2
History of Geriatric Medicine

Mary Ann Forciea, MD

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Commentary

From the years following the founding of the United States up to the period before World War II, the majority of ongoing care of the elderly in the United States and Great Britain was provided in three sites:

- homes of those older adults or the homes of family members
- grouped with the poor (poor homes or work farms)
- grouped with the mentally ill (asylums).

Placement within these sites was determined primarily by economics rather than by medical illness or functional status. Physicians made little distinction between the care of older patients and treatment of any other adult, other than to spend less time in diagnosis and therapy of older patients, especially if those patients were suffering from chronic diseases. The achievement of longevity was unusual; surviving to retirement slowly became more common throughout the twentieth century.

Along with increases in longevity during the twentieth century, several other developments contributed to changes in the care of older adults:

- increased professionalism in medicine and nursing
- standards in training of physicians and nurses
- increasing standards of research into clinical problems of older patients
- large numbers of WWI wounded veterans who needed chronic care were forced into existing institutions
- large numbers of conscientious objectors assigned to chronic care hospitals began to write about and lobby for improved care.

In the United States, the Flexner report had revolutionized the training of physicians away from "apprenticeships" toward formal curricula in accredited universities. Academic physician teachers and researchers began to look critically at the care of all patients, even occasionally at older patients. Similarly, nursing training began to move toward academic centers. At the same time, younger, mentally intact patients and their families who demanded more than custodial care challenged institutional facilities. The observations and activism of staff assigned to these facilities as alternatives to military service were positive forces for change.

In the 1940s in Great Britain, Marjory Warren began publishing papers describing her transformative work for elderly patients in a hospital for the chronically ill. She summarized her process of assessment of patients in that facility and the development of her "Geriatric Unit" in a paper in 1948 (1). She described the categories of patient that she felt belonged more appropriately together:

The chronic "up-patients" (ambulatory patients)
Chronic continent bed bound
Chronic incontinent bed bound
Senile, quietly restless (not noisy or annoying) and
Senile, demented (noisy and/or annoying).

She strongly advocated, for the first time in major medical journals, for careful assessment of patients on entry into institutions of care, for special training of medical students in the assessment and care of those patients, and for strong links to hospitals or teaching centers. She shared information on design, equipping, and staffing her units, and she provided data on admissions, mortality and discharge rates. The enduring quality of some of the challenges of care for these frail, older patients was captured in the passage:

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In the beginning, the Geriatric Unit was regarded by most of the medical staff as a convenient unit to which to transfer all their unwanted patients, medical and surgical, old or young and usually without consultation. This old tradition has died slowly . . . (1)

Her advocacy for assessment of the older patients in her care greatly influenced the generation of British physicians whose members established Geriatric Medicine in the National Health Service after World War II. Geriatric evaluation of the older adult began to develop in the United States in the 1960s and 1970s. This protocol of initial evaluation, usually by a team of professionals and often linked to function status complaints and outcomes, spread to nursing homes (2), office practices (3), and housecalls (4). Williams and colleagues (5) published a protocol of evaluation for patients referred for long-term institutional care and documented unnecessary loss of autonomy without careful evaluation prior to placement. In the United States, the commitment of the Veterans' Administration to specialized care of older veterans allowed the development, testing, and training of specialized programs focused on older patients. The first controlled trial of a program of initial geriatric assessment and subsequent care appeared in 1984 (6). Rubenstein and colleagues demonstrated that specialized evaluation and care resulted in improved function that was maintained longer than usual care.

While techniques of assessment and care have been developing over the last thirty years of practice (see later chapters in this volume), education in the interdisciplinary team practice, which is the foundation of that assessment, has been evolving more slowly. The Hartford foundation has invested funds and support to develop instructional methodologies to promote team practice (7). Certainly the blossoming of the field of education in the skills involved in successful practice of medicine and nursing should aid efforts to prepare health professionals for the world of practice with older adults in the twenty-first century.

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THE EVOLUTION OF A GERIATRIC UNIT

Marjory W. Warren, M.D.

During the present century, as a result of greatly improved welfare of almost all sections of the community, the tremendous expansion of preventive medicine and research work in the realms of therapy, there has been a marked age shift in the population of Great Britain.

The following tables fully endorse this statement.

TABLE 1. GREAT BRITAIN—NUMBER AGED 60 OR OVER

Year	Men	Women	Total
1901	1,071,519	1,336,907	2,408,426
1939	2,511,200	3,197,400	5,708,600
1944	2,737,000	3,590,000	6,327,000
1946	2,828,000	3,759,000	6,587,000

TABLE 2. GREAT BRITAIN—TOTAL POPULATION

Year	Total
1901	37,000,000
1944	47,628,000

TABLE 3. GREAT BRITAIN—EXPECTATION OF LIFE

Year	Men	Women
1891–1900	44.1 years	47.8 years
1901–1910	48.5 years	52.4 years
1942	61.7 years	67.4 years

In addition to these facts are two other conditions which have seriously added to the problem of the overall care of the elderly sick, namely: the enormous loss of houses from aerial destruction during the World War II and the retardation of the building programme brought about by the war, and the post war economy; the diminishing tendency for the elderly to be cared for by their own family. This latter reason would form subject matter for an article on its own. Suffice it here to point out that various factors contribute to the condition, such as, the smaller size of the family, the frequent scattering of the members of the family to widely separated parts of Great Britain, or even overseas, and to the present day weakening of the sense of filial responsibility.

The fascination of Medicine lies in its basic qualities—its wide social and humanitarian aspects, its progressive nature and its variety. Of all branches of Medicine, that of treatment of the chronic elderly sick has received, so far, less attention than others and consequently offers the widest scope for pioneer work and research. With the ageing of the population of Great Britain this subject has become not only one of academic interest, but one calling for urgent reform and practical solution.

Marjory W. Warren, M.D., is Deputy Medical Director, West Middlesex County Hospital, Isleworth, England; member of the Medical Society for the Care of the Elderly recently formed in England.

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Although the term "geriatric," first used by Nascher in 1909 in America, has not yet been generally accepted in medical circles in Great Britain, there is a good deal to recommend its use. The word has the merit of defining patients in the upper age groups and separating them from the so-called "chronic" patients of the younger groups. At the present time, the majority of the elderly sick are referred to as "chronic" because the maladies and multiplicity of diseases from which they suffer call for treatment of long duration and almost always leave residual disabilities.

Of recent years, there has been a gradual awakening to the general inadequacy of treatment meted out to the majority of elderly sick and many sections of the community realise the urgent need for a much better service both for medical treatment and social care.

From the figures quoted previously and our knowledge that the morbidity rate rises with increasing age there can be no doubt that in the future provision must be made for much larger numbers of elderly sick than has been necessary in the past, and this provision must, moreover, be varied and suitable for all types. With a changed economic outlook, it must be presumed that many more classes of persons, whether sick for short or long term conditions, will need hospital accommodation. In the immediate future, if indeed ever, there is no likelihood that nursing and domestic personnel will be available for individual hire as in the past. Even if such help is obtainable, the greatly increased rates of pay, especially of domestic workers, will certainly make it impossible for the elderly and sick professional and middle class persons, on a small fixed pension, to remain cared for in their own homes. This side of the problem is manifest today, for already there are many such persons who have not the means to obtain the help that is essential and who find it almost impossible to gain admission to hospitals or institutions providing beds for long term illness of elderly sick. We also see pathetic cases of the well-to-do with ample means and large homes, yet who are unable to obtain the help that they need and are living in considerable discomfort and great loneliness.

All this at first suggests the need for a much larger number of hospital beds at a time when building is difficult, and the shortage of nurses acute. There are, however, one or two other factors which should be considered before plans are drawn up. Firstly, the treatment of many of the acute conditions amongst younger patients is shortened by modern therapy, such as sulpha drugs and penicillin, to mention but two, and so the turnover of such conditions should be possible in fewer beds, thus releasing some for the long stay cases. Some preventable diseases may never need hospitalization at all. Secondly, and this is not yet sufficiently widely appreciated, much can be done to rehabilitate elderly patients so that a considerable number may be discharged from the hospital. Some could return to their own homes and those unfit to return home could enter a small residential home, thus retain-

ing a modicum of liberty and using much less costly accommodation than would be provided in a hospital bed with full equipment and nursing staff.

In this connection it should be remembered that a number of the most crippling conditions from which the long-term chronic sick suffer are preventable. Many more conditions may be found preventable or treatable when more time and research has been devoted to such cases.

THE EVOLUTION OF THE GERIATRIC UNIT

During the past twenty years certain changes in administration affecting the treatment and care of large numbers of the long-term elderly sick patients have appeared. In 1929 large numbers of sick persons in hospitals, previously administered by Boards of Guardians, became the responsibility of the respective County Councils with their County Medical Officers. Later, certain additional institutions for the chronic sick and infirm, previously the responsibility of Public Assistance under the Poor Law, were appropriated by Public Health. In July 1935, one of these Poor Law Institutions, carrying about 700 chronic sick and infirm persons, became by change in legislation part of the general Public Health Hospital, which had itself been taken over by the County Council from the local Board of Guardians in 1929.

This change in responsibility called for immediate reform in order to raise the standard of the care and treatment of persons in the Institution to that of the Public Health hospital of which it had now become a part.

As there must still be many such institutions both in Great Britain and in other countries carrying large aggregate numbers of chronic sick and infirm persons, it is thought that it may be of interest to study the development and growth of one which has built up a Geriatric Unit from some of these wards, and to discuss the functions and future rôle of such a unit in the general hospital. It is the account of this pioneer unit still in the making which is the subject of this article.

CAUSES OF FAILURE IN THE PAST

There can be little doubt that in the past failure to obtain good results for the elderly sick and infirm, has been brought about by too little attention from medical and nursing staffs. It may be profitable here to consider the reasons for these failures.

1. Lack of continuity in the care of the elderly sick brought about mainly by lack of medical interest and consequent early transfer of the long stay patient away from senior medical staff to the hospital for "chronic" patients.
2. Failure to investigate and treat fully by modern methods all patients with whatever condition and of whatever age.
3. Failure to provide first class equipment for the chronic elderly sick comparable to that used for the younger acute patients.
4. Lack of appreciation on the part of medical persons as to how much can be done to rehabilitate and resettle elderly sick patients.

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With these points in mind, and before any plans were made as to the ultimate development of a Geriatric Unit, every patient (about 700 in all) was fully examined, medically assessed and, where necessary, given appropriate treatment. In the majority of cases, relatives and friends were interviewed concerning the future. Almost immediately about 200 relatively able-bodied elderly persons were transferred to a Residential Home for old people close to the Hospital and run by Public Assistants, thus freeing accommodations for acute medical patients. Approximately 150 patients attached to the mental observation wards were left in the care of the psychiatric staff. This left about 350 really chronic sick patients to be cared for and treated.

The survey took in all about seven months, and on its completion certain facts emerged and certain preliminary recommendations were made. Facts revealed were:

1. That hitherto there had been no classification of patients.
2. That, in consequence, all wards contained so many different types of patients that the accommodation and equipment could not possibly be best for each, nor could any one staff cater really well for all.
3. That none of the modern ancillary services for patients were in use in the wards, nor had it been considered necessary that there should be such services. Indeed, physiotherapists and occupational therapists thought it unprofitable to work on such wards, and a fully trained nursing staff felt it a bore and somewhat beneath them to work with the chronic elderly sick.
4. That wards were large, overcrowded, dull and inadequately lighted.
5. That ward equipment was neither modern nor adequate.
6. That beds were all low, black and of an old-fashioned type and, therefore, difficult from a nursing point of view.

DEVELOPMENT OF A GERIATRIC UNIT

Preliminary plans for reorganization were drawn up and substantial changes were made in March 1936. Classification was started as follows:

1. Wards for investigation and treatment of geriatric patients, including new admissions and those transferred from other departments in the hospital.
2. A ward provided with a majority of cot beds for patients needing some restraint for physical or psychological reasons, but not bad enough to be segregated in the mental observation ward.
3. Ward for female patients whose main or only disability is incontinence of urine and/or faeces.
4. Ward for patients getting up and about and awaiting vacancies in Residential Homes or with friends.
5. Ward for patients no longer needing active medical treatment or rehabilitation, but still requiring a good deal of nursing and some medical supervision.

(These patients need not necessarily be kept in wards of the hospital but could be nursed in a Long Stay Annexe if such accommodation were available outside the hospital, *but* they *should remain the medical responsibility of the Geriatric Unit.*)

Although no major reconstruction was sanctioned, certain improvements and structural alterations of a minor character were undertaken between 1936-1938. These included removal of frame work obstructions interfering with free movement between one part of a ward and another, such as, the replacement of narrow doors by swing doors and a considerable improvement in lighting by installation of individual indirect lighting. The wards were repainted cream in place of the dark colours previously used and the low, black, old-fashioned beds were replaced by high nursing beds, easy-moving, with adjustable back rests and in light pastel shades. In the ward for up patients, low beds were used of a similar modern pattern, and in light colours. The total number of beds was reduced to conform to the standard spacing and each was furnished with a single modern locker, a bed table and a pair of ear phones conveniently hung at the head of the bed.

The wards were equipped with modern clinical aids, similar to those used in the acute wards, and gradually they fell into line with the general wards of the hospital. Additional equipment was added to these wards suitable to their special kinds of patient, for example, hand rails were fixed in parts of the ward devoid of beds so that patients could maintain independence in walking, even in the early stages. Additional arm chairs of varying types were obtained, as more of this type of furniture is needed when larger numbers of long-stay patients are under treatment. For the cot bed ward and the ward for incontinent patients larger stocks of bed linen were supplied.

Following this preliminary classification and segregation, with improved and additional equipment and in a new spirit for this type of patient, the unit set to work to deal with its large numbers of inherited patients, many of whom were bedridden without adequate medical cause, and to tackle its new admissions with an air of hopefulness. Under these new conditions the embryo of the Geriatric Unit was born.

GROWTH OF THE GERIATRIC UNIT

The early years were devoted to pioneer work in internal organization and administration, to improvement in staffing, to details of equipment and to the building up of teamwork, especially amongst nursing and ancillary staff, including physiotherapists and occupational therapists. Many improvements and changes have been made, and today, though far from perfect, an experimental centre is well-established.

In 1942, when the turn-over on these wards had increased considerably, it was found possible to gradually allocate about 90 beds for the Tuberculosis Service, and so the Geriatric Unit was reduced to approximately 200 beds.

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New admissions to the Geriatric Unit are never made directly into the ward for incontinent patients, or into the ward for up patients, as it is thought that all patients admitted to these wards should be assessed first. On the male side, the numbers being much smaller (about 1:3) than on the female side, it has not been possible so far to arrange for the same degree of segregation. Incontinence amongst men is never such a serious problem, and a well-trained staff can deal with the majority of incontinent patients by simple nursing methods. At present men needing cot beds have to go to the observation ward attached to the mental block.

Progress at first was necessarily slow, the patients were difficult to re-educate, some were hopeless, and in the early days there was no really good teamwork. One ward which was entirely satisfactory from the start was the ward of 45 female patients set aside for incontinents. In this ward, first-class nursing has been done and a good deal of re-education satisfactorily completed. Many elderly patients have been "cured" of their incontinence and have been able to return home or enter a residential home on leaving this ward. It has never been regarded as a permanent home for patients admitted, although, of course, the turnover must inevitably be very slow, and a certain number of patients must finally be regarded as incurable.

In a different way, the cot bed ward has also done very good work, and the staff on this ward has also treated in an atmosphere of hopefulness and with the right psychological approach. The results have been very promising, considering the type of patient.

In the beginning, the Geriatric Unit was regarded by most of the medical staff as a convenient unit to which to transfer all their unwanted patients, medical and surgical, old or young and usually without consultation. This old tradition has died slowly, but recently there has been evidence that this custom is disappearing and now patients are usually referred in consultation first as to suitability. Also, it is more generally accepted that young chronic patients should not in principle be sent to geriatric wards.

The onset of the war temporarily relieved the hospital of numbers of infirm patients when relatives took their folk with them to be together in the greater danger which lay ahead. With air raids, however, new problems arose and numbers of elderly persons were rendered homeless, and sometimes in one night lost all the younger members of the family. Others were themselves the victims of air raids and suffered physical and psychological trauma. Such cases clearly needed full medical treatment and custodial care in whatever seemed the best accommodation.

The majority of the patients admitted were suffering from:

1. General debility including malnutrition, anaemia, etc.
2. Psychiatric conditions, including senile dementia.
3. Cardio-vascular degenerations, including cerebral arterio sclerosis, cerebral thrombosis, etc.

4. Arthritis—usually of the degenerative type.
5. Progressive nervous diseases.
6. Chest diseases.
7. Neoplasms.
8. Injuries—often referred from the orthopaedic department for rehabilitation.

Patients were unselected except on age (those over 60 years being preferred) and a number were primarily treated in the acute wards. When it became apparent that the prognosis was hopeless they were transferred to the Geriatric Unit, while others of advanced years who were expected from the outset to do well were admitted to the wards for acute patients.

For the aforementioned reasons, and because of the war and difficult housing conditions, the over-all picture could not be considered as quite normal. The results on statistical grounds are obviously less good than would have been obtained had the Unit admitted all new geriatric patients to its wards and if it had refused all geriatric patients who were transferred owing to poor prognosis.

In spite of all these abnormal conditions, however, in 1944 two wards in the unit, one male and one female, started keeping full records of all patients admitted or transferred to its wards, and some interesting figures have emerged. These figures are now published from this young and experimental unit for academic interest, as the writer knows of no previously published comparable figures from a Geriatric Unit of a general hospital, and hopes that other similar units may be encouraged to publish their figures for comparison.

TABLE 4. MALE WARD—CONTAINING 35 BEDS

Year	Admitted	Discharged Home	Discharged Resident Home	Died	Percentage Total Discharges	Percentage Deaths
1944	297	90	23	123	38	41.4
1945	292	86	25	139	38	47.6
1946	191	48	17	78	34	40

TABLE 5. FEMALE WARD—CONTAINING 45 COT BEDS

Year	Admitted	Discharged Home	Discharged Resident Home	Died	Percentage Total Discharges	Percentage Deaths
1944	155	35	15	65	32	43
1945	207	49	30	93	38	45
1946	222	41	27	91	30	41

These figures suggest that of all new admissions probably only about 25 per cent will form a residuum.

THE GERIATRIC UNIT TODAY

The department today carries almost 200 beds and accepts new patients admitted to the hospital (in the age group 60 years plus) and also patients referred to it from medical or surgical staff. These transfers are mainly patients from the medical side who are considered likely to need a very long stay in hospital or who are unlikely to improve much. Those transferred

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from the surgical or orthopaedic departments fall into two categories: (a) those whose rehabilitation will require a very long period in hospital; (b) those whose primary condition, e.g., fracture, etc., is complicated by another disease.

The Unit does not accommodate *all* patients over 60 or even over 65, as a number of senile dements are admitted directly to the psychiatric wards attached to the mental observation wards and all surgical emergencies and some medical cases are admitted directly to the general medical and surgical wards.

Recently there has been a greater tendency for medical staffs from general wards to acknowledge that these so-called "chronic" elderly patients will probably do better in the atmosphere of the Geriatric Unit, and in the hands of those staffs who are most interested in such conditions. Such recognition of the value of this department is of course very encouraging.

There have been requests recently for the Unit to conduct Out-Patient sessions, which are being arranged for and will undoubtedly develop in the future as patients themselves learn of their existence. Already old patients are writing in and asking to be seen in the Geriatric Unit.

PHYSICAL MEDICINE

The great need for physiotherapy in these wards is fully recognised and this work is developing slowly but surely. Better results are being obtained as more staffs become available, and in addition to the services of the trained physiotherapists, some of the assistant nurses are doing excellent work under medical direction and supervision. Patients are, therefore, having combined treatment as individuals in the wards and also in small classes in the gymnasium. The gymnasium is a part of a vacated ward and has been very simply equipped for this sort of rehabilitation.

All the wards of the unit are now visited frequently and regularly by the occupational therapists who are beginning to take great interest in the results of their labours and are naturally greatly encouraged when they witness the increase in morale and the physical improvement of their patients. All the usual useful handicrafts are presented and a remarkably high standard of work is being done.

SOCIAL MEDICINE

All wards in the unit enjoy the services and invaluable help of the medico-social workers who work in very close co-operation with medical staff, often doing combined rounds with the medical officer and the ward sister.

FUTURE OF THE GERIATRIC UNIT

As the department gains experience, confidence and more skill, it should be able to prevent a great number of the conditions which are so prevalent and so crippling amongst elderly persons today. It should also be in a position to undertake still more treatment for both in-patients and out-patients

with a quicker turn-over, due to better teamwork and improved technique. It is essential that it should develop its teaching side both for medical and nursing students and post graduates, so that the future generations will be much better equipped by experienced personnel. The department will surely develop research as soon as its foundations are well-laid, for without this stimulus, progress must inevitably remain slow. Eventually, it should become the recognised department for advice concerning old age and conditions mainly dependent upon senescence. It should, in time, overcome the opposition from the more conservative sections of the medical and nursing professions, proving itself to be an invaluable and practical department in the hospital, enjoying the prestige and dignity which it has earned.

Medicine has responsibilities towards the elderly sick and infirm, equal to any other section of the community and must undertake these if it is to remain worthy of its high traditions.