



**GUTHRIE TRUST WITNESS SEMINAR, CENTRE FOR THE HISTORY OF
MEDICINE
University of Glasgow**

**THE DEVELOPMENT OF OLD AGE PSYCHIATRY
FROM THE 1960s UNTIL 1989**

9th May 2008

Seminar team:

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CNWL NHS Foundation Trust, London**

Professor Tom Arie, professor emeritus, University of Nottingham

**Dr Malcolm Nicolson, director, Centre for the History of Medicine,
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Editor:

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Introduction

The specialty of old age psychiatry¹ has been developing in Britain since the 1940s.

We decided that a project was needed to capture the oral history memories of some of the early pioneers of the specialty, and that we would do this in the format of a witness seminar. Witness seminars are features of academic contemporary history research, and have for several years been used in the exploration of medical history by the Wellcome Trust at University College London.² Our seminar was hosted by the Centre for the History of Medicine at the University of Glasgow in May 2008. They have a special interest in social aspects of medicine. Generous financial support was given by the Guthrie Trust, to whom we are most grateful.

'Witnesses' were invited who could recount their own experiences of the history of old age psychiatry and introduce topics for discussion. The seminar was advertised in the Newsletter of the Faculty of the Psychiatry of Old Age at the Royal College of Psychiatrists, through the Centre for the History of Medicine, University of Glasgow, and by word of mouth.

More details of the format of the seminar are given in the main transcript in the introduction given at the seminar.

The sound recording of the meeting has been transcribed and footnotes added. Of note amongst the participants were several leading members - chairmen and secretaries - of the Group, the Section then the Faculty of the Psychiatry of Old Age at the Royal College of Psychiatrists,³ each of whom had a huge role in shaping and developing the specialty in Britain, a model which has been adopted in many countries around the world.⁴

The transcript should be of particular interest to old age psychiatrists, as well as others interested in the history of psychiatry, older people's health and medicine more generally.

¹ The terms 'old age psychiatry' and 'psychogeriatrics' have been used interchangeably, and this reflects their usage both historically and by seminar participants. The hyphenated term 'psychogeriatrics' may be used at times to denote collaborative working between geriatricians and psychiatrists, and reflects its use in official documents.

² Wellcome Trust Centre for the History of Medicine at UCL http://www.ucl.ac.uk/histmed/publications/wellcome_witnesses accessed 9.9.08

³ Chairmen: Dr Felix Post (73-78), Dr Sam Robinson (78-81), Prof Tom Arie (81-86), Prof Brice Pitt (86-90), Prof Dave Jolley (90 -94)

Secretaries: Prof Brice Pitt (73-78), Dr Peter Jefferys (78-82), Prof Dave Jolley (82-85), Prof John Wattis (85-89)

⁴ For example, Snowdon J, Draper B. 'The Faculty of Psychiatry of Old Age' *Australasian Psychiatry* (1999) 7: 30-32; Shulman K. 'The future of geriatric psychiatry' *Canadian Journal of Psychiatry* (1994) 39: no 8 supplement 1 s1-s8

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(Left to right: Sam Robinson, Tom Arie, Bill Boyd, Gordon Langley: Glasgow 2008)

Seminar programme

List of speakers introducing topics for discussion

Dr RA (Sam) Robinson	The earliest days - before 1970
Prof Brice Pitt	Early collaboration with other specialties and agencies
Prof James (Jimmy) Williamson	Psychogeriatrics seen from geriatrics
Dr WD (Bill) Boyd	The Scottish scene
Dr Klaus Bergmann	Research
Dr Nori Graham	Psychogeriatrics from the perspective of a junior doctor in the earliest days, and from the perspective of a part-time woman trainee
Prof Tom Arie	Educational opportunities and outcomes
Prof David (Dave) Jolley	The next generation of psychogeriatricians
Prof John Wattis	Surveying the specialty: the development of psychogeriatrics towards 1989 and recognition by the DHSS

Please note: References in the footnotes to *The Oxford Dictionary of National Biography*, *Who's Who* and *Oxford English Dictionary* can be accessed either via an Athens password, or for most places in England and Wales, via local authority libraries' online reference scheme.

Transcript of proceedings

Dr Malcolm Nicolson, director, Centre for the History of Medicine, University of Glasgow:

Open the windows, shut down the radiators if you're too hot or cold or whatever, just let us know. We are recording this event and it's important that people really speak into the microphone and also let us know who they are, if you don't do that I'll shout to you, OK?!

Anyway, any questions about housekeeping speak to me - and I'm looking forward to an interesting and cordial afternoon. And so I'll hand over to Claire.

Dr Claire Hilton, consultant old age psychiatrist, London:⁵

Thank you, Malcolm, and thank you all so much for coming. I hope everybody is going to enjoy the afternoon and that we will produce an important historical document in the process.

My name's Claire Hilton. I'm an old age psychiatrist but in my spare time I dabble in history.

The scope of the seminar today is to explore the development of mental health services for older people in Britain from 1960 to 1989. I'd just like to remind you of the format of a witness seminar. We have with us some very eminent witnesses to the early years of the specialty of old age psychiatry and some of them will be introducing various topics to encourage reminiscence and discussion. Those of you who weren't witnesses to the various events also have a very important role - to ask questions and encourage discussion. You are not here just as interested observers, but you're all essential to help produce as complete a record of events as is possible.

To our witnesses, we want to hear your stories and experiences, the things that happened behind the formal events, behind the documents and behind the reports and we want to understand better the significance of the developments in human terms - what changed? How it influenced people's lives - the patients, the families and the staff? You are welcome to either sit in your seats when you give your presentations or come and sit out here, whichever you would prefer.

Perhaps we could have a show of hands. Who are the psychiatrists here? Quite a lot, about 15. What about geriatricians? Only one. What about historians? About 8. And others? A few others. Thank you.

Visual aids are not permitted in a witness seminar, but I have two, mainly for the benefit of clinicians rather than historians. Clinicians have the tendency to bring history up to the present time and to view events through

⁵ For further biographical information on participants see appendix 1.

the retrospectoscope. But today is different, we really want you to time-travel back to the years 1960 to 1989. It's up there on the poster, and to try and remember what life was like at that time. Of course if you were practising medicine before 1960 you're very welcome to add in the earlier days.

I have another visual aid - a red card. I shall have no qualms about holding it up if anybody is boring me and hogging the microphone for too long - a red card means 20 seconds and no more! But really, seriously, please try and be concise because we want everyone to have the chance to talk and, if you want to contribute a question or a comment you must use the microphone as the proceedings are being recorded. Please introduce yourself briefly, just one sentence and always give your name when you speak otherwise the people transcribing the recording are really going to have a nightmarish job in trying to unscramble the sources of their information. So please be patient in waiting for Leigh, who's over there, to bring the microphone to you. We also have Steve at the back who's in charge of the recording.

One other point, please define any abbreviations. It's not just that some of us weren't in the specialty of old age psychiatry before 1989, but there's the Scottish *versus* the South of the Border differences, like the SHHD - Scottish Home and Health Department and the DHSS - Department of Health and Social Security. That would really be a great help.

So to begin with I'd like to ask Dr Sam Robinson to introduce the first topic which is 'The earliest days - before 1970.'

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(Left to right: Bill Boyd, Gordon Langley, Dave Jolley, Sue Jolley: Glasgow 2008)

Dr RA (Sam) Robinson, consultant in old age psychiatry, Crichton Royal,

Dumfries then Edinburgh:

Well first of all it's a great pleasure and honour to be here and to see so many Kent and younger faces.⁶ Excuse me sitting and reading, but I've discovered that even geriatricians are taken by surprise by the infirmities of old age.

A fellow at Crichton Royal in 1952 was expected to do a piece of original research. My consultant was Willie McAdam.⁷ He believed that dementia in the elderly was associated with a slowing EEG.⁸ He suggested that we try to establish a qualitative relationship; my part was to devise an intellectual rating scale sensitive enough to enable patients to be divided into 'mild', 'moderate' and 'severe' impairment groups refined by neurological examination and history. Willie, blinded of course, would grade the EEGs into categories of mild, moderate and severe slowing. We found an almost embarrassingly high degree of correlation significance at the 0.01 level.⁹

In the course of this work I spent a good deal of time in the back wards. At that time the Crichton Royal was one of Britain's leading psychiatric hospitals. However, as was the custom generally at that time, most elderly patients, certainly all organics, were admitted directly to the long-stay wards where they were often under the care of the newest recruit to the staff.¹⁰ It was inevitable that efficient diagnosis and treatment suffered. About this time PK McCowan,¹¹ the far-sighted superintendent, decided that all patients regardless of age should be admitted to one of the acute admission wards.

It fell to me to produce a paper outlining the results of our EEG study. Willi Mayer-Gross, the director of research,¹² arranged that I should present it at

⁶ Kent = known, little used south of the border! Used in Northern and Western Scotland (Oxford English Dictionary online)

http://dictionary.oed.com/cgi/entry/50126003?query_type=word&queryword=kent&first=1&max_to_show=10&sort_type=alpha&result_place=1 accessed 2.8.08.

⁷ William McAdam qualified in medicine in 1937. He was consultant in charge of the EEG department at Crichton Royal. He also wrote on subjects related to old age. (*The Medical Directory*, 1969)

⁸ Electroencephalogram, recording of electrical brain wave activity

⁹ McAdam W, Robinson RA. 'Senile intellectual deterioration and the electroencephalogram: a quantitative correlation' *Journal of Mental Science* (1956) 102: 819-825

¹⁰ In the context of old age psychiatry, organic conditions include the various dementias and delirium, whereas functional illnesses are mainly depression, psychotic illnesses and neurotic conditions.

¹¹ Tait AC. 'Obituary: Peter Knight McCowan' *Psychiatric Bulletin* (1979) 3: 117

¹² Freeman H. 'Gross, William Mayer- (1889-1961)', *Oxford Dictionary of National Biography*, Oxford University Press, 2004 <http://www.oxforddnb.com/view/article/51731> accessed 2.8.08

Mayer-Gross's important early contributions to the care of older people included: Mayer-Gross W. 'Arteriosclerotic, senile and pre-senile psychoses' *Journal of Mental Science* (1944) 90: 316-327; Mayer-Gross W. 'Convulsion treatment in patients over 60' *Journal of Mental Science* (1945) 91: 101-103. In addition, the standard textbook of psychiatry from the 1950s was being developed at Crichton

the Third Congress of the International Association for Gerontology, to be held in London in the summer of 1954.¹³ There it was received in a rather bemused silence - EEGs were still something of a novelty.¹⁴ Speaking in the section on treatment and management was Raphael Ginzberg from the Veterans' Administration Hospital, Tomah, Wisconsin.¹⁵ We happened to spend a good deal of time together during the congress and his views and experience impressed me. He had already published several papers on what he called 'attitude therapy' and other topics.¹⁶ Sadly he died soon after our meeting. But he had passed some sort of a baton to me.¹⁷ I cannot now recall when the notion of a specialised programme for the elderly occurred to me, it may have been on the long train journey home, which some of you will know gives ample time for rumination, but I still had at least three general trainee years ahead of me.

The opportunity to put some of my day-dreams into practice came some years later when there was a change of superintendent, James Harper, who was looking for some innovative ideas. An unfortunate result of the post-1952 policy of admitting all patients regardless of age to one of the acute admission wards was that admission wards tended to become blocked with partially recovered old people. Such a mixture of young and old was not in the best interest of either. The elderly person's restlessness was reactivated with the arrival of each new disturbed psychotic and the latter was projected only too readily into what was imagined to be a chronic and irremediable state. A logical solution seemed to be to create a specialised unit with its own admission ward and at the same time to apply some of the more recent developments in geriatric medicine.¹⁸ I suggested

Royal whilst Sam Robinson was a junior doctor there: Mayer-Gross W, Slater E, Roth M. *Clinical Psychiatry* (London, Cassell, 1954).

¹³ Macleod I. 'Introduction' 1-3, in *Old Age and the Modern World, Report of the Third Congress of the International Association of Gerontology 1954* (Edinburgh, Livingstone, 1955). Other speakers at this conference included Drs Martin Roth, Felix Post and David Kay, (p.393). There was no section on old age psychiatry or psychogeriatrics; it did not exist as a specialty. The section instead was called 'Neuropsychiatry'. The neuropsychiatry programme had been organised by Felix Post at the request of his geriatrician colleague, Dr Marjory Warren (Post F. 'Marjory Warren Memorial Lecture' Unpublished manuscript, Institute of Psychiatry. R16068 Feb 1979)

¹⁴ Robinson RA. 'The correlation between EEG abnormality and senile arteriosclerotic organic deterioration' 433-437, in *Old Age and the Modern World*, see footnote 13.

¹⁵ Ginzberg R. 'Psychiatric and psychological techniques in the treatment and management of elderly psychotics' 457-462, in *Old Age and the Modern World*, see footnote 13.

¹⁶ Ginzberg R. 'Attitude therapy in geriatric ward psychiatry' *Journal of the American Geriatrics Society* (1955) 3: 445-62

¹⁷ Clearly, Ginzberg was an important influence on Robinson. If Ginzberg influenced the founding of the Crichton Royal psychogeriatric department, he ultimately also had an influence on the development of services in the rest of the UK. Ginzberg wrote widely on the psychological needs of older people.

¹⁸ Geriatric medicine was recognised as a medical specialty in its own right in 1948, at the time of the establishment of the NHS. The philosophy of care became one of actively identifying and treating illness in older people and providing rehabilitation to achieve maximum independence e.g. see 'BMA report of the committee on the care and treatment of the elderly and infirm' *British Medical Journal* (1947) 1: Supplement 133-140.

such a psychiatric-geriatric service and the idea was eventually accepted. It was not without its opponents; some felt that this would be a luxury service which would dilute our already stretched manpower; others would be quite happy to unload their organics, but wished to retain remediable cases; yet others felt that all patients with intellectual problems, regardless of age, should be included.

The contributions to old age psychiatry of earlier staff members Mayer-Gross and Martin Roth helped to carry the day. A compromise was eventually agreed in that for a trial period of one year I should be responsible for all newly referred patients of 65 years and over, though not as a full-time commitment. The Board of Management gave me two weeks study leave in order to view the field, psychiatric and geriatric. I found several psychiatrists with a special interest in the elderly. There were Derby and Joan wards. Some specialised units admitted selected elderly patients, but nowhere did I find the sort of comprehensive service which I had in mind. We opened our doors on June 16th 1958. Our catchment area was South West Scotland, 2500 square miles, largely rural / agricultural, total population 150,000 of whom just over 10% were 65-plus.

Claire Hilton: Thank you very much. Who'd like to start discussion or make some comments?

Dr Klaus Bergmann, consultant old age psychiatrist, Brighton then Newcastle-upon-Tyne then Bethlem and Maudsley:

I was lucky enough to see Sam Robinson's unit when I came across to the Crichton and it really was remarkable for the way it was run and he may be surprised to see the thing that impressed me most.¹⁹ It was to see the chronic and mainly demented old ladies sitting in a circle peeling potatoes and talking to each other instead of the useless occupational therapy that they usually have to do and they were thoroughly socialised and doing something they'd done all their lives and I thought, really this was something that impressed me enormously. It may be too small to impress you from my impression, but I was very, very taken by it. Thank you.

Sam Robinson: Yes, well, of course we were indebted to a very active OT department, so most of the ideas came from them. But a lot of people rather decried such tasks and felt that 'It was not medicine', but it certainly was rehabilitative.

Klaus Bergmann: The patients didn't decry it, they looked alive and chatting to each other and competent.

¹⁹ Robinson RA. 'The organisation of a diagnostic and treatment unit for the aged in a mental hospital' 186-205, in *Psychiatric Disorders in the Aged, World Psychiatric Association Symposium* (Manchester, Geigy, 1965)

Dr Peter Jefferys, consultant old age psychiatrist, Harrow:

My memories are from 1969. I recall when I worked alongside Tom Arie when he started at Goodmayes that he told me that perhaps one in four of all over-65 admissions to mental hospitals were dead within a month of admission.^{20 21} Now the figure may not be one-in-four, but a figure of that order stuck in my mind; mortality post admission in psychiatric hospitals in the 1960s was high.^{22 23} It has relevance to Sam's observation about admitting someone to the back wards and not giving up on them. It is also relevant to the link with geriatric medicine that we'll hear about later.

Professor Tom Arie, Goodmayes Hospital, London then professor of Health Care of the Elderly, Nottingham:

Thanks, Peter, for reminding us of these early days.

I think it would be nice to put on record that when I started my unit in January '69 in an old mental hospital in East London my medical staff of two included a medical student on an elective, Peter Jefferys. Peter came and was my companion and helper and set about laying down the basis for a record system, using Cope-Chat™ cards.²⁴ (I think about two thirds of the audience here won't know what they are, but they were cards with holes that you put knitting needles into, having first clipped the relevant holes). I still have the cards and I still have the knitting needle with a cork on the end to make it less traumatic and I have the clippers for snipping open the holes.

²⁰ Goodmayes Hospital, Ilford, Essex

²¹ Arie T. 'The first year of the Goodmayes psychiatric service for old people' *Lancet* (1970) ii: 1179-1182

²² The mortality for admissions to geriatric wards was probably around 25-30% in the first month (Lord Amulree 'The formation of a geriatric service' (Typescript, 1953, British Geriatrics Society (BGS) archives).

²³ In Martin Roth's seminal study on the diagnosis of mental disorders in old age, data from the 1930s and 40s were analysed retrospectively (n=450). He identified a 36% death rate in people over 60 years of age in the first 6 months following admission (Roth M. 'The natural history of mental disorders in old age' *Journal of Mental Science* (1955) 101: 281-301). Connolly, Lumsden and Ross in a prospective study in 1961 found that 30% of 149 people aged over 60 died in the first 6 months of admission (Connolly J, Lumsden MR, Ross D. 'The care of old people 6 months after admission to a psychiatric hospital' *Medical Officer* (1964) 111: 195-198). Another study by Dr Cuninghame Dax at Netherne Mental Hospital gave similar results. He identified that, of older people admitted over a 2 year period, 40% died and 40% were discharged; 80% of these events occurred within the first 6 months of admission (BMA (1947) para 32. See footnote 18). These studies included some patients suffering from delirium.

²⁴ A simple early technology for the indexing of information used Cope-Chat™ (Copeland and Chatterson Ltd) index cards. These stiff cards were used for a plethora of indexing purposes with applications that included patient hospital records, library indexes, and the manipulation of census data. The cards were also used as a mechanism to index research data, <http://www.strychnine.co.uk/copechat.html> accessed 18.7.08.

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Cope-Chat™ card, knitting needle and clippers: unclipped (above) clipped (below) (Photographed by Tom Arie)



Peter was indispensable, and he spent about two months with me at the end of which he asked for a day off. We granted him a day off and the day off was to go to University College Hospital where he was a student and sit the surgery prize, which he won! So there's a little flash-back. I don't think the figures were quite as terrible on mortality, Peter, but of course there was a high mortality. And in those days one of the great issues was the misplacement of patients, and that is a story in itself.²⁵

The great problem was chronicity - the fact that once in you were at risk of never leaving. We showed at the end of our first year that we had greatly improved both the mortality and of course, above all, the return to the community from the hospital.

There is another person sitting next to Peter today who was our first - dare I say it now, it's very politically incorrect - 'married woman' doctor, but there were such people in those days, part-time - and that was Nori Graham. She'll no doubt have some comments to make. 'Part-time married women' as we still called them then, were a staple arm of our staffing and many of them went on to very great things.²⁶

Dr Gordon Langley, consultant psychogeriatrician, Exeter, then and now:

There were developments in the South West as well Scotland and London, which I'd like to put on the record. I think we probably started in Cornwall with Tom Wilson and Jimmy Donovan in the late 50s²⁷ but it certainly spread to Exeter.

I was appointed in '65 to run, with the geriatricians, a joint unit, and although it took us two years to get it open, for various shortages, it opened then and we had a very happy relationship for many years. It concentrated on the small group of people who fell between my general psychiatric colleagues who still looked after the elderly and the psychiatric patients that the geriatricians had a problem with. So we were looking at a narrow path, and our results, probably after an average stay of two months, about a third went home, a third went into long-stay care and a third went into some sort of private residential care. That was the early days of psychogeriatrics in Devon, anyway.

²⁵ Kidd CB. 'Misplacement of the elderly in hospital: a study of patients admitted to geriatric and mental hospitals' *British Medical Journal* (1962) ii: 1491-1495. This work undoubtedly influenced thinking at the time, although the conclusions were subsequently disputed. (Copeland JR, Kelleher MJ, Kellett JM, Barron G, Cowan DW, Gourlay AJ. 'Evaluation of a psychogeriatric service: the distinction between psychogeriatric and geriatric patients' *British Journal of Psychiatry* (1975) 126: 21-29). Also see footnote 199.

²⁶ Politically incorrect it may have been, even then, but Tom Arie was a staunch advocate for women doctors to achieve consultant posts. Arie T. 'Dear Royal Commissioners: a new deal for half our doctors?' *Lancet* (1976) ii: 1073-1076; Arie T. 'Married women doctors as part-time trainees' *British Medical Journal* (1975) iii: 641-647.

²⁷ Donovan JF, Williams IEI, Wilson TS. 'A fully integrated psychogeriatric service' 113-125, in *Recent Developments in Psychogeriatrics: a Symposium*. ed. Kay DWK, Walk A. (London, RMPA, 1971)

Professor David (Dave) Jolley, consultant psychogeriatrician, Manchester then Wolverhampton then Manchester again:

I'm Dave Jolley, Manchester. I spent ten years in Wolverhampton as well, but I'm again back in Manchester.

Like Peter I was a London medical student during the 1960s at Guy's Hospital and just to reflect, it was a most exciting time for psychiatry. Psychiatry as a whole was becoming less stigmatised. David Stafford-Clark who was one of the consultants at Guy's was the 'television doctor' at the time.²⁸ People seem to have forgotten about him, but he was very much someone who sold psychiatry as a good discipline that people could have sympathy with. For the medical students, he brought along marvellous people like William Sargant to talk in charismatic mode.²⁹ Then came Russell Barton who was the medical director at Severalls Hospital.^{30 31} I went and spent my special attachment for two months in the 'lunatic asylum' of Severalls. Russell had opened it up, taken down iron bars, and one thing and another. He had Tony Whitehead who was a medical assistant running an old age service and driving about in an ambulance with goodies in it - coal and tinned soup and stuff like that - so that you could help people stay at home.^{32 33} It was a wonderful and very exciting time and I think it was a privilege to be part of it.

And thanks very much, Sam for your talk. I still use the Crichton Royal Behaviour Rating Scale.³⁴ Let me say, I think it is terrific. Very brave. Psychogeriatrics began as part of social psychiatry's development and then we go on to celebrate the relationship with biological psychiatrists and the geriatricians, that's marvellous.

One of the things at Severalls, and also at Goodmayes, where I had the privilege to work with Tom Arie and Tom Dunn was that, yes, we worked in the community and went round and about every night seeing lots of people but we didn't neglect the people who were in the hospital. A lot was done to improve conditions in the hospitals and give back dignity to the

²⁸ Rollin H. 'Clark, David Stafford- (1916–1999)', *Oxford Dictionary of National Biography*, Oxford University Press, 2004 <http://www.oxforddnb.com/view/article/72839> accessed 2.9.2008. Also, written for a general readership, see, David Stafford-Clark *Psychiatry To-day* (Harmondsworth, Penguin, 1952).

²⁹ Physician in psychological medicine, St Thomas's Hospital. See his autobiography, William Sargant *The Unquiet Mind* (London, Heinemann Ltd, 1967).

³⁰ Rollin H. 'Obituary: Russell William Andrew Charles Barton: formerly physician superintendent, Severalls Hospital, Colchester, Essex, and later, *inter alia*, director, Rochester Psychiatric Center (USA)' *Psychiatric Bulletin*. (2003) 27: 35

³¹ Colchester, Essex, and see Gittins D. *Madness in its Place: Narratives of Severalls Hospital 1913-1997* (London, Routledge, 1998).

³² Jolley D.' Obituary: John Anthony Whitehead' *Psychiatric Bulletin* (2003) 27: 478

³³ The Severalls Hospital older peoples' service is described in detail in Whitehead T. *In the Service of Old Age. The Welfare of Psychogeriatric Patients* (Harmondsworth, Penguin, 1970).

³⁴ See footnote 19.

long-stay patients. So that's three ways, I think, social, biological and long-stay, that impact was made from those early days.

Professor John Wattis, consultant old age psychiatrist, Leeds then Huddersfield, and visiting professor, University of Huddersfield since 2000:

I just want to lay down a quick marker to the issues that are emerging for me. One is that in the early days I think there was a much closer link in many places between geriatric medicine and psychiatry at a clinical level³⁵... and I've forgotten what the other one is, but I'll tell you later!

Dr Colin Godber, consultant psychogeriatrician, Southampton:

I was a psychogeriatrician in Southampton from 1973 to 2005, now retired. I was just reflecting back. If you look at how things were in the NHS around 1960, it was still offering care from the cradle to the grave, only the very well-to-do went into nursing homes, so the NHS did the rest and the NHS budget at that time was about a billion pounds. That's my sole contribution on the 1960s; I hadn't got anywhere near psychogeriatrics at that time.

John Wattis: The other piece that I was going to say that really stands out is that the care of people with severe dementia was still recognised to be a health service responsibility at that stage.³⁶

Tom Arie: One of the interesting things to me is how people actually came into our field and I hope we'll hear a bit more of that, people's personal journeys into the field.³⁷ What strikes me is that there seem to be two important factors, although they didn't account for everyone. One was a charismatic figure who had inspired them. In my case there were two actually, one of course was Felix Post about whom we will speak more and another was Jerry Morris, professor of social medicine which was the other specialty I was in.^{38 39}

³⁵ Through much of the 1960s and 70s, geriatrics and psychiatry were practiced from separate, specialist hospitals. Neither specialty was yet fully established in most district general hospitals. Thus close collaboration often had to be carefully planned. However, during this period, psychiatrists and geriatricians collaborated to set firm foundations for good joint working. For examples see Enoch MD, Howells J. *The Organisation of Psychogeriatrics* (Ipswich, Society of Clinical Psychiatrists, 1971); Andrews J, Bardon D, Gander DR, Gibson KB, Mallett BL, Robinson KV. 'Planning of psychogeriatric care: a report of a joint working party of geriatric physicians and psychiatrists' *Gerontology Clinics* (1972) 14: 100-109; 'Joint report of the British Geriatrics Society and Royal College of Psychiatrists on matters relating to the care of psycho-geriatric patients' *British Journal of Psychiatry* (1973) 123: 'News and Notes' 2-3.

³⁶ Resources and responsibilities for old age psychiatry were delineated in DHSS *Services for Mental Illness Related to Old Age* HM(72)71 (London, HMSO, 1972), and applied specifically to England and Wales.

³⁷ Although some of this was revealed during the seminar, please also see biographies in appendices 1 and 2.

³⁸ Hilton C. 'Felix Post (1913-2001) pioneer in the psychiatry of old age' *Journal of Medical Biography* (2007) 15: 31-36

And that leads me to the second thing - people came from a background, very often, a bit divergent from mainstream medicine, for instance several of us were in epidemiology which at that time was a peripheral guerrilla activity, now it's well into mainstream medicine. Others came from a background outside medicine, or came into medicine late, and I was one of those. We were on the whole a group of odd-balls. We had different strings to our bows, and we had come up in front of some charismatic figure that gave us a pointer, not often an explicit pointer, not directing us into the field, because the field didn't exist, but somehow opened our eyes to it.

John Wattis: Tom's brought this to memory - when I went for my interview to be a lecturer in Tom's department, one of the people, I don't think it was Tom, because I'd been a missionary - said 'What can you bring to this job apart from missionary zeal?'

Claire Hilton: Anybody else? - Perhaps I can just ask Sam Robinson one question to finish this section, which is, what were your best and your worst memories of the years before 1970?

Sam Robinson: Before 1970? Well I think the best memory must be that the unit was a success and after the year's trial it was decided that it would become a full part of the hospital programme. Of that period I can't think of any bad things at all, it all seemed to be pretty good - no, I can't say anything bad.

Claire Hilton: Excellent. Thank you, shall we move on to the next section? I'd like to ask Professor Brice Pitt to introduce 'Early collaboration with other specialities and agencies' and then Professor Williamson to talk about 'Psychogeriatrics as seen from geriatrics', and then we will discuss both those topics together.

Professor Brice Pitt, consultant old age psychiatrist, Claybury Hospital then the London Hospital then St Mary's and the Royal Postgraduate Medical Schools, University of London:

I've been asked to speak from my individual experience, without overheads, slides or PowerPoint - a blessed relief which may also give you the pleasure of seeing my face!

In 1966 I was senior registrar to John Pippard at Claybury Hospital, Essex. The ethos was the therapeutic community that dominated at least the admission wards, and I loved it. About 80% of the admission wards were run according to the therapeutic community and I would say about 5% of the other wards, and I was caught up in this. I thought it was absolutely wonderful and found it liberating.

I was in my last year as senior registrar, having done the first two years at St Clements Hospital⁴⁰ where I mainly did research into post-natal

³⁹ 'Morris, Prof. Jeremy Noah', *Who's Who 2008*, A & C Black, 2008; online edn, Oxford University Press, Dec 2007 <http://www.ukwhoswho.com/view/article/oupww/whoswho/U28178> accessed 6.6.2008

⁴⁰ Mile End, East London

depression which is far and away the best thing I've done,⁴¹ but where I also was the senior registrar to a very quaint psychiatrist who didn't actually have a diploma of psychological medicine, Dr Ford Robertson.⁴² He was a general psychiatrist with an interest in psychogeriatrics. He ran a functional ward and a functional day hospital for older people. So I had some experience, and I had been trained in old age psychiatry (which I conspicuously missed at the beginning of my career when I spent four years in the army and never saw an old person at all).

Anyway, in 1965 Drs John Pippard and Dennis Martin, the superintendent, asked me if I'd be interested in doing a job in old age psychiatry because they were thinking of advertising for a psychogeriatrician. I'm not sure anybody had actually advertised a post for a psychogeriatrician before. Anyway, I said 'Yes', but I only said yes because I wanted to remain in the therapeutic community. I didn't mind doing old age psychiatry, I was not antipathetic to it, but I had no vocation. And then the appointments committee - the other candidates were very impressive, I won't mention their names unless they wish to later if they happen to be here, but I got the job because I was the favoured guy, you know, I was the local internal candidate.

And so I started with 400 beds, all full, on ten wards. I started with a waiting list of 40, all people who'd been seen by general psychiatrists and put on the waiting list for admission for their continuing care for their dementia. I had a senior house officer who happily had an MRCP in medicine, terribly lucky, because an awful lot of medicine, I discovered (well I knew it already), was needed in old age psychiatry. He was a first rate chap - David Toms. Tom Arie knew him at Nottingham. I had a part-time clinical assistant and I had an untrained, but extremely good, social worker. The catchment area was about 650,000, so that was about 60,000 old people spread through four boroughs, three in North and East London and one in rural Essex. I had no idea that this was an impossible task - because there were no templates. Obviously I knew something of the excellent work being done in other places but really I didn't haven't anybody to say 'This is the way you do old age psychiatry'.

I was very concerned about these people on the waiting list and in those days I prayed! And so there was a great plague that descended and wiped out about 30 patients from one of the wards, so I had enough vacancies to create an admission ward. I don't know whether that should be recorded, but anyway, it's spoken now!!! It had nothing to do with

⁴¹ Pitt B. 'Atypical Depression following childbirth' *British Journal of Psychiatry* (1968) 114: 1325-1335

⁴² From 1910, and until the Membership of the Royal College of Psychiatrists examination was introduced in 1971, the Diploma in Psychological Medicine (DPM) was a recognised specialist qualification for doctors working in mental health (Bewley T. *Madness to Mental Illness: a History of the Royal College of Psychiatrists* (London, RCPsych, 2008) 128). The DPM was awarded by various bodies. Almost all were Conjoint Board diplomas, the Maudsley being an exception in having a University of London DPM (Personal communication, Tom Arie).

prayer, I'm sure. It was just the way the cookie crumbles. We have already heard about the very high mortality of people coming in, notably from Martin Roth's research at Chichester.

The other thing was, I decided just like Sam Robinson has told us, I wanted a comprehensive psychiatric service dealing with all forms of mental illness over the age of 65. To be perfectly honest I wasn't certain this would be for the benefit of these people, it would be for the benefit of those working in the field who found it more interesting and varied and I don't think anybody's quite proven that there's more to it than that, but it was certainly something I was able to fight for. So in the first instance the people I had to relate to were the other psychiatrists in general psychiatry. For one thing, I said 'Look, I don't really want you to go out doing domiciliary visits and putting people on waiting lists, I would like to do them.' But they said 'We get paid to do these.' That was a problem which eventually got overcome because they saw it was reasonable if I was going to be dealing with these people that I should actually do the visits. I wasn't, to be honest in those days (as I am now!), I wasn't that bothered about the money. In fact very often I did home visits for no money at all, because my policy was to go and see the person if I could, if it was feasible, rather than make any decision about admitting them before they'd been seen at home. Nowadays I realise - I've read the excellent report of the last meeting here all about the days of domiciliary visits and how they've all gone - but I was reminded of what a heady time that was and what you could learn.⁴³

In its therapeutic community, Claybury regularly had general plenary meeting for more senior staff at which one was allowed to bring up things that were really worrying one and when I said 'I want to take everybody over the age of 65', they said 'Well, but you've got such an awful admission ward.' So I said, 'I need a better admission ward then don't I? I mean, if I'm to do the job.' And so with the help of the chief male nurse and matron, as they were called, and also an extremely sympathetic and empathic and understanding hospital secretary, the administrator, I created - we created - a (Ha Ha!) mixed-sex admission ward which we thought was fantastically progressive and I regarded that as one of my great achievements (Ho, Ho!). But it worked extremely well and I think it was the first mixed-sex admission ward in fact in Claybury which was rigidly divided, as some of you will remember, those who were around 43 years ago, rigidly divided into a male and a female side.

Now, working with four London boroughs there were four geriatric services, and I recognised that the people who knew most about providing hospital services for old people were the geriatricians so I sought to get to know them. Some were welcoming and a few were paranoid - that can be developed later if necessary. I was particularly inspired by Malcolm

⁴³ 'The history of domiciliary visiting in geriatric medicine' Witness Seminar, Centre for the History of Medicine, University of Glasgow, May 2007, unpublished transcript.

Hodkinson at St Ann's Hospital, Tottenham. I went on a ward round with him and he was very impressive. He went round with this group of physios and OTs⁴⁴ and social workers. He really showed me the multi-disciplinary team in action, rather than just talking about what it might do. It was all there, everybody was there at the time, and also he said, 'You don't want a waiting list, you never admit for continuing care, and you don't want to run a sleepy service' and I thought 'My God, the one thing I do not want ever to be accused of by Malcolm is running a sleepy service,' and so I tried to get my finger out.

Claire Hilton: Could you bring your introduction to a close, please?

Brice Pitt: Oh all right - I'll just go on to say that at a later stage I happily joined Christopher Silver in a joint psycho-geriatric assessment unit at a branch of the London Hospital⁴⁵ - a model which, save for Arie and Dunn at Goodmayes,⁴⁶ has never really flourished, mainly because of some of the problems that some geriatricians developed in their relationships with us and also their desire to get back into general medicine.

I must just say that the waiting list was dealt with by finding out who was on it, then finding out how many were alive, were dead or had been admitted to general or geriatric wards with fractures, strokes and other genuine medical emergencies. Those who were alive and at home I visited, and thus began a policy of visiting everyone referred for a comprehensive assessment, whether a DV had been requested or not,⁴⁷ which often found alternatives to admission, and helped me to get to know the catchment area from middle-class Enfield and Woodford, working-class Walthamstow and Tottenham to tied cottages in rural Essex. Sometimes I got lucky and met the general practitioner too, a very important thing to do.

I also must say that I took various directors of social services out to lunch to try to get a better relationship, mainly the debate was about 'Part Three'⁴⁸ places: how do you actually get any psychiatric patients into residential homes and how do people get patients from residential homes into psychiatric hospitals? I must - I'll finish on this - Dr DeLargy in Leytonstone had a notorious policy that he would only admit to a bed made vacant by

⁴⁴ Physiotherapists and occupational therapists

⁴⁵ Pitt B, Silver CP. 'The combined approach to geriatrics and psychiatry: evaluation of a joint unit in a teaching hospital district' *Age and Ageing* (1980) 9: 33-7. The joint psycho-geriatric assessment unit had been proposed in 1950 and again in 1970, but had never really become established. (Ministry of Health 'Care of the aged suffering from mental infirmity' HMC(50)25 (1950), typescript, Kings' Fund Library); DHSS *National Health Service Psycho-geriatric Assessment Units* HM(70)11 (London, HMSO, 1970)). Also see footnote 203 for joint provisions in Exeter.

⁴⁶ Arie T, Dunn T. 'A 'do-it-yourself' psychiatric-geriatric joint patient unit' *Lancet* (1973) ii: 1313-1316

⁴⁷ The term Domiciliary Visit (DV) was introduced in 1948 at the inception of the NHS. DVs were carried out at the request of the general practitioner and commanded a specific fee. Home visits instigated by the consultant or other team members did not carry this remuneration.

⁴⁸ National Assistance Act 1948, Part Three, required local authorities to make provision for older peoples residential homes, and applied to England, Scotland, Wales and Northern Ireland.

the acceptance of a patient from his ward into a residential home.⁴⁹ This was hated by social services and although I got a certain amount of *schadenfreude* from it, I felt it wasn't really on and tried to get a better way of working.

In those days, incidentally, the Alzheimer's Society did not exist,⁵⁰ and Age Concern did exist as the Old People's Welfare Committee and it changed its name to Age Concern in 1971⁵¹ and then I'd better shut up.

Claire Hilton: Thank you, Brice.

Brice Pitt: Oh, sorry!!! No, the other thing I had to do - had to eventually - I got so lonely and we, all of us, working in this got so lonely, we wanted to meet each other,⁵² so we got together and formed a Group which became a Section which became the Faculty of the Psychiatry of Old Age with regular representation from what I think was then the DHSS and we never looked back, did we?!⁵³

Unidentified voice: Encore!

Professor James (Jimmy) Williamson, consultant geriatrician, Edinburgh:

I was appointed consultant chest physician in Edinburgh in 1954 and joined the team of Professor Sir John Crofton who at the age of 96 I still see at least once a month and he's as fit as a fiddle, mentally, although he's not very fit physically.

⁴⁹ DeLargy devised various innovations in care, including for respite: (DeLargy J. 'Six weeks in; six weeks out. A geriatric hospital scheme for rehabilitating the aged and relieving their relatives' *Lancet* (1957) i: 418-419). DeLargy was one of the early advocates and pioneers of geriatric medicine who saw themselves as holistic practitioners for older people. Geriatrician Marjory Warren also wrote on the needs of people with dementia (Warren M. 'Care of Chronic Sick' *British Medical Journal* (1943) ii: 822-823; Warren M. 'Care of the chronic aged sick' *Lancet* (1946) ii: 841-843), as did Lionel Cosin (e.g. Cosin LZ, Mort M, Post F, Westropp C, Williams M. 'Experimental treatment of persistent senile confusion' *International Journal of Social Psychiatry* (1958) 4: 24-42).

⁵⁰ Founded 1979, and initially called the Alzheimer's Disease Society
http://www.alzheimers.org.uk/site/scripts/documents_info.php?categoryID=200126&documentID=81
accessed 18.7.08.

⁵¹ Founded in 1940 as the Old Peoples Welfare Committee (later National), chaired by Eleanor Rathbone, to alleviate the increasing problems experienced by old people during the Second World War http://www.ageconcern.org.uk/AgeConcern/our_story.asp accessed 18.7.08.

⁵² In 1971 a 'coffee house' group of psychiatrists working with older mentally ill people began to meet to exchange views and consider ways of improving psychogeriatric services (Group for the Psychiatry of Old Age (GPOA), Royal College of Psychiatrists, minutes of inaugural meeting, 9 Feb. 73, item 2).

⁵³ Group for the Psychiatry of Old Age, Royal College of Psychiatrists 1973-78. The Section started in 1978, and became a Faculty in 1988.



Professor Jimmy Williamson with Sir John Crofton (right), both pioneers of the triple chemotherapy treatment for tuberculosis
(http://www.rcpe.ac.uk/Whats_New/archive/2005/november-05.php, accessed 18.7.08, Royal College of Physicians of Edinburgh)

Now, we had a splendid time but when it got to 1958 I decided that probably the best time in chest diseases was over for me. During the war throughout Europe there was an enormous epidemic of tuberculosis, and when the war ended, in every country in Europe except two, the epidemic ended, mortality and incidence rates came tumbling down, except in Scotland and Portugal. Now, nobody knows why that was - we still don't know why that was - so when I joined the Crofton team in Edinburgh in 1954 our job was to control tuberculosis which we did - I won't go into the details of that but we certainly controlled it - and within two years having started with a waiting list of 400 patients we were transferring beds to other specialities, principally geriatric medicine.

So when it came to 1959 I decided I'd embrace geriatric medicine. I asked to see the senior administrative medical officer, who's still a friend of mine, and I went to see him on a Monday morning and we chatted and he said to me 'What is it you want to talk to me about?' and I said ' I want to transfer to geriatric medicine' and he looked at me and got up and walked across

the room, opened the door and said 'Come in' and his secretary came in and he said 'Say that in front of a witness!' Now that's funny. But once I became a geriatrician I realised that it wasn't all that funny because it was absolute hell. I mean when I joined the geriatric service in Edinburgh, there was one consultant in a city of nearly half a million people. He did six sessions a week and so I joined and I was given half the city, but I was also given the county of Mid-Lothian which was 120,000 people or something like that and quite a big area. And the thing that I realised was that the way we worked in the chest service and the way we tackled the tuberculosis epidemic, was team work. And that was why I embraced geriatric medicine because I thought I don't want to spend the rest of my life doing bronchoscopies and things of that sort, I want to work in a team, I want to have members of a team respecting my view and sharing it and getting ahead with it.

So we got on with the problem of geriatric medicine. But it was an enormous task - the first message I learned was that patients were being referred so late, patients with a stroke would be stuck in bed and two months later they would ask for somebody to do something about it, the geriatric service, and by that time, of course, it was too late. So we did a survey, we took a random sample of old people and had them seen by a consultant geriatrician, a psychiatrist and a social worker and we found that there was an enormous non-reported stratum of disability and serious illness in the community and we got this published in the *Lancet*⁵⁴ and it was the editor of the *Lancet* who said the title should be 'Non-reported illness in old age'. Among the highest ranking non-reported conditions were dementia and depression. So I realised what I already knew, that we had to do something about mental illness in old people. We had already been making overtures to the psychiatrists but with not much success. However we got a new professor of psychiatry - I think it was Alexander Kennedy,⁵⁵ wasn't it Bill? - Yes - so he came along and he was full of ideas some of which were very good, some of them probably weren't quite so good. Anyway, one of the things that he said was 'We're going to run a delirium unit' - not a delirious unit. So we sacrificed twelve beds, twelve precious geriatric beds, and his senior lecturer, Frank Fish, came along once a week and we ran this unit.⁵⁶ We wrote a little paper on it.⁵⁷ Theoretically it was for people who had suddenly become confused, having

⁵⁴ Williamson J, Stokoe IH, Gray S, Fisher M, Smith A, McGhee A, Stephenson E. 'Old people at home: their unreported needs' *Lancet* (1964) i: 1117-1120

⁵⁵ 'Kennedy, Professor Alexander', (1909-1960) *Who Was Who*, A & C Black, 1920-2007; online edn, Oxford University Press, Dec 2007

<http://www.ukwhoswho.com/view/article/oupww/whowaswho/U239379>

accessed 2.9.2008

⁵⁶ GH. 'Obituary FJ Fish' *British Medical Journal* (1968) ii: 832

⁵⁷ Fish F, Williamson J. 'A delirium unit in an acute geriatric hospital' *Gerontology Clinics* (1964) 6: 71-80. Fish's contributions to old age psychiatry are less well known than his monographs *Schizophrenia* (Bristol, John Wright, 1962) and *Clinical Psychopathology: Signs and Symptoms in Psychiatry* (Bristol, John Wright, 1967).

previously not been confused. But in fact, as you can well imagine, by the time we started analysing them - they were a very mixed bunch, some of them were dementia - or as we called them in these days chronic brain syndrome - and some of them were depression, some of them were pneumonias or anaemia, whatever, and we had quite an exciting time. But it wasn't possible to extend this as a general service, this was to really experiment. And my main benefit from it was I learned a great deal about psychiatry, and psychiatry of old age, from Frank Fish because my knowledge of psychiatry up until then was almost non-existent - I mean the training I got as a medical student - I think I saw two psychiatric patients and that was about all I knew about psychiatry.⁵⁸

Anyway we ran this unit successfully but under enormous pressure and then Frank moved to Liverpool to the chair of psychiatry and then we moved the hospital so that the twelve beds that had been the delirium unit no longer existed but we still continued to have visits once a week from a psychiatrist, Sally Gray, who was extremely co-operative and helpful to us.

Then after some time had passed we managed to get three new wards. This was heavenly, having struggled in broken down old workhouses and warehouses and goodness knows what, we suddenly entered brand new well designed wards - 90 beds, three wards of 30 beds - and we, my colleague and myself, decided we should give one of these wards to the psychiatric service.⁵⁹

We had a meeting with the psychiatrists and the senior administrative medical officer and they expressed great pleasure at this, the psychiatrists expressed their gratitude. And then I said 'And what are you going to do?' There was a pause and he said 'We'll try and get a senior registrar to come along once or twice a week.' So I got up and walked out. But the senior administrative medical officer, a very sensible chap whom I still see regularly - he persuaded me to come back in again and we pursued it from there and eventually we advertised a post as a consultant psychogeriatrician. And to my delight and slightly to my amazement Sam Robinson applied for the job. And of course, I was kind of surprised because I knew that he was running a very excellent service in Dumfries and Galloway and he was going to have to start with an enormous load and an enormous amount of ignorance and in-built suspicion, especially among the medical profession. However Sam came along and we proceeded from

⁵⁸ Geriatricians acquired considerable knowledge about mental illness in old age. Lionel Cosin, for example, started a psychiatric unit in his geriatric day hospital (Cosin LZ. 'The organisation of a day hospital for psychiatric patients in a geriatric unit' *Proceedings of the Royal Society of Medicine* (1956) 49: 237-239). For more information on Cosin see Irvine RE. 'Obituary: LZ Cosin' *British Medical Journal* (1994) 309: 189.

⁵⁹ Robinson RA 'Psychiatric care of the elderly: the organisation of a comprehensive service' 159-169 in *The Provision of care for the elderly* ed. Kinnaird J, Brotherston J, Williamson J (Edinburgh, Churchill Livingstone 1981)

there and ran the unit. We didn't run it jointly, but we collaborated closely and attended each other's case conferences and all that sort of thing.⁶⁰

Claire Hilton: May I interrupt? Because I do want to let other people respond to what you're saying because it's all so interesting.

Jimmy Williamson: Well I hope so too! Yes, I am drawing it to an end - in fact I have drawn it to an end but I didn't say that! So that was it.

Claire Hilton: So any questions, either to Professor Brice Pitt or Professor Williamson?

Klaus Bergmann: There was quite a lot of stimulus that the two specialities got from each other, Jimmy, so why do you think they've grown apart, and that geriatricians have grown towards wanting to be 'real physicians' and the psychiatrists as well.

Jimmy Williamson: Well can I say first of all that has not happened to anything like the same extent in this country you're in today. The care of the elderly in a specialist sense has been not preserved intact but it's certainly been guarded and still is being guarded. I don't want to name names but I think it's very sad and I think somebody will have to resurrect what's her name? - the lady in London - Marjory Warren,⁶¹ yeah.

Gordon Langley: I'd just like to put on record the collaboration with Exeter geriatricians. Jack Simpson and Bill Wright I'm sure were motivated towards a joint unit long before I was appointed, maybe nudged from Cornwall.⁶² I was welcomed and accepted with them and we had a very positive relationship, perhaps because I'd been a GP [general practitioner] for three years before I took up psychiatry and perhaps because by then I had an Edinburgh membership.⁶³ If there was any - it was hardy friction - let's say questioning - it came from my consultant psychiatric colleagues who didn't know what this specialty was all about - 'We're all seeing old people, you know, what's the song-and-dance about it?' And that was quite persistent, but nevertheless we overcame it. Indeed they were seeing old people. Devon, a retiring area, had over 20% elderly in many towns. It might also be noted that the Exeter medical officer of health Edward Irvine was on the management committee of the psychiatric hospital, and was most helpful, as was director of social services for Devon, John Hamson. I

⁶⁰ Robinson RA. 'Psychiatric care of the elderly: the organisation of comprehensive services' 159-169, in *The Provision of Care for the Elderly* ed. Kinnaird J, Brotherston J, Williamson J. (Edinburgh, Churchill Livingstone, 1981)

⁶¹ MMD. 'Obituary: Marjory Warren' *British Medical Journal* (1960) ii: 867-868

⁶² Cornwall had undertaken a major survey and review of its care for older people in 1947. Care was far from adequate, as indicated by the photograph taken by Dr Charles Andrews, and now in the possession of Gordon Langley (page 23). Notes of discussion on Andrews' report on long-term or chronic sick patients are recorded in 'Public Assistance Committee, institutions and general purposes sub-committee. Minutes of a meeting held at County Hall, Truro 15.Sept 1947' (Typescript, BGS archives). Also see Andrews CT. 'Early days in rural England' *Modern Geriatrics* (Jan 1971) (unnumbered pages in reprint, BGS archives).

⁶³ Membership of the Royal College of Physicians of Edinburgh

gather now there are four whole-time consultant psychogeriatricians in Exeter.



Madron Infirmary, Cornwall: a corner of the day room 1947
(Courtesy of Gordon Langley; see footnote 62)

Peter Jefferys: Referring to collaboration: the specialities that were absolutely essential in developing old age psychiatry in the '70s included, as already mentioned, geriatric medicine. I had the privilege of working for Malcolm Hodkinson for two years as his SHO [senior house officer] and registrar and wrote a paper with him, 'Making hospital geriatrics work', in the *BMJ*.⁶⁴ Partnership with public health physicians who could be valuable allies in

⁶⁴ Hodkinson HM, Jefferys PM. 'Making hospital geriatrics work' *British Medical Journal* (1972) iv: 536-539

recognising the need for specialised services for older people was important. One's general psychiatric colleagues were often the least helpful in terms of support for development and change. Social services managers were usually allies and every old age psychiatric service had its own approach to how they worked with them. I had a standard question at interview panels for candidates in the '70s and '80s 'You start your new job as consultant old age psychiatrist - whether you like it or not you have a induction meeting with the director of social services - what are you going to offer him, or her?' Many applicants didn't understand what the question was about, but most successful old age psychiatrists realised that understanding that you are on the same planet, how you're going to work together for the common concern of the older people who need your services was important.

No one so far has mentioned general practice. It is worth setting the scene. In the mid-1970s general practice began to establish vocational training, and to establish itself as a specialty in its own right. Later in the '70s, as a lobby its support for health service developments became more significant. An important dimension for many of us in this room was the advocacy and support for our services by general practice.

Dave Jolley: Dave Jolley, Manchester and other places. Just to say - returning to the relationship with geriatric medicine - this is Glasgow. A lot of geriatric medicine came from here,⁶⁵ - Ferguson Anderson,⁶⁶ Bernard Isaacs,⁶⁷ John Dall, and I think John Brocklehurst was here for a bit and was the first professor in Manchester. It was a tremendous thing to begin to work with these wonderful people. Many of the courses that taught old age psychiatrists and physicians were run by geriatricians. We were all enthusiasts for health care of the elderly, and although we didn't use that term, that's how it was. Bernard was a great psychogeriatrician, there's no doubting that.⁶⁸

We didn't always have shared wards. When I was appointed in Manchester I was recognised as honorary lecturer in both departments of psychiatry and geriatric medicine. Things were together, and we ran an out-patient clinic, together. It was easier to get along in the out-patients than in beds. We said it was dangerous to get into beds together, you

⁶⁵ Brocklehurst J. 'Unsung Heroes: Glasgow and the origins of geriatrics' *Newsletter of the British Geriatrics Society* (March 2005) http://www.bgsnet.org.uk/March05NL/08_heroes.htm accessed 19.7.08. Five past presidents of the BGS have been Glasgow graduates, namely, William Ferguson Anderson, John Brocklehurst, James Williamson, John Dall and Brian Williams.

⁶⁶ Williams B, Dall J. 'Obituary: Sir William Ferguson Anderson' *British Medical Journal* (2001) ii: 637

⁶⁷ Arie T. 'Isaacs, Bernard (1924–1995)', *Oxford Dictionary of National Biography*, online edn, Oxford University Press, Oct 2008 <http://www.oxforddnb.com/view/article/58197> accessed 14.10.2008. The aphorism of the medical presentations in old age, the 'geriatric giants' is attributed to Isaacs: incontinence, immobility, instability (falls) and intellectual impairment.

⁶⁸ Isaac's contribution to the mental wellbeing of older people was huge and includes, written jointly with Barbara Grey, *Care of the Elderly Mentally Infirm* (London, Tavistock Publications, 1979).

know, just for a smile. But the British Geriatrics Society⁶⁹ was also wonderful and people would go to joint psychiatric-geriatric meetings. It's still the case I think that the papers in *Age and Ageing*⁷⁰ have got more relevance than many of the papers in - certainly the Yellow Journal⁷¹ and possibly the Orange Journal.⁷² So it was a real help to us that we worked as social-medical people with physician hats on or psychiatrist hats on. We probably need to go back to Klaus's question 'How did we all fall out?' Or 'How did it all fall apart?' It seems a shame doesn't it?

Jimmy Williamson: Can I just say one thing? The other thing is that the academic input from geriatricians and psychogeriatricians was pretty slow in coming because the universities' door wasn't open.⁷³ But once that happened and we got students into wards and into our day hospitals and into our home visiting services then we changed the attitude of students very, very rapidly and that was probably one of the most important things that happened in the early and the middle days. The people who became the GPs then had a different approach, a different view of old age. It wasn't just putting them away somewhere but it was finding out what the problems were and how they could support them and their carers and I think that is something we should bear in mind and emphasise.

Brice Pitt: I'm Brice Pitt, healer of the mind! And former old age psychiatrist. I think the problem for many psychiatrists and geriatricians is they don't actually have the rapport or the enthusiasm. I mean these services, these joint services worked mainly because people got on extraordinarily well and were very committed. Now if you depend upon people being like that in their work it's rather difficult to plan for it. It requires a big commitment of one's time, I think, to work very actively in liaison with geriatric medicine and psychiatry. The other thing is that I'm embarrassed because I cannot remember his name, he's a distinguished geriatrician, he doesn't call

⁶⁹ British Geriatrics Society from 1959, originally the Medical Society for the Care of the Elderly, was founded in 1947 for 'the relief of suffering and distress amongst the aged and infirm by the improvement of standards of medical care for such person, the holding of meetings and the publication and distribution of the results of such research'. Early members included Marjory Warren, Trevor Howell, Lionel Cosin, Lord Amulree, Tom Wilson <http://www.bgs.org.uk/About/composition.htm> accessed 20. 7.08.

⁷⁰ *Age and Ageing* is the official journal of the British Geriatrics Society.

⁷¹ *British Journal of Psychiatry*

⁷² *International Journal of Geriatric Psychiatry*

⁷³ William Ferguson Anderson was the first professor of geriatric medicine (Glasgow, 1965), Tom Arie was the first psychogeriatrician to be appointed professor (Nottingham, 1977), and Elaine Murphy was the first professor of psychogeriatrics (Guys Hospital, London, 1983). Geriatrics and psychogeriatrics took very different routes to academic acceptability. Geriatrics had its origins in hospitals for the 'chronic sick' (previously Poor Law infirmaries), and the impact of clinical intervention and rehabilitation was associated with it becoming recognised as a clinical specialty under the new NHS in 1948. Meanwhile, ideas for psychogeriatrics emerged from Scotland in the early 1940s (see p.36). Psychogeriatrics evolved from strong clinical research roots, but initially had less profound widespread clinical impact or recognition than geriatrics. Important developments in psychogeriatrics at the Maudsley Hospital, a postgraduate psychiatric teaching hospital, were associated with the charismatic clinical leadership, teaching, research and writing of Felix Post, appointed there in 1947.

himself that, he calls himself a geratologist ... who am I trying to think of? Ah yes, Grimley Evans - a very charismatic, lovely man who really tried to drag geriatric medicine back into general medicine and was very active in making geriatricians, I think, feel less comfortable about being geriatricians.⁷⁴ I may be slandering him, I like him, but I think he didn't help the process.

Colin Godber: In the first issue of *Recent Advances in Geriatric Medicine* I was asked to write a chapter entitled 'Conflict and collaboration between geriatricians and psychiatrists.'⁷⁵ While researching that article I certainly was interested to find the many different models of good collaboration. I remember there was even a geriatrician in Middlesbrough who kicked the psychiatrists out altogether and did all the psychogeriatrics himself.⁷⁶ Where collaboration worked best there were usually two enthusiasts committed to community based services. If they ran a joint unit they had an agreement that admission only happened if there was a genuine need for joint care and that the appropriate specialist arranged prompt transfer or discharge when the joint management was no longer needed. Tom Arie and Tom Dunn managed on a tiny unit because neither had difficulty admitting to their acute units and each guaranteeing to discharge people when they no longer needed that joint unit. Each accepted patients to their own unit if assessed as needing it by the other and therefore never had to use the joint unit inappropriately. In some cases, such as the successful joint assessment unit in Cornwall led by the geriatrician Tom Wilson, one or other specialist was the main driver and underwriter of the unit's policy and turnover. In Southampton collaboration was hampered by the contrasting styles of the two specialties, with the geriatricians very much hospital based and happy to play second fiddle to the other physicians. I was very much in favour of the Scottish evangelical tradition of geriatric medicine led by Jimmy Williamson and Ferguson Anderson. There were many geriatric units in England showing that sort of resolve and community focus, chiming well with the new trend in old age psychiatry and attracting students and

⁷⁴ Grimley Evans J. 'Integration of geriatric with general medical services in Newcastle' *Lancet* (1983) i. 1430-1433

⁷⁵ Godber C. 'Conflict and collaboration between geriatric medicine and psychiatry' 131-142, in *Recent Advances in Geriatric Medicine* ed. Isaacs B (Edinburgh, Churchill Livingstone, 1978)

⁷⁶ Prinsley DM. 'Psychogeriatric ward for mentally disturbed elderly patients' *British Medical Journal* (1973) iii: 574-577. Some geriatricians also held the Diploma in Psychological Medicine (DPM) e.g. Kenneth Hazell ('Hall of Fame', BGS archives), John DeLargy (DeLargy J. 'The importance of morale in old people' *Medical Press* (1956) 235: 296-300), and James Affleck ('Hall of Fame', BGS archives). The earliest geriatricians who took over the chronic sick hospitals were faced with the care of patients with multiple pathologies including dementia. They only had people 'certified' for admission to mental hospital if other methods of care were impossible. Some people with dementia, they thought, could be managed safely at home. Others, in institutions, required various different levels of support. Disruptive behaviour and impaired communication led to people with dementia being placed in separate wards from those functioning well intellectually. The ethos of best possible rehabilitation was applied to people with dementia just as much as to people with physical illness (Andrews (1971), see footnote 62).

trainees to the specialties. Increasingly, however, the initiative slipped to those, epitomised by Grimley Evans, who hankered for the trappings of general medicine, at great cost to prevention and rehabilitation for older people.

Tom Arie: On the subject of geriatrics and psychogeriatrics I just want, as briefly as I can, to make a few points, as I think they ought to be written into the record. Mention has been made of my lovely colleague, Tom Dunn in Goodmayes.⁷⁷ He was the local geriatrician and I've often said that when you go into a new job you expect to find all sorts of disasters, like when you buy a house you expect to find things that the surveyor didn't mention. Just occasionally it happens the other way around, you go into a new job and you find a nugget of pure gold, and that was Tom Dunn. We worked together entirely harmoniously - an utterly sensible man with whom one constantly saw eye-to-eye. I came to feel that geriatrics and psychogeriatrics should be working collaboratively, as we did in Goodmayes.

So it came about that I was appointed in 1977 as a psychiatrist to a chair of geriatrics. I went to Nottingham to what they had named 'Health Care of the Elderly' where everyone expected a geriatrician, where the two external assessors were professors of geriatrics, both of them were knighted, though I think not entirely for appointing me! And at that time the supportiveness of people like Jimmy Williamson and Fergie Anderson, and other leading figures in geriatrics such as Norman Exton-Smith⁷⁸ to the appointment of a psychiatrist to what was in fact a chair of geriatrics was deeply moving and really needs to be recorded. It reflected harmony and friendship.

It wasn't always so on the coal-face, and when we set up a joint department in Nottingham the local geriatricians, it has to be said, were rather put out that a psychiatrist had been appointed to their chair. They saw it first, as sort of stolen by another specialty and we had great difficulties in putting together the resources for the psychiatric component, but we finished up with an entirely integrated joint department with physicians and psychiatrists and other professions related to the field and I think that was really a marvellous thing, and I'll come back to it when I talk about education because it enabled us to teach across the board on old people. So that's very important.

In reply to the point 'Why have things changed?' with geriatrics being said now to be redundant, yes, it's certainly the influence of individuals having the ear of government, but there is a sense that desegregation of the old is desirable, and, perhaps meaning well, some people in government feel

⁷⁷ Armstrong J. 'Obituary: Thomas Bryce Dunn' *British Medical Journal* (2008) 337: a862 http://www.bmj.com/cgi/content/extract/337/jul18_1/a862 accessed 31.8.08

⁷⁸ Irvine RE. 'Norman Exton-Smith' *Munk's Roll 1989-93* 9: 160-6 (Royal College of Physicians of London)

that that is right and popular. It's ageist, they claim, to have special arrangements for old people and the pros and cons of this story are not straightforward but they need to be related afresh - i.e. why it is necessary to concentrate on an unprestigious, neglected, unsexy group and why if you don't concentrate on them and make it your priority they will be neglected. And I think politicians, well-meaning, often not being made sufficiently aware of this, are taken with the ageist desegregatory line. Just as there are targeted services for children (it hasn't always been so) so there need to be some targeted services for the old.

Marie Bergmann, married to Klaus:

My name's Marie Bergmann - rather an intruder, so I'd like to make an outsider comment. It seems to me that true co-operation stems from the psychiatrist having a curiosity, interest and knowledge in the physical side of illnesses that can come up - and that the geriatrician needs to have a psychiatric interest and drive for knowledge on that side because if they're just two separate people they don't even know when to hand over - you get that instinct of 'that's not quite right for me, I need some other side to it.' That's what I feel, I may be quite wrong.

Dr Nori Graham, consultant old age psychiatrist, Royal Free Hospital, London:

Just for the record, when I was appointed old age psychiatrist to a consultant job in a teaching hospital in London, I was given no beds at all, the opposite of many of the stories you've been hearing, but the four beds I was offered were from the geriatrician and I've always worked extremely closely with geriatric medicine really until I left the Royal Free.

Claire Hilton: Any other comments?

Sam Robinson: I would like to ask Brice a question - I think you mentioned the meetings that preceded the Group for the Psychiatry of Old Age but you didn't mention the personnel, I wonder could you do so now?

Brice Pitt: Well, there was that Tom Arie, there was - who else was there? - Jim Cockburn who never was an old age psychiatrist - he acted as if he was - there was I think Loic Hemsy.⁷⁹ He unfortunately was one of the many of us who - well not us - but of our former colleagues who didn't make it through this tough career. There was Raymond Levy? No there was not Raymond Levy - but there might have been! Ha, Ha, Ha!!! Who else was there?

Tom Arie: I think the group was you, Brice, and the places I remember us meeting were at Goodmayes, at Long Grove where there was Jim Cockburn and Loic Hemsy, and there was Carrick McDonald at Warlingham Park - I think that was probably it, our little coffee-house group as you called it at the

⁷⁹ ACH. 'Obituary: Loic Hemsy' *Psychiatric Bulletin* (1988) 12: 555

time. Then Raymond came in a few years later when he returned to the Maudsley from being a general psychiatrist at the Middlesex ...⁸⁰

Brice Pitt: ...and then we all went to Felix and said 'Will you be king?' - or something!⁸¹

Claire Hilton: Can I just make one comment if there aren't any others, possibly to trigger a couple of comments, briefly, from anybody in the audience. I like the quote that 'It has been said that psychogeriatrics belongs to the family of psychiatry, is married to geriatrics and conducts an often stormy affair with social services.' How does that live up to peoples' recollections?

Brice Pitt: *C'était moi!* I think I said it! I won't continue!

Colin Godber: I think in my experience the relationship was a bit different. I wouldn't say I had an affair with social services, we generally got on well with them. I never went in for 'swapping' which was a sort of much derided practice because if I swapped a patient who was in a social services bed I'd never be able to discharge them, therefore it was a very bad deal for the psychogeriatric service, that was the only reservation I had about it. But with geriatric medicine I sort of locked horns with the professor and my colleagues built up a very nice relationship with the rest of the geriatricians and I have to say I got on, personally, very well with the professor, but it's just that we always seemed to have a different view on anything to do with how to run a service.

Claire Hilton: Thank you. I think we should move on to the next section, thank you very much for your contributions.

Dr WD (Bill) Boyd, consultant psychogeriatrician, Edinburgh:

I'm Bill Boyd,⁸² psychiatrist, psychogeriatrician from Edinburgh. I think we're allowed to reminisce here - it's really reminiscence therapy for me. I'm going to be a little bit naughty and say that my psychiatry started in 1930 because I was born in the physician superintendent's house of a mental hospital in Fife. And I say that because actually I was closely involved in that hospital right through my childhood and adolescence and what a happy place it was - and that's all I'm wanting to say of those days. Those hospitals get such a bad name nowadays, but it is worth recalling that all patients, including the elderly, were looked after, to my mind, extremely well. The physician superintendent knew the names of all his patients, of course, and the social events which I used to go to filled me with great joy and I think quite a lot of the patients too. So, I didn't start in psychogeriatrics in 1930!

⁸⁰ Others included Klaus Bergmann and Garry Blessed (Newcastle). Arie T. 'Martin Roth and the "Psychogeriatricians"' 231-238, in *Contemporary Themes in Psychiatry: A Tribute to Sir Martin Roth* ed. Davison K, Kerr A. (London, Gaskell, 1989)

⁸¹ Dr Felix Post (1913-2001) was invited to chair the newly formed Group for the Psychiatry of Old Age, Royal College of Psychiatrists. GPOA minutes 9 Feb. 73 item 5.

⁸² Bill Boyd interviewed by Tait D. *Psychiatric Bulletin* (1997) 21: 769-774

I've also got 'The Scottish scene' as my title, but if you don't mind I think I'll keep to the very personal reminiscence, except to say that in Scotland what I remember over these years are the several reports which came out and which I certainly was very much aware of. Just remembering names, there was a 'Millar Report',⁸³ there was the 'Tait Report',⁸⁴ there was Gerald Timbury's report⁸⁵ and so on and as far as I recall, all of them were taken up with the problem of the ageing population looking for the best way to find space for them, the appropriate level of staffing for them, the type of accommodation for them and so on and I think that was the theme in all these reports which took us through from the '60s.⁸⁶

Anyway I started psychiatry when I was in the army and of course I only saw young men there and I saw psychotic young men and learned about this new drug called Largactil.⁸⁷ That was my introduction to psychiatry. When I came out of the army - and now I'm into 1957 - my first job in psychiatry was in a peripheral hospital as they were called, in a peripheral mental hospital in Lothian, where there was a super service, great interest in community care and so on. But there was the old people's ward which I still remember quite well because the old people sat around the wall, some of them sat on commodes all day long, the nurses rushing around with disinfectant spray and trying to keep the noise down, etc, etc. It was really pretty grim in those days, as some of you will remember. But when I came into psychiatry at the Royal Edinburgh, as Jimmy Williamson has said, my senior there was Frank Fish and every Monday morning he'd set off - we didn't know where he went, really, but he went off to see someone else in another hospital and came back full of enthusiasm about this other place and this other person and about all the old ladies he'd been seeing. So I began to understand that there was something else going on in the world of psychiatry that I didn't know much about.

And then my real interest came around 1969 to '70 when at the Royal Edinburgh Hospital, a large psychiatric hospital, the admission wards were

⁸³ Millar M. (chair), *Services for the Elderly Mentally Disordered* (Millar Report) (Edinburgh, Scottish Home and Health Department, 1970). This report concentrated on organisation and strategy for elderly care not on target levels of provision.

⁸⁴ Tait A. (chair) *The Future of Psychiatric Services in Scotland* (Tait Report) (Royal College of Psychiatrists Scottish Division 1973). Tait was physician superintendent, Crichton Royal Hospital.

⁸⁵ Timbury G. (chair) *Services for the Elderly with Mental Disability in Scotland* (Timbury Report) (Edinburgh, HMSO, 1979) Timbury was physician superintendent, Gartnavel Royal Hospital. The Timbury Report in many ways was amalgam of all that had gone before, including decentralisation of long-stay care. For other references to reports relating to Scotland also see Christie AB. 'The Scottish scene' Section Newsletter (1985) 7: 17-20 (unpublished typescript, circulated to members of Section); Royal College of Psychiatrists (Scottish Division) 'The psychiatrist's contribution to the care of the elderly' (Unpublished typescript, 1977, GPOA archives).

⁸⁶ The earliest report was indeed in the 1960s, thus preceding written plans in England: *The Psychiatric Services for Old People in Scotland* (Henderson Report) (RMPA, Scottish Division, 1969).

⁸⁷ Chlorpromazine, introduced 1952, was the first anti-psychotic, Shorter E. *A History of Psychiatry* (New York, Wiley, 1997) 246-251.

gradually drowning in old age which I guess was happening around the country and we were really having great problems in the numbers game and in finding places for young psychotic patients.

I should have said at the beginning that I was also part-time senior lecturer at the University of Edinburgh and of the two lectures which I had to give per annum to under graduates, one was on organic psychiatry and one was on old age. They gave me that because I'd studied neurology at some point, I think that was why. So in organic psychiatry I found myself talking about these fascinating conditions which I hadn't actually seen, but they were pre-senile dementias, Pick's disease, Jacob Cruetzfeldt disease, and Alzheimer's disease which was a very rare condition too and it intrigues me that Dr Alzheimer and myself are surprised to find that later in our lives, or my life, Alzheimer's is such a wide-spread condition, and that the name has spread so far. And the other thing I had to do in the old age lecture was to tell these students about the advancing problem of the elderly and I showed them the appropriate graphs showing the numbers going up and so on. I don't know if any of them noticed what I said, or remembered it, but it's always intrigued me that each generation, or each decade, another group of politicians and clever people come along and say we've got a problem, we've just discovered that the population of the elderly is increasing. The giving of those lectures was my main involvement in psychogeriatrics.

And then slightly later we had this problem of increasing numbers of old people coming into acute wards. Others have talked about this already. We decided to make a radical change. My colleague - there were very few of us consultants in those days at the Royal Edinburgh - one of us was to do long-stay psychotic patients and one of us - and I drew the lucky number - I was to deal with the geriatric population. And the best thing, the first good thing that happened was that we did have two small quite attractive wards, occupied by old people and we decided they would be admission wards for old people, over 65, organic and functional. The biggest problem was with the nurses in charge, the charge nurses in the wards. They really didn't like this at all. They didn't want their old fashioned ways to be taken over and yet they became so enthusiastic and such wonderful allies in the new role that they were asked to play. I've really always remembered that, and certainly when I was doing my reminiscing for this session today. So that was the first thing, of setting up a proper service for the elderly. We were very short of space, very short of beds and we did have, in spite of what others have said, we did have a waiting list. The way I coped with that was by the team approach which we've heard about too. Every morning we did our 'cardex' meeting and we talked about who was the latest, most immediate problem that was facing us and of course we had general practitioners who were angry and cross at us, we had consultants from the general hospitals angry and cross at us, and the patients we'd seen ourselves in their homes, who weren't angry and cross, but their

relatives were very, very distressed. So that was a way of coping, I found the only way of coping, with the huge pressure that we had.

And the other way I had at that stage was that a health visitor - and it does come back to personalities this whole business, I think, a health visitor who decided that she would be a psychogeriatric health visitor and she and I did the visits - I did the visit and then she came along a day later to sort of say 'How did you get along with that chap?' and then gave them huge advice and support and helped me to make an appropriate assessment of the people I'd seen. Still desperately needing a day hospital and then a ward became empty - it's funny how wards just happen to become empty at the right time and it just makes all the difference. This was an acute psychiatric ward which, I don't know why it wasn't used - well I do, but we won't go into that - and the best thing I did was appoint the sister to that ward who was absolutely brilliant, who had all the enthusiasm and the youth - I could go on about her quite a lot.

I must also talk about the geriatrician because I didn't talk during the discussion. I went to see the geriatrician when I was formally appointed as psychogeriatrician, I went to see him and he agreed to see me, put it that way. And he sat behind his desk and smoked his pipe and there was a lot of smoke coming out of it. He wondered aloud whether they could find any patients for me. They would try to help me to see some patients. He was not in the business of co-operation. However, when Jimmy Williamson came back⁸⁸ the whole scene changed for me, because I now had a unit with which I could liaise and which I did.

And the last thing! And this is the last lap, honestly! The voluntary sector again - we did manage to persuade the local funny little old group called the Edinburgh and Leith Old People's Welfare Council which had residential homes, to open a day centre, not a day hospital, but a day centre. But they did take mildly demented people and it formed another placement that we could find for the people we were seeing at home. So that covers my interest.

Claire Hilton: Thank you very much. There are several comments already.

Bill Boyd: ... (seeing Dr Reid take the microphone!) If you are going to say that's not true! ...

Dr Andrew Reid, consultant psychiatrist, Dundee:

Just a little idiosyncratic perspective from the Scottish scene. Psychiatrists had a great difficulty recruiting to learning disability in the 1960s and one of the initiatives in Scotland was the Committee on Staffing Mental Deficiency Hospitals chaired by then Professor Ivor Batchelor suggesting joint work between general psychiatry and learning disability.⁸⁹ I was appointed to one

⁸⁸ From the University of Liverpool

⁸⁹ Batchelor IRC. (chair) *The Staffing of Mental Deficiency Hospitals: Report of a Subcommittee Constituted Jointly by the Standing Medical Advisory Committee and the Standing Nursing and*

of these Batchelor posts in 1972. A few months previously Brian Ballinger had been appointed.

In the 1970s Brian's interest increasingly focussed on old age psychiatry and he developed a female psychiatry service in Tayside but the elderly male service remained completely unreconstructed. Then at a staff meeting with Hector Fowlie, well known to many of you here, I volunteered to take on the male old age psychiatry service on the basis of four sessions of general psychiatry, four sessions of old age psychiatry and three sessions of learning disability which is a bit of an odd combination and would give the College nightmares now. But anyway it did lead to a male old age psychiatry service and it also provided me with a clinical base for developing a research interest in dementia in learning disability along with a very astute neuropathologist in Edinburgh, Anthony Maloney.⁹⁰ This was really virgin territory at the time because people with learning disability had very limited life expectancy and nothing was known about dementia amongst them. Their life expectancy was just beginning to increase and Anthony and I had this productive collaboration for some years. We were able to show that dementia in people with learning disability could be diagnosed clinically, and the clinical diagnosis could eventually be confirmed neuropathologically.⁹¹ Over the years since then problems of old age have become much more of an issue with learning disability and this research project has become increasingly relevant. We also had a stake in Alzheimer's disease and Down's syndrome work which has proved another fruitful line of investigation

Claire Hilton: Any other comments from the Scottish scene?

Peter Jefferys: It's just an observation, Dr Boyd mentioned Dr Timbury. In the '70s when he was very active in the Royal College, although he wasn't an old age psychiatrist, he was very much an ally and a supporter as well as a fixer and a doer. His contribution as a Scotsman to the development of old age psychiatry in England and within the College needs to be credited. He died suddenly as people will know.⁹²

Claire Hilton: Thank you. If there aren't any other comments at the moment ...

Sam Robinson: I would like to make a comment, but it applies rather to the paper on collaboration by Brice. On one occasion when I was severely under the weather, bed wise, at Crichton Royal, I wrote to the medical officer of health

Midwifery Advisory Committee (London, HMSO, 1970). Batchelor, Sir Ivor (Ralph Campbell), *Who Was Who*, A & C Black, 1920–2007; online edn, Oxford University Press, Dec 2007 <http://www.ukwhoswho.com/view/article/oupww/whowaswho/U6753> accessed 28.9.2008

⁹⁰ Reid AH, Maloney AF. 'Giant cell arteritis and arteriolitis associated with amyloid angiopathy in an elderly mongol' *Acta Neuropathologica* (1974) 27: 131-137; Reid AH, Maloney AFJ, Aungle PG 'Dementia in ageing mental defectives: a clinical and neuropathological study' *Journal of Mental Deficiency research* (1978) 20: 67-76

⁹¹ Yates CM, Simpson J, Maloney AF, Gordon A, Reid AH. 'Alzheimer-like cholinergic deficiency in Down's syndrome' *Lancet* (1980) ii: 979

⁹² CMBP. 'Obituary: Gerald Timbury' *Psychiatric Bulletin* (1985) 9: 211

suggesting that we should meet and discuss our mutual problems and he wrote back and said that he didn't have any problems, but he'd be quite happy to hear mine!!

Claire Hilton: Any other comments ...? I'd just like to add one. If you take our history back to the 1940s I think we should mention that Scotland had a major role in the very early development of old age psychiatry. In the 1940's there was Willie Mayer-Gross at Crichton Royal writing about how older depressed people benefited from ECT.⁹³ We had at the same time Felix Post in Edinburgh writing about making accurate diagnoses and multi-disciplinary working⁹⁴ and we had Erwin Stengel, also in Edinburgh, writing case reports about dementia which included social factors and stresses on the family.^{95 96} And I think we have to include that as a very important part of the development.

Any other comments about Scotland?

Jimmy Williamson: Tony Maloney was mentioned by one of the speakers and could I just say that it's always amazed me that Alzheimer's disease was almost unknown until 1976 when Tony Maloney wrote his paper on the pathology of patients with chronic brain syndrome, showing that they did have the features of Alzheimer's disease.⁹⁷ This reminded me of when I was a student I went to do a clinical clerk-ship in a hospital near Glasgow. It was 1942. There was a ward which contained 30 or 40 patients with post-encephalitic Parkinson's disease and the other clinical clerk and I - it was Christmas time - we said we must put on some sort of show for these poor patients because they were all perfectly mentally clear, but most of them were pretty severely disabled. So we put on a sort of pantomime for them and I was to be the consultant physician and we were looking around for a very exotic disease that nobody would ever have heard of so we looked up the text book of neurology and here was a chapter on Alzheimer's, pre-senile dementia⁹⁸ and so we used this as an exotic condition that nobody would ever know anything about and it wasn't until 1976 that it did become known again.

Gordon Langley: If we're talking about pathology in psychogeriatrics I think the name of Nick Corsellis ought to be mentioned. He was working on the pathology of senile dementia and paralleling much of Roth's work, first in

⁹³ See footnote 12.

⁹⁴ Post F. 'Some problems arising from a study of mental patients over the age of 60 years' *Journal of Mental Science* (1944) 90: 554-565

⁹⁵ Jenner FA. 'Erwin Stengel. A personal memoir' 436-444, in *150 years of British Psychiatry* ed. Berrios GE, Freeman H. (London, Gaskell, 1991)

⁹⁶ Stengel E. 'A study on the symptomatology and differential diagnosis of Alzheimer's disease and Pick's disease' *Journal of Mental Science* (1943) 89: 1-20

⁹⁷ Davies AP, Moloney AJF. 'Selective loss of cholinergic neurons in Alzheimer's disease' *Lancet* (1976) ii:1403-1404

⁹⁸ Stelzmann RA, Schnitzlein HN, Murtagh FR. 'An English translation of Alzheimer's 1907 paper, "Über Eine Eigenartige Erkankung Der Hirnrinde"' *Clinical Anatomy* (1995) 8: 429-431

Runwell in the 1950s when I got there, and later at the Maudsley and his work clarified a lot of the issues that we have since worked with.⁹⁹

Claire Hilton: Thank you. I think these two last comments from Professor Williamson and Gordon Langley, lead very nicely into the next section which is Klaus Bergmann speaking about research and then at the end of Klaus's section we're going to have a break.

Klaus Bergmann: I'm Klaus Bergmann, ex-Maudsley, ex-Newcastle, ex-Sheffield, right? I'm going to give a much more distant view in some senses that it's not just my reminiscences, though I've got too many of those. Claire Hilton was kind enough to mention me in the tail end of the German Jewish contribution to British psychiatric services¹⁰⁰ so I think I'd like to tell a story pertaining to my ethnic origins.

There was a group of German Jewish refugees at a café in Swiss Cottage, in London, and they were discussing life in Germany before they left, before they had to flee.

The first one talked about his life as a company director, his eminence.

A prominent judge was another one.

A great university professor and surgeon in a university hospital.

A great success in business with branches all over the town, in Germany.

And there was finally another little man and they turned to him and said 'What were you then?' He said 'Me? I was nothing' he said 'but the Pekinese here was a St Bernard'!!

Now I still feel I'm in the Pekinese class, but I did know and was aware of a lot of St Bernard's! And I'm going to talk about some of them, preferably without brandy round their collar.

Now my first contact with research in the area was the Newcastle-on-Tyne team with Martin Roth and David Kay and they carried out one of the first random survey samples of older people in the community.¹⁰¹ But perhaps you should go earlier than that and look at Roth's work at Graylingwell, Chichester, because what he did was really to, first of all, elegantly and simply describe the major syndromes and to sort them out.¹⁰² Secondly, to subject them to follow-up and outcome measures, and in psychiatry outcome is often vague, but survival is fairly good, and most people can tell whether someone's dead or alive, and whether you were still in hospital or not was also something that was unarguably measurable. So he used those and he followed up people with major descriptions of affective disorders, late paraphrenia (I know that that's been challenged as a term,

⁹⁹ Corsellis JAN. *Mental Illness and the Ageing Brain* Maudsley Monograph 9 (London, OUP, 1962)

¹⁰⁰ Hilton C. 'A Jewish contribution to psychiatry: Edward Mapother, Aubrey Lewis and their Jewish and refugee colleagues at the Maudsley Hospital and Institute of Psychiatry 1933-1966' *Jewish Historical Studies* (2007) 41: 209-229

¹⁰¹ Kay DWK, Beamish P, Roth M. 'Old age mental disorders in Newcastle upon Tyne Part 1 A study of prevalence' *British Journal of Psychiatry* (1964) 110: 146-158

¹⁰² See footnote 23, Roth (1955).

but it describes people with schizophrenia-like and persecutory symptoms in old age), the dementia group and the delirium group and he found, on follow-up, the most incredible and quite clear cut differences in outcome. A high proportion of the dementias were dead, 50% of the deliriums had gone out and the other 50% were dead. A high proportion of the depressives achieved discharge, virtually none of the paraphrenics did; this was in the age before regular neuroleptic medication. And so he established not only a difference in outcome, perhaps repeating what Kraepelin had done for the psychiatric population but also a way of looking at people that was no longer lumping them all together in a therapeutically hopeless mass.¹⁰³

Having these definitions allowed epidemiology to take its course and it did in countries that had good electoral samples - and that's mainly Scandinavia and Great Britain. In America such a thing would have been quite impossible - decent epidemiological work took a long time to come to root in America and France and Germany with their mixtures of private practice and their clinics - they weren't so suitable. Anyhow, in the Newcastle survey - David Kay did very careful work to look at all the electoral wards and the social strata they represented and he obtained random samples that were representative to the population as a whole in Britain, and his team went out and they did semi-structured interviews to determine the diagnostic categories and ascertain the people with absence of psychiatric morbidity, and also a verbal inquiry into physical capacity and health which was, in fact, quite good.¹⁰⁴ And then these patients were examined again. This is perhaps where I come in for my small snapping Pekinese role - that I followed up the original Kay, Beamish and Roth sample and extended it.¹⁰⁵ There were significant differences in outcome between the diagnostic groups so although they were nothing like severe enough to force them into hospital they did, very significantly, differ for mortality and for institutionalisation. And this was an important thing because it was discovered, really, that the vast majority of psychiatric pathology in old age was not in hospitals and institutions, it was in the community. This had a profound influence on the treatment and care of people.

Dr Kay had already made significant contributions before this. After working at Graylingwell with Professor Roth, he got a foundation scholarship of some kind to Swedish hospitals. Now, in Sweden they are painstakingly careful in having psychiatric records, I think, kept by each

¹⁰³ Engstrom EJ, Weber MM. 'Emil Kraepelin (1856-1926)' 49-52, in *A Century of Psychiatry* ed. Freeman H. (London, Mosby-Wolfe, 1999)

¹⁰⁴ Roth M, Kay DWK. 'Social, medical and personality factors associated with vulnerability to psychiatric breakdown in old age' *Gerontology Clinics* (1962) 4: 147-160

¹⁰⁵ Kay DWK, Bergmann K. 'Physical disability and mental health in old age' *Journal of Psychosomatic Research* (1966) 10: 3-12; Kay DWK, Bergmann K, Forster E, McKechnie A, Roth M. 'Mental illness and hospital usage in the elderly: a random sample followed up' *Comprehensive Psychiatry* (1970) 11: 26-35

priest in the locality about outcome and admission and so on. He took a cohort of elderly people with psychiatric diagnoses in Swedish hospitals and then went back through their records.¹⁰⁶ I can't give you all the things here, because she'll stop me! But one of the things that I thought was very interesting - he looked at people, ladies, women perhaps if I may use that word, who had either affective disorders or paraphrenic disorders which had started later in life, and looked at their early records. And he found that of those ladies in both groups who had had their children - if I may put it - 'out of wedlock' the people who later became depressed - but at that time had no morbidity visible - were more likely to marry the putative fathers than were the ladies who later got paraphrenia. So already he demonstrated, by such a skilful research record evaluation, the inherent personality differences between the two groups before they ever got ill. It was the quality of that kind of work and David Kay's analytic ability that amazed me and impressed me, and I was very lucky because he was my supervisor.

In our follow-up work we looked at the predictors of mortality in institutionalisation of the 300 people Kay, Beamish and Roth survey. It was certainly clearly evident that people with dementia died much more frequently, were institutionalised more frequently and people with affective disorders also died more frequently than those that were normal.

Then we actually had to do what the DHSS paid us for, which is something that one does reluctantly, but slowly and hesitantly, and we found out that the needs of people was what they wanted us to look at and we looked at the fulfilled and unfulfilled needs and there were a remarkable number of unfulfilled needs for unknown psychiatric disorder. People didn't have any kind of day-care, didn't have any kind of even out-patient attendance and very few actually received manifest treatment for psychiatric disorder although it was present to a very large degree.^{107 108}

And the other thing we were able to do was to produce one of the earlier tables of incidence of senile dementia against age groups. Later, of course, this was superseded by much more standardized questionnaires and follow up by Copeland *et al.*¹⁰⁹

Claire Hilton: I'll stop you in about a minute.

¹⁰⁶ Kay DWK. 'Outcome and cause of death in mental disorders of old age: a long term follow-up of functional and organic psychoses' *Acta Psychiatrica Scandinavia* (1962) 38: 249-276

¹⁰⁷ Kay DWK, Beamish P, Roth M. 'Some medical and social characteristics of elderly people under state care' *Sociological Review* (1962) (Monograph 5) 173-193

¹⁰⁸ Kay DWK, Roth M, Hall MRP. 'Special problems of the aged and the organisation of hospital services' *British Medical Journal* (1966) ii: 967-72

¹⁰⁹ Copeland JR, Kelleher MJ, Kellett JM, Gourlay AJ, Gurland BJ, Fleiss JL, Sharpe L. 'A semi-structured clinical interview for the assessment of diagnosis and mental state in the elderly: the Geriatric Mental State Schedule' *Psychological Medicine* (1976) 6 439-449; Copeland JR, Dewey ME, Griffiths-Jones HM. 'A computerized psychiatric diagnostic system and case nomenclature for elderly subjects: GMS and AGE-CAT' *Psychological Medicine* (1986) 16: 89-99

Klaus Bergmann: OK, right. And so this was important. Sorry, I have to turn the page over. So the interesting thing to me, too, was how well normal people did in old age and that the vast majority of the elderly were not hypochondriacal, they were fit, they were active, they were capable and they often did a lot of work to support their families.¹¹⁰ This really drew me into old age psychiatry, the feeling that there was something to aim for, there was a model that represented the majority of older people, and that entering treatment, and care of the elderly in a psychiatric unit, was aiming for something that was quite evidently possible. I was lucky, too, that I attended the meeting of the World Psychiatric Association in 1965,¹¹¹ I think, in which Dr Stokoe, Sam Robinson, Nick Corsellis, all presented their work and of course the beginning of the plaque and psychiatric standardised measurements between Professor Roth, Professor Tomlinson and Dr Blessed were clearly presented.¹¹² The other person who impressed me enormously, and it was the first time I ever heard him or met him, was Felix Post, presenting his very careful study of paranoid illnesses, their treatment, their liability to relapse without treatment and the outcome of his series of follow-ups.¹¹³ I could present more, but I'm going to be stopped so I'll stop voluntarily!

Sam Robinson: I was interested in your comments about the contribution of Jewish psychiatrists. I've just been reading *Hitler's Gift*,¹¹⁴ which is a book by the widow of Peter Medawar - but that is devoted to scientists, mostly physicists - I'm not aware of any comparable book on medicine.¹¹⁵

Klaus Bergmann: I don't know about medicine, but psychiatry, Dr Hilton - Frau Dr Hilton, if I may call her that - has written on it.¹¹⁶

Sam Robinson: It's certainly a book waiting to be written. Which brings me to my other point which links in with the Scottish scene. The PK McCowan whom I mentioned was a very broad minded chap and he recruited to the

¹¹⁰ Bergmann K. 'The normal elderly - a by-product of a survey' 251-256, in *Contemporary Themes in Psychiatry: a tribute to Sir Martin Roth*, ed. Davison K, Kerr A. (London, Gaskell, 1989)

¹¹¹ *Psychiatric Disorders in the Aged, World Psychiatric Association Symposium* (Manchester, Geigy, 1965). Note that the terms 'psychogeriatrics' or 'old age psychiatry' do not appear in the title: the terms were almost unknown. This conference was a major event with an international faculty of presenters, and still clearly remembered 40 years later by delegates and speakers alike.

¹¹² Stokoe IH. 'The physical and mental care of the elderly at home' 237-246; Robinson S. 'The organisation of a diagnostic and treatment unit for the aged in a mental hospital' 186-205; Corsellis N. 'Cerebral degeneration and the mental disorders of later life' 292-309; Roth M. 'Psychiatric problems of old age in relation to the problem of ageing' 84-89; Blessed G, Tomlinson S. 'Senile plaques and intellectual deterioration in old age' 310-321; in *Psychiatric Disorders in the Aged*. See footnote 111.

¹¹³ Post F. 'Diagnosis and management of paranoid syndromes' 108-120, in *Psychiatric Disorders in the Aged*. See footnote 111. Also see Post F. *Persistent Persecutory States in the Elderly* (London, Pergamon Press, 1966).

¹¹⁴ Medawar J, Pyke D. *Hitler's Gift: The True Story of the Scientists Expelled by the Nazi Regime* (London, Piatkus Books, 2001)

¹¹⁵ Cooper J. *Pride versus Prejudice. Jewish Doctors and Lawyers in England 1890-1990* (Oxford, Littman Library, 2003)

¹¹⁶ See footnote 100.

staff at the time of Hitler's repressions very many Jewish psychiatrists including Willi Mayer-Gross, Erwin Stengel, Robert Klein,¹¹⁷ Liselotte Frankl,¹¹⁸ Fritz Berliner and Frederick Kräupl Taylor.¹¹⁹

Unidentified voice: And Martin Roth?

Klaus Bergmann: Ah, well he was second generation.

Sam Robinson: I will just make a comment about Martin Roth here. I think he absorbed from Mayer-Gross a good deal of his interest in old age psychiatry. As junior staff we were entertained to a chapter of *Clinical Psychiatry*¹²⁰ each week in the early '50s, and Mayer-Gross had more or less already delineated the five categories of mental illness in older people.¹²¹ The main difference was that Martin substituted 'late paraphrenia' for 'paranoid states'. And, moreover, the most valuable part was - as you've said - Roth's studies on incidence and outcome.¹²² It was, I think, particularly benevolent of PK McCowan that he recruited all these people in the knowledge that they were going to out-shine him, which was a pretty rare event.

Tom Arie: I think there was another dimension of research which is worth recording, and that is that the exercise of setting up a new field of psychiatry and testing out whether it was viable was a research project. A null hypothesis was being tested. Certainly, I saw it in that way. Psychiatry was stigmatised, mental hospitals were stigmatised, (psychiatry in general hospitals was beginning). The elderly were stigmatised. What if anything was remediable about this unattractive farrago of working with mentally ill old people in large asylums that would bring in good people and transform it? Was it inherent to working with mentally ill people, with old people? Was it the shoddiness of the institutions, which contaminated those who worked in them? Was it because good people, able people, didn't want to be seen as working in slums, in low status settings? Was it because the work was inherently unrewarding? These were hypotheses that were inherently being tested and it was certainly very much in my mind when I went into this field saying 'Must it be so? Or can it be very different?' And results, in a sense, were self-evident - that extremely able people came into the field, and that it could be made both intellectually and emotionally rewarding to them.¹²³ Good work could come out of it. It could ultimately, and I won't go on because we'll be talking a bit about education later, ultimately become a quite major activity in universities, could be made

¹¹⁷ His contribution to the care of older people included: Klein R, Mayer-Gross W. *The Clinical Examination of Patients with Organic Cerebral Disease* (London, Cassell and Company Ltd, 1957).

¹¹⁸ CY. 'Obituary: Liselotte Frankl' *Psychiatric Bulletin* (1989) 13: 334

¹¹⁹ MS. 'Obituary: Frederick Kräupl Taylor' *Psychiatric Bulletin* (1989) 13: 394-395

¹²⁰ Mayer-Gross W, Slater E, Roth M. *Clinical Psychiatry* (London, Cassell, 1954)

¹²¹ Affective, senile, and arteriosclerotic psychoses; delirious and paranoid states.

¹²² See footnote 23, Roth (1955).

¹²³ Arie T. 'Morale and the planning of psychogeriatric services' *British Medical Journal* (1971) iii: 166-170

attractive to students, and so on, and these were open questions which were tested in the field. 'Action research' is the word that's sometimes used, perhaps it's the right word. So what we're recounting here is the result of a research project by all of us.

Bill Boyd: Thinking about research, it comes to me that the Medical Research Council (MRC) unit for brain metabolism in Edinburgh worked - still working perhaps¹²⁴ - but with George Ashcroft in charge did a lot of work which, maybe, didn't reach the clinicians so much, but it was a very active, forward looking unit. I'd just like to mention that.

John Wattis: Just another reflection - which is the whole importance of the post Second World War inception of the National Health Service as creating a context in which all this social entrepreneurship by doctors both on the research and on the clinical field could actually happen. It's changed now, we've moved to a more totalitarian top-down sort of thing, and we're perhaps also even moving to a more market led situation, but we did have this brief period which was highlighted to me recently speaking to a Polish doctor - where we had a social - if you like a socialist state but not a communist state - a non-totalitarian socialist state and I think that created the environment in which old age psychiatry thrived briefly and hopefully will thrive again.

Peter Jefferys: A brief anecdote: in 1976, at Northwick Park Hospital where I was a new consultant, there was a consultant-wives group. This was a group of consultant-wives, because consultants had to be men, which wanted to have a social opportunity. Twice a year they would have a social get-together - all the hospital consultants and their wives and partners (men were allowed to be honorary wives!). I was introduced to the wife of another consultant in the general hospital. She asked me 'And what's your specialty?' and I said 'psychogeriatrics.' Her face dropped 'Oh I am sorry!'

Another question is 'Where did funding for research come in the '70s and '80s?' My recollection is that it was hard to find to find money for research into old age psychiatry - very difficult indeed. There was not, as now, pressure from Alzheimer's and other societies to fund. The MRC was grudging - it had one or two specialist units - but otherwise it was generally grudging. In some university departments there were advocates, like Martin Roth, who was quite good at getting money, but most of the time there was precious little research. There was support from the DHSS for some service initiatives, with very considerable support in the '70s and some of that required some pump priming money, but in terms of the cost of doing decent, high quality research it was absolutely as tough as anything in the '70s.

¹²⁴ Not listed on Medical Research Council website
<http://www.mrc.ac.uk/AboutUs/UnitsandCentres/UnitCentreDetails/index.htm?FL=&OBJ=Edinburgh>
accessed 20.7.08.

Klaus Bergmann: Could I come on to Peter Jefferys, he's quite right. Martin Roth was one of the best money-extractors I've ever met, although he wasn't proud of it. I once mentioned it to him and he gave me a funny look. But he had a special relationship with both Dr Cohen¹²⁵ and then Dr Brothwood¹²⁶ at the DHSS, and unlike nowadays where you presented to vast committees to get refused or doubted, he seemed to get it in an easy way. When I was appointed consultant he said 'Oh, I'm sorry you're going, I've got five years more money.'

Claire Hilton: I'm going to stop you there because it's important that we do have a break and it's nice to be stopping on a high with lots of money! So thank you.

Tea Break

Claire Hilton: Are we ready to start again? I'd like to ask Dr Nori Graham to talk about psychogeriatrics from the perspective of a junior doctor in the earliest days and from the perspective of a part-time woman trainee.

Nori Graham: Thank you very much, Claire, Tom, Malcolm for inviting me. It seems I'm the only woman speaker amongst the witnesses - *plus ça change!* Just to summarise my career until I entered old age psychiatry. I got married in 1960, qualified as a doctor in 1961 and had three children in '64, '65, and '68. I desperately wanted a job in psychiatry. I'd always wanted to be a psychiatrist. There I was, an Oxford graduate, living round the corner from the Maudsley Hospital, but did anyone want to employ a part-time doctor? Forget it! And of course, I was a woman! Forget it even further. So it was a male world. But happy the evening I had dinner with Tom who I'd known from before. He told me how he was starting this new unit at Goodmayes Hospital, and he was looking for part-time girls! It was girls that he always used to call us thirty to forty year olds, up until extremely recently! Of course, we never dared call him a boy! He offered me three clinical

¹²⁵ Dr R H L Cohen CB MRCS (1907-1998) was on the staff of the MRC from 1948, serving as Deputy Chief Medical Officer from 1957-62. He was seconded to the Ministry of Health as Principal Medical Officer from 1962, was Deputy Chief Medical Officer to Sir George Godber from 1967, and finally was the first Chief Scientist to the Department from August 1972 until his retirement on 1 April 1973. See Wilson JMG. 'Richard Cohen: First Chief Scientist at the DHSS' *Journal of the Royal Society of Medicine* (1998) 91: 222-224. Cited in Witness Seminar Transcript ed. Reynolds LA, Tansey EM. *Clinical Research in Britain 1950-1980*. Wellcome Witnesses to Twentieth Century Medicine Volume 7, 2000, <http://eprints.ucl.ac.uk/2073/1/wit7.pdf> accessed 9.9.08.

¹²⁶ Brothwood J. 'The organisation and development of services for the aged with special reference to the mentally ill' 99-112, in *Recent Developments in Psychogeriatrics* (see footnote 27); Dr John Brothwood MRCP, FRCPsych, FFOM. Medical Officer, then Senior Principal Medical Officer DHSS, 1964-1978, an ally of old age psychiatry. 'Brothwood, Rev. John', *Who's Who 2008*, A & C Black, 2008; online edn, Oxford University Press, Dec 2007 <http://www.ukwhoswho.com/view/article/oupww/whoswho/U8930> accessed 2.9.2008.

assistant sessions (that's all he had!) and it was a long way from where I lived - an hour there and an hour back but beggars can't be choosers, and so I made the decision to do three clinical assistant sessions in two days a week, Tuesdays and Thursdays.

I began in 1969. It was a landmark decision for me, it really was, and the beginning of an extremely rewarding professional life that has really changed my life. I was so lucky to be part-time. I mean I think anyone who's had the opportunity to be part-time knows how wonderful it is. You've got the happiness having a job and finding that rewarding, you're able to spend time with your family, so you don't miss out on that score and you earn a bit of money for you have to have a bit of money to get out of the house. I was extremely fortunate in having a supportive husband. My husband, as some of you know, is a child psychiatrist and there was a point when I thought two psychiatrists in a family, it's never going to work, but I desperately wanted to do psychiatry myself so I didn't let that stand in my way. And I had good support at home to care for my children when I was out of the house. It was somebody who came in when I left and left when I came in. And these were always mature women who had brought up children themselves, I was really fortunate. They were the equivalent of grandparents; it was very reassuring. And of course although I didn't make very much money, (at that time clinical assistant sessions paid more than trainee sessions), it didn't leave very much money over, but what an investment, looking back, what an investment that was!

For some reason when I started having children I lost all my ambition. I spent two years in Goodmayes followed by three in a hospital nearer my home. For six years I never even thought I'd become a consultant or do any exams and I said to one of my colleagues, a consultant colleague - a male who will remain nameless - I said 'Should I bother taking these exams, these membership exams?' And he said 'No, I wouldn't bother.' I went straight home and opened the books!!

So I got my membership exams in 1976 but before that I decided to persuade Professor Russell who was professor of psychiatry at the Royal Free Hospital at the time - I said to Gerald 'You must do something for part-time women, it's high time, here I am, clinical assistant, I need to be on the ladder.' He took two years, but he really plugged away into getting me a traineeship and in the midst of that I got my membership so he had to turn his mind to changing registrar to senior registrar. He used to phone me up and tell me the progress he was making - I'd be peeling potatoes with all these children around waiting for their supper. I owe a great deal to him. So I got into old age psychiatry by sheer chance; it was a job opportunity - I never even thought of what sort of psychiatry I wanted to do and what a lucky chance that was!

What are the advantages and disadvantages of being part-time? At the time I thought only of the advantages. If you're only at work for a short

space of time you have to focus on the one thing and it's the patients, you don't have to do any of the other sorts of things that people go off to do and I found that quite helpful. The important thing as a part-timer, then as now, is you've got to lead the way, you've got to know what you want and mould your own career, but you've also got to have some supporters. In this room are several of my ardent supporters through all the years that I've been working and I couldn't have done without them.

So what do I feel about psychogeriatrics and those early days? I just remember these huge wards with large numbers of patients but what was so phenomenal for me was to be with Tom who was such a charismatic person. He really paved the way for my future. He told me how - he showed me, not me personally, but all of us. Many of us part-time women who worked with Tom went into old age psychiatry afterwards and that must, and does, reflect on Tom. He made it so exciting, he even made the blood test results exciting - I mean we used to leave on a Tuesday and think how can we wait until Thursday to hear that blood test result! I remember a famous time, Tom, when you know I'd forgotten bits of my medicine and you accompanied me to my car and I was crying my heart out because I just couldn't remember some certain haematological indices and you said to me 'It will get better!' Well, it never really did! But you introduced me to the idea that when somebody does a good job, you reward them. You introduced me to the whole idea that everything about an older person can be seen as good. Taking me on visits, impressing on me the importance of listening to carers and to families as well as introducing the idea of volunteers onto wards to do paramedical things like occupational therapy that I'd never seen happen before. Then, of course, as a result of all this, I saw people getting better, I saw people being discharged, I saw us starting to empty those wards - how fortunate I was. This was only part of what I learnt and I hope that I've been able to pass on what I learned to others in a similar sort of way when I became a consultant in old age psychiatry. I got a part-time job at the Royal Free back in 1981 and was given virtually no resources. I was given a room without a window, half a locum secretary, a third of a junior doctor and four beds. These came from the geriatrician, Michael Green, with whom I'd started to do domiciliary visits so that I could learn more about how he worked and how to work with him when I became consultant. That was my beginning and, although it sounds a most deprived existence, in fact it was the very opposite because of course everything was out there in the community and our lack of resources meant we did everything we could to prevent people from coming into hospital.

There are two other things I really want to mention - one of them is, of course, if you working part-time, you're bringing up the family, some things have to go and research was one of those. But before I became a consultant Gerald Russell said to me 'Now's your moment to take part in some research' and I had the real privilege of working with Enid Levin at

the Institute of Social Work looking into the problems of carers of people with dementia at home. I saw 150 families and learned about all their problems - I learnt so much, so quickly before I became a consultant. So that was one piece of research.¹²⁷ And the other piece of research which has also been a landmark in my life is taking part with Anthony Mann in the Camden 'Part Three' home study, looking at the amount of depression and dementia in residential homes - and to this day that study is quoted.¹²⁸ The findings are still valid and now, at last, this year, we have the *National Dementia Strategy*.¹²⁹ I can't believe it's taken all this time to get where we are.

Claire Hilton: Thank you Nori. Can we move on to Tom's contribution on 'Educational opportunities and outcomes' and then we will discuss junior doctors training and so on?

Tom Arie: Well, what can I say? Nori, I wasn't quite expecting that - it's good that this isn't illustrated or you'd see me blushing! An important thing to say, very seriously, is that excellent people like Nori came to us and that gave one so much confidence, the fact that people like this, people of this quality and enthusiasm and intelligence actually wanted to work here. People were joining us - one must be on the right track! I'm at least as much in Nori's debt as she so kindly speaks of being in mine and in the debt of all the other quite remarkable people we got.

Now, all of us have had this experience that was referred to earlier on - people saying 'Couldn't you get a better job?' or 'What bad luck you have to go into psychogeriatrics!' Nowadays when I go to meetings I see the younger generation of colleagues, of whom there are now so many, including extremely able academics, whose excellent work gives me so much encouragement, one thinks, well this is the living proof that this important, necessary, neglected field can give every sort of intellectual and emotional satisfaction to good people.

Now, education. I come from a rather bookish background. Goodmayes was my real first step out of a teaching hospital. And what a world away it was from the teaching hospital, the London, where I was still a senior lecturer when I went to Goodmayes. At Goodmayes there was no tradition of education. This was before the days of structured training schemes, rotating schemes supervised by the College. This was in some ways an asset, for I could largely recruit my own staff. I was determined that

¹²⁷ Levin E, Sinclair I, Gorbach P. with Essame L, Graham N, Mortimor J, Waldron G, Waterson J. *Families, Services and Confusion in Old Age* (Aldershot, Gower Publishing, 1989)

¹²⁸ Mann AH, Graham N, Ashby D. 'Psychiatric illness in residential homes for the elderly: a survey in one London borough' *Age and Ageing* (1984) 13: 257-265; Ames D, Ashby D, Mann AH, Graham N. 'Psychiatric illness in elderly residents in Part III homes in one London borough: prognosis and review' *Age and Ageing* (1988) 17: 249-256

¹²⁹ Department of Health, *National Dementia Strategy* (2008)

<http://www.dh.gov.uk/en/socialcare/deliveringadultsocialcare/olderpeople/nationaldementiastrategy/index.htm> accessed 7.9.08.

everything should be done, as far as one could, in a spirit of teaching; that was fun for me, and I think it was appreciated.

And of course, as Nori says, in the end we had a sequence of fourteen part-time married women, for whom we tried to offer more than just being 'a pair of hands', to offer them teaching, something that developed them and their careers. How far we succeeded is not for me to say, but it was certainly fun doing it and I've never done so much personal teaching before then or since then as I used to do in Goodmayes. Indeed, psychogeriatricians quickly learn to utilize what might not self-evidently be assets, and one of the phrases that came into my mind at the time was 'that trouble can be a teaching tool.' We had so much trouble - the workings of the system, the frustrations, that it can actually be built into teaching material, and so can be put to constructive use. So this phrase that I coined at the time 'trouble as a teaching tool' was also relevant.

The other thing that I quickly learnt was the legitimising value of print. Very important was to publish, and as we published we became better known, that brought more people, that brought a certain measure of acclaim and thus of clout with the authorities, and again made it easier to have teaching opportunities, more invitations to teach, more people coming on attachments, and I think for the purpose of our record one needs to mention a few of them. Of course there was Nori, and another excellent person, Rosemary Meier, who joined us very early. There was Dave Jolley, and Ken Shulman - now the leading psychogeriatrician in Canada.¹³⁰ Ilana Glass¹³¹ and Fiona Subotsky¹³² were two of our people who did great things later on, though not in psychogeriatrics. Then we had various geriatricians who came to us who later became very prominent, Jackie Morris¹³³ and Mary Piper¹³⁴ were among them. Others are here and have already spoken - Peter Jefferys, Colin Godber, all sorts of people that passed through the unit and helped it to be a teaching resource. Later there was Elaine Murphy who became the first professor of psychogeriatrics (I was the first psychogeriatrician professor and Elaine was the first professor of psychogeriatrics, and she is now a very eminent person). So it was said by a well wisher at the time that Goodmayes had become the 'Queen Square of psychogeriatrics'.¹³⁵ That is not a fair boast, there were other, more eminent places, but it set a mark on what was possible.

¹³⁰ Both Dr Rosemary Meier and Professor Ken Shulman are psychiatrists in Toronto.

¹³¹ Ilana Crome (née Glass) is professor of addiction psychiatry, Keele University Medical School.

¹³² Dr Fiona Subotsky, emeritus child and adolescent psychiatrist, South London and Maudsley NHS Trust, and treasurer of the Royal College of Psychiatrists.

¹³³ Dr Jackie Morris is honorary consultant geriatrician, University College Hospital, London and former secretary, British Geriatrics Society.

¹³⁴ Dr Mary Piper, formerly secretary, British Geriatrics Society, now Prison Health Unit, Department of Health.

¹³⁵ 'Queen Square' is colloquially used to refer to both the prestigious National Hospital for Neurology and Neurosurgery at Queen Square, and the Institute of Neurology, University of London.

However, I noticed, preparing for this meeting and looking back at papers I wrote at the time, they almost always ended on the same note, that there is a limit to what you can do in a mental hospital on the periphery of East London. I wanted to see teaching about old age much more at the core of medical schools. So it became hardly resistible to me when I was approached by the medical school in Nottingham, which was the first new medical school in our time, to set up a department there. And this is what I eventually did after eight years at Goodmayes.

I went to Nottingham in 1977 and the deal I did with Nottingham was, first of all, we had to be in the main university hospital, if not immediately, then as it was progressively commissioned, and secondly and equally important that although we had the shortest clinical course in the UK we should have the opportunity to have students exposed to us to an extent that we could hope to affect the 'product' of the medical school. I didn't want us to be just a tokenistic addendum, but wanted to have an opportunity to make a real impact on the students. And that was agreed. It wasn't painless, but we got agreement to it, and we had a month's full-time attachment of students to our department. Now, I must remind people that this was not a department of psychogeriatrics; this was a combined department of old age psychiatry, old age medicine, and in time it developed an orthopaedic-geriatric service, a stroke service, a continence service, a comprehensive and seamless department for the elderly.¹³⁶ I should also emphasise because it's not always clear when we speak of our Nottingham Department of Health Care for the Elderly, that it wasn't a department where we were all jacks-of-all-trades. The psychiatrists did psychiatry, the physicians did medicine, but we worked together as one, and although we had all sorts of problems, none of the problems arose in any way as a cleft between the physicians and the psychiatrists.

So, what did we teach? At the time I described 'a portable mini-curriculum' for teaching about old age, and it was short and simple. We taught about the ageing of individuals and about ageing in society. We taught the clinical practice of looking after old people, we taught about planning, provision and evaluation of services and we tried to teach realistic and appropriate attitudes to ageing and old age.

And did we succeed? Well I hope John Wattis who did some evaluation studies will talk more about them, but there were one or two straws in the wind that we weren't doing badly.¹³⁷ Perhaps I should also say before I come to those, very quickly, that what we offered the students during that

¹³⁶ Psychiatrists, geriatricians and social workers in Nottingham had taken an important lead in piloting a joint service in the 1960s. (Morton EVB, Barker ME, Macmillan D. 'The joint assessment and early treatment unit in geriatrics' *Gerontology Clinics* (1968) 10: 65-73)

¹³⁷ Wattis JP, Smith CW, Binns V. 'Medical students' attitudes to old people and career preferences: a comparison of two universities' *Medical Education* (1986) 20: 498-501; Smith CW, Wattis JP. 'Medical Students' attitudes to older people and career preferences: the case of Nottingham Medical School' *Medical Education* (1989) 23: 81-85

month was a clinical clerkship, attachment to firms, a systematic course of lectures and seminars, and the clinical clerkship was very much outside the hospital as well as within the hospital. Also, each student did a project and wrote it up under supervision. So the programme, repeated many times a year, was quite taxing for the staff. And the fact that it was taxing for our relatively small staff, actually, I think, made us better, for it's important to be stretched and we worked very hard on the teaching.

One outcome was that the students got up a petition to the Student-Staff Consultative Committee that the length of time in our department should be doubled - to two months. Well that was clearly completely impractical, but it was again another sort of face validation that we were getting somewhere.

Well, there's more to say, but that's probably it for the moment - with one other thing I need to write into the record again. In 1980 we started at the request of the British Council a series of two-week residential courses and those were happy things and very fruitful. They brought, over the course of the years, people from thirty different countries. Many colleagues in the room now came and helped us and took important parts in them. The courses gave much support to people who were pretty solo, working alone in many different parts of the world, often without an effective health service to support them, without colleagues. So among the things which the courses did was to produce a world-wide supportive network, plus they planted seeds in many countries which are still germinating and have grown into important things.¹³⁸ This next year I shall go back to two of them to see how they're doing. So there was the educational potential in an international setting and that was rewarding.

Claire Hilton: Thank you very much Tom and Nori. Any Questions?

Colin Godber: It wasn't so much a question but I would certainly acknowledge my debt to yourself, Tom, and to Klaus. In 1973 the psychiatric service for older people in Southampton was very poor and a post was established to try and improve things.¹³⁹ Unfortunately they couldn't fill it, which seemed a pity. I was a lecturer in the new medical school, envisaging a future in general psychiatry, but thought I might apply. I'd seen a few of your publications and various other things that showed it could be an interesting field. I therefore took a couple of days to visit you and Klaus and that really switched me on. I applied for and got the post but suggested to the panel that as I'd had no training with older people my first month in post should

¹³⁸ The International Psychogeriatric Association developed as a result of the Nottingham British Council courses. Its somewhat controversial and traumatic birth is described in the IPA website. Finkel SI. *Spotlight: History of IPA, Part One The Creation Of An International Organization - In A Circus-Like Atmosphere* http://www.ipa-online.org/ipaonlinev3/publications/bulletinarchive/spotlight_ipa_history_p2.asp accessed 29.7.2007.

¹³⁹ Rudd TN. 'A new approach to psychogeriatrics' *British Hospital Journal and Social Medicine Review* (1969) Jan 17, 108-110. Dr Rudd was geriatrician in Southampton and advocated the development of a psychogeriatric service.

comprise a fortnight at Goodmayes with Tom, a week in Newcastle with Klaus and Garry Blessed and a week at the Bethlem with Felix Post. That was my training in old age psychiatry, and that was after I'd been appointed. You both showed that making it an interesting learning experience for trainees is crucial. Within our service therefore we tried to involve the juniors heavily in the community; each trainee built up their own case-load: when they left they handed any patients requiring further follow up to me. The next trainee started with a clean slate. I think that helped attract many of them back into the specialty, gradually populating the developing services across Wessex, not to mention our own. In that context the trick is to get the service moving and then attract good people in to take it forward. Henry Rosenvinge was our first registrar. I encouraged him to get his higher training with Klaus in Newcastle and by the time he finished we managed to create a second post and tempt him back to it. David Wilkinson was our first senior registrar and we were lucky to create another post at the right time to secure him. Each came in with new ideas and really took the service forward. I positioned myself in their slipstream and continued to milk the applause up till the day of my retirement. Henry borrowed the Brighton Clinic model of day hospital, set up a pioneering sitting service and was a brilliant educator.¹⁴⁰ Fifty *per cent* of his trainees on the general psychiatry rotation subsequently chose old age psychiatry as a career. Like Tom he was a special case but I think that presenting it in the right way to trainees was one of the things that helped our specialty to flourish. In the early years the medical students in Southampton got one morning in old age psychiatry. They would all come out in a mini-bus and we would line up - myself, the registrar and a few of the community psychiatric nurses to take out a couple of students each on a morning of home visiting. By the time Henry retired every student spent a third of the psychiatry placement with us and it was regularly rated by them as the best of all their clinical placements.

Tom Arie: Can I ask a question? Does anyone know how many - not that they're the central thing in this - but how many professors of old age psychiatry there are now, I've lost count ... It's an interesting question, how many there are now? I don't know, does anyone know? No, well we've lost count in other words. But in '89 how many were there? About four or five?¹⁴¹

Brice Pitt: I've got a question for each, actually. Nori, the Section used to say that you should never accept a job which was manifestly, hopelessly under-provided, when you took this job with four beds at the Royal Free Hospital, was that a wise choice? I'm sure it was exciting being consultant old age psychiatrist at the Royal Free but was it not a bit reckless and what hopes

¹⁴⁰ The Brighton Clinic, Newcastle-upon-Tyne

¹⁴¹ See footnote 80, Arie (1989). There were 4 professors at the time of writing, although others were appointed shortly after: Tom Arie 1977, Elaine Murphy 1983, Raymond Levy 1984, Brice Pitt 1986.

did you have for getting anywhere with those four beds and however much home visiting you did?

Nori Graham: Well, I mean it was a slow start and it was exactly what I wanted and I've repeated this in other parts of my life - if you start with nothing you know exactly what you want and you very, very slowly and gradually start getting what you want. *The Rising Tide* was out,¹⁴² I just knew what the formula was and every year when I went away on holiday I'd go down to the admin corridor and I'd say 'You know when I get back, I would like ...one more of this or one more of that.' And it was slow - but I loved the slow drip. I ended up with a vast service, the envy of everybody and it still exists - I've been back and it's still all there and I think that's the way to do things is to start with - really, I don't envy people who get landed with a whole set of stuff so I was able to carve it all out myself.

Brice Pitt: But it's very unusual to be able to say, 'Well I'll have a catchment area of, say, about 2000 to start with ...'

Nori Graham: The catchment area of North Camden was given to me and I waited for the phone to go, I remember sitting in my windowless room and my first call was from a very well known general practitioner with whom I'd done my GP traineeship - John Horder.¹⁴³ He asked me to go out on a visit with him and that was my first visit. You know - my colleagues all said, 'Well there's nothing you can do about elderly people, so you won't get many requests and you don't need any beds' - but slowly I was able to demonstrate - and it was exactly what I wanted. In a similar way when I became chairman of the Alzheimer's Society UK in 1987 it was also very small. Indeed I made it even smaller because that was the way that one could grow things the way that everyone said they ought to grow. I think it's a slow but sure process - the problems arise when you're given a whole mass of things. So that's my preferred way of working.

Brice Pitt: Thank you. And Tom - I've wanted to ask you - you've given us really an account of the service at Nottingham which was as good as it gets - it was - I think, it couldn't be better - but it's not there now, so why is it not there any more?

Tom Arie: I'll tell you some of the reasons. I spoke of the deal I did before I went there and I reckoned I'd done another deal before we left, that was that there would be two professors when I left, one in medicine, one in psychiatry. I thought the department needed that - and times were very hard, money was very short, and it was very easy to appoint neither professor. The result was I didn't have a successor, so there was no professorial chairman of the department and inevitably in the end the

¹⁴² Dick DH. *The Rising Tide - Developing Services for Mental Illness in Old Age* (Sutton, Surrey, NHS HAS, 1982); Dr Dick was the director of the Health Advisory Service (HAS).

¹⁴³ 'Horder, Dr John Plaistowe', *Who's Who 2008*, A & C Black, 2008; online edn, Oxford University Press, Dec 2007 <http://www.ukwhoswho.com/view/article/oupww/whoswho/U20760> accessed 6.9.2008.

services moved into more traditional channels, geriatricians, as was becoming modish, towards medicine and rehabilitation, and old age psychiatrists into psychiatry.

The good news is that the teaching programme which I've described remained, and has remained as it was, up to now. There is a combined Health Care of the Elderly teaching programme, just as there was in my day. So the two services have come apart, but their components are still there, they're still very good friends. So some measure, I think it was a victim of the financial and political constraints of the time. I don't think there was anything inherent about it that had disarticulation built into it. It could've gone totally differently.

Peter Jefferys: It's really a question - did either College or national requirements on training for psychiatrists and training programmes make any difference to the development of the specialty in this period?

Claire Hilton: Do you think that will be answerable in minutes? Do you want to answer that Tom?

Tom Arie: No, I don't think I want to very much because I don't think I could do it very briefly.¹⁴⁴ I do want to finish though with one comment that Nori left out, and it is to emphasise the importance - perhaps it is too obvious - and that is the importance of carrying one's colleagues in the rest of the hospital with one. I particularly recall Nori Graham's retirement, where sitting at the table at which we had dinner were members of the Trust Board, there were managers, there were clinical colleagues all of them holding Nori in enormous regard and affection. These things are crucially important, and I'm not saying them just as a compliment to Nori, but I think it's very important, if you can make yourself liked with people you can do great things and that's what Nori did.

Claire Hilton: Shall we have Dave Jolley on 'The next generation

¹⁴⁴ This is a very complex issue. There was a dearth of recognised senior registrar training posts in the 1970s and 80s. Any training in old age psychiatry was considered to be part of general adult psychiatry. With no specific training requirements for old age psychiatry, training was not always adequate, and people were applying for consultant posts with inadequate training in the field. At times these candidates were appointed. More training may have allowed more rapid development of services. Indeed, some old age units with excellent, pioneering leadership were denied trainees. For example, Portsmouth, one of first districts in UK to have a fully developed old age service, recognised by the British Postgraduate Medical Federation since 1976, had never had a senior registrar, despite HAS recommendations that they should have one (The Beaton Unit, Portsmouth 16 Oct 1981, archives of Tom Arie). In part lack of training was linked to lack of recognition of old age psychiatry as a distinct specialty, thereby directly linking quotas of psychogeriatric trainees (of which there were insufficient), to the general adult psychiatry trainees (whose numbers were being capped because there were estimated to be too many). Not until 1989 when psychogeriatrics was recognised as a specialty could training be developed and tailored with a view to adequately filling consultant vacancies and developing services. There are numerous references in Section archives: e.g. Executive Committee 17 Dec 1987 47 EC/87 JPAC, 63 EC/87 AOB, 62 EC/87 a.

of psychogeriatricians' and John Wattis on 'Surveying the specialty: the development of psychogeriatrics towards 1989 and recognition by the DHSS' next?

Dave Jolley: OK, so I'm Dave Jolley, for these purposes from Manchester, originally from Wolverhampton and I actually worked there for a period in this career. I said I was born to be a psychogeriatrician and I mentioned earlier, I got a bit involved as a medical student with Russell Barton and Tony Whitehead and things like that. As a trainee I came across Professor Arie doing his Maudsley lecture.¹⁴⁵ Why was I there? Why did I have to listen to this? I learnt about the ladies, part-time doctors.

I was being trained in psychiatry in Manchester. Manchester was general hospital psychiatry and we were doing high quality stuff, we had good people like David Goldberg¹⁴⁶ and Neil Kessel¹⁴⁷ and so on. What we didn't do was anything to do with old people; 'Anybody could do that, even those geriatricians' they said. And I said, 'Well I'll have to learn how to do this' and David Goldberg, bless him, said 'Yes OK, we've got nobody who can do it.' So they found the money to pay for me for a year to go and work with Tom, with Felix Post and to call on wonderful people like Klaus and Garry Blessed in Newcastle and Albert Kushlick¹⁴⁸ and other people who had interest at the time. I was introduced to the Group which became the Section - we've mentioned it today - but really it's been the lifeblood of this specialty. It's been absolutely amazing to be able to go along and spend time with these great men.

So when I was appointed in 1975, the great men, and some of them are here today, who had established that this is it, this is what you can do, and I got things set up accordingly. Tom had been involved in looking into a tragedy in the North West of England where people had been moved from one hospital in Bury in the teeth of winter to another hospital just outside Bury. That would mean they were no longer administratively the responsibility of Bury with the first - the 1974 -reorganisation of the healthcare system. Many of them died within weeks, it was just terrible. The *Manchester Evening News* took it up and one thing and another.¹⁴⁹ So that was how the University Hospital of South Manchester got the money together to appoint me and Public Health decided - they built - they

¹⁴⁵ Maudsley Bequest Lectures, Royal College of Psychiatrists. Tom Arie gave three - two in the 1970s (1972, 1976) and one in 1991.

¹⁴⁶ Professor Emeritus, Institute of Psychiatry, London. 'Goldberg, Sir David (Paul Brandes)', *Who's Who 2008*, A & C Black, 2008; online edn, Oxford University Press, Dec 2007 <http://www.ukwhoswho.com/view/article/oupww/whoswho/U17375> accessed 6.9.2008.

¹⁴⁷ Deakin B, Hay G, Goldberg D, Hore B. 'Obituary: William Ivor Neil Kessel' *Psychiatric Bulletin* (2004) 28: 309-310

¹⁴⁸ Jolley D. 'Psychiatrist into psychogeriatrician' *British Journal of Psychiatry* (129) 'News and Notes' (Nov 1976) 11-13

¹⁴⁹ North Western Regional Health Authority 'On the transfer of patients from Fairfield Hospital to Rossendale Hospital' (April 1975, typescript, archives of Professor Tom Arie)

designed - a not very good 56 bed, 50 day-place standard ESMI unit.¹⁵⁰ Fourteen of them, each worth loads of money and they popped them around the Region, you see.

I was appointed in 1975 - it was me in the North West. This was the model around the country - people like myself who'd been enthused, loved it, learned a bit - Robin Phillipot went to Liverpool, John Wattis later went to Leeds, and Sammy Gaspar and John Young were in the West Midlands and there were ones or twos in each Region. We'd got to help others to come in. The key thing was senior registrar posts. Had we got any? Not on your nelly!¹⁵¹ Would they give you any? Well, they might give you one, but you had to try and win every time, so if somebody came into that post you wanted them to be interested and carry on and people did and that's how we populated, didn't we? The thing that held us together I think was the fact that there was the Section at the College which eventually became the Faculty and all the wisdom that was shared, it really functioned as a major group.¹⁵² And it's been possible to turn the map of England so that everywhere has got at least one - what we were aiming for was one person for 30,000 older people - Colin when he started was one to 40,000, where I started it was one to 30,000 and as has been said, it's impossible to do it properly and we moved on, trying to make it doable by, if you like, less devoted beings. Perhaps that's been part of the mission - the model became a consultant for every 10,000 - and that's been more or less achieved at the moment. Interesting to listen to Nori talk because she was talking about a time when junior doctors actually were attached to a firm and utterly devoted to it. That was a key element of good clinical learning and service delivery. At the moment all that good practice has been lost, which is a great pity.

Just a note about research. We've been involved in a bit of research, but I have to say - I was brought up to believe that those that can do it, do it, those that aren't quite so good, teach it, and those that are completely beyond the pale, they get put into research!

That's me!! I've finished!!

Claire Hilton: Thank you, Dave,

Dave Jolley: Are we going to do John now?

Claire Hilton: Yes!

John Wattis: Thank you very much. I feel that in honour of Claire and Nori, with their permission, I should declare myself an honorary woman - I've been an honorary Black before because I have adopted black children - so I hope you will admit me into the ranks of honorary womanhood for the time being.

¹⁵⁰ Elderly Severely Mentally Ill

¹⁵¹ For example, Wattis J. 'Manpower problems in psychiatry of old age' *British Medical Journal* (1985) 291: 1281

¹⁵² Minutes of Section and Faculty, Royal College of Psychiatrists Archives

My name is John Wattis, I trained at Liverpool Medical School, I worked as a missionary in Uganda during Idi Amin's time and after that nothing in the UK caused me any fear!! I also trained in a therapeutic community in my basic psychiatric training, the John Connolly Hospital in Birmingham - a highly successful small general psychiatric unit which they bulldozed because I don't think therapeutic communities are very successful because people don't like them. I think Dingleton survived as a catchment area therapeutic hospital but I don't think there are very many left.¹⁵³ Anyhow I got an exposure to old age psychiatry whilst I was there because one of the general consultants opened an old age ward, and I was looking for a career in academic psychiatry. I wasn't particularly looking for a career in old age. But this job came up in Nottingham and actually I think I was your first appointed academic member of staff, Tom, wasn't I? So I was appointed in Nottingham and Tom, as always with his enthusiasm, seduced me into old age psychiatry - which was great. It wasn't just married women doctors he was interested in, he was interested in my wife as well! He actually persuaded her to take up the post as research officer and it was as a result of that that we started a series of surveys¹⁵⁴ which I actually completed after I left Nottingham but the first one was published in the *BMJ* on Saturday 9th May (I've had it pointed out to me) - in 1981, so a marvellous coincidence and I then went on to do a series of surveys which I won't try and bore you with the results because they're all there in the documents. But basically there was a point in the mid 1980s where it was possible to use statistics spuriously, as I'm sure Klaus would approve of if he had his calculator here to check. You could draw a graph which showed that the number of old age psychiatrists was increasing exponentially and by the year 2000 there would be no doctors who were not old age psychiatrists! However that didn't come to pass.

The other piece of research that I was thinking Tom was going to say more about and I can't say a great deal about it, was trying to look at medical students' attitudes towards older people. That was particularly my wife's interest and Tom gave her permission and encouragement to pursue it and what we discovered was that in Nottingham - and I haven't revised the papers, because I thought Tom was going to do this - but basically going through the Department of Health Care of the Elderly their attitudes towards

¹⁵³ Dingleton Hospital, Melrose, Scotland closed in 2001

<http://www.archiveshub.ac.uk/news/dingleton.html> accessed 6.9.08

¹⁵⁴ These surveys were largely necessary since the DHSS collected no data on old age psychiatry as it was not a recognised specialty. Wattis J, Wattis L, Arie T. 'Psychogeriatrics: a national survey of a new branch of psychiatry' *British Medical Journal* (1981) i. 1529-1533; Wattis J, Arie T. 'Further developments in Psychogeriatrics in Britain' *British Medical Journal* (1984) 289: 778; Wattis J. 'Geographical variations in the provision of psychiatric services for old people' *Age and Ageing* (1988) 17: 171-180; Wattis J. 'Senior registrar training in old age psychiatry in the United Kingdom' *Psychiatric Bulletin* (1988) 12: 233-234; Wattis JP. 'A comparison of "specialized" and "non-specialized" psychiatric services for old people in the United Kingdom' *International Journal of Geriatric Psychiatry* (1989) 4: 59-62; Wattis JP. 'Old age psychiatrists in the United Kingdom - their educational role' *International Journal of Geriatric Psychiatry* (1989) 4: 361-363.

older people improved enormously as did their knowledge. Unfortunately although the knowledge persisted by the end of the course, most of the attitudes had reverted under the influence of the rest of the medical school. And we did a similar study in Leeds soon after I moved there - we did find that the attitudes were more positive generally in Nottingham than they were in Leeds, so even though there was a sort of treatment effect which then partly wore off, having the department there in Nottingham seemed to generally make the attitudes better amongst the medical students there. That's a very brief summary.¹⁵⁵

So I think that is me too. Just one other thing, to introduce a bit of controversy - I had this idea that when my generation and those a little older than me and I don't know if there any are a little younger than me, but we were kind of entrepreneurs, we were kind of leading the service and the image that I have now is that it is very much more difficult for people because of the way things are structured with the purchaser/provider split and also with so many other people telling them how to do things. It's very much harder to do the kind of things that Nori did and to a lesser extent I did, and others did, in building up services and just knowing whose door to knock on and knowing which strings to pull and now you've got to go through so many committees and so many different levels, it's quite difficult to innovate in the way that we were able to.

Claire Hilton: Thank you. Any comments or questions?

Colin Godber: Stimulated by that last comment I think that the DHSS had a clear blueprint for psychogeriatric services. In this model each district would have a psychiatrist with an interest in the elderly to look after people with dementia. Neither it nor the College favoured our model of a comprehensive service for the over 65s but we persevered and the DHSS (and eventually the College) swung round in support.¹⁵⁶ I'm now involved with our local Primary Care Trust and find few takers when I say 'What you need to do is ignore what the government is saying and do what you think is going to be right.' In those days you could get away with it, sadly you can't now.

Klaus Bergmann: I'd like to follow what Colin Godber said. I remember a period before 1989 when we were starting the old age psychiatry Group, when we met the sort of resistance from general psychiatrists which said 'I can do everything you can do and probably better and I don't see the need for you'

¹⁵⁵ See footnote 137.

¹⁵⁶ The proposal that psychogeriatrics was recognised by the DHSS as a specialty in its own right was developed largely by the Section for the Psychiatry of Old Age but was eventually also based on recommendations from a report made on the initiative of the Royal College of Physicians (SPOA Archives 52 EC/88 8 Sept 1988; Royal College of Physicians / Royal College of Psychiatrists *Joint report: Care of Elderly People with Mental Illness: Specialist Services and Medical Training* (RCP London/ RCPsych, Feb 1989)).

and I think this has been successfully overcome.¹⁵⁷ I once tried to point out at a meeting at the Maudsley that perhaps we were following the same path that paediatric psychiatry - child psychiatry - had followed earlier and Professor Russell put me down very promptly.¹⁵⁸

Nori Graham: Just following again, on from John's last point - about the difficulties that consultants today have in all these things, you know, about telling them which boxes to tick and all the rest of it, but if you were looking back into the '60s - the actual clinical work remains the same. We've still got an ever increasing number of older people, mainly living at home. I still think - and those consultants that do it with their teams and nurses going out to visit people in their own home and doing the assessments at home and trying to keep people, for as long as possible, at home and tying this all up with the GP and the geriatrician - it's still all happening. I don't think that's changed at all. It's just that the entrepreneurial thing is very, very difficult because, I think, people find it - it's not as exciting I don't think, really - I think that's the word I'm looking for.

Dave Jolley: Sticking to the time span that we have here, it was a time of massive growth, and even though we didn't have our own senior registrar posts, people allowed us to use them. I think we did negotiate an extra five or six didn't we?¹⁵⁹ - and they were used very positively. People were getting an amazingly good, rewarding experience of being able to go and see people, use clinical skills - I mean the research element was there too - Felix [Post] had shown that you could treat depression in older people¹⁶⁰ and we had shown that it was probably as effective as treatment in younger people.¹⁶¹ Tom and others, Brice, and so on, had shown that the social model worked and helped. Even though you couldn't give a treatment that made dementia go away, you could make life a lot easier for everybody and life-expectancy improved. The Crichton Royal studies showed increased life expectancy in dementia, in response to better quality of care, simple approaches.¹⁶²

¹⁵⁷ The tensions between general and old age psychiatrists are discussed in Hilton C. 'The provision of mental health services for people over 65 years of age in England 1970-78' *History of Psychiatry* (2008) 19: 297-320.

¹⁵⁸ Gerald Russell was professor of psychiatry and head of the Department of Psychiatry at the Institute of Psychiatry, London. 'Presentation of new honorary fellows' (introduced by Prof J Hubert Lacey) *Psychiatric Bulletin* (1995) 19 794-5.

¹⁵⁹ With difficulty: 'It was reported that there appeared to be some confusion at the DHSS over these posts ... the Central Manpower Committee had approved ... seven posts in principle to be reviewed in 1980 whether they should be implemented ...' (Executive Committee, Section for Psychiatry of Old Age, 27 Sept 1979 25EC/79).

¹⁶⁰ Post F. *The Significance of Affective Symptoms in Old Age: a follow up study of 100 patients*. Maudsley Monograph 10 (London, Oxford University Press, 1962)

¹⁶¹ Baldwin RC, Jolley DJ. 'The prognosis of depression in old age' *British Journal of Psychiatry* (1986) 149: 574-583

¹⁶² Christie A. 'Changing patterns of mental illness in the elderly' *British Journal of Psychiatry* (1982) 140: 154-159; Christie A. 'Survival in dementia: a review' 33-44, in *Recent Advances in Psychogeriatrics 1*. ed. Arie T. (Edinburgh, Churchill Livingstone, 1985); Christie A, Train J. 'Changes in patterns of care for the demented' *British Journal of Psychiatry* (1984) 144: 9-15

People came to it because they could see that - and of course the great friendship with geriatricians and with mainstream medicine and, as Peter said, friendships and effective work with social services and general practice and so on. It was a very good professional life that we were able to sell to people. That's how it expanded.

Peter Jefferys: Another positive point: I want to give credit to the DHSS and in particular to our link doctors in the Department who were supports and allies through the '70s and into the '80s of old age psychiatry. They recognised the exciting developments that colleagues - some in this room and some not here any more - did in old age psychiatry - they were willing to give their voice and sometimes their money, from the centre, to initiatives, not just the buildings, but also the people and gave hints and nudges and pushes on manpower. A significant reason we got posts in old age psychiatry designated for training was because the DHSS leaned on the Royal College and said this must happen.¹⁶³ It was an important phase. They saw and recognised - not everyone could be charismatic, but if you wanted a decent service for older people with mental health problems, there needed to be both a shift in the Royal College's view of the specialty and of manpower and resources. It was a period when the alliances - and several people made direct personal 'under-the-table' alliances and informally negotiated with colleagues in the Department. It was an important period - when the professionals in the DHSS had greater impact on policy.

The other relevant development with impact was the Health Advisory Service.¹⁶⁴ People will know the HAS service was initially started following the Ely mental handicap hospital scandal¹⁶⁵ and then extended to psychiatry and geriatrics. There is no doubt that their visits and their persistence in looking at ways of improving standards in mental health services and older peoples' services gave focus and consistency in looking at how old age services could be improved. They described the ugly when it was ugly, but they also commended the good. It had an influence on both government policy and was also an important influence for us.

¹⁶³ A careful reading of Old Age Section and other College papers, together with the influential Joint Royal College of Psychiatrists and Royal College of Physicians report (see footnote 156), suggests that the relationship between the DHSS and College with respect to the development of training posts and recognition of the specialty as a whole was not as straightforward as suggested in the witness seminar.

¹⁶⁴ Baker AA. 'The Hospital Advisory Service' *British Journal of Psychiatry* (122) 'News and Notes' (June 1973) 16-17

¹⁶⁵ Webster C. *The National Health Service. A Political History* (Oxford, Oxford Paperbacks, 1989), 80. Also described in Crossman R. *The Diaries of a Cabinet Minister Vol 3. Secretary of State for Social Services 1968-70* (London, Hamish Hamilton Ltd, 1977), *passim*.

Finally - there was the trouble-shooting dimension of our work. My first day as a consultant, I get a call from social services saying: 'We've got a problem, can you help us? One of our old-people's homes is flooded and we've had to evacuate everyone. There is a lady with dementia on the medical ward, who's been there for three or four days, following a fall. The physician is sending her home. The ambulance driver took her home and her neighbour, who normally looks after her, is in hospital herself, so the ambulance driver brought her back. The consultant is now saying "Send voluntary cars and leave her on the doorstep, it's social services responsibility". Social services have no places. "What are you going to do?"' I go to my new ward which is shared with all the general psychiatrists, one ward in the district general hospital - serving 200,000 population - and I say 'I'm your new consultant, please can I have a bed for this lady who's on the medical ward - social services will place her as soon as they can?' They say 'We're not here to do psychogeriatrics, there's a policy saying that psychogeriatrics aren't admitted to this ward' and I say 'Well, actually, I'm your new consultant, whether you like it or not.' I learned a month later that the staff had all signed a petition protesting against the appointment of a psychogeriatrician and sent it to the Regional Health Authority. Anyway - so I then went back to the medical ward and I said 'Can you hide this patient over the weekend?' It was a Friday, these things always happen on a Friday - 'When's the consultant's ward round next?' and they said 'Tuesday' and I said 'Well can you hide the patient till next Tuesday, I will promise you I will move the patient by Tuesday.' On the Monday I went to a meeting of all staff in psychiatry - and I said 'I'm the new boy on the block, at some point you've got to trust me, we're in this together, if you want a decent old age service you've got to do something and help me find a bed for this lady.' And they found me a bed and social services were eating out of my hand after that!

I used this as an example of what it was like - the opposition from peers, opposition from colleagues and mistrust was pretty strong.

Claire Hilton: Thank you, Peter. I'm aware that we're moving into the last half-hour and there are a lot of people over there who haven't said anything, I was wondering if any of the people at the back have got anything to add ...?

Dr Mia McLaughlin, consultant old age psychiatrist, Lanarkshire:

Hi, Mia McLaughlin, consultant old age psychiatrist, Lanarkshire and I have to say I'm thoroughly enjoying it. Just wanted to ask, nowadays we get a lot of comments particularly from social services, saying the families aren't there to look after the people any more and community is breaking down, I wouldn't say it's entirely my experience - what was this community support, family support like all these years ago?

Klaus Bergmann: Well speaking as a centenarian!! and specially with regard to my work in Newcastle, the support was fantastic and just to be anecdotal, there was an aged lady, a single childless lady who was living in a marked state

of dementia requiring body care as well as total provision of meals and this was kept going by two nieces, one of whom 'topped' her in the morning and the other one who 'tailed' her in the afternoon and I discovered this on the survey, it was not part of the clinical thing at all.

I think my other experience was on the 'Costa Geriatrica' in Brighton and that divided quite clearly into two. There were the 'Old Brightonians' if I may call them that, with respect to David Cameron who's an 'Old Etonian', but these were Old Brightonians and they looked after their elderly just like everywhere else. There were the 'émigrés' who'd retired to Brighton and they were, as soon as a crisis came, in a most perilous and unsupported situation and their relatives were living everywhere, up into Buckinghamshire, Essex, Hertfordshire and with the best will in the world couldn't do things. So it was a very mixed situation but it certainly wasn't a rejection of the elderly.

Bill Boyd: Just to say my own experience of this was that relatives had enormous difficulty in looking after demented old people but the presence of, as I mentioned earlier, someone such as a health visitor who really was committed to visiting them and sharing their problem with them, that made a very big difference. And I do think there was a change; the better we had that service going the more the relatives were able to cope.

John Wattis: Out of deference to my public health trained colleague Tom Arie - two things I think have happened, one is the relative number of working-age adults compared to the number of older people to look after and the number of younger dependents has changed. I couldn't give you the exact figures but there's been quite a change. And the other is the phenomenon that Tom used to refer to as 'spiralism' where people move all the time, they go somewhere else for training so that except in some - well I suppose we should use the term working-class neighbourhoods - where perhaps people don't move out as much, there's so much more movement of people around the country. I mean, my parents, my father's dead now, but twenty years ago or more, my parents actually moved to Leeds to be near us and the grandchildren, you know so they were following us.

Claire Hilton: Any other comments?

Dr David Findlay, consultant psychiatrist, Dundee:

David Findlay from Dundee. To what extent do colleagues feel we're currently recreating in care homes some of the problems we had previously in long-stay wards?

John Wattis: You've touched on a hobby-horse of mine. I'm quite interested - not as interested as Claire is in history of psychiatry - but I am quite interested and we mustn't forget that the county asylums came in, partly, into being

because of the abuses that were occurring in the private mad-houses.¹⁶⁶ And I think that one of the problems is undoubtedly there are many care homes where the standard of care is higher than it was on the long-stay wards that I first inherited when I became a consultant, so we shouldn't be too bleak about it. But I think the quality of inspection that can be maintained by the Social Services Inspectorate on a very intermittent basis is very different to the quality of inspection that we as consultant psychiatrists used to maintain on our long-stay wards, because we'd be in there at least once a week and we would see what was going on. I think there's a real problem of invisibility in a lot of these small units that people don't know what's going on all the time.

Nori Graham: This is also a hobby-horse of mine because I actually work in probably the largest care home in the country at the moment, on a part-time basis, and I'm in no doubt at all that care homes are the old long-stay wards, full stop. However, this issue is getting publicity and very, very gradually the government is taking the matter much more seriously and I think, already there is some change. There are going to be many more changes and I think it is going to involve our successors in our own field of old age psychiatry taking much more of an interest and it should and will be part of their job description to be going into care homes on a regular basis.

Gordon Langley: Certainly, the price of moving from the Exeter hospitals into the community in the three districts, North Devon, Exeter, Torbay, was moving the care of the long-stay demented into the private sector. It was the only way our then district administrator said he could pay for a locality service, to virtually shut down and privatise, if you look at it that way, the service for long-stay demented. Somebody earlier said there was a time when the health service gave comprehensive care, you know, it would be nice to see at least some balance so that the homes weren't over-worked. I still see an elderly demented lady in a nursing home. The home doesn't pretend to have psychiatric skills and it's very sad. I think she would do better where people understood the attitudes to old age. But it's very patchy, there may be some good homes, I don't know. It's very patchy and very sad.

Colin Godber: I don't think we are covering the history of old age psychiatry if the name 'Thatcher' hasn't been mentioned!! She wrecked the development of community care. In our district we were getting a lot of collaboration with the local authority building up services in the community. She froze their funding and created a loophole in the Social Security rules that funded a mushrooming of private rest homes and then nursing homes. As the NHS pulled out of long-term care the funding was not ring-fenced to enable

¹⁶⁶ The *County Asylums Act* (1845) made it obligatory for each county in England and Wales to provide an asylum for its pauper lunatics, whilst the *Lunacy Act* (1845) established the 'watchdog' body of the Commissioners in Lunacy. The *Lunacy and Asylums Act* (1857) established the Board of Commissioners in Lunacy for Scotland and made other provisions for Scotland in line with those already existing in England and Wales. <http://www.mdx.ac.uk/WWW/STUDY/Law.htm#8+9Victo126> accessed 21.7.08.

social services to meet their huge new responsibilities under the Community Care Act.¹⁶⁷ As a result of that it took an awful long time for Community Care to become a reality. This poverty of funding also made it much harder to raise the level of training of care staff in residential and nursing homes - the old 'Part Three' homes run by social services were very expensive but they did a lot better in terms of the quality of training they offered.

Dave Jolley: I'm just trying to cope with the various points that say 'God, it's terrible, isn't it?' Because we've also had Peter saying 'God, it was terrible, wasn't it?' It was. And what we've got, actually, is an infrastructure of lots of people who are interested in older people with mental health problems, including dementia, that massive structure has been produced by this process and we have to rejoice at that and what's important is that you use the skills and the interests in the situation, here and now. And 'here' and 'now' are different, as Klaus says, one population in Brighton needs a different approach from another population in Brighton with different characteristics, at the same time. In addition, a successful approach in Brighton in the 1970s may not be best suited to the current scene for things which change with history. So it's important not to despair. Rejoice at what we've achieved, I think, and use the principles which Tom and Brice and Klaus and others have taught us in the situations that we now have. That's the task, that's what's happened, that's what we've gained.

Klaus Bergmann: But to follow on Colin's 'Thatcher lament', it's true that we were working, certainly in Newcastle, towards co-operative working in elderly mentally infirm homes in which we took equal responsibility, we visited regularly and at a stroke these were abolished, sold off or privatised and I think if one wants to sum up the difference between the old psychiatric hospital scandals and nowadays it's sweeping it under one big carpet or hundreds of small rugs!

Marie Bergmann: I had a lot of experience with my mother, trying to find a home for her. She was quite badly demented by this time and one of the fears was that most of the nicer looking homes, which she also rejected, I knew that they wouldn't keep her for very long because they're privatised and they don't have to keep their awful patients and my mother was not a good patient and she had a lot of difficulties and they didn't want to deal with them and they didn't have to and so I had enormous difficulty. We looked at over eleven homes and in the end we were lucky, but it didn't look the smartest.

Peter Jefferys: Good news and bad news. The government has announced it is going to change the law so that Human Rights Act does extend to private care homes.¹⁶⁸ I was involved as the independent expert in the case which

¹⁶⁷ National Health Service and Community Care Act 1990 (c.19), Office of Public Sector Information, http://www.opsi.gov.uk/acts/acts1990/ukpga_19900019_en_1 accessed 12.10.08.

¹⁶⁸ 'Extending Human Rights Act to private care homes (16.01.06)' Age Concern,

went to the House of Lords, of the woman, an elderly woman in a private home whose relatives got under the skin of the home management, private home, big company, and they said 'Let's throw the lady out.' She was doing very well in the dementia home but they didn't like the family so they threatened to throw her out and that was seen as consistent with the Human Rights Act. The government is now going to change that - which is one point.

Second is that there are some excellent partnerships between both voluntary and privately run homes and health practitioners in old age psychiatry and in many places is working extremely well. Sometimes it's not, but often it is working well and the way ahead is to make sure those partnerships work effectively in future. The problem of fragmentation of commissioning is an issue.

The other initiative that may or may not help older people who are vulnerable in care homes is the extension of the Mental Capacity Act with the Deprivation of Liberty provisions that's going to come in next year which means that any person who lacks capacity who's in long-term care in a care home or in hospital will have to have their capacity assessed, and also their best interests reviewed by a best interest assessor and that will mean that vulnerable older people will - and there's a resource issue - but, legally, there will be an obligation to review those. And that's a significant policy change, forced on the government by the European Court of Human Rights, following the Bournemouth decision but it's a change that may make a difference in exposing some of the most vulnerable subject to abuse.¹⁶⁹

Claire Hilton: I think we're gradually moving into the current rather than the past. Has anybody got any other comments about the past up to 1989 before we draw this to a close?

Jimmy Williamson: When I first became a geriatrician there was a system in operation called respite care, and that meant that there was a bargain struck between the geriatrician - because there weren't any psychogeriatricians in these days - and the family and they said 'We know you've got a considerable burden, we will admit your mother (or your grandmother or whatever it was) for two weeks, twice a year, or something like that and I found this strange because - I mean obviously you want to share the burden - but you admit the lady for two weeks in July and she's perfectly all right when she's admitted, in three weeks, she gets home and she gets influenza and then the argument was 'Well you've just had your

<http://www.ageconcern.org.uk/AgeConcern/131201CF63CA4A6683385D620E493F93.asp>

accessed 21.7.08

¹⁶⁹ European Court of Human Rights: *HL v United Kingdom*, Application no 45508/99, decision of 5 October 2004. *R v Bournemouth Community and Mental Health NHS Trust, ex parte L* [1998] 2 WLR 764; *R v Bournemouth Community and Mental Health NHS Trust, ex parte L* [1999] AC 458

mother in for two weeks, so you'll have to put up with her, despite the fact she's got ...'

I thought that was highly illogical and we arranged with good families that we would take the patient in when they were in trouble, you know if the caring daughter got influenza for example, then we would say 'Let us know and we'll take your mother in.' And what happens now? If anything.

Dave Jolley: What happens now, respite like that is provided, by and large, by the local authority and they do it as well as they can. The doctor is often very worried because people are placed in homes away from their own GPs, people don't know about them at all, but it's become a social function.

Jimmy Williamson: I found it an illogical and wasteful process.

Mia McLaughlin: It has become very much a social service remit to look after respite, but it's usually done on a much more flexible basis unless the family specifically want two weeks every three months or something like that. Having said that, we do have some patients where carers really struggle to manage, then we'll take them in every couple of months, when they're struggling, for a week or two. But we're very lucky because we've quite a lot of beds.

Tom Arie: I just want to prod Nori into saying a word about the Alzheimer's Society. I have in mind a record of a meeting and one of the conspicuously non-existent things in our period, the early part, was a voluntary body of great clout and I think the Alzheimer's Society movement is sufficiently important just to hear a little bit more about it.

Nori Graham: The Alzheimer's Society was started in 1979 by two women whose relatively young husbands both had dementia. They contacted each other through newspapers and got together with a couple of doctors and they started to form a group and that was the beginning of a small group in 1979. From 1979 it developed, branches began to spring up around the country, the office a sort of two up and two down in Fulham. Jonathan Miller became president; he managed to get a grant out of the DHSS, a Section 64 grant.¹⁷⁰ Gordon Wilcock was the chairman and a very good chairman he was and he did it for a requisite number of years, seven or so, and the next chairman after him was Christine Kirk. I was a member of the Alzheimer's Society just looking on. I didn't really know what voluntary organisations did but I watched Christine Kirk and thought 'Oh my goodness, what does it do to take on a thing like this?' Six months later I read in the newsletter that she was standing down. And then a few weeks

¹⁷⁰ The Secretary of State for Health, through the Section 64 General Scheme of Grants (S64 of the Health Services and Public Health Act 1968), has power to make grants to voluntary organizations in England whose activities support the Department of Health's policy priorities. Section 64 grants represent the greatest single source of financial support that the Department of Health provides to the voluntary sector http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Section64grants/DH_4032519 accessed 7.9.08.

later I got a phone call from Christine Kirk who I didn't know at all. My secretary took it, and she said would I have any interest in becoming chairman of the Alzheimer's Society. My secretary, who had had contact with voluntary organisations because of her very short stature, said 'You know it's really good to be part of a voluntary ... or take a lead part in a voluntary sector ...' Anyway, to cut a long story short I became chairman in 1987. With one or two others, we were able to formulate clearer aims and objectives. I went to the launch of the new Alzheimer's Society's office last week, overlooking the River Thames in St Catherine's Dock. It now has 1500 staff round the country and several hundred in the national office and is a much respected organisation. It did take a bit of rescuing. When the new treasurer, the newly appointed executive director and I went to the DHSS we managed to rescue back the Section 64 grant that they were about to take away from us because we were able to put a business plan on the table and say 'These are our aims and objectives.'

I remember I used to stand up at the Faculty meetings until everyone was bored silly with me - everyone used to say 'Oh there she is again talking about the Alzheimer's Society. But a few years later - seven years later - when I stood down, people were coming up to me and saying 'Nori, you don't need to get up any more, I've now become chairman of my local branch and you know we're doing this' - and it's been fantastic what's happened. Many people in this room have been involved and indeed I should add that some people in this room were also asked if they would like to be chairman, back in 1987, but declined!

Unidentified voice: It needed a woman!!

Claire Hilton: And on that note I think we're going to have to stop because some people have got to get away on time. I've thoroughly enjoyed this afternoon, I hope everybody else has and I think like all good pieces of research, it raises even more questions than it has tried to answer. But I think it's been absolutely fascinating and very noticeable as well are all the modest contributors this afternoon. So I'd like to thank everybody who's come and also take into account the very many thousands of miles everybody, in total, has come to be here today. I thoroughly enjoyed listening to all the wonderful memories of all the important events in old age psychiatry and thank you to the witnesses for sharing all these with us.

Just one little word - some people have already thrown out their old archives and memorabilia of old age psychiatry - if anybody does have any archives lurking in cupboards, please don't throw them out but let me know - or perhaps Malcolm - because they really need to be looked after for future generations.

I'd like to thank Steve for the recording, Leigh for taking the microphone around and Lydia, who some of us have had contact with before, who's not in here at the moment, for doing a lot of the organising.

But I've also got two little presents. One's for Malcolm. Thank you ever so much for adopting this proposal for a witness seminar. As you probably know the Wellcome Trust (London) witness seminar scheme rejected this proposal three times - it sounds as if they had some difficulties in the past with another psychiatry witness seminar - and they really haven't shown much interest in older people. Well, I think, and hope, that their loss is Glasgow's gain and I'm really looking forward to seeing the transcript, edited and available online.

I've also got a little present for Tom, just to say thank you for all your wisdom and patience and humour and e-mail enthusiasm - yes, there was one day in February when you sent me nine in one day!! And thank you so much for all your energetic collaboration on this project right from the beginning.

Tom Arie: I don't know what to say! Claire, you spoke about patience and humour, and you have certainly demonstrated that. Working with you over the past year has been a great joy, but I didn't realise, and don't quite believe, that I went so over the top that I sent nine e-mails!! But isn't she wonderfully gentle, yet firm, and hasn't she kept us splendidly in order ... Thank you, Claire.

Claire Hilton: It's a shame that some people have got to rush away but for anybody who can stay, we are going to Bonham's Wine Bar for some food, anybody who wants to can join us...

Reflections

This transcript was made on one day, with a small group of people. It can not give a wholly comprehensive view because of the select nature and small size of the group. On the other hand, the afternoon was so full that even if there had been more people it would have been difficult to have added more contributions in the time available. What is clear however, was the impact of the individuals and the events they recounted, and the recollections about the people they knew - whether Pekineses or St Bernards. The participants gave very personal insights into the origins of old age psychiatry and their experiences. Appropriately, as hosted by the University of Glasgow, several of the participants were from closer to Glasgow than representing the whole of Britain, giving a distinct Scottish flavour. But in reality, developments in Scotland not infrequently appeared to precede those in England. Some features of the development of the specialty were not explored, for example clinical practice at the time, nor developments after 1989, nor specific aspects of service provision such as long-stay care, all of which would be worthy of exploration in their own right.

Despite attempts to attract people to the seminar from other disciplines, such as nursing, and significant publicity, such as in the Newsletter of the Faculty of the Psychiatry of Old Age and invitations to geriatricians, the group of witness seminar participants remained small. Sadly, there appeared to be little interest from practicing clinicians. Historical insights and understanding the past are valid in their own right, and can also be relevant to clinical practice today. For example, it is useful to draw on historical sources to argue for continued old age psychiatry specialisation in the context of the current (2008) threats to merge it once again with psychiatry for adults of working age. This annotated recording should help clinicians and others to think about the development of their specialty, and consider from a historical perspective the strengths and weaknesses of an ever changing service provision.

A witness seminar gathers peoples' reflections, reminiscences and opinions. Such oral history is subjective but is vital to understanding the process of development of a medical specialty. It should also help bring to life the personal, dynamic and very human aspects of the subject in their historical context, away from the more traditional document based historical approach. I hope we have succeeded in this, but with such a format I am aware of the possibility of factual errors, for which oversights I apologise.

I feel very privileged to have been involved with this project and to have met and listened to so many pioneers in our field of old age psychiatry.

We would welcome your comments and your own reflections on the issues covered. Do let us know! (claire.hilton@nhs.net)

Participants:

Professor Tom Arie

Dr Klaus Bergmann

Mrs Marie Bergmann

Dr WD (Bill) Boyd

Dr David Findlay

Dr Colin Godber

Dr Nori Graham

Dr Claire Hilton

Dr Peter Jefferys

Professor David (Dave) Jolley

Dr Gordon Langley

Dr Mia McLaughlin

Dr Malcolm Nicholson

Professor Brice Pitt

Dr Andrew Reid

Dr RA (Sam) Robinson

Professor John Wattis

Professor James (Jimmy) Williamson

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Our thanks to all the participants who travelled long distances, prepared talks, provided autobiographical information, and checked and rechecked the manuscript.

We are also grateful to others who attended the event even though they neither asked nor answered questions, and to staff and students of the University of Glasgow who participated behind the scenes.

Lydia Marshall undertook much of the administrative work. Sheena Rennie transcribed the tapes and Cheryl Brook read the manuscript. Their help is warmly appreciated.

The Guthrie Trust, the Scottish Society of the History of Medicine, generously sponsored the event.

Appendix 1

Biographies of witnesses

We asked each witness participant to provide us with a short biographical resume of about 500 words. Some provided more, some less. This section has been compiled mainly from their accounts, and the style and length of each entry is based on what they wrote. It aims to complement both the theme of the witness seminar i.e. the early development of the specialty of old age psychiatry, and the content of the seminar as told to us by the participants. It therefore does not attempt to give full biographical data, but looks more at the earlier years of the participants' careers and how they came into the specialty.

The issue of the social background of early geriatricians and how they came to specialise in geriatric medicine was highlighted by Professor Margot Jefferys. It appeared to her that 'impressionistically' fewer than might have been expected had parents who were in the medical profession, or well to do, and there was a tendency to drift through medical specialties rather than follow well defined career paths before finding their career niche.¹⁷¹ Hence our questions to witnesses on family background, schooling, first publication and any factors which may have influenced their choice of career.

¹⁷¹ Jefferys M. 'Recollections of the pioneers of the geriatric medicine specialty' 75-97, in *Oral History, Health and Welfare* ed. Bornat J, Perks R, Thompson P, Walmsley J. (London, Routledge, 2000)

Professor Tom Arie, Goodmayes Hospital, London then professor of Health Care of the Elderly, Nottingham¹⁷²

Tom Arie was born in Prague, his father a lawyer and journalist, and mother a teacher. He came to this country with his parents in 1939. After Reading School, a state grammar school, he read classics in Oxford, and then medicine, qualifying in 1960. Becoming interested in the hospital as a small society, at the time a topic much in vogue, he obtained an MRC Junior Research Fellowship with Professor Jerry Morris in the MRC Social Medicine Unit at the London Hospital. He was advised to do some psychiatry before taking up the fellowship, and in the course of doing a junior psychiatric job in Oxford he decided to go for a full psychiatric training. So he went on to the Maudsley, after a summer spent in general practice.

After the Maudsley years and the DPM he reverted to the plan to join Prof. Morris at the London, but did so as lecturer in social medicine (the then equivalent of what became community medicine, and is now usually called public health), a new post, where he also became senior registrar in psychiatry (one could hold two jobs concurrently in two specialties in those days - though there was only one salary!)

Tom was curious about the unfashionable areas of medicine and how work in them could be made attractive and satisfying and more effective, and he wanted to remain a clinician. He was attracted to the field of ageing by the teaching of Dr Felix Post in his old people's unit at the Bethlem/Maudsley and by Prof. Morris's interests in public policy, so when a new job was created at Goodmayes Hospital in outer East London for a consultant psychiatrist to set up a service for old people he applied and was appointed. He started in January 1969. Psychogeriatrics seemed, and has proved to be, a good way of combining social medicine with clinical practice.

Tom spent eight years developing the unit at Goodmayes, writing on related matters, and expanding the scope for medical student teaching there. Important was the close collaboration in a joint medical/psychiatric unit with his Ilford geriatrician colleague Dr Tom Dunn. In 1977 he moved to the new medical school at Nottingham University, as Foundation Professor of Health Care of the Elderly. There a department for older people's mental and physical health was set up, with a substantial teaching role.

Tom's working life has been varied and interesting. He has enjoyed being present at the birth and growth of the new specialty of old age psychiatry. Tom was also able to aid the development of old age psychiatry internationally through the British Council courses he set up and through the World Health Organisation from 1980. Versions of these courses were exported, some through several generations: thus,

¹⁷² Also see *Oral History of Geriatrics as a Medical Specialty*, Tom Arie interview summary, National Sound Archive 1991 <http://cadensa.bl.uk/uhtbin/cgiisirs/vlsoB4N9xS/10190012/9> accessed 26.9.08. The *Oral History of Geriatrics* project comprised 72 interviews (c. 1991) including Colin Godber, Peter Jefferys, Brice Pitt and Jimmy Williamson. Other geriatricians and psychiatrists mentioned in this witness seminar and appendices were interviewed, including Tom Dunn, William Ferguson Anderson, Mohan Kataria, Felix Post and Martin Roth.

the 'Arie' courses in Melbourne have since ranged throughout South East Asia under the direction of Professor Edmond Chiu, a distinguished alumnus of Nottingham.

When asked to reflect on early influences which may have drawn him into old age psychiatry he replied

Who knows! I took up medicine late, but it had long appealed, but why?
Once I was in medicine, I was fascinated by medicine as a social system, as well as by clinical medicine, and I tried to find a career path which allowed me to pursue both. Also, dare I say, I liked looking after people!

Tom's first published article was on favism in antiquity.¹⁷³

¹⁷³ Arie T. 'Pythagoras and Beans' *Oxford Medical School Gazette* (1959) 2: 75-81



Ward scene, Goodmayes Hospital, 1969 (from the archives of Tom Arie)

Dr Klaus Bergmann, consultant old age psychiatrist, Brighton then Newcastle-upon-Tyne then Bethlem and Maudsley

I was born in Dresden on the 18th December 1930 into a German Jewish family. We emigrated in 1937 via Palestine to England. Our residence permit was only temporary till the outbreak of war in 1939, when we became 'enemy aliens'. My father was one of the few of his contemporaries not to be interned on the Isle of Man as his hat factory would have had to close and the English workers would have lost their jobs.

I was educated at St George's School one of the few private schools not demanding the Common Entrance exam. Academically I learnt little especially during my sixth form time and was lucky to get into medical school at Sheffield University in 1950. It had always been my intention to train as a psychiatrist but I was warned not to confess to such a shameful wish! Furthermore, Professor Stengel, who had just arrived as foundation professor, advised me to do general medicine and neurology before starting my psychiatric career.

When my registrar time was up and no senior registrar posts were vacant in Sheffield the time had come to do some research. However, with 2½ children the time for looking around was limited. The best job on the market was with Professor Martin Roth and Dr David Kay carrying out a survey of older people living in the community, firstly following up the survivors of the original survey and then seeing 500 subjects for a new service. My interest was in the apparent *tabula rasa* represented by neurotic disorder in later life. Did people develop neurotic disorder in old age and what happened to neurosis developing in earlier life? (Where do the flies go in winter time?)¹⁷⁴ and determining the needs of this community resident sample.¹⁷⁵

I learned many lessons from the elderly people I met on the survey. The most important was that the majority of my respondents were normal, coped well and led useful lives more often supporting their younger families than requiring their support and that malfunctions were mainly the result of physical or psychiatric ill health. My wish to continue working with older people gelled and I entered the field without psychiatric hospital experience but also without the therapeutic nihilism so often engendered by such experience.

My first consultant job served the coastal strip around Brighton (the 'Costa Geriatrica'). The catchment area contained 50,000 persons over the age of 65 years and the main psychiatric hospital was 15 miles into the hinterland. The main aims were to bring assessment and care nearer to the coastal strip where most of the elderly lived. Some general hospital beds and an

¹⁷⁴ Bergmann K. 'The neuroses of old age' 39-50, in *Recent Developments in Psychogeriatrics*. See footnote 27.

¹⁷⁵ Foster EM, Kay DWK, Bergmann K. 'The characteristics of all people receiving and needing domiciliary services: the relevance of psychiatric diagnosis' *Age and Ageing* (1976) 5: 245-255

old tuberculosis villa provided the in patient and day hospital components, and increased out-patient sessions and home visits to reduce the waiting time before someone could be seen, were the main components of a rudimentary community service. But increased action led to ever increasing demand, without any corresponding increase in resources. High level demands were unavailing and it became time to move.

Professor Roth invited me to set up student teaching and a new general hospital psychogeriatric unit in Newcastle-upon-Tyne.¹⁷⁶ Research was mainly focused on developing early ascertainment within a nearby teaching practice and to carry out a controlled assessment of early intervention. Ultimately this proved unsuccessful. A lack of commitment from the general practice and an objection to screening from the DHSS led to a gradual rundown of the project.

My last 25 working years were happily spent at the Bethlem Royal and Maudsley Hospitals enjoying the dying years of independence and good resources especially the talented junior staff most of whom were better educated and more intelligent than I was.

Klaus is married to **Marie Bergmann**, a retired school teacher who followed her husband round the country with his various job changes offering endless support.

¹⁷⁶ Bergmann K, Eastham EJ. 'Psychogeriatric ascertainment and assessment for treatment in an acute medical ward setting' *Age and Ageing* (1974) 3: 174-188

Dr WD Bill Boyd, consultant psychogeriatrician, Edinburgh

Bill's father was a psychiatrist and he was brought up within the walls of a mental hospital. He was educated in an independent school, and then attended Edinburgh University from where he graduated in medicine in 1954. Two years national service included a psychiatric attachment in Singapore for the second year. On his return in 1958 he held a psychiatric post at Rosslynlee Hospital, Roslin, Midlothian. Following training posts at the Edinburgh Royal Infirmary and Royal Edinburgh Hospital he was attached to the Medical Research Council unit studying the epidemiology of psychiatric disorders. From 1963 to 1968 he was consultant psychiatrist and physician superintendent at Herdmanflat Hospital, East Lothian then from 1968 to 1982 consultant psychiatrist, Royal Edinburgh Hospital, and then from 1982-84 also physician superintendent there. From 1984 to 1991 he was a Commissioner on the Mental Welfare Commission. He also held various senior posts within the Royal College of Psychiatrists.

His first academic publication was a survey of admissions to an acute psychiatric ward.

Dr Colin Godber, consultant old age psychiatrist, Southampton¹⁷⁷

I was born in 1940. My father was a doctor in public health¹⁷⁸ and my mother was a nurse. I was educated in the independent sector, then trained at Oxford and the Middlesex Hospital, qualifying in 1964. Following registrar training at the Maudsley Hospital (1968-71) I became lecturer in psychiatry in the new medical school at Southampton (1971-3).

On behalf of the professor in Southampton I had been involved in a rationalisation of psychiatry locally including the establishment of consultant posts in rehabilitation and psychogeriatrics (both seriously neglected) and a new one in general psychiatry for which I intended to apply. Disappointingly the psychogeriatric post drew no applicants and was in danger of being watered down. I wondered whether this might be a more worthwhile challenge. This was not entirely an act of masochism as I had been impressed by a recent publication on the topic¹⁷⁹ and had seen articles in the *BMJ* by Tom Arie which clearly indicated that this field could be exciting as well as needy. Visits to Buckinghamshire,¹⁸⁰ Goodmayes and Newcastle

¹⁷⁷ Also see *Oral History of Geriatrics as a Medical Specialty*, Colin Godber interview summary, National Sound Archive <http://cadensa.bl.uk/uhtbin/cgiirsi/Y8vfRT8AJg/10190012/9> accessed 26.9.08.

¹⁷⁸ Brindle D. 'George Godber at 100' *British Medical Journal* (2008) 337: 324-326

¹⁷⁹ *Recent Developments in Psychogeriatrics*. See footnote 27.

¹⁸⁰ To the Aylesbury service run by Dr Michael White and Dr Roy Simons. Their service was highly regarded and was one of the first recognised for senior registrar training for old age psychiatry. Unfortunately neither Michael White nor Roy Simons were able to attend the witness seminar. However, Michael White (March 2008) sent us a written contribution of his recollections of his experience of setting up the service in Aylesbury in 1970.

When the time came to think of moving on after senior registrar posts, I wrote round the majority of Regional Hospital Boards asking if they had any plans for consultant led services for the elderly mentally ill and infirm. I only had three replies; two did not know what I was talking about. The third was from Dr Rosemary Rue, then the deputy senior medical officer at Oxford, asking me to come and see her. This I did, and found that a consultant post was planned for the Aylesbury area; I visited, discussed the problems of the elderly in the hospital and my ideas for a new service with the medical director of St John's Hospital. I applied and was appointed in spring 1970.

When I told my bosses at Gloucester, I was informed it was nothing to be proud of, as any fool could get a job with geriatrics. On my first day in Aylesbury, the medical director took me into his office and said 'Now you're here, what do you really want to do?' When I replied that for which I had been appointed, he was taken aback. I was allocated a block of 'chronic' wards, full of old people of uncertain diagnoses and left to get on with it. Any empty beds could only come by deaths; there was no way that any patient, however deserving, could be admitted; as the odd bed became available, it was shared out, on a two-weeks in, x weeks out basis, with the value of x depending on the total demand. The pressures and stresses of this I need not elaborate on. It was great when I heard of the Group for the Psychiatry of Old Age within the College; I found these small, informal meetings very helpful; (later, when the Group became a Section, larger numbers and increased formality changed the ethos, I felt).

switched me on sufficiently to apply. At interview I had to acknowledge my total lack of experience and training in old age psychiatry, suggesting that, if appointed, I could partially rectify this by spending my first month of employment on a crash training with Klaus, Tom and Felix Post. At a later date I also visited Sam Robinson in Edinburgh and Ferguson Anderson who had done so much to inspire a generation of geriatricians.

My patch was the city of Southampton, comprising 28,000 elderly, not too bad by 1970s standards. My base was at Moorgreen Hospital comprising 100 geriatric and our 130 beds (of which all but 10 were long-stay, not to mention a waiting list of 20). A big bonus was the excellence and appetite for change of the nursing staff and their leadership and two experienced GP clinical assistants. Another was the support of the director of nursing in the local public health department who used two of her vacant health visitor posts to establish our first community psychiatric nurses. I had indicated at interview that although the job description had focussed on dementia I proposed a comprehensive service for the over 65s. I wrote to all the general practitioners to this effect, indicating that all patients would be seen and treated (the same day if possible) at the venue from which they were referred and that until we had reclaimed enough beds to guarantee admission for those needing short term treatment or respite I could not offer long-stay and would need their support in that.

The first two years were extremely busy. New referrals rose to 500 a year, with an increasing proportion of functional illness as general practitioners began to see it as treatable, and better by us than by the general psychiatrists. The admission policy gradually got the assessment unit beds turning over again. The level of home follow up was high and with no day-care at that time our back up to carers was through regular relief admissions, and the guarantee of short rescue admissions to help with flare ups and crises. When we became able to offer long-stay vacancies they were offered to the patient/family most in need. We felt we were winning as steadily more families opted to carry on with the respite care on the clear guarantee that when they signalled they would get the next vacancy. This was reflected in a steady fall in the average long-stay duration from 4 to 1 year. We were able to capture some very useful data on the changing pattern of service through the Southampton Psychiatric Case Register. Nostalgically I hung on to some

My first step was to make overtures to the general hospitals in Aylesbury. Once they found I did not conduct sacrifices at full moon things went well. I was always aware in my negotiations that Dr Rue was in the background pulling strings or kicking backsides as necessary. I was especially fortunate in Dr Lorna Davies, the geriatric physician, who, once she got over the shock of a psychiatrist wanting to be helpful, was herself a great support to me. Eventually I acquired a ward and day unit adjacent to Dr Davies and an office and secretarial staff. I was also able to get going an experiment with one of our nurses, and one from the local authority, being sent to work out from the hospital helping in patients' homes; this gradually built up into a weekday 9 to 5 service employing several charge nurse/sister grade staff.

of that data for years but as it was simply gathering dust and I hadn't realised that it might soon have had a currency in the history of medicine, I disposed of it earlier this year.

The Royal College of Psychiatrists Old Age Group meetings were a great source of mutual support and ideas. They were very informal and generally subversive towards the College establishment and the DHSS advisers (who were supportive but still attached to a service model we were keen to displace, and were still planning resource needs in terms of growth in the over 65 population which hugely underestimated the rise in the prevalence of dementia). This anarchic tendency, often articulated by Klaus Bergmann, must have been a bit embarrassing for our elder statesmen, Felix Post and Sam Robinson, and probably for Tom Arie, whose strategy included the need to access the corridors of power. Because there were so few psychogeriatricians, even very junior figures like myself would get co-opted onto working parties of one sort or another. It was nice to get a finger in the bigger pie.

My first academic publication was a chapter in a book edited by John Wing compiling research involving the Camberwell Case Register.

When asked about early influences for a career in old age psychiatry Colin replied 'I can't think of any ... apart from a general encouragement at home of an ethic of social service and responsibility.'

Dr Nori Graham, consultant old age psychiatrist, Royal Free Hospital, London

Nori's talk in the witness seminar was extremely autobiographical. Some additional points are added here.

Nori was brought up in Manchester. Her parents were theoretical chemists. She wrote

I wanted to be a doctor from a very early age probably because my parents (Russian Jewish refugees), in particular my father, was always certain that this was a good career for a woman. His sister was a doctor.

Basically I did medicine against all the odds. I went to an independent school, Manchester High School for Girls. I was much better in the arts than the science subjects and my school wanted me to do languages but I was very determined that I wanted to do medicine. My father was also very clear that I should go to Oxford which I was very fortunate to be able to do.

A close friend of the family was a psychiatrist. That might have been an influence on me. The other influence was the University College Hospital psychiatric teaching which was so good.

Nori trained in general practice and also worked in family planning and child welfare before moving into psychiatry. Her psychiatry training was with Tom Arie at Goodmayes, then at Friern Hospital, and then as senior registrar at the Royal Free Hospital. She was a consultant in old age psychiatry at the Royal Free Hospital from 1981 to 2000.

From 1984 to 1994 she was chairman of the Alzheimer's Disease Society, UK, and was subsequently chairman of Alzheimer's Disease International (1996-2002), and is now a vice-president of both organisations.

Nori has been awarded both an honorary doctorate (D.Univ. Public Services, Open University 1996), and an honorary fellowship of the Royal College of Psychiatrists (2005).

Nori's first publication was on psychiatric illness in residential homes for the elderly.¹⁸¹

¹⁸¹ Mann AH, Graham N, Ashby D. 'Psychiatric illness in residential homes for the elderly: a survey in one London borough' *Age and Ageing* (1984) 13: 257-265

Dr Claire Hilton, consultant old age psychiatrist, London

I was brought up in East London, and attended Woodford County High School, a state girls' grammar, where there was an expectation that if you were good at science subjects you would go into medicine. My parents went along with this - they had both left school at 14 years of age, and they wanted a better education for their children.

My first paper was a case study written during my student elective at the MRC Sickle Cell Unit in Jamaica.¹⁸² In those days I wanted to be a haematologist! However, a taster of psychiatry during general practice training led to me swapping to psychiatry. I started as a psychiatric trainee in 1989, the last year of the scope of our witness seminar. We had moved from London to Manchester in 1987, and my eldest son was an insomniac one year old by 1989.

My SHO training started at Withington Hospital, South Manchester in January 1989. It was to be a whole year of old age psychiatry part-time on the 'PM (79) 3' scheme. The clinical tutor was sure that I would enjoy it, and she didn't think I would survive the alternative on the professorial unit. I was somewhat ambivalent. What was old age psychiatry? Was there anything that could be done for the old and demented?

Within weeks my heart was set on a career in old age psychiatry, despite a dread of even more examinations and a far off uncertainty as to whether a consultant post would ever be achievable. The patients were so rewarding to work with. And the atmosphere in the department was so wonderfully positive and nurturing.

Some events of that year spring to mind.

I vividly recollect Dr Dave Jolley, the senior consultant whom I held in awe, bounding up the stairs into the offices on the second floor with a beaming smile announcing 'We're a specialty!' I really couldn't understand what he meant, and didn't dare ask. Surely we were doing the job weren't we? It took me years to discover the significance of his jubilant comment and his role in the process of achieving recognition by the Department of Health of psychogeriatrics as a specialty in its own right.

Ethel, an extremely large lady, is unforgettable. Unfortunately her discharge summary had not appeared in the notes, and Dr Jolley was somewhat angry, but did not tell me so. Instead he told his personal assistant Ruth. Ruth told me, and I assured her that I had seen the typed copy. She then phoned the GP who faxed it back and it reappeared in the notes. I had never been in the

¹⁸² Graham C. 'Sandra' *Bart's Journal* (Winter 1983-4) 42-46

position before of a consultant actually apologising. Dr Jolley was a very important role model: he always praised you for something well done, but kept quiet if you had done something badly. You just knew. It was a very powerful motivator, and too rare in medicine. I hope I have learnt to give the same positive reinforcement to my own trainees.

I won't forget the tragic suicide of Helen Rana, a fellow trainee on ward 'P 2 and 3', and realising the vulnerability to mental illness of many working in psychiatry.

I remember the humaneness shown to a patient with an affective disorder who was also terminally ill with cancer. She was nursed on the old age psychiatric ward where she felt safe.

Still vivid in my mind is the elderly lady who repeatedly wandered to the corner shop and bought what she thought she needed - bread and butter. She was the patient who taught me to check the refrigerators of forgetful people. When you arrived at her front door, if you introduced yourself as from Withington Hospital she anxiously replied 'Go away, I don't want to be in the workhouse' and seconds later when her short term memory failed and she repeated 'Who are you?' and you replied 'I am from an organisation which wants to keep old people safe at home' she warmly welcomed you into her ramshackle house.

1989 was an extremely important year for me. Career wise, I haven't looked back.

In terms of early influences on my choice of career, I think that I always liked and had a curiosity about old people. There was, for example, the very, very old Mrs Archer who lived in the flats where we lived until I was 6, and she always made us wonderful birthday cakes covered with smarties, jelly babies, chocolate buttons and other goodies arranged in concentric circles stuck on white glacé icing - an elderly lady of great and meaningful talent. Visiting her, and visiting my grandparents, were enjoyable adventures with treats and smiles attached.

Dr Peter Jefferys, consultant old age psychiatrist, Harrow¹⁸³

My interest in psychogeriatrics began as an undergraduate. My turn-on to psychogeriatrics was effected by Tom Arie in my final year elective. I learned that he was just about to begin his first consultant post in psychogeriatrics at Goodmayes Hospital. He invited me to spend my elective with him. I jumped at the opportunity, having not been so keen on the alternative I had almost organised studying the link between rabies and vampire bats

From 2 Jan 1969 for eight weeks I spent Monday to Friday with Tom, sharing the journey in his mini from Highgate to East London and back each evening. I observed interviews with old people and their families, and then tried my best to do something similar. I was a fly on the wall in the wards of the traditional mental hospital rigidly segregated into female and male sides with a starch-capped matron and a chief male nurse. I also joined Tom's meetings with the policy makers in East Ham and Redbridge. GPs - particularly Arnold Elliott, white haired socialist and thorn in the flesh of the BMA - found it easier to let Tom join their committees than try and shut him up. And Tom Dunn, the gentlest of geriatricians from Chadwell Heath Hospital.

Tom's charisma is recognised by everyone who has had the privilege of contact with him. I found his willingness to share his analysis of clinical and management dilemmas and his responsiveness to suggestions and criticism from others - even from a medical student - exhilarating. Goodmayes was hit by a whirlwind, except for one night charge nurse on a ward of Tom's that we visited, accompanied by our wives on the evening of the annual hospital party some 8 weeks after he started. We had got bored with the big wigs party in the Board Room (hospital staff were strictly segregated by status, so there were three simultaneous but separate parties on the same night). After some difficulty distinguishing the nurse from the patients Tom asked him what he thought about all the recent changes on the ward that he was so proud of. Even Tom was lost for words when the nurse replied 'What changes?', denying any knowledge that there was a new consultant.

After house jobs, my elective experience made me apply to work with Malcolm Hodkinson, at the brand new MRC-NHS hospital at Northwick Park, as an SHO in geriatric medicine. Malcolm's enthusiasms, management expertise, commitment to multi-disciplinary working and academic resourcefulness are well recognised.

As a registrar at the Maudsley Hospital from 1972 onwards I never got the chance of working with Felix Post but was enthused by community and rehabilitation psychiatry. It was at St Francis Hospital in Dulwich in 1975 that I

¹⁸³ Also see *Oral History of Geriatrics as a Medical Specialty* Peter Jefferys interview summary, National Sound Archive 1991 <http://cadensa.bl.uk/uhtbin/cgiirsi/qObhdakxS/10190012/9> accessed 26.9.08

first took serious clinical responsibility for older patients as a psychiatrist, providing the psychiatric input to a joint psycho-geriatric assessment unit managed by Dr Mohan Kataria, a geriatrician from Kings College Hospital. In my final months at the Maudsley I met Dave Jolley while he was on attachment with Felix Post. Mutual respect for each other was established and over the following decade Dave repeatedly tried to tempt me to join him in Manchester as a consultant.

I applied for a consultant post in psychogeriatrics at Northwick Park and Shenley Hospitals in late 1975 - the first dedicated old age psychiatric post in what was then North West Thames Regional Health Authority. I began on 1 April 1976, with just four years full time training in recognised psychiatric posts. I was single-handed, serving the outer London Borough of Harrow, with a population of 30,000 over 65. I forged alliances with public health, local GPs and with geriatric medicine and insisted on involving senior hospital administrators (as they were designated then) in all my strategic discussions. My general psychiatric colleagues were contrite when they explained that unfortunately I would have to make do with a GP vocational trainee from the Northwick Park scheme rather than a junior psychiatrist. Within months they recognised the exceptional quality of the GP trainees and the close link it gave me into the best of local general practice in Harrow, which I of course encouraged.

But in spite of numerous partnerships I often felt rather alone. I was expecting to take responsibility for four long-stay psychogeriatric wards at Shenley Hospital about 12 miles from Northwick Park, comprising 110 beds, to be overseen on 3 half-days. On arrival I found I had been allocated 160 patients, including the male 'sick ward' and my protests fell on stony ground. My general psychiatric colleagues were united in saying it was my job as the most junior consultant to look after the extra patients, even though I had less equivalent allotted time than anyone else. I gave a three month ultimatum and there was a stand-off which eventually resulted in my losing the extra wards but I was virtually sent to Coventry for over a year by many of my consultant colleagues.

In this situation I gained greatest support from other old age psychiatrists via the newly formed Old Age Psychiatry Section of the Royal College of Psychiatrists. In 1978 I was pressed by Brice Pitt and Tom Arie to be the first secretary of the new Section, working with Sam Robinson as chair. It was an exiting time. The Section had an outstanding group of innovative old age psychiatrists, many of whom have participated in the witness seminar.

Senior Section members both from Scotland (particularly Sam Robinson and Bill Boyd) and England stimulated constructive dialogue with both the British Geriatrics Society and the Royal College of Physicians of London during the late '70s and early '80s. That increased the reputation and credibility of the

speciality amongst the senior establishment in the Royal College of Psychiatrists some of whose members were beginning to realise that its future lay in creating alliances and looking out rather than looking in on itself. By about 1979 the Royal College was positively eager to have Section officers present at important meetings with the DHSS, partly when it became clear that the Department officers already knew the key old age players well. The Section became increasingly determined for recognition of old age psychiatry as a specialty. This in turn meant the identification of designated senior registrar training posts to provide appropriately qualified candidates to fill service gaps. Policing and monitoring the outcome required determined efforts

Professor David (Dave) Jolley, consultant old age psychiatrist, Manchester then Wolverhampton and Manchester again

Born to be a psychogeriatrician

On reflection, it seems to me that it was inevitable - preordained - that I should spend my professional life in service of old people with mental illnesses.

I was born December 1944 and so grew up with the advantages of the Welfare State, a free grammar school education and guaranteed health care within the National Health Service. Joseph Sheldon was conducting the first survey of the Social Medicine of Older People in my home town. Family life was all important - grandparents, aunts, uncles and cousins all living within our street or a short walking distance. Values were aligned to the Methodist Church and honest working-class endeavour. A career offering a good income and opportunity to be helpful to others was a dream to dream, but achievable because of the unique circumstances of the time. Teenage Sundays were spent with gran - initially at home, telling stories over and over, collecting flowers from neighbours' gardens - and then at St George's Hospital Stafford, where I was bemused to find that my father and I were hailed by her as old friends from Shifnal - not a portion of her life we had shared.

Medical School training was at Guy's Hospital (1963-9). The clinical years included time with iconic figures. Psychiatry was led by Dr David Stafford-Clark. He invited other celebrity psychiatrists to teach us. These included Dr William Sargant from St Thomas's and Dr Russell Barton - physician superintendent of Severalls Hospital, Essex. I was very drawn to Russell Barton who had a real feel for the experiences of patients as individuals, and also as a group of considerable size within the population. He offered the opportunity to spend time during a specialist attachment with his team. I saw patients housed 50 to a bedroom, staffed by two nurses from another culture. I heard of the dramatic advances which had seen the bars which separated males from females taken down and work and other diversions provided to encourage rehabilitation and the respect of patients as equal human beings. I learned of pioneering efforts to provide community services for older people.

I came to Manchester in 1970. Withington Hospital had become the University Hospital of South Manchester and Professor Neil Kessel with Dr John Johnson had planned the establishment there of an academic general hospital psychiatric unit. This was a wonderful opportunity. Professor David Goldberg joined the staff from the Institute of Psychiatry - confirming its academic credentials.

John Brocklehurst had come to Withington as the first professor of geriatric medicine in an English university and Tom Arie, Brice Pitt and others had begun to spread the good news of psychiatry for older people as a positive

force in the pattern of geriatric medicine, influenced too by the community psychiatry movement.

So locally and nationally there was encouragement to see the provision of care for older people with dementia and other mental health problems as the medicine of the moment. A key experience was my chance attendance at Tom Arie's Maudsley Lecture in 1972. I had already found greatest interest in patients with chronic disorders not resolved by treatments available. Dementia presented perhaps the most extreme example of this genre. My Methodist upbringing led me to a natural affinity for the underdog - the unfashionable, the least prestigious. For it is here that the greatest impact might be made with the humblest of advances. Thus it was necessary to obtain training to equip me to join the venture to improve services for older people.

Bizarrely, but in keeping with the thinking of the time, the 'comprehensive' psychiatric service developing at Withington did not expect to take responsibility for older people, especially older people with dementia. Nor was there any other unit in the North West equipped to provide training in the emerging discipline of psychogeriatrics. Thus it was that David Goldberg, in liaison with colleagues and with sponsorship from the North West Regional Hospital Board arranged a do-it-yourself training programme which took me to Goodmayes Hospital with Tom Arie, the Bethlem and Maudsley Hospitals with Felix Post and Raymond Levy and back to Withington for geriatric medicine.

Scandals had played a major roll in generating popular awareness of the plight of older people with mental health problems. The exploitation of patients at Whittingham Hospital near Preston was reported by Barbara Robb¹⁸⁴ and the thoughtless transfer of patients to their deaths in Bury/Rosendale moved the North West Regional Hospital Board (encouraged by Professor Arie and others) to determine a new pattern of psychiatric services for older people. One component of this was to be the provision of purpose-built accommodation in local hospitals. The other was the need to develop community services, integrated with other agencies working with older people, including geriatric medicine.

I was appointed the first consultant psychogeriatrician in the North West of England in November 1975. With the appointment came responsibility to develop a service for the population of 30,000 older people with limited resources, to develop a teaching and training programme as honorary lecturer within Manchester University and to advise the Region on developments in the field.

¹⁸⁴ Robb B. *Sans Everything. A Case to Answer* (London, Nelson, 1967)

Dr Gordon Langley, consultant psychogeriatrician, Exeter

Gordon Langley attended Wintringham Grammar School, Grimsby, Lincolnshire, a state school. His father was a teacher and headmaster.

The outstanding teaching of biology at Wintringham probably encouraged him to study medicine. He qualified in 1949 at Newcastle Medical School. After a year as a house surgeon at the Royal Victoria Infirmary he spent two years in National Service, principally as a regimental medical officer with the first battalion of the Royal Northumberland Fusiliers in Korea and Hong Kong. After returning to the UK he worked in general practice in Lincolnshire, Oxford and Southend for three years. He then entered psychiatry as a trainee at Runwell Hospital, Essex. At Runwell, he worked with the pathologist Nick Corsellis, spent some time in day to day care of the sick ward - a useful experience for a career in psychogeriatrics - and wrote his first academic paper.¹⁸⁵

In Devon, after the Second World War, one local hospital was allocated the care of older people - Exe Vale, Exminster. At that time all the local psychiatrists worked across all ages in all the hospitals for a total population of 600,000. Staff at Exe Vale were unhappy to be left solely with the care of elderly patients. However, new admission wards were built and in the early 60s two psychiatric medical superintendents, Lewis Cooper and Eric Bartlett, and two geriatricians Jack Simpson and Bill Wright, planned a joint psycho-geriatric assessment clinic there in a ward modified for the purpose. In 1965 Gordon was appointed as a consultant general psychiatrist in Exeter with special responsibility to work in the psycho-geriatric assessment unit (later, Hallett Clinic¹⁸⁶) alongside the two geriatricians. He also had general psychiatric duties, initially in North Devon and later in Exeter district.

The opening of the Hallett Clinic was delayed until 1967 due to a shortage of nurses, but it still became operational shortly before the opening of a similar purpose-built unit in Bodmin, Cornwall (The Charles Andrews Clinic). Once operational, the converted ward in Exminster comprised 30 beds, had an occupational therapy unit, a designated social worker and a clinical assistant (initially Dr. Llewellyn Roberts). All general psychiatrists had admission beds at Exe Vale, with the Hallett Clinic concentrating on difficult overlap problems in admissions originating in either the geriatric or psychiatric services referred by one of the three (later four) consultants providing the in-patient care.

Each week the psychiatrist and geriatrician conducted their own rounds and then met for a joint round. The relationships were amicable and productive and remained in this format until Exe Vale was closed in 1986 when staff transferred to a ward alongside those of the geriatricians in Heavitree Hospital, Exeter.

¹⁸⁵ Langley GE, Robin AA. 'A pilot trial of orphehadrine ('disipal') in patients treated with reserpine' *Journal of Mental Science* (1960) 106: 682-685

¹⁸⁶ See footnote 203

Gordon Langley developed an interest in 'way of life' services that promoted interaction and engagement in all wards. These included: reality orientation, validation therapy and reminiscence therapy learned from Mick Kemp but extended for use by drama therapists,¹⁸⁷ and music therapy (the Workers Education Association were willing to provide a folk singer on the basis of the audience, patients, being signed up under their regulations for a free service). Personal contacts with a community theatre group associated with the Drama Department of the University of Exeter, and Rolle College led to the formation of a reminiscence theatre group which visited wards and residential homes, talked to residents, enacted their stories, returned to perform them, and then returned again to discuss them.

¹⁸⁷ Langley DM, Langley GE. *Dramatherapy in Psychiatry* (London, Croom Helm, 1983); Langley DM, Langley GE. 'Dramatherapy' in *Care of the Long Stay Elderly Patient* (2nd edn.). ed. Denham MJ. (London, Chapman & Hall, 1991)

Professor Brice Pitt, consultant old age psychiatrist, Claybury Hospital then the London Hospital, then St Mary's and the Royal Postgraduate Medical Schools, University of London^{188 189}

Brice Pitt's father was a highly successful general surgeon, his mother a nurse. He was educated at Epsom College. He wanted to be an actor but his father wanted him to be a doctor. Psychiatry was a sort of compromise. Brice trained at Guy's. His entry to old age psychiatry was opportunistic, as he described in his contribution at the witness seminar. However, there may have been some sort of lasting impression created in childhood, as he related 'My sainted grandmother had a stroke and threw a knife at me in a tantrum: this affected me profoundly and left me wondering why.'

After working as a consultant at Claybury Hospital, Princess Alexandra Hospital, Harlow, the London and St Bartholomew's Hospitals, he was appointed professor at St Mary's in 1986.

His student textbook *Psychogeriatrics: An Introduction to the Psychiatry of Old Age* (Edinburgh, Churchill Livingstone, 1974), was well received, an extremely popular and readable short text, which includes many memorable quotes e.g. 'colleagues who argue that [psychogeriatrics] should not exist are in no stronger a position than Canute holding back the waves'.

Brice has written about his own episodes of 'feeling low'. He has also managed to combine work as a psychogeriatrician with writing plays and novels, acting and theatre directing.

His first publication was together with Morris Markowe on the development of a day hospital.¹⁹⁰

¹⁸⁸ Brice Pitt requested that his biographical summary was taken from an interview by Elaine Murphy 'A Conversation with Brice Pitt' *International Journal of Geriatric Psychiatry* (1995) 10: 1085-1091.

¹⁸⁹ Also see *Oral History of Geriatrics as a Medical Specialty* Brice Pitt interview summary, National Sound Archive 1991 <http://cadensa.bl.uk/uhtbin/cgiisirs/BLMW1dvUMJ/10190012/9> accessed 26.9.08.

¹⁹⁰ Pitt B, Markowe M. 'A new pattern in day hospital development: the West Middlesex Day Hospital' *British Journal of Psychiatry* (1963) 109: 29-36

Dr Andrew Reid, consultant psychiatrist, Dundee

Andrew Reid qualified in medicine in 1965 at St Andrews, was awarded his MD in 1972, and holds the fellowships of both the Royal College of Physicians of Edinburgh and the Royal College of Psychiatrists.

He was consultant psychiatrist for Dundee Psychiatric Services from 1972 to 2003 and latterly clinical director, Dundee Primary Care Trust.

Dr RA (Sam) Robinson, consultant in old age psychiatry, Crichton Royal Hospital, Dumfries then Edinburgh

Ronald 'Sam' Robinson was brought up in Northern Ireland. He attended Sullivan Upper School, an independent grammar school. His father was a transport official and his mother a teacher. He qualified in medicine at Queen's University, Belfast.

Sam's passages included here both give glimpses of a past era of psychiatry and complement those in his presentation at the seminar.

In 1950 I was a houseman in cardiology at the Royal Victoria Hospital, Belfast. An unknown patient was admitted, apparently in coma. No metabolic cause was found. The visiting well-known neurologist, Sidney Allison, who had a DPM, was of the opinion that this was either 'grande hysteric' or catatonic schizophrenia. The patient was transferred to Purdysburn, the local mental hospital. Sidney was impressed by my detective work in identifying her and in contacting relatives and asked whether I was interested in psychiatry. When I admitted the possibility and asked for his advice he suggested that I took the option of spending my next trimester in neurosurgery, and then six months in Purdysburn. After that he would give me a post as SHO for two years because he considered that a good grounding in neurology was essential for psychiatrists. (I discovered much later that applicants for his service were in short supply.) I took his advice, but was severely unimpressed by the mental hospital. I decided that if this was psychiatry it was not for me. A new experienced senior registrar said that I shouldn't give up psychiatry without trying a decent hospital, either the Maudsley, or Crichton Royal, Dumfries. There happened to be an advertisement for a houseman at Crichton Royal in the *BMJ* the following week. I asked Charlie Robinson, the superintendent (no relation) for a reference but he declined, saying that it would be a waste of his time and mine: 'you need a higher degree to get a job there.' However, I persisted and he eventually agreed. Imagine my surprise (and his) when I got a letter by return offering me the job.

I started at Crichton on 1 September 1951. I was shown the ropes by one of the Crichton fellows, John Harrington - who gave me my nickname on account of my supposed facial resemblance to Sam Costa (no beard then) a disc jockey.

Willi Mayer-Gross was a warm ebullient pyknic with a sparkling eye. A week or two after my arrival he invited me to come to his office at nine o'clock the following morning. My colleagues warned me that this would be for my statutory dose of LSD - and so it turned out; no ifs or buts. After the colourless and tasteless drink my reactions and sensations were monitored for the next four hours by Mayer-Gross, Robert Klein and (I think) John Raven, director of psychological research.¹⁹¹ Among the various procedures was an EEG. My peers had regaled me the previous evening with expectations of vivid visual

¹⁹¹ John Raven developed the psychology assessment tools, the Mill Hill Vocabulary Scale and Raven's progressive matrices, both still in use today.

and tactile hallucinations, pictures sliding down walls and multiple delusions. To my disappointment none of these occurred; it was for me a complete non-event.

There was plenty of ... teaching; Mayer-Gross had numerous visitors and usually persuaded them to give an impromptu lecture ... I remember particularly Oliver Zangwill, William Grey Walter, William Sargant and Eliot Slater.

Insulin coma therapy was Mayer-Gross's main clinical responsibility ... a group of about 30 schizophrenics were treated each morning. The coma, induced by an insulin injection, was gradually increased in duration to a maximum of 30 minutes. The coma was terminated by intra-gastric glucose administered by stomach tube. The routine was remarkably efficient; in the case of the occasional delayed recovery, glucose was given intravenously. Unresponsive patients were sometimes given ECT during coma. However it was not a job for the introspective. The sight of 30 patients, all in coma at the same time could be a surreal and somewhat daunting experience. Such a potentially lethal procedure was only possible thanks to an alert and highly trained nursing staff. A feared but very rare complication was delayed insulin shock. I was called one night to see a patient who had slipped back into coma. In spite of massive intravenous glucose his blood sugar refused to rise. Dawn was breaking before there was detectable biochemical response and he began to show signs of recovery. His mental illness seemed unaffected by the experience. Later I got a rocket from M-G for failing to call him. It is sometimes overlooked that in the best regimes insulin patients had an intensive rehabilitative programme. Each afternoon the group, including the nurses, had a varied programme of sporting and group activities designed to stimulate and re-socialise. Some of us felt that it might have been these rather than the coma which contributed to the many undoubted recoveries. Post-leucotomy patients were also included.

Sam's first medical publication, on EEG and organic deterioration, was mentioned in his talk.¹⁹²

Sam outlined factors which may have influenced him pursuing a career in old age psychiatry. In particular

When I was a teenager my widowed maternal grandfather came from England to live with us. As he passed through the stages of general frailty, incontinence and intellectual impairment I had firsthand experience of the problems of old age. The burden on my mother in those pre-washing machine days must have been severe.

He also recalls that his father and grandfather were both herbal remedy enthusiasts.

I can still remember Dr Collis Browne's Chlorodyne (opium), Liquifruta,¹⁹³ slippery elm bark¹⁹⁴ - but there were many others.

¹⁹² See footnote 14.

and

I had a largely unsatisfied curiosity about human anatomy and physiology. When faced with a very difficult question my mother often used to say 'You'd have to be a doctor to understand that.' In fact I had almost no contact with doctors ... In consequence I grew up with the fantasy that doctors were omniscient. The rude awakening when I encountered the clinical medicine of the 1940s possibly turned me towards psychiatry.

For 'a helpful reflection of the state of the art in the early seventies', Sam particularly recommends *Modern Perspectives in the Psychiatry of Old Age* ed. Howells JG. (New York, Brunner/Mazel, 1975).

¹⁹³ Cough and cold remedy

¹⁹⁴ Generally used for various gastrointestinal problems, but could also be used to induce abortions

Professor John Wattis, consultant old age psychiatrist, Leeds then Huddersfield, and visiting professor, University of Huddersfield since 2000

My father was a flight-sergeant air gunner, military policeman, civilian policeman, salesman, charge-hand process worker with UKAEA and finally a work-study/management services worker with UKAEA. My mother trained as a hairdresser, was in the ATS as a wireless intercept operator in the War and after a variety of other jobs settled as a civil servant. There are no doctors in the family that I know of. I went to a Catholic direct grant grammar school, then to Liverpool Medical School (interviews at three London Medical Schools resulted in 'waiting list' rather than the 'offer' I got from Liverpool; those were still the days when they could and did ask which Medical School your father went to and what position you played at rugby!)

I spent several months in hospital with a rare disease when I was a few years old. Whether that influenced my decision to go into medicine I don't know. It certainly seemed to be what we used to call a 'vocation'. After my house jobs in Liverpool (including one with the famous haematologist D J Weatherall) I ran a mission hospital in Uganda with my wife (by this time I was an Anglican) during the time of Idi Amin. I returned wanting to work in psychiatry (or possibly general practice). I think the story from there is picked up in my witness seminar account.

My first significant publication was the In the BMJ (1981) with Tom and my wife about the development of a new branch of psychiatry. Prior to that I had published a series of case studies on 'Stripping as a sign of depression in elderly women' in the *Midland Medical Review* and a comparison of geriatric and psychogeriatric home visits in *Geriatric Medicine*. Other published research includes the development of old age psychiatry services, alcohol abuse in old age, the prevalence of mental illness in geriatric medical patients, and outcomes of psychiatric admission for older people.

I was responsible for pioneering old age services in Leeds as a consultant and senior lecturer for nearly twenty years. I was chairman of the Faculty of the Psychiatry of Old Age at the Royal College of Psychiatrists, and on the College committee that advises on the higher training of doctors in general and old age psychiatry.

Since retiring from the NHS in 2005 I have continued as visiting professor of old age psychiatry at the University of Huddersfield, teaching various professional groups at undergraduate and postgraduate level as well as being an active member of the Ageing and Mental Health Research Group. I am committed to a multi-disciplinary and inter-agency approach to health care of the elderly that sees mental health and illness in the context of physical health and social pressures.

My approach to healthcare for older people is founded on three principles:

- A recognition of the importance of *good relationships* between individuals and between different health and social care providers,

- A firm commitment to the need to *develop and integrate evidence based practice* and
- An emphasis on the need for *creativity in improving treatment and services*.

Professor James (Jimmy) Williamson, consultant geriatrician, Edinburgh¹⁹⁵

Jimmy Williamson was the youngest of three children and the only son in his family. He was educated at Wilshaw High School, Lanarkshire. He always wanted to be a doctor and was very much encouraged by his mother. He graduated from the University of Glasgow in 1943. He did not do army service because of a severe illness – diphtheria as a final year medical student. His subsequent work included being an assistant in general practice and a registrar in thoracic surgery, and five years as a consultant chest physician. In 1959 he transferred to geriatric medicine. He was subsequently President of the British Geriatrics Society 1986-88, and held chairs of geriatric medicine at both Liverpool and Edinburgh universities. He was awarded the CBE, an honorary D.Sc. (University of Rochester, New York), and the City of Vienna Ignatius Nascher Award 2001.¹⁹⁶

Other ‘non-witness’ participants:

Dr Malcolm Nicolson, director, Centre for the History of Medicine, University of Glasgow

Dr Mia McLaughlin, consultant old age psychiatrist, Lanarkshire

Mia is clinical lead in old age psychiatry in her service. She wrote

I came [into old age psychiatry] via palliative care but my first publication, which I can't quite remember was on genetics and alcohol dependency. I grew up in Ireland, went to state schools and my father was an engineer and my mother a social worker.

Dr Susan Jolley, Manchester

Dr David Findlay, consultant psychiatrist, Dundee

David Findlay commenced his psychiatric training at Gartnavel Royal Hospital, Glasgow in 1980 following a discussion with Gerald Timbury. He also spent a year in Geriatric Medicine at Stobhill Hospital, Glasgow. After a period as lecturer in the Department of Psychiatry, University of Dundee, he returned to Gartnavel Royal, then to Royal Dundee Liff Hospital with Brian Ballinger, Andrew Reid and Anne McHarg. Later, as policy adviser on older people at the Scottish Executive Health Department, he worked with John Loudon who had been one of Scotland's earliest old age psychiatrists.

¹⁹⁵ Also see *Oral History of Geriatrics as a Medical Specialty* James Williamson interview summary, National Sound Archive 1991 <http://cadensa.bl.uk/uhtbin/cgiisirsi/gLKtiTcCR/10190012/9> accessed 26.9.08.

¹⁹⁶ Nascher was an Austrian émigré who moved to New York, who coined the word ‘geriatrics’ in 1909.

Appendix 2

Additional biographical information

Some of the people invited to participate as witnesses were unable to attend. Of those, some sent us a written contribution, largely focusing on their early years in old age psychiatry or geriatric medicine. All of these contributors had an important role in service development.

Michael White's contribution appears in footnote 180.

The other people contributing biographical information were
Dr Michael Denham
Professor Robin Jacoby
Professor Kenneth Shulman
Dr Roy Simons

Dr Michael Denham, consultant geriatrician, Northwick Park Hospital, Harrow

Michael Denham is a widely respected geriatrician, now retired, and is also known for his research into the history of geriatric medicine.¹⁹⁷ He appended most of the footnotes to his account, which have been cross referenced to footnotes earlier in the text.

I arrived at Northwick Park Hospital as senior registrar in geriatric medicine to Malcolm Hodgkinson when the hospital opened in 1970. At that time the geriatric service to Harrow was provided by the geriatric department based at Edgware General Hospital under the control of Dr Allan Binks and colleagues. It was a very large area and I am sure that Allan was happy to have his burden much reduced. Relations between the two geriatric units deteriorated somewhat when it became clear that different styles of geriatric medicine were practised. This happened when Malcolm published 'Making hospital geriatrics work'.¹⁹⁸ The story has it that the district administrator waved the article at Allan and said 'What are you going to do about it?'

When Northwick Park opened the general psychiatrists had beds in the district general hospital and large numbers of other beds at Shenley (a psychiatric hospital in Hertfordshire). They expected the geriatric department to provide the local psychogeriatric service. Eventually the stage was reached when one ward of our rehabilitation hospital was filled to capacity with patients we considered to have predominantly psychiatric problems. To give credit to the general psychiatrists they did help when patients had non-organic psychiatric problems.

When I was appointed as the second consultant in 1973, a clause was inserted into my contract to the effect that I was to provide medical advice to elderly psychiatric patients in Shenley when requested by the general psychiatrists. However they never asked, in spite of reminders from time to time and prodding even by their own spokesman.

The situation changed when Peter Jefferys arrived in 1976. He started a psychogeriatric service with a few beds at Northwick Park and some at Shenley. He became very busy. He got rather irritated when his colleagues did domiciliary visits on elderly patients and then referred the after care to him. We suggested that we took over the physically heavily dependent patients from Shenley but Peter felt that it would be unfair to move them at this stage of their life. Over time the number of psychogeriatric patients in our wards reduced as nature took its course and/or as Peter took some of them to Shenley.

During the late 1970s I became involved with the British Geriatrics Society and was soon aware of the longstanding difficulties between geriatricians and psychiatrists regarding psychogeriatric patients. Much had been written about

¹⁹⁷ Denham MJ. 'The history of geriatric medicine and hospital care of the elderly in England between 1929 and the 1970s' Unpublished PhD thesis, 2004, University College London.

¹⁹⁸ See footnote 64. Allan Binks provided a slower stream type of geriatric service compared to Malcolm Hodgkinson.

misplacement of these patients.¹⁹⁹ Members of the BGS and the Royal College of Psychiatrists met to produce a pragmatic solution,²⁰⁰ setting up a special interest group.²⁰¹ The general approach was that if a psychogeriatric patient presented with a predominantly medical illness then the geriatrician should be responsible for care. If the main problem was psychiatric or behavioural then the psychiatrist or psychogeriatrician would take over. That was the theory but I got the impression that it did not get wide acceptance by general psychiatrists.

In the 1950s the Ministry of Health suggested that psychiatric units for the elderly should be set up alongside geriatric units as part of a complete service for the elderly.²⁰² Later the Ministry, some geriatricians and psychiatrists got enthusiastic about joint psycho-geriatric assessment units, which would admit patients directly from geriatricians, psychiatrists or social workers.²⁰³ The Ministry supported the concept but there was a tendency for the units to silt up because the patients were not transferred on to their appropriate geriatric or psychiatric department. The DHSS was also aware that in the 1970s when new geriatric units were set up, general psychiatrists saw this as an opportunity to off load their elderly patients with mental disorders.²⁰⁴ In the 1980s and 90s the two Royal Colleges, of Physicians and Psychiatrists, held joint working parties to produce reports about the care of elderly confused patients.²⁰⁵

I don't think I really appreciated the value of the community psychiatric nurse until I went on secondment to the Health Advisory Service.

¹⁹⁹ Cook LC, Cunningham Dax E, Maclay WS. 'The geriatric problem in mental hospitals' *Lancet* (1952) i. 377-382; Hodkinson HM, Evans GJ, Mezey AG. 'Factors associated with misplacement of elderly patients in geriatric and psychiatric hospitals' *Gerontologia Clinica* (1972) 14: 267-273; Langley GE, Simpson JH. 'Misplacement of the elderly in geriatric and psychiatric hospitals' *Gerontologia Clinica* (1970) 12: 149-163. Also see footnote 25.

²⁰⁰ Exton-Smith AN, Robinson KV. 'Psychogeriatric assessment units' *Lancet* (1970) i. 1292. Also see footnote 35.

²⁰¹ I was secretary of the group 1978-1982.

²⁰² See footnote 45.

²⁰³ For example, Langley GE, Wright WB, Sowden RR, Cobby JM, 'The Exe Vale joint psycho-geriatric assessment unit, (Hallett Clinic)' *Age and Ageing* (1975) 4: 125-128. Also see footnotes 45 and 136.

²⁰⁴ 'Ministry of Health and Department of Health and Social Security: Pharmaceutical and Therapeutic Services. Medical and dental hospital staff establishments', National Archives, Kew, MH 149/1698. <http://www.nationalarchives.gov.uk/catalogue/displaycataloguedetails.asp?CATLN=6&CATID=8225635&i=1> accessed 19.10.08.

²⁰⁵ For example, see footnote 156.

Professor Robin Jacoby, professor emeritus in old age psychiatry, University of Oxford²⁰⁶

Old age psychiatry, my early days

I got into old age psychiatry by chance. In fact, before I ever thought of becoming a psychiatrist, when I was a medical registrar in Southampton in about 1973, I recall a conversation with Colin Godber, a truly great pioneer of our speciality. Colin had just become an old age psychiatrist and told me that James Gibbons, then the professor of psychiatry in Southampton, had asked him why he had voluntarily demoted himself from the first to the fourth division. Secretly, I wondered the same thing.

I went to the Maudsley in 1974 by chance. I was coming to the end of my term as a medical registrar, and had been told that I needed to do some research to advance my career. I had come into medicine late from a modern languages background with only basic science to my name, and did not have the confidence to do research. I wanted to go to Africa to study infectious diseases, and was arranging a senior registrar post at the University of Northern Nigeria in Zaria. However, I was newly married and my wife did not want to go to Nigeria because it was associated with parental deprivation for her: her father had been a colonial administrator there. Then I met Sebastian Kramer, (now a consultant child psychiatrist at the Tavistock), a fellow arts graduate with whom I had been a student at Guy's. He said 'Come to the Maudsley. It's like being back at university again.' So I went and had a look and stayed there 20 years.

After a year and a half at the Maudsley as a junior doctor I was feeling rather disillusioned with psychiatry, and was seriously considering going back into general medicine. I thought that as I had stepped off a highly competitive career ladder, the only opening for me would be in geriatrics, i.e. an involuntary demotion from the first to the fourth division. In preparation for this I thought that I ought to do a final six-month stint in psychogeriatrics, and I applied to do it with Felix Post. This was from October 1975 to April 1976 - my only formal training in old age psychiatry!

What can I say? Felix and I simply hit it off. His intelligence, his quirky sense of humour, his consummate clinical skill and, beneath his superficially severe *Herr German-professor* demeanour, his devotion to his patients, all these qualities attracted me from the outset. He had the reputation of being fierce, but my predecessor told me that he just needed reassurance that his patients were being looked after in the way he demanded. I never encountered his fierce side. I never again thought of going back to general medicine. And I never again thought of old age psychiatry as the fourth division.

²⁰⁶ Izmeth Z, Gulati G. '15 minutes with ... a professor in old age psychiatry' *British Medical Journal* 13.2.08 <http://careers.bmj.com/careers/advice/view-article.html?id=2772> accessed 19.10.08.

Felix only once ticked me off, and in the nicest possible way. I had been presenting a case at the ward round, and was repeatedly interrupted by the psychologist on the team. Eventually I lost my temper and asked her very forcefully to let me finish after which she could have her say. After the round Felix took me on one side and gently chided me. I apologised, saying that, although I had lost my temper with her, it was not right for her to interrupt me. 'I know, I know,' said Felix, 'but you see, you have to treat these people like psychotic patients.' It goes without saying that I followed his advice to good effect in my subsequent career.

The second great influence on me was Raymond Levy. I had been his registrar on his general adult psychiatry firm at the Maudsley in 1975, and we had got on well. We shared the same sense of humour. He is francophone and I speak fluent French. In 1977 he offered me a research post to study CT scanning in elderly psychiatric patients at the Bethlem, and that is when my career as an academic old age psychiatrist became fixed. When I wrote my thesis, I gave it to him as my supervisor and did not hear anything for several weeks. I knew he had a lot on his plate at the time, so I waited patiently for his comments. Eventually I had to ask him, as time was running out. He got quite huffy, saying that he had a lot of problems to deal with and, furthermore, my thesis was 'very boring'. I replied that, if he thought it was boring, what about poor old me, who had been bored stiff writing it and rewriting it on a typewriter two or three times. Then we both had a good laugh, and I got my thesis back soon afterwards. Our CT study, published in 1980, was the most comprehensive in its day.²⁰⁷

I suppose the golden part of my career as an old age psychiatrist was at the Maudsley as a consultant from 1983 to 1994, working alongside Raymond Levy, Klaus Bergmann and Marisa Silverman. On the whole we got on very well because we had shared values, a shared approach to our patients and, apart from Marisa, a shared rather ribald sense of humour. But Marisa was like a tolerant mother to the three of us whom she treated as naughty boys. I am sure we were envied by our general psychiatry colleagues for our cohesion and rather obvious happiness with our work. If managers or colleagues tried to trim our sails during the competition for resources, we responded in such a way that they gave us the name of *The Irritable Tendency*. We were very proud of this title.

I am asked to say what the challenges, rewards, frustrations were, and what research I did and what came out of it. I have hinted at the challenges in the preceding paragraph, but I have to admit that we were lucky at the Maudsley and Bethlem in having pretty good resources for the time. The rewards were intellectual interest and a patient clientèle who were mostly warm, sympathetic, grateful and usually a whole lot nicer than their younger counterparts. I am averse to own trumpet-blowing and have already

²⁰⁷ Jacoby RJ, Levy R, Dawson JM. 'Computed tomography in the elderly: 1. The normal population' *British Journal of Psychiatry* (1980) 136: 249-255; Jacoby RJ, Levy R 'Computed tomography in the elderly: 2. Senile dementia: diagnosis and functional impairment' *British Journal of Psychiatry* (1980) 136: 256-269; Jacoby RJ, Levy R. 'Computed tomography in the elderly: 3. Affective disorder' *British Journal of Psychiatry* (1980) 136: 270-275

commented on our CT research. I believe that the study of continuation therapy for old age depression by the Old Age Depression Interest Group changed clinical practice, I hope for the better.²⁰⁸ I am also proud of the textbook *Psychiatry in the Elderly*. The first edition came out in 1991, and the fourth has just come out as the *Oxford Textbook of Old Age Psychiatry*.²⁰⁹ I believe that, in its approach and its values, it contains a legacy from Felix Post, Raymond Levy and Klaus Bergmann.

I believe that the academic/clinical split in medicine as a whole has resulted in creative tension. At the Maudsley it was there, too, but quite rightly there was an academic tilt of the scales. There is no doubt that Felix Post, Raymond Levy and Klaus Bergmann made invaluable contributions to academic and clinical old age psychiatry, not least in training future professors, researchers and NHS consultants.

For me it has been an enormous privilege to have been a part of such a great development in medicine.

²⁰⁸ Old Age Depression Interest Group 'How long should the elderly take antidepressants? A double-blind placebo-controlled study of continuation / prophylaxis therapy with dothiepin' *British Journal of Psychiatry* (1993) 162: 175-182 (principal investigator - Robin Jacoby)

²⁰⁹ Jacoby R, Oppenheimer O. (eds.) *Psychiatry in the Elderly*, (Oxford, Oxford University Press, 1991); Jacoby R, Oppenheimer C, Denning T, Thomas A. (eds.) *Oxford Textbook of Old Age Psychiatry* (Oxford, Oxford University Press, 2008)

Professor Kenneth Shulman, Lewar chair in geriatric psychiatry, Sunnybrook Health Sciences Centre, University of Toronto

Reflections of a Canadian trainee July 1976 to September 1978

As a graduate of the University of Toronto medical and psychiatry training programs, I was seeking specialty training in old age psychiatry in 1976. At that time, the two best known names in the field were Sir Martin Roth based in Newcastle working with Klaus Bergmann and Garry Blessed, while Felix Post had established an academic unit at the Bethlem Royal Hospital in London. Felix agreed to accept me as a clinical assistant / registrar beginning in January 1977 but I had six months to fill prior to that placement. On Felix's recommendation, I contacted Tom Arie who agreed to accept me at Goodmayes Hospital on 1 July 1976. In those six months trailing around with Tom on domiciliary visits, I saw first hand the exciting clinical laboratory that he established for the development of psychogeriatric services based on several principles including comprehensive assessment in the community prior to any admission. This was a radical change in approach to the admission of old people to psychiatric units. Moreover, he tried to make the drab Victorian 'bin' a more home-like and less institutional environment although this was extremely difficult under the circumstances.

On 1 January 1977 I went to join Felix Post and Raymond Levy at the Bethlem Royal and Maudsley Hospitals and Institute of Psychiatry. I finished as senior registrar in September 1978. At the Maudsley, one honed one's clinical skills in phenomenology, diagnostic assessment and classification while having clinical research opportunities. It was there that I collaborated with Felix on the first study of mania and bipolar disorder in late life.²¹⁰ The Maudsley / Bethlem Royal had a rich archive of medical records which I mined successfully in determining a number of significant risk factors for mania in late life.

During my stay in London, I also had an opportunity to collaborate with the geriatrician Professor Norman Exton-Smith at the academic geriatric unit at St. Pancras Hospital. At that time, there was virtually no formal liaison between psychiatric and geriatric services and Norman Exton-Smith gave me a great opportunity to have clinical experience consulting on psychiatric issues on the geriatric medical unit.

During the two years that I spent in London I attended a number sessions of the Group for the Psychiatry of Old Age. I had exposure to the opinion leaders of that day including Tom whose passion for supporting the most vulnerable of the psychiatric population was a driving force behind the service delivery movement. Klaus Bergmann's cheeky intelligence informed the research agenda while Brice Pitt's humour and pithy commentary created a conceptual framework for discussion. I remember Brice Pitt coining the expression:

²¹⁰ Shulman K, Post F. 'Bipolar affective disorder in old age' *British Journal of Psychiatry* (1980) 136: 26–32

'geriatric psychiatry is general psychiatry only more-so'. Colin Godber was also a significant presence at those meetings reflecting his intense devotion to the care of the seriously mentally ill elderly including experience using ECT in later life at his psychogeriatric unit in Southampton.

This was a heady time for the field of geriatric psychiatry and offered excitement and inspiration to young aspiring geriatric trainees who included John Breitner, who has gone on to a research career in the United States, Marissa Silverman, who continued to work as a geriatric psychiatrist at the Maudsley, and Robin Jacoby who became a consultant at the Maudsley and eventually assumed the first chair of old age psychiatry at the University of Oxford. I returned to the University of Toronto and became head of the new division of geriatric psychiatry.

Dr Roy Simons, consultant old age psychiatrist, Aylesbury, Buckinghamshire

Now that I am a recipient of services for the elderly, I am confirmed in my belief that such services should involve primary care including domiciliary aspects and a functioning arm of a specialist service operating from a hospital base. The outreach element is much valued by families like mine.

After I graduated from medical school I spent several years abroad including eight years in Australia in general practice, and was appointed to a clinical assistant job at a large mental hospital. Even then, this institution was outdated, and in spite of demographic differences, with a younger population than England, was occupied by the usual large numbers of elderly people with a mixture of diagnoses.

When I returned to this country (for domestic reasons) I decided to go for further training and to qualify in psychiatry. I arrived in Buckinghamshire about the same time as Michael White was appointed as consultant with an interest in psychogeriatrics. He encouraged me to submit an entry in the annual senior registrar essay competition, organised, I think, by the Mental Health Foundation.²¹¹ At that time I was interested in three-generation households where a mentally deteriorated grandparent was the cause of problems for the family. That was what I wrote about.

The situation of the old mental hospitals over the whole country was the former county asylums full of over 65s occupying large numbers of beds on a long-stay basis, a bed becoming available only infrequently for any new case. The prospect for the future seemed pretty daunting and I remember thinking there must be better ways of looking after this enlarging population than heretofore.

The die was cast and when an opportunity arose I applied for a consultant job in Buckinghamshire. Luckily I met a quorum of like minded people meeting regularly at the RSM²¹² in London and providing a stimulus to new thinking and very welcome support, and morale was boosted at that time - it did need it. I suppose, all in all, my choice of subject was influenced by coincidence of circumstances, background, timing and people and it emerged only later what the job entailed. Luckily, the requirements and my temperament were closely matched. That was most fortunate and I look back at those demanding times with much pleasure and satisfaction.

²¹¹ Anthony Clare won, but Roy was also awarded a prize.

²¹² Initially meetings of the Group for the Psychiatry of Old Age took place in the Royal Society of Medicine (RSM) building, Chandos House, Queen Anne St, London W1.

Appendix 3

Archival sources used to compile footnotes

Archives of Professor Tom Arie
British Geriatrics Society, London
Institute of Psychiatry Library, London
King's Fund Library, London
Royal College of Psychiatrists, London



Ward scene, Nottingham, 1987 (from the archives of Tom Arie)