On the appointed day 1,143 voluntary hospitals with some 90,000 beds and 1,545 municipal hospitals with 315,000 beds were taken over by the NHS in England and Wales. The local authorities lost ‘the general, poor law, tuberculosis, infectious diseases, mental and mental deficiency hospitals and


institutions, which were transferred to the [new] hospital authorities' (p.373). The local authorities were left the residue functions, which did not easily fit in elsewhere. Unfortunately there were no extra nurses or medical staff, and the same staff generally cared for the same people in the same buildings as before the change over.33

Jameson, in his annual report of 1948, returned to the subject of increased demand for beds for the chronic sick, which was most apparent in London and the South rather than the industrial North – a trend, he said, that had been apparent before 1948.34 Beds for the chronic sick had filled up in August and September well before the usual seasonal increase. Consequently when the winter demands for chronic sick beds came, there were no empty beds and many acutely ill elderly people could not be admitted. The Emergency Bed Service had an extremely difficult time.

The writer of an editorial in the Lancet took up the admission difficulties for the newly created NHS in 1948. He considered rigid selection was necessary for those with chronic illnesses.35 Those who were refused admission by the hospital could be referred to the Emergency Bed Service, which might be able to help. Howell responded, suggesting the Ministry of Health inculcate an atmosphere of


treatment and progress in chronic sick hospitals, as was the case in the West Middlesex and Orsett Lodge Hospitals.\footnote{36 Howell T. H., "Admission and Visit," \textit{Lancet}, 1948, \textit{1}: 1007.}

In the same year the \textit{Lancet} editorial writer of 'No Room at the Inn' provoked a flurry of correspondence.\footnote{37 Editorial, "No Room at the Inn," \textit{Lancet}, 1948, \textit{2}: 977.} The writer predicted pressure on hospital beds in the early months of the coming year. General practitioners would have great difficulty in obtaining admission for their elderly patients because they were perceived as being slower to recover from their illnesses. The writer echoed the need for improved domestic help for elderly people, which could help maintain them at home. He argued for temporary re-opening of closed wards during danger periods. Those responding to the editorial included Amulree who mentioned that pioneer work had shown nearly half of the so-called chronic sick could be discharged, and appealed again for improved co-ordination/collaboration between local authorities and the health authorities.\footnote{38 Lord Amulree, "No Room at the Inn," \textit{Lancet}, 1948, \textit{2}: 1026.} Dr Charles Andrews, a respondent from Cornwall, considered collaboration relied on local enthusiasm, but there should be a statutory committee linking both them and the voluntary bodies.\footnote{39 Andrews C. T., "No Room at the Inn," \textit{Lancet}, 1949, \textit{1}: 80.} Another writer, the Secretary to the Emergency Bed Service (EBS), agreed with the predicted pressure on hospital beds in the coming winter.\footnote{40 Breen G. E., "No Room at the Inn," \textit{Lancet}, 1949, \textit{1}: 80-81. The EBS was founded to facilitate admission of patients to hospital – the general practitioner could refer patients to the Service, which would then make the necessary contact with local hospitals until admission was agreed or refused.}
implied some doctors did not make sufficient use of community services before referring patients. Others responding attributed the increased pressure on the EBS to the new NHS admission arrangements and that now the local authority no longer had a statutory duty to provide accommodation for the sick. Mr Arthur Blenkinsop, the then Parliamentary Secretary of State to the Ministry of Health, in discussing local authority accommodation, reported local authorities were building more attractive accommodation for old people in their new housing estates but accepted hostels were also needed.\textsuperscript{41}

The 1951 Annual Report of the Ministry of Health again discussed the difficulties of admitting the aged and infirm 'who waver between sickness and health and...the "border-line" case' (p.16).\textsuperscript{42} While it was clear the hospital service cared for the sick and the local authority looked after those in need of care and attention, it was unclear whose responsibility were those who did not fit neatly in either category. There was a further problem of the aged infirm person who needed only care and attention at a time when the local authority had no beds. The hospital authorities, according to RHB (51) 115, could not refuse admission while a local authority bed was being found.\textsuperscript{43} Consequently the Ministry called for 'the closest and smoothest cooperation between hospital and the local authority'. It noted the National Corporation of the Care of the Aged


\textsuperscript{43} Ministry of Health.: \textit{Emergency Admissions to Hospital}. RHB, (51) 115; HMC, (51) 107 London: Ministry of Health, 1951.
tried to help by establishing hostels, with the Regional Health Boards or the local authorities funding the cost of maintenance.  

**Lord Amulree’s general views**

Whereas Warren mainly concentrated on the hospital aspects of geriatric care, Amulree promoted a comprehensive view of both community and hospital services for frail and sick elderly people. His views were well expressed in his first major publications after his appointment to UCH, *Adding Life to Years* and *Proper Use of the Hospital in the Treatment of the Aged Sick*. As he said:

> There must be a new approach to the conception of the care these patients need, and this can only be attained when it is widely realised that long term illnesses require just as much skill and consideration as short term ones. The success of a hospital cannot be measured only in terms of a rapid turnover of beds, but of a rapid turnover of beds combined with the satisfactory disposal of every patient who leaves them. If the National Health Service is to achieve its aim it must be possible for every old person who is ill, and who cannot be cared for in his own home, promptly to be admitted to hospital for treatment, and equally promptly to be

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44 The title, National Corporation of the Care of the Aged, was used by the Ministry of Health but presumably was meant to be the National Corporation of the Care of Old People

discharged to suitable surroundings as soon as the need for that
treatment is over (p.39).46

It was imperative that the medical profession accepted illness in old age was not
synonymous with chronic sickness, about which nothing could be done and had to
realise many elderly patients had rehabilitation potential.

Amulree's philosophy of care of older people was coloured by the effects of
the Poor Law and the results of the Local Government Act. His book, Adding
Life to Years, started with a lucid history of the care of old people from the early
1800s, through the Royal Commission on the Poor Law and the Unemployed of
1905, the Local Government Act of 1929 to the NHS Act of 1946 and the
National Assistance Act of 1948.47 Not everything was bad in the workhouse
system: there were some good features amongst the bad. On the one hand it was
ture the buildings were often bleak with inadequate sanitation and medical
attention was not satisfactory, mainly due to lack of medical staff. It was also true
the wards contained an ill-assorted group of patients – children, young, old, and
those with senile dementia. On the other hand, the patients did receive a bed with
clean linen, meals were plentiful though uninteresting and the quality of nursing
was astonishingly high, even though the majority of nurses were untrained.
Furthermore, patients could switch, with ease, between the institutional home and

46 His book Adding Life to Years had a preface written by the chairman of the National Old
People's Welfare Committee, Alderman Fred Messer MP.

47 Lord Amulree, op. cit., note 45.
the infirmary as their physical condition demanded, a feature totally lost with the new NHS.

Amulree had mixed views about the results of the Local Government Act of 1929. Much good followed from it but it had had a disastrous effect on the fortunes of the aged sick. The aim of the Act, in transferring the infirmaries from the Public Assistance Committees to the Public Health Committees, was to improve the standard of work carried out in those infirmaries. The corollary was that as the Public Assistance Infirmaries began to improve their standards of work they became more selective in their clinical interests. They admitted more acute work, which meant less interest in the chronic sick. Amulree argued the fortunes of the aged sick continued to suffer during the Second World War because many Public Assistance Infirmaries were up-graded to acute hospital level for the expected air raid casualties. They feared admitting elderly people because they, too, anticipated bed blocking.

Amulree noted the large number of beds occupied by the chronic sick and thought the majority did not need to be there. In 1950 he stated about 70,000 beds were occupied by chronic sick patients of which 85% were elderly. In 1951 Mr Arthur Blenkinsop, Minister of Health, said there were 46,000 chronic sick beds in England and Wales, with 42,419 elderly people in local authority homes. In 1952 Ministry of Health reported nearly 57,000 beds in hospitals throughout the

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country were allocated to the chronic sick, with a waiting list of 8,800. The reasons for these statistics included: the increasing proportions of old people in the population; housing and domestic problems making it difficult for them to be cared for at home; the financial advantage to relatives of getting old people into hospital; and the removal of the social stigma which used to attach to admission to a Poor Law institution. Amulree advocated improved home support services with domiciliary visiting, treatment in the patient’s home and local health clinics as ways of alleviating the problem.

He readily appreciated the wide range of assistance given to elderly people by the many voluntary organisations, such as ‘Friendly Societies’, which had provided accommodation, financial and social help. The National Council of Social Services called together the major voluntary societies concerned with the aged, which resulted in the formation of the National Old People’s Welfare Committee under the leadership of Miss Eleanor Rathbone. This National Committee with its ‘wisdom and experience of older societies...[was] able to help the state in its new planning by representing the views of the voluntary societies on important matters of policy’ (p.16). It set up local groups with the aim of establishing homes, clubs, visiting schemes and meals service.

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51 Initially the National Old People’s Welfare Council (NOPWC) was part of the National Council of Social Service. In the late 1960s the Council separated from the NOPWC, which became Age Concern with Marjorie Bucke as Assistant Director. NOPWC provided the secretariat for the International Association of Gerontology in London in 1954.
The Amulree Years

Lord Amulree's specific views on care of the sick elderly patient

The key features of Amulree's specific philosophy included consultant status for the senior physician in charge of sick elderly patients, classification of patients, rehabilitation, effective discharge arrangements, and development of solutions to the problem of senile dementia. A service for the elderly required physicians of consultant status 'not so much because high academic learning and distinction are necessary...as to enable the doctor in charge to be of equal status with his colleagues who look after the 'acute' wards' (p.38). This would prevent 'chronic' wards becoming dumping grounds for transferred patients from 'acute' wards because in future the physician in charge of the 'chronic' wards would have to sanction such transfers.

He restated the need for proper examination, diagnosis, and investigation. Geriatric units should have full access to diagnostic and treatment facilities. Once turnover had been established in a geriatric unit, the length of stay would fall rapidly; for example in one unnamed unit the average length of stay for the 'inherited patients' was 3-4 years, while for the newly admitted patients it was nine weeks. In his St. Pancras unit the average length of stay was reduced to about 40 days for those patients who stayed in hospital for less than six months.\(^\text{52}\) This was due to the high death rate of 30-40\% in the acutely ill new admissions, and successful rehabilitation in survivors. Patients with fractured neck of femur,

The Amulree Years

who previously were treated conservatively, now had an operation because modern anaesthesia had improved considerably.\textsuperscript{53}

He was convinced the elderly should have rehabilitation, especially those who had had a stroke. Mental stimulation was most important. It should be possible to select those elderly patients who could be encouraged to get out of bed, given physiotherapy and encouraged to carry out treatment themselves either alone or in a class with others, where the spirit of competition could progress rehabilitation still further. The beneficial effect of rehabilitation on the mind and attitudes of the patients became apparent even to the outsider: a newspaper boy noted that before the rehabilitation regimen started only two papers were left each day for the whole ward, but nine months later every patient bought his own paper.\textsuperscript{54}

Amulree acknowledged discharging aged sick from hospital could be difficult. The longer the patient stayed in hospital the more tenuous the home ties became and the increased likelihood of the person 'giving up'. This could be prevented if relatives of the patient were to be tactfully informed, on admission,

\textsuperscript{53} It was true modern anaesthesia was improving. However in 1955 Dr. Philip Bedford in Oxford quoted 18 cases of extreme dementia occurring in old people after general anaesthetic/emergency surgery for a variety of acute/emergency surgical conditions. A subsequent study by Dr. Bernard Simpson and colleagues of 741 elderly patients who underwent elective surgery with a general anaesthetic failed to find any evidence of mental change. Of course anaesthesia had improved in the period following the Bedford article and the later study was on elective patients not acutely ill patients. Bedford P. D., "Adverse Cerebral Effects on Anaesthesia on Old People," \textit{Lancet}, 1955, 2: 259-263. Simpson B. R., Williams M., Scott J. F., Crampton Smith A. and Banks A. Leslie, "The Effects of Anaesthesia and Elective Surgery on Old People," \textit{Lancet}, 1961, 2: 887-892.

\textsuperscript{54} The continued importance of rehabilitation was emphasised by the creation of National Demonstration Centres for medical rehabilitation of the elderly. By 1986 there were some 30 of these centres. Parkinson J. and Tattersall A., \textit{National Demonstration Centre in Medical Rehabilitation of the Elderly}. Harrogate: NHS Training and Studies Centre, 'Care of the Elderly Convention', 1986.
that the expectation would be for the patient to return home in the not too distant future and therefore the person’s accommodation should be retained. In effect, the message was: ‘admission is not a bed for life’.

Amulree considered sick elderly patients should have their own ward, and not be with younger patients. These wards should be cheerful, pleasant, and provided with mental stimulation. The previous arrangements under the Poor Law with large unattractive, poorly decorated, overcrowded, drab wards and day rooms, and stone stairs were unsatisfactory. The walls of the corridors and wards were of unplastered brickwork with dark green or brown dado. The dado could be removed, the bare brick walls plastered, the colour of the bed frames changed. The beds should be of differing heights: nurses needed higher beds for the bedfast patients, while the semi-ambulant patient required a lower one. Sanitary arrangements should be improved where these were inadequate and inconvenient.\textsuperscript{55}

He contended a long-stay annex was needed for bedfast geriatric patients who failed to respond to rehabilitation, a view supported by the Ministry of Health.\textsuperscript{56} This annex should have access to all the hospital specialist and diagnostic facilities but no patients should be admitted to it unless they had been fully

\textsuperscript{55} Dr Joseph de Martino, nearly 22 years later, reported North West Metropolitan Regional Board geriatric wards still existed on upper floors of buildings with no lifts, and access was only possible by narrow angular steps. An appreciable number of wards had only one toilet and one bathroom for every 15-30 patients. De Martino J., "Geriatric Service: Hospital Problems Part 2," Medical World, 1968, 106 (2): 16-20.

\textsuperscript{56} Ministry of Health. Treatment of the Elderly Chronic Sick. R.H.B.(50) 39, H.M.C.(50) 38. National Health Service: 1950. This publication recommended that the annex should be on the ground floor and that it should be an integral part of the hospital either on site or at a distance.
investigated and treated. They should be transferred from the annex to the main geriatric unit and back again as and when clinically necessary, because as he put it, ‘One can never be sure when the apparently irremediable will become remediable’ (p.934). He viewed the annex as a small, friendly, pleasant, well-decorated building with a homely atmosphere with paintings obtained from the Red Cross. The lighting should be over the bed not just in the centre of the room. Beds should be arranged in small units of four beds rather than in large wards. Boredom should be defeated by radio or television. There should be few rules and the widest latitude in permitted hours of visiting and number of visitors allowed. Patients should be dressed in indoor clothes of their choice.

Amulree highlighted medical aspects of unnecessary continued bed rest. Some patients were kept in bed for social rather than medical reasons. Some were still in bed long after the original condition had been cured, others were kept there because it was easier and/or tidier for the nursing staff, and sometimes no reason could be found. However some patients had firm views about continued bed rest. To their way of thinking, the very fact of staying in bed was a protection against discharge to a world they felt threatening. Dr. Richard Asher, a consultant physician at the Central Middlesex Hospital, wrote eloquently in 1947 about the evils of bed rest and how it came about. Bed rest was the first thing to be done in any illness: ‘Illness is measured by the length of time in bed...Bed is not


58 Asher R. A. J., "The Dangers of Going to Bed," British Medical Journal, 1947, 2: 967-968. In this paper he reported being given charge of a lady with nervous disability and a whitlow, who had been in bed for 17 years but who was successfully mobilised.
ordered like a pill or a purge but is assumed as the basis for all treatment’ (p. 967). The risks were chest infection, deep venous thrombosis, bed sores, constipation with overflow incontinence of urine, weakness of muscles, foot drop, osteoporosis, mental lethargy with resistance to being made to get up and demoralisation.

Amulree reviewed the nurse and rehabilitation staffing requirements of a geriatric unit. Good quality nursing care was essential but nursing shortages with poor recruitment could occur because the work with elderly people was thought by nurses to be monotonous, but when the geriatric unit was run with enthusiasm and energy to allow the nurses to see progress, staffing could improve as Warren had found.59 The ratio of nurses to patients in a busy geriatric unit should be similar to that of an acute ward e.g. 1:1.5/2.5.60 He thought greater use could be made of assistant nurses or nursing orderlies. Every geriatric unit would also need adequately staffed departments of social service (almoners), physiotherapy and occupational therapy.

Amulree commented on the problems of incontinence of urine and/or faeces, which could have such a devastating impact on a person’s morale and impose a considerable laundry burden on the carers. He considered incontinence in the

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60 Amulree op. cit., note 45. Norris found, in the Birmingham region, the ratio of nursing staff per 100 beds for the chronic sick hospitals was 23.1 compared with 47.8 for 100 acute beds. A Regional Standard Index also showed chronic sick wards had fewer nurses than acute wards. De Martino thought nursing administrators considered the function of a geriatric ward was mainly custodial and staffed the wards accordingly. This was quite inappropriate when the wards were active with a high turnover of patients. Norris V., "Role of Statistics in Regional Hospital Planning," British Medical Journal, 1952, I: 129-133. De Martino J., op. cit., note 55.
absence of organic disease was often due to difficulty in getting to the toilet in
time, which could easily be remedied, for example, by changing bed height,
placing a commode or urinal near-by, mobilising the patients out of bed as much
as possible or placing the bed near the toilet.

He devoted a substantial section to confusion and 'senile dementia' and the
problems these presented for the carers. Temporary confusion, he said, might
result from an acute/sub acute illness, loneliness or under nourishment, which
could respond to in-patient treatment allowing the patient to return home.
Unfortunately inappropriate drug therapy could make matters worse and there
would be some patients who did not respond to treatment. He drew attention to a
London County Council initiative, which had set aside one of their large mental
hospitals in South London for such patients, and the experiment was considered a
great success.

Amulree stressed the need for community help for the aged sick. The general
practitioner should be able to contact the geriatric department, who would arrange
for the patient to be visited at home by a member of the medical staff. The latter
would decide whether the patient could be managed at home with services or
whether admission was necessary. If home care was considered appropriate the
necessary services such as home help, meals, chiropody, or district nursing
service could be arranged. 61

61 A study, based in Barrow-in-Furness, showed one quarter of acute male admissions and nearly
one half of female acute admissions were admitted unnecessarily. Domiciliary services could have
been used instead. Forsyth G. and Logan R. F., op. cit., note 11.
Amulree was not particularly enamoured with the term 'geriatric' and thought it unnecessary to create a new speciality to be staffed by 'geriatricians'. He thought patients should never be under the care of a 'geriatrician', although he accepted the word seemed to have come to stay. However the British Medical Association committee's report of 1948 thought establishing geriatric units would secure a much better provision of services for the aged sick. Amulree considered the physician treating the aged infirm needed good medical knowledge, a sense of the ridiculous, much patience and an empathy with older people. The reward was the privilege of working with elderly people, which could be rich and satisfying, since they were mellow, humorous, concerned and remarkably resilient.

Making hospital geriatric medicine work

In April 1949 Amulree was appointed to University College Hospital and St. Pancras Hospital, which had been taken over from the London County Council by UCH on 5th July 1948. His arrival was welcomed.

Drs. Norman Exton-Smith and George Crockett, who were Amulree's assistant medical registrars, described St. Pancras Hospital in its early days as a

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63 John Brocklehurst, Professor of Geriatric Medicine at Manchester, stated geriatric medicine required consultants with wide ranging skills – ability to lead and coordinate the rehabilitation team, to take clinical responsibility for 200-300 beds, to have community responsibilities, as well as ability to teach and research. Brocklehurst J. C., "Personal View," British Medical Journal, 1969, 2: 51.

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newly created geriatric unit.\(^6^5\) Before the appointed day the hospital had a total of 243 beds with 108 for men and 135 for women. The effective number of geriatric beds was 120, with no bed increase until 1950 when the King Edward's Hospital Fund provided an additional 30 beds in a half way house in Highgate, called Thomas Barlow House.\(^6^6\)

Exton-Smith and Crockett described the all-too-familiar scene. Medical diagnoses were vague, e.g. senility or hypertension. The patients however were clean, well nourished and without bedsores, but almost all had painful stiff joints, resulting from prolonged immobilisation in tightly made beds, which made rehabilitation difficult. The patients' mental state was one of apathy with little to occupy their minds. Some were depressed, perhaps because they had been evacuated around the country following air raids. The nursing situation was better than might have been expected because nurses rotated from the main hospital (UCH). The wards had walls painted in drab 'institutional' green with beds crowded back to back. Investigative facilities were limited; radiographers visited from other LCC hospitals and pathological specimens were sent to a district laboratory. Ward orderlies did shopping for the patients.


\(^6^6\) De Martino affirmed some geriatricians thought the value of the halfway house was debatable, because many developed a custodial function as the patients waited for a welfare place. De Martino J., "Geriatric Service Hospital Problems Part 1," *Medical World*, 1968, **106** (1): 18-24. The Guillebaud report discussed half way houses in a footnote on page 214. It pointed out there were two types of such houses: long-stay, with which the report did not agree, and convalescent, which the report thought was part of a proper health service. *Report of the Committee of Enquiry into the Cost of the National Health Service*. Cmnd. 9663. London: HMSO, 1956.
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As Warren and colleagues had done earlier, Exton-Smith and Crockett examined the patients and reviewed the diagnoses. The original case notes proved poor sources of clinical information. They found modern treatment such as antibiotics and mercurial diuretics meant fewer patients died, and required treatment for their original condition. They noted that improving access to toilet facilities was often associated with improvement in incontinence. Exton-Smith and Crockett considered nursing the chronic sick was not necessarily dull. Medical students needed teaching on these patients, especially those who would enter general practice. The scope for research into the diseases of old age was 'wide open' and unexplored.67

The change of management from custodial care to investigation and treatment was greeted with mixed feelings and a certain lack of warmth in the majority of patients. Many were resigned to staying in a 'chronic ward' for life. Relatives said the patients had been told they would be in hospital for the rest of their days and consequently homes had been given up. Patients were worried about the future of their pensions and their LCC pocket money if they were to leave hospital. The reason for/aim of physiotherapy exercises had to be explained to the patients, who needed to be convinced of the benefits in order to respond. Some

67 Dr. John Wedgwood, a contemporary of Exton-Smith, and who worked as a consultant geriatrician at Bury St. Edmunds before being appointed to the Middlesex Hospital, London considered the strength of Amulree's unit lay with his registrars, especially Exton-Smith. He was in a good position to make this observation because he had control of two wards at St. Pancras for a time when he started work as a consultant geriatrician at the Middlesex Hospital. He thought Amulree was a good clinical opinion although he found his wards were markedly uninspiring. However Exton-Smith attributed the successful development of the unit to Amulree's initiative, enthusiasm and support given to his junior staff. Wedgwood. Personal Reminiscences. Exton-Smith A. N., "Obituary: Lord Amulree," British Medical Journal, 1984, 288: 156.
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were pleased with their improved mobility, others were diffident, and yet others saw little point in rehabilitation since they had nowhere to go. Relatives, too, were worried: 'if he gets up, he'll want to come home'.

In 1951 Amulree and colleagues described the result of one year's work in the new geriatric unit. Of the 155 inherited patients (those present at the time of take over), 95% were or had been bedridden, but at the end of the first year 90% had improved. The remainder were bedridden with gross deformities, which could have been prevented. Of those patients admitted after the unit opened, over half had died or had been discharged, whilst one fifth of the total were thought suitable for discharge to a hostel. The average length of stay was about 70 days but by 1952 it was only 50 days. The unit was reduced in size from 155 beds to 120, although Amulree said in 1955 he had 128 beds. Amulree reasoned if the unit had managed to achieve a 50-day length of stay for all patients, then 1200 new patients could have been admitted at the same cost to the hospital. This would have eliminated the waiting list. He considered the longer the aged patient waited at home before admission to hospital the more difficult and the longer his treatment became. Waiting lists were therefore conducive to longer stay in hospital.


The main factors, which contributed to a quick turnover and reduction of the length of stay, were: home visiting; the out-patient department which was yet to be fully developed; investigations; ward treatment; and planned discharge from hospital. The first factor was home visiting because it allowed the geriatric staff to assess the patients and their social conditions, the need for admission and if so, how soon. It also improved contact with the general practitioner. Those who did not require admission could be seen in the out-patient department. The review revealed how the waiting list situation had changed: some patients had died, some had been admitted elsewhere and others no longer needed admission. These visits did not attract a fee, unlike domiciliary visits which did. The latter made at the request of the general practitioner who wanted a clinical opinion for a patient who was unable to visit the hospital. Amulree and colleagues concluded some patients need not have been admitted if they had been given earlier treatment at home and social services had been better. The results of 127 home visits made by the doctors at St. Pancras Hospital are shown in the table 6.1:

70 Domiciliary visits were/are one of the services provided by the NHS. The Ministry of Health provided interesting data regarding what were presumably domiciliary visits, which would have been registered for payment as opposed to home visits, which were not paid and presumably not registered. In 1951, consultants had seen 157,970 patients at home, and Senior Hospital Medical Officers and Senior Hospital Dental Officers saw 13,223. The corresponding figures for 1950 were 149,322 and 15,908. Ministry of Health. Report of the Ministry of Health Part 1 for Period 1st April 1950-31st December 1951. London: HMSO, 1952.
The Amulree Years

<table>
<thead>
<tr>
<th>'Disposal'</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to St. Pancras Hospital, either immediately or subsequently</td>
<td>55</td>
</tr>
<tr>
<td>Awaiting admission</td>
<td>4</td>
</tr>
<tr>
<td>Admitted elsewhere</td>
<td>23</td>
</tr>
<tr>
<td>Out-patient treatment</td>
<td>21</td>
</tr>
<tr>
<td>Nothing required</td>
<td>11</td>
</tr>
<tr>
<td>Died</td>
<td>10</td>
</tr>
<tr>
<td>Refused treatment</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>127</strong></td>
</tr>
</tbody>
</table>

Table 6.1 The number and results of 127 home visits made between
June 1\textsuperscript{st} 1949 and May 31\textsuperscript{st} 1950.\textsuperscript{71}

While home visits could prevent unnecessary admissions they could not
prevent iatrogenic illness after admission. Amulree's staff drew attention to this
problem. Dr. Mercer Rang found two out of three patients developed conditions
they did not have when they were admitted.\textsuperscript{72} Drs. Arnold Rosin and Roy Boyd
found nearly three quarters of elderly patients admitted to active geriatric wards
developed complications during their in-patient stay, which were thought to have

\textsuperscript{71} Op. cit., note 68.

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caused one seventh of the deaths. Control patients of all ages admitted to general medical wards had a much lower complication rate.\textsuperscript{73}

The second main factor contributing to improved turnover and reduction in length of stay was ward treatment and overcoming the current policy of prolonged bed rest. Some care staff thought it easier to keep aged patients in bed rather than getting them up, or thought they should be in bed because they 'deserved a rest', while still others believed that bed rest prevented falls, which could result in litigation. Mobilising geriatric patients could prevent contractures and incontinence and help the patient return home.

The third factor was discharge from hospital. Patients and relatives must not be given the impression that, once the patient was admitted, they had a ‘bed for life’. At admission, or soon afterwards, both parties must be told that patient stay in hospital was only temporary and the patient's room/accommodation must not be given up. This should reduce resistance to discharge. The three main causes of delay in discharge were lack of a vacancy in a welfare home, reluctance of relatives to cooperate in the patients' discharge, and delays in arranging the necessary domiciliary services for the patients when at home. Elderly people

\textsuperscript{73} Rosin A. J. and Boyd R. V., "Complications of illness in geriatric patients in hospitals," \textit{Journal of Chronic Diseases}, 1966, 19: 307-313. Others noted similar situations. Two Scottish geriatricians showed that half of those patients admitted for a 'holiday' admission died, were transferred to other units or were not fit to return home. Isaacs B. and Thompson J., "Holiday Admissions to a Geriatric Unit," \textit{Lancet}, 1960, 1: 969-971. Professor John Brocklehurst urged caution when considering admission e.g. mental confusion due to the change of environment. Brocklehurst J. C., "Coordination in the Care of the Elderly," \textit{Lancet}, 1966, 1: 1363-1366. Dr. Stevens also pointed to the high death rate in patients admitted for 'social' reasons. Stevens R. S., "Reasons for Admitting Patients to Geriatric Hospitals," \textit{Gerontology Clinica}, 1970, 12: 219-228.
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should be followed up after discharge because of their social dependency, perhaps in the day hospital, or by visits from the health visitor.74

Amulree was aware of the pressure to admit elderly people to hospital, which received considerable publicity in the early National Health Service years. A Lancet editorial, 'Hospital Admissions' stated many general practitioners complained it took too long to arrange admission to a hospital: they were left hanging on to the phone while enquiries were made.75 Examination of Emergency Bed Service records showed admission enquiry times varied. The times for London voluntary hospitals in January 1947 ranged from 4.8 minutes for the most efficient to 15 minutes for the least. In 1951 the Ministry of Health responded to concerns about admitting emergencies to hospital in the coming winter.76 It requested Regional Boards to overhaul their machinery for admission for the acute sick, and, where it did not exist, suggested setting up an admission bureau. Further, it reminded authorities not to close wards for redecorating during the winter, that waiting lists should be restricted, and additional beds be put up within the capacity of the nursing staff to manage such an increased work load.

74 Brocklehurst also thought that prompt discharge, when treatment was over, was as important as prompt admission. Brocklehurst J. C., ibid. Dr. Richard Parnell, a geriatrician at Sutton Coldfield, considered high turnover resulted from having an adequate number of geriatric beds, adequate staffing and a day hospital. Parnell R. W., "Some Measures of Consultant Management," Gerontologia Clinica, 1971, 13: 136-144. Dr. Angus MacPhail and Dr. Desmond Bradshaw in a study of delayed discharges from general medical wards in 1967 found 5.8% of the patients had spent seven or more days in hospital unnecessarily, usually due to lack of social service support. Not a few patients had been discharged to houses 'which, in terms of brick, no longer existed.' MacPhail A. N. and Bradshaw D. B., "Delayed in Hospital," Lancet, 1967, 2: 89-91.


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These difficulties prompted Graham, formerly the admission officer for the South East Office of the King Edward’s Hospital Fund Emergency Bed Service (EBS), to respond.\textsuperscript{77} He attempted to answer the question - did the admission of elderly people really block beds? He listed the excuses given by hospitals for refusing elderly people: the most common was fear the patient would block a bed. He surveyed requests for admission over a 16-week period, 5\textsuperscript{th} November 1950 to 24\textsuperscript{th} February 1951- a time of extreme pressure on hospital beds. The result of the 2,268 requests for admission and the ‘fate’ of elderly patients accepted for admission are given in the tables 6.2 and 6.3 below. The first shows under two thirds of the elderly were accepted for admission as against 91\% of younger people.

<table>
<thead>
<tr>
<th></th>
<th>Under 60 Years</th>
<th>Over 60 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1,436 (63%)</td>
<td>832 (27%)</td>
</tr>
<tr>
<td>Accepted for admission</td>
<td>1,309 (91.2%)</td>
<td>514 (61.8 %)</td>
</tr>
<tr>
<td>Not accepted for admission</td>
<td>127 (8.8%)</td>
<td>318 (38.2 %)</td>
</tr>
</tbody>
</table>

Table 6.2 Shows the number of requests for admission to the South East Office of the Emergency Bed Service between November 5\textsuperscript{th} 1950 and February 24\textsuperscript{th} 1951.\textsuperscript{78}

The ‘fate’ of the 514 older patients accepted for admission is shown in the table 6.3 below.


\textsuperscript{78} Ibid.
The Amulree Years

<table>
<thead>
<tr>
<th>Accepted for admission: 514 older patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actually admitted</td>
</tr>
<tr>
<td>Discharged after examination</td>
</tr>
<tr>
<td>Died just before/after admission</td>
</tr>
<tr>
<td>Refused admission</td>
</tr>
</tbody>
</table>

Table 6.3 Shows the ‘fate’ of elderly patients accepted for admission.79

Only 463 were actually admitted: 58% of these were discharged or died within a month. Just 20 patients were still in hospital on the 100th day. The average length of stay was 31 days. Graham followed up the 318 patients who were refused admission. Ninety were re-submitted. In 70 other cases the general practitioner promised to re-submit the patient the next day but failed to do so. In 85 cases the general practitioner was going to request a domiciliary visit or improved home support. The majority of the rest were put on the local hospital waiting list. Graham concluded the general belief that elderly patients blocked beds for years was a fallacy and he hoped his results would allay fears and help to put matters in a true perspective.

Amulree and colleagues contended the great majority of the elderly sick did not stay in hospital much longer than younger patients.80 They found in 1952 the average length of stay for elderly patients admitted to St. Pancras after a home visit was about 40 days, after the long-stay patients were excluded from the calculation. This compared with average length of stay on medical wards at UCH of 35 days. He did not yet know how long his ‘long-stay’ patients would actually

remain in hospital, although 16 out of his 40 long-stay patients were still in hospital eleven months later.

In 1953 Amulree returned to the subject of rehabilitation.\textsuperscript{81} He reiterated proper diagnosis, examination and treatment could identify those patients who could respond to rehabilitation. This might be achieved in one to one sessions with the physiotherapists or in a class where emulation and competition could act as a valuable spur to progress. Patients were encouraged to exercise by themselves. He supported Warren's method of 'bed end' exercises to facilitate mobilisation.

In 1955 Amulree gave the F. E. Williams lecture at the Royal College of Physicians.\textsuperscript{82} He reviewed the progress of elderly care and announced 60 geriatric units were now in place. However he questioned what had been achieved and how well had discharged patients managed at home and remained active and happy or returned to dependence and misery. He did not consider it possible for geriatric units to admit all those over a certain age since the average age of patients in most general wards was already high. He reviewed data relating to 1,956 admissions to St. Pancras Hospital in the years from 1949 to 1954, see table 6.4 below. He did not explain the 'unclassified group', but perhaps he meant the age had not been recorded.


\textsuperscript{82} Lord Amulree, "Modern Hospital Treatment and the Pensioner," \textit{Lancet}, 1955, \textit{2}: 571-575.
The Amulree Years

<table>
<thead>
<tr>
<th></th>
<th>Under 60 years</th>
<th>61-70</th>
<th>71-80</th>
<th>81-90</th>
<th>91 +</th>
<th>Unclassified</th>
</tr>
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<tbody>
<tr>
<td>1949</td>
<td>9</td>
<td>7</td>
<td>18</td>
<td>9</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>1950</td>
<td>14</td>
<td>36</td>
<td>102</td>
<td>39</td>
<td>6</td>
<td>31</td>
</tr>
<tr>
<td>1951</td>
<td>27</td>
<td>83</td>
<td>181</td>
<td>96</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>1952</td>
<td>5</td>
<td>118</td>
<td>224</td>
<td>84</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>1953</td>
<td>8</td>
<td>79</td>
<td>176</td>
<td>87</td>
<td>7</td>
<td>19</td>
</tr>
<tr>
<td>1954</td>
<td>8</td>
<td>67</td>
<td>224</td>
<td>110</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Totals</td>
<td>71</td>
<td>390</td>
<td>925</td>
<td>425</td>
<td>38</td>
<td>107</td>
</tr>
</tbody>
</table>

Table 6.4 Shows the age range of patients admitted to St. Pancras Hospital between 1949 and 1954.83

Admission was based entirely on medical need. In the early days of the unit general practitioners would request admission for patients who were appropriate for admission to a welfare home, but such requests had become rare. The patients who needed admission were categorised into 3 groups – those who needed immediate admission, those who could wait a short while and those who needed respite admission in the future.

Amulree and colleagues made 1,325 home visits from 1949 to 1954. Nearly one third of patients lived with their spouse, one fifth lived with children and over one third lived alone. The proportion of those he saw who were living alone was much higher than the proportion in the overall elderly population in St. Pancras – 38% compared with 18%. Amulree thought this might have been due to his rather broad definition of living alone; for example he extended the definition to include those who had regular visits from relatives or friends. Nearly half of those who

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83 Ibid.
lived alone were in ground or first floor accommodation, thus mostly avoiding steep stairs, but others lived on higher floors. The one toilet was usually on the ground floor, but sometimes was in the garden or back yard. Of those living alone, 5% lived in squalid conditions: his graphic descriptions are very reminiscent of the situation described by Dr. Guy Wigley, a deputy Medical Officer of Health in West Ham in 1951.84 This clinical picture of self-neglect did not receive wide recognition until much later.85

Amulree reported the results of the 1,956 admissions to his unit: only 325 remained in hospital more than 6 months. Within 2 months 44% were discharged to their home, welfare home or other accommodation, 22% had died, and 5% were transferred to other hospitals or wards. Of the 1,119 patients discharged, 17% were readmitted mostly within a year of the initial discharge. Others could have been discharged to welfare home had a vacancy been available. He made it clear an active geriatric unit would experience a high death rate because the patients were both elderly and acutely ill.

84 Wigley G. S., "Care of the Aged Healthy, Aged Infirm, and Aged who are Chronically Sick," Journal of the Royal Sanitary Institute, 1951, LXXI: 39-42.

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He arranged follow up of 246 discharged patients who had been admitted between 1st June 1953 and 2nd September 1954. They were seen at home at 6 months by the almoner. This was considered the best arrangement since follow up in the out-patient department would either be costly or inconvenient for the patients. The almoner found 40% were active, 26% had died, 28% were housebound and the remaining 6% were bedridden.

Amulree's view of the future was that the geriatric unit should be in the general hospital, closely linked to accommodation for the frail ambulant and with access to a long-stay annex. All should be the responsibility of the health service. In addition better social service support, including home help, home nursing and meals on wheels were needed, as well as an easy transfer of patients between hospital and the welfare home. He thought prevention of disease was very important and that dirt, ignorance and overcrowding contributed to the prevalence of disease. Achieving these goals could remove the most potent cause of disabilities in the last years of life.

As Amulree began to write fewer papers in his later years, his registrars took up the baton. Rosin, for example, who became consultant physician at Guy's Hospital in London and later still a consultant physician in Israel, described the then current hospital admission data and what happened to the patients on discharge.86 He found increasing age, physical frailty and illness of the patients were reasons for admission to the geriatric wards. Nearly three quarters of the

patients were over 75 years. Nearly one half of them died during admission. Of those discharged, nearly one half needed moderate to considerable personal help and one quarter of the group received domiciliary services from the local authority. Nearly one third were readmitted within six months. The overall impression was those admitted were amongst the most disabled of the elderly community and many had limited capacity for independent existence.

Amulree's last major foray into print was a review in 'Twenty-five Years of Geriatrics' published in 1971. In it he acknowledged the debt to be paid to the early pioneers including Warren, Cosin, Brooke and the second wave of Tom Wilson and Charles Andrews. They had established beyond question the value of classification, diagnosis and rehabilitation. They had shown many so-called chronic sick could be treated and discharged, thus reducing the number of beds required. Amulree maintained geriatrics was a highly specialised branch of medicine, which could improve or restore many elderly people to a reasonable level of activity. The most successful geriatric departments were those integrated into the general hospitals. Amulree thought geriatric units should admit acutely ill patients because it was good for staff morale to see patients improve and return home. He reiterated the aim of geriatric medicine was to add life to years, although there would be times when it might be inappropriate to treat elderly patients.

Amulree noted that geriatric medicine was now well established, but only one

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London teaching hospital had a geriatric unit – his own. The resistance to establishing geriatric units in teaching hospitals was hard to understand since many publications had demonstrated how a properly run unit could reduce pressure on beds. Part of the problem was lack of acceptance of the speciality by other consultants. He acknowledged, in the early days of geriatric medicine, general physicians considered the speciality to be ‘a subnormal branch of the profession into whose beds could be deposited all unwanted long term sick patients so that they would no longer block ‘acute’ beds’ (p.98). It also seemed to Amulree that some hospital authorities had a very limited view of what was necessary to create a geriatric unit. They thought once their ‘chronic sick’ ward was renamed ‘geriatric ward’ and a part time general practitioner service replaced by a consultant in geriatrics, honour was satisfied and no further effort was necessary, although the conditions under which the patients lived and the treatment which they received showed little change from former days. He looked forward to the day when consultant physicians in geriatric medicine would be accepted as equals by their medical and other colleagues. Amulree decried the poor quality of hospital buildings to which the elderly were admitted although attempts at upgrading had been carried out. He deprecated the lack of funding to carry out new building, to provide adequate equipment and recruit all types of staff. The ‘knock on’ effect was poor recruitment of medical staff, and the lay press still saw the geriatric ward as almost synonymous with the old ‘chronic sick’ wards. However the Ministry was able to report in 1972 there were 252
geriatric physicians, while the number of geriatric units in England and Wales had risen from 60 in 1955 to 250 in 1971.\(^8\) Another major problem in managing a successful geriatric unit was the failure of the authorities to realise that because the nursing work on these wards was heavy, the number of nurses required on these wards should be the same as on acute wards. All too often the numbers had remained unchanged since the Poor Law days.

Overall, Amulree concluded, in spite of all the difficulties, geriatric medicine had made great advances in the past twenty-five years and gave examples of specific developments which benefited the frail elderly person. He quoted day hospitals for rehabilitation with relief for relatives; the respite regime of Dr. John De Largy with six weeks in hospital and then six weeks at home,\(^9\) developments of modern anaesthesia and surgery; joint ward rounds between surgeon and the geriatrician; home visits and the work of Brooke; the role of the almoner; rehabilitation departments with chiropody and the occupational therapy. He thought elderly mentally infirm patients might benefit from attending day hospitals, and commended geriatricians having sessions in a psychiatric unit for the elderly. A basic requirement was an effective social service with home helps, meals on wheels and district nurses. Again he deplored delays in transferring patients between hospital and welfare homes. However the criteria for admission to these homes were changing and increasingly frail elderly people were being

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\(^8\) Medical Staffing Division of DHSS, "Hospital Medical and Dental Staffing in the National Health Service in England and Wales," *Health Trends*, 1973, 5: 47-50.

The Amulree Years

admitted to them and newly admitted clients tended to be older than those in voluntary homes. Overall local authority homes had many more mentally handicapped residents and they began to outnumber those who were physically handicapped.90

On a positive note he was pleased to note that the Royal College of Physicians of London had accepted senior registrars for specialist training in geriatric medicine and the College had set up in 1972/3 a Standing Committee on Geriatric Medicine.91 He championed the need to train medical students in geriatric medicine. He was pleased to see textbooks on geriatric medicine had appeared although few general medical textbooks included a section on geriatric medicine.92

Conclusions

Amulree’s legacy was to take over the baton so ably carried by the early reformers and to thrust the comprehensive view of care of the elderly person into


91 Additional evidence of the acceptance of the speciality was the appointment of geriatricians as examiners for the MRCP examination. This happened in 1973 when Dr. John Wedgwood was appointed an examiner. The number of geriatricians appointed as examiners slowly increased and now there are about six to eight on the list (the number varies slightly from year to year). The first geriatrician to be appointed a Censor (a senior examiner) was Professor Sir John Grimley Evans in 1990; the second was Dr. Michael Denham in 1992. The Diploma of Geriatric Medicine of the Royal College of Physicians was established in 1986. Nevertheless acceptance of geriatricians (or general physicians with a strong interest in older people) into the Fellowship of the College was slow: only 5 were elected between 1941 and 1950, one in the next ten years, although 7 were elected between 1961 and 1970. By 1966-1970 the average yearly number of elections of all physicians to the Fellowship was 150.

92 One of the first major textbooks on general medicine to include geriatric medicine as a separate section was the 2nd Edition of The Oxford Textbook of Medicine in 1987.
the public domain. I consider he was unique amongst geriatricians in having a 'wide angled' view of the care of elderly people. He did this as a clinician, a medical officer of the Ministry of Health and a Liberal peer in the House of Lords. He showed great perception in appointing very able senior registrars who became consultants in the speciality such as Drs June and Philip Arnold, Boyd, Crockett, and Rosin. However his most important and significant appointment was Norman Exton-Smith, who became the first Barlow Professor of Geriatric Medicine at UCH and the new 'flag bearer' for the speciality.

Amulree wrote extensively including the first comprehensive articles on care of the elderly in England. He will be possibly best remembered for his maxim 'Adding Life to Years', as well as his stature, wisdom and willingness to help colleagues. When all his achievements are taken into account there is a case for calling him 'the father of British geriatric medicine'.

Annex One

Amulree, working at St. Pancras, was not alone in having waiting list problems. A nearby local London district was also in trouble. In 1951 the Paddington Group Hospital Management Committee acted because its waiting list was steadily increasing. It decided, after consultation with the general practitioners, each person on the list and living at home should have a home visit from a part time general practitioner specialist, Dr. Koloman Kropach. He would arrange admissions, out-patient department attendance or social service

support as appropriate. As in the Birmingham surveys, the study was flawed because the social service department was not involved. The following criteria were used to decide which category was appropriate for the patient: in favour of admission were acute illness, chronic illness needing regular daily and night nursing care, and ‘bedfastness’. In favour of care at home were: chronic illness without ‘bedfastness’ with adequate care at home, ability to attend the out-patient department, and adequate home nursing. In favour of admission to welfare home were those frail ambulant elderly people who required only limited help with self-care. Between January and March 1951, 169 people were reviewed, although 26 other people on the list and referred from other hospitals, were not visited. Of that total of 169, 48 were recommended for admission, but 121 were thought not to need admission. Of the latter 95 needed no further action, but 26 required assistance from home helps, home nurses etc. The study was repeated for the next three months. This showed that 99 people were reviewed. Of these 68 were recommended for admission. The remainder did not require admission. However 20 needed home helps, an out-patient department visit or other referral. Some old people still considered large welfare homes as workhouses and were aware they would have to give up some of their pension if they entered a home. Voluntary organisations supplied home helps, meals on wheels and emergency coal supplies.

Kropach visited the sick bays of the local London County Council (LCC) homes. Luxborough Lodge, for example, had a 50-bedded sickbay, which admitted 305 patients in the 6-month period September 1950 to March 1951.94

94 The Lodge closed in 1965.
The staffing and facilities for acute and chronic sick in welfare homes were thought either inadequate or unsatisfactory. On the other hand had these people been living at home, they would have presented very considerable admission pressure on local hospitals. Kropach concluded home visits could help in rationalising a waiting list. He strongly advocated much better co-operation between the general practitioners, the hospitals and the local authority services.\textsuperscript{95}

\textsuperscript{95} Sir Edward Bligh, Chief Officer of the London County Council Welfare Department, deplored the general inability to admit elderly people from their own homes to hospital but pointed to a local London example of good cooperation between one of their council homes and a local hospital where elderly residents could be admitted for short periods of in-patient treatment and then returned home. Bligh Sir Edward, "Care of the Aged Healthy, Aged Infirm, and Aged who are Chronically Sick," \textit{Journal of the Royal Sanitary Institute}, 1951, \textit{LXXI}: 43-48.
Chapter Seven

The Multi Centre Development of Geriatric Medicine in England

General Introduction

This chapter deals with the next phase in the growth of geriatric medicine, which was influenced by three factors: the increase in the number of new consultants, the work of the early pioneers and the realisation of the extent of inadequate treatment of the chronic sick. To illustrate this phase I use articles, obituaries and national sound archives of geriatricians who were active at the time.

First, the numbers of consultants increased after the war. Webster stated firmly 'the NHS...began with confident anticipation that consultant services would be rapidly expanded' (p.306). At a national level a new training structure for doctors was created, based on the London undergraduate teaching hospitals model and aimed primarily at newly qualified doctors who intended to become specialists. These ranks of doctors-in-training were swelled by demobilised doctors from the Services, many of whom were given supernumerary positions under a special scheme arranged by the Government. By 1948 the postgraduate education scheme had been in operation for about two and a half years and 5,746

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officers had undertaken postgraduate training in the universities of England and Wales.\textsuperscript{2} Of these, 2,946 officers had been given hospital appointments at registrar grade for specialist training. Some of these doctors, such as Ronald Benians, John Firth, Robert Irvine, John Wedgwood, and Tom Wilson entered geriatric medicine. Unfortunately this considerable influx of doctors produced a wide based/narrow peaked pyramid of doctors trying to achieve consultant status, resulting in large numbers in the lower ranks struggling for many fewer consultant posts. As both Godber and Jefferys pointed out, many consultants entered geriatric medicine by default because of fierce competition in other areas of the health service.\textsuperscript{3} In 1949 regional committees estimated the number of consultants they would require and graded their existing staff. This resulted in large numbers of existing hospital staff being appointed Senior Hospital Medical Officers (SHMOs). This was viewed as an inferior consultant grade but following vigorous representation some SHMOs were made up to consultant.


The second factor was the work of the early pioneers, which was becoming more widely known. This had a major career influence on doctors such as John Agate, Joseph Greenwood, and Tom Wilson.4

The third factor was that the newly created Hospital Management Committees (HMCs) began to realise the extent of inappropriate medical care of the chronic sick. They created consultant appointments in geriatric medicine, which occurred in a haphazard and unplanned manner across England. As a result the number of consultants in geriatric medicine increased from 6 in 1948 to 160 in 1967.5

The Post War Generation of Consultants in Geriatric Medicine

The consultants described in this chapter are by no means the sum total of all those who might be called 'Post War' or 'Second Generation' geriatricians. Unfortunately not all of them spoke or wrote of their work or experiences. Those who are mentioned in this chapter are chosen for inclusion because they wrote

4 Articles relating to the elderly mentally ill in the medical press in the 1970s stimulated the growth of psychogeriatrics. Dr. (later Professor) Thomas Henry David Arie CBE, MB, FRCPsych, FRCP, was and still is probably the leading exponent of psychogeriatrics. He qualified in 1960 in Oxford. In his 1970 paper he described his service at Goodmayes Hospital in Essex, and how he had recruited able and enthusiastic doctors. He discharged over half of his 276 admissions, reduced his bed requirements, increased his admission rate and reduced the death rate. He established a joint unit with the local geriatrician. He became Professor of Health Care of the Elderly at Nottingham University in 1977 until 1995 when he retired. Arie T., "The First Year of the Goodmayes Psychiatric Service for Old People," Lancet, 1970, 2: 1179-1182. Arie T., Geriatrics as a Speciality. London: British Library, National Sound Archive, 1991.

articles about their practice of geriatric medicine and/or were interviewed for the National Sound Archive.

The consultants frequently created their own style of service independently of each other, although those trained by existing established consultants, such as Exton-Smith or Woodford-Williams (see later in this chapter), were most likely to follow the methods in which they had been taught. Many became self-taught geriatricians visiting the early pioneers to 'learn the ropes'. This lack of a unified approach probably resulted from an overall absence of any single authority or person(s) responsible for the progress, expansion and growth of the speciality. Thus, from the point of view of this thesis, the immediate consequences are fragmented, divided, disparate styles of development, although over time a degree of unity did appear, such as the use of progressive patient care.

Scrutiny of the written and oral material provided by these new consultants allows some general conclusions to be made. Many had served in the Armed Forces and some had had very exciting experiences. They joined the ranks of demobilised doctors undergoing retraining and seeking consultant posts. Those who entered geriatric medicine often did so by second intent, mainly because of the intense competition for general medical posts.

Geriatric medicine proved no easy task for them. The new consultants had to fight antagonism and resistance from their fellow consultants. They had to struggle for status, acceptance, and staff. They had to try to match resources to needs. Sometimes nurses did not agree with the new style of care, believing it cruel to get old people out of bed. Support for the geriatricians more often came from administrators and lay people than medical professionals. Often they had
responsibility for very large number of beds scattered between several old hospitals, which usually lacked investigative facilities. The waiting lists were huge and were usually tackled by home visiting. Improvement in staffing and resources only came slowly. A few geriatricians, such as Agate, Amulree, Exton-Smith and Woodford-Williams, became national or world-renowned figures.

The consultants, described in the following pages, are listed according to the geographical area where they worked, which can be seen in the map below (Figure 7.1).

Figure 7.1 Map showing multicentre areas of development of geriatric medicine in England.
Central London and Professor A. N. Exton-Smith at the Whittington and St. Pancras Hospitals

Professor Arthur Norman Exton-Smith, CBE, MA, MD, FRCP, (1920-1990), was one of two sons of Arthur Smith, a science teacher at Ilkeston Grammar School. He was educated at Nottingham High School, Pembroke College, Cambridge and University College London (UCH). He qualified in 1943, passed the MRCP examination in 1948, and obtained his MD in 1951 on the subject of *The Ecology of Old Age*, based on his experience of home visiting. He was elected FRCP in 1964. He joined the RAMC in 1944, taking part in the invasion of Normandy on D Day+1 and later serving in France, Belgium and India. He was demobilised in 1947 but joined the Army Territorial Reserve in 1953, retiring in 1959 with the rank of lieutenant colonel of the medical division of the Army Emergency Reserve. From 1948-1951 he was Amulree's registrar at St. Pancras Hospital. He was consultant in geriatric medicine at the Whittington Hospital (a few miles north of St. Pancras Hospital) from 1951-1965 and then at UCH from

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1965-1973, when he replaced Amulree on his retirement. He became the first Barlow Professor of Geriatric Medicine at UCH in 1973 staying there until he retired. Thereafter he set up a geriatric neurophysiology unit at the Whittington Hospital. He married in 1951 and had a son and daughter.

Unhappily he suffered from a pathological fracture of the neck of the femur in 1982, which originated from a hypernephroma. It was followed by eight years of recurrent illness due to a series of bone secondaries, often associated with great pain and over 20 operations to remove secondary growths. He bore his tribulations with great heroism, while all the time trying to help others. In his latter days he walked on one and one half artificial femurs, and went upstairs by means of a stair lift. He would demonstrate to visitors to his home the workings of his hydraulic bath seat and his Pegasus airbed. Eventually he became too ill to stay at home and died in Edenhall Marie Curie Home in North London.

He was a key member of many committees and organisations. He was Editor of Age and Ageing (which replaced Gerontologia Clinica as the official journal of the British Geriatrics Society), Secretary and later President of the British Geriatrics Society (1978-81), Consultant Advisor to the Department of Health and Social Security, a member of the committee on Medical Aspects of Food Policy and a governor of the National Council for the Care of Old People (NCCOP). He was the first geriatrician to be elected as a councillor of the Royal College of Physicians in 1969. He was the first secretary of the College’s Committee on geriatric medicine and was the prime mover behind the College producing its first.
report on Medication in Old People. He gave the College's F. E. Williams lecture in 1975.

Exton-Smith introduced detailed assessment of the clinical management of sick elderly people and developed research into the diseases of old age. His work showed that home visits, effective diagnosis, treatment and rehabilitation increased patient turnover, reduced length of stay, and prevented patients becoming bedfast invalids. He adapted progressive patient care (PPC) to fit the needs of geriatric medicine. He led and/or encouraged research work, imbuing enthusiasm in his able research team, his registrars and other colleagues. He established a special research unit at St. Pancras Hospital and supported work into thermo-regulation, control of the autonomic nervous system, falls, osteoporosis, osteomalacia, fractures of the femur, pressure sores, nutrition of

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7 Irvine viewed the creation of the Royal College of Physicians geriatric committee as an important step towards acceptance of the speciality, previously seen as 'professionally suspect'. Irvine R. E., Fifty Years On, *BGS Newsletter*. September, p 13-15, 1997.


The Multi Centre Development of Geriatric Medicine in England

the older person\textsuperscript{12}, meals on wheels, terminal care\textsuperscript{13}, predicting mortality\textsuperscript{14} and cognitive assessment. He wrote many papers and in 1955 published a substantive textbook on geriatric medicine: \textit{Medical Problems in Old Age}. He co-authored other books including: \textit{Symposium on Vitamins in the Elderly} in 1968 with D.L. Scott, and \textit{Metabolic and Nutritional Disorders in the Elderly} in 1980 with F. I. Caird. He edited \textit{Geriatrics} and \textit{Practical Geriatrics} in 1985. He was an enthusiastic organiser of conferences and meetings in this country and abroad, including Belgium, Holland, Germany and Italy. He was a dedicated and successful 'fund raiser'.

He strongly supported non-medical personnel who researched into medical and social care of the elderly person. He worked with Doreen Norton on geriatric nursing, who became the world's first Professor of Gerontological Nursing. In 1962 she co-authored with Exton-Smith and Rhoda McLaren, \textit{An Investigation of Geriatric Nursing Problems in Hospitals}, and she was sole author in 1967 of \textit{Hospitals and the Long-stay Patient: a Study of Their Practical Nursing Problems and Solutions}.\textsuperscript{15} An important result of the first work was the devising of the Norton Score, which is still used today to assess risks of patients developing

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pressure sores. Norton noted in the year following the publication of the investigation, she received 167 requests to speak on the subject.\textsuperscript{16}

In 1962/3 Exton-Smith supported research of Miss Barbara Stanton into the nutritional intake of elderly women living alone in Hornsey and Islington.\textsuperscript{17} They found those with a low calorie intake tended to have deficiencies in other nutrients such as calcium and vitamin D. In 1971 they investigated the value of meals on wheels.\textsuperscript{18} In 1969 some 13,000,000 meals were provided to over 100,000 people at home although the scale of provision varied widely between local authority areas. An average of 56.5 meals/1000 elderly population, with a range of 27.9-231.6/1000, was delivered in London. The majority had meals delivered five times weekly. Half liked the meals and if those who gave a qualified 'yes' were included, then three quarters of the recipients were satisfied with the meal. The average nutritional value of the meals supplied by the various kitchens varied considerably, depending on the size of the portion, how the food was prepared and served. Food wastage was high.\textsuperscript{19}

Exton-Smith's many awards demonstrate his eminence in the field of geriatric medicine. He was awarded the Moxon Medal of the Royal College of


\textsuperscript{19} In 1961 the government had shown its interest in meals on wheels by sponsoring a survey, which was organised by NCCOP. This revealed some organisations provided the services up to seven days a week but the majority of recipients received the meals only twice a week. The report suggested local authorities took over the responsibility for administering the service, providing the meals and vehicles, while the voluntary organisations would deliver the meals. Harris A. L., \textit{Meals on Wheels for Old People}. London: National Corporation for the Care of Old People, 1961.
Physicians, the Founders’ Medal and the Dhole Eddleston prize of the British Geriatrics Society, the Henderson Medal of the American Geriatrics Society, the Lord Cohen medal of the British Society for Research in Ageing, the Sandoz international prize for gerontological research and was awarded an Honorary Doctorate of Medicine by the University of Nottingham. In 1981 he received the CBE.

His early studies of his geriatric unit

Exton-Smith had already described in 1949 the early geriatric service at St. Pancras Hospital, when he was Amulree’s registrar. In 1952 he reported the results of visits to 215 patients (80 males and 135 females) referred for admission to St. Pancras Hospital between July 1949 and Jan 1951. He found one fifth of them were suitable for care at home, and were not admitted, thus saving hospital beds. Three quarters of those referred lived in tenements: only one quarter lived at street level. The rest had to climb stairs to visit the toilet or use the facility in the yard outside. Exton-Smith found the duration of the illness, which prompted the request for admission, varied widely: three quarters of the patients had been ill for less than a month but the rest had been bedridden for much longer, even as long as 6 years. In the latter cases the request for admission was precipitated by illness or strain in a carer.


21 Townsend in 1962 found that the probability of elderly people requiring admission to a welfare home was inversely related to the number of surviving children. Townsend P., The Last Refuge. London: Routledge and Kegan Paul, 1962.
In 1962 Exton-Smith and colleagues described the results of treating 334 patients who were assessed on admission, on discharge and three months after discharge. Over one third of admissions died because they were so severely ill. At follow up, half of the survivors had maintained their improvement at three months after discharge, which was almost as great as younger patients treated in the general medical beds.

In the same year Exton-Smith and colleagues used a scoring system to assess the activities of daily living and its application to home visits. This study showed that of those seen at home, two thirds were admitted to hospital or nursing home, less than one in ten went to a residential home and one quarter remained in their own home with additional social service support. Those with the lowest score were the most disabled, and were most likely to be admitted to hospital.

**Progressive patient care and bed norms**

In a paper given at a 1973 conference sponsored by the DHSS and in a later unpublished paper, Exton-Smith encapsulated his thoughts about the components of an effective geriatric department. These included: an adequate number of beds, both in total and in the District General Hospital (DGH); progressive patient care (PPC); adequate staffing; consultation with other consultant colleagues;

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home visits; and a day hospital.\textsuperscript{25} He judged that approximately half to two thirds of all geriatric beds should be in the main hospital where the main diagnostic and treatment facilities were based, while the remainder should be in smaller units near the patients' homes. The size of the department should be related to the catchment area linked to the recommended Ministry of Health bed norms.\textsuperscript{26}

Exton-Smith thought most departments had developed some form of PPC, the principles of which he amplified in an article to the \textit{Lancet} in 1962.\textsuperscript{27} This basically involved moving patients from ward to ward as and when they improved and/or required further treatment.\textsuperscript{28} The concept was first developed in America in an attempt to overcome a shortage of skilled nurses and comprised five main zones: intensive, intermediate, self help, long term care and home care. It entailed classification and subsequent treatment of patients according to their medical and nursing needs. Application of this system to elderly patients meant most of them were admitted to the initial treatment ward, where they would stay as short a time as possible. From there patients would be discharged home, or moved to the continuation care wards, where they would be divided into two groups: continued rehabilitation or continued nursing care. From those wards the patients could be

\textsuperscript{25} Exton-Smith A. N. and Millard P.H. ibid.

\textsuperscript{26} The Ministry of Health in 1962 established a bed norm for a geriatric service in England and Wales: 10 beds/1000 population over 65 years, see Chapter Eight. Exton-Smith qualified the norm by pointing out that some units created an active service with fewer beds. This applied to England and Wales not to Scotland and Northern Ireland where larger norms were accepted, because of a relative lack of welfare accommodation.


discharged, moved to a halfway house to await a place in a welfare home or returned home.

Exton-Smith described his experiences of PPC. He admitted 442 patients from their homes through 190 beds during a six-month period. Of this total 67% went to the initial treatment ward, 30% to the continuation ward, and 3% directly to the halfway house. A further 78 patients were admitted by transfer from other hospital wards to the continuation ward — a total of 520 admissions. Of the 298 patients admitted to the initial treatment ward, 70 (24%) were discharged home, 18 (5%) were transferred to the halfway house, and 149 (50%) to the continuation care wards. Overall 61% died: many patients were in the terminal phase of their illness. The disadvantage of the system was loss of nursing continuity because of the need to transfer patients from ward to ward. However Exton-Smith argued it was good for patients’ morale for them to see they were moved on as they improved. Dr. Robert (Bobby) Irvine, consultant geriatrician at Hastings, writing in 1963, supported PPC and demonstrated its introduction increased admissions to his unit from approximately 600 admissions per year before introduction to 1400 within three years — an annual turnover of 5.9 patients per bed. He accepted the move from ward to ward was upsetting to the patients, but it was only for a short

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29 Rosin writing in 1970, discussed a possible solution for hospital beds being ‘blocked’ by elderly patients awaiting transfer to a welfare home. He thought it would be both economical and beneficial to the patients if they were placed in units jointly run by hospital medical staff and the welfare department but administered by the local authority. Thus transfer to a home would be a matter of simple internal transfer. Rosin A. J., "Why Were They in Hospital so Long?" Gerontologia Clinica, 1970, 12: 40-48.

time. The system was good for medical staff because their expertise was
concentrated where it was most needed. Dr. Peter Horrocks also believed in PPC
but he organised it all on one ward, so the acutely ill patients were at one end
where the nursing staff could see them, next came the rehabilitation patients while
the long-stay patients were at the far end.31

The concept of PPC was widely followed throughout the United Kingdom, as
Professor John Brocklehurst and Dr. Keith Andrews found.32 They sent postal
questionnaires to 289 geriatric units in the United Kingdom in 1982. Four out of
every five of the 214 geriatric departments, who responded, practised one of three
forms of PPC. First, there were those who combined acute and rehabilitation
wards but who had separate long-stay wards (37.5%); second, there were others
who had separate acute, rehabilitation, and long-stay wards (24.4%), and last
there were yet others who combined acute, rehabilitation and continuing care all
on the one ward (21.1%). 16.8% other units operated variations on the main
concept of PPC, although 2.3% of these never admitted any acutely ill patients.
The first and largest group had the highest bed/population ratio, the second the
highest discharge rate per bed and the third had the highest consultant/bed ratio.
Nurses in the acute, rehabilitation and long-stay wards developed their own
expertise and did not necessarily mind nursing in the one type of ward, but
thought it was discouraging for the nursing staff if they only looked after

31 Horrocks P., Geriatrics as a Speciality. London: The British Library, National Sound Archive,

32 Brocklehurst J. C. and Andrews K., "Geriatric Medicine-The Style of Practice," Age and
continuing care patients. Brocklehurst and Andrews thought moving patients from ward to ward could induce confusion in some of them, but their real reservation was beds in this scheme were never used effectively because the exact proportion of in-patients in each stage was never constant, i.e. the number of vacancies did not always match the type of patients who needed admission. They considered optimal bed usage would only be achieved by admitting directly to every bed. Exton-Smith disagreed. Dr. Jim Leeming, a geriatrician in Manchester, differed yet again: he did not entirely support PPC and thought patients did not like being moved to a long-stay ward.  

In spite of Exton-Smith's optimism about geriatric services, problems still lay ahead. The Chief Medical Officer, Sir George Godber, reported in 1963 that the geriatric hospital was in too many instances not a part of the general hospital. Five years later he considered better accommodation and equipment for geriatric
medicine was needed.\textsuperscript{35} In 1971 the DHSS reiterated the message that acute geriatric services should be in the district general hospital.\textsuperscript{36} The following year, the Department stated the minimum standard for a geriatric service required one geriatrician per district, which had yet to be achieved countrywide.\textsuperscript{37}

**Staffing**

Exton-Smith realised the efficiency of geriatric units also depended on the quality and number of the medical, nursing and rehabilitation staffs. The number of consultant geriatricians had increased from 6 in 1948, to 246 in 1972, to 377 in 1978, and reached 476 in 1988.\textsuperscript{38} The number of senior registrars in the speciality coming through the system was encouraging and had increased from 3 in 1950 to 77 in 1978. This expansion was greater than in any other speciality. In 1977 the Royal College of Physicians recommended the appointment of general physicians with an interest in geriatric medicine, increasing the rotation of junior medical staff between general and geriatric medicine, increasing the experience of geriatric senior registrars in general medicine, and integrating general and


\textsuperscript{38} Office of Health Economics. *Compendium of Health Statistics 7th edition*. London: Office of Health Economics, 1989. The British Medical Association noted 10\% of geriatric consultant posts were unfilled in 1984 and the true situation was worse because there was a tendency not to create new posts in times of financial stringency. It noted a considerable shortfall in the number of consultant posts needed to meet the DHSS target of one consultant geriatrician per 10,000 over 65 years. British Medical Association. *All Our Tomorrows: Growing Old in Britain*. London: British Medical Association, 1986.
Sir Henry Yellowlees, the Chief Medical Officer, in his annual report for 1979, said an estimated 750 consultants in geriatric medicine were needed. This compared with 'only 349 whole time equivalents in post and a continuing shortage of suitable staff in the training grades. Figures for recruitment to the senior registrar grade indicate that expansion in numbers is unlikely to exceed 10 a year' (p. 102).

Exton-Smith pointed to the shortage of nursing staff in geriatric wards, which was in part due to a 'faulty deployment of available nursing skills' together with a lack of recognition that active geriatric wards required the same nursing staff ratios as general wards: the British Geriatrics Society in 1968 had recommended a ratio of 1 nurse: 1.25 patients for acute and rehabilitation wards and 1:1.5 for long-stay wards. The British Medical Association and the DHSS recommended somewhat similar levels. Andrews and Brocklehurst concluded, from the results of four different questionnaires and visits to 356 geriatric departments, there should be a minimum of one nurse per 4.8 beds in the mornings and afternoon.


41 The Society emphasised the importance of student nurses working on acute geriatric wards. British Geriatrics Society. Memorandum on Nursing Staff in Hospital Geriatric Departments. London: British Geriatrics Society, 1968. In 1982 the BGS recommended a minimum nurse/patient ration of 1:16 with a majority being trained staff. BGS Memorandum on the Provision of Geriatric Services. 3.82 (a) 1982.

with one nurse per 6.9 beds in the evening and one per 10 beds at night. Their surveys had, of course, shown much better ratios but some were worse.43

Rehabilitation staff were vital. Physiotherapists assisted patient treatment but also advised on equipment and building design. They were needed to advise all caring staff, including doctors and nurses, on the correct way to assist elderly people to undertake basic activities such as helping patients to stand up properly from a chair. Occupational therapists were needed to ensure patients at the time of discharge could wash, dress and feed themselves. However the DHSS did not set any minimum standards of staffing numbers in 1972, but suggested more efficient use of existing staff.44

A key feature of any geriatric service was the almoner’s department. Miss B.L. Robertson, Exton-Smith’s almoner at UCH, described in 1953 the nature and difficulties of her work.45 A thorough understanding of the patient’s personality and environment was required, using interviews with the patient, relatives, neighbours and social services personnel. Difficulties in discharge could arise when patients lost his/her home or home support was lacking.

Consultative service

Exton-Smith emphasised geriatric physicians should provide a consultative service to consultant colleagues who admitted elderly people. It was particularly


45 Robertson B. L., "Social Welfare with Special Reference to the Chronic Sick and Aged," in, A Report on the Treatment and Care of the Elderly Chronic Sick in Bristol. Bristol Local Medical Committee, 7, The Dell, Westbury-on-Trym, Bristol, 1953.
important to collaborate with the orthopaedic surgeons since they admitted many elderly women with fractured femurs.46

**Home visits**

Exton-Smith viewed home visits as important because they ensured the right patients were admitted to the right bed and reduced the misplacement of elderly patients in geriatric/psychogeriatric hospitals.47 They also gave the doctor an insight into patients' home/social problems, which could be useful when planning discharge. However Exton-Smith visualised a time when the value of home visits would need to be reviewed as more day hospitals came on line.

Dr. Michael Bendall, in 1978 at UCH, was able to compare the results of Exton-Smith's original home visits in 1952 with his own in 1973/4 and 1978.48 This showed the percentage of those admitted following a visit had fallen from 80% to 49%, because of improved social service support and the opening of the

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46 A collaborative scheme between physicians and geriatricians in Scotland in 1977 resulted in the mean stay for females over 65 years in general wards being reduced from 25 to 16 days and for the over 85s from 50 to 19 days. These changes were not due to increased transfers to the geriatric department. Burley L. E., Currie C. T., Smith R. G. and Williamson J., "Contribution from Geriatric Medicine within Acute Medical Wards," *British Medical Journal*, 1979, 2: 90-92.

47 Kidd made the problem of misplacement clear. Kidd C. B., "Misplacement of the Elderly in Hospital," *British Medical Journal*, 1962, 2: 1491-1495. A 1977 study by Mrs Andrea de Berker and Professor Peter Millard of referrals to Guy's Hospital in South West London showed that many of those referred did not need in-patient treatment and were fit enough to come to the out-patient department. Two thirds of those admitted returned home and almost all were discharged within one month. de Berker A. and Millard P. H., "Geriatric Referrals," *Health and Social Service Journal*, 1973, 82: 3044-3046.

day hospital. The demand for home visits could be considerable. Dr. Clark, a
geriatrician in Brighton, carried out over 800 a year.49

**Day hospitals**

Exton-Smith listed day hospitals as one of the major innovations in the
blooming growth of geriatric medicine. They were an effective way of providing
continuity of medical/rehabilitation care and helping patients to manage at home.
He only wrote in general terms of their structure and function, perhaps because he
did not acquire one at St. Pancras hospital until about 1972. However Rosin, at
St. Pancras Hospital, was able to describe how it was possible to give
physiotherapy on a day care basis without a day hospital.50 He found that day
treatment reduced the demand from general practitioner for in-patient admission
since many patients could now be managed in the day unit, which they much
preferred.51 He found it difficult to compare costs of in-patient care with day
hospital care and came to no specific conclusion.

Because day hospitals attracted much official and clinical comment an
overview is given in Chapter Nine.

**‘Outreach’ medicine**

Exton-Smith listed other significant developments such as preventive
medicine, consultative health centres, and screening programmes in the overall

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50 Rosin A J., "After Care of Elderly Patients Discharged from Hospital," *The Medical Officer*
1965, 113:62-64.

51 Ibid.
creation of a medical service for the elderly. Health centres/screening/case finding were largely the work of geriatricians in Scotland such as Professors Sir Ferguson Anderson and Jimmy Williamson. These initiatives may have been driven by the limited availability of residential beds and social service support in Scotland as compared with England. Screening programmes in Scotland showed general practitioners were largely aware of the major disorders affecting the elderly at home but were less aware of minor disorders such as problems with sight, hearing and care of toenails, which could have a major impact on quality of life.

Long-stay care

Exton-Smith thought elderly patients, who needed skilled nursing and needed to remain in hospital, should be in accommodation outside the main hospital, perhaps a communal hospital, and remain under the care of the consultant geriatrician. However P.M. Halliburton and Dr. William Wright in 1973 found evidence of widely differing trends within the general framework of standards of

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Little evidence of deliberate cruelty was found although some patients were nevertheless treated in small inconspicuous ways, which ultimately denied them occupation, identity and dignity. The best way of improving patient management was 'the instigation of better practices arising from pooling ideas when a multidisciplinary team [including doctors, nurses and rehabilitation staff] sits down together to discuss patients' (p.1301).

Achievements of geriatric medicine

By 1973 Exton-Smith was able to make upbeat generalisations regarding the achievements of geriatric medicine. Initially the speciality had developed from existing custodial practices, establishing the value of rehabilitation with improved care of the neglected chronic sick. Later improvements were made in accommodation, equipment and staffing.

Geriatric departments had made an effective contribution to the work of the district general hospital because of their increased bed turnover, the provision of a consultative service to consultant colleagues, improved collaboration with the local authorities and the initiation of preventive geriatric medicine in the community. Exton-Smith emphasised rehabilitation was a team function e.g. nurses must have basic knowledge of physiotherapy. Professional boundaries between members of the caring staff might need to be blurred on occasion. He promoted the value of the multidisciplinary case conferences, particularly for

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53 Halliburton P. M. and Wright W. B., "Variations in Standard of Hospital Geriatric Care," *Lancet*, 1973, 1: 1300-1302. There are two points here. The CMO, Dr. Yellowlees, in 1980 accepted up to 10% of elderly patients would need continuing care. Op. cit., note 40. The second point is that in subsequent years widespread transfer of continuing care patients occurred from the NHS to the private/voluntary sector.
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those patients with difficult medical and social problems. Other areas to which geriatricians had contributed, included pre and post-graduate education, and research into the diseases of old age.

In his 1980 paper Exton-Smith pressed home the achievements of geriatric medicine using official data. He quoted Hospital In-patient Enquiry (HIPE) data for England and Wales 1976, which compared data from 1972-1976 for geriatric and general medicine as well as general and orthopaedic surgery. This showed the majority of 65-74 year old patients were in general medical wards, while the majority of the 75+ year-old patients were in geriatric wards. The data also established that the average length of stay in both general and geriatric wards was shorter for the 65-74 year old patients, than those aged over 75 years, see table 7.1. Exton-Smith thought this was because the 'young' old tended to have a single disease with fewer social problems, while the over 75s were more likely to have mixed medical/social problems with degenerative conditions. The latter took longer to improve, lengthening the average length of stay and skewing the data. The HIPE data show geriatric departments over the four-year period in question had achieved a 21% decrease in average length of stay for the 65-74 year old patients and a 15% reduction for those over 75 years.

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54 Exton-Smith A. N., op. cit., note 33.
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<table>
<thead>
<tr>
<th>Speciality</th>
<th>Median duration of stay (Days)</th>
<th>Average length of stay (Days)</th>
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<tr>
<td></td>
<td>65-74 years</td>
<td>75+ years</td>
</tr>
<tr>
<td>General Medicine</td>
<td>10.9</td>
<td>11.7</td>
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<tr>
<td>Geriatric Medicine</td>
<td>19.4</td>
<td>22.6</td>
</tr>
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<tr>
<td>Orthopaedic Surgery</td>
<td>14.6</td>
<td>18.0</td>
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</table>

Table 7.1 Shows the average and median length of stay in medical and surgical wards in England and Wales for 1976.\textsuperscript{55}

Exton-Smith considered the use of hospital beds was dominated by the over 65s. When the NHS was created in 1948, only 25% of hospital in-patients were over 65 years, but by the 1970s the proportion had doubled in general wards of most hospitals. In 1984 the BMA report stated 45% of acute beds were occupied by the over 65-year-old patients.\textsuperscript{56} Exton-Smith considered the high death rate of the elderly patients was because they were often very ill, resulting in one third dying during admission or shortly after discharge. In a 1962 study he found that, at three months after discharge, of 212 patients originally admitted with acute

\textsuperscript{55} Op. cit., note 33.

illnesses, half were still improved and rather more than a quarter had deteriorated or died.\textsuperscript{57}

Official sources endorsed the achievements of geriatric medicine. The Central Office of Information in 1974 reviewed the post war developments in geriatric medicine and made very positive comments. It considered it had contributed to a more rapid recovery and discharge of elderly patients.\textsuperscript{58} Furthermore Exton-Smith reported that 'a senior medical officer of the Department of Health said in 1956 that the National Health Service could not have begun without [the] achievements in geriatrics, since so many hospital beds would otherwise have been unavailable' (p.1).\textsuperscript{59}

However Exton-Smith realised outstanding difficulties and problems remained. These included the relation between geriatric and general medicine, the recruitment of medical and nursing staff, improvement in long-stay accommodation, the need for a country wide geriatric service, better collaboration with psychogeriatricians and the need to overcome negative attitudes in senior


\textsuperscript{59} Exton-Smith A. N., op. cit., note 33.
physicians. He noted with pleasure the work of Dr. Arie and that the Royal College of Psychiatrists had set up a special group to consider the Psychiatry of Old Age.

Further details of the efficiency of geriatric medicine are given in Chapter Nine.

**Conclusions**

Batchelor wrote in 1984, in a review of geriatric services sponsored by the Nuffield Provincial Hospital Trust, that geriatric medicine lacked consultants of high calibre and academic standing. Exton-Smith was an outstanding exception. He became a world-renowned figure in the speciality for his work on acute geriatric medicine and for his research, which was supported by the Medical Research Council and the Nuffield Foundation. His unit was much visited. He inspired many to follow in his footsteps. He worked tirelessly on behalf of the speciality and was much in demand as a speaker. Many tributes were paid about him at a celebration of his life held in the Royal College of Physicians. It became clear he was a private man with many interests such as antiques, early English watercolours and flying model aeroplanes, many of which were unknown to those present.

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He was a wise diplomat in his efforts to influence and change official thinking within the Royal College, the Ministry of Health and the Department of Health.

All in all he was a great man, a gentleman and a gentle man.

**Greater London: Dr. J. D. B. Andrews and the West Middlesex Hospital**

Dr. James David Brwyn Andrews qualified in 1950 and obtained his MD two years later. He was a Senior Hospital Medical Officer in Coventry in 1957, and later became consultant geriatrician at St. Tydfil’s Hospital in Methyr Tydfil, in 1958. In 1960 he succeeded Warren at the West Middlesex Hospital following her accidental death. He became clinical editor of *Gerontologia Clinica*, and when it ceased publication, was appointed editor of *Gerontology*.

In 1957, while at Coventry, he wrote a paper for his Hospital Board describing the local current geriatric service.62 A waiting list of 41 patients in January 1957 had been eliminated in one month because of the mild winter, home visiting and an increase of 17 beds. Home visiting revealed some patients had died, some could be managed at home and others refused admission. He had to admit patients whom, he thought, were suitable for welfare home admission but lacked suitable accommodation. The morale of the nursing staff was very high, but the wards were overcrowded. He requested an adequate number of day rooms, basic ward medical equipment such as an ophthalmoscope and a lumbar puncture set. He recommended patients were classified and basic data collected

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e.g. state of hearing, continence, vision, mental state and physical mobility. Blood investigations were difficult to organise due to the laboratory being ‘off site’. He thought confused patients should be in their own ward. The service lacked rehabilitation and an almoner service. Nearly 11% of the patients were suitable for Part III accommodation but there were no vacancies. He organised temporary ‘holiday’ admissions. He requested improved accommodation for the speech therapists, occupational therapists, a laundry service for the incontinent, an increase in Part III accommodation and special homes for the blind.

After his appointment to the West Middlesex Hospital, following the untimely death of Marjory Warren, he found the geriatric unit continued to be visited. Dr. J. Th. R. Schreuder came in 1962.63 At that time Schreuder found the unit had 218 beds and a share of 48 other beds in a halfway house. This was a concept supported by Warren but not by Andrews who thought the patients should go straight home. Schreuder was told that about 10% of the patients became long-stay and their average expectation of life was 3 years. He noted overcrowding on the wards, which lacked equipment. The day hospital, which also lacked equipment, had opened five weeks before his visit.

In 1967 Dr. H. G. Jespersen from Denmark visited the unit under the auspices of the Council of Europe.64 Andrews then had five members of medical staff, two and half physiotherapists, four occupational therapists, two almoners and had a


share in two speech therapists. The unit had 232 beds with a share in 30 beds in a halfway house. In 1966 749 patients were admitted, with most of them coming directly from the general practitioner. The majority were discharged. Only 9% became long-stay. 40% of those admitted died. The geriatric out-patient department saw 1,509 attendances of which 399 were new patients.

In 1965 Andrews described a year’s experience with the geriatric out-patient department at the West Middlesex Hospital, which had been started by his predecessor Marjory Warren. During 1963 three clinics a week had been held and 368 patients had attended. Two thirds were referred for a consultant opinion but some were sent in the hope of obtaining in-patient admission, for extra services such as wheel chairs, for social reasons to assist admission to a welfare home, and requests for holiday admission. He thought the out-patient department differed from the general out-patient department because it dealt with multiple pathology and more handicapped people.

In 1967 and 1971 he described the West Middlesex day hospital, which had been functioning for five years. He considered the day unit allowed nurses to be deployed to other duties since fewer nurses were needed in day hospitals than in-patient wards, that these units cost less than in-patient care and prevented psychological disturbances to patients by avoiding in-patient admission. Medical investigations and procedures, such as bone marrow aspirations and total dose

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iron infusions, could be carried out in the day unit. Nursing procedures such as dressing leg ulcers and giving enemas were performed. In 1966, 221 new patients had attended with 4,197 total attendances, with patients attending 1-5 times a week, for an average length of stay of 13 weeks.

In two papers, in 1962 and in 1972, he considered the problems posed by mentally confused patients. In the first paper, he and a colleague recommended a special type of residential accommodation for the ambulant confused elderly people, which would permit them to live in an environment suited to their needs. In the 1972 paper he was a member of a North West Thames Regional group on planning psychogeriatric care, which defined the areas of clinical responsibility of geriatricians and psychiatrists to improve understanding between them and the resources required. No social worker was included in the group even though local authority care was considered. The authors were unenthusiastic about psychogeriatric assessment units because of difficulties discharging patients from them. The behavioural pattern of the patient rather than the basic medical/psychiatric condition should be the criterion for assessment.

67 Andrews J. D. B. and Insley M. L, "The Long-stay Psychogeriatric Unit," Gerontologia Clinica, 1962, 4: 94-99. Dr. Morag Insley (1924-) qualified in 1946 and married a doctor. She worked for a time at Cowley Road Hospital, Oxford and saw the work of Cosin. Later she moved to Wales with her husband, and was eventually appointed consultant at St. Newport in 1960. She took a year's study leave to take the DPH at Bristol in 1972/3. She remained rather restless and moved to Cornwall where she had a post in community medicine with social service liaison, which covered the Scilly Isles. She was very happy in this job. Insley M. Geriatrics as a Speciality. London: The British Library, National Sound Archive, 1991.

Greater London: Dr. J. G. Pritchard and Queen’s Hospital, Croydon

Dr. John Guthrie Pritchard qualified in 1958 at St. Mary’s Hospital and obtained his MD in 1968. His career in geriatric medicine started in the Queen’s Hospital where he was Junior Hospital Medical Officer. Later he became assistant physician in geriatric medicine at Foresthall Hospital, Glasgow, and then consultant geriatrician at Nunnery Fields Hospital in Canterbury before finally moving to St. Luke’s Hospital, Huddersfield.

In 1961 he described his survey of chronic sick admitted to the geriatric unit at Queen’s Hospital in Croydon, which was not the local general hospital. The unit had 410 beds, which was just over the recommended ratio of 10/1000 for the local population over 65 years. 102 beds were provided for the psychogeriatric patients, 9 for those with multiple sclerosis, and 88 were long-term rehabilitation beds. ‘Permanent’ or continuing care patients blocked about half of the beds. The remaining beds had a more active function and were used to help control the district waiting list of 425 patients. Home assessment showed 20% of the waiting list patients did not require urgent admission. He surveyed the 338 patients admitted by transfer from the general hospital to the unit over a 4-year period and whom the general physicians considered totally irremediable. Of these patients 30% were discharged home, 60% died and 10% remained in hospital. 3,170 people were admitted from home during the period. Overall deaths and discharges figures for 1956-1959 showed a turnover of 2.1-2.3 patients/ bed/year.

In 1964 he and a colleague reviewed the 'chronic sick' in the geriatric unit.\textsuperscript{70} One difficulty was agreeing a definition. They suggested 'geriatric' meant those patients with potentially remediable conditions and capable of being restored to health or adjustment to disability, while 'chronic sick' meant those who were untreatable by modern geriatric methods. Their new data showed the turnover of patients in 1952 was 1.3/patients/ bed/year, which doubled to 2.6 in 1961, using 435 beds. The waiting list rose considerably from 899 to 1,474 in 1961. The death:discharge ratio reversed with more discharges than deaths. 10%-20% of admissions were considered to require long-term accommodation.

**Greater London: Dr. C. P. Silver and St. Matthew’s Hospital, London**

Dr. Christopher Patrick Silver, MD, FRCP, qualified in 1942. He was consultant geriatrician at the London and Tower Hamlets Hospitals, and though appointed by the London Hospital he never had beds in the main teaching hospital. In 1965 and 1967 he described the geriatric service in the East End of London in 1962.\textsuperscript{71} This was an area which had undergone extensive rebuilding following the bombing of World War Two and little remained of the notorious poverty and other features of life of the East End. The unit was based at the 300-bedded St. Matthew’s geriatric hospital, where there was good


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rehabilitation but many other facilities of a general hospital were lacking. However in 1962, 31 beds were made available in nearby general hospitals, which were used for general assessment.

He studied 455 patients who were considered the most intractable patients and who had been admitted to St. Matthew's Hospital from home or by transfer. 44% of the patients died while in hospital, 48% were discharged home while 7% were still in-patients 2 years after admission. 5% were in hospital for less than 90 days. The death rate of 12% at six months after discharge compared with 17% at three months found by Arnold and Exton-Smith and with 26% at six months found by Amulree.¹²

In 1970 he described a social club run by the hospital and the local authority for the healthy and frail elderly, some of whom were brought to the centre by local authority transport.¹³ Later he reviewed the situation in East London between 1962-1972, when there were 6,286 admissions of 3,988 patients.⁷⁴ The likelihood of death increased with age, and the longer the patient stayed in hospital the more likely he was to die in hospital and less likely to return home.

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Transfer of patients from general wards could take as long as several months, which was partly due to the lack of private nursing home beds.

**Greater London: Dr. A.J. Mester and St. Alfrege's Hospital, Greenwich.**

Dr. A. Joseph Mester, MD (Cracow), who died in 1967/8, described his unit at St. Alfrege's Hospital, as consisting of two separate blocks of three storeys each.75 Each floor contained one ward divided into two — one for the bedridden and one for the ambulant. He had responsibility for 268 patients many of whom were women under 60 years. The male wards contained many surgical and post surgical patients. The unit served the boroughs of Greenwich and Deptford. The population of Greenwich was almost entirely made up of weekly wage earners with many members of the family out to work each day. This reduced the potential for family support for an ill relative. Housing conditions were often poor, with a heavy demand for hospital beds for the aged.

He reviewed the unit's activity over one year. He admitted 546 patients, some of whom were readmissions, into 268 beds giving a throughput of 2.0 patients/bed/year. The patients came directly from the general practitioners, internal hospital transfer, the Emergency Bed Service, the local Medical Officer of Health and the casualty department. During the winter he made home visits to all the people on the waiting list to assess priority of admission but during the summer this was unnecessary because of less pressure on the beds. He was able to arrange smooth transfer of his patients into welfare accommodation by taking

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patients on an exchange basis, and arranging transfers of mentally ill patients to the nearby Tooting Bec Hospital. The death rate of 43% was high, with most deaths occurring in the winter months. He arranged for the health visitor to assess progress made at home by those patients who were discharged. He maintained early treatment was essential to maintain a high turnover of patients. He thought his present allocation of 11/beds per 1000 population was about right for his requirements.

Greater London: Dr. J. C. Firth and St. Albans Hospital.

Dr. John Clifford Firth JP, MB, MRCP, (1917- ) was born in Acton in London, the son of a pharmacist, and qualified in 1941 at UCH Medical School. He was actually sitting the final examination in the Examination Building in Queen’s Square when a German aircraft bombed Buckingham Palace. After house posts he joined the RAMC, serving in Sicily, Italy, Trieste and Hungary. After demobilisation he passed the MRCP in 1951 and undertook further training, including SHMO in geriatric medicine at St James’ Balham. He was appointed consultant geriatrician at St. Albans in 1964, with additional responsibility for the young chronic sick. He had beds in seven hospitals, and discovered patients in St. Mary’s Hospital in Luton were only X-rayed on Thursdays even if there was an urgent need; that was the routine. The general physicians were not particularly helpful; some did not even talk to their colleagues, and on one occasion they all went on holiday leaving him in charge of the whole hospital. They were unable

to understand why he was unable to take away their patients on the day of their request. Eventually his smaller hospitals were discarded, a day hospital was opened, a new hospital was built with geriatric beds included and four colleagues joined him.

**The West: Drs C. T. Andrews and T. S. Wilson and Cornwall.**

Dr. Charles Thomas Andrews MD, FRCP, (1903-1990), was born in Killeter, County Tyrone of a farming family. He qualified from Queen's University, Belfast in 1927. In 1930 he obtained his MD and passed the MRCP in 1932. In that latter year he entered general practice in Truro and was appointed consultant physician to the Royal Cornwall Infirmary in 1938. In 1946 the county Medical Officer of Health, prompted by the Ministry of Health, asked Andrews to investigate conditions in the former workhouses. He surveyed them the following year, during which time he visited Marjory Warren, coming away 'with a clear idea of what was required in his survey'. He examined every patient in the seven workhouses, some of which were Dickensian beyond belief and one was 'a

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nightmare'. His report, issued in 1947, was accepted *in toto* by the county council. Andrews recommended the appointment of a consultant geriatrician with appropriate staff. The British Medical Association originally delayed the appearance of the advertisement because the word 'geriatrician' was new to them. Dr Tom Wilson was appointed at the age of 29, the first consultant in geriatric medicine in Great Britain, and some three months before the 'appointed day'. Andrews continued to support geriatrics and in 1967 the purpose built psychogeriatric unit at Bamcoose was named after him. In retirement he wrote books on the history of the Royal Cornwall Infirmary and the Cornish mental hospitals.

Dr. Tom Scott Wilson, MD, FRCP, (1918-2000/1), was born in Belfast and was the youngest of five brothers whose parents were teachers. He qualified in medicine in Belfast and served in Bomber Command from 1942–1947. He was medical officer in charge of the ex-POWs in Changi prison. On demobilisation he went to St. John's Hospital in Battersea, where Howell worked and visited Warren, becoming very friendly with her. He stayed at St. John's for about a year and a half, and researched into the causes and treatment of incontinence. This became the basis of his MD and a later paper. It was Warren who suggested he considered applying for the post in Cornwall. He was involved in the creation of the Medical Society for the Care of the Elderly. Later Eric Morton joined him as

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the second consultant and gradually the number of consultants in geriatric medicine increased to four. He thought geriatrics ‘took off’ because some doctors believed strongly in it, lay people gave encouragement and some influential general physicians supported the speciality.

Andrews and Wilson ‘turned round’ the old custodial system of care of chronic sick patients. Their 1953 paper provides an interesting ‘vignette’ of the initial state of their unit.80 Aged and chronic sick patients were placed in seven widely separated Public Assistance Institutions and two joint user institutions in Penzance, Helston, Redruth, St. Austell, Falmouth, Launceston, and Liskeard. The authors noted the area was geographically isolated: the sea was to the north, west, and south and Bodmin Moor was to the east. They examined and classified 454 patients, whose average age was 71 years: see table 7.2. Some of them had been in hospital for long periods and one mentally defective patient had been an in-patient since his admission in 1881 some 70 years earlier.

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<table>
<thead>
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<th>Type of Patient</th>
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<tr>
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<tr>
<td>Acute sick</td>
<td>16</td>
</tr>
<tr>
<td>Chronic sick – remediable</td>
<td>114</td>
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<tr>
<td>irremediable</td>
<td>162</td>
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<td>Psychotic</td>
<td>63</td>
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<td>Mentally defective</td>
<td>39</td>
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<td>Blind and deaf</td>
<td>10</td>
</tr>
<tr>
<td>Others</td>
<td>8</td>
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</tbody>
</table>

Table 7.2 Shows the type and number of patients examined by Andrews and Wilson.

The buildings varied in quality but most were the same drab institutions found in other parts of the country. There was no modern hospital. Sanitation was inadequate and earth closets were still in use in the 'house' side of one institution. Heating was by coal fires; windows were often high and small. The only medical attention was provided by a general practitioner, who visited once a week, and who did not keep records. Patients were admitted at the request of the general practitioner with the agreement of the relieving officer. They were generally admitted for life and apparently were never discharged. There were no almoner, physiotherapy, or occupational therapy services. The quality of nursing was good although there was a nursing shortage. There were only 7 State Registered Nurses (SRN) in the 7 institutions. Patients were often kept in bed resulting in the usual problems of contractures, muscle wasting and incontinence:

Ibid.
The staff had to be convinced of the value of getting patients out of bed. Andrews and Wilson concluded the chronic sick were getting a poor deal.

Andrews and Wilson began their programme for change in 1948. Rehabilitation and almoner staffs were appointed. They concentrated the acute services in one central unit, Bamcoose Hospital, which was close to Redruth General Hospital, where laboratory and X-ray facilities were available. They designated their other units as long-stay annexes. Potentially remediable patients, as well as acutely ill new admissions, were moved to Bamcoose Hospital for active treatment. There was often considerable resistance to discharge, since both patient and relatives had expected a bed for life. In spite of these problems throughput was almost tripled from 200 patients in 1947 to 575 patients in 1951, producing a turnover of 1.7 patients per bed during the study period. The average length of stay was just over 7 weeks for men and nearly 10 weeks for women. Over 40% were discharged home, nearly one third died and 1 in 5 went to long-stay beds. They considered home visiting most valuable: they visited 355 patients before admission finding one quarter did not require admission. They noted elderly people with specific disabilities were referred to general medicine whereas those referred to them had mixed physical and social problems. Nearly one quarter of all their admissions to Bamcoose were patients with a stroke. As the unit became more successful so the number of referrals increased. In 1951 a modern long-stay unit was opened in Penzance, and in subsequent years more

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long-stay beds were provided in other centres. They decided not to hold outpatient sessions because of the long distances patients would have to travel.

In 1951 Andrews reviewed the situation. He deplored lack of statutory powers to coordinate the work of various groups looking after elderly people. He thought mentally confused patients should initially be admitted to a geriatric ward for assessment by both the geriatricians and the psychiatrist. Medical students should be taught about the medical and social problems of older people. There was wide scope for research and better education of doctors. However general physicians remained unconvinced of the value of geriatric medicine and considered it an inferior branch of medicine.

In 1973 Datta, a senior medical officer, and Andrews evaluated progress in geriatric practice in West Cornwall over a 20-year period. The total population had increased by 15%, but the over 65s had increased by 29%. The number of patients referred for admission had increased by 56%, although the proportion requiring admission decreased from 61% to 46%, which was largely a response to increased welfare accommodation. The mean age of those admitted had risen because of an increase in those over 80 years living in the area. The unit now admitted many more acutely ill patients with the resulting increase in mortality. The waiting list for non-urgent admissions remained static over the years, while the percentage of acutely ill patients increased. Fewer patients were being

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discharged from hospital to welfare homes because preadmission assessment prevented inappropriate admission. In 1967 a day hospital was opened, followed by a purpose built psychogeriatric unit in Barncoose the following year, though discharge was hampered by lack of vacancies in the psychogeriatric wards. The county council had begun a programme of providing purpose built welfare homes to replace existing unsatisfactory public assistance institutions. The authors concluded that their 1953 calculations of bed requirements of 100 acute beds with a sex ratio of 1 male: 2.2 female beds, and a ratio of long-stay to acute beds of 3.2:1, were accurate. However if the Department of Health norm of 10/1000 beds for the over 65s was applied, then a total number of 520 beds was needed as against the 420 beds they actually had. Eventually the unit comprised four consultants, two senior registrars and two wards in the district general hospital.85

The West: Dr. W. Hughes: Stapleton and Manor Park Hospitals, Bristol.

Dr. William Hughes, MD, DTM, MRCP, (1904-1981), was born in Athlone in Ireland.86 Like other members of his family he studied medicine at University College, Galway, qualifying in 1926, and successfully completed his MD thesis in 1934. After passing the MRCP and DTM examinations, all in 1934, he joined the Colonial Medical Service and between 1934-8 he was attached to a leper colony in Singe Bolo. In 1939 he became medical officer at Kano and later physician and lecturer at the School of Medicine in Lagos, Nigeria. At the end of the war he became a general practitioner in Liverpool before becoming Residential Medical

85 Wilson T. S., op. cit. note 78.

Officer at the Belmont Hospital in Liverpool. In 1945-6 he worked for the Control Commission on Malnutrition in Germany. In 1950 he was appointed area consultant geriatrician in Bristol with its population of 650,000. He was initially based at Stapleton Hospital, and later at Manor Park Hospital. He was reported to have a great sense of humour and enjoyed riding horses. He published several clinical papers including one on presbyophrenia.87

He was a man with wide, mixed clinical experience. He tackled the problems of the aged sick with considerable energy.88 On the 'appointed day' there were 1,711 aged sick people (1,735 in his 1951 paper), housed in 9 Public Assistance Institutions: 5 were designated as hospitals and 4 were 'joint user' institutions. These facilities lacked laboratory and X-ray facilities, surgical theatres, and special therapy departments. There was an extensive shortage of nurses, and medical staff was inadequate. The proportion of bedfast cases was high. A further 850 ambulatory old people were in local authority and voluntary homes.

The wide spread geographical clinical practice necessitated concentration of services centrally at Stapleton Hospital, an old building erected to house Napoleonic prisoners of war, and where Hughes had 120 beds. Patients were admitted from the waiting list, and by internal transfer from the acute wards provided they had rehabilitation potential. Eventually he acquired the necessary

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investigative and rehabilitation facilities, increased medical staffing and the services of the almoners' department.

He classified the patients, which showed they consisted of psychotics (both certified and uncertified), mental defectives, social misfits, sexual perverts, epileptics, blind people, and acutely ill and chronically sick elderly patients. Many patients, who had been in hospital for a long time, did not wish to be discharged from hospital and many relatives were strongly opposed. The division of responsibility between hospitals and local health authorities complicated their discharge, which led to infinite haggling between the two. He did exchange a number of psychotics and mentally defective patients with docile or bedfast patients from the local psychiatric hospital. There remained a hard core of 352 long-stay cases, some of whom had been in hospital for up to 4 years. The result of his energetic approach was that the admission rate increased three fold in an eight-month period in 1951. Over one third of admissions died mostly within the first few weeks of admission, one third were discharged and only 12% were still in-patients.

Subsequently a new 20-bedded subsidiary centre at Weston-super-Mare was set up. However he encountered considerable resistance to his idea of changing the function of the smaller peripheral hospitals, along the lines of the 1947 British Medical Association report. This suggested a long-stay annex should be used for local patients, thus releasing beds in the centre for acutely ill patients. Local management committees and general practitioners did not accept this idea. The local hospital staff wanted to admit a mixed range of acute, rehabilitation and long-stay patients even though they lacked essential equipment. The nursing staff
thought the acute hospital would ‘cream off’ the more interesting patients. Ultimately a compromise was reached whereby the peripheral hospitals took some acute and some long-stay patients.

Hughes assisted the Bristol Local Medical Committee in 1950 in its response to RHB (50) 39. This stated an initial requirement was an accurate diagnosis of elderly people leading to suitable treatment and discharge home. The committee accepted the prime aim was to help the older person to remain at home for as long as possible. At that time 11% of the population was over 65 years. A bottleneck existed of those patients who could not be discharged, thus preventing acute admissions. The waiting list for admission in 1951 was three times that of 1948. The committee considered out-patient department investigation and treatment had a role for the elderly, although some general consultants were not in favour. The division of responsibility between the three sections of the NHS complicated the management of the elderly chronic sick.

Hughes in 1953 returned to the difficulty of placing frail ambulant people who needed help with dressing, toileting and feeding and who could not manage on their own. The local authority insisted their residents should be self-caring and should be able to manage stairs. An alternative arrangement of lodging the

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patient with a local family did not prove popular especially as the person got older.

The West: Drs. W. B. Wright and J.H. Simpson and Exeter

Dr. William Bryce Wright qualified in 1950, obtaining both the London and Edinburgh memberships in 1956. He became FRCP Ed in 1971 and FRCP in 1979. He wrote clinical papers and stated the case for geriatrics with his colleague Dr. John Harold Simpson, who qualified in 1943, obtained the MRCP in 1949 and the MD in 1952. He wrote about misplacement of elderly patients in geriatric and psychiatric wards/hospitals.

In 1967 they both put forward the case for geriatric medicine. They considered the growth of the specialty arose out of necessity. The problem of the chronic sick arose out of misdiagnosis and poor prognosis, with the age of the patient influencing the expectations: ‘what can you expect at his age?’ Doctors entering geriatric medicine often had had their career sights originally set on another discipline. A newly appointed consultant geriatrician had the challenge of taking on a task, which had beaten others and therefore he became a pioneer. He had to understand the roles of the various members of the rehabilitation team, the local authority and the Medical Officer of Health. He had to diagnose the patients, reclassify those thought to be irremediable and treat appropriately. He needed to convert his beds into functional units of acute, rehabilitation and long-stay, to acquire office space, secretarial support and to work within a clearly defined catchment area of responsibility. An efficient geriatric unit could expect


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to have a high death rate of about one third because patients were in their last illness. One half should be discharged within six weeks and only one sixth should become long-stay and who would probably survive 18-24 months.

In 1972 Wright discussed the future of geriatric medicine and general internal medicine. He considered poor recruitment in geriatrics was due to inadequate knowledge of the speciality, understaffing of the departments, lack of financial inducement and status. He thought it would help if geriatric and general medicine shared a common pool of beds and rotated junior staff. Whenever older patients were admitted, they should have appropriate treatment for their needs.

The East: Dr. J. N. Agate: St. Luke's Hospital, Bradford and Ipswich General Hospital.

Dr. John Norman Agate, CBE, MD, FRCP, (1919-1998), was educated at Aldenham, Trinity Hall Cambridge and the London Hospital. While still a medical student he acted as a dresser in North East London hospitals during

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92 Wright W. B., "Geriatrics and General Medicine," *Age and Ageing*, 1972, 1: 120-124. However the Royal Commission on the NHS in 1979 supported the concept of consultant physicians with a special interest in geriatric medicine, the need to meet the health requirements of older people, to improve independence for those living at home, and to improve training for all professions involved in the care of the elderly. Sir Alec Merrison. *Royal Commission on the National Health Service*. 1979. London, HMSO.
wartime bombing raids and also looked after some chronic sick patients. His house posts were in the London Hospital where he was later registrar and senior registrar. He passed the MRCP in 1944. He joined Sir Donald Hunter's research group on industrial (occupational) diseases as senior registrar. He published many papers and was awarded his MD on the effects of vibration on the hands of people who used pneumatic tools. After four years with the research unit, he served a short service commission in the medical branch of the RAF, where he ended as squadron leader. Initially he applied for general medical posts but competition was severe. Geriatric medicine was just starting and so he applied successfully for such a post in Bradford in 1953. He asked the appointment board if he could have 4-6 weeks before starting in order to visit geriatric units, which included those of Amulree, Cosin, Warren, Howell and Wilson.

He found he had responsibility for 730 beds in seven units with minimal help but he did have 4 wards in the general hospital (St. Luke's). Patients' clinical notes were conspicuous by their absence. Many of the hospital buildings were in a poor state and lacked day rooms. The wards were equipped with solid high-sided cot beds, which were designed to prevent patients climbing out of bed, but one did so killing herself. The roofs of the wards leaked and there was no heating, resulting in a ward temperature of 35°F. One house physician threatened to certify the cause of death of a patient as neglect due to the leaking roof and the low temperature. This caused a 'flap' in the hospital administration and the

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hospital committee was ‘blackmailed’ to provide heating to the wards. The waiting list was large but when he assessed it he found many patients had died. He was not impressed by the attitude of one general surgeon who, on being asked to perform a mid thigh amputation for gangrene, refused because he thought the patient would die. There would be an inquest and the publicity surrounding the death would be bad for his private practice. Agate found the nurses were enthusiastic and gradually turnover improved. He established a weekly patient review with the Bradford psychiatrists. He presented a paper on mental disorders to the IAG at its Venice meeting in 1957.4

Agate’s wife and two children did not like living in Bradford, mainly because of the ‘smog’ conditions. Consequently he successfully applied for the consultant geriatric post in Ipswich, where in 1958 he set up a new unit from scratch. This time he only had 520 beds to look after, although his ‘patch’ covered 1000 square miles. The outlying hospitals were up to 30 miles from the centre and three were in large ‘incorporated’ 18th century ex-workhouses. One ward of one hospital was made of corrugated iron and was very rudimentary. He also had responsibility for a 1919 hospital with a dwindling number of tuberculosis patients. He improved the quality of the ward conditions by changing the colour of the decorations and trying different patterns on the floor. At first he only had 12 beds in the main hospital. Initially the general physicians were suspicious of him, although eventually he became chairman of the medical staff committee for

4 Agate J. N., Mental Disorders of the Elderly Approached by a Method of Joint Consultation. Fourth Congress of the International Association of Gerontology: Venice, Italy. 1957.
six years. He reduced the long waiting list by home visits, so that the original waiting time for admission of 53 days was reduced to 2-3 days. He considered that if an elderly person was left at home for 53 days either he/she would have died or got much worse and therefore would take much longer to get better. In 1967 he opened 50 acute beds followed by a further 50 rehabilitation beds 10 years later. As the situation changed, so nursing recruitment improved. In the mid 1960s he organised major refurbishment of four peripheral longer stay hospitals.

In his interview in the National Sound Archive, he related a number of anecdotes, which throw light on the then prevailing attitudes towards the chronic sick. For example, he had to struggle to acquire bed curtains. ‘Why do you want bed curtains? All they’ll do is hide behind them,’ was the reply to his request. On another occasion he asked for proper washbasin facilities for the nurses and doctor. ‘What do you want with washbasins? In the old days we used to have a bowl and jug...that was perfectly adequate.’ A third example related to a first floor ward, which recently had had its floor renovated but had been left with gaps between the floorboards. He pointed this out with no effect. However one day a lady was very incontinent on to the floor and the urine passed through to the ceiling of the floor below, falling on to the bald head of an unkempt man in the ground floor ward. Agate reported this to the Chairman of the House Committee who refused to pay for any more work. Agate rang the Chairman of the Hospital Management Committee threatening to declare both wards unfit for human habitation. The necessary work was carried out in 10 days.

He published widely. In 1963 he published *The Practice of Geriatrics*, which went into a second edition in 1970; *Geriatrics for Nurses and Social Workers* in

He served on several national committees, including the Joint Committee of Health and Social Services Council, and held several offices in the British Geriatrics Society. The Society asked him to negotiate with the British Medical Journal to see if it would publish the Society’s journal but the overtures were rebuffed, because ‘[geriatrics] isn’t of sufficient importance.’ Eventually Karger published the new magazine, Gerontologia Clinica. However the feeling persisted that a British publisher was needed, so eventually Agate was sent off again. This time he secured the services of Baillière Tindall who in 1972 published the new journal, Age and Ageing, although the Oxford University Press later took over. He became editor of Modern Geriatrics. In 1978 he was awarded the CBE for services to geriatric medicine. He set high standards and though he possessed a ‘short fuse’, he was a kind man. Outside medicine, his interests included music, photography and cars. In retirement he wrote about local medical history e.g. Blythburgh Hospital in Suffolk.

In 1965 he reviewed current British geriatric service, from its inception by the small number of pioneers. Geriatric departments had evolved from the old Poor Law institutions, which contained ‘a mixed clientele of the aged, defective and destitute, together with vagabond and ne’er-do-wells’. These facilities were

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intended as Houses of Industry not hospitals. The pioneers had shown rehabilitation could restore chronic sick patients who could be returned to the community, making beds available for others. However some senior doctors in hospitals and many general practitioners believed elderly patients were incapable of recovery and therefore accurate diagnosis and treatment was pointless. Thus the newly appointed consultant geriatrician was:

presented with several hundred patients, housed in very overcrowded conditions in antiquated buildings with no amenities or comforts, rudimentary plumbing and no medical equipment or diagnostic aids whatever. His patients have usually been kept in bed for long periods for 'safety' or supposed convenience of nursing, they were unsorted and even largely undiagnosed; they are without any intelligible medical records (p.122).

There was a long waiting list for admission and colleagues complained about 'blocked beds'. The nursing staff were largely untrained and few in number. His first tasks were to improve conditions for the patients by improving the ward decorations and basic equipment of beds, chairs as well as aids for sanitary use and helping mobility. The consultant needed to be not only a good clinician but also to be knowledgeable in administration and sociology. He maintained the elderly person had as much right to an accurate diagnosis as anybody else particularly in view of the fact that they had given the best of their life to us. This required access to the relevant investigative and X-ray facilities. However he cautioned against over zealous investigation when ethically it might be appropriate to limit treatment and let nature take its course. The geriatric
department required an adequate number of beds for assessment, rehabilitation and long-stay patients. Good liaison with the local authority was essential to ensure those discharged had the proper social service support. The geriatrician needed to understand what was 'normal' for the elderly person in respect of physical and mental state, that people 'age' at different rates, the natural history of many diseases changes with old age, and social problems become mixed up with medical factors.

In his 1966 publication he pointed out the different ways in which disease could present in older people such as the absence of cardiac pain, infections not associated with fever, and mental confusion becoming the commonest mode of presentation of many illnesses. He reiterated the need to mobilise the older person out of bed to avoid the dangers of bed rest. He thought many departments were able to discharge 60% or more of their patients. Death rates were inevitably high; 'indeed the admission policy of departments with abnormally low death rates -- below 30% of intakes - may be open to question'. He noted it was usual for new departments 'to find the waiting lists are quickly reduced to nominal figures and admission to its beds to be possible upon demand, or after only a few days delay'. He argued against those gloomy persons who said initial high turnover could not be maintained: a high turnover could indeed be maintained provided energy and resource were applied and if staffing was adequate. Great scope for research in clinical geriatrics existed. He thought geriatric medicine was very rewarding to practise and made a most important contribution towards the health and welfare of a very large section of the community.
Dr. William Davison TD, MD, FRCP (Ed), (1925-1993), qualified from Edinburgh University in 1948. After his house jobs, which inclined him towards paediatrics as a career, he joined the RAMC serving overseas including Hong Kong, which turned his interests towards anaesthetics and surgery. In 1954 he went to Sunderland General Hospital as surgical registrar, where he met Dr. Lyn Woodford-Williams (see later in this chapter-p 266). He became a senior house officer (SHO) in geriatric medicine looking after a 50-bedded ward without help. He passed the MRCP examination, becoming senior registrar in the speciality and working for Oscar Olbrich in Sunderland (see later). In 1960 he was appointed consultant geriatrician at Cambridge, with responsibility for 600 beds in five towns, but with no junior staff other than general practitioners. None of the hospitals had a medical secretary or X-ray facilities. Over a period of time he developed the geriatric service based at the old workhouse at Chesterton in the outskirts of Cambridge and opened an out-patient department. He noted spare

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bed capacity in the general medical wards in Newmarket Hospital but he was rebuffed when he requested the use of them: 'over my dead body' said the chairman of the hospital management committee. After the chairman died, Davison got his beds. Eventually the RHB built two new wards for elderly patients, which were so poorly constructed the roofs had to be replaced. When he started he had a waiting list of 300+, which he ignored unless the general practitioner rang about the patient. He assessed all his in-patients: medical standards had slipped and medical notes were scanty. He bullied the local authority to take patients. He got the patients out of bed and into their daytime clothes, which caused outraged 'do-gooders' to write to the local papers about this 'sadistic' treatment. Some of the nurses never overcame their resistance to the change. Like others he found the best support came from lay people such as the administrators, while there was marked resistance from the general physicians. He commented that consultants, who came into geriatrics by second intent, often retained their original interest and despised geriatrics. He established a general practitioner vocational training scheme, which was not appreciated at first. Over time he acquired junior medical staff including senior registrars, and was allocated beds in the new Addenbrooke's Hospital, Cambridge. This became the site for a new medical school and ultimately a chair was established in clinical gerontology.

He wrote clinical papers and was the main author of Lecture Notes on Geriatrics, first published in 1977 by Blackwell, Oxford. He examined for the Royal College of Physicians and the Chartered Society of Physiotherapists, and
was a member of the General Nursing Council from 1978 to 1983. He was seconded from time to time to the Health Advisory Service (HAS).

He was kind, good humoured, patient and skilful in committees, inspiring trust, but could become brutally direct when the occasion required. He served in the Territorial Army rising to be Colonel commanding the County of London General Hospital. In this capacity he became the Queen’s Honorary Physician. He worked for Age Concern and the British Association for Service to the Elderly. He took a keen benevolent interest in the medical students and junior medical staff. The remark most often made about him was ‘he was a lovely man’. He died of carcinomatosis associated with a painful vasculitis.

The East: Dr. R. G. Benians and Rochford Hospital

Dr. Richard Gore Benians MD, FRCP, (1916-2003) was born in Kent, the third child of a middle-class family. His father was a pathologist. He studied at St. John’s College, Cambridge and between 1934 and 1937 undertook his clinical training at the Middlesex Hospital. He qualified in 1940 and after house posts joined the RAMC. He served in Ireland, Egypt, Sicily, Italy, Madagascar, India and Persia. While he was in Sicily his battalion lost one third of its men. After demobilisation he went to the North Middlesex Hospital in 1946 for refresher purposes, eventually becoming a senior registrar at Chase Farm Hospital. He passed the MRCP in 1949 and obtained his MD on the subject of chronic bronchitis. He was appointed an SHMO in chest medicine at Bradford where he

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...stayed for seven years and met Agate. However consultant posts in chest medicine were decreasing in number due to the decline in tuberculosis, so he became a consultant in geriatrics at Southend, which he thought was the worst geriatric post in the country at the time. He had only 120 beds but needed 420. The consultants treated the geriatric beds as a dumping ground. His predecessor, Dr. Samuel Ciemens, a general surgeon, had to give up due to severe dermatitis, and was appointed medical superintendent. Benians found poor quality medical and rehabilitation staff although the situation slowly improved and eventually a second consultant geriatrician was appointed. He concluded a geriatrician needed good medical and non-medical skills and be prepared to carry out a large number of home visits.

The East: Dr. T. B. Dunn and King George’s Hospital, Ilford

Dr. Thomas Bryce Dunn, MB, MRCP, (1920- ), was the youngest of five brothers who qualified from Edinburgh.99 After his house posts, he joined the RAMC and served in a field ambulance unit going to Normandy on D+1, Brussels, Germany and Turkey. He passed the MRCP in 1949. Like many others he found a bottleneck of doctors trying to obtain jobs. He was appointed to further training posts in King George’s Hospital in Ilford, where a conscious effort was made to avoid admitting patients with strokes. Because few general medical consultant posts were advertised, he applied for and was appointed to the consultant geriatric post in Ilford. There he took over beds in the fever unit.

maternity wards, old tuberculosis wards and a pre-war workhouse style hospital in Hornchurch, eventually acquiring 250-300 beds, a day hospital and increased support staff. He established joint sessions with the orthopaedic surgeons and psychiatrists, and visited Arie at Goodmayes, where the psychogeriatric unit consisted of fine buildings but was very overcrowded with patients. He remained keen to undertake acute medical work and to improve the quality of care of the long-stay patient. He found geriatric medicine satisfying. Eventually he was allocated wards in the main hospital, but these were taken back by other specialities when their own wards were closed. He operated a vague age related admission policy, trying not to admit the young elderly unless there was good reason.

The North: Dr. J. M. Greenwood and the Withington Hospital, Manchester

Dr. Joseph Mellor Greenwood, MD, DPH, (1908-1999), and honorary lecturer at Manchester University, was born in Bolton, where his father was a draper. His mother died while he was still young and his father remarried a nursing sister whose brother was a general practitioner. He qualified at Manchester University in 1929, worked in a variety of hospitals, completing his M.D in 1934 on midwifery infections after childbirth. He obtained the DPH in 1937. He enjoyed medical administration, became Resident Medical Officer and later deputy Medical Superintendent at the Withington Hospital, which had 1,200 beds and an annex of 400 chronic sick beds. He became Medical Superintendent


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at the hospital on the death of the incumbent. During the war he was seconded to the Ministry of Health to review the hospitals in the North East to help them cope with the expected wartime casualties. At one stage he thought he admitted ‘very many, 800 I think, in one night as a result of the bombing.’ He was promised a consultant post when the war ended but he was not appointed as one. Consequently he did consider emigrating, until he read Warren’s article. At this point he decided ‘this was something to get one’s teeth into and I did’. He was appointed consultant geriatrician at the Withington Hospital, Manchester in 1950 – the first in Northern England. His fellow consultants resisted his appointment because they considered that geriatrics was not needed. In time he built up an effective rehabilitation unit and increased staffing to two senior registrars, several registrars and housemen. In 1949 he wrote of his experiences with the chronic sick, and a survey based on that of Thomson in Birmingham.\textsuperscript{101} He compared his results with those of Thomson. He found the proportion of those aged over 60 years was roughly similar, but many more of those in Manchester had been in hospital for longer e.g. over half of the residents had been in-patients for more than three years and over a quarter for more than 5 years. Greenwood thought over half of his patients could be rehabilitated, but suitable accommodation for those fit to leave hospital was lacking, which blocked beds. He considered the longer the patient was bedfast the less the chance of recovery. The best chances of recovery occurred if the patient was admitted directly to the geriatric unit.

Greenwood concluded the geriatric unit should be attached to the general hospital with annexes for the long-stay patients, and with an out-patient department for investigation and treatment. His unit increased turnover through the 400 beds from 682 admissions in 1951, to 1,004 in 1954. He noted the first admissions often had an inaccurate diagnosis and the medical records were out of date. He thought it inappropriate to admit very confused patients to a geriatric ward and considered pre-admission visits were valuable because they saved hospital beds. Domiciliary health care should be available for those who would benefit. Eventually his waiting list disappeared but his success brought referrals from North Manchester and Cheshire. Another geriatrician joined him and eventually he persuaded the RHB to create a chair in geriatric medicine, which was filled by Professor Brocklehurst (see below).

The North: Professor J. C. Brocklehurst and Bromley, Guy's and Withington Hospitals

Professor John Charles Brocklehurst CBE, MD, FRCP, (1924- ), was born in Liverpool, the son of an engineer. He was educated in Glasgow and qualified in 1947. His initial house posts were in Foresthall and Stobhill Hospitals, Glasgow, (an old workhouse), where he began his long-lasting interest in urinary incontinence and which formed the basis of his MD thesis. He joined the RAMC as a National Serviceman and went round the world. On demobilisation he returned to Stobhill Hospital. He was not sure what speciality to follow but was

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inclined towards surgery. He developed 'itchy feet', travelled abroad, had some
general practice experience, went to Newfoundland and India, and then returned
to the United Kingdom. He passed the MRCP examination. He then went to
Bournemouth as an assistant physician to Philip Arnold, the local geriatrician. In
1960 he was appointed consultant geriatrician at Bromley, with 250 beds in three
hospitals but moved to Guy's Hospital in 1966 as a consultant physician in
general and geriatric medicine, where in fact he had no beds but was based at
New Cross Hospital. He found many Asian doctors filled the junior posts,
which made it difficult to suggest that geriatric medicine was equal to general
medicine. While he was at Guy's, Professor John Butterfield, the Professor of
Medicine encouraged him.

He was appointed Professor of Geriatric Medicine at the Withington
Hospital, Manchester in 1970. The hospital had 1,300 beds of which 420 were
geriatric. Drs Greenwood and Leeming were the existing consultants.
Brocklehurst found the general physicians were reluctant to rotate their junior
staff through the geriatric wards. He taught medical students, stimulated the
development of psychogeriatric medicine and wrote extensively on clinical,
management and descriptive subjects. In the 1980s a second chair was
established at Manchester, which was filled by Professor Roy Fox, who left after
three years to go to Canada and was replaced by Professor Raymond Tallis.

103 He succeeded Rosin who had taken a consultant post in Israel.

104 Professor John Butterfield (later Lord Butterfield) maintained his support for the speciality
when he became Regius Professor of Physic at Cambridge. There he wrote the forward of
Davison's Lecture Notes on Geriatrics published in 1977
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Brocklehurst thought Keith Joseph, when he was Secretary of State, was instrumental in creating endowed chairs of geriatric medicine, a view supported by Godber. He viewed Warren’s contribution as tackling the gross neglect in the early years of geriatric medicine. However the shortage of nurses still persisted. He became a firm supporter of the medical charity The British Foundation of Age Research, later renamed Research into Ageing. After retirement he was appointed assistant research director of the Royal College of Physicians, where he directed interest into audit, day hospitals and the problems of incontinence in the elderly.

The North: Dr. R. V. Dent and Crumpsall Hospital, Manchester

Dr. Ronald Verdun Dent MB, FRCP, (1916-1999), was born and bred in Norfolk and returned there after his retirement.105 He was said to be a modest, gentle and good-humoured man. He qualified from Christ’s College, Cambridge and Charing Cross Hospital in 1940 and after his house posts he passed his MRCP. He joined the Royal Navy in 1944, serving on D-Day, in Egypt and Malta. He was demobilised in 1946. He married a doctor and worked for a while at Chase Farm Hospital, and then Enfield. While there he heard a loudspeaker message for a Dr. Griffith to go to the ‘chronic ward C urgently, some time in the next fortnight’. Out of curiosity he went to the ward and started to take an interest in chronic sick patients.

After an appointment as deputy medical superintendent in a hospital near Southend, he was appointed consultant geriatrician at Crumpsall Hospital in

Manchester in 1852. There he had 62 beds in the acute hospital and 365 beds in a nearby annex, whose poor state was quite a shock to him. There was no rehabilitation, no equipment, virtually no therapy staff and funds were short, but he found good nursing. To tackle the waiting list he started a rehabilitation programme, visited people at home, and established good relationships with the local authority. He developed an enthusiastic committed team, which enabled him to create a good geriatric service. However the psychogeriatric patients remained a problem. The general physicians were not interested in treating the elderly, 'what do you expect at their age,' and he faced resistance from some nurses who did not like this new approach to care of the elderly. He got most support from the HMC. He strongly advocated the creation of a professorial chair at Manchester. In 1977 he retired to Norwich and was placed in charge of a local hospice, Priscilla Bacon Lodge.

The North: Dr. H. Droller and St. James' Hospital, Leeds

Dr. Hugo Droller MD (Munich), FRCP, (1909-1995), was a German refugee from the Nazis. He re-qualified at Glasgow in 1935, and was at first medical tutor at Sheffield before serving with the RAMC. He was appointed consultant geriatrician at St. James' Hospital, Leeds in 1950. With one colleague he was
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given responsibility for 1,300 beds and a waiting list of 600.\textsuperscript{106} He established a modern geriatric service incorporating innovative methods of rehabilitation. By 1966 the geriatric department reduced its requirements to 396 beds, and by 1966 he had achieved a turnover of 5 patients/bed/year.\textsuperscript{107} The death rate was 43% because the patients were often very ill. He believed geriatric medicine benefited from recruiting doctors trained in other medical disciplines. He was a scholarly man who expected his juniors to follow his own wide reading of medical literature. In retirement he produced a personal and family record of persecution of the Jews in Nazi Germany.

In 1958 he reported on the value of the out-patient department in geriatric medicine, having opened his in 1952.\textsuperscript{108} The aim was to supervise the immediate post discharge period of elderly people, to investigate those referred to the unit, to relieve the handicapped and to help the lonely and mentally confused return to a conventional social life. Four main groups of patients attended: those with diseases of the central nervous system, those with skeletal disorders, yet others with general medical conditions and those with psychiatric problems. A number of patients had lost their social 'graces' and required retraining to make them fit to live with others. Patients were never discharged from the clinic until the

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\textsuperscript{107} The 1957 Boucher report recorded the Leeds unit consisted of 687 beds of which 74% were allocated to females patients. Boucher, C. A., \textit{Survey of Services available to the Chronic Sick and Elderly. 1954-1955.} Ministry of Health. Reports on Public Health and Medical Subjects No 98. 1957. Droller made a special point of interviewing relatives shortly after admission of the patient and just before discharge.

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doctors were sure the patients would manage successfully at home. Thus of 407 patients, 125 were discharged but 214 still attended, 56 were admitted to the geriatric ward, 12 refused to attend or died at home. Droller thought the outpatient department saved in-patient beds, since some elderly people could be investigated and treated without admission, while in-patients could be discharged earlier.

In 1959 he and colleagues organised a Leeds Regional Health Board conference on ‘The Care Of the Aged’. They described the geriatric service in Leeds, which had been in existence for 10 years since the beginning of the NHS. Acutely ill elderly people were admitted immediately but the chronic sick would be admitted only after assessment of the duration of their illnesses. Patients were moved on to other wards as they improved along the lines of PPC. Holiday admissions were accepted. They reiterated the need for consultant geriatricians to be first and foremost physicians. Problem areas included shortage of nurses and social workers, and the need to improve integration with public health, welfare and mental health services.

In 1969 he reported the results of a clinical and social questionnaire of 372 patients admitted during May (end of winter) and October (end of summer) under one geriatrician at St. James’ Hospital. It was implemented in response to complaints of the quality of service provided by general practitioners and the


local health authorities. The social assessment was carried out by health visitors and by social workers seconded by the local Medical Officer of Health. The questionnaire attempted to answer the questions: could admission have been avoided or prevented by the use of locally available services and was isolation a factor in hastening admission? All the patients were frail, very old and sometimes very ill. Indeed nearly half died. He concluded family support obviated admission of severely mentally impaired patients, although little financial inducement existed to do so. Families tended to care for their ill relatives to the point of exhaustion. 25% of admissions did not receive the community services they needed, which occurred particularly in those living alone. In some cases the range of services available was unknown to the patients and/or the relatives. In the majority of cases there were no preventable medical or social factors, which could have been dealt with and would have prevented admission. Many of the patients thought to be living alone had regular visitors. He thought the general practitioners needed help from the geriatric service, the local authorities needed to be streamlined and available at any time. Apart from papers on the work of the geriatric unit he published clinical articles, including a paper on the problems in designing trials of drugs used to improve memory.\textsuperscript{111}

The Multi Centre Development of Geriatric Medicine in England

The North: Drs. O. Olbrich and E. Woodford-Williams and Sunderland General Hospital

Dr. Oscar Olbrich, PhD, FRCP Ed, (1901-1957), was an ex-nephrologist from Vienna and another refugee from the Nazis. He re-qualified in 1941 in Edinburgh, obtained the MRCP Ed. in 1942 and gained the PhD in 1947. He took house posts in Edinburgh Royal Infirmary, followed by a period as a general practitioner, and then he became physician in charge of the House of Refuge for the Destitute in Edinburgh. He was appointed a clinician at the Royal Infirmary in 1943. However he really wanted to undertake research, so in 1950 he became director of the gerontology department in Sunderland, where he had responsibility for 600 beds. He persuaded the regional senior administrator medical officer to fund his requirements for a research laboratory. He published 23 research papers mainly on changes in the blood, renal function, the heart, prostate and water/electrolyte balance. He was elected secretary of the clinical gerontological research committee section of the IAG. He created a modern, medical clinic for the elderly sick, which provided only a one-week wait for an appointment and could provide an in-patient bed within 24 hours. He was responsible for the creation of the local meals on wheels service. Olbrich concentrated very much on acute work, leaving his assistant Dr. Lyn Woodford-Williams, to concentrate on rehabilitation. He was described in many ways: having a warm charming manner, full of energy, a gifted teacher, but also a funny didactic foreigner with

an atrocious accent and a liking for chocolate Swiss rolls. He had a dominating personality, was impatient of others if he considered they had made a mistake and was a tyrant in the mould of the continental professor. He was devoted to Woodford-Williams but abused her unmercifully in public and trampled over her.

Much of the description of the Sunderland unit comes from his colleague Dr. Eluned (Lynn) Woodford-Williams, CBE, MD, FRCP, FRC Psych, (1913-1984), who qualified in 1936 from UCH. She was born in Liverpool, the eldest of four daughters. Her father was a dental surgeon and her mother was the daughter of a horticulturist. She was educated at Liverpool College and later at the Cardiff High School for Girls. Her initial house posts were at UCH, including that of Sir Thomas Lewis who diagnosed her mitral valve disease, which was to be the ultimate cause of her death some 50 years later. She was not clear in what direction her career should progress; initially she considered paediatrics but eventually she became an assistant to Olbrich. She managed her department with

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considerable energy and trained a number of consultants who became well known in the future e.g. Dr. William Davison.

In 1958 she organised the inaugural meeting of the European clinical section of the IAG because of the early untimely death of Olbrich. Shortly afterwards she was appointed co-editor of *Gerontologia Clinica*. She left Sunderland in 1973 to become the director of the Health Advisory Service (HAS), a post she held with great distinction. The experience extended her knowledge of psychiatry and consolidated her views on good management in geriatric medicine. In 1979 she was appointed CBE for services to medicine and elected FRCPsych, an honour she greatly appreciated. She married Dennis Sandford, a surgeon, who made a career move to Sunderland. They separated but when she became very ill from bacterial endocarditis, he took her away from her home in Wales, back to Sunderland for her final days.

Woodford-Williams described the function of a geriatric unit in 1967. It aimed to provide a comprehensive medical service to maintain the independence of the elderly at home for as long as possible, to provide an environment for teaching, and to carry out research. Correct diagnosis, treatment and rehabilitation, effective reintegration and maintenance into the home environment achieved these functions. This required team work with adequate numbers of staff and adequate beds in the general hospital. She thought some geriatricians

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115 Olbrich contributed to the IAG meeting in London in 1954, which was also notable for participations from, amongst others, E M. Widdowson, Professor R. A. McCance, Professor R. Titmuss and Sir Russell Brain.

poorly understood the proper integration with hospital, community health and welfare resources. Doctors in general needed to be trained in the care of the elderly, and more funding was required for staff, building and equipment. The obstacles to the progress of geriatric medicine were due to the prolonged influence of 'Public Assistance' and the wartime evacuation of Public Assistance Institutions, which revealed overcrowding, understaffing, poor accommodation and lack of facilities. Geriatricians had shown what could be achieved by reversing the old style custodial approach to care.

The North: Dr. P. McEwan and Bradford Royal Infirmary

Dr. Peter McEwan MA, MB, ChB, FRCS Ed., (1881-1973), was the second son of a Perthshire farmer and was educated at Perth Academy at the age of 9 years, taking all the honours it offered. He left at 15 with a scholarship to Edinburgh University. He obtained the MA in 1901 and graduated in 1905. After initial house jobs he specialised in surgery passing the FRCS Ed in 1907. He went to Bradford Royal Infirmary as assistant surgeon. During the First World War he served in the RAMC and was awarded the Croix de Guerre. In 1920 he became full honorary surgeon at Bradford Royal Infirmary developing an interest in thyroid surgery. In 1943 he reported on 321 successive thyroidectomies without a death, many of which he anaesthetised himself. Unfortunately he suffered a massive spinal paralysis after a septicaemic infection. He eventually returned to work but had a tendency to fall so had to teach himself how to fall

safely. He retired in 1946 but was appointed consultant geriatrician in 1948, eventually retiring again in 1951.

In 1949 he reported a survey of 701 geriatric patients in Bradford and used the results as lessons to show 'what not to do'. He found, like others, the patients were decrepit in mind and body, dull, listless and apathetic. Their joints were often stiff and painful. Everyone regarded them as hopeless and useless, but much could be done to improve them. The old atmosphere of gloom and apathy could be changed and the patients could be mobilised.

The best place for the old person was his/her home: their interests, relatives and friends were all there. They knew their own house and retained their independence. Family bonds were not weakened. He considered admission could be prevented by access to a geriatric out-patient department, which had physiotherapy attached, and adequate community support such as laundry, home help, and meals on wheels. However some patients would require admission such as those with a terminal illness, senile confusion where relatives could no longer cope, patients who were alone at night, and those who might benefit from hospital treatment. The waiting list would need a periodic review to remove those who no longer needed admission.

He thought the geriatric service would work most efficiently if there was a chief medical officer in charge who might be a physician, surgeon or orthopaedic surgeon. Such a person would need to keep up to date on current treatments to

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give the best care, encourage morale in the nursing staff, so that the geriatric wards became a happy place. He believed the patients should stay on the same ward for the duration of their treatment to preserve continuity of care. He thought psychogeriatric patients should have their own ward. All patients should have ready access to investigative facilities. Ward accommodation should be bright, well heated, free of draughts and have non-slip flooring. He realised about one third of the patients would die within three months of admission, one third would go home but the remainder should not be allowed to block beds. He thought patients would get the best treatment if geriatrics became a speciality.

The North: Dr. W. H. Lloyd, and District General Hospital, Oldham and Manor Park Hospital, Bristol

Dr. William Harry Lloyd MB, MRCP Ed., qualified in 1946 and obtained the MRCP in 1951. In 1961 he wrote a paper prompted by the assumption that most of the problems of old age were social in origin rather than medical.\textsuperscript{119} During a 12-month period of January 1\textsuperscript{st} to December 31\textsuperscript{th}, he, and usually his almoner, visited 558 patients on the waiting list and assessed their medical and social needs. He did not visit those who needed to be admitted within 48 hours. Nearly two thirds of those seen were admitted, 17\% were referred to the out-patient department and 20\% referred back to the general practitioner. The reasons suggested for admission were either medical or social. Those considered to have social problems by the general practitioner had been ill for so long, the original illness had been almost forgotten and indeed the patient could not remember
when they were last well. However those with medical problems could remember when they were last well. They concluded ‘social’ problems were usually secondary to physical disease.

In 1966 he argued the limited impact of geriatric medicine as a medical speciality was due to three factors. First, ageing was confused with disease. Second, geriatric medicine emerged because of political pressure rather than from the medical profession, with the result few geriatric units existed in teaching hospitals. Third, ‘a geriatric patient is distinguishable by his age and the complexity and magnitude of the problems he poses’ (p.345).120

The North: Dr W. Fine and Newsham General Hospital, Liverpool

Dr. Wilfred Fine, MD, FRCP, (1915- ), qualified in 1939 at Guy’s Hospital. He was appointed to the Emergency Medical Service during the war and worked at Maida Vale in 1942 as Resident Medical Officer.121 He obtained his MRCP in 1943. He became Deputy Physician Superintendent at Southend Hospital, Rochford. Later he served in the RAMC becoming a Major. He obtained his MD in 1947. He was demobilised in 1949, becoming supernumerary senior registrar

at Orsett Lodge Hospital, then after one year obtained a consultant post at Newsham Hospital.\(^{122}\)

This hospital was viewed as a ‘dumping ground’ with 1,200 ‘chronic sick’ beds, although this had reduced to 500 beds by 1977. It lacked an out-patient department, and had a waiting list of 300-500 people, which meant that patients could wait years for admission. Examination of the list showed that many patients had died, some had got better, others had been admitted elsewhere and some had become irremediable. Patients with relatives who applied pressure were able to get admission faster than those who had no relatives. Many of the new admissions were malnourished with evidence of Vitamin C deficiency. Over 200 accidents occurred on his wards in the first two months of his appointment. He had to convince the general practitioners that acute illness should be the main cause for admission, a policy they did not greet with much enthusiasm. He established a large out-patient department, which allowed patients to see the consultant much earlier than had been the practice. In 1961 he opened a day hospital, the first in the North of England.\(^{123}\) He thought it gave relatives more relief than the patients. He found many requests for admission to the day unit

\(^{122}\) Gibson, who was physician superintendent at Newsham hospital, recorded in 1955 that 3,216 patients of all ages, of whom 43.9\% were over 60 years, were admitted in 1951. The long waiting list for admission at that time was increased due to the ‘flu’ epidemic. Admissions fell to 3,017 in 1952 and to 2,992 in 1953, which was associated with a fall in the death rate. He noted an increasing length of stay with age. Gibson K. B., "Work of a Geriatric Unit," \textit{Lancet}, 1955, \textit{1}: 960-964. Dr. Robert Kemp, who worked for a while at Newsham Hospital, argued for better community care for the frail elderly to reduce the dangers of admission to hospital e.g. infections, over investigation and treatment, and the emotional danger of dependency. Kemp R., "Old Age a Regret," \textit{Lancet}, 1963, \textit{2}: 897-900.

\(^{123}\) Fine W., "Integration of a Day Hospital into a Geriatric Service," \textit{Gerontologia Clinica}, 1964, \textit{6}: 129-142.
were for faecal incontinence, which was usually secondary to retention of faeces. Gradually he transformed the geriatric unit raising its status, improving medical staffing, developing daily living activities with the occupational therapists, and turning it into an active one of 600 beds. In 1959 he published a paper reviewing 227 falls, which had occurred to his patients when they tried to get into or out of bed. Prevention lay in constant nursing supervision particularly when the patient was getting in or out of bed, floor level lighting, non-slip flooring and well fitting slippers. He found he had to learn general management and not to discharge patients on a Friday.

In 1977 he responded to a medical student's letter about geriatric services. He noted the writer underlined possible antipathy of the young towards the old, which could cause difficulties in recruitment into the speciality, because it was seen as unglamorous, difficult and financially unrewarding. Fine considered those who taught medical students 'rationalised their failures in treating the elderly by denigrating geriatrics'. He disagreed with those general physicians who maintained 'we all practise geriatrics nowadays' because they treated the straightforward patients with bronchopneumonia or left ventricular failure.

True geriatrics involves the successful rehabilitation of the patient who is found lying on the floor completely helpless, confused and incontinent, the ability rapidly to diagnose...the frequently multiple


pathology which has precipitated such a geriatric syndrome, the ability to inspire a medical team...to motivate a nursing team, the ability to organise rehabilitation...Successful geriatric medicine, like genius, involves 10% inspiration and 90% perspiration. Maybe that is why it is not so popular (p.953).

**The South: Dr. T. Rudd and Southampton**

Dr. Thomas Newton Rudd MD, FRCP, (1906-1995), qualified at the London Hospital in 1929, and obtained both the MD and the MRCP in 1932.\(^\text{126}\) He was a descendent of Isaac Newton, hence his second Christian name. He became a general practitioner in Tiverton in 1932, where he was also a member of the staff of Tiverton hospital, but later moved to the London County Council fever service in 1938. He joined the RAMC during the war, serving in the United Kingdom, Algeria and Normandy, ending it as a commander of a medical division. After the war he returned to Cornwall and was distressed by low standards in the Belmont Hospital, an old workhouse, as compared to Tiverton Hospital. He

started regular ward rounds and made medical notes. He became so absorbed in this work he decided to specialise in geriatric medicine. He gave lectures to nurses, which became the basis of a book *Nursing the Elderly Sick*, published in 1952, and which went into six editions. He published *Human Relations in Old Age: Handbook for Health Visitors, Social Workers and Others*, in 1967. In 1957, at the age of 51 years, he was appointed consultant geriatrician at Southampton, where he had responsibility for 300 beds. Later Dr. Fred Ashton joined him but unfortunately he died young. After his retirement in 1971, Rudd worked as a locum consultant and for the HAS. He died of laryngeal cancer.

In 1959, two years after his appointment as consultant, he wrote a general paper on the development of a geriatric service, accepting that the initial difficulty in starting such a service was overcoming the prejudices against old age, with the elderly being viewed as dirty and distasteful. The best care was obtained when medical, nursing, hospital and other departments all believed in the dignity and moral worth of old age. Urinary and faecal incontinence were challenges to proper management. He valued the early pre-admission assessment of the patient by the geriatrician and the almoner.

A more detailed account, written in 1963, considered the problems of long term illness in old age, leading to lengthening of the waiting list for admission to hospital and residential homes, bed blockage, shortage of staff, and the poor

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professional status of the medical staff. He still considered pre-admission assessment visits were useful but realised more acutely ill patients were being admitted to geriatric wards. He thought geriatric wards were the appropriate place for those aged people who needed special facilities, acknowledged the complexity of home support which was unacceptable to general practitioners, the essential support of the relatives and that it was cheaper to keep a person at home than in hospital.

He deplored the heavy workload of the single-handed consultant who managed an acute high turnover geriatric unit with clinical responsibility for 400+ beds. He supported the concept of the 'right patient in the right bed', and not placing elderly physically frail patients with those who were confused. This highlighted the lack of agreement over what constituted a 'geriatric case' and what was a 'psychogeriatric' case, and lack of co-operation between geriatric and local authorities to prevent misplacement in local authority homes. He thought patients could feel abandoned by relatives when admitted to hospital, which could result in the struggle for life being given up. He encouraged good nursing morale by ensuring nurses worked in stimulating enthusiastic wards with support from medical and nursing management. He commented 'it is, however, general experience that delay in providing admission to a welfare home often leads to an individual becoming a hospital case instead: similarly patients requiring a short period of hospital treatment may become long term cases if speedy admission is

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impossible’ (p.399). Ultimately he argued for an increase in beds for the geriatric department, which would be administered by an experienced well-trained clinician of consultant status, more residential home places, and effective cooperation between all agencies concerned with care of the elderly. An audit of care and a mutual programme of education were required to overcome the prejudices against old age.

He wrote articles about health in retirement, and questioned why people ignored health warnings. He advised on sensible life style before retirement, and discussed professional and public attitudes towards elderly people where, once again, he reiterated the prejudices against the old. He warned against unnecessary admission of the old to hospital where they were likely to suffer from cross infections, inappropriate drug medication and psychological reactions.

The South: Dr. R. E. Irvine and St. Helen’s Hospital, Hastings

Dr. Robin Eliot Irvine, C.B.E., MD, FRCP, (1920-2002), was the son of a teacher and was educated at Winchester, Cambridge and Guy’s Hospital, which had been evacuated to Tunbridge Wells during the war, from where he qualified in 1944.129 After house posts he joined the RAMC and served in the Middle East and Palestine, where he contacted jaundice and tuberculosis. As a result he was invalided out of the service. He was appointed a supernumerary house officer under a scheme for ex-servicemen and obtained the MRCP in 1948. He was appointed to further training posts including the Brompton Hospital, Guy’s

Hospital, then as senior registrar at Newcastle. At this point he found it difficult to obtain a consultant post in general medicine. He then became senior registrar to Olbrich in Sunderland. He concluded Olbrich practised acute geriatric medicine, while Woodford-Williams concentrated on rehabilitation. His view was many patients did not need admission to hospital had they been treated earlier and correctly. He thought the original members of the MSCE did not always get on with each other, e.g. Mitchell and Howell fell out, but did not give details.

After two years at Sunderland, he was appointed consultant at St. Helen's Hospital, Hastings in 1958. Though this was an old workhouse it had investigative facilities. He noted several anomalous situations: all the wards had curtains around the patient beds except the geriatric wards, and the Matron of one of the voluntary hospitals would not give a reference to any nurse who applied to the old infirmary.

He found Hastings a friendly place to work in. The Hastings Hospital Management Committee decided each of their three hospitals should have a separate function and should be of equal esteem. The Matron of the geriatric hospital did much to raise standards and improve nursing ratios. With her help he introduced open visiting to the wards. He threw away the waiting list because it represented the old style of geriatric medicine. He considered that if general practitioners referred a patient then admission should be arranged at once, not

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130 It took a little time for the staff to get used to the system but it was viewed as helpful to the patients and improved communication with relatives. Irvine R. E. and Smith B. J., "Patterns of Visiting," Lancet, 1963, 1: 597-600. He reiterated the need for improved nursing establishments to cope with the heavy work on acute geriatric wards. Smith B. J. and Irvine R E., "Nursing Workload in Geriatric Unit," Gerontologia Clinica, 1971, 19: 161-170.
assessed in the casualty department. He did not have to fight for resources, as had some early pioneers. As already mentioned he supported PPC. While he believed the ideal geriatric department was 'age related' to serve patients over 75 years, with younger patients admitted as appropriate, he realised some geriatricians wanted an integrated arrangement with acute medicine. He noted that the 1977 Royal College of Physicians Report on Medical Care of the Elderly, which suggested a coming together of general and geriatric medicine, 'has only been heeded to a limited extent. A spirit of give and take is needed on both sides' (p.24 JRCPL). His service was assisted by the presence of many private nursing homes in Hastings. He increased medical staff, established good links with Guy's Hospital for house physicians and arranged to take all patients over 75 years. Together with Mr. Michael Devas he established a world-renowned orthogeriatric service. He wrote clinical papers, co-authored a textbook, The Older Patient, which went into three editions, and wrote many obituaries of earlier geriatricians. He was active in the British Geriatrics Society becoming its President 1981-4.

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The South: Professor M. R. P. Hall and Southampton General Hospital

Professor Michael Robert Pritchard Hall MD, FRCP, (1922- ), was born in Ceylon (Sri Lanka), the son of a tea planter. He was educated at Shrewsbury. He served in the Indian Army from 1940-6, and then studied medicine, qualifying from Worcester College, Oxford in 1952. After early training posts in Oxford he became senior registrar in endocrinology at the Radcliffe Infirmary. At this point he started to look for mixed general/geriatric medicine posts.

In 1962 he was appointed to Newcastle General Hospital as consultant physician in general and geriatric medicine, where he had responsibility for acute beds and two general medical wards. The aim of the appointment was to set up a geriatric service. He had only 5-6 beds/1000 for over 65-year-old people and a waiting list of over 100. He tackled the list by discharging patients. He found some patients had been in hospital for many years and one, who acted as a 'bookies' runner, had been an in-patient since his 13th birthday. The Hospital Management Committee thought he was cruel by discharging patients from the hospital to Part III accommodation. He responded by saying he would be happy to take back any patient who did not like his new accommodation. None took up the offer. Those nursing staff, who did not like his new approach to geriatric care, left the hospital. He had good social support and he undertook much teaching of medical students. He thought geriatric medicine was innovative and should be integrated with general medicine in Newcastle, unlike the situation at Sunderland. He worked with the local psychogeriatricians, Professor Martin Roth and Dr.
Gary Blessed. By 1967 an overall integrated system of geriatric/general medicine with eight consultants was introduced. In 1970 he was appointed professor of geriatric medicine in Southampton joining Rudd and Ashton.

Hall, working with colleagues in the mental health services for the elderly, published a paper in 1966 on the organisation of hospital services for older people. They thought the present system of in-patient services for the aged had several defects: haphazard selection of the appropriate unit for admission, delays in admission; and defective liaison between the various units admitting the elderly. They argued the current system of compartmentalised medical, geriatric and psychiatric services was not in the best interests of patients and led to misplacement of patients and delayed recovery. They supported the establishment of short stay geriatric units on the general hospital site where the patients could be physically and mentally assessed by physicians and psychiatrists. These units should be supported by out-patient departments, day hospital facilities with close liaison with the local authority and the general practitioners. Early referral should be encouraged. This was sensible because many elderly people had mixed physical, mental and social problems. 40% of patients in geriatric wards had marked mental symptoms, while a further 18% had organic mental changes of a lesser degree. In mental hospitals half the elderly

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patients had arteriosclerosis or senile degeneration, while in residential homes mental and physical disorders were common.

In 1972 he argued for improved geriatric services and community teams to support the frail elderly, which could lead to a much-reduced need for long-stay beds. He did not support the creation of consultant posts of physicians with duties only for acute geriatrics and another for the long-stay unit.\(^{135}\)

He wrote extensively about geriatric services, particularly in the United Kingdom and worked for many organisations, including the British Geriatrics Society, Age Concern, Research into Ageing, the local British Medical Association, and the Brendon Care Foundation.

**The South: Dr. H. L. Glyn Hughes and the South East Metropolitan Regional Board.**

Dr. Hugh Llewellyn Glyn Hughes, CBE, DSO, MRCS, LRCP, was senior administrative medical officer at the South East Metropolitan Regional Board. Though he was not a clinician, he considered the problem presented by the 'chronic sick' and in his 1951 article he discussed how medical care for the elderly in-patient and those on the waiting list might be improved.\(^{136}\) Prior to the 'appointed day' in 1948 many county councils centralised their waiting lists for their Public Assistance Institutions. When Regional Health Boards were set up, they divided the list, apportioning the patients to their local hospital management


committee. Surveys showed the true list was smaller than originally thought because some patients had died and some no longer needed admission. However within a short time the list began to lengthen once more as general practitioners put patients on the list, having previously thought it was a waste of time.

He suggested tackling the waiting list by classifying the patients into those who needed to be in-patients for investigation, treatment and rehabilitation, those requiring long-stay care but who still needed some rehabilitation to prevent them becoming bedfast, those who needed a long-stay annex, and last those requiring half way house accommodation where they could await discharge. He thought one medical practitioner should be responsible for the service in each hospital management committee area, which would regularly survey the patients on the waiting list and look after those being investigated. Consultants in physical medicine should look after those needing rehabilitation. An area geriatrician should have responsibility for those needing long-term care. A consultant geriatrician would be needed to coordinate the activities. Close liaison with the Medical Officer of Health, the local authority and the voluntary organisations would be necessary.

The South: Dr. S. J. Firth and Brighton General Hospital

Dr. Stanley Joseph Firth MD, DPH, (1902-1997), was born in Manchester. His mother was a nurse and his father a teacher, but after marriage they became Master and Matron of a workhouse. In this position they looked after the able

bodied and the sick, the mentally ill, maternity patients, children and the elderly infirm. Firth was educated at Manchester Grammar School and went on to qualify at Manchester University in 1925, obtaining the DPH in 1928, and his MD in 1936. His house posts include Brighton and Hastings Hospitals.

He returned to Brighton General Hospital in 1932 eventually becoming physician superintendent, medical director and in 1956 consultant geriatrician. He found general physicians had little interest in the elderly patients, especially in their social problems. He served on many non-hospital committees including the British Medical Association, the British Geriatrics Society and NALGO. He retired in 1967. Dr. Clark succeeded him.

In a 1949 paper he mused on the term 'chronic sick' patient. Apart from those with tuberculosis and malignancy, he thought it should be applied to those who had been in-patients for over six months, the senile elderly long-stay patient, the young chronic sick, and patients transferred from acute units as hopeless. The care of such patients was particularly important, especially the quality of the nurses who might be despised by colleagues for undertaking such work. Ward accommodation should be bright, cheerful and on the ground floor.

The South: Dr. A. N. G. Clark and Brighton General Hospital

Dr. Anthony Neville Gordon Clark MD, FRCP, (1924- ), was born in Yorkshire and qualified in 1948. After house posts he joined the RAF serving in the Middle East. He wrote his MD in 1951 on skin diseases and passed the MRCP in 1959. He was persuaded to enter geriatric medicine by Sir Ronald

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Tunbridge and worked as a senior registrar for Droller in Bradford.\(^{139}\) He found Droller rather daunting with his memory of patients, humanity and leadership of the rehabilitation team. He learnt much from him especially when accompanying him on a home visit. He was a consultant at Stoke-on-Trent before going to Brighton to succeed Stanley Firth.

As he looked back over his clinical time in geriatrics he mused on problems. Trained staffs and equipment were in short supply, and funds limited. Units were too large sometimes with over 750 beds, and the demand for admissions was considerable. He noted lack of recognition and status from fellow consultants and much time was taken in administration.

The spectre of the workhouse hung over the efforts of the geriatrician: older patients referred to the municipal hospital as ‘the spike’. He obtained improvements to his unit after a TV programme showed rain coming through the roof of one of his wards. The matron clearly thought this was underhand and never talked to him again; however the ward nurses were pleased. He remembered he had one patient, in an outlying hospital, who was born in a geriatric bed and never left. He personally found home visits very useful and geriatric medicine both interesting and stimulating as a career. There was such a wide range of interesting situations e.g. the Diogenes syndrome.\(^{140}\) He served on


local social service committees, which were keen not to spend much money because it meant putting up the rates.

Problems about the quality of accommodation at Brighton Hospital still existed in 1971 when the South East Metropolitan Regional Hospital Board published a Regional review. The local accommodation was well below acceptable standards. The waiting list for female patients had lengthened due to bed closures, and nurse shortages. The consultant and other medical staff lacked office space; the upper floor of some ward blocks lacked lifts and carrying patients and bodies by stretcher up and downstairs was dangerous. (figs. 7.9, 7.10)

Figure 7.9 Patient being carried down the fire escape.142

Figure 7.10 Body being carried down the fire escape.143

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141 South East Metropolitan Regional Hospital Board. Development of Services for the Elderly and Elderly Confused. 1971. South East Metropolitan Regional Hospital Board.

142 Ibid.

143 Ibid.
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Equipment ordered eight years ago had still not been delivered. Damp was coming through the walls and roofs in one ward block, which had been condemned by Brighton Corporation in 1938.

The South: Dr. I. M. Brown and Eastbourne Hospital.

Dr. Ian MacDiarmid Brown MB, (1919- ), was educated in Aberdeen and qualified in 1942 from the University. He served in the RAMC, and learnt to drive a tank while he was with the Royal Horse Artillery. Later he served with the 17/21st Lancers, then the 4th Hussars (Churchill’s old regiment). He served in Algiers and Italy in the Monte Cassino campaign, where he was nearly killed by a booby trap but was warned in time. He was with the troops when they crossed the river Po, moving with them to Venice and Trieste. Eventually he was billeted in a house in Austria, which had belonged to Hitler’s doctor. There he was shown Hitler’s walking stick, which had been given to the doctor. Brown appropriated it.

After demobilisation he became medical registrar at Eastbourne Hospital and eventually was appointed medical superintendent, when it transferred from the local authority to the NHS. The building was an old Napoleonic hospital before becoming a workhouse. He set up a day hospital, met Warren and ‘could not stop her talking’. He made a film of the work of his unit, which was shown at an international meeting. By 1991 he was the only surviving original founder member of the Medical Society for the Care of the Elderly. He became involved

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in the BGS and organised delegates to go to meetings of the IAG. He joined the British Medical Association becoming a council member in 1958, was on the council of the Medical Superintendents’ Society in 1959 and was its president in 1969. After retirement he worked as a locum geriatrician, for the HAS, and set up the local Alzheimer’s Disease Society.

The South: Dr. S. M. Vine and Reading Hospital.

Dr. Samuel Maudsley Vine MB, FRCP, (1919-), was a descendent of the founder of the Maudsley Hospital.145 His father was a veterinary surgeon. He qualified from Emmanuel College, Cambridge and Guy’s Hospital in 1943. After house posts he joined the RAMC serving in the Indian Army. He went to the Far East, Dakar, Singapore, and gave medical care to the ex-prisoners in Changi jail. He passed the MRCP in 1952. After several training posts he decided to enter geriatric medicine because he was appalled and saddened by differing standards of care between the geriatric and general medical wards in Fulham Hospital. He became a senior registrar in Brighton at a time when Dr. Firth was in post, but found it difficult to work with him. He was appointed to the consultant geriatric post in Reading where he had to fight for resources and the unwelcoming attitude of the general physicians. However the Regional officers supported him. He wrote leader articles for the Lancet. He thought geriatric medicine made a great leap forward when the Royal College of Physicians recognised it as a speciality.

The Midlands: Drs. W. Morton and E. V. B. Morton at the City Hospital, Nottingham.

Dr. William Morton (1909-1960), MD, was educated at Glasgow High School and graduated from Glasgow University in 1930, obtaining his MD with commendation in 1936. After an initial house surgeon post in Glasgow he became residential medical officer at the Withington, Manchester and in August 1939 he became its Medical Superintendent. However he left to serve in the RAMC, attaining the rank of lieutenant colonel in charge of the medical division of Chester Military Hospital. In 1946 he was appointed Medical Superintendent of the City Hospital, Nottingham and later was made consultant physician there. He was actively involved in the care of old people in the community becoming chairman of the East Midlands Old People’s Welfare Committee. He was a founder member of the Medical Society for the Care of the Elderly, was chairman of its Executive 1953-6, and treasurer 1954-6. He was president of the Sheffield Regional Group of occupational therapists and treasurer of the Nottingham Medico-Chirurgical Society. He died at the early age of 51 leaving his wife and three children of school age.

During his time at Nottingham he was the driving force behind many developments including the geriatric unit, a new theatre block, out-patient, X ray department and occupational therapy departments. In a 1952 paper he described his geriatric unit, which was set up with the approval of the Sheffield RHB. He

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set up treatment and assessment wards for the chronic sick and started a ‘holiday service’ for relatives caring for older people based on the 833 bedded City Hospital, Nottingham. He aimed to create a geriatric service along the lines proposed in the 1947 British Medical Association report. There were two geriatric wards, of 25 beds each, especially equipped with physiotherapy apparatus and supported by a team of doctors (including a shared registrar and house officer), nurses, rehabilitation staff, speech therapist, chiropodist and an almoner. A psychiatrist visited daily. An out-patient department opened but transport difficulties were encountered.

Patients were admitted as emergencies (two wards were on ‘receive’ for elderly patients two days each week), from the waiting list, as re-admissions and by transfer. Usually the patients were of pensionable age but on occasion younger patients were admitted if they had a long-term illness. However he accepted he could not take all elderly patients referred to the hospital because of the sheer numbers. Patients could be transferred, as required, from the City Hospital to the Sherwood Hospital, a joint user facility, where there were 228 geriatric beds. Initially 95% of all patients in the geriatric beds were bedfast but this figure fell to 55% at the time the article was written.

He reviewed progress over one year when 479 patients were admitted to the beds at the City Hospital, 135 were emergencies and 344 were from the waiting list. He had a turnover of 1.15 patients/bed/year, which improved to 1.42. Women had to wait between 1-8 weeks for admission, while men waited 2-10 days. Unlike others he did not carry out home visits due to lack of staff, but a social worker would carry out a social assessment if required. Approximately one
third of his patients died. A further one third were discharged but one third were still in hospital. However 6 months later only 9.6% of those admitted were still in-patients. He established good liaison with the local authority over admission to welfare beds. He reported the long-stay annex initially contained 95% bedfast patients but eventually this was reduced to 43%. He realised the earlier the timing of the discharge the easier it was to arrange.

In 1956 the pressure of acute admissions, especially the elderly in wintertime, blocked beds for waiting list patients whose number and time to admission now all increased. The ‘knock on’ effect caused some patients to deteriorate and to die at home before admission. He noted the reluctance of general physicians to admit elderly people, because ‘they fear that they will be left holding, not the baby, but the grandmother’ (p.1256). He reported some patients made rapid progress leading to successful discharge but many stayed in hospital due to lack of social service support.

Dr. Eric Vodden Bradshaw Morton MD, FRCP Ed, (1919- ), was appointed to the post of geriatrician following the death of Dr. W. Morton. He qualified in 1942, passing the MRCP Ed in 1948, and obtained his MD in 1958. He became a senior registrar in cardiology but was unable to obtain a consultant post so he took a research post at Boots. Then the consultant post in geriatric medicine was advertised in Nottingham. ‘I knew them and they knew me’ so he got the job, even though he knew nothing about geriatric medicine. The situation had

deteriorated since the death of Bill Morton. There were 600 beds in 5 hospitals with 400 in Sherwood Hospital, together with a waiting list of 300. He went on his own training course visiting Scottish services, Oxford and Ipswich. He had useful support from the Group Secretary and the medical consultants. The Professor of Medicine, Joe Mitchell, did not believe in geriatric medicine but supported Morton 'as a necessary evil'. Gradually he acquired good calibre medical, nursing and rehabilitation staff. He established good relations with the local mental health and social services. Although he enjoyed seeing patients at home he missed acute medicine and began to feel he wanted to move. He applied for several chairs including Manchester and Southampton. He left and went to India for a year under an Edinburgh University scheme. His wife wanted to live in Cornwall, so he joined Tom Wilson. This turned out to be a poor professional move and he felt isolated. He started an out-patient department, a joint assessment unit with the psychogeriatricians, an orthopaedic geriatric ward and a general practitioner vocational training scheme. Eventually beds were obtained in the main general hospital. After he retired he continued to work 5 sessions per week in the day centre and enjoyed it.

In papers of 1966 and 1968 Morton and colleagues described setting up a joint short-term assessment and early treatment unit for elderly patients with

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mixed multiple medical, psychiatric and social problems.\textsuperscript{150} The geriatricians, psychiatrists and the chief welfare officer, all had an equal access to the beds, and they managed it. The medical staff came from Sherwood Hospital, while the psychiatrists came from St. Francis Hospital. Each week a case conference was held. It was intended patients stayed in the unit for one month. During a three-month period 33 patients were admitted: one third were referred by each of the three groups. Half of the patients returned home within one month. The remainder were transferred to the appropriate speciality group. About one third had no psychiatric symptoms, 10\% had medical symptoms and another 10\% had mixed social/psychiatric symptoms.

In 1968 Morton elaborated on the joint assessment unit. 244 patients were admitted in the first 20 months of the unit. The proportion of admissions from the three groups remained the same: one-third from each group. Over half were discharged back to the community within one month. At follow up of the first 100 admitted to the unit 43 had died, 24 were in a home, 20 were independent in their own home, 6 were in a long-stay geriatric ward and 7 were in a long-stay psychogeriatric unit. Overall the unit was thought successful in managing those with mixed and complex social, medical and psychogeriatric problems. It stood as an example of good cooperation between all three services.

Quality of care of long-stay patients in institutions is questioned: the birth of the Hospital (later Health) Advisory Service (HAS)

Concerns arose about the quality of care of the elderly in hospital in spite of the advances and achievements in treatment. Major disquiet erupted when Barbara Robb, on behalf of Aid for the Elderly in Government Institutions (AEGIS), published, Sans Everything: a Case to Answer in 1967.151 AEGIS was an action group set up in 1965, concerned with the care of old people in hospitals, especially mental hospitals. The book was a passionate cry of distress at the undignified suffering of elderly people in hospitals.152 Instances of inappropriate care, authoritarian and depersonalised systems were given in wards of mental and geriatric hospitals in England and Wales and included four essays, which suggested solutions. The names of the hospitals and the complainants were at first kept secret.

The publication received wide publicity and eventually the Minister of Health was told the identity of the complainants and the hospitals concerned.153 Enquiries by special committees were instigated at hospitals in Banstead, Cowley Road in Oxford, Frien Barnet in North London, St. James in Leeds, Stortes Hill in Kirkburton, St. Lawrence in Bodmin and Springfield in Manchester. Only Cowley Road Hospital and the North Wing of St. James Hospital were geriatric


The committee structure was broadly similar. Each was chaired by a Queen’s Counsel and contained a doctor, a nurse, and one or more lay members who were from outside the region concerned. Amulree was a member of the team, which visited Banstead hospital, while Exton-Smith went to Cowley Road. The results were published as a White Paper in 1968.154

Professor John Martin, who held the Chair of Sociology and Social Administration at the University of Southampton, concluded the results of the enquiries were a disappointment to the critics. The committees considered the majority of allegations of cruelty were unfounded or were based on unreliable evidence. The complaints were considered inaccurate, vague, lacking in substance, misinterpretations or over emotional.155 The committees were often impressed by the quality of care and the attempts made to improve the ward environment. Martin noted the reports were considered a ‘white wash’, and considered it curious that deep probing of allegations was not carried out. The unnamed director of Cowley Road Hospital, presumably Lionel Cosin, was singled out for praise for his achievements in changing a custodial regime into an active geriatric unit, with 100 acute beds out of 212 beds. The reports frequently commented about the quality of nursing in spite of the old inappropriate buildings, inadequate nurse staffing, lack of equipment/resources and inappropriate administrative response. An editorial in the *Lancet* supported the need for adequate numbers of nurses, describing the ratio of one nurse to three

154 *Findings and Recommendations Following Enquiries into Allegations Concerning the Care of Elderly Patients in Certain Hospitals.* HMSO, 1968.
patients, some of whom were incontinent, as quite scandalous. The writer believed geriatric nursing was hard but if nurses were given leadership and proper equipment then the work could be rewarding. It was imperative nurse/patient ratios were improved to 1/1.25 for acute geriatric wards, 1/1.35 for rehabilitation wards and 1/1.5 for long-stay wards and one to two for ambulant patients: these levels had already been achieved at Hastings. Robb remained unsatisfied and complained to the Council of Tribunals, which rebuked the Minister but no further action appeared to have been taken.

In 1967 a further scandal occurred at the Ely Hospital in Cardiff in a unit for the mentally subnormal. A nursing assistant made a number of specific allegations of cruelty to patients, and pilfering of their food and property. Geoffrey Howe, Q.C., chaired the enquiry in 1969, which confirmed the allegations and reported that the whistle blower had been victimised. When the scandal broke, according to Martin, the Secretary of State, Richard Crossman, thought he had been caught out because he had no inspectorate to warn him of bad performance. He was therefore politically ‘at risk’. However it transpired that the Department of Health had known of the problem but nothing was done.

155 Martin J. P., op. cit., note 152.

156 Editorial, “The Vulnerable in Hospital, Lancet, 1968, 2: 273

157 Smith B. J., “The Deployment of Nurses in Geriatric and General Wards,” Gerontologia Clinica, 1965, 7: 44-50. She listed the main factors influencing staff allocated to wards: type of ward (sex of the patients and the type of their illness), size of the ward (small wards were extravagant of staff), rate of turnover, General Nursing Council requirements, regional nurse establishments and nurse morale. She considered geriatric nursing was one of the most exacting and highly skilled branches of nursing.

158 Martin J. P, op. cit. note 152.
This led Crossman to create the Hospital Advisory Service (HAS) in 1969, which was to act as his 'eyes and ears' in geriatric units and psychiatric hospitals, but would not investigate individual complaints.\(^{160}\) It was to be responsible only to him and was to be independent of the Department. Visits to hospitals started in 1970 and were carried out by teams of 'in post' professionals: consultant geriatricians or psychiatrists, senior nurses, paramedical staff, administrators and later social workers. It is best considered as a form of 'peer review'. The hospital visits lasted one to three weeks and reports remained confidential to the unit concerned, although many years later reports were made public. Later the Service was renamed the Health Advisory Service when it took on a social/community component.

\(^{159}\) Martin J. P., op. cit. note 152.

Chapter Eight

The Role of the Medical Officers of the Ministry of Health

Introduction

In this chapter I review the input of those Ministry medical officers, who were concerned with the care of the elderly, and relevant Ministry’s publications.

The Ministry of Health and its medical officers took action before, during and after the Second World War targeting the hospital care of the ‘chronic sick’. Before the War, health care was reorganised with control of Poor Law infirmaries passing to the local authorities; health surveys were carried out to satisfy the Ministry that the authorities were achieving a reasonable standard of efficiency in their hospitals; and doctors were exhorted to classify patients and improve standards of care. During the War the Ministry published a document recommending educating doctors about the chronic sick. After the War, Amulree and Sturdee at the Ministry publicised the plight of the chronic sick and bedfast,

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2 An example of bad medical practice relating to totally inadequate diagnosis is mentioned in Chapter Three, (p.56).

emphasising their plight could be reversed and bed requirements reduced.\(^4\) Their words were supported in a 1949 \textit{Lancet} editorial: ‘the plight of old people is one of the biggest and most embarrassing problems facing the National Health Service’ (p.740).\(^5\)

**The Men from the Ministry of Health**

The main impact of the medical officers of the Ministry of Health occurred after the Second World War. Several are associated with the development of geriatric medicine: Dr. (later Professor) A. L. Banks, Dr. E. L. Sturdee, Lord Amulree, Dr. C. A. Boucher, Admiral J. M. Holford and Sir George Godber.

Dr. Arthur Leslie Banks MD, FRCP, DPH, Barrister-at-Law, (1904-1989), qualified in 1926 from the Middlesex Hospital.\(^6\) After completing house posts he joined the medical service of the Post Office and then the Greater London Council. In 1937/8 he moved to the Ministry of Health where he was Regional


Medical Officer in the Eastern Region. One of his main functions was to organise care of refugees from bombed areas of London. While he was working for the Ministry he studied law and was called to the Bar. By 1947/8 he became a Principal Medical Officer. He left the Ministry when the Regius Professor of Physic at Cambridge, Sir Lionel Whitby, invited him to take the Chair of the newly established Department of Human Ecology.

In 1945 he wrote a paper entitled *The Care of the Infirm and the Long-Stay Patient*. For background information, he visited Warren and Mrs A. V. Hill, who organised homes for old people in North London. He recognised putting elderly people in bed for any length of time was likely to induce 'bedfastness'. He restated the need to classify patients and avoid attaching labels to them, since this inhibited constructive thinking about diagnosis and/or investigations. Preliminary investigations and treatment should be in a general hospital. He deprecated the practice of segregating so called 'chronic sick' patients in the infirmary wards of Poor Law institutions. Those who required long-stay care should be in special wards, separate from those who were dying. He reviewed hospital wards, equipment, lighting, flooring, day rooms, hostel provision for the 'chronic sick', and care in the home. He was keen that staff of general hospitals should readily admit and treat the infirm. He reiterated the need for rehabilitation, correct diet for long-stay patients, home helps and meals on wheels.

Dr. Edwin Laurence Sturdee, CBE, MRCP, DPH, (1886-1962), was a principal medical officer at the Ministry of Health. He came from a naval family, being a nephew of Admiral Sturdee, the victor of the First Battle of the Falkland Islands. He qualified from Bart’s Hospital in 1910. After house posts he became Medical Officer of Health at Exmouth and Exeter. During the First World War he served in the Royal Navy as a temporary surgeon lieutenant, writing three papers on infectious disease topics. He received the OBE for his war service. In 1920 he obtained the DPH, joined the Ministry of Health and worked on the investigation of an outbreak of typhoid fever in Croydon in 1937. Initially he was in charge of general public health and medical intelligence. Later he took great interest in geriatric medicine. He was a popular, good natured, able medical administrator and was described as ‘handsome, sympathetic and accomplished’ (Lancet). He retired in 1951. He was appointed CBE for his work in epidemiology and public health.

Sturdee, with Lord Amulree as his assistant, made the presentation to the Parliamentary Medical Committee in 1946. This emphasised the need for early admission of sick elderly people for diagnosis and treatment, which could help

8 In 1914 Admiral Von Spee’s modern armoured cruisers, the Scharnhorst and Gneisenau, defeated Admiral Cradock’s cruiser squadron at the Battle of Coronel. The tables were turned when Admiral Sturdee’s squadron with two modern battle cruisers, the Inflexible and Invincible, sank the German ships. Another member of the Sturdee family, later to become a Rear Admiral, served on the Exeter during the Battle of the River Plate in 1939. Anonymous, "Obituary of E. L. Sturdee," British Medical Journal, 1962, 2: 1691. Anonymous, "Obituary of E. L. Sturdee," Lancet, 1962, 2: 1335.

9 Amulree and Sturdee op. cit. note 4. At the time Sturdee must have been aware of the work of Marjory Warren, either directly or from Bank’s report, although she is not mentioned in the published summaries. Certainly Dr. Tony Clark thought Sturdee introduced Amulree to Warren. Clark A. N. G., The History of Geriatric Medicine, in, Effective Geriatric Medicine: a DHSS, Harrogate Seminar 1982, Unpublished. 1983.
prevent chronic illness. The types, design and staffing of accommodation required for the elderly outside hospital were reviewed. Sturdee noted a number of interested persons wrote letters and articles to the Press on the subject.\textsuperscript{10} Overall he thought the Parliamentary Presentation made ‘the work of medical men who were trying to improve the treatment of chronic disease...known’ (p.360) and the result was perhaps greater than the ‘somewhat elementary account of the subject deserved’ (p.360). In this paper he reviewed the care of the aged and destitute from the 1550s to the 1940s. He recorded 70,000 beds in England and Wales were occupied by the chronic sick.

Sturdee continued to write about the elderly. In another 1947 paper he drew attention to the growing proportion of the elderly and that more elderly chronic sick patients were seeking admission to hospital.\textsuperscript{11} He urged the public to realise many such patients could be treated and improved. Every hospital should admit them to enable medical students to be given relevant teaching. In 1948 Sturdee wrote again of developments in geriatric medicine including maintaining good health, old people’s clubs, and changing housing needs as people grew older.\textsuperscript{12} He asserted ‘plans for the elderly must show not only a proper spirit of charity but also an appreciation of the contribution that the older age groups can still make to the world’ (p.405).


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Sturdee helped to bring the early pioneers of geriatric medicine together and was chairman at the inaugural meeting of the Medical Society for the Care of the Elderly. Howell commented in 1974 that Sturdee encouraged all doctors interested in the speciality to visit each other. He thought that, without the encouragement and support of the medical officers in the Ministry of Health, geriatric medicine would not have become recognised, nor could the present national network of geriatric units have been established.

The next influential figure in geriatric medicine was Basil William Sholto Mackenzie, Lord Amulree. As mentioned earlier he joined the Ministry of Health in 1936 where he worked on the delivery of cancer services for three years and, in 1939, was the author of an official report on the adequacy of the treatment of cancer patients. Later he worked on the health risks associated with living for periods of time in air raid shelters. As war approached he was directed to the care of the ‘chronic sick’ in Public Assistance Institutions. This brought him into


14 More career and personal details are given in The Amulree Years: Chapter 6, (p.152).
contact with Warren, Cosin and Howell. According to Sir George Godber, Chief Medical Officer 1961-73, Amulree became their most trusted ally in the Ministry. He left the Ministry in 1949 becoming consultant physician at UCH and St. Pancras Hospital. Kenneth Robinson, a former Minister of Health, considered Amulree helped to put geriatric medicine ‘on the map’.

It could be argued that the 1946 Parliamentary Presentation by Amulree and Sturdee was the spur to a stream of publications and reports relating to the medical care of the elderly. Before its publication in April 1946 only one specific article about the care of the elderly infirm/geriatric medicine, the Bank’s report, and two monographs on medical problems of old age were published in the U.K. After the Presentation many articles, letters and editorials appeared, the British Medical Association formed a committee to report on the care of the old and

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infirm, and the Medical Society for the Care of the Elderly (the forerunner of the British Geriatrics Society) was set up.\textsuperscript{19}

Dr. Christopher Anthony Boucher OBE, MA, DM, DPH, O St J, was the next influential medical officer at the Ministry of Health. He qualified in 1934 from Oxford and Guy's Hospital. After house posts, he was appointed assistant Medical Officer of Health at Shoreditch. Later he became medical director of the Ministry of Health's Mass Radiography Unit, eventually becoming a Principal Medical Officer. His interest in older people began in the late 1940s, but his main contribution to clinical geriatric medicine was the \textit{Survey of Services Available to the Chronic Sick and Elderly}.\textsuperscript{20} He died in 1981.

In 1949 Boucher highlighted the problems faced by society and the aged as the numbers of elderly people increased and became more dependent on a decreasing proportion of younger people.\textsuperscript{21} The prime need was for earlier intervention and prevention of disorders and disease in older people, which could prevent the development of chronic diseases. Improved cooperation and collaboration between organisations with responsibility for the old was needed:

\textsuperscript{19} In 1946, after the Presentation to the end of that year, there were articles by Amulree and Warren, and editorials in the British Medical Journal and \textit{Lancet}. In 1947 articles were published by Cosin and Howell, the BMA Committee made its first report and the Annual Report of the Ministry of Health mentioned the work of Amulree and Sturdee. In 1948 articles were published by Amulree, Cosin, Howell, Warren, Brooke and Sturdee, editorials appeared in the \textit{Lancet}, Sheldon published his book on \textit{The Social Medicine of Old Age} and the first \textit{Annual Report} of the NCCOP appeared. In 1949 Andrews, Boucher, Brooke, Exton-Smith, Howell, Lowe, McEwan, Warren, and Wilson published articles and letters, many editorials appeared in the \textit{Lancet} and Professor Thomson gave the Lumleian lecture at the RCP.


the arrangements at St. Helier Hospital in Carshalton were singled out for praise as an example of good practice. As an instance of a possible prevention target he mentioned that 4,000 elderly people died each year following accidents in the home.

He expounded on a plan for older people in a *Lancet* article in 1949.\(^{22}\) Pensioners should carry on working if they felt so inclined. He was concerned that acutely ill elderly people would not be admitted to hospital because of a bias against old age, and general practitioners did not have the time to give adequate attention to the older person. He acknowledged it was difficult to discharge some old people from hospital because of lack of suitable accommodation and full nursing homes. The problem posed by frail ambulant older people, who were neither ill nor healthy, required attention.

He realised the early enthusiasts for rehabilitation in the former local authority hospitals had made considerable advances, resulting in about half the patients being discharged. However he wrote 'it is believed that about one third of all old people in the country fall ill every year, and need the services of a doctor; yet only a very small proportion of those suffering from treatable conditions ever reach hospital'.\(^{23}\)

The solution lay in several areas. First, full co-operation and collaboration between the hospital staff, the local Medical Officer of Health, the local authority services and the general practitioners were needed. Second, the geriatrician


\(^{23}\) Ibid, p.745.
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should have a joint appointment with the RHB and the local authority, which could improve transfer of patients/clients between hospital wards and the welfare homes. However the appointment required the local authority to have suitable, adequate accommodation. Last, prevention of chronic illness required attention.

He was troubled about professional medical attitudes towards geriatric medicine and geriatricians. The word 'geriatrician':

suggests...the creation of a new speciality, which has already roused suspicion, though those who are most suspicious may also be those who in the past have ignored their responsibilities. It is doubtful whether such a speciality would attract specialists of the highest academic rank; other things being equal, such doctors will prefer appointments as general physicians in which they will see cases of greater variety and interest, besides getting quicker results and more mental stimulation and satisfaction.\(^{24}\)

While he was unsure about a new speciality of geriatric medicine, he was clear the ‘physician for the elderly’ should have passed the MRCP examination, have understanding, enthusiasm for the elderly and ability to co-operate with colleagues.

In 1957 the *Survey of Services Available to the Chronic Sick and Elderly*, a text of 55 pages, was published. It followed from the Ministry of Health's decision in 1954 to survey the services for the physically chronic sick in England and Wales, to discover where and in what way services might be improved and deficiencies corrected. It was the first attempt on a national scale to assess the quality of services, (hospital, local health authority services, welfare authority and voluntary services) available to the growing population of old people, and to draw conclusions from the assessment.

The introduction reiterated the critical findings of the wartime surveys. After the inception of the NHS the demand for admission by chronic sick patients increased, especially in the summer of 1948. The size of the elderly population was changing. In 1901 only 1 in 25 people were over 65 years, but by 1954 this figure had become 1 in 9, and it was predicted to increase to 1 in 7. The one night census by Abel-Smith and Titmuss was noted, which showed elderly people with a living spouse were less likely to be admitted to hospital than those without one.

The study, carried out between 1954 and 1955, collected data and examples of good practice. For the sake of clarity, Boucher accepted a geriatric unit was

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one where active treatment and rehabilitation took place. Differences in interpretation regarding the responsibilities of hospital and local authorities were found e.g. elderly people might be thought fit for discharge from hospital but the medical officer of the welfare authorities might disagree, and vice versa.

The survey found 9,833 patients were awaiting admission to chronic sick/elderly beds with demand highest in the winter months. However the numbers were inaccurate because some patients had died, some had recovered, and others had left the district. General practitioners sometimes put patients on the list after pressure from relatives, or in anticipation that the person’s condition might deteriorate in the future. Some elderly people were put on the list without their knowledge. Sometimes general practitioners failed to put patients on the list because they had given up hope of ever obtaining admission. The only accurate way of assessing the true size of the list was a home visit. This could be time consuming and was sometimes resented by the general practitioners who thought their judgement was being questioned.

Data collection showed there were 56,010 beds for the chronic sick: 54,737 provided by the NHS and 1,273 provided under contractual arrangements with private and voluntary homes. This equated to an average of 11.2 beds/1000 for those over 65 years, with a range of 6.1 in the North West Metropolitan region to 14.0 in Oxford and Leeds. The proportion of those over 65 years varied with an overall figure of 11.5% for England and Wales. The quality and quantity of

27 In the 1970s there was argument about the definition of what was a ‘geriatric bed’. It was agreed it was one for which the consultant geriatrician had responsibility.
ancillary hospital services and the adequacy of welfare home accommodation also
varied across the regions.

No correlation could be demonstrated between the number of chronic sick
beds and the adequacy of the service provided, indeed the presence of many beds
did not automatically ensure a good service for the sick elderly person:

In a large city in another Region the proportion of chronic sick beds
was higher than in any other group in the Region, and considerably
higher than the national average; the beds were plentifully staffed
by doctors, nurses and ancillary staff, and a consultant geriatrician
was in charge; the welfare accommodation was generous, and the
local authority provided excellent domiciliary services supported
by an active Old People’s Welfare Committee and other voluntary
services. This city showed the longest waiting list in the Region
and gave evidence of an unsuccessful hospital service for the
chronic sick (p.15).

On the other hand some units with comparatively few beds provided an efficient
package of care. Boucher reported bed turnover (assessed using deaths, transfers
and discharges) gave a national range of 1.4-2.7 patients/bed/year. High turnover
was associated with high mortality. Some units had a very high turnover e.g. 5.6
in Sunderland, where Olbrich re-admitted patients six to seven times a year.
Boucher thought length of stay might be a better way of assessing efficiency. He
concluded it could not be assumed more hospital beds for the chronic sick were
needed. Furthermore:
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the success of the available services depends much on the personality of the doctor in charge and on his appreciation of the sociological factors...the remedy for an inadequate service is not always an increase in beds because too often a generous provision appears to result in stagnation and apathy (p.15).28

Discharge difficulties, out-patient department and day hospitals were assessed. Geriatricians classified nearly 4,500 patients as fit for discharge. However some were unwilling to leave hospital, and some relatives refused to help. Frail elderly patients, who did not need hospital care but required considerable help with dressing, feeding and toileting, were unacceptable to welfare homes. One possible solution was the 'half way' house, some of which had been funded by the King Edward's Hospital Fund.29 However these facilities were for continued treatment and rehabilitation, leading ultimately to discharge and not for permanent residence. Some geriatricians used them as accommodation for those awaiting placement. Few out-patient departments were in operation. He concluded it was too early to give a firm opinion of the value of day hospitals.

Poor quality hospital buildings, usually in former municipal hospital or Public Assistance Institutions, were reported. Some had no lifts, were poorly

28 Dr. Baker, the first Director of the HAS, supported this view in 1970, 'the most important single aspect in determining the effectiveness of geriatric and sick services is the attitude of senior staff and management' (p.23, para 80). Baker A., Annual Report of the National Health Service Hospital Advisory Service for 1969-1970. London: HMSO, 1970.

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decorated, with inadequate heating, lighting, baths, sluices and day areas. Some premises were not on the main district hospital site.

Boucher discussed the attitude of general physicians towards geriatricians, for he had gained the impression ‘geriatricians were regarded as medical practitioners of a clinical calibre who could not always claim equality with other consultants.’ Those arguing against the new speciality thought almoners could solve social problems and the general physician could manage rehabilitation. Considerable prejudice against consultant appointments in geriatric medicine and ignorance of the value of rehabilitation was reported. One group with 447 chronic sick beds had no resident medical officer and the physician in charge did not believe in geriatrics. In another case a group with 417 patients was in charge of a physician who was more interested in paediatrics and had not visited his long-stay unit for a long time. In other areas beds were in charge of general practitioners, a paediatrician, an obstetric/gynaecological specialist and an anaesthetist. However where a geriatrician was appointed the service improved and many geriatricians had achieved remarkable results attracting the interest of general physicians.

Staffing of geriatric units was assessed. Boucher found a shortage of nurses in chronic sick wards with an average of 3.3 beds/nurse (a range of 2.3-4.5). Indeed the deficiency resulted in the closure of 350 chronic sick beds. The reasons were probably multi-factorial: poor working conditions, slow turnover of patients, frustration due to bed blocking and tiring unpleasant work. Student nurses were not given experience of chronic sick wards. Hospital physiotherapy
services were usually adequately staffed but occupational therapy, chiropody and almoner services were under staffed.

Local authorities provided a range of services to the 95% of the elderly population who lived at home, some of whom lived under conditions of great hardship. Health visitors made about one million valued visits annually to old people, where they acted as liaison between hospital and the patient at home. They gave advice to the aged about diet, hygiene and general care, but staff shortages limited their activities. Nearly half of all visits made by home nurses were to the elderly, and over one third of visits to the home nurse were made by the aged. These nurses reported lack of notice of discharge and poor liaison between the hospital, general practitioners and home nurses. Some patients were discharged prematurely and should still have remained in hospital. In 1954 32,000 home helps attended 204,992 cases, 62% of whom were over 65 years. The duties performed included housework, washing clothes and writing letters. The service was sometimes confined to ‘office hours’ and limited by lack of staff. Local authorities maintained their service-masked deficiencies of the hospital service.

Data collection showed 64,886 beds were in local authority accommodation. However census returns for the night of 1st January 1955 gave a figure of 69,162 residents of whom 49,513 were elderly. The disparity was explained by the survey figures being taken over a period of time, while the census was a one-point-in-time study. 10,000-15,000 elderly people were living in homes provided by voluntary organisations. Thus there were 1.5 beds/1000 population with a range of 0.5-2.5. More of those admitted were increasingly physically and
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mentally frail. The waiting list of 7,354 represented the equivalent to one person for every nine beds, but as usual the total was probably inaccurate, because it related to the person making the assessment, e.g. the district welfare officer (who often was the ex-relieving officer), or the assistant Medical Officer of Health. Some welfare homes had sick bays. A number of homes were considered inadequate; some lacked lifts or were unsuitable for the frail ambulant. Those managing welfare homes considered some residents were suitable for hospital admission and were reluctant to admit elderly people who had been discharged from a mental hospital.

Voluntary organisations and local authorities provided a range of services. The former provided services including home visiting, meals on wheels, physiotherapy, old people’s clubs, and a collection package or a launderette service. Some local authorities provided night attendants but the need appeared over estimated. The local authority laundry service was valued but commercial laundries were not keen to take on such work, collection of soiled material frequently posed problems and articles were often in a poor state.

Boucher noted lack of liaison and cooperation between and within individual services and main providers. Individual services developed projects in isolation without consulting other concerned organisations. Some geriatric units thought they were the complete solution to the problem and under-rated the value of the local authority and the difficulties they faced. In some places the hospital and local authority appeared to ignore each other. Liaison committees did not always help.
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Boucher judged the number of beds for the chronic sick in England and Wales were sufficient if correctly used and distributed.\textsuperscript{30} He did not recommend a bed/1000 population figure although the regional average was 11.2/1000 for the over 65 years.\textsuperscript{31} He thought good rehabilitation, adequate local authority accommodation and social service support could result in the 'saving' of 4,500 beds. He accepted that waiting lists for hospital rarely reflected true demand, and bed turnover/occupancy rates did not necessarily reflect efficient usage.\textsuperscript{32} Many geriatric facilities were not on the main hospital site and the quality of this accommodation was often poor, although some improvements had been made.

He viewed the appointment of a good clinical consultant geriatrician, with knowledge of social factors and statutory services, as more likely to be successful than a general physician with an interest in the elderly. These geriatricians would need adequate junior medical staff, ancillary and social services support, combined with effective liaison between services.

Commentators had mixed views of the report. Webster thought it gave information and a fair account of geriatric services, but was thin on statistics relying on impression and anecdote rather than quantitative methods.\textsuperscript{33} Bridgen


\textsuperscript{31} The ratio of 10/1000 over 65 years comes from the Ministry of Health. \textit{A Hospital Plan for England and Wales}. London: HMSO, 1962.

\textsuperscript{32} A study of the demand for hospital beds in Teeside supported the view that waiting lists were unreliable as a means of assessing bed requirements. Airth A. D. and Newell D. J., \textit{The Demand for Hospital Beds - Results of an Enquiry on Tees-Side}. University of Durham, 1962.

thought the report revived the Ministry of Health’s limited interest in the elderly, which seemed to have lapsed following the departure of Amulree to UCL.\(^3\)\(^4\) Bridgen maintained the report’s recommendation that ineffective geriatric services were due to inefficient bed usage rather than lack of beds, was inconsistent with the evidence. He seems to have ignored Boucher’s caution in deciding what was the most appropriate number of beds for a geriatric unit, bearing in mind local facilities, problems and the ‘drive’ of the geriatrician.

In 1963 Boucher presented a paper to the IAG in San Remo, Italy entitled *Trends in Geriatric Hospitals in Britain*.\(^3\)\(^5\) He reviewed the growth of geriatric medicine since the days of Warren. The hospital surveys carried out towards the end of the Second World War found evidence of poor accommodation for the chronic sick. In 1947 the British Medical Association called for the creation of geriatric units to carry out proper investigation and treatment of these elderly people. Progress was slow, but by 1963 there were 145 units with six in teaching hospitals in London and the provinces. The number of geriatric beds had remained more or less constant, but patient throughput had increased from 2.55 in 1961 to 2.67 in 1964. The Hospital Plan of 1962 reinforced the government’s view of the need for a geriatric unit in every district general hospital.\(^3\)\(^6\) Overall


the current national total of 58,701 beds represented 10.2 beds per 1000 population over 65 years, which was in line with the ratio recommended in the Hospital Plan of 10/1000. The emphasis was on effective use of existing beds rather than acquiring more. The Minister of Health had asked Hospital Boards to ensure that adequate resources, including all necessary medical, nursing and rehabilitation staff, were provided. There was good scope for teaching and research. Increasing use was being made of out-patient departments and day hospitals. He supported the idea of psychogeriatric assessment units and closer cooperation between the two specialities, which could obviate the 'common experience that geriatric units care for some patients with mental changes about which they have had little experience, to the detriment of the patients themselves and others in the geriatric wards' (p.693). He noted the majority of admissions to the geriatric wards were from general practitioners, while about 20-25% were transfers. Bridgen considered Boucher was still dominant in the Ministry of Health in the 1960s resisting any change in policy towards geriatric beds.37 Sheldon summarised the work of Boucher saying he 'knew every geriatrician personally, was persona grata to all, and did a great deal to further the development of the speciality'.38

37 Bridgen P., op. cit. note 34.
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In 1970 Admiral John Morley Holford, CB, OBE, FRCP, (1909-1997), a senior principal medical officer of the Ministry of Health gave a personal opinion of the geriatric services in the seventies.39

The general principles were the same. The day hospital was now accepted as an essential part of the geriatric unit, and psychogeriatric units for assessing mentally confused patients were also supported. The disadvantage of bed ‘norms’ was that the geriatric service tended to adapt itself to what was provided rather than organise itself to reflect needs. He hoped more local authorities would take preventive action and assess those needy, apathetic and deprived people who failed to request help. He viewed geriatric medicine as deprived of resources.

Sir George Godber, MD, DPH, FRCP, Chief Medical Officer 1961-1972, maintained a strong interest in the care of the elderly and geriatric medicine40.


He was born in 1908, the son of a farmer, and educated at Oxford and the London Hospital Medical School qualifying in 1933. From his medical student days he always wanted to enter public health medicine. After completing his DPH he was appointed Assistant County Medical Officer in Surrey. He joined the MOH in 1939, where he learned much about the elderly and found most doctors knew nothing about Public Assistance Institutions.

His knowledge of the chronic sick and the elderly started during the war. He was chosen at the age of 34 years to be a member of the Sheffield hospital survey team, which gathered information for the forthcoming NHS. He noted the rivalry between the Public Assistance and Public Health Committees for control of the infirmaries. Hospitals, which received evacuated patients during the war, found some could have been treated but had been ignored. He was aware of the work of Warren, Howell, Brooke, Cosin, Andrews and others, remaining in touch with them both formally and informally. He considered geriatric medicine had developed from almost nothing and was 'internal medicine played slowly with a

strong social bias' (p.92). He paid tribute to these early workers: 'the most striking change was the development of geriatrics, and later psychogeriatrics, which showed how much could be done for the group of people long lumped together and neglected as the 'chronic sick' (p.290). However:

There are those who do not seem to realise that it [geriatric medicine] has occurred at all, and it is fair to give credit to the pioneers of geriatrics whose example has given hope of recovery or at least to a measure of independence for many old people who would formerly lived out a meagre, inactive existence in a hospital ward (p. 39).44

He knew which hospitals and which doctors were trying to improve the situation, and considered the Boucher report was more a commentary on the current state of care of the elderly rather than a great future plan. A major problem was shortage of funds for capital development.

He tried to influence the work of consultants in his administrative roles. He was secretary of the Committee, which produced 'The Development of Consultant Services' in 1950.45 He was also chairman of the Committee on


Consultant Establishment and therefore could influence appointments in geriatric medicine. Although he considered Warren’s achievements were not well known amongst the general physicians at this time, he encouraged RHBs to make consultant appointments in geriatric medicine. Some regions were better than others. The London Teaching Hospitals were, in general, very slow to introduce geriatric medicine into their hospitals. He developed a good grasp of what was happening in geriatric medicine and what was required.

He realised the profession had to be persuaded to change, even though there was support from some of the Presidents of the Royal College of Physicians such as Lord Platt, Lord Rosenheim and Sir Raymond Hoffenberg. He took a pragmatic approach to persuasion:

Now you’ve got a profession that has to develop a policy...[and]...has to be persuaded to develop in a particular way. If you want to be blocked then you go bull headed at it and say ‘Stop this nonsense, produce a profession of geriatrics’. You don’t do that, you simply move them by steps which are not quite large enough for them to appreciate in the direction where you want to go...you really edge towards an outcome.

Several politicians supported the cause of old people. Kenneth Robinson urged priority for geriatric medicine. Sir Keith Joseph helped to establish

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46 Godber Sir George, op. cit., note 43.
47 Godber Sir George, op. cit note 40.
professorial chairs in geriatric medicine at UCH, St. George's Hospital and Birmingham. Enoch Powell always insisted on seeing the worst wards.

The Publications

A different way of assessing the impact of the Ministry of Health on geriatric medicine is to review the official circulars, memoranda and documents issued between 1944 and the 1980s, on the subject of the elderly and geriatric medicine. It is likely the Ministry's medical officers had input into many of these publications.

The documents started during the Second World War. In 1944 the Inter Departmental Committee on Medical Schools reported on the training of medical students, recommending that medical students should be taught on patients with chronic diseases.\textsuperscript{48} Voluntary hospitals would have to admit such patients, a practice they had previously tried to avoid. The fact the comments were reiterated during subsequent years suggests this message fell on deaf ears. In 1945 the hospital surveys were highly critical of accommodation for the chronic sick.\textsuperscript{49} In 1947 the Ministry of Health issued circular 49/47 for improving of existing public assistance services for aged persons, particularly those in homes for reasons other than ill health.\textsuperscript{50} It foreshadowed the changes in the 1948 new legislation. In 1948 the National Assistance Act, and a subsequent NHS


\textsuperscript{49} Nuffield Provincial Hospitals Trust. \textit{The Hospital Surveys}. Oxford: Oxford University Press, 1946

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publication, contained a classification of the 'sick' and 'infirm'.\textsuperscript{51} In 1950 the Ministry issued two circulars about the treatment of the elderly mentally infirm and the chronic sick.\textsuperscript{52} The first supported short-term admission to a psychiatric assessment unit for diagnosis and treatment, which could avoid certification under the Lunacy Act. The second referred to setting up an effective geriatric service, the need for investigation and treatment, accommodation outside the hospital and adequate domiciliary services. Further documents appeared in 1950. One related to the development of consultant services. It reminded consultants they would be expected to care for the chronic sick.\textsuperscript{53} Admission to wards for the chronic sick should always be by way of the wards or hospitals for acute cases. In 1951 another circular considered the problem of emergency admission, especially of the elderly, and recommended establishing a bed bureau.\textsuperscript{54}

Boucher's report paved the way for two circulars, which reviewed the range of geriatric services provided by the NHS and the local authorities.\textsuperscript{55} Circular HM (57) 86 pointed to the value of the out-patient departments, day hospitals

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\textsuperscript{53} Ministry of Health. op. cit., note 45.


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especially those for the elderly mentally infirm, in-patient services, classification and treatment of the elderly sick, holiday admissions, rehabilitation services, management of the waiting list and arranging smooth informed discharge of patients into the community. The Ministry took the view it was not possible to recommend any particular number of beds per head of population, because of local factors, although it appeared that a geriatric unit with 1.2 beds/1000 population could be effective. In other words there needed to be more efficient use of beds. The circular discussed the management of geriatric departments, concluding with the comments:

The survey suggests, at least, that in too many cases where large departments for the elderly sick are in the charge of general physicians whose main responsibilities lie elsewhere, much of the work has perforce to be left to juniors and that such departments are usually less successful than those in the charge of a specialist geriatric physician (p.6). Hospital authorities should give high priority in the allocation of their resources to the establishment in every hospital centre of a geriatric department under the charge of a specialist physician, whether a general physician with a special interest in the subject or a physician working only in this field, and full supporting services (p.7).

The Minister recognised the lack of candidates to fill the necessary consultant posts in geriatric medicine but this was not to be taken as an excuse to fail to improve services for the chronic sick. The geriatric department should provide investigation, treatment, rehabilitation, and be properly staffed. The value of
holiday admissions was reiterated, and the requirement for a smooth and continuous flow of patients between hospital and Part III accommodation. Home visiting of patients on the waiting list was commended. Poor discharge arrangements came in for criticism: ‘the minister has on many occasions drawn attention to the importance of notifying general practitioners when their patients are discharged’ (p.10), and the Medical Officer of Health should be informed if the patient lived alone or was likely to need domiciliary services. The circular called for the young chronic sick to be cared for in accommodation separate from the older chronic sick person.

Circular HM 14/57 defined the division of responsibility between the local authorities, and the hospital authorities. No clear statement was made concerning the frail ambulant who needed long term help with dressing, toileting and washing, and who were not considered fit enough for a welfare home. On the other hand it said ‘it is not regarded as the responsibility of the hospital authority to give all medical or nursing care needed by an old person, however minor the illness or however short the stay in bed; nor to admit all those who need nursing care because they are entering upon the last stage of their lives’ (p.2). Improved co-ordination and integration of all local authority services was recommended.

56 This nettle was grasped in 1965 when a Ministry circular, HM (65) 77, stated ‘the elderly people whom local authorities may need to admit to or to retain in homes can be broadly defined as those who are found, after careful assessment of their medical and social needs, to be unable to maintain themselves in their own homes, even with full support from outside, but who do not need continuous care by nursing staff...some incontinent residents...may also be manageable in a residential home.’ (p.3 para 5) Ministry of Health. Care of the Elderly in Hospitals and Residential Homes. H.M. (65) 77. London: Ministry of Health, 1965.
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The subject of hospital geriatric departments reappeared in the 1962 Hospital Plan, and later documents.\(^5\)\(^7\) This plan visualised a 10-year hospital building programme. As already mentioned it established the geriatric bed norm of 10 per 1000 people over 65 years, with emphasis on more effective use of existing beds rather than acquiring more.\(^5\)\(^8\) The Minister of Health asked Hospital Boards to ensure that adequate resources, including all necessary medical, nursing and rehabilitation staff, were provided for the geriatric service. In the mid 1960s the Ministry of Health issued a document, which referred to the care of the elderly in hospital and residential homes, 'It should be the object of the hospital authority to provide as soon as possible in every area an effective hospital geriatric service' (p.4).\(^5\)\(^9\)

In the early 1970s the DHSS published documents which considered the psychogeriatric patient, the quality of accommodation of those in residential care, and the requirements for a geriatric service and day hospitals.\(^6\)\(^0\)

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\(^5\)\(^7\) Ministry of Health, op. cit., note 31.


reiterated the advice given about psychogeriatric assessment units suggesting one unit for each district general hospital. In 1971, DS 329/71 detailed once again the functions of in-patient and out-patient services of a geriatric unit, access to diagnostic facilities, beds, and a day hospital. The census paper related to those in residential accommodation and noted ‘the local authority had many more mentally confused residents particularly in the younger age groups’ (p.35). DS 95/72 set minimum standards for geriatric units including medical and nursing staff. In 1974 the Central Office of Information issued the Care of the Elderly in Britain, which reviewed topics including financial support, employment leisure activities, and health aspects.\textsuperscript{61} In 1981 the Department of Health and Social Security issued guidance about the roles of general and geriatric medicine.\textsuperscript{62} Again current policy requirements for a geriatric service, and resource allocation were reviewed. It reported 42 health districts in England in 1978 still lacked geriatric beds in general hospitals.

**Comment**

Many trenchant criticisms have been made of the Ministry of Health and, by implication, of its medical officers. Commentators have argued geriatric medicine was not a prime interest of policy markers. In 1956 the Guillebaud report on the cost of the NHS declared: ‘the older age groups were currently


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receiving a lower standard of service than the main body of consumers and that there are also substantial areas of unmet need among the elderly’ (p.40). Ruck argued in 1960 those in authority were aiming to restrain demands by restricting non-acute hospital care and increasing the emphasis on rehabilitation and domiciliary care. He argued the split between hospital and welfare accommodation meant infirm older people in institutions were shut out of the development of geriatric medicine. Webster in 1991 contended ‘the NHS failed to bring a revolution in their hospital care’ with innovation inhibited ‘by insufficient leadership from above and inertia within the system’ (p.178). He considered the Treasury was in part to blame, and thought, in some respects, the early NHS compared unfavourably with the situation in the pre-war years. Chronic and mental services received a smaller share of capital and revenue and hospitals fell into disrepair due to poor maintenance budgets. Furthermore an increasing gap developed between best practice and old style care of the chronic sick. He concluded, in spite of all the reports, enquiries and recommendations, there was still ‘the absence of a single connected review of services for the elderly [which] seemed unforgivably negligent to the social analysts of the time’ (p.174). Thane was of the same opinion: ‘when the NHS came into being, it offered no

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65 Webster C. op. cit., note 33.
clear guidelines for the treatment of old people' (p.444). Wilkin and Hughes took a similar view, arguing the NHS had failed to establish clearly defined objectives for a health service for the elderly. Bridgen in 2001 argued that health officials and many in the medical profession hampered the emergent clinical management in geriatric medicine and restricted access of elderly people to medical and nursing care. He judged 'the development of health and welfare services for older people in the early post years has generally been regarded as disappointing' (p.507). He asserted the creation of bed norms for geriatric units meant a reduction in beds where units had over the 'norm'. Here I would disagree with him. I think he missed the point that high turnover units with a small waiting list frequently operated with fewer beds than the recommended bed norms. I accept standards of care do not necessarily equate with high turnover. However high turnover units generally admitted patients by first intent, which meant they started immediately on the appropriate treatment, reducing the risk of developing chronic conditions, reducing length of stay, increasing the likelihood of successful discharge and increasing the ability to admit more patients.

In defence of the Ministry of Health, the Department of Health and Social Security and their medical staff, it must be accepted that the development of post war medical services was limited by the financial state of the country, the elderly

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68 Bridgen P., op. cit note 34.
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were low in the list of priorities and their needs were not widely understood. William Beveridge and the Nuffield Foundation both cautioned that the provision of care of the elderly had to take account of the country’s limited wealth, labour and resources. Beveridge in 1942, while acknowledging ‘the nature and extent of the provision to be made for old age is the most important and in some ways the most difficult, of all problems of social security’ (para 233), went on to write ‘It is dangerous to be in any way lavish to old age until adequate provision has been made for all other vital needs such as the prevention of disease and the adequate nutrition of the young’ (para 236).69 The Nuffield Foundation in 1947 wrote that although sympathy for the problems of ageing and the hardships for old people were widespread, it realised that the country’s wealth and labour resources were limited.70 Watkin wrote that in the immediate post war period the country went from ‘one economic crisis after another. Britain had finished the war bankrupt and in debt to America’ (p.138).71

There was another quandary: the problems of old age were not fully understood. Amulree and Sturdee wrote in 1946 ‘not only is the problem of the treatment of the chronic sick not being met, but most people do not realise that there is a problem’ (p.617).72 Years later the Director of the NHS Hospital


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Advisory Service wrote in 1984, ‘too many...health authorities remain pessimistic and uncommitted towards specialist services for old people’ (p.12). Kenneth Robinson in 1991 accepted geriatrics and psychiatry were the poor relations in the NHS.

In the face of financial difficulties, competing priorities and ignorance of the new style medical care of older people, what could the Ministry of Health do? It could only cajole because it had no executive power over the RHBs, HMCs, or individual consultants: as Sir George Godber put it, the problem was to persuade people, but if change were attempted by dictat there would be resistance. Ultimately, of course, responsibility for the NHS lay with the politicians. Enoch Powell, one time Secretary of State for Health, accepted the NHS was designed to rest responsibility for its development with politicians.

On the positive side, some observers noted improvements: the Phillips report in 1954 said ‘It is now recognised that active medical treatment in special geriatric units may enable a large proportion of such patients to return to normal

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home life or to a local authority home' (p.9, para 36). There are encouraging signs that modern methods of geriatric treatment will reduce the numbers who up till now have been retained in both general and mental hospitals. It would be premature to embark on long-term building plans for the accommodation of increasing numbers of chronic sick and other old patients in hospitals until there has been more experience of recent developments' (p.83, para 326). By 1973 Professor Exton-Smith, consultant geriatrician at UCH, considered 'the priority given by the DHSS in supporting the development of geriatric services, the interest of doctors, nurses and social workers...is increasing’ (p.24). Professor Batchelor, Professor of Psychiatry at Dundee, felt confident enough to write in 1984 ‘it [geriatric medicine] has established its expertise and has had notable success in developing and raising the standards of services for the old’ (p.46). Perhaps therefore it is reasonable to conclude that criticism of the Ministry of Health and its medical staff should be less harsh and more considerate of mitigating factors.


Chapter Nine

Effectiveness and Efficiency of Geriatric Medicine

Introduction

In this chapter I assess the efficiency of geriatric medicine using published articles and official data. Due to the 'skew' effects of patients who stay in hospital for very long periods, the value of 'average' or mean findings can be limited. Median values are therefore often of greater significance.

Measurement of bed management and effectiveness of hospital services received limited attention in the early years of the NHS. The Hospital In-patient Enquiry (HIPE) started in 1949 but did not become compulsory until 1957.¹ Thus effectiveness of geriatric units, in the formative years of the speciality, has to be assessed from articles written by geriatricians. These give limited information about bed numbers, turnover, waiting list and social service support. Data comparison is often not possible. Exton-Smith put the matter on firmer ground when he used HIPE data from the 1970s to support his contention that geriatric

¹ HIPE data samples approximately 1 in 10 of all deaths and discharges in England and Wales. In 1970 it was the only source of detailed information about in-patients in virtually all non psychiatric hospitals. It provided statistics on a continuous sample of non psychiatric in-patients, including number of in-patient admissions, duration of stay, waiting times for admission, bed use, sex, age, marital status, diagnosis, departments, regions, types of surgical operation and types of accidents. In 1970 patients aged over 65 years occupied 33,629 beds daily in geriatric departments, (with a mean length of stay of 86 days), 14,935 chronic sick beds (with a mean stay of 191 days), and 36,664 beds in other hospital departments. Keith S., "The Hospital In-patient Enquiry," Health Trends 1970, 5:13-14. Evans D., "Hospital In-patient Enquiry: 1-Methods," Health Trends, 1969, 1:16.
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medicine was pulling its weight and thus helping general medicine and the NHS hospital system as a whole.

Efficiency of Geriatric Services: Early Studies - Spectrum of Delivery of Services

Examination of published clinical data shows that a spectrum of delivery of geriatric services was developing in the early years of the NHS. At the one end were units with a long waiting list, low patient turnover and a greater than the national average of allocated beds. At the other end was the reverse: higher patient turnover, little or no waiting list and fewer beds, see table 9.1. The units concerned came from different parts of the country and covered different social backgrounds. The low turnover/long waiting list departments were in Nottingham (Morton), Cornwall (Andrews), Greenwich (Mester), Croydon (Pritchard), and East End of London (Silver).\(^2\) The Boucher (1957) and BGS (1962) surveys found similar evidence. The higher turnover units were in Camden, (Exton-Smith); Hastings (Irvine); Harrow and North Tottenham in North London (Hodkinson and Jefferys); Hull (Bagnall and his colleagues) and Oldham (Joshi

and his colleagues). The higher turnover/little or no waiting list groups were beginning to provide total medical care for all medical emergencies for pensioners. Much of the high turnover was due to discharge rather than death, in a ratio of about 2:1. The turnover was not entirely attributable to ‘recycling’ the same patients, since 85-89% of the patients were admitted for the first time. The 1962 BGS survey of 124 geriatric units showed 1 in 10 units had a turnover in the range of 4.0 - 6.75 as compared with 40% which had a turnover of 0.8-2.3. Geriatric medicine was thus beginning to move away from its role of rehabilitation towards a more acute model of care.

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Effectiveness and Efficiency of Geriatric Medicine

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<th>Low turnover units</th>
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<td>Admissions/bed/year</td>
<td>0.8 – 2.3</td>
<td>5.5 – 10.2</td>
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<tr>
<td>Discharge/death ratio</td>
<td>1.2: 1</td>
<td>2:1</td>
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<tr>
<td>Available beds per 1,000 over 65 years</td>
<td>10.4 – 11.2</td>
<td>Recommended norm: 10 (1962)</td>
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<td>Proportion still in hospital</td>
<td>28% – 63% at three months, 12% at six months</td>
<td>14% at 6 months</td>
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Table 9.1 Characteristics of low and high turnover units.4

The differences which existed between the units at the ends of the spectrum are probably due to several factors. First, those doctors practising the slower stream approach were reporting shortly after the end of the war and were probably in the first wave of post-war appointments. Those practising higher turnover were writing in a later period, about 10-30 years after the war, and probably represent later appointments. Second, the proponents of the low turnover units practised mainly, if not entirely, a rehabilitation approach to geriatric care, with few acutely ill patients being admitted by first intent. Facilities tended to be poor, staff

limited and resources lacking. The high turnover groups combined rehabilitation with admission of more acutely ill patients, who would previously have been admitted to the general medical wards. It was these patients who generally got better rapidly or died quickly. Many of these geriatricians practised some form of PPC. Moreover the Director of the HAS in 1984 commented that ‘ten years ago...geriatric services [were] isolated from the mainstream medical activity, lacking general medical beds and adequate day hospital places, without sufficient nurses, paramedical staff or secretarial support. In these hospitals expectations of patient recovery were low...It is sad to report that such units are still common place’ (p.12).\(^5\) A third factor was the availability of local facilities, social service support and the local elderly age structure. Lastly the personality and ‘drive’ of the geriatrician was most important, as Boucher noted in 1957.\(^6\)

Those operating a high turnover pointed to many advantages. The system allowed for the majority of patients to be admitted on the day of request and treatment started at once, which tended to ensure a shorter average stay in hospital, which was just over two weeks in the Hodkinson and Jefferys study.\(^7\) An optimistic attitude maintained on admission raised morale amongst the staff, patients and relatives. The absence of a waiting list meant less resistance to discharge from the general practitioners, relatives and patients, since should re-admission be required, it would be arranged immediately. Similarly a ‘trial’


\(^7\) Hodkinson H. M. and Jefferys P. M., op. cit., note 2.
discharge could be attempted with greater confidence since prompt re-admission was not a problem. The absence of a waiting list removed the need for premature referral for admission.

A high turnover unit required: an adequate number of beds with a sufficient proportion in the district general hospital; sufficient medical, nursing and rehabilitation staff; adequate investigative facilities; a clearly defined admission policy; support of the local general practitioners; good social service and community support; and probably most important of all the consultant's determination not to have a waiting list. A clearly defined admission policy was essential with no barriers to admission, such as pre-admission assessment. The department must make clear the age demarcation for admission. Patients who were physically fit but were mentally disturbed should be referred to the psychogeriatricians. Those requiring residential care would need referral to the local social services. Collaboration with medical colleagues and the orthopaedic surgeon was essential. Continuous pressure and drive needed to be applied by the consultant to prevent delays in investigations and rehabilitation.

Low turnover units tended to produce a less favourable therapeutic environment, with lower expectation of discharge. Patients and relatives might have had to wait several weeks or even a few months for admission to be arranged, and they would therefore not be keen for a discharge if they knew that

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8 The 1962 British Geriatrics Society survey showed the activity of a unit depended on having an adequate number of medical staff of all grades, while another Society report in 1968 recommended a nurse/patient ratio of 1:1.25 in the active and rehabilitation wards and 1:1.5 in the continuation ward. British Geriatrics Society. Memorandum on Nursing Staff in Hospital Geriatric Departments. London: British Geriatrics Society, 1968.
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they would have to wait a long time for re-admission, should this prove necessary. Chronic deterioration could occur while awaiting admission, and many weeks of invaluable rehabilitation time would be lost. Much depended, of course, on the age structure and health of the local population, and the quality/extent of social services, the presence or absence of local care and nursing homes, and the admission criteria for welfare homes.9

Those operating the lower turnover units criticised colleagues at the other end of the spectrum, because they thought the latter were reneging on their duties. Their particular complaint was the high turnover consultant had very few long-stay patients and if they were not looking after them, then somebody else must be doing their job. The air of the discussions got heated on occasion. For example, Professor George Adams of Belfast in 1974 referred to "the geriatric physician with a high turnover and no long-stay problem is...suspect as a gerontological spiv. Somebody, somewhere, must carry the can for him" (p.790).10 Those operating the high turnover/no waiting list system maintained they admitted potential long-stay patients, such as patients with a stroke, by first intent. This allowed immediate investigation, treatment, which could prevent a long-stay situation developing. When such patients were admitted first, say, to general medical wards then taken by transfer, it was not uncommon to find appropriate


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treatment had been belated and sluggish. The longer they waited the more valuable rehabilitation time was lost and a potential rapid discharge became a much slower one.

Alongside this developing spectrum of care was another change, which also caused great argument. This related to the way units organised their consultant teams in relation to general medicine. In Newcastle and Oxford an 'integrated' system was established. Joint medical and geriatric consultant teams were created. The combined teams looked after all admissions in jointly run wards. Professor Grimley Evans was a strong supporter of this system. However the Director of the Health Advisory service had reservations: 'there is as yet no published evidence that such 'integration' arrangements are preferable to separate well-supported general hospital geriatric wards as judged by length of stay, prevention of long term disability and avoidance of prolonged institutional care' (p.14). However in most units the way consultant geriatricians worked with general medical colleagues very much related to the local conditions: it was very much 'horses for courses.'

There were other arguments. Geriatricians maintained they had heavy workloads, which were poorly understood by the general physicians, and which limited their ability to help their general medicine colleagues. Exton-Smith in 1963 listed many duties of the consultant geriatrician: in-patient and out-patient

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work, administration, home visits, day hospital duties, consultations with other consultants, teaching, research and liaison with the local authority. Later he and Millard quoted Dr. Albert Kushlick, who defined the workload of the consultant geriatrician. The geriatrician was responsible for a catchment population covered by nearly four consultants in each of general psychiatry, general surgery and general medicine, by two consultants in trauma and by one and a half in chest diseases. He served a population covered by 100 general practitioners, 13 local authority medical officers, 25 social workers, 37 health visitors, 50 district nurses and 175 home helps. The BMA in 1976 listed the tasks of consultant geriatricians as: pre-admission home assessment visits; domiciliary consultations at the request of the general practitioner; inter unit and inter hospital consultations; out-patients, day hospital work and on-call commitment; ward rounds and supervision in assessment, rehabilitation and continuing care wards; attending multidisciplinary case conferences; collaboration with psychogeriatricians, general practitioners, community physicians, social services and voluntary associations; teaching medical staff, and paramedical staff; talks to pre-retirement associations; research; and committee work. Furthermore geriatric patients were more likely to have one or more of the ‘geriatric giants’: poor mobility, incontinence, mental abnormalities, fall and stroke, which usually meant long periods of rehabilitation.


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Thus the geriatrician, whilst pulling his weight in reducing the length of stay and increasing turnover, had extensive duties particularly in the community, which were not necessarily paralleled or appreciated by his general medical colleagues.

**Efficiency of Geriatric Medicine: Official Data.**

**Introduction**

Although Hospital In-patient Enquiry (HIPE) data collection began in 1949, the amount of material was initially limited and, in the earlier years, the statistical waters were muddied. Data for acute geriatrics and chronic sick, and sometimes even the young disabled, were all combined, although later disentangled. Later, too, those compiling HIPE data realised figures using average of length of stay for geriatric patients could be misleading: one patient who stayed in hospital for perhaps one or two years will have a major distorting effect on the mean value. Median length of stay was therefore introduced in 1973: this measured the time taken to discharge half the patients, although many official statistical reports continued to use average (mean) length of stay. In 1980 the CMO reported ‘the average length of stay for patients in hospital departments of geriatric medicine is steadily diminishing – more so than in any other hospital speciality. Only 10% remain in hospital for more than six months; the median length of stay is only 21.7 days’ (p.102).\(^\text{16}\)

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The available data for geriatric medicine and general medicine

It is helpful to consider first the number of deaths and discharges, and length of in-patient stay in relation to the number of beds to show that activity in geriatric medicine was steadily increasing. By combining data for Great Britain from the Office of Health Economics, and Health and Personal Social Services Statistics for England, (see table 9.2), it can be seen there were 81,000 deaths and discharges in geriatric medicine and young chronic sick beds in 1949 in England and Wales, which steadily increased to 554,000 in Great Britain in 1991. The comparable data for general medicine show 672,000 in 1948 increasing to 2,367,000 in 1991. Table 9.3 shows that between 1965 and 1981 the average length of stay for geriatric medicine with chronic sick fell from 128 days in 1965 to 67 days in 1981. The comparable figures for general medicine were 18 days falling to 11 days. Table 9.4 shows that between 1973 and 1978 the median length of stay for general medicine was 9.4 days falling to 7.5 days and for geriatric medicine was 24.4 days falling to 20.4 days. The table also illustrates the difference between the mean and median lengths of stay for geriatric medicine, e.g. in 1973 the difference was 73.3 days and in 1978 was 59.3 days i.e. the differences suggest the ‘skew’ effect was weakening. Office of Health Economics reported changes in average bed numbers in Great Britain between 1959 and 1991. Table 9.5 shows there were 62,000 average available beds for


18 OHE ibid (Table 3.21).
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geriatrics and the young disabled in 1959, which peaked at 72,000 in 1978, before falling to 61,000 in 1991. General medical beds over the same period decreased slowly but steadily from 89,000 to 49,000.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>672,000</td>
<td>839,000</td>
<td>1,109,000</td>
<td>1,546,000</td>
<td>2,367,000</td>
</tr>
<tr>
<td>Geriatric Medicine with Young Disabled</td>
<td>81,000</td>
<td>145,000</td>
<td>179,000</td>
<td>284,000</td>
<td>554,000</td>
</tr>
</tbody>
</table>

Table 9.2 Deaths and discharges for England and Wales (1949-69) and Great Britain (1979-91) for General and Geriatric Medicine between 1949 and 1991.19

<table>
<thead>
<tr>
<th>Average length of stay</th>
<th>1965</th>
<th>1975</th>
<th>1981</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>18 days</td>
<td>13 days</td>
<td>11 days</td>
</tr>
<tr>
<td>Geriatric Medicine and chronic sick</td>
<td>128 days</td>
<td>94 days</td>
<td>67 days</td>
</tr>
</tbody>
</table>

Table 9.3 Shows the average length of stay for England for general and geriatric medicine between 1965 and 1981.20

<table>
<thead>
<tr>
<th></th>
<th>1966</th>
<th>1973</th>
<th>1978</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine All ages</td>
<td>Median length of stay</td>
<td>N/A</td>
<td>9.4 days</td>
</tr>
<tr>
<td></td>
<td>Mean length of stay</td>
<td>19.3 days</td>
<td>14.0 days</td>
</tr>
<tr>
<td>Geriatric Medicine All ages: 50-64+</td>
<td>Median length of stay</td>
<td>N/A</td>
<td>24.4 days</td>
</tr>
<tr>
<td></td>
<td>Mean length of stay</td>
<td>96.1 days</td>
<td>97.7 days</td>
</tr>
</tbody>
</table>

Table 9.4 Shows the mean and median lengths of stay for England and Wales for general and geriatric medicine for 1973.21


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Effectiveness and Efficiency of Geriatric Medicine

<table>
<thead>
<tr>
<th></th>
<th>1959</th>
<th>1978</th>
<th>1990/1</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>89,000</td>
<td>63,000</td>
<td>49,000</td>
</tr>
<tr>
<td>Geriatric medicine and young disabled</td>
<td>62,000</td>
<td>72,000</td>
<td>61,000</td>
</tr>
</tbody>
</table>

Table 9.5 Shows the average number of available beds for geriatric (with young disabled) and general medicine for Great Britain between 1959 and 1991.22

Other data show geriatricians were treating more of the 'old' elderly than their general medicine colleagues, and throughput (discharges per bed) for geriatric medicine was accelerating faster than general medicine, although it could be argued geriatric medicine was starting from a lower base line than general medicine. Table 9.6 shows between 1973 and 1978 the majority of discharges of the 'old' elderly were from geriatric wards and both geriatricians and general physicians were steadily increasing the number of patients they treated in this age group. Table 9.7 shows throughput for geriatric medicine had increased nearly five times and general medicine had nearly doubled between 1965 and 1993/4.

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22 Office of Health Economics. op. cit., note 17. (Table3.21).
Effectiveness and Efficiency of Geriatric Medicine

<table>
<thead>
<tr>
<th>Estimated Discharges</th>
<th>1973</th>
<th>1978</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>65-74</td>
<td>75+</td>
</tr>
<tr>
<td>General medicine</td>
<td>160,580</td>
<td>105,260</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>51,660</td>
<td>140,230</td>
</tr>
</tbody>
</table>

Table 9.6 Shows the estimated total number of discharges in general medicine and geriatric medicine for England and Wales for the age groups 65-74 and over 75 years.23

<table>
<thead>
<tr>
<th></th>
<th>1965</th>
<th>1975</th>
<th>1985</th>
<th>1993/4</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>19</td>
<td>24</td>
<td>33</td>
<td>36.4</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>3</td>
<td>4</td>
<td>7</td>
<td>14.8</td>
</tr>
</tbody>
</table>

Table 9.7 Shows the throughput for general and geriatric medicine in England between 1967 and 1985.24

Conclusion

These data provide evidence that the contribution of geriatric medicine to the care of the elderly was increasing steadily. Although the average number of available beds for geriatric medicine overall remained static, the number of deaths and discharges steadily increased, the average and median lengths of stay decreased, patient turnover increased, and geriatric medicine was taking more of the 'old' elderly than general medicine. The speciality was 'pulling its weight'.

23 DHSS op. cit., note 21. HIPE 1973 (Table 12). HIPE 1978 (Table 12).

Annex 1 Day Hospitals

Since day hospitals were and are still considered by many geriatricians a vital and integral part of a district geriatric service, it seems appropriate to give a flavour of the debate and discussion surrounding their use.25

Day hospitals had their origins in the Soviet Union in the 1930s where they were developed for schizophrenic patients. The United Kingdom development for the physically frail elderly patients began when Cosin in Oxford opened the first geriatric day unit in 1956. Exton-Smith listed the many uses of day hospitals including: rehabilitation, physical maintenance of old people, providing follow up care after discharge from hospital, treating depression, and performing medical procedures, e.g. ECGs.26 Professor John Pathy used his day hospital in Cardiff as a substitute for an out-patient department, because he considered the official out-patient department poorly served elderly frail patients.27 Brocklehurst in 1970 listed the main types of patients attending day hospital as those with arthritis, stroke or other cerebro-vascular disorders, or those requiring rehabilitation after an operation for a fractured neck of femur.28 Others used day hospitals to provide companionship and alleviate loneliness, which if not managed, could lead to


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apathy, depression and malnutrition.29 The DHSS supported these collective views on the role of the day unit as an out-patient department and for rehabilitation.30 The first Director of the Hospital Advisory Service considered day hospitals were economical in the use of staff, saved beds, prevented admissions and allowed patients to be discharged earlier.31

Clinicians and official sources reviewed the number and size of day hospitals. Brocklehurst reported day hospitals had increased in number from 12 in 1960 to 120 by the end of 1970 with almost two thirds of geriatric departments so equipped.32 The usual size was 20-40 places per day, which could serve a population of 60,000 to 180,000 over 65 years of age. The DHSS thought 50 day places were too unwieldy and fewer than 20 were uneconomic. It recommended 2 places/1000 for those over 65 years. Exton-Smith thought this was adequate.33


33 Drs. Gurcharan Rai and Philip Murphy working in North London considered only 0.5 places/1000 were needed provided there were clear operational policies in place, proper medical assessment and multidisciplinary management. Rai G. S. and Murphy P., "Analysis of a Geriatric Day Hospital," Age and Ageing, 185, 14: 139-142. Dr. Anthony Martin and Professor Peter Millard considered larger units were less efficient because patients attended unnecessarily, and reduced the suggested number of places to about 15. Martin A. and Millard P. H., "The New Patient Index-A Method of Measuring the Activity of Day Hospital," Age and Ageing, 1975, 4: 119-122.
Brocklehurst emphasised day hospitals must be distinguished from day centres, which were for elderly people with predominantly social problems.\textsuperscript{34}

Day hospitals could only be effective if they had adequate staff.\textsuperscript{35} Ten whole time equivalent (WTE) nurses and a rehabilitation team were needed to provide a service for 30-day patients as well as one session of consultant time and two sessions of junior doctor time. Regular case conferences were necessary to monitor patient progress and arrange discharge. Millard thought 60-90 minutes of trained therapy time were required for each planned day hospital place.\textsuperscript{36} Physiotherapy helpers might solve a shortage of fully trained physiotherapy staff.\textsuperscript{37}

The main efficiency problem for day hospitals was transport. The best option was to have dedicated, purpose built and designed ambulances, which could carry up to eight people, and which could not be diverted to other duties. Professor Tom Arie, a psychogeriatrician, made pertinent comments about his day hospital patients, which could be applied to geriatric day units.\textsuperscript{38} He was worried about those patients who lived in country districts and who had to travel for long periods and distances from home to hospital and back. They would have limited


\textsuperscript{35} Op. cit, note 29


\textsuperscript{38} Arie T., "Day Care in Geriatric Psychiatry," \textit{Gerontologia Clinica}, 1975, \textit{17}: 31-39.
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time for rehabilitation. He, perhaps tongue in cheek, wrote of the transport
difficulties in rural areas: ‘patients coming from further parts of our catchment
area spend almost as long in the ambulance as at the hospital’. He wondered if
they could establish a new form of psychiatric day care called ‘transport
therapy...the patient is jogged along the country side for several hours...the
hospital became irrelevant and to travel happily becomes more important than to
arrive. Meals can be taken at a friendly transport cafe, always provided there is a
greater-than-average provision of functioning lavatories’ (p. 37). Millard
analysed the delays due to the actual collection of the patients. He calculated an
ambulance, with a tail lift for 10 people, probably took 5 minutes per patient to
get them into the vehicle and thus the ambulance was stationery for about one
hour in its journey.39 Therefore the patients might spend between half an hour
and two and half-hours travelling to/from the day unit. Perhaps it was not
surprising travel sickness was often given as the reason for non-attendance.

Day hospitals were criticised for poor audit of their function, and their value
has been the subject of long standing debate. Most of the criticism was aimed at
poor working policies and limited consultant input. Millard in 1980 studied day
hospitals in the South West Thames Region.40 All had developed in an ad hoc
manner without clear operational policies of function. Most of the units provided
long-term care rather than short-term treatment. He considered only 0.5
places/1000 people over 65 years were required. Drs. Rai and Murphy in 1985

39 Millard P. H., op. cit., note 36.
40 Ibid
thought formal medical assessment of referrals and multidisciplinary management were essential to get the most effective use of the day unit.  

Trenchant criticism of day hospital function came from Drs David Lubel and Michael Denham in 1993 who surveyed the use and function of day hospitals using 88 consecutive reports of the HAS on elderly care services in England and Wales, which took place between March 1988 and June 1991. This was one of the largest surveys of geriatric day hospitals and sampled approximately 43% of health authorities. The main problems were ineffective operational use and poor leadership/management. 81% of geriatric departments failed to make the best use of their day units: the main reasons were over attendance for social reasons, and continued attendance for excessive long periods due to limited social service support. Nearly half the reports referred to transport problems and in one third there was a lack of rehabilitation. Nearly two thirds of reports referred to poor leadership: some geriatricians seldom visited their day hospitals and/or failed to develop clear operational policies. In only a few cases was there evidence of a close working relationship with the social service department. Where the consultant seldom visited, ‘the medical work of assessment and review was frequently delegated to a clinical assistant or a relatively inexperienced junior member of staff...resulting in many patients attending for no discernable reason’ (p. 26). They concluded the situation could be corrected by agreeing operational

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41 Rai G. S. and Murphy P., op. cit., note 33.
Effectiveness and Efficiency of Geriatric Medicine

policies, and arranging a comprehensive audit including monitoring the level of consultant input.

Criticism of day hospital function is fair in one way but not in another. Randomised clinical trials, sophisticated statistical analyses and the need to demonstrate 'Value for Money' did not exist when Cosin set up the first geriatric day hospital. Empirically they were viewed as a valuable asset to the geriatric service and were built on an 'ad hoc' basis.

Assessment of Day Hospital Function (a) General

Over the years, two main approaches were used to assess day hospital function: the general and the scientific.

The general approach to assessment used patient attendances, staffing, activity, costs and patient satisfaction surveys to assess effectiveness but reliable data proved difficult to obtain. Simple attendance rates were difficult to evaluate, since they depended on the size of the unit, the availability of transport, public holidays, and staff shortages. The total number of new patients treated and their length of stay were thought to be a better indicator of efficiency, but length of stay might be a function of the size rather than the activity of the unit. Larger units tended to reduce the frequency of attendance thus reducing the length of stay. Woodford-Williams and colleagues found, after four years' experience, that 50% of patients benefited and the unit was an inexpensive way of treating

43 Martin and Millard developed a New Patient Index to provide a more accurate assessment and concluded that larger units were less efficient than smaller ones because patients attended unnecessarily. Martin A. and Millard P. H., op. cit., note 33.
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depression.\textsuperscript{44} However Brocklehurst in his early experience of day hospital use was disappointed that only a few of his patients could actually be discharged on completing treatment.\textsuperscript{45}

Geriatricians tried to assess the potential for day hospitals to save in-patient beds and to estimate/compare day hospital costs with in-patient treatment. Farndale in his 1961 review of the day hospital movement found no evidence on a national scale that they saved in-patient beds, but the survey was made early in geriatric day hospital development.\textsuperscript{46} Brocklehurst concluded about 4\% of his patients would have had to be admitted as an in-patient if no day hospitals had been present. Dr. Anand and colleagues thought day units could prevent admission and/or shorten in-patient stay but produced limited data to support this assertion.\textsuperscript{47}

Day hospital treatment was generally thought, certainly in the early days, to be less costly than in-patient treatment because they avoided ‘hotel’ costs. However increasing costs of the ambulance service and keeping the patient at home limited the financial benefit. Millard thought it cost about £10 per day per patient to attend the day hospital and perhaps the money could be better spent on

\begin{thebibliography}{99}
\bibitem{44} Woodford-Williams E., McKeon J. A., Trotter I. S., Watson D. and Bushby C., op. cit., note 29.
\end{thebibliography}
other forms of treatment.48 Dr. Marion Hildick-Smith, a geriatrician based at Canterbury, concluded a 'twice weekly attendance was good value for money' but more frequent visits could prove costly. She admitted it was difficult to identify specific costs of day hospital such as transport, staffing, staffing ratios and capital costs and it could be argued that 'like was not being compared with like.'49

General support for day hospitals came from official sources. In 1971 the DHSS concluded day hospitals made 'a highly significant contribution to the total care of the elderly population and at the same time improved the effectiveness of in-patient services.'50 The Central Office of Information in 1974 thought day hospitals helped the elderly to live alone and enjoy active lives in spite of disability.51 In 1994 the National Audit Office considered day hospitals were an important contribution to community health services helping old people to live independent lives in their homes.52 Furthermore day hospitals had 'improved their efficiency and were working purposefully towards clear objectives.' However it noted patients spent nearly one third of their time quite inactive and between 8-25% of patients failed to attend for their appointments.

48 Millard P.H., op. cit, note 36.
50 DHSS. op. cit., note 30.
Assessment of Day Hospital Function (b) Scientific

Scientific assessment of day hospitals used properly designed trials. However these proved difficult to organise because they were bedevilled by methodological limitations of the studies. Patients usually attended for different reasons. The number of patients attending individual day hospitals might be small. The day units had different roles in different localities, and finally there were difficulties in defining the control groups. The Royal College of Physicians reviewed 13 research studies including 6 randomised controlled trials, only two of which were based in the United Kingdom. Unfortunately they tended to give contradictory results depending on the nature of the treatment received by the control groups. The College review failed to come to any firm conclusions about the value of day hospitals, but it supported their general use and philosophy, and gave firm guidelines of good practice.


54 Royal College of Physicians op. cit., note 25.
Summary and Areas for Future Research

The Medical Care of the Sick Elderly People in England: A Sea Change

A marked change in the medical care of the elderly 'chronic sick' occurred in England in the 20th century following earlier neglect by the majority of those in the medical profession. Often elderly patients were not assessed, diagnosed or treated in the same manner as the acutely ill. Medical notes were frequently sparse of detail. The breakthrough in improved medical care initially came from a few inspired pre-war/wartime reformers, followed by others in the post war years. They successfully applied the usual methods of classification, diagnosis and treatment to the elderly. Many of these later consultants entered the speciality by second intent because of failure to obtain preferred posts in general medicine but they rose to the challenge. Additional support for improved care of the older patient came from lay people, a few influential general physicians, some medical officers of the Ministry of Health and a small number of politicians. Unfortunately the political will to produce an effective geriatric service with clearly defined objectives was lacking. The Ministry of Health, itself, could not force change, it could only encourage. Furthermore it did not 'lead from the front' but followed examples of good practice set by the geriatricians.

The newly appointed post war consultants in geriatric medicine had to embark on a steep learning curve. They learned that illness in the older person differed from younger people and more time was required to recover, that extensive teamwork was needed for successful rehabilitation and that support
from local social services was usually essential to provide alternative accommodation or domiciliary support services. In the early days they had responsibility for very large numbers of in-patients, who were often kept in bed for no discernable medical reason, which could ultimately lead to a totally bedridden state. Generally there was a long waiting list for admission, which was often precipitated by the death or illness of the carer, or the person's inability to prepare meals for him/herself. These new geriatricians had to provide a service although they lacked adequate resources and staff, had poor ward accommodation, inadequate investigative/treatment facilities and were not always based on the main hospital site. Progress was hampered by the economic situation, the less-than-supportive comments from some leading public figures, by continued antagonism from general physicians and limitations in social service support.

In spite of severe constraints on the service they could provide, these new inexperienced geriatricians gradually made their impact on hospital services for sick elderly patients. Progressive patient care was widely practised. The death rate of new admissions was high because they were often very ill. Many so-called 'chronic sick' patients were discharged, and eventually only about 10% required continuing care in hospital. The huge waiting lists were usually tackled by home visiting, which revealed that the true list was substantially shorter because some patients had died, moved, recovered or had been admitted elsewhere. Concomitant with this evolution in care, medical staffing, accommodation and investigative facilities were enhanced or increased. More geriatric units were placed in the district general hospital where the main investigative facilities were
to be found. Official data showed that patient turnover increased, length of stay shortened, and in some cases fewer beds were required. The Hospital (Health) Advisory Service was set up to ensure standards of care were maintained or improved. Major charitable organisations began supporting research into the ageing process and created national councils for the ‘care and comfort of the aged poor’.

Changes in the style of management of geriatric services developed among geriatricians themselves. Some remained wedded to the continuance of the speciality wholly committed to the care of elderly people. Others advocated a rapprochement with general medicine which meant joint ward rounds with general physicians, while still others wanted to be more like general physicians, and go on unselected emergency take for patients of all ages.

However many problems remained. Misplacement of patients in hospital and local welfare homes was widespread. Early surveys of ‘bed blockers’ failed to include a member of the social service staff in the survey teams. Their presence was vital when arrangements for domiciliary support or alternative accommodation were needed. Charges of ‘bed blocking’ by elderly patients continued, geriatricians lacked sufficient beds in the general hospital, pressure to discharge patients persisted, which was often coupled with resistance to discharge by patients or relatives or both, and social service support was frequently deficient. Relatives and patients were often less than keen for transfer from hospital to a local authority home because hospital accommodation was free while that provided by the local authority was means tested.
Summary and Areas for Future Research

Suspicion, even hostility, from the general physicians continued. Some of the many reasons for this negative attitude of physicians towards geriatricians have already been noted but there were other factors. General physicians could not agree who should look after chronic sick patients. On the one hand they did not want to do the job themselves and did not want these patients in general hospitals. On the other hand they were contemptuous of those who did provide the medical care they disdained to carry out themselves. They considered geriatric medicine to be 'a refuge for doctors who had failed to make their way in some more desirable speciality' (p. 1076): indeed they were not 'proper' physicians. They were irritated that geriatricians attained consultant status in a shorter time than they had. This hostile attitude became clear when the paucity of merit and distinction awards to geriatricians is considered.

Another aspect of the relationship between general medicine and geriatric medicine was the attitude of general consultants towards a specialism of geriatrics. Most were specialists themselves e.g. in cardiology or gastroenterology, but they had no enthusiasm for a speciality of geriatric medicine. Paradoxically many geriatric physicians considered geriatric medicine as the last outpost of 'general medicine' because they had to cover all aspects of physical and mental diseases as well as social problems in the older person.

General medicine also showed evidence of 'sexism'. Very few female consultants were appointed to highly-sought-after specialities in medicine or

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surgery. However this attitude was much less apparent in geriatric medicine where many consultants are female. The trend to more female appointments at consultant level is likely to increase in the future as the number of male medical students steadily falls while that of female students increases (about 60% of medical students are female at the present time). The medical profession as a whole is likely to experience more part-time female appointments.

There remained yet another area of concern: the negative attitude towards older people themselves. 'Not only [is there] a lack on empathy, accountability and respect for older people, but also...gross under-resourcing of essential services for the aged...Children are seen to have needs, whereas elderly people are often regarded only as having problems' (p. 14).² Children have emotive appeal, especially when there is a request for money, but this is totally absent in respect of older people. The fact that this older age group has a vast wealth of experience just does not seem to count. Philanthropic organisations have helped the cause of the elderly and the retired people have become more vocal and aware of their voting rights but 'ageism' remains. There is still great prestige attached to youth and beauty, while job opportunities still discriminate against the older person in spite of government pronouncements promoting the value of older people and their employment potential. The medical profession still seems reluctant to treat older people and concentrates its efforts towards younger productive wage earners. As McClymont and her colleagues pointed out this attitude ignores the fact that 'many older people...remain fully independent; run
Summary and Areas for Future Research

their own households; maintain recognised and socially useful roles with their children...and still play a prominent part in their local community and sometimes in even wider social and political life.\textsuperscript{3} This negative attitude towards the elderly was also evident in the widespread reluctance to educate medical students about the medical and social problems of the elderly. Many early geriatricians realised medical students needed such teaching but University departments and teaching hospitals were reluctant to take up the challenge.

Areas for Future Research

There are many important areas for possible future research which have not been developed within this thesis because of constraints of time and space: these include the role of the nursing profession in the care of ill older people; maintaining quality of care/life particularly for those in continuing care; developments in medical, surgical, pharmaceutical, and rehabilitation treatments, and the creation of the psychogeriatric service.

Nursing aspects

The role of nursing in the care of the elderly has many facets. Nurses have a far closer and personal relationship with patients than doctors. Thus means they can influence patients' quality of life and care in a way doctors cannot achieve. Unfortunately, because nurses do not write as many articles as doctors, it is not


\textsuperscript{3} Ibid.

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easy to assess their views, attitudes or therapeutic approach. The reasons for this 'failure' to publish are not clear but could relate to lack of time, interest or need. However joint publications between nursing and medical societies have tended to fill the gap. The Royal College of Nursing (RCN), sometimes together with the British Geriatrics Society and the Royal College of Physicians, has published reports indicating how good quality nursing care can be achieved.\(^4\) Nursing input was particularly valuable in the compiling of the advisory group report on *A Better Home Life*\(^5\). The RCN advanced the cause of geriatric nursing by publishing its own journal devoted to the subject: *Nursing Elderly People* (incorporating *Elderly Care*). Joint publications between nurses and doctors also attest to the former's strong empathy with sick older people, especially those in continuing care, and the need for high standards of nursing care.\(^6\)

Just as the medical profession found it difficult to recruit into the speciality so too did the nurses, in spite of one senior nurse considering that nursing sick elderly people was 'true nursing' and therefore the basis of all good nursing practice.\(^7\) The reasons were similar: unattractive surroundings, poor facilities, etc.


\(^7\) Norton D., "Nursing in Geriatrics", *Gerontologia Clinica*, 1965, 7: 51-60. Indeed Doreen Norton felt so strongly that she considered 'no nurse should be launched upon the world as 'qualified' without having had geriatric nursing experience welded into the structure of his or her training' (p. 51).
overcrowding, unpleasant work, lack of esteem or recognition by colleagues, a perception that geriatric nursing was all 'chronic' and therefore lacking more interesting 'acute' nursing. One official approach, which aimed to overcome poor recruitment, was to award an extra 'geriatric' weighing payment to those working on a designated geriatric ward. However this measure was considered by some to attract nurses into the speciality for the wrong reasons: financial benefit rather than a real belief in the value of nursing older people. The extra payment also annoyed other nurses who did not receive the payment although they worked with older people but who were not on designated 'geriatric' wards.

Assessments of nursing methods and evaluation of nurse specialists have been receiving increasing attention. For example, the Norton bed sore scale has been already mentioned. Other scales have been introduced but the Norton scale remains a valuable tool. The Welsh National School of Medicine assessed the value of health visitors in the care of the elderly. Although their role was not clear, the study concluded that a good health visitor was better than a general practitioner in identifying social, environmental and carer problems. A general review of care standards, which included nursing input, was published by the British Geriatrics Society 1997.

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9 Vetter N. J., Jones D. A. and Victor C. R. *The Effectiveness of Health Visitors Working with the Elderly*. Cardiff: Research Team for the Care of the Elderly, Welsh National School of Medicine, 1982 (year uncertain).

Quality of life

Quality of life is a major topic about which much has been written. It is usually measured by objective methods but these techniques are of limited value to the continuing care patient where subjective methods are more appropriate. Unfortunately this approach tends to produce 'softer' data. Dr. Peter Horrocks, a Director of the Health Advisory Service, maintained that the evaluation of quality should be continuous and dynamic not a short term exercise. He thought that the joint publication by the RCN, the Royal College of Psychiatrists and the British Geriatrics Society, 'Improving Care of Elderly People in Hospital', would prove helpful as would his own article in Age and Ageing. Other publications giving a general coverage of the subject include Continuing Care for Older People and Long-term Care for Elderly People. In 1995 the Royal College of Physicians published a useful report on the management of incontinence, which can be a crucial factor in quality of life. The HAS often made recommendations concerning chronic sick patients. Professor Rudolf Klein and others have


assessed its value.15 A history of the Service would be of considerable interest especially if individual reports were considered.

**Specific treatments**

A subject, which is barely touched on within this thesis, is a discussion of specific treatments.16 It covers medical, surgical, pharmaceutical, equipment and rehabilitation aspects. The important anaesthetic/surgical report by Dr. Philip Bedford and the follow up study have been mentioned. Exton-Smith organised a trial of Ripple Mattresses and noted that drugs were improving mortality. Several geriatricians described the results of trials of drugs, which aimed to improve mental state. Unfortunately the results were usually unpromising, mainly because in the early days it was not possible to distinguish between the various types of dementia. Geriatric teams have written about assessment and the value of NHS continuing care homes.17

The major impetus of assessment of treatment interventions came relatively late in the history of geriatric medicine with the Royal College of Physicians acting as the catalyst. For example it was not until 1989 that the Royal College published the report of the treatment of patients with a fractured neck of femur

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and mentioned the innovative work of the ortho-geriatric unit at Hastings. In 1991 the College reviewed the results of medical and surgical cardiological interventions in older people and concluded they could achieve as much benefit as younger people, implying that the elderly should not be excluded from the benefits of modern therapy. The following year the College listed assessment scales for older people. The Associate Director of the College Research Unit pointed to the value of sequential audit in all domains of geriatric care. However it was not until 1999 that the problems of surgery and anaesthesia in older people were highlighted in the CEPOD report.

An emotive aspect of therapy for older people is age related rationing of treatment, which has attracted considerable attention and debate over the years. Despite the proven benefit of new methods of treatments or investigations it has proved difficult on occasion for elderly people to obtain access to them. In 1994 the MRC unequivocally pointed out that older people were persistently excluded from research, screening procedures and treatment for medical conditions such as breast and cervical cancer screening, admission to coronary care units, clinical

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Summary and Areas for Future Research

trials for cancer therapy, coronary bypass surgery, hypertensive and thrombotic therapies.\(^2\) It was suggested that there should be less reliance on chronological age and greater value placed on biological age instead.

The Psychogeriatric Service

Another major very important subject in its own right is the development of the speciality of psychogeriatric medicine, which started in the 1960s-1970s. Several times within this thesis mention is made of the problems of misplacement of elderly sick patients in either geriatric or psychiatric wards and the reluctance of general psychiatrists to admit elderly confused patients, for reasons similar to those expressed by general physicians when asked to admit physically ill elderly people. The early psychogeriatricians faced similar problems and opposition as those of the reforming geriatricians. Once again imaginative thinking relied on a few far-sighted individuals such as Dr. (later Professor) Tom Arie and Professor Brice-Pitt. This subject merits a thesis of its own right.

The British Geriatrics Society

The Society has grown substantially in statute and membership since its inception in 1947. The types of articles presented at meetings and published in *Gerontologia Clinica* and *Age and Ageing* have changed considerably in calibre. Its administrative headquarters have ‘metamorphosed’ from existing in a suitcase, to two rooms in the Age Concern Headquarters in Mitcham, to two floors in the Regency buildings opposite the Royal College of Physicians to its present

permanent accommodation in an entire building in St. John's Square in Central London. It now has an extensive archive section. The history of the Society in its early days has been described by Howell and Adams but there is now a need for a thorough up-to-date piece of research.24

Thus, although this thesis covers the broad clinical aspects of the development of geriatric medicine, there remain many exciting areas for potential research, which might promote the cause of older people whether well or sick.

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A number of references in the main text are referred to as 'unpublished'. This usually means papers circulated before meetings or conferences, which were available to delegates but not published in the normal way.

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