Little grains of sand

RONALD GIBSON

In the Canary Island of Lanzarote there is a particularly excellent hotel from which an elderly man sets out each morning, irrespective of the weather, with a plastic bucket, a long-handled soft broom, and a dustpan, to sweep the terraces. He starts from the same corner and goes from one end of the top terrace down the twisting paths to the far end of the lowest level. He carefully sweeps round the recumbent bodies of browning Britons, Germans, or Scandinavians, clad in little more than a thick layer of sun lotion, and every now and then stoops to sweep a tiny pile of sand into his dustpan and from there into his bucket. I have never seen him at the end of his journey on the bottom terrace next to the sea, but I have no doubt that each day he ends up in the same corner. The wind and the rain, with leaves and twigs from trees and bric-à-brac from the beach, add to his work somewhat but may bring a welcome variation from the monotonous and almost invisible sand. I have no idea what sort of man he is. He has a peaceful look to him, a gentle smile, and seemingly endless patience. Moreover, he has chosen to go on working after he could have retired, boosting his income but preserving his independence and, with it, his self-respect and security. I found him well worth watching.

It was justifiable to wonder why he bothered or to believe that his employers gave him this unskilled and repetitive job as a kindly gesture to keep him occupied. Yet, roads, steps, and pavements outside the hotel, apparently not so carefully tended, are piled high with dust, sand, and unconcealed tourist pollution. Which must give us pause, I think, for there is clearly more to this than meets the superficial glance.

I would like to sketch a brief history of the care of the elderly over the past century and a half, from the years when humanitarianism, seriousness of thought, self-discipline, and self-reliance were becoming uppermost in peoples' thoughts.

Overseers of the poor

The basis of welfare legislation for 250 years was the Act of 1597 which called on parishes to appoint "overseers of the poor." A hundred years later the first workhouse was built as a place of shelter. By 1793 there was concern that it cost more to keep a man and woman in a workhouse (allowing for shelter, food, clothing, and medical attention) than to maintain them outside. This important observation is well worth noting.

Two years later a system of out-relief was instituted whereby inadequate current wages were made up to a basic minimum from poor relief. This proved to be so expensive that a drastic change was advocated, and the policy adopted was that able-bodied paupers were to be forced to fend for themselves. The parish, while not allowing them to perish from want, was to be seen as the hardest taskmaster, the closest paymaster, and the most harsh and unkind friend to whom the poor could apply.

In 1833 it was considered that only the abolition of out-relief could restore the labourer's self-respect, and a year later a royal commission advised that, except as to medical attendance, all relief to able-bodied persons or their families, otherwise than in a well-regulated workhouse (and those are ominous words)

should be declared unlawful and cease. Out-relief was restricted to the old and other "impotent" poor.

The Poor Law Amendment Bill, which received Royal Assent in 1834, ensured that the able-bodied inmate of workhouses was penalised compared with the lowest class of independent labourer outside. The various ways devised to make his life generally unpleasant included providing prison-style uniform, separating him from his wife and children, and subjecting him to the hardest and most tedious labour that could be devised. Grim austerity was the key-note.

Under the scheme of grouping parishes together to form unions it was intended that there should be separate buildings for healthy-bodied women and able-bodied men, the old and the infirm, and the sick; but in many areas this could not be implemented on grounds of cost. Prison-like buildings thus remained—and still exist today—which were simple, solid, strictly functional, and "wholesomely repulsive."

New entrants to these unions were searched, washed, and had their hair cropped; their clothes were removed and replaced by workhouse dress. They had wooden beds with flock-filled mattresses of sacking with no pillows. Occupants were tightly packed together, few enjoying the luxury of a single bed. They had to eat with their fingers, and no one was allowed to leave—even to attend church.

The Times considered that they were subjected to slow starvation. Sir Arthur Bryant comments that: "To men and women nursed in a kindlier tradition, it seemed an outrage that old folk who had laboured all their lives and become destitute through no fault of their own should be torn from their homes, separated from each other's company, and herded in sexes into prison-like institutions."

And G M Trevelyan, in his *English Social History*, says: "the poor law commissioners, in their preoccupation with the problems of the adult workman, overlooked the expediency of treating old people, children, and invalids with the kindness that was in every sense their due."

He does, however, point out that the new Poor Law made it easier to carry out the many improvements suggested later by a philanthropy that "gradually became more humane as it became more experienced and scientific."

Involuntary victims

The elderly, whose care I want particularly to consider, were thus involuntary victims of the 1834 Act. They could not "enjoy their indulgencies" as recommended by the Royal Commission because they had no separate type of workhouse of their own. The dread with which they must have predicted confinement in the workhouse may be imagined: austere buildings, impersonal control, rigid regulations, and little if any regard for the needs of their age group.

Some idea of the hardship of their existence may be gained by citing conditions at Cambridge where, in 1836, the sum of 3/- weekly for outdoor relief was allowed for every pauper of advanced age. Butter at that time was 10d a lb, tea 3/3d, cheese 6d, beef and mutton 6½d, and coal 28/6d a ton. This amounts to virtual starvation, yet it was regarded as preferable to admission to a workhouse.

Conditions to which the elderly were subjected as little as 150 years ago were appalling. Only very few (as in York) were saved from incarceration by the concern, philanthropy, and generosity of individuals, guilds, or the churches; the vast majority must

The 150th York Oration given to the York Medical Society on 14 October 1981.

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have prayed for death to intervene before physical helplessness left them no alternative but to surrender their independence and be lost in the dreadful confinement of the union—described as a “bastille to imprison the aged.”

By 1867 the old and infirm formed the largest single group in workhouses. They numbered, for example, over 10 000 of 28 000 occupants of 40 London workhouses. They had to be obedient to the rising bell at 5 00 am, to breakfast from 6 30-7 00, to work—if even remotely possible—from 7 00 to 12 00 and again from 1 00 to 6 00 or 7 00 pm. They were in bed by 8 00 pm in cold rooms, sparsely furnished with only two to three beds. Even as late as 1872 no allowance was made for failing digestions, crumbling teeth, or fluctuating appetites. The same container was used for gruel, suet pudding, meat, or rice.

By 1900, although a real improvement in workhouse diet had started, there was still a reluctance to make old peoples' quarters too comfortable: there was little in the way of furniture, of occupation, books, needlework, or contact with the outside world. Despite a gradual progress towards greater freedom and independence, couples married for over 40 years were still separated from each other in their latter years in the workhouse, and in 1895 (when one in three citizens over 70 years of age had to seek union help) only 200 married couples in England and Wales had their own rooms, but by this time they were allowed to brew their own tea without first having to obtain permission from the board of guardians and there was a general release of tobacco to the over-60s.

As we reach the turn of the century, it is necessary for future reference to underline the dreadful trauma to the elderly of being torn by a so-called humanitarian State from their own homes and their own beds to a prison-type of disposal. Their only crime against the State was that of having lived too long and saved too little to be able to preserve their independence.

The gradual relaxation of the rigid programme for the elderly in workhouses continued throughout the early years of this century. The deserving of both sexes, for example, were provided with day rooms. Yet in 1911 one government inspector, reporting on the Cambridge workhouse, said of the sick wards that the majority of the bedridden were helpless, the nursing staff wholly inadequate, there were few nursing appliances, not a slop sink in the whole infirmary, and the female side was destitute of water supply except for a drinking water tap . . . “there was no provision for a sink or for hot or cold water. The nurse had been in the habit of keeping medicines and drugs in the unlocked food cupboard. There are no ward reports, neither is there a fitting diet for the sick. Eighty-three women and two boys and girls had one bath between them.”

In 1909 an old age pension was introduced—5/- a week for a single person and 7/6d a week for married couples; from this anyone with an income of over £30 a year was excluded. Four years later the term “workhouse” officially ceased to exist and was replaced by “poor law institution.” In 1919 we achieved a Ministry of Health to replace the Local Government Board, and in 1929 boards of guardians were abolished. The names could be changed, but in all other respects the poor law institutions were still general mixed workhouses, housing—as always—a large contingent of the elderly.

By 1924, 10/- a week could be drawn by any old person whose income did not exceed £65 5s 0d a year, but this was a long way below a bare subsistence level if no other resources were available. Further financial aid could be obtained by applying for outdoor relief under the poor law, and in 1940 there was an Old Age and Widows Act to provide supplementary pensions at a cost to the Exchequer, and the National Assistance Board helped with grants towards rent, extra bedding, special diets, and extra fuel or laundry.

In 1946 the Seebohm Rowntree Committee, making a general survey of the problems of aging and the care of the aged, concluded that: “a considerable number of people who are living independent lives or many who are living as guests of their children are really unfit on physical or mental grounds to do so . . . old people maintain a hopeless struggle against adversity

in order to cling to their last vestige of independence. Such excessive devotion to independence can be explained, partly by the present serious lack of suitable homes for old people, partly by the regulated life which is widely believed, not always with justice, to be the common feature of all institutions.”

In fact, with a few exceptions, the committee found that little had changed since 1900. Institutions accommodated a motley assembly of the destitute, the majority being aged. Apathy and indifference abounded among the inmates, who spent their time sitting round the room on hard chairs or wooden benches. The food was very dull, consisting of large slabs of bread and margarine except for a midday meal of meat and vegetables.

The large numbers encouraged inflexible rules and rigid management. Everyone went to bed at the same time, often in insufficient light. It was said that: “for many the long dark nights must have been torture, lying on hard beds, sleeping comparatively little, and having dozens of people coughing and snoring around them.”

This report aroused interest in the problems of old age, but for financial reasons a brake had to be put on too much change too quickly, and no less a person than Lord Beveridge cautioned against being too lavish with old age before other items had been catered for. Old people, whose cause was unemotive yet deserving, attracted little priority where welfare was concerned.

The National Health Act of 1946 brought with it many potential benefits to the elderly, embodying a complete range of care for them in hospital or at home, with a free provision of family doctor and specialist services together with such additional necessities as dentures, spectacles, and hearing aids. Following closely after this, in 1948, came the National Assistance Act, which required local authorities to provide accommodation for the aged in need of care and attention, including meals, recreational facilities, holidays, and many other benefits.

In 1958 the Phillips Committee emphasised the vital need for adequate domiciliary services, for effective co-operation between general practitioners and hospitals, for separate accommodation for those too infirm for existing homes, and for closer co-operation between the many authorities responsible for the care of the elderly.

So all “must be well”

So much for the background. All is set fair, we may say, to banish fear from those who are growing old in the community. A humanitarian society, or a well-intentioned parody of it, learning from experience over the years (as prophesied by Trevelyan), has slowly come to terms with the problems and needs of the elderly. Comprehensive and benevolent legislation has covered all possible contingencies. So all, on paper at any rate, must be well.

If this be so—and I accept that in most respects it could be so—why are so many of us still concerned about the problems of old people? The answer is threefold: firstly, care for the elderly has been based on the tradition that such care inevitably necessitates tearing them from their homes and placing them in State-owned premises of one sort or another—only now, in the 1980s, are we seeing the first real effort to break from this concept. Secondly, care is still handed out to the elderly reluctantly as an “assistance” to ease the conscience of the State and not as a just reward for years well spent in the service of the State, and, thirdly, too many of the facilities provided by the State are not activated by those who are responsible for the care of the elderly.

I can illustrate these shortcomings best by glancing briefly at the three stages of old age.

The average healthy man or woman in Britain is unprepared for what is to happen on the day he or she becomes arbitrarily judged to be an old-age pensioner. Adjustment to a new life and often a limited and inadequate income takes time, as will the acceptance that society, though superficially polite and understanding, no longer appears to need them nor, particularly, to

want them. From being active and useful citizens they are suddenly, at the stroke of midnight on an appointed day, discarded (except for the housewife, who is not acknowledged as in need of retirement at any age; on the contrary, her work will be increased by the addition of a full-time resident husband to wait on). Some have not the wish and others not the will to show that they can still fulfil a useful role in society; a number fight back and find a niche for themselves through which they can preserve their motivation and their self-respect. For the majority, however, the years go by happily enough and with them an almost imperceptible sacrifice of independence to an unaccustomed semi-dependence. Until now, the only defect in care noticed by them is that their pension, though adequate for the day-to-day running costs of living, will not cover little extra luxuries or such capital necessities as new clothes, house maintenance, and unexpected emergencies. But still, they are a long way from the days when the State merely guaranteed to prevent them from starving.

So to the second stage—of semi-dependence. This brings more reliance on near relatives (or one particular relative), friends, and neighbours; a call on the home-help service and meals on wheels, boosted by visits to pensioners' clubs with perhaps weekly lunches and outings provided by voluntary organisations supported by local authority funding. This stage progresses remorselessly, often spurred on by the death of one of the partners, to a need for regular visits by a health visitor and, one hopes, by a family doctor. Still the home life survives, supported by supplementary allowances, day and night attendance allowance, and other possible benefits provided by the State. In addition, vision and hearing can be regularly checked; the law provides for dental treatment and chiropody; the Health Service makes it possible for regular medical examinations—including urine analysis and blood pressure readings, with laboratory tests to eliminate the possibility of anaemia to which the elderly are so prone.

The State, therefore, in this stage of old age, can be seen at its most benevolent. It can hardly be faulted. Both the State and the elderly deserve more than they get.

Intentions into practice

We cannot sit back and purr at such benevolence or indulge in any starry eyed misconception because we have now to consider how these good intentions are carried into practice. We find that where new lenses, hearing aids, dentures, or chiropody are required, elderly citizens frequently have to fight every inch of the way to achieve an examination and to fight again to get satisfaction from it. The more dependent they are and, in consequence, the less their voices can be heard, the lower the priority they receive. Yet since their life style and their contentment so much depend on these items, especially as they become increasingly confined to their homes, you would think that extra effort would be made to ensure that their needs are promptly met. Sadly, I fear, the contrary is all too often the case.

Medical and surgical treatment for the elderly in Britain is, in my view, incomparable, but how many are regularly checked to prevent the chronic conditions that so much debilitate them and can spoil their lives? The answer is, very few—and this despite the fact that family doctors receive additional remuneration for patients of this age group. How many, too, have total care provided for them by a primary health care team of doctor, nurse, health visitor, and social worker?

Lack of time, personnel, and finances are cited as reasons for what can be, in fact, lack of effort or capable organisation. Yet, if it is possible for old people to benefit from preventive care in some areas, why not everywhere? Why should some be denied the standard of care given to others because they live in the wrong place? And why should the elderly have to exist with failing eyesight and hearing, chronic urinary infection, diabetes, anaemia, high blood pressure, or any other debilitating condition

or handicap simply because the services available to help them are not used?

Now to the third stage of aging: the household, seemingly semi-dependent, although in fact teetering chronically on the brink of collapse, breaks down. The cause may be a fall with a fractured limb, an acute illness, or too great a chronic burden on the local health and welfare workers, relatives, or neighbours. Whatever the cause, admission to hospital is the result.

If the illness is acute a hospital run by the health authority will admit the patient. First-class treatment and care may ideally enable a discharge back home or to a convalescent home, once the health and welfare services have agreed (with each other, with the hospital, and with the family doctor—a time-consuming process) to shoulder the responsibility of continuing care. It is when the patient—for one reason or another—cannot be discharged from the acute hospital that the trouble starts and, once having started, progresses inexorably and, all too often impersonally, to what I described in an address to the Royal College of Nursing in 1965 as a disposal—a description to which I adhere today.

The Boucher report in 1957 stated that the efficient use of hospitals depended on the full support of local authority and voluntary organisations whose function it was to supply the rehabilitation services and welfare homes for the patients whose hospital treatment is completed. The same still applies today, and it is no exaggeration to say that it is common to see over half the beds in wards of acute hospitals taken up by elderly patients, many of whom could be discharged if there were anywhere for them to go. The concentration is on how bad this is for the hospital when it should be on how soul and body destroying it is for the patient.

Where should they be able to go? Like any other patients they should be able to return home. Unlike other patients, however, there are special conditions relating to the elderly which sometimes make a return home difficult or impossible. My submission is that, with a reorientation of the concept of care away from the old tradition of the "simple, solid, strictly functional, and wholesomely repulsive union buildings" to a determination to preserve home care for as long as possible, the number of "impossible" cases for whom there is no other answer than the long-stay hospital could be reduced to an absolute minimum.

I concede that sheltered accommodation in flats sited in an all-age-group environment with a resident warden (allowing for the unfortunate connotations inherent in the word "sheltered") may be included within the term "own home," for in these the old people are preserving their independence, sleeping in their own beds surrounded by their own belongings, screened from the rigid and awful routine of long-stay hospitals, and, in fact, are still part of a local community. Such a flat is, in fact, a home-from-home. I am less happy about the hotel-like accommodation provided in local authority homes for the very reason that, excellent as they may be and so often are, every single one of the criteria for home care has to be discarded, to be replaced by the awful trauma of sheltered and restricted community living. The Department of Health's 1981 consultative document on care in the community is heartening to read in that it is based on the thesis that "most people who need long-term care can and should be looked after in the community."

The department acknowledges that such services require the co-operation of neighbourhood and voluntary support, primary health care services, and personal social services. And here, of course, is the rub. Once again central Government is at the mercy of local authorities to activate what it now acknowledges as the overwhelming wish of the people. The awful separation of the health services from the social services is here seen at its most dangerous; separated administration, funding, resources, and personnel must inevitably complicate and delay the achievement of home care and, worse still, preserve an inequality of care from one area to another; yet a determined central purpose could, even if it takes a decade or more, break for ever from the old traditions and achieve for the elderly the recognition and the

support they deserve and should have had for generations past.

This will leave the State still with those—the barest minimum—for whom home or home-from-home care is impossible. The most drastic changes of all are required for these unhappy people, for many of them are doomed to remain in hospital in the old buildings provided as sheltered accommodation for their nineteenth century forebears. Tarted up inside as so many of them have been, and gallantly supported by friends of the hospital, they are totally insupportable as buildings in which to house the elderly (or for that matter, any generation) today. Excellent nursing, a more suitable diet—with a choice of food—curtains, day rooms, physiotherapists, and one improvement after the other, while excellent in themselves, have not and cannot ever disguise the awfulness of the inmate's existence. A nurse once commented to me that the patients she felt most sorry for were those who knew where they were. The concept of the ward with long lines of beds, of day rooms with armchairs lined round the walls, of rigid hours—including times for potting in the night, for washing at 5.00 am and sitting in or beside the bed until breakfast is served, of going early to bed in hospital beds, with hard mattresses and almost bullet-hard pillows; generally of being treated as one unit among many in a restricted environment is deplorable and should be unacceptable to today's society. Yet, no matter how the nurses may try, they cannot avoid, especially too few as they are, the awful rigidity of the building and its stark resemblance to the early Victorian union.

Unacceptable and indefensible

I find the plea that this is all that can be done for people doomed to long-stay institutional care wholly unacceptable and the low priority given to the care of these people indefensible. Let me give one example of the result of the battery-hen type of treatment inevitable in a long-stay ward, by citing hypothermia: old people, even in wards no longer cold, are put to bed between cold sheets (deprived of the much loved hot water bottle). It may take them hours to warm up, if they ever do. They may just have achieved a degree of comfort sufficient to allow them to sleep when they are taken from their bed—whether necessary or not—to be potted. In due time they are returned to bed, and the warming up process has to start all over again. Or take communications—never the strongest point in the hospital service but at its very worst in relation to the elderly. Old people may not even know the name of the doctor in whose care they are; they undergo radiography or are otherwise investigated without being told why or given the results of the examination; they are told (as I have overheard myself and so has everyone else in the ward) that they are going to be “opened up” tomorrow to see what is wrong with them and will they please “sign here.” Perhaps worst of all, their relatives are left in almost total ignorance of what is going on.

I know that I am generalising and that there are areas of excellence all over the country (I have seen them), but nevertheless the principle of long-stay care in hospitals—even comparatively new hospitals—with long lines of beds in open wards and rigid institutional routine is dreadful.

Gleam of light

The one gleam of light here is the community hospital sited near the patient's own home, with friends and neighbours helping in their care and their own family doctor looking after them. It is over time for these hospitals to receive the praise that they deserve, and recent indications that they are to be supported and multiplied must be translated from paper to practice. Nevertheless, the urgent priority now must be to eliminate the hospital-concept and to replace it with modern buildings suitably designed for long-stay patients in the 1980s. If it is possible for the private sector to give individual care and

nursing in special caring homes for the frail and chronic sick among the elderly population, where from semi-dependence to terminal care they enjoy privacy, their own rooms, and beds, it is not impossible for the State to follow suit—even if this means some additional financial support for the private sector, or better still, an elimination of the terms “private” and “public” so that both can work together and between them preserve the dignity and independence of the old for as long as is necessary.

I am not without hope. We have come a long way since the middle years of this century. Government intentions, spurred on by the determination of the people, may soon achieve for our elderly citizens what so many of us know that they should have and which, by the turn of this century, must be an accepted and well-deserved reward from a truly humanitarian society.

Which brings me back to the gentleman with the soft broom, the plastic bucket, and the spade. All that stands between him and the possible indignity of dependence on the State are those little grains of sand he sweeps up every day. In Britain, I submit, we must be able to pat him on the back and tell him he can give up whenever he likes for we have arranged for his continuing independence, comfort, and security until his dying day.

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ONE HUNDRED YEARS AGO SIR,—The following brief particulars of some curiosities of human nature, which exist in the interior of Queensland, in the shape of hairless people, will, I think, be of interest to readers of the Journal.

There are at present living on the station of Mr G M Kirk, at Gulnabar, St George, Queensland, an aboriginal man and woman (brother and sister), entirely devoid of hair on their heads, faces, and every part of their bodies. There was another sister, similarly hairless, but she died a few years ago. These blacks were brought in the same hairless state to the above station when young, and are not able to give any account of their parents or tribe; but I am informed by Mr Kirk that intelligent blacks about his station state that there is a tribe of hairless blacks, similar to these, living on a creek named the Wallam, eighty miles west of the Balonne River, and about five hundred miles west of Brisbane; and that these people came from that tribe. Mr Kirk has not seen them; but it is quite possible that such a tribe might exist comparatively unnoticed, as these blacks are very sensitive concerning their hairless condition, and always keep their heads and bodies covered. The two survivors on Mr Kirk's station were seen and photographed by Baron Macleay, the Russian explorer, in September last, who, having heard of their existence, travelled a long distance to see, and was much interested in them. I have now some of his photographs before me; they represent a well-formed and developed man and woman of middle age, but without a particle of hair visible on their heads or bodies; and Mr Kirk informs me that upon the most careful inspection, none is to be found. If, as the blacks assert, there is a tribe of such hairless people, they are great natural curiosities; and these three, if viewed only as instances of a family freak of nature, are still interesting as examples of the fanciful whims of Dame Nature—more especially when taking into consideration the fact, that the Australian aborigines are naturally a very hairy race of people.—I am, sir, yours faithfully, J HIGHAM HILL, MD, FRCSEd. (*British Medical Journal*, 1881.)