Growing Old in Oxford 1930 – 1960

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Contents

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ABSTRACT

This thesis explores how old people in Oxford were cared for between 1930 and 1960, before and after the inception of the welfare state. Its purpose is to analyse how some families and professionals responded to the transition from the poor law to the welfare state, and examine any changes in this process. Admission to a state institution was usual for old people who were without financial and social resources. In Oxford the Cowley Road Hospital, originally built as a workhouse in the nineteenth century provided this treatment over this period of time.

The thesis investigates the relationship of this institution to the broader community in relation to the care of old people. From the 1930s geriatric medicine, a speciality emerged spearheaded by Dr Marjory Warren, geriatric medicine. Early pioneers of geriatric medicine, working in state run institutions, were advocating the need for change in provision for old people, and this study examines their role in this process of change. Within this group of doctors, Dr Lionel Cosin, an initiator and influencer of change and policy in post-war care for old people, was appointed to the Cowley Road Hospital soon after the inception of the welfare state. This thesis, seeks to discover, in conjunction with the changes arising from the introduction of the welfare state, if old people in Oxford benefited from his position.

By using oral histories as a major source of evidence, alongside documentary sources, this investigation aims to bring fresh perspectives to the study of the process of ageing. Within the context of national legislative changes, it discovers how a city responded to these, and juxtaposes how families cared for their older relatives. Each chapter examines aspects that contributed to changing provision and attitudes towards old people by professionals and relatives. Local evidence is compared with national to suggest that the city was progressive in its care and attitudes towards old people.

ABBREVIATED TERMS

BGS	British Geriatric Society (formerly Medical Society for the Care of the Elderly)
BMA	British Medical Association
BMJ	British Medical Journal
BRCS	British Red Cross Society
CMO	Chief Medical Officer
COS	Charity Organisation Society
CRH	Cowley Road Hospital
CWO	Chief Welfare Officer
DN	District Nurse
GP	General Practitioner
LGB	Local Government Board
MOH	Medical Officer of Health
MOW	Meals on Wheels
NSA	National Sound Archives
NHS	National Health Service
NOPWC	National Old People's Welfare Committee
NCCOP	National Council for the Care of Old People
NCOAP	National Conference on Old Age Pensions
NSPA	National Spinsters Pensions Association
OCSS	Oxford Council of Social Services
OCC	Oxford City Council
OT	Occupational Therapist
OPH	Old Person's Home
PAI	Public Assistance Institution
PAC	Public Assistance Committee
RI	Radcliffe Infirmary
WVS	Women's Voluntary Service

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CHAPTER ONE

An introduction to the political, social and economic context of old people

The aim of this study is to examine whether there was any change in the perceptions within the community of the Cowley Road Hospital, a local institution inherited from the poor law, before and after the inception of the welfare state. Cowley Road Hospital, (CRH) built in 1865 was initially a workhouse and provided for the poor in Oxford. As an institution it had a long history, witnessing major changes in social policy and housing thousands of inmates, until its closure in 1981 and demolition soon after. Local residents could not fail to be aware of the workhouse as it was positioned on a major thoroughfare to the city centre. Folklore surrounding the institution has evolved over the years across the city. Even today some older people still recall the CRH as being a former workhouse. But many changes were made to the institution as a result of government policies and local management strategies. Although the establishment was created as a mixed workhouse for all the poor in 1865, particularly from the 1930s, the majority of inmates were old people.[1] After the radical social reforms creating the welfare state during 1945 to 1948, the CRH became a geriatric hospital until its demolition in 1982. By this time the institution had provided the locus of care for old people for over 100 years.

Provision for the care of old people in the period 1930-1960 was influenced by the development of the welfare state from the poor law, progress in geriatric medicine, the role of pressure groups, and demographics. Against this background the thesis provides a critical history of the CRH, explores key legislative changes, and identifies previous influences associated with the welfare of old people that are significant in its history. Given that there were noteworthy policy changes made during the recent life of the CRH, mainly from 1930 to 1960, this thesis seeks to discover whether the local population perceived any changes in the role of the CRH before and after the inception of the welfare state.

This thesis begins in 1930 when the 1929 Local Government Act became effective. Administrative changes in poor relief distribution arose from this legislation, namely

[1] Oxford City Council Minutes and Reports 1930-1948, document the composition of inmates and show that the majority of these are old people.

the creation of public assistance committees. The inception of the welfare state brought an opportunity for radical change. By 1960, twelve years had elapsed since the establishment of the welfare state reforms and there were noticeable effects, both economically and socially. Evaluation of the effects of these reforms was an on-going process, leading to parliamentary committees and reviews of the new system, especially in the health and welfare departments. During the 1950s, there was a relative period of stability, but the outcome of the evaluations began to take effect in the early 1960s, bringing about more change, such as the move from institutionalisation to community care. The time period selected for the study will concentrate on the construction of facilities for old people following the 1929 Local Government Act, identify any associated problems for elderly persons experienced with the onset of the Second World War and analyse the effects for old people during the transition to, and in the early years of the welfare state. 1960 is an appropriate time to complete the study as an adequate period of time had passed to measure change. What is distinctive about this investigation in relation to the study of old age is that its purpose is to present an historical examination from a community perspective.

This study will examine the role of an institution that provided the main care for old people between 1930-1960, this being the CRH. It was a common national feature that old poor law and public assistance institutions continued to accommodate old people after their transfer to the welfare state. One of the major aims of this study is to examine changes in the CRH before and after the inception of the welfare state and to measure the community's response to them. The transfer from the poor law to the welfare state had a tremendous impact on people in England and subsequently affected the delivery of care for them. This thesis will look at the care provided for old people in Oxford and make comparisons with the national provision.

This chapter is in two parts and will first introduce the political, social and economic background that old people have lived in during the twentieth century. Secondly, it will explain how and why the investigation relates a general context to a local situation.

Changing perspectives on ageing

This investigation will examine a community's changing views of an institution and attitudes towards old people using a variety of sources. Both documentary and oral sources are used representing different aspects of memories of the changing community

and developing a collective picture. As Tosh points out: "History is collective memory, the storehouse of experience through which people develop a sense of their social identity and their future prospects."[2]

However, the history of ageing is under researched, and Gordon commented on the paucity of literature on the subject, noting that it was only during the 1970s that papers on this topic began to be published regularly.[3] More publications and studies have followed since, but it is still a relatively new area of historical research. To my knowledge, there have not been any studies relating to ageing that chart how past legislative changes affected a community, and discuss this in conjunction with local people's recollections of change. In this respect this study is of a pioneering nature and whilst drawing on previous work to present the general context, my main focus will be to concentrate on local aspects.

Valuable insights have been given into the study of the lives of old people by contemporary scholars: Thomson, for example, gives an illuminating piece on residential care for old people since 1840 using bureaucratic records as his primary sources.[4] By primarily using data from the New Survey of London (carried out between 1928 and 1930) and other documentary sources Gordon draws conclusions on family support structures in working class London in the early 1930s.[5] Lyon and Colquhoun use the works of Booth, Sheldon and Rowntree to review nutritional conditions for old people living alone in the twentieth century.[6] Thane has made extensive contributions to studies on old people's lives. Her work spans from Ancient Greece to the present day and documents the experiences of old people in different societies. Within these works Thane covers topics such as ageism, economics and images of old age, and contextualises contemporary ageing.[7] Investigations such as these are valuable in the study of senescence because they establish a basis from which to measure, and give a chronological account of the process of change. By examining other works a general

[2] J. Tosh, The Pursuit of History (2nd edn., London: Longman, 1991), p.1.
[3] C. Gordon, 'Familial Support for the Elderly in the Past: The Case of London's Working Class in the Early 1930s' , Ageing and Society, 8, (1988), pp. 287-320.
[4] D. Thomson, 'Workhouse to Nursing Home: Residential Care of Elderly People in England Since 1840', Ageing and Society, 3, (1983), pp. 47-69. This work investigates the history of institutional care of old people.
[5] C. Gordon, 'Familial Support'.
[6] P. Lyon and A. Colquhoun, 'Home, Hearth and Table: a Centennial Review of the Nutritional Circumstances of Older People Living Alone', Ageing and Society, 19, (1999), pp. 53-67.
[7] P. Thane, Old Age in English History, Past Experiences, Present Issues (Oxford: OUP, 2000). This study addresses many aspects of ageing through different times and in different societies culminating in perceptions of ageing today and the economic challenge of ageing in the twenty first century.

picture has developed of the history of old age. Although still a relatively new area of research, an impressive scope of historical studies has been opened out with themes ranging from pension and welfare state provision, family responsibilities, and institutional care, through to the introduction of geriatric medicine. Within these themes are debates on the structured dependency of elderly people, the medicalisation of old age and whether families provided more care in past times.

Discussion has evolved from these writings and will doubtless be continued, particularly as the older population has increased and previous practice has assumed more significance. Studying old age has been popular recently, although Townsend earlier considered that there was a 'conspiracy of silence' between 1910 – 1946, even though the aged population of 65 years and over doubled.[8] The establishment of the welfare state might appear to be a watershed in the provision of care for old people. In theory, almost overnight a different society was created. But did inherited attitudes and new expectations cause conflicts? What is missing in the historiography is the discussion on the process of ageing in a changing society from the personal perspectives of old people themselves. It is the intention of this thesis to address this gap both by building on previous research, and by using documentary and oral sources to discover how old people in one city adapted to the process of change.

The political economy of old age

The care of old people both nationally and locally has been influenced by significant demographic and social factors. Since 1601, English society has considered that provision had to be made for the impotent poor who were unable to provide financially for themselves. Demographic changes caused by industrialisation and urbanisation also influenced the role of the extended family in care provision. This complex perspective is rehearsed in demographic studies, notably those of Laslett and Thomson.[9] One of the fundamental arguments presented is that there was little difference in family support pre- and post-industrial society.

Thane suggests that in pre-industrial times there was no obligation for families to give total care to their elderly relatives, although this sometimes happened. It is her opinion

[8] P. Townsend, The Last Refuge (London: Routledge and Keegan, 1964), p.27.

[9] See P. Laslett, Household and Family in Past Times (Cambridge: Cambridge University Press, 1972). This work presents comparative studies on size and structure of the family over three centuries with an international perspective; D. Thomson, 'The Welfare of the Elderly in The Past: A Family or Community Responsibility', in M. Pelling and R. Smith (eds.), Life, Death and the Elderly, Historical Perspectives (London: Routledge, 1991), p. 207; D. Thomson, 'The Decline of Social Welfare: Falling State Support for the Elderly Since Early Victorian Times', Ageing and Society, 4, (1984), pp. 451- 482.

that old people chose to remain independent of their families. A statistical breakdown and an explanation of household composition in pre-industrial England is given by Wall.[10] Help was given to older people by their relatives if their own family was not affected by this action, and if there were resources available. If there were no family members available to help, the poor relief system would contribute, albeit with minimal funds.[11] Economics played a key role in determining choices for old people. Limited financial support for old people in the community had been granted since the Old Poor Law.[12] On the whole, an ad hoc mix of welfare arrangements supported an old person in the community in pre-industrial society.

One of the major factors that influenced kinship care was the economic changes within the family arising from industrialisation. In 1834 the New Poor Law was introduced. This legislation was of a deterrent nature and whilst allowing for outdoor relief, there was an attempt to reduce this from the 1870s. Old people were caught up in this policy, despite the fact that it was not framed for them, and there was no national consistency in poor relief.[13] King suggests that there were clear regional discrepancies in the implementation of this legislation inherited from previous practice.[14] Whilst there was an apparent national legislative framework, on a local basis the service and funding varied considerably, resulting in inconsistencies.

Initially when the New Poor Law was introduced in 1834, if fit old people were admitted to the mixed workhouse, they were generally considered alongside other paupers as the able-bodied poor. Having to be admitted to the workhouse was viewed as a sign of improvidence by the commissioners and this also applied in the main to destitute old people at this time.[15]

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[10] R. Wall, 'Residential Isolation of the Elderly, a Comparison Over Time', Ageing and Society, 4, (1984), pp. 483-503.

[11] Thane, Old Age, pp. 119-146, discusses the role of the family in pre-industrial society;

[12] See for example J. Smith, 'Widowhood and Ageing in Traditional English Society', Ageing and Society, 4:4 (1984), pp. 429-449. This article examines the economic support given to widows in the seventeenth and eighteenth centuries and the changing structure of widowhood. Smith also compares the effectiveness of parish and kin provision to that of the welfare state.

[13] Thane, Old Age, p.171 provides analysis on the 'crusade against out-relief' in relation to old people. Also see M. Crowther, 'The Later Years of the Workhouse 1890-1929', in P. Thane (ed.), Origins of Social Policy (London: Croom Helm, 1978), pp. 36-55, where the author notes concessions were being made for old people in some areas towards the end of the nineteenth century.

[14] S. King, Poverty and Welfare in England 1700-1850, A Regional Perspective (Manchester: Manchester University Press, 2000), pp. 258-259.

[15] M.A. Crowther, The Workhouse System 1834-1929, The History of an English Social Institution (London: Batsford Academic, 1981), pp. 42-43.

At the end of the nineteenth century, there was a relaxation of policy towards old people, partly due to the Local Government Board (LGB) taking over responsibility for workhouse administration. The Royal Commission on the Aged Poor in 1895 was critical of the conditions for elderly persons in the workhouses, and recommended that more help should be given to help them remain in the community. Conditions for old people who were accommodated in the workhouses were improved in some areas and distinctions were beginning to be made regarding the 'deserving' aged poor. Charles Booth's survey of 1894, also drew attention to the plight of old people. His survey revealed that the chances of pauperism increased with age and the majority of inmates in workhouses were old people.[16]

The Royal Commission on the Poor Laws and the Relief of Distress (1905 – 1909) reviewed the general state of the poor and produced the Majority and Minority Reports. Both reports were critical of the workhouses, and whilst there were political differences between them, each suggested that smaller, specialised institutions should be introduced to provide for the different categories of inmates. The Minority Report considered that voluntary organisations should organise the services, whereas the Majority Report, thought that the state should be the provider. Both agreed that new methods to relieve poverty had to be instigated, poverty was not self-inflicted, that relief had to be de-stigmatised, and that provision should be of a substantial amount. Each group suggested the aged should have separate accommodation and be recognised as a specialist need group. None of the recommendations was fully implemented.

Old age pensions were introduced in 1908 while the commission was sitting. Introducing the first old age pension legislation reflected changing attitudes towards help for poor old people. Pension provision was influential in helping old people remain independent in their own homes, and reduced workhouse admissions for the aged. Although strict criteria governed the eligibility for the pension, this system essentially replaced the inconsistencies of out relief for the "deserving" old poor. The payment of this benefit was an acknowledgement by society that old people with low incomes needed some financial assistance and that their misfortune was not self inflicted. Whether this system of pension provision was adequate became the

[16] C. Booth, The Aged Poor in England and Wales (London, 1894, reprinted New York 1980).

subject of debate for several decades. Pensions became a multifaceted, highly charged political debate.

A significant marker reflecting shifts in attitudes was the change of name from workhouse to Poor Law Institutions in 1913. One of the effects of the First World War was that unemployed and other types of inmates were removed from the workhouse, leaving mostly elderly people. This began to affect the image of the workhouse as Crowther describes: ".....in these large cities the ordinary workhouses became even more firmly associated with the aged and helpless poor."[17] In 1920 nearly 30 per cent of the inmates were over 70 years old, and by 1929 more than 60 per cent of inmates in the institutions were in the sick and general wards, indicating the high proportion of sick and old people in state institutions. [18]

New legislation in 1929, the Local Government Act, transferred administrative responsibility from the poor law guardians to newly created public assistance committees. Expectations of family responsibilities were addressed in the 1930 Poor Law Act, but the result was not as clear as intended. Crowther discusses anomalies and different interpretations in this part of the legislation. In legal definitions, the family had the prime responsibility to maintain its members. Failing this, ratepayers took on this duty in the form of institutional accommodation, or out relief. Gradually, throughout the twentieth century the state began to accept more responsibility for the helpless, however, the Poor Law still applied, thus creating inconsistencies in the definition of family responsibilities.[19]

During the next ten years most of the inmates of these poor law institutions continued to be the old and sick. A crisis occurred during the Second World War when hospitals were needed for civilian and military casualties.[20] Government reports began to identify the need for alternative accommodation for those old

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[17] Crowther, Workhouse, p. 74.
[18] Crowther, Workhouse, pp. 96 & 89.
[19] See the Poor Law Act 1930 Chapter 17 15 (1) (b); and M.A. Crowther, 'Family Responsibility and State Responsibility in Britain before the Welfare State', Historical Journal, 25:1 (1982), pp. 131-145. The author discusses the state and the role of the family in caring responsibilities.
[20] B. Abel Smith, The Hospitals 1800-1948 (London: Heinemann, 1964), pp. 424-429, discusses the effect of the war on the hospital services; and R. Means and R. Smith, The Development of Welfare Services for Elderly People (London: Croom Helm,1985), detail and analyse the outcome of the war on old people in hospitals and the response of the authorities pp. 25-66.

people who were not sick and the need for specialist units for old people.[21] Parallel to this, the medical profession were re-evaluating treatment programmes, and a movement in favour of the creation of a medical speciality for old people emerged, although this generated much contention. Resources were a powerful force in this debate as health "managers" ultimately recognised that until solutions were found, old people would occupy acute beds and inhibit general progress in medicine.[22] Subsequently, solutions were instituted and for some these were considered unsatisfactory as they produced a sense of ambivalence in the care for old people. In many ways compromises were made, and according to some, only half solved the problem. Old people's health care thus began to be on the agenda for the medical profession from the 1930s.[23]

Family care tended to be dependent on other factors at this time, for example, the reduction in family size, and the effects of the First and Second World Wars. The birth rate was declining and families had become smaller, therefore there were fewer unmarried children staying at home to help. The First and Second World Wars saw the loss of many lives. Both these factors contributed to reduced family size. But the destruction of towns and cities during the Second World War resulted in new communities being established and thus separated families. The effect of these factors was that family size could restrict the support that could be offered, but doubtless it did not influence old people's wishes to remain independent. Old people did not always want to live with their families, and frequently wanted to retain their independence as long as practically possible. Townsend and Sheldon addressed this aspect of ageing in their surveys. Sheldon described some of the practical help given to old people by their relatives that contributed to them staying in their own homes. It was his opinion that old people wanted to remain independent, and in his survey 35 per cent of relatives lived very near and this family support was of "fundamental importance". Townsend makes an important point in his study, old people who lived alone did not mind this as

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[21] See Means and Smith, Development, who provide references to government reports throughout their text to illustrate the response of the authorities to the problems caused during and after the war with regard to old people's hospitalisation.

[22] During the period under review hospital managers were not known as health managers which is a relatively new term.

[23] C. Webster, 'The Elderly and the Early National Health Service', in R. Smith and M. Pelling (eds.), Life, Death and the Elderly: Historical Perspectives (London: Routledge, 1991), p.167. Webster outlines some of these issues, as does M. Martin in 'Medical Knowledge and Medical Practice: Geriatric Medicine in the 1950s', Social History of Medicine, 7:3 (1995) pp. 443-461.

long as they lived near their families, as they felt as this meant they "were not really living alone."[24]

Uniformity in the delivery of welfare services was addressed by Beveridge's proposals for the welfare state, but even under this improvement Macnicol considered old people's pension provision second rate.[25] The advent of a statutory retirement age of 65 years for men and 60 years for women in 1948, brought about other concerns by social commentators. Retirement alongside pensions raised the issue of structured dependency. Imposing a retirement age was seen to create an enforced dependency on the state and prematurely disengaged older people from society.[26] Regardless of these issues, retirement with a pension gave many old people a certain degree of security. For those coming up to retirement in the late 1940s and early 1950s, expectations were raised about how their lives would be improved after the age of 60 for women, and 65 for men, especially in conjunction with other welfare state benefits.

The proportion of people aged over 65 years was increasing. Broadly speaking within this group there were older people who were fit and well and needed no help, and others who were frail and ill needing care and help. Amongst the former some may have needed accommodation because of their limited social and financial resources. Others who were sick could generally be divided into two groups, those who may have had family support, but their illness required more care than families could provide, therefore they were admitted to an institution; and those who were ill and had no family or social support. Essentially an old person without financial or social means was more likely to be admitted to a public assistance institution than those who could afford private care and had family support.

Social pressure to improve the welfare of old people increased in the 1940s. Old people were not represented by an official body such as a trade union. Their interests

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[24] P. Townsend, Family Life of Old People (London: Routledge and Keegan, 1957), p. 42; J.H. Sheldon, The Social Medicine of Old Age (London: OUP, 1948), pp. 150-156, described some of the help given to old people by their relatives that contributed to them staying in their own homes.

[25] John Macnicol, The Politics of Retirement in Britain, 1878-1948 (Cambridge: Cambridge University Press, 1998), pp. 285-385, provides a very detailed history of pension history and gives evidence to illustrate this point.

[26] P. Townsend, 'The Structured Dependency of the Elderly: A Creation of Social Policy in the Twentieth Century', Ageing and Society, 1 (1981), pp. 3-28; P. Johnson, 'The Structured Dependency of the Elderly: A Critical Note', in M. Jeffreys, (ed.), Growing Old in the Twentieth Century, (London: Routledge1989), pp. 62-72.

in the first three decades of the century were effectively taken up by politicians and philanthropists. Initially concern was focussed on the provision of pensions. Campaign groups for pensions were active in the first part of the century such as the National Council for Old Age Pensions.[27] In the early 1940s pressure groups developed with a wider brief than pension provision such as the National Old People's Welfare Committee (NOPWC) and the National Corporation for the Care of Old People (NCCOP). These organisations had a different focus which generated further debate and publicity on the more general needs of old people. Prominent persons took positions of leadership in these bodies and used their influence.[28]

Thane provides a comparison of family support from 1945 to the end of the twentieth century, and suggests that there is consistency in the material support given by families to their older relatives. On a wider level, Thane makes the point that many changes occurred within those 55 years and old people had a different profile at the end of the century to the beginning. Their lives and expectations of old age had changed but family relationships were still important.[29] Crowther also suggests that although the legal definition of family responsibilities changed in 1948, as the welfare state gave new provisions for old people, this did not lead them to abandon older relatives. In many ways this gave opportunities for relatives to give better and extra assistance.[30] Evidence presented by Wall supports this, as he suggests that there was no major change in household structures (except for older men) until 1962.[31] In practical terms the situation for old people was mixed, with some who wanted to remain independent in their community for as long as possible, while others didn't or couldn't. When living independently became impossible due to illness or poverty, then the options were to live with family, (if this was available), to depend on state care, a public assistance institution pre-welfare state, and, after 1948, an Old People's Home (OPH), or to receive care in a hospital. Being admitted to an institution either pre- or early post-1948 was considered a reflection of one's social standing and carried stigmas. Of course, within the group that had to live with their families, there were situations where

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[27] J. Macnicol, Politics pp. 235 -244, follows the campaigns of such organisations in his comprehensive study on pension history.
[28] References to membership of such organisations are mentioned in NOPWC reports, other information is gained from contributors to the oral history collection by M. Jeffreys, 'Geriatrics as a Speciality', C512, 1990, held by the NSA at the British Library.
[29] Thane, Old Age, pp.407-435.
[30] Crowther, 'Family Responsibilities', pp. 144-145.
[31] Wall, 'Residential Isolation'.

the old person or the family resented having to be in this position. On the other hand some old people did want to live with their families, and their families wanted them to do so, and often this was a convenient arrangement.[32]

Previous studies have clearly indicated that old people have been subjected to discrimination in their social status and financial provision. What has remained consistent during the period of time covered in this study is the powerlessness of old people; they were either dependent on their families, or the state, with little status and official representation. These themes are explored further by discovering what life was like in one community for old people between 1930 and 1960.

Definitions of old age

Old age is not a modern phenomenon, for scholars throughout the ages have observed the ageing process and some have offered theories to explain it.[33] Thane suggests there are a variety of ways (which may overlap) to define old age, such as chronologically (by birth date), functionally (in relation to physical ability to carry out tasks), biologically (with regard to physical fitness and characteristics) and culturally (everyday perceptions). All these definitions have histories. According to Thane the significant ages marking old age in history are 60 and 70 years.[34] Political reasons for establishing the onset of old age have been identified by historians.[35] Janet Roebuck is of the opinion that no "real consideration was given to the definition of "old age" as such" and suggests there was a continued acceptance of the inherited pension age established from the First World War.[36] Retirement can be seen in a negative context as imposing withdrawal from work by older workers, or more positively relieving workers from the hard physical work in industry. It has also been linked to periods of mass unemployment as older workers can be retired to make way for younger (usually

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[32] Thane, Old Age, pp. 287-307, examines the period from 1830s to the 1930s; and a contemporary comparison is made in pp. 407–435.

[33] J. Grimley Evans, 'Geriatric Medicine: A Brief History', BMJ, 315 (1997), pp. 1075-1077, refers to Aristotle's and Francis Bacon's theories. Grimley Evans also includes the works of eighteenth and nineteenth century physicians in the USA and in Britain who wrote about diseases in later life. See also P. Thane, 'Geriatrics' in W.F. Bynum and R. Porter, (eds), Companion Encyclopaedia of the History of Medicine (London: Routledge, 1993), pp. 1092-1118, for the early history of ideas about ageing.

[34] Thane Old Age, p.24.

[35] See P. Johnson, 'Parallel Histories of Retirement in Modern Britain', in P. Johnson and P.Thane (eds.), Old Age from Antiquity to Post Modernity (London: Routledge, 1998), pp. 211-225; A. Blaikie and J. Macnicol, 'The Politics of Retirement, 1908 – 1948' in Margot Jeffreys, (ed.), Growing Old in the Twentieth Century (London: Routledge,1989), pp. 21- 41. These authors detail pension history and illustrate the political implications underlying the changes.

[36] J. Roebuck, 'When Does "Old Age" Begin: The Evolution of the English Definition', Journal of Social History, 12:5 (1979), pp. 416-428.

male) workers and so increase productivity in the workforce. However, once retired there was little financial help. Some see this situation as marginalising older people into "a condition of structured dependence." [37]

Age definition and the ageing process is dynamic but it is, as Johnson suggests:

"A matter of social convention and legal and administrative definition." Furthermore he asserts that the: "Institutionalisation of the public and private pension systems which provide benefits at set ages, the associated development of formal retirement ages, ...and the establishment of other age thresholds for inclusion or exclusion from certain groups, activities or enlightenments had by the 1970s, created a set of social conventions that old age began at sixty or sixty-five."[38] Johnson thus illustrates the way a socially constructed definition of old age has been created. Grimley Evans discusses the biological aspects of ageing: "The average length of human life has increased over the centuries as living conditions have improved and childhood mortality has fallen; the maximum lifespan of our species is determined largely by our genes and will be the same as it ever was."[39] It seems that the individual rate of ageing is multi-variant, dependent on social, economic and biological influences. Seebohm Rowntree's survey of old people in 1947 used the ages of 60 for women and 65 for men as cut off points. The author justified the reasons: "...as these ages had been established by the 'Widows', Orphans', and Old-Age Contributory Pensions Acts of 1925 and 1940 as the earliest ages at which state pensions are paid, and in consequence most published statistics relating to old age take the pensionable ages of 65 and 60 as being synonymous with the beginning of old age."[40]

This study accepts the definition of old people as women over 60 and men over 65.[41] The age someone was eligible for a pension came to be identified with the beginning of old age. Understanding how and why pensions were established is crucial as this reflects society's attitude to old age. Although this thesis will not be examining pension

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[37] Macnicol and Blaikie, 'Politics of Retirement 1908 – 1948', pp. 21- 41. See also J. Quadagno Ageing in Early Industrial Society (New York: Academic Press, 1982), p.167, who also considers that "It is no accident, ...that the concept of unemployment appeared around the same time that retirement became a recognised census category, for among the aged poor, retirement and unemployment were synonymous."

[38] P. Johnson, 'Parallel Histories'.

[39] Grimley Evans 'Geriatric Medicine', pp. 1075-1077.

[40] B. Seebohm Rowntree, Old People, Report of a Survey Committee on the Problems of Ageing and the Care of Old People (London: OUP, 1947), p.1.

[41] Some statistical information used for this study has been compiled from surveys, official documents and other sources which do not use these age bands. Therefore there may be some variations in the presentation of information.

history as it is a complex and detailed discussion, it is essential to appreciate that pensions for older people were fundamental in recognising their place in society. [42] For these reasons it is necessary at this stage to review the sequence of events responsible for pension provision in order to set the context for the twentieth century.

Pensions

Old people began to be defined as a social group from the middle of the nineteenth century; the aged poor were recognised as a "marginalised social group".[43] At the end of the nineteenth century and the beginning of the last century it was probable that older people without social or economic resources would have to go into an institution, the workhouse. Workhouses varied throughout the country as did conditions within, depending on local provision. Thomson suggests that few elderly people lived in the workhouse as out relief was provided for them and that legislation governing family responsibilities was limited and was not regularly enforced. Thane questions this assertion and re-evaluates evidence that gives a more positive role of the family in helping older relatives.[44] However the population of older people in the workhouses increased.

Outdoor relief was available but was not necessarily adequate to live on and dependent on local guardians' distribution policies. Examples of how different areas operated illustrate how outdoor relief was often associated with the 'deserving' and 'undeserving' poor.[45] From 1871, when the LGB was established, outdoor relief was restricted particularly to adult able-bodied males. Towards the latter part of the nineteenth century the allocation of outdoor relief was also linked with the Charity Organisation Society (COS), which held firm views on providence and thrift. This organisation was primarily concerned with the 'deserving' poor and the guardians with the 'undeserving'. By becoming active in the process of distributing allowances, the COS were influential in reducing the rates of outdoor relief at the

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[42] See Macnicol, Politics, for a comprehensive critical study of pension history, as his works describe in detail the role of governments, labour movement, pressure groups and individuals in the development of pensions.
[43] P. Thane, 'Gender Welfare and Old Age in Britain' in A. Digby and J. Stewart, (eds.), Gender Health and Welfare (London, Routledge, 1995), pp.189 - 207.
[44] D. Thomson, 'Welfare', in M, Pelling and R. Smith, (eds.), Life, Death and the Elderly, Historical Perspectives (London: Routledge, 1991), p. 207; and Thane 'Old People and their Families', in Martin Daunton, (ed.), Charity, Self Interest and Welfare in the English Past (London: UCL, 1996), p. 117.
[45] Thane, Old Age, pp.178-179.

end of the century.[46] Old people who had supplementary incomes (for example from club saving schemes) were not allowed to claim outdoor relief.[47] Consequently, if only a limited amount of subsistence was granted to an old person, or subjective criteria were applied to applications for outdoor relief then, for many, the only available institution available for those who were destitute was the workhouse.

As previously outlined, the economic status of old people was of fundamental importance to their well being. The establishment of pensions is extremely significant in the history of the welfare of older people as without financial resources, they became dependent on the family or the poor law. Whilst the experience of poverty for all groups of needy people was similar, old people were more vulnerable by virtue of their age and increasing disabilities often brought about by illness and a life of scarcity. It is for precisely this reason that pensions were important for elderly people as their ability to work was restricted and consequently their income was limited.

Identifying the key players instrumental in the development of pensions can be traced back to Booth[48] who carried out surveys in the late 1880s and early 1890s, and, as a result, developed a special interest in old people's circumstances.[49] In his opinion, old people were pushed into poverty because they were unable to earn a living and not, as the New Poor Law had assumed, because of individual moral failings. Thus he was an early advocate of old age pensions.[50] In 1893, the Royal Commission on the Aged Poor, (of which Booth was a member), exposed the fate of 'deserving' old people who, after a lifetime of working and existing on low wages faced the end of their days in the workhouse. Attitudes of this kind challenged the values of the New Poor Law. By this time old people had generally come to be considered as the 'deserving' poor as a result of Booth's surveys and a general change in the perception of their predicament. But there was still a current of opinion that felt that old people should be prudent and prepare financially for old age.

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[46] A. Digby, The Poor Law in Nineteenth-Century England and Wales (London: Routledge, 1982), pp.25-27.
[47] Quadagno, Ageing, p. 105.
[48] See Macnicol, Politics, pp. 60-84, who details influences prior to Booth.
[49] Booth, Aged Poor.
[50] Thane, Old Age, p174.

When pensions were first introduced it was within a moralistic framework, distinguishing the 'deserving' from the 'undeserving' old poor. Pensions of between one shilling (5p in today's currency) and five shillings (25p) a week were then paid to people over seventy years old, with good character, who had not been in prison for any offence including drunkenness, had not been habitually out of work and had incomes of under £31 10 shillings (£31.50p) a year. Originally the pension was not granted to people who had claimed poor relief after 1 January 1908. This was reviewed in 1911, because it was seen as penalising people who had worked until their mid 60s and then became dependent on the poor law before qualifying for their pension. On 1 January 1909, when the Act was implemented, 490,000 people qualified for the pension, the majority being women. Administration and allocation of the pensions was carried out by new district pensions committees. It was not the intention of the act to provide total subsidy but "an addition and an incentive to desirable private saving".[51] Of course criticism can be made regarding the regulations of payment as the act suggested that only particular persons of good standing would be eligible, therefore still leaving many old people without. However, the legislation gave people an income that was not associated with poor relief and this in itself was a historical step. There is no doubt that the introduction of old age pensions in 1909 came about because of social pressure and, once economic responsibility was taken by the state, then the debate was likely to continue in the public arena and raise other areas of concern about old people's circumstances. Trades unions put pressure on the government to increase the pension during the first year of the war and the government were also lobbied by the churches and Friendly Societies. By 1916 the pension was raised by 2s 6d (12 1/2p) for pensioners suffering hardship, and extended to include all pensioners in 1917 for the duration of the war to cope with rising prices.[52]

Raising the pension in 1916 was a response to a war time problem but to withdraw the rise would have posed a dilemma. In 1919, the Ryland Adkins Committee was established, with a brief to " consider and report what alterations, if any, as regards rate of pension and qualification, should be made in the existing statutory scheme of old age pensions." Evidence was heard from a cross section of people working in

[51] Thane, Foundations of the Welfare State (London: Longman Group 1982), p. 83.
[52] Thane, Foundations, p. 130.

either pension departments, or campaigning for improvements for old persons.[53] The Committee heard of some of the miserable circumstances that old people were living in, and how pensioners in poor health had to take on work in order to survive financially. But the economic effect of the war influenced the Committee, as the Treasury informed them that pensioners could not be given preferential treatment: "...I think it is quite impossible to restore people like old age pensioners who are not part of the industrial machine, to as favourable a position as they occupied before the war..."[54] This view made clear the low priority given to old people, especially in relation to their employment status. An increase in the pension to ten shillings (50p) a week was recommended as was further investigation of a contributory scheme for pensions from the ages of 65 and 70, and the clauses refusing pensions to those who had been imprisoned and had not been working were abolished. Another recommendation was that wives and aliens were also to receive pensions. The debates during this Committee covered several highly controversial areas such as universal pensions, thrift penalisation, means testing and the reduction of the age of pension eligibility. As a result the Committee was split. Two reports were submitted and the government accepted the Minority Report and incorporated it into the Old Age Pensions Act 1919, mindful that accepting anything less than pre war provision would not appease the trade unions, Friendly Societies and others campaigning for improved pensions.[55] Pension rates were doubled to ten shillings (50p) a week and the maximum means limit was increased to forty-nine pounds seventeen shillings and sixpence (£49.87 1/2p) per annum. Old people were now entitled to a minimum income of one pound a week. Gilbert considers that the composition of the Ryland Adkins Committee members created an insipid report, but the structure of the proceedings of the Committee resulted in evidence being presented which illustrated just how difficult life was for old people.[56] Consequently a fair degree of sympathy was given to the pensioners by the Committee. However, Macnicol suggests that the government were concerned at the way the proceedings were structured and the financial implications for the future.

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[53] Thane, Old Age, pp. 311- 318, the author also lists the witnesses coming from government departments, trade union representatives, Friendly Societies, National Council for Old Age Pensions (NCOAP), cross party MPs and a female voluntary social worker.
[54] Permanent Secretary to the Treasury, Ryland Adkins Report, quoted in Thane, Old Age p. 316.
[55] Thane, Foundations, p.143.
[56] B.Gilbert, British Social Policy, 1914-1939 (London: Batsford, 1970), pp. 236-239.

Further debate and pressure led to the Anderson Committee being established, and the introduction of the Widows and Orphans Contributory Pensions Act in 1925. [57] This Act introduced the policy of national insurance contributions so that those covered by national insurance could make additional payments to entitle them to pensions without a means test. In 1929 the Act was extended to include widows' pensions to those whose husbands had died before the scheme began, and women who had not previously been eligible, because their husbands were aged over 70 when the 1925 Act came to effect. By 1933, 446,000 women and 264,000 men were receiving pensions. There were three types of old age pensions all at the rate of ten shillings a week, the contributory pension for those eligible for national insurance and aged between 65 and 70 years; the partially contributory, which was paid without a means test for those aged over 70 years; and the non-contributory means tested pension for those over 70 years who had not paid National Health Insurance contributions themselves, or had not been married to a man who paid contributions.[58]

Unmarried women were campaigning for changes in pension law and the National Spinsters and Pensions Association argued for pensions for working women to be on the same basis as for widows, but this suggestion was rejected. The Old Age and Widows' Pensions Act 1940 was seen as pension legislation that discriminated in favour of women as this Act reduced the pensionable age for insured women and the wives of pensioned men, from 65 to 60.[59] This legislation introduced a system of supplementary pensions and an Assistance Board, responsible to central government, to administer the benefits. According to Thane, prior to this legislation, only ten per cent of pensioners had previously applied for poor law relief, and the government anticipated similarly low applications for the new Supplementary Assistance. But many pensioners applied for assistance within days of the new scheme operating. The increase in numbers claiming this benefit immediately stimulated debate about the eligibility of some claimants, which in turn led to the

[57] Macnicol, Politics, p.169, explains the political reasoning behind the development of contributory pension; he also considers that the extraordinary high calibre of the membership of the Committee indicates the importance that old age pensions was now receiving and lists members and further details of the Anderson Committee, p. 191.
[58] See Thane, Foundations, p. 199, for further details on these changes.
[59] See H. Smith 'Gender and the Welfare State: The 1940 Old Age and Widows' Pensions Act', History, 80:26, (1995), pp. 382-399, for discussion and clarification of "the origins of the Act's provisions relating to women and the relationship between the NSPA and inter-war feminists."

household means test being applied to aged applicants. This raised complications as at this time old people lived in a variety of accommodation therefore determining a household presented problems. For example, in working-class communities it was common practice for two households to share one house as independent units particularly during war time as daughters or daughters-in-law moved in with their parents or parents-in-law whilst servicemen were absent, and many old people were independent lodgers in other people's homes.[60] Following protests about tactics used by officials to assess 'households' the first of the Determination of Needs Bills was introduced in parliament in January 1941. The rules were changed to allow people applying for Supplementary Assistance to have sufficient income for living expenses and contributions for rent before any other income was assessed. As a result 200,000 pensioners were able to apply for the supplementary pension. When the Determination of Needs Act was discussed in Parliament in 1943, MPs also raised the need for higher old-age pensions, especially in the light of the impending Beveridge Report, which was proposing radical reforms for a welfare state.[61]

Seebohm Rowntree clearly identified the needs of pensioners when he carried out his survey in the mid 1940s, and discovered that there was a lack of awareness by pensioners of their eligibility to claim this benefit. Ignorance of the scheme was seen as inevitable as it was a new venture and more time was needed to disseminate this information.[62] Pensioners were also reluctant to apply because they did not want to subject themselves to inquiries made by officials of the Assistance Board or they saw these payments as charity.

During the Second World War, the government began to review the needs of older people under the auspices of the Beveridge Committee on Social Insurance and Allied Services. Much information was collected by the committee which ranged from: problems with the existing pension structure; immediate need for improved medical help for pensioners outside the public assistance remit; and the lack of

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[60] Thane, Old Age, pp. 355-356; 120,000 applications to the Assistance Board were received in the first four days; 1,275,000 applications had been filed by the time the first payment was made; and by 1941 the Assistance Board was supplementing one-third of all old age pensions. Thane interprets this contrast in take up of assistance from the Poor Law to the New Act as indicative of the "fear and hatred of the Poor Law." Thane describes how officials would use "devious ways to assess the extent of interaction associated with such arrangements" and would arrive at meal times to try to catch pensioners sharing a meal with relatives or neighbours.

[61] Thane, Old Age, p.356, refers to the relevant Hansard debates.

[62] Seebohm Rowntree, Old People, p. 15-16.

institutional provision. Blaikie and Macnicol suggest that Beveridge's focus was limited to establishing a single pension which was to be integrated into the social insurance system.[63] Furthermore they suggest that Beveridge portrayed older people as a burden and foresaw that maintaining older people was going to be extremely expensive. The system that was eventually instituted was a transitional system of contributory pensions, introduced between 1945-65, to be paid on retirement from work. During the transition period the National Assistance Board was to top up pensions based on a means test. Concern was expressed by the National Federation of Old Age Pensions Associations and the Old People's Welfare Council at the proposed small amount of pension which was at a lower rate than for sick people and the unemployed.[64] Since 1909 the inclusive cost of living had doubled and five shillings (25p) a week was recognised as inadequate. [65] Although concerns were expressed at the rates established for the old age pensions, this legislation was a vital component within the development of welfare state policy.

The debate on general pension provision and retirement has effectively resulted in two models emerging on the implications of such policy. Townsend argues that dependence of older people is 'structured' and related to class.[66] Supporting this, Walker is of the view that retirement is a "twentieth century phenomenon" and increasing the dependency of older people is a deliberate attempt to remove older people from the workforce.[67]

In contrast, Smith and Thomson consider that retirement has been in existence throughout history.[68] Smith does not consider that poverty among the elderly was a new problem for the nineteenth and twentieth century and suggests that there should be recognition of the earlier assessments attempting to resolve the relationship of the individual, family and the community in providing for the poor. The arguments of Smith and Thomson are related to demography, pension provision today and

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[63] A. Blaikie and J. Macnicol, 'Politics of Retirement', p. 34.
[64] Means and Smith, Development, pp.124-5.
[65] E Samson, Old Age in the New World (London: Pilot Press, 1944), p. 2.
[66] P. Townsend, 'The Structured Dependency of the Elderly: A Creation of Social Policy in the Twentieth Century', Ageing and Society 1, 1, 1981, pp. 5-28.
[67] A. Walker, 'Pensions and the Production of Poverty in Old Age' in C. Phillipson and A. Walker, (eds.), Ageing and Social Policy. A Critical Assessment (London: Gower, 1986), pp. 185-186.
[68] R. Smith, 'The Structured Dependency of the Elderly as a Recent Development: Some Sceptical Thoughts', Ageing and Society, 4:4 (1984), pp. 409-28; and D. Thomson, 'The Decline of Social Welfare: Falling State Support for the Elderly Since Victorian Times', Ageing and Society, 4:4 (1984), pp. 451-82.

collectivity. Blaikie and Macnicol discuss the two contrasting opinions and conclude that there are other factors to consider in this debate. Retirement produced a mixed reaction amongst working people. Ceasing work created more leisure time, but the penalty for this was restricted income and "enforced idleness." Pensioners were generally very poor. [69] Contemporary archives from the National Old People's Welfare Committee, a pressure group campaigning for better conditions for pensioners, support this claim.[70]

There is evidence to suggest that the provision of pensions was "highly gendered." Early pension debates were concentrated on male industrial workers which reflected the male dominated industrial society.[71] In general, the economic framework of welfare has traditionally been framed by the position in the labour market, which was usually male. Furthermore, the need for pensions was probably greatest amongst women as they lived longer than men. Roebuck and Slaughter consider that the reduction of the pension age for insured women to 60 years, under the Old Age and Widows and Pensions Act 1940, gave an opportunity for policy makers: "...[to] convert more elderly people into "old age pensioners," members of the reserve labour force, who could and should be moved out of jobs to make room for younger people."[72] By analysing the pension history for women, they conclude their argument with a quotation from Sontag that: "Ageing is much more a social judgement than a biological eventuality" which can be attributed to both men and women. But women too needed to have economic security in their old age in order to maintain legal, social and financial independence. Women did live longer and more women than men were admitted to public assistance institutions.[73]

The combination of social pressure, economics and the conception of the welfare state resulted in the Beveridge Report, where generally little priority for old people's welfare was given compared to younger people.[74] The wider implications of the

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[69] A. Blaikie and J. Macnicol, 'Politics of Retirement', pp. 22-24, the authors present the different arguments by these writers.
[70] See NOPWC conference reports and leaflets for consistent references on how to improve facilities and benefits for pensioners.
[71] Macnicol, Politics, p 404, expands this point by explaining how in general the organised masculine labour movement represented male workers but women's organisations (who were less powerful) except for the National Spinsters' Pensions Association were silent on pensions.
[72] J. Roebuck and J. Slaughter, 'Ladies and Pensioners: Stereotypes and Public Policy Affecting Old Women in England, 1880 – 1940', Journal of Social History, 13:1 (1979), p.112.
[73] See Thane, Old Age, pp. 21-24, for a fuller discussion. Thane traces this back to the ancient world.
[74] Beveridge Report 1942 Social Insurance and Allied Services, CMD 6404 HMSO.

Beveridge Report are discussed in Chapters Four and Six in relation to the establishment of the welfare state and the development of services. This report envisaged radical change from the poor law to the welfare state. It was a great opportunity to create better facilities for older people, yet this did not happen, and the reasons for this will be discussed below. Historians analysing pension history connect "conservative" and "radical" origins in the establishing of pensions and consider the politics of retirement illustrate a political dilemma.[75] Opposing political perspectives may well explain the low proportionality of services for older people as compromise had to be reached. Although not up to the expectations of those campaigning for more provision it did ensure old people were in a better position than in previous times. The culmination of this process was that the welfare state provided a pluralistic remedy in providing generic services for old people.

The post-war period resulted in political, social and economic changes, which in turn provided a new frame of reference for the definition of old age. Research on old age at this time covered a wide range of older people's needs. Harper and Thane consider that there were four major areas of research, employment, housing, social issues (such as poverty and loneliness) and socio-medical issues.[76] During this time the profile of older people was being raised. Links were being made between social conditions and health. Three main concerns were identified during this period, the national economy, individual health and personal welfare and moral obligations to older people. The economy and health were the concerns that generated most research and interest. Retirement became acceptable but not without concerns with regard for the implications for old people's health and welfare. The outcome of this concern was much research and professional debate about the problems of imposed retirement and the disengagement from society by old people. Agencies involved in the wellbeing of older people such as the National Old People's Welfare Committee (NOPWC) took a lead by establishing a Preparation for Retirement Committee in 1960 and began to give retirement a more positive image. Opinions on structured dependency have emerged and opened up the political debates on ageing.[77] Harper and Thane aptly describe this

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[75] Macnicol, Politics, p 401

[76] S. Harper and P. Thane, 'The Consolidation of 'Old Age' 1945 -1965', in M. Jeffreys, (ed.), Growing Old in the Twentieth Century (London: Routledge,1990), p. 44.

[77] P. Townsend, 'The Structured Dependency of the Elderly: A Creation of Social Policy in the Twentieth Century', Ageing and Society, 1 (1981), pp. 3-28; P. Johnson, 'The Structured Dependency of the Elderly: A Critical Note' in M. Jeffreys, (ed.) Growing Old in the Twentieth Century, (London:

process of change for old people and society: "Society gradually adjusted to the emergence of a new distinct phase in the life cycles of most people, a period of post-employment leisure normally preceding by many years the onset of marked physical decline."[78] There were arguments for and against compulsory retirement. For many, after years of hard physical work stopping and being assured of financial security was a blessing, but others were reluctant to retire and found the process difficult. Even after the establishment of the welfare state, pensions were not necessarily adequate for the needs of some old people, particularly those with just a state pension.[79] Other benefits and support systems, as well as an adequate income, were found to be necessary to ensure that old people had a respectable retirement - such as housing provision, access to health care, leisure facilities and social inclusion. With an increasing ageing population supplying these needs came with a high price tag for the community.

Oxford case study

Oxford City has been selected for this investigation because of its mixed economic base with strong manufacturing industry, a university and a teaching hospital. Another key component in selecting Oxford for this study is that one of the first pioneers of geriatric medicine, Dr Lionel Cosin, was appointed as medical director of the CRH in 1950. This was a crucial time in relation to the establishment of the NHS and the development of geriatric medicine. Opportunities were available for change, and given the rising population of older people, combined with changing attitudes towards old age, then this provided a fitting time for new beginnings in this area.

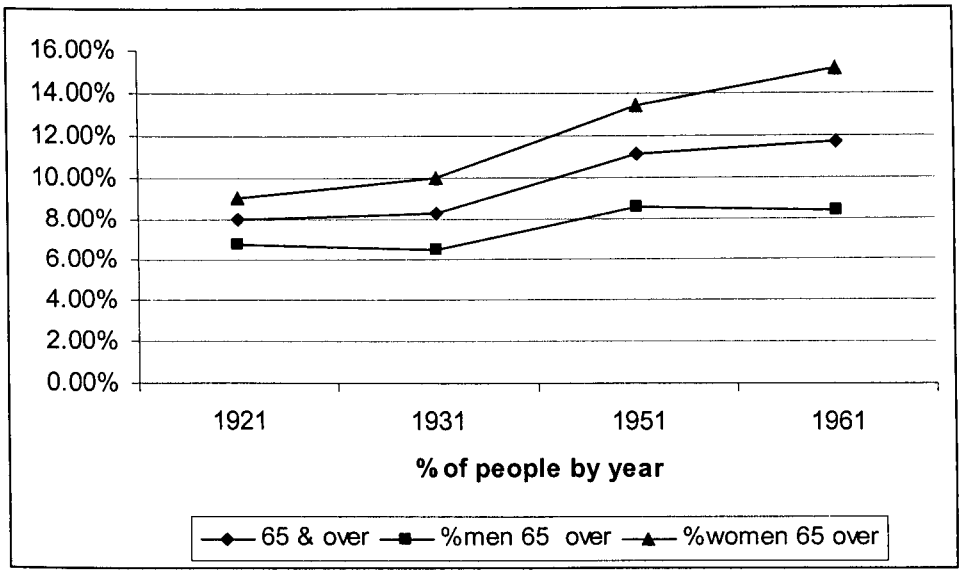
The population of Oxford rose from 57,036 in 1921 to 106,291 in 1961. Oxford City boundaries were changed in 1929, thus increasing the population. Generally speaking there is evidence of old people living longer in the city from 1921 to 1961 which corresponds with the national age profile. More women were shown to be living longer than men in the city. The table below shows how in terms of absolute numbers, the older population rose from 1921 to 1961 in Oxford.

Routledge,1989), pp. 62 -72; see also R. Smith, 'The Structured Dependence of the Elderly as a Recent Development: Some Sceptical Historical Thoughts', Ageing and Society, 4:4 (1984), pp. 409 - 428.

[78] Harper and Thane, 'Consolidation', p. 59.

[79] For example reports from the early NOPWC conferences (1946 onwards) flagged up the pertinent concerns for old people such as accommodation problems, support systems in the community and health care.

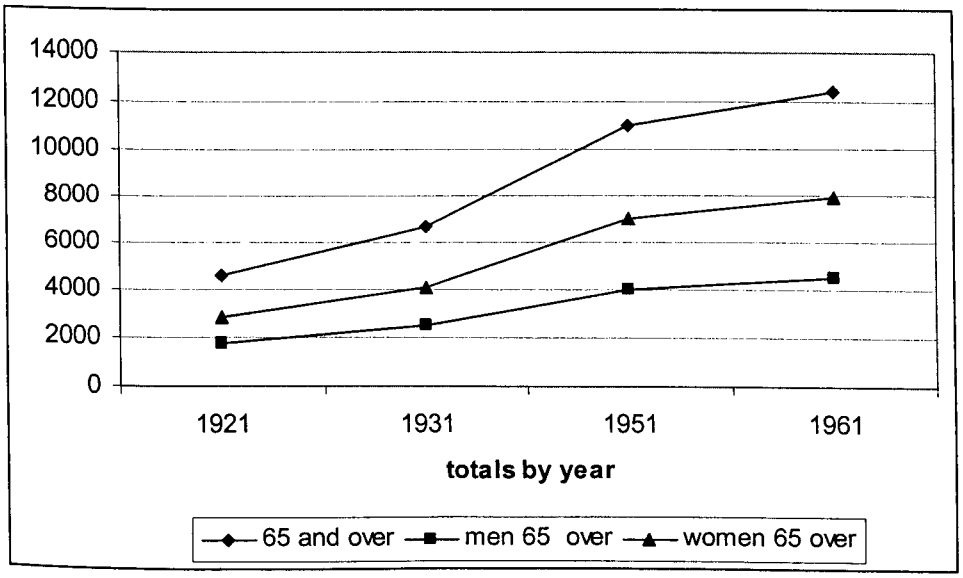
Figure 1.1 Percentage of those aged 65 and over by year in Oxford



Source: Census of England and Wales, 1921, 1931, 1951 and 1961.

Figure 1.2 illustrates the increase in the proportion of older people living in Oxford over the five decades. This table also confirms that women were living longer than men. Health profiles compiled from the local MOH reports correspond with national MOH reports and provide evidence to suggest that Oxford was fairly representative.

Figure 1.2 Total of people aged 65 and over by year in Oxford

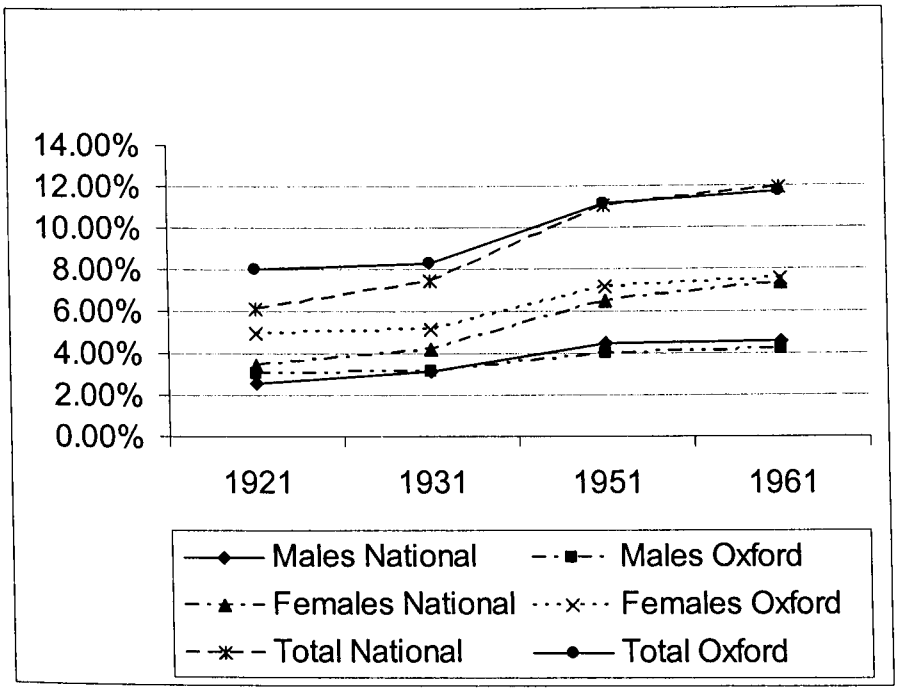


Source: Census of England and Wales, 1921, 1931, 1951 and 1961.

Additionally, the proportion of those aged 65 and over in the city, was 8 per cent in 1921 with the national average being 6 per cent, however, from 1931 it was broadly comparable with the national average, both rising to 12 per cent by 1961.

Compared with the national age profile Oxford City can be seen as initially being slightly below the average in 1921, but, from 1931 onwards ran virtually the same. (See Figure 1.3) As noted above gender profiles show that women were living longer both locally and nationally. This evidence also confirms that Oxford had a similar age profile to the national average.

Figure 1.3: Comparison of Oxford and national age profiles for men and women aged 65 and over



Source: Census of England and Wales, 1921, 1931, 1951 and 1961.

In the first half of the century many people did retire to Oxford particularly civil servants and similar professionals. Bourdillon described the common impression that Oxford had a very high older population:

> Since Oxford is a young town, industrially the number of retired wage-earners must be low, and this factor, combined with that of the university's floating population, makes the proportion of retired people in Oxford lower than in England and Wales as a whole, that is 4.6 per cent of the total population, aged 14 and over, as against 5.5 per cent....Nevertheless the impression that Oxford is

> the resort of many retired civil servants and people of a similar social position is too strong to be abandoned. [80]

Whilst this may have been the case at the time Bourdillon was writing, in the 1930s, evidence presented in this thesis demonstrates that Oxford's over 65 year old population synchronised with the national average. Figures 1.1 – 1.3 and Table 7.1 provide detailed breakdowns of this information. Although the local death rate fluctuated slightly, it was similar to the national average. It is discussed in Chapter Seven in relation to epidemiological influences.

The city had a balance of professional and industrial workers with significant numbers employed in the university, hospitals and the car industry. During the nineteenth century the major industry in the city was provided by tradesmen, craftsmen and the university. At the turn of the century many of these industries were still thriving but new ones were developing as Oxford became more industrialised. The university supported secondary trade particularly in the printing, food and accommodation sector. Since the beginning of the twentieth century the main industrial developments in Oxford have been in printing, the university, the car factory and railway expansion. Oxford University had dominated the employment market until the early 1920s and one of the biggest employers in the city was the Clarendon Press situated in Jericho.[81] Another major industry was bookbinding where many women were employed. Women also became landladies, were in service or did charring. Small business such as tailoring and boat building (particularly for the university) were thriving. The transport business was growing and employed people to work on the railways and also as tram workers. Tourism development generated custom for the hotel and restaurant trade from the 1920s, and there was an increased demand from the university for bookbinding, printing and publishing. By far the most significant industrial development in Oxford during this period was the establishment of the Morris Motor works in Cowley.[82] As a result of this the occupational structure of the population changed by introducing a new group of semi-skilled workers who could earn as much as traditional craftsman. Many benefits to the city arose from the expansion of the car industry which provided a major

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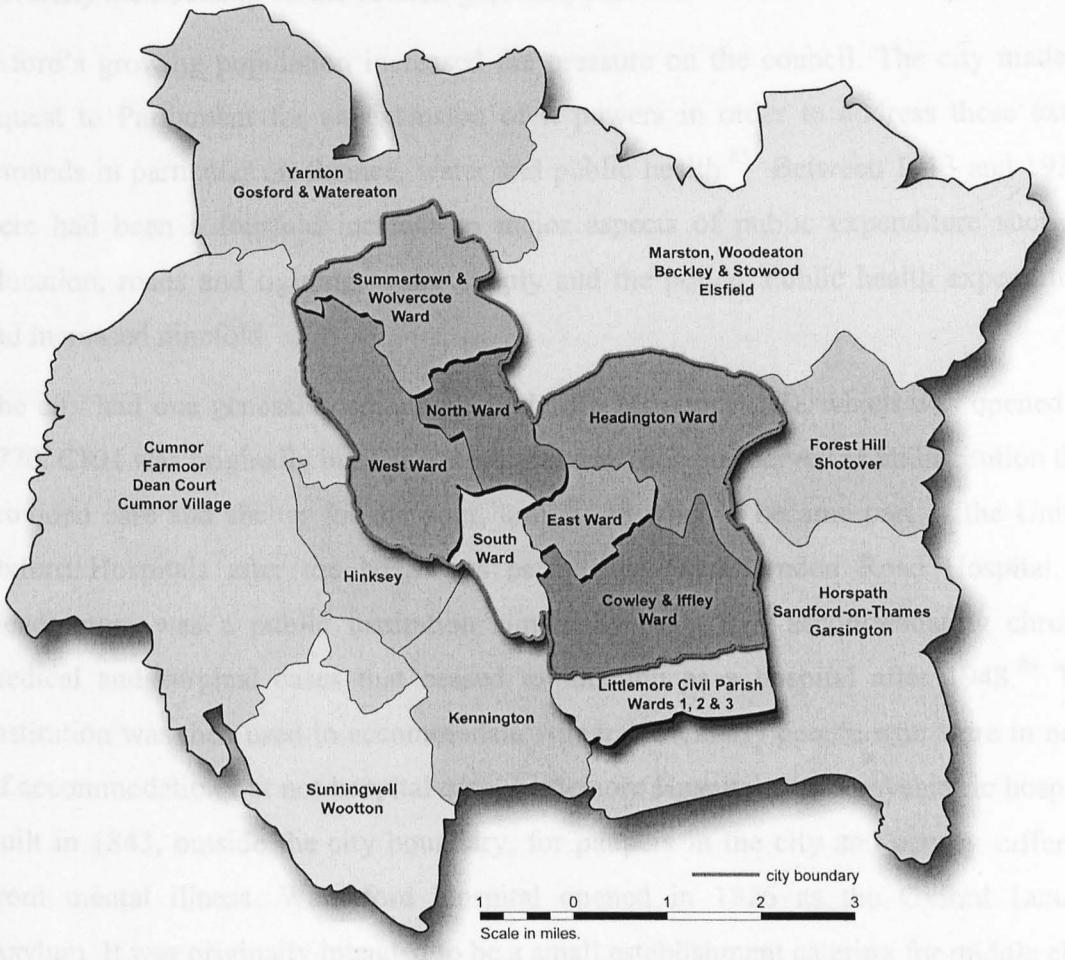
[80] A. Bourdillon, A Survey of the Social Services in the Oxford District II, Local Administration in a Changing Area (Oxford: OUP, 1940), p. 65.

[81] K. Field, "Children of the Nation? A Study of the Health and Well-being of Oxfordshire Children", unpublished PhD thesis, Oxford University, 2001, p. 69, described the "paternalistic" relationship of the Clarendon Press with the local residents of Jericho many of whom worked in the press.

[82] R.C. Whiting, The View from Cowley, The Impact of Industrialization upon Oxford 1918-1939 (Oxford: OUP, 1983), pp. 29-52. Whiting contextualises the development of the car industry and the effect of this in the city. This study also relates the industrialization to the labour movement in the city.

source of employment in competition with the university, and other traditional local industries. The building industry also expanded as a direct result of the increased population that arose from industrial growth in the city. Once this industrial boom stabilised, so effectively did the population. Employment in Oxford was relatively stable from 1945-1960. Some of the local traditional occupations such as tailoring and domestic service had collapsed, and there was an increase in the professional classes such as lawyers, doctors and estate agents. Over the twentieth century Oxford became a more industrialised city with a changed population reflecting local employment opportunities.

Figure 1.4: Map of Oxford City



Source: Oxford City Census Tracts1951

A substantial amount of residential development occurred between the late nineteenth century and 1936.[83] See Figure 1.4 for the geographical context of the city in relation to the county boundaries. Boundaries of the city were changed in 1929 and in the 1950s. Subsequently outlying villages such as Headington, Cowley and Iffley were included into the city which inevitably increased the population. Oxford became a city and county borough following the Local Government Act of 1888. The university was

[83] See Changing Faces Series, Robert Boyd Publications. This series documents historical changes of communities within Oxford City, based on documentary evidence, memories from local residents and photographs. Communities included are, Jericho, Cowley, St Clements and East Oxford, Headington, St Ebbes and St Thomas, Wolvercote with Wytham and Godstow, Marston, Littlemore and Sandford, North Oxford, Summertown and Cuttleslowe, South Oxford and Iffley.

represented in the city government, although throughout the twentieth century the university membership on the council gradually receded.[84]

Oxford's growing population increased the pressure on the council. The city made a request to Parliament for an extension of it powers in order to address these extra demands in particular on finance, water and public health.[85] Between 1913 and 1936, there had been a fourfold increase in major aspects of public expenditure such as education, roads and lighting, water supply and the police. Public health expenditure had increased ninefold.

The city had one general hospital, the Radcliffe Infirmary (RI), which was opened in 1770. CRH was originally built as a workhouse in 1865 and served as an institution that provided care and shelter for the poor, until 1948 when it became part of the United Oxford Hospitals after the NHS was established. The London Road Hospital, in Headington, was a public institution similar to the CRH, accommodating chronic medical and surgical cases that ceased to function as a hospital after 1948.[86] The institution was then used to accommodate vulnerable elderly people who were in need of accommodation but not hospital care. Littlemore Hospital was a psychiatric hospital built in 1843, outside the city boundary, for paupers in the city and county suffering from mental illness. Warneford Hospital opened in 1826 as the Oxford Lunatic Asylum. It was originally intended to be a small establishment catering for middle class residents who were able to make a contribution towards their treatment. After 1948 it became part of the National Health Service. The Warneford, Littlemore, London Road Hospital and the RI are hospitals featured in this study, but it is the CRH that is one of the main focuses of this thesis and is therefore described and discussed in great detail throughout.

Content and structure

This chapter has contextualised old age within a political and social frame from 1930 to 1960. A picture has emerged of the different dimensions of the history of old age. The major themes underpinning this study of old age are, the financial status of elderly

[84] The Local Government Act 1972 enabled reorganisation of local government in 1974. Oxford became a district and was no longer a county borough. From then onwards the university had no separate representation on the council.
[85] C.J. Day, Modern Oxford, A History of the City reprinted from the VCH, 1983, pp.242 – 243.
[86] Before 1930, the London Road Hospital in Headington had been the Union Workhouse for Headington Union.

people, the role of the family in providing care and the provision of welfare and health care. Within these interlinking themes, attention has been given to illustrate how priorities for old peoples' welfare have evolved. Financial provision, general health and welfare provision and family help are all part of the overall integral components in establishing quality care for old people.

The workhouse was a key establishment in provision for residential accommodation for old people during the nineteenth and most of the first half of the twentieth century. This institution has a 'reputation' for accommodating the poor and hopeless, and for its inhumanity. As old people became the largest group of inhabitants in workhouses, and subsequently, the public assistance institutions, these institutions became associated with geriatric care. Having outlined these issues in relation to the workhouse, and established that old people's care and services have been considered a low priority, this investigation seeks to discover if, and how, inherent attitudes towards them continued by various means.

Chapter Two will discuss the methodology employed for this investigation, in particular, in relation to the use of oral history. The themes addressed in this thesis mainly cover health and welfare aspects of old people's care. There is so little information available from a first hand experience, to indicate how families and professionals coped with ageing people and the difficulties they encountered. By interviewing local residents, information is gathered and triangulated against documentary sources to complete a picture that has not been presented before. This chapter seeks to explain how and why, this aspect has not been covered previously. Additionally it will attempt to ascertain the need to capture and preserve memories that reflect historical societal changes that are not necessarily covered in official documents before they are forgotten.

Using oral histories for this investigation is particularly important in the study of ageing. All these experiences will provide a collective memory of ageing in a local community which will add fresh perspectives to the historiography of ageing. The chapter will address the complexities of oral history and seek to demonstrate the importance this methodology can contribute to historical studies. Data gathered from the testimonies has been used for qualitative and quantitative analysis in conjunction with each other. Personal details have been used to attempt to provide a more evocative

impression of everyday life for older people between 1930-1960, that may reflect national patterns.

Chapter Three will set the CRH in historical context and examine national developments that influenced poor law provision in Oxford, and identify what was available for old people before the welfare state arrived. Oral testimonies from relatives and professionals will aim to establish community expectations and perceptions of the CRH, and explore the influences behind these. Comparisons will be made between the expectations of the relatives, and those of the professionals in relation to city council reports. The unmet need of old people will be uncovered.

This chapter will attempt to illustrate how the poor law principles underpinned attitudes towards old people's care in Oxford. The CRH was providing a welfare service and, whilst not of today's standards, without this some old people would probably have suffered further.[87] Professionals' testimonies will be employed to show how the CRH was recognised as a necessary service, but in addition will illuminate the hatred of the institution by the community. Relatives' evidence will reveal a more complex picture in their attitudes towards the CRH. Rooted in their attitudes was the fear of an institution of which few had had any direct experience.

These attitudes may well have had "knock-on" effects for the care of old people. The stigma of admission of a family member into the workhouse has been well documented.[88] Logically the stigma relates to the attitude and vice versa, and this may well have influenced family's attitudes towards providing care for elderly relatives.[89] An insight into family dynamics and consequent arrangements for older relatives has been gained from the oral histories. By locating local infrastructures available to old people this chapter will examine patterns of caring by families. Attitudes, expectations and family responsibilities towards older relations at a time when there was little state help, reflect a community's approach to old people. As there is minimal documented information available on how old people and their families managed during this time, then this initial evaluation gives an essential baseline from which to measure the process of later change. Instilled attitudes towards the legacy of the workhouse in

[87] See Crowther, Workhouse, p. 269; A Digby, Pauper Palaces, (London: Routledge and Keegan, 1978), pp.13-14, the author suggests that in the context of the period the union workhouses in Norfolk under the New Poor Law effectively provided a welfare system.
[88] See J Finch, Family Obligations and Social Change (Cambridge: Polity Press, 1989), pp. 57- 85.
[89] E. Roberts, Women and Families: An Oral History, 1940-1970 (Oxford: Blackwells, 1995), pp. 175-196.

Oxford left a mark in the city. Were these fears of the workhouse justified and did they influence later take up of care for old people? This theme will underline much of this thesis.

The development of geriatric medicine is crucial in the history of old people's welfare as the majority of residents and in-patients in public assistance infirmaries were aged. Chapter Four seeks to discover whether there were any significant changing medical attitudes pre-and post-NHS which influenced old people's care. Doctors in the hospitals and in the community were on the front line when it came to the care of old people. Those working in hospitals witnessed institutional conditions and problems, while doctors in the community were confronted with the poor environmental circumstances that old people lived in. This chapter explores these issues by using original material from the doctors who worked with old people before 1948 and in the early days of the NHS. Articles by doctors working with old people published in medical journals before 1948 have been analysed, together with an oral history collection from the national pioneers of geriatric medicine, in order to present a picture of what doctors were identifying as major problems.

These rich sources of data raised a number of issues that doctors were confronting both within their profession and on more general levels. Within the hospitals one of the primary concerns was the high rate of hospital beds occupied by old people and the length of hospital stays. There were two aspects to this concern which spanned pre- and early-post-NHS eras. First beds were being blocked,[90] and, secondly, some doctors questioned why old people should be hospitalised and introduced new treatment methods to expedite their discharge.

Bed blocking was of particular significance during the Second World War as beds were needed for civilian and military casualties. Later, when hospitals were under the jurisdiction of the NHS, questions were raised as to the economics of old people occupying beds in general hospitals. Meanwhile, in 1947 a group of doctors who had been specialising in work with old people had formed a professional organisation called the Medical Society for the Care of the Elderly. This society addressed medical issues and also became involved in campaigning for changes in old people's welfare by participating in campaign groups such as the National Old People's Welfare Committee

[90] Bed blocking is a relatively new phrase, and used to describe the process of old people being hospitalised for longer than necessary as alternatives are not available.

(NOPWC) and the research group, National Corporation for the Care of Old People (NCCOP). Specialising in geriatric medicine was not regarded as a high status position within the medical profession, and a certain degree of cynicism by their contemporaries towards those practising in this area reflected a more general prejudice towards old people. Arguments developed within the profession suggesting that the creation of geriatrics as a speciality would marginalise old people even further, and that old age would itself become medicalised.

Poor law medical officers were practising in run down old buildings, some in appalling conditions, and although promises were made that the welfare state would improve facilities, in reality many poor law institutions were retained particularly for old people. Some of these establishments had inherited staff who had worked under a poor law ethos so that doctors keen on making changes came up against staff resistance to change. Evidence is apparent in the doctor's testimonies that, in conjunction with the general low priority given to old people's care, combined with out-dated poor law influences, changing attitudes and provision was indeed an enormous challenge. The chapter thus intends to illustrate the prejudice towards old people inbuilt in social provision which in turn determined their welfare services.

Becoming a geriatrician was considered by some as a back door route to consultancy and not a primary career choice.[91] Whilst there might be some truth in this theory there are also some other reasons why doctors chose to specialise in geriatric medicine. Chapter Five follows the career path of one eminent geriatrician, Dr Lionel Cosin and traces his developments in geriatric medicine. As one of the earlier pioneers of gerontology he was involved in government discussions laying down the plans for old people's care under the welfare state, he was a co-founder of the Medical Society for the Care of the Elderly and was instrumental in changing treatment methods for old people. Dr Cosin was appointed as the clinical director of CRH in 1950, two years after the transfer to the NHS. Given his background and philosophy this chapter aims to examine if, and how, his appointment contributed to changes in the CRH in the early years of the NHS. This was a considerable task in view of the community's outlook, professional attitudes to old people, government policy and an outdated establishment. All these general aspects have been the focus of previous studies, and contribute in

[91] M. Jeffreys, 'Pioneers of Geriatric Medicine' in J. Bornat, R. Perks, P. Thompson, J. Walmsley, (eds.), Oral History, Health and Welfare (London: Routledge, 2000), p.77.

some way, to the slow rate of progress in the development of old people's care post welfare state. Crowther describes how fear of workhouses engendered strong community feelings.[92] Means and Smith make strong arguments that old people's welfare services were inferior and explain how this emanated from government policy.[93] By charting the development of geriatric medicine Thane outlines the argument proposed by some practitioners that this speciality would medicalize old age.[94] This thesis asks whether Dr Cosin played an important role in accelerating change in the delivery of up-to-date care for old people in Oxford.

By analysing national and local oral testimonies by professionals who worked with older people, and were aware of Dr Cosin's professional philosophies, this study seeks to identify whether Dr Cosin was responsible for changing practice and care in the CRH. There is no doubt that change was effected in the CRH following his appointment, but emerging from the oral histories is a more intricate portrayal of professional development and rivalries in the institution.

Positive changes for old people in the CRH were certainly recognised and acknowledged by professionals but community recognition was slower. In Chapter Six relatives' perceptions of how the introduction of the welfare state affected old people's lives are disclosed. Comparisons are made of the use by the community of the CRH pre-and post- welfare state. In the light of the assertions regarding the reputation of the CRH, the struggles in the development in geriatric medicine and the general discrimination against old people, rapid change of attitudes in the community would have been improbable. Recollections of the transition to the welfare state will illustrate the speed and extent of adaptation to a new system, and attempt to ascertain the degree to which local professionals contributed to this process.

Improvements in health care were not the only developments for old people made under the auspices of the welfare state. Other services were provided - mostly residential provision - particularly in response to local need. A scrutiny of evidence from testimonies on the take up of facilities is balanced against possible shifts in family responsibilities arising from demographic factors. Patterns of care which were associated with gender imbalances are explored. Society was changing fast, some

[92] MA Crowther, Workhouse, pp. 267-272.
[93] See Means and Smith, Development, pp.121- 166.
[94] Thane, Old Age, pp. 436-457 discusses the issue of medicalizing old age in relation to the emergence of geriatric medicine.

people adapted quickly and took advantage of facilities, others still depended on family support. There was no prescriptive model to adopt. By the end of the 1950s the provision of OPHs had increased, some community facilities had been introduced and the CRH began to expand. Evidence suggests that more people were using these facilities. The chapter argues that there are probable indicators this was the beginning of a turn round in attitudes and expectations.

A case study of Oxford City is examined in Chapters Seven and Eight, with the intention of assessing whether old people's care in Oxford was representative. With the benefit of combined documentary and oral sources, this will be measured by using the studies by Rowntree, Sheldon and Townsend for national comparison. Information from the Oxford MOH reports presents an epidemiological and demographic profile, and this is complemented with accounts by relatives of their experiences of health problems by elderly people. Documentation of the chronological bureaucratic changes will seek to show how the city implemented new legislation in Chapter Eight. The case study gives the opportunity to discover unmet historical needs. One outstanding area of need was the lack of care for old people with mental health problems (dementia). As this was raised in the national and local oral collections and the MOH reports, the inference must be that there was little understanding of the condition by the authorities.

Within the political, economic and social framework outlined above this thesis has sought to unravel what lay behind the fear of the workhouse during the middle decades of the twentieth century, despite a substantial change in policy and legislation which altered the way old people were cared for. In addition the thesis has attempted to show how these radical changes affected the perception and attitudes of the community towards care for old people.

An original study

There were several nationally renowned studies on the welfare of old people undertaken in the late 1940s and 1950s. Seebohm Rowntree's survey on the problems of ageing and the care of old people in 1947 highlighted generic issues of old age.[95] A survey of social and health needs of old people in Wolverhampton was carried out by Sheldon in 1948.[96] In the 1950s Townsend reviewed poverty and dependency amongst

[95] See Seebohm Rowntree, Old People.
[96] JH Sheldon, Social Medicine.

old people.[97] Rowntree illustrated the limitations of institutional care; Sheldon noted the proximity of children living near their parents; and Townsend commented on how old people chose to live independently. Although attempts were made to gather personal information about old people's lives through these studies the process of growing old was not fully investigated. Most of the studies were carried out from a sociological and medical perspective rather than recording information for historical purposes. All three studies offer first hand experiences of the lives of old people in an informative national context. This study has used this previous research as a general context for a local study which will further develop understanding of the lives of old people. What is of particular importance in this study is that by using oral history methodology, relatives are able to recall how old people managed their lives as they aged, during a time when facilities and services were limited and undeveloped. Information has also been collected from professionals who were working "on the front line" with old people before and at the start of the welfare state. Combined together these oral histories provide a unique study of the collective process of change in a community from the poor law to the welfare state.

Previous studies have not addressed the process of change from this perspective. They have mainly concentrated on services, facilities, family relationships and poverty. Whilst these aspects will be incorporated into this thesis a distinctive dimension here is that the information comes from people who have witnessed events. As today's older population increases and we are all expected to live longer, knowledge on how old people coped in the past will help us to understand how contemporary society's attitudes have evolved. An example of this would be the change in attitudes towards old people spending time in an institution such as hospitals, nursing homes or Old People's Homes (OPH) as today these establishments do not have workhouse connotations.

For some very old people admission to an institution even today will still have some negative, or stigmatising implications associated with poverty and social standing, but in all likelihood these attitudes are diminishing. Other aspects of life that altered over the years for old people include medical changes, family expectations and patterns of caring. This investigation will explore how old people and their families adapted amid the radical social changes of the inception of the welfare state.

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[97] Townsend, Family Life.

CHAPTER TWO

Methodology

A historiographical introduction to the political, social and economic context of old people was presented in Chapter One. Before 1948 an old person without adequate financial and social means would probably have had to be admitted to the workhouse, but the workhouse produced, or aroused a particular revulsion in the community. In order to discover some answers to the questions posed in the previous chapter, such as how did old people and their families manage in the 1930s; whether attitudes towards state care changed following the inception of the welfare state; and whether the Cowley Road Hospital was still seen as a workhouse after 1948, a combination of methodologies will be used. Further aspects of these political, social and economic areas will be explored, and related to the methodology employed for my thesis in this chapter. The study investigates the process of ageing from personal perspectives, and contextualises local administrative and practical changes arising from legislation. Welshman compared national policy for old people's services with local provision under the 1946 NHS Act, from 1948 to 1974, and used a case study of Leicester to illustrate this.[1] He also related his findings to the general "decline" of the traditional public health administration in England and Wales between 1948 and 1974. Some aspects of his work overlap with the period under review for this thesis and comparisons will be made in later chapters. This study differs from Welshman's in that it uses oral sources as well documentary sources to provide a community perspective, and is not confined to the 1946 NHS Act.

The focus in this thesis is Oxford City. Oxford's population, age structure and health profile were consistent with the national profile, as illustrated in Chapters One and Seven. A case study of Oxford City in Chapters Seven and Eight will give an opportunity to illustrate how one city responded to social, legal and political change in its provision for older people. This has enabled a chronological account of these changes to be measured and evaluated within a national context.

Primary sources consisted of specialist medical literature in medical journals, social surveys, official papers, reports from voluntary agencies, oral history collections of

[1] J. Welshman, 'Growing Old in the City: Public Health and the Elderly in Leicester 1948-1974', Medical History, 40, (1996), pp. 74-89.

early pioneers in gerontology, newspapers and professional writings. Social surveys carried out by Rowntree, Townsend and Sheldon are also used. Some local surveys received national attention and are employed to provide baselines and reference points to identify how other areas provided for older people. Official papers referred to include census data for 1921 and 1951, government reports and command papers. These documents gave a political and social context to the study. Secondary sources provided analysis on significant aspects of the history of welfare provision for older people.

Local documentary sources consulted include Oxford Health Authority reports post-1948; city council reports from 1920-1966; local MOH reports (up to 1965); newspaper reports 1930-1960; St Lukes Archives, (a nursing home established in the 1950s); miscellaneous documents located in Oxfordshire Public Record Office; and in the health authority archives, such as notes made by the head occupational therapist in the early 1950s and Radcliffe Infirmary Annual Reports. Data collected from local sources made up a picture of care for older people in the city. Health and social care archives illustrate administrative aspects associated with older people's care in the city, and show how government guidelines and legislation were interpreted, particularly at the time of the change over from the poor law to the welfare state. MOH reports provided insight into local medical priorities and show concerns for the health of older people. Newspaper reports highlight issues about older people that were considered to be of public interest. Editorials also followed national discourse on development in care of older people.

Unfortunately records from the CRH and the Laurels (Oxford's other workhouse) were destroyed but city council and health authority reports were available for documentary evidence. During the course of my research I met with Dr Cosin's family members who kindly donated his private papers to me.[2] This collection of papers has informed my research particularly in relation to the development of geriatric medicine. In addition, the papers of Dr Cosin provide information of his own career path, a record of his publications, and progress in the CRH post-1948. Dr Cosin's archives compose his biography, give further dimensions to the medical literature and profile his work within the context of the development of gerontology pre-and post-welfare state.

[2] These papers are now stored at the Centre for Health, Medicine and Society at OBU and a hand list is available.

Oral histories will play a big part in this thesis and are important on two main counts. First, families have their own histories which contribute to a local framework and ultimately shape a community.[3] Detailed information about people's lives in a community will trace how shifts occurred during a time when society was changing quite fast, and reflect a micro picture of the national situation. Secondly, aspects of local history can vanish, and in this context, it is the history of CRH that could vanish. How the community related to this institution has never been examined in detail and CRH represented national policy for many decades. Within this study triangulation methods have been used, and this methodology underpins the thesis throughout. Combined together oral and documentary sources will give a fuller picture of a community's experience of ageing in relation to an important institution in the city.

People interviewed for the study came from two groups, relatives of old people and professionals who worked in health and welfare departments. Their contributions will be focussing on memories of care for old people before the welfare state and post welfare state. Relatives, (dependent on their age) will recall how their grandparents coped before 1948, and their parents after the change to the welfare state. Some respondent's parents were elderly well before 1948, and some of the professionals who originated from Oxford also contributed on a personal level. A collection of oral histories from pioneers of geriatric medicine has been used for this work and provides a national context of medical services and facilities.[4]

Oral history

A fundamental question to be addressed is why oral history is being used in this thesis. Tonkin suggests that using memory can help to make sense of the past and understand the future, and that individual memory is often representative of collective memories.[5] Critics of oral history argue that memory can distort history, and that consequently there will be problems with collective memory. Historians working with oral evidence have the task and opportunity to demonstrate that this method complements rather than threatens traditional approaches. In the context of the thesis, oral sources will be used to suggest how inherited practices influenced new systems - that is the change over from

[3] S. Caunce, Oral History and the Local Historian (Esssex: Longman Group, 1994).pp. 6-26.
[4] M. Jeffreys, 'Geriatrics as a Speciality' C512 was collected during 1991. The collection is held at the British Library in the National Sound Archives.
[5] E. Tonkin, Narrating our Pasts: The Social Construction of Oral History (Cambridge: Cambridge University Press, 1992), p. 12.

poor law to welfare state. Understanding how people perceived this change provides extra dimensions that may possibly challenge some stereotypical assertions.

For the purposes of this thesis changing over from the poor law to the welfare state can be seen from three levels, the bureaucratic, professional and personal. The bureaucratic perspective is documented in official reports but there are unanswered intriguing questions involving the second level such as how did the local professionals anticipate and respond to the inception of the welfare state? Older people and their families had expectations that things would be different, and on the third level it will be useful to discover whether, and how, they used the new services. Finding out the answers to these questions will give some insight into perceptions about services for older people pre- and post-welfare state that bureaucratic sources do not address. Compared with the administrative records the testimonies provide more illustrative data, particularly on personal levels of experience of the system. Additionally the testimonies indicate how the system was - or was not - working in specific areas. Oral histories, therefore, will open up different areas of interest and additionally will give a perspective of "history from below".

Lummis considers that: "Oral evidence not only adds to our understanding of documents, but occasionally illuminates how people used them."[6] He illustrates his point by using an example from his own research, demonstrating how birth certificates were manipulated for families' convenience. In her study of contraceptive practice, Fisher considers that oral testimonies collected for her study provided information not covered in survey questionnaires, and offered a new perspective in the historical debate on contraceptive practice. Her view on the benefits of oral history as a collection of data can be more generally applied as she suggests that the semi-structured interview format allows for more questioning than a traditional approach: "The communication between interviewee and interviewer gives the historian unprecedented scope to explore and delve into particular questions and issues. Few social historians can guarantee that their concerns will be addressed by their sources, oral historians by contrast can select the agenda and ask whatever questions they like"[7] Fisher further stresses the uniqueness and advantages of oral history that enable important different perspectives to be discovered in historical studies:

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[6] T. Lummis, Listening to History (London: Hutchinson, 1987), p. 80.
[7] K. Fisher, 'An Oral History of Birth Control Practice, c1925-50: A Study of Oxford and South Wales' (unpublished PhD thesis Oxford University, 1998), p. 47 and p. 297.

> It is the respondents' complex representations of the intricacies of their contraceptive choices, negotiations and conflicts, which have formed the core of this thesis, and reveal the unique value of the methodology of oral history. It is the sole means of recovery of these vital and intimate perspectives which can radically challenge the understanding of major demographic and social changes.

Oral testimonies are unique. They reveal events that happened in the privacy of people's homes; incidents that generally do not get mentioned in documentary sources and were probably related by people who have not been previously canvassed for their opinions. This is certainly the case for the majority of respondents in this study, (excluding the professionals). Furthermore, Lummis is of the opinion that oral histories: "Recapture the actual activities of people who never voluntarily participated in formal organisations."[8] It is essential to understand that much of the caring of older people was done in the isolation of people's own homes at a time when requesting help from statutory agencies was often not considered an option. No formal organisation, other than pressure groups were representing older people's interests, although pension provision was taken up by the trade union movement. Little is known about these individual circumstances. One of the aims of this investigation is to discover more about the experiences of older people and their families during this period of time. Relatives' testimonies, as well as those involved professionally, and as carers, are used in this study to record the process of change in the perception of ageing. By using this methodology the thesis aims to illustrate that there was real change in perceptions of institutions and care during this period. Testimonies are used to illustrate lives of older people in Oxford from a citizen's perspective.

Writers on black working-class history have suggested that collecting oral evidence has the advantage of: "Highlighting aspects of working-class history which are passed over in the official and semi-official literature that exists and the works of conventional historians."[9] This claim can be extended to apply to the historical studies of older people. Oral sources are appropriate materials for historians to use their "traditional critical skills" since they offer a "...unique insight into the formation of popular historical consciousness – something which should be of abiding interest to all historians."[10]

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[8] Lummis, Listening, p. 81.
[9] H. Goulbourne 'Oral History and Black Labour in Britain: An Overview', Oral History Journal, 8:1 (1980), pp. 24-34.
[10] Tosh, Pursuit, pp. 206-227. Tosh outlines his criticisms of oral history in this chapter but identifies the strengths that oral history can bring to the discipline.

Indeed there is a dearth of oral information on old age. Roberts' oral history study on the lives of working-class women included examination of the relationships between kin, and addressed family responsibilities in caring for their elders. Roberts concluded that there was a mixture of support for old people in the community for kin and non-kin older people.[11] Her study explored a wide range of aspects of working-class women's lives, but the information on older people's lives is limited. The process of ageing from a familial perspective is notably missing. However, Jeffreys interviewed professionals, particularly doctors, involved in the early development of geriatric medicine. Her project provided oral evidence on how doctors throughout the country treated older people, facilities and services available for old people, the response of the medical profession to the development of gerontology, the role of doctors in establishing policy for older people's welfare and personal career plans. [12]

Oral history theory and methodology

Respondents for this investigation were recruited via a snowballing technique; after the interview, respondents were asked if they knew others who might participate in the study. To generate initial interest a letter was sent to the Assistant Director of Social Services requesting permission to interview volunteers in old people's homes (OPHs). Another letter was sent to the Red Cross, who ran a Home from Hospital Scheme at the local hospital, and an article based on this letter was written in the Oxford Third Age Newsletter inviting people to participate. Such methods involved two levels of recruitment. When an intermediary was involved, such as the head of an OPH, (s)he initially approached the respondent, whereas when a recommendation by a friend was made the first approach, was made by myself. Selection of residents to interview was dependent on the head of home and may have been based on particular criteria, such as popularity, articulacy and other factors. Either way when contact was eventually made by myself, respondents had the brief of the study explained to them, and what the interview would entail. For those referred by a friend this first contact was usually over the telephone, and the potential respondent had the opportunity of whether or not to

[11] E. Roberts, Women and Families, an Oral History, 1940-1970 (Oxford and Cambridge: Blackwells, 1995), pp. 175-198.
[12] M. Jeffreys, 'Recollections of the Pioneers of Geriatric Medicine Speciality' in J.Bornat, R. Perks, P. Thompson and J. Walmsley, (eds.), Oral History, Health and Welfare (London,: Routledge, 2000), pp. 75-97. Also see Jeffreys, 'Geriatrics'.

proceed. Those who participated in the study had an interview arranged at the respondents home or an OPH.

At this juncture, the issue of informed consent was addressed and started with respondents being given a more detailed explanation of the study. Informed consent is of considerable importance for participants and a moral obligation for the oral historian; it was essential that respondents were made aware of the purpose of the research and what was expected of them. Participants were informed that they could withdraw from the interview at any time and assured of their anonymity and confidentiality. They were also told how the information they contributed would be used in the thesis, for seminars and publications. Several participants did not mind their real names being used, but to give uniformity as others did not, initials are used to identify respondents. Permission was again requested to tape record the interview. If the potential respondent was unhappy about proceeding, then there was a further opportunity for them to withdraw from the study. Some respondents were prepared to talk to me but did not want to be taped. Their biographical details are not included. Two other people were visited but were inappropriate to interview. A consent form designed by the National Sound Archives was signed.

Yow balances the risks of harm to the participants as small in comparison to the good resulting from the research. Dilemmas were encountered over some aspects of informed consent, as in order to obtain oral histories without bias, too much detail about the study's aims and objectives should not be disclosed as participants may wish to slant their responses to please the researcher. Yow poses a question: "By not telling all, do I leave the narrator vulnerable to harm?"[13] Answering this provided a framework to measure that participants were aware of the general scope of the study. It was important that their contributions were made without being unduly influenced. Being aware of the balance between extracting personal information from people, and enabling them to contribute information, is a challenge for the historian and essential from the outset.

Rolph describes her work with a vulnerable group of people and shows how oral history research with people who have learning difficulties has presented ethical dilemmas as accessing these people usually entails a bureaucratic explanation procedure with professionals making decisions on whether the participant can be

[13] V. Yow, Recording Oral History, A Practical Guide for Social Scientists (London: Sage, 1994), pp. 89-91. Yow discusses informed consent and the problems with the need to restrict bias.

approached. There is a balance between offering and ensuring confidentiality for people who have no control or knowledge of their records, and enabling them to choose to articulate their views. Rolph considers there is no easy answer to ethical dilemmas.[14] During the collection of these oral histories for my research I was well aware of these dilemmas and practised within ethical boundaries by being honest and open with respondents. For example, whilst ensuring respondent's names are not divulged there are occasionally circumstances described which can identify the person. Fortunately this was not a common experience, and generally speaking, those that could be identified corresponded with those who were happy to use their real names. Mauthner and Birch discuss the complexities of researching private lives and placing them in the public arena. These are debated within a social sciences domain but the ethics underpinning the practice can equally be transferred to oral historians, and I have found their discussion of the ethical issues very helpful.[15]

Historians' sampling techniques discussed by Hudson, were given consideration, and although this study is not intended to be statistically reliable, I have attempted to interview as wide a group as possible.[16] An interesting perspective on representation is put forward by Bertaux, who suggested that other aspects have to be taken into consideration, and proposes a different perspective on representivity when using this methodology:

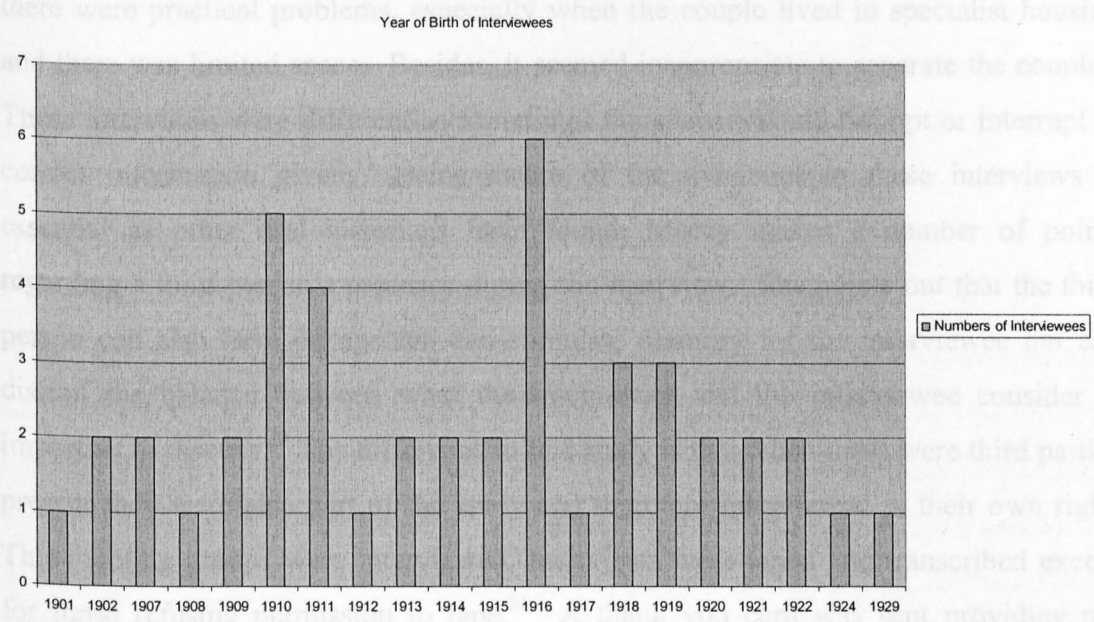
> We gathered about thirty life stories from bakery workers, the first life story taught us a great deal, so did the second and the third. By the fifteenth we had begun to understand the pattern of socio-structural relations which makes up the life of a bakery worker. By the twenty-fifth, adding the knowledge we had from stories of bakers, we knew, we had it: a clear picture of this structural pattern and of its recent transformation. New life stories only confirmed what we had understood, adding slight individual variations. We stopped at thirty: there was no point going further. We already knew what we wanted to know.
>
> Thus we went through a process of 'saturation of knowledge' this process confers to the idea of 'representivity' a completely different meaning. In short we may say that our sample is representative, not at the morphological level (at

[14] S. Rolph, 'Ethical Dilemmas: Oral History Work with People with Learning Difficulties' Oral History, 26:2 (1998), pp. 65-71.
[15] M. Mauthner, M. Birch, J. Jessop and T. Miller (eds.), Ethics in Qualitative Research (London: Sage, 2002). This collection by social scientists discusses a variety ethical issues arising from qualitative research, ranging from informed consent to conflicts in practice.
[16] P. Hudson, History by Numbers, An Introduction to Quantitative Approaches (New York: OUP, 2000), p.10, outlines the historians perspectives in sampling theory.

the level of superficial description), but at the sociological level, at the level of socio-structural relations.[17]

Over 65 people from different areas in Oxford City were interviewed for this study. Figures 7.2 and 7.4 in Chapter Seven tabulate the distribution of respondents' childhood and adult homes across the city. Seven people were not recorded and their details have not been used for statistical purposes. Respondents were aged over 75 years from the beginning of the interviewing date in 1997, and had to have lived or worked in Oxford between 1930 and 1960.[18] This gave them the opportunity to remember their grandparents' lives from the 1920s onwards pre-welfare state; and their parents' lives from the 1950s post-welfare state. The respondents lived in different areas of the city and came from different social and class groups.

Figure 2.1: Age Profile of Respondents



Source: oral histories

Respondents were from two groups: those who were in professional occupations concerned with caring for older people during 1930 – 1960, and those who had personal community experience of older people. See Appendix A for personal details on the respondents.

[17] D Bertaux, 'From the Life-history Approach to the Transformation of Sociological Practice', in Bertaux (ed.), Biography and Society, (London: Sage, 1981), p. 37.
[18] Two respondents were under the age of 75 years.

All the respondents had lived in Oxford City at some time between the 1930s and the 1960s. Illustrated in Figure 2.1 are the age profiles of respondents. The ages of respondents in 1930 ranged from one year to 22 years old, and in 1960 the youngest respondent would have been aged 31 and the oldest 53 years. The professionals interviewed were from the following occupational backgrounds: general practice, nursing, occupational therapy, physiotherapy, social work, police force, voluntary work and local politics.

The respondents were interviewed in their own homes (or in an OPH). Gauging the length of the interviews was important as some of the respondents got quite tired and it was necessary to have a second interview with four respondents, two of whom were professionals, and two who were relatives. Two married couples were interviewed together. Consideration was given to the possibility of interviewing separately but there were practical problems, especially when the couple lived in specialist housing and there was limited space. Besides, it seemed inappropriate to separate the couples. These interviews were different as sometimes the spouse would prompt or interrupt to correct information given.[19] Being aware of the dynamics in these interviews is essential as other oral historians have found. Macey makes a number of points regarding a third person's presence during the interview. She points out that the third person can also have an agenda, can stimulate memory for the interviewee but can disrupt the balance between what the interviewer and the interviewee consider is important to discuss.[20] The difference in this study is that when there were third parties present they were also part of the study and therefore interviewed in their own right. Three sibling groups were interviewed. Interviews were taped and transcribed except for those refusing permission to tape.[21] A thank you card was sent providing my telephone number and address, and an invitation to contact me if they remembered anything else. Whilst recognising that the oral historian is not a therapist, talking to people about family history may provoke uncomfortable memories.[22] Collecting the

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[19] P. Thompson, The Voice of the Past (2nd edn., Oxford: OUP, 1978), p. 121, acknowledges the problems of this scenario.

[20] B. Macey, 'Social Dynamics of Oral History Making: Women's Experiences of Wartime', Oral History, 19:2 (1991), pp. 42-48.

[21] Four interviews are not recorded three of these were professionals. One doctor wrote his own account of the CRH, another professional did not want to pursue with recording, a social worker was interviewed over the telephone and wrote a letter, and for one person the tape recorder did not work

[22] A. Thomson, 'Anzac Memories: Putting Popular Memory Theory into Practice in Australia', Oral History, 18:1 (1990), pp. 25-31, makes the point that oral historians are not going to be around to pick up the pieces of memories that "were no longer safe".

information and leaving people without further contact seemed a stark ending after such an intimate discussion. Sending a card acknowledged the help and contribution that had been given by the respondent, and hopefully made them feel valued and respected. Two people did reply to the card, one to clarify information given during the interview and the other to invite me to an exhibition.

National and local documentary sources established the basis for the interviews[23] and a background understanding of context.[24] One of the advantages in using oral history is the opportunity to question previous decisions either in a bureaucratic or a family context, and this information can help to provide a fuller historical picture.[25] Two examples of this can be illustrated at this juncture. First, one of the participants was a member of Oxford City Council in the 1950s and was able to respond to questions regarding decisions made by the council at that time. Secondly, family members were able to describe how decisions were made in the families about the care of their older relatives. The interviews were carried out with open questions, were designed to be flexible in order to accommodate the person's experiences, and were based on a life history approach. There was no note taking during the interview. The tape recorder was generally used to record all the information, and this then left the interviewer free to engage with the interviewee without distractions.[26]

A number of basic ground rules when conducting an interview were adopted. In order to establish good communication, the interview should be addressed in an equal manner and the interviewer must be aware of her power in an interview situation. Inter-personal skills play an important role in interviewing and can influence the quality and quantity of the information received. The researcher should not engage in conversation with the interviewee as it is important not to influence the latter's contributions. Effectively a one-sided relationship is being created with the researcher collecting information on personal details, and not giving out any of their own background.

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[23] These primary sources include Oxford City Council Minutes and Reports, Oxford Mail and Times articles, national surveys (Seebohm Rowntree, Townsend and Sheldon) and medical literature. Contemporary writings also contributed to the overall picture.

[24] There are other methods that can be used to collect and analyse oral histories for further discussion see A. Straus and J. Corbin, Basics of Qualitative Research, Grounded Theory Procedures and Techniques (London: Sage, 1990), and B. Glasner and A. Straus, The Discovery of Grounded Theory, Strategies for Qualitative Research (New York: Aldine, 1967).

[25] Yow, Recording, pp. 10-11, outlines the importance of being able to question bland decisions recorded in institutional documents and also to question how family decisions were made "..that in the aggregate influenced history but are nowhere written down..."

[26] This is a method recommended by P. Thompson and R. Perks.

Whilst information that is given is dependent on the respondent Portelli makes the point that the historian is in control of the historical discourse, as they are responsible for the selection of respondents and the questions asked.[27] On the other hand collecting oral histories provides a voice for people who are not normally heard and, in this case, the care of, and welfare for older people is being explored. Other issues can influence the balance of interviews, for example class, gender, race and age differences can make significant barriers and could influence contributions.[28] Certainly these factors played an important role in this research since interviews ranged from the older male professional's attitude to a younger female researcher with no medical knowledge, to an older working-class man suggesting that if you have not lived through the 1930s and 1940s it is difficult to understand the experience.

Inevitably interviewees from whatever background will decide to edit their contribution for whatever reason. This may be related to professional reasons or conduct, individual privacy, or both. People may feel that particular memories are irrelevant or may be shameful. Portelli presents a view that the silences can be seen as respondents exerting power in the interview:

> ...'Revolutionary vigilance' (keeping certain things from an interviewer who comes from another class and may make uncontrolled use of them) is attenuated; and the opposite attitude, a consequence of class subordination (telling only what the informant thinks may be relevant from the researcher's point of view rather than his or her own) gives way to more independent behaviour.[29]

Respect has to be given to the respondent and painful memories provoked by the oral history interview may not be appropriate to discuss. In sessions where childhood is recalled there are bound to be occasions when people have upsetting and unresolved memories brought back. Silences could be as a result of recollections of difficult reminiscences. During her oral history collection, Field encountered an interview where the questions triggered off memories of a traumatic childhood. The respondent did not continue whilst the tape was running, but explained further details when the tape was

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[27] A. Portelli, 'The Peculiarities of Oral History', History Workshop, 12 (1981), pp. 96-107.
[28] K. Olson and L. Shopes, 'Crossing Boundaries, Building Bridges: Doing Oral History among Working-class Women and Men' in S. Berger Gluck and D. Patai, (eds.), Women's Words, The Feminist Practice of Oral History (New York and London: Routledge, 1991), pp. 189-203. The authors confront these issues in their research and relate this to the status of particular groups in the community in a wider context.
[29] See Portelli, 'Peculiarities'.

off but these were outside the remit of her work.[30] Similar situations occurred in some of my encounters and respondents would ask me to turn off the tape and provide personal information about a family member that was often outside the scope of the study. These incidents can explain silences, in that they are too personal and inappropriate to recall with a stranger and, because they are effectively "illicit", possibly recriminating, respondents did not want them recorded. However, silences are significant and can represent both a personal and a wider political perspective. Diana Gittins suggests that "Silences are thus created consciously, unconsciously, and at a number of levels, not just within individuals but among the collective generally. Silences are, in the widest sense political."[31] Echoes of this were experienced in this study with regard to professional's experiences of the CRH, particularly before the reforms of 1948. (Chapter Four further examines professional practice during this time and deals with aspects of silences in this context, especially in relation to the passage of time and developed experiences). One should avoid both over interpreting silences and personal intrusion. Anderson and Jack suggest that the role of the interviewer has a specific role and consider the interviewer's need to be sensitive to privacy and integrity and thus to follow the narrator.[32]

Interviews were constructed with the above in mind. For the first interviews it was important to assess what memories were being recalled by the respondents. This gave the opportunity for a respondents' perspective to be presented. Each person had a unique experience, but similar patterns emerged and were cross-referenced with documentary information. Bloom has identified a general process in learning. His cognitive domain is based on six steps of knowledge, comprehension, application, analysis, synthesis and evaluation. Based on my experience as an oral historian, there was considerable relevance for these steps in the process of interviewing.[33]

Taking an oral history is a skilled task for the historian. Whilst the person is giving information there is a sophisticated process in action for the interviewer. Previous

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[30] K. Field, 'Children of the Nation'? A Study of the Health and Well-being of Oxfordshire Children, 1891-1939' (unpublished Ph.D thesis, Oxford University), p. 99.
[31] D. Gittins, 'Silences: The Case of a Psychiatric Hospital' in M. Chamberlain and P. Thompson (eds.), Narrative and Genre (London, Routledge, 1998), p. 46.
[32] K. Anderson and D. C. Jack, 'Learning to Listen: Interview Techniques and Analyses' in S. Berger Gluck and D. Patel (eds.), Women's Worlds, The Feminist Practice of Oral History (New York: Routledge, 1991), pp.11-25.
[33] See B. S. Bloom, Taxonomy of Educational Objectives. The Classification of Educational Goals (London: Longman 1979) (Vol 1Cognitive domain, Vol 2 Affective domain). (First published in 1956) Bloom expands his educational objectives in these volumes.

knowledge from documentary sources is being recalled, as is information from other respondents. This informs the interviewer on how to follow up with appropriate questions related to the personal details of the current interview, whilst putting previous information into context. As more oral histories are collected then there is more information to process so that the procedure becomes more detailed. Patterns and similarities emerge and contribute to the validity and reliability of the evidence. Bertaux contributes further by suggesting that such a synthesis is an ongoing process, bringing together life stories, statistics and every piece of evidence.[34]

Oral history provides a unique methodology to recapture the detail of changes in institutional and collective perceptions. However, as this study was addressing specific questions regarding the welfare of older people and the place of an institution, some boundaries had to be established. This posed some problems in collecting the data, as the reason for using oral histories was to open up new lines of enquiry from a different focus.[35] Using a life history approach generated an immense amount of data. Delimiting the area of investigation is known to be difficult as there are many interesting aspects to study. Bryman provides various examples of other methodologists, particularly those studying ethnography, who have run into difficulties in framing a research question prior to fieldwork and subsequently misconstrued their data, and acknowledge the importance of flexibility in ethnographic research.[36] In view of the wide potential of information from the oral histories and the aim of uncovering new perspectives, a balance had to be struck in order to address the research questions. This study wanted to discover how older people were cared for between 1930-1960. As it was extremely unlikely that there would be anybody alive who was old during this period, the information would have to come from descendants and professionals, who worked with older people during this time. Family members would be able to inform the study of more intimate private details whereas the information collected from professionals would be on a more general level. However, some of the professionals had lived in Oxford as children and voluntarily contributed information on their own family's experiences. The original plan was to interview family members about their grandparents' care pre- welfare state compared to the care of their ageing parents in the

[34] D Bertaux, Life-history', p. 40.
[35] P. Thompson, Voice, p. 7.
[36] A. Bryman, 'Contemporary Social Research: 18 Series' in M. Bulmer (ed.), Quantity and Quality in Social Research (London: Routledge, 1988), p. 99 illustrates these points.

1950s after the inception of the welfare state. Given the diversity in ages of the respondents and consequently their parents and grandparents it has been difficult to separate pre- and post-welfare state experiences as the cut off time is not simply defined.

The oral history interviews have provided information for quantitative analysis. The information used for quantitative analysis is based on factual data such as year of birth and death, demographics and family construction. On occasions some people did not have all the biographical details available, and, for example very few people knew when their grandparents were born, or their date of death. Given this situation, approximate times had to be estimated by working out the date of the grandmothers' death by reading through transcripts and calculating dates. For example, from comments such as, "my grandmother died when I was 13 and she was about 76." Based on this information some comparisons can be made with the previous surveys, and these are evaluated in Chapter Seven.

The reliability of memory was an important issue. It is unavoidable that older people will get confused at times, but in this research, aspects of evidence are measured against each other, that is city council minutes and newspapers are triangulated with interviews. This is a procedure recommended by Lummis to cross reference and identify any discrepancies.[37] On occasions dates and place names may have been inaccurate but much of the information for the purpose of this study is based on perceptions. This is of course a contentious point with some historians as the perceptions will be considered subjective and retrospective. But I agree with Portelli who considers that: 'Subjectivity is as much the business of history as the more visible "facts."' These memories can reveal many aspects such as class and perceptions in a similar way to memoirs and Portelli challenges the assertion that workers' accounts of a sit in should be any less valid than accounts by eminent politicians. Oral sources are of a different level of credibility and should be treated as valid.[38] Discussions with colleagues working in other projects revealed that they had reached similar conclusions. Whilst researching for this thesis I have attended three series of Oral History

[37] T. Lummis, 'Structure and Validity in Oral Evidence', in R. Perks and A. Thomson (eds.), The Oral History Reader (London 1998), p. 276.
[38] A. Portelli, 'The Peculiarities of Oral History', History Workshop, 12 (1981). Also see Fisher, 'History of Birth Control Practice', her work is an argument supporting Portelli's position as she discovered more intimate details by talking to people face to face rather than in documentary evidence.

Workshops at the Oxford Wellcome History of Medicine Unit and also the Oral History Group at Oxford Brookes University.

As well as collecting my own oral histories I have read thirty testimonies from Margot Jeffreys', collection of memories from the pioneers of geriatrics at the National Sound Archives. The theme of this project was the development of geriatrics as a medical speciality. In total 72 people were interviewed, all born before 1921, who qualified before or during the Second World War and worked as consultants in geriatric medicine in the 1940s, 1950s and early 1960s.[39] The reasons for reading these oral histories were generally to discover further information regarding the national situation, and to specifically consult Dr Cosin's interview to discover any further information about him. Those selected were the oldest contributors who were practising in the 1940s and 1950s, and talked about their own and national experiences of the development of gerontology. This data had a good 'fit' with my own.[40]

Analysis

Qualitative and quantitative analyses have been used to analyse the oral histories and reinforce and enhance each other. Once the oral histories were collected it became apparent that there was a considerable amount of demographic information generated from the interviews. (See my questionnaire template in Appendix B). In order to utilize this information effectively, quantitative analysis was used to tabulate the data by designing a spread sheet using SPSS (Statistical Package for Social Scientists). Usually a questionnaire would have formed the basis for a spreadsheet but the original method of analysis was qualitative, thus resulting in many variables in the data. The spreadsheet was designed to answer the following questions. On the experience of grandparents: Were the respondents grandparents alive when they were children? Where did their grandparents live and did they have contact with them? Did their family help the grandparents, and did any grandparent live with the family when they got older? Were any of their grandparents admitted to an institution?

And with regard to the experience of parents: Where did the parents live? Did they need help from their family? Did any parent live with the family, and if so, who did and with

[39] M. Jeffreys, 'Geriatrics', was collected during 1991.
[40] R. Elliot, 'Growing Up and Giving Up: Smoking in Paul Thompson's 100 Families', Oral History 29:1 (2001), pp. 73-84, uses secondary analysis of oral histories and makes similar comparisons.

whom did they live? Did any parent need institutional care and why? Were any in-laws cared for by the family?

To reiterate, this information was not intended to be statistically reliable, but provides a picture of the domestic circumstances of older people during the time of the study. The work of Sheldon, Rowntree and Townsend informed these questions and some comparisons to their findings can be made.

Analysing the data generated by qualitative research has posed challenges. Field discusses various techniques adopted for analysis amongst social scientists and the relationship of historical analysis to these methods.[41] As open-ended questions were used for interviews for my study, and this line of questioning was generated by the experience and responses of the interviewee, there was no pattern in the transcripts. All were unique interviews. Analysis of the data in each case had to be referred back to the interview. It was therefore essential also to relate the experiences of the respondents to general changes being experienced by society at large. As Holstein and Gubrium state: "The analytical objective is not merely to describe the situated production of talk, but to show how what is being said relates to the experiences and lives being studied." This analytical process has been used to structure the interviews to show "hows" and "whats" over a period of time.[42] Miller and Glassner discuss the need to be cautious when analysing open-ended interviews, but accept that such cultural experiences need to be accepted. The main purpose of the analysis is to understand the context of the stories and "put them to honest and intelligent use in theorising about social life."[43] Whilst each oral history is unique in terms of individual experiences and dynamics, each has been contextualised and validated against other oral histories and other sources.

A system of coding and categorising was adopted to analyse the qualitative data. The oral histories were transcribed and typed up and re-read.[44] Professionals were separated from the relatives' experiences, but, where there was overlap in describing family circumstances, these were analysed alongside this group. Themes were identified,

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[41] Field, 'Children', pp. 105-106.
[42] J. Holstein and J. Gubrium, 'Active Interviewing' in D. Silverman (ed.), Qualitative Research, Theory, Method and Practice (London: Sage, 1997), pp.113-129.
[43] J. Miller and B. Glasner, 'The 'Inside' and the 'Outside' Finding Realities in Interviews' in D. Silverman, (ed.), Qualitative Research, Theory, Method and Practice (London: Sage, 1997), pp. 99-112.
[44] The interviews were typed up by myself. Punctuation of the transcripts has been added by me in order to make the extracts easier to read.

coded and categorised. They covered an enormous scope of themes and perceptions ranging from professionals perceptions of the establishing of the welfare state to residents' perceptions of the use of the CRH pre-and post-welfare state. Whilst not wishing to over simplify the process of coding and categorising, respondent's testimonies produced clear categories for analysis. Themes that emerged mirrored the documentary and secondary sources, and included poverty, family responsibilities and medical care. Additionally this thesis used previous research to inform the interviews.[45]

Conclusion

The different methodologies used for this thesis effectively complement each other. Overall, the underlying principle was the triangulation of sources; the data has been cross referenced. It has been reassuring to note that although oral histories are presenting a particular perspective they have married with documentary sources and with each other.

Old people's history has not been at the forefront of historical studies. It is only recently that attention has been given to studying how old people lived in the past. Gittins considers that, along, with other minority groups, old people were irrelevant and not featured in general history: "Women, servants, children, ethnic minorities, the elderly, mentally disordered and those with different sexual preferences and identities: all of these groups at one time or another have been regarded as irrelevant, silenced out of official, public history."[46] Official records address only limited aspects of old people's welfare and care and this is evident in this study both on a national and local basis. As with other comparable groups these bureaucratic sources can be supplemented to good effect by oral histories. Another local example where this has been done fruitfully is the work of Davies. She has studied the experiences of psychiatric patients from a patient's perspective by using their narratives of memories of their illnesses and treatment. Her study is an example of how agency records will present a particular aspect of patients' histories, but exclude the reality of their experience. Davies uses her work to challenge stereotypes and presents patients'

[45] A. Straus and J. Corbin, Basics of Qualitative Research, Grounded Theory Procedures and Techniques (London: Sage, 1990), pp.74-142, provides in-depth models for coding and categorising data. These methods could be adopted for some oral history analysis but given the nature of the methodology for this study it is not appropriate.

[46] Gittins, 'Silences', p.47.

voices, which she considers have not been included in psychiatric history.[47] My thesis presents a fresh perspective on the past lives of old people who have traditionally had little voice or bargaining power in society, during a time when communities were experiencing social and political changes.

[47] K. Davies, 'Narratives Beyond the Walls: Patients' Experiences of Mental Health and Illness in Oxfordshire Since 1948', (unpublished Ph.D thesis, Oxford Brookes University, 2002), pp. 10-62.

CHAPTER THREE

The role of the Cowley Road Hospital from 1930 to 1948

It was the most the most dreadful thing if you had nobody to look after you and you really had no money of your own and nowhere else to put yourself the workhouse was the only thing....it was a great dread....up the Cowley Road it was called in Oxford....you had to go up the Cowley Road.[1]

This chapter will examine national developments that influenced poor law provision for old people before 1948 in Oxford City; as well as identifying residents' and professionals' expectations of the CRH, and influences behind these expectations. By examining both professionals' and relatives' perspectives of provision, similarities and differences will be identified and measured alongside Oxford City Council's bureaucratic reports on provision for old people, to compare standards of care and evaluate unmet need. This section will also explore the infrastructure available to support old people before the inception of the welfare state in Oxford. It is my understanding that this has not been done before and therefore this aspect of work is of a pioneering nature. Another part of this chapter will be to contextualise the CRH.

What happened to old people before the welfare state?

Old people have coped with ageing in a variety of ways throughout time. Of course their health, financial circumstances and social conditions influenced ways of coping. Obviously an old person with health problems, poor financial resources and no supportive social structures would have been the most needy, and conversely someone in good health, with adequate financial resources and family and community support would probably be well cared for. People in the middle of these two extremes had a mixture of experiences. What did happen to the dependent, frail mother of an unmarried woman who had to go out to work to survive; or the sick mother whose grown up children have their own families, lived in overcrowded conditions and were poverty stricken themselves? Did society recognise these needs and how were they resolved?

Broadly speaking, before the introduction of the New Poor Law in 1834, evidence suggests that old people managed, and were integrated into their communities through local or parish communal support. Relief was available under the Old Poor Law, old people were able to be given financial relief mainly in their own homes, but it seems

[1] Mrs RB OX38, 23/7/99, p. 5.

that the majority of old people did not claim for relief. Evidence also suggests that old people tried to be independent and only applied for relief when other resources had failed, but overall there were limited facilities available.[2] Studies have documented how old people managed and were cared for in pre- modern England.[3] This thesis is concerned with the time period immediately before and after the welfare state. In view of this the most relevant influences in state provision for old people prior to the introduction of the welfare state have arisen from the New Poor Law.

Poverty, inequality and industrialisation were key components influential in the reform of the Old Poor Law. Dissatisfaction with the cost of the system led to the Royal Commission on the Poor Laws, culminating in the Poor Law Amendment Act of 1834. This legislation was considered a watershed in the administration of poor relief as changes were made aiming at national uniformity in the delivery of assistance, whereas previously the parochial system had varied from parish to parish. The need for change in the system was related to the development of industrialisation, and the Poor Law Amendment Act was seen to have a class based interest favouring capitalism.[4] Profit for employers, (Crowther compares farmers to industrialists), led them to restrict welfare for the poor. Crowther is of the opinion that the Poor Law Commissioners believed in individualism and the report was based on an "ill-assorted mixture of the new individualist philosophy and rural paternalism." The Commissioners' Report influenced the legislation. Moral and economic principles underpinned this new law, primarily aimed at the able-bodied labourer, to ensure that the conditions of the workhouse were worse than for those who remained independent in the community. As a result paupers did not want to use the workhouse.

In 1834 the Commissioners introduced a classification system which separated able-bodied people, sick people, old people and children. Initially, old married couples were separated, but regulations were relaxed in 1847 so that couples were able to have a room together if they requested this, but not all Poor Law unions provided this facility.[5]

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[2] P. Thane, Old Age in Eglish History, Past Experiences, Present Issues (Oxford: OUP, 2000), pp. 147-159, provides documentation on how old people were cared for under the Old Poor Law.

[3] See P. Johnson and P. Thane, (eds.), Old Age from Antiquity to Post-Modernity (London: Routledge, 1998) for discussion on care and provision for old people during this time; and P. Thane, Old Age, pp. 17-147, which covers aspects of old people's lives from Ancient Greece and Rome up to the New Poor Law at the beginning of the nineteenth century.

[4] A. Digby, The Poor Law in Nineteenth-Century England and Wales The Historical Association, (1982), pp. 5-14; and Crowther, Workhouse, p. 19.

[5] See Crowther, Workhouse, pp. 43-44 where the author details these and other conditions.

Conditions in the workhouses were harsh and disciplined. Able-bodied people in the workhouses were expected to work to contribute towards their keep, and as there was no retirement age, old people were considered in principle to be able-bodied. Essentially the Act had introduced the deterrent workhouse and expected those who feared it to find work and take precautions to avoid admission in old age. Inevitably many of the inmates were not able-bodied and unable to contribute to their keep. The effects of this may have been overlooked by the Commissioners when they established a deterrent policy. For the next hundred and fourteen years the workhouse, constructed from a moralistic philosophy, became a changing institution, dependent on social and political influences. Notwithstanding this the workhouses were effectively early old people's homes.

When the Local Government Board took over administrative responsibility for the Poor Law in 1871, they found a need: "To soften, if not to obliterate, the workhouse's grim reputation."[6] Much of the work was tending to the sick and vulnerable, as by this time less able-bodied men were inmates, and this change challenged the initial philosophy of the workhouse. Additionally, attitudes towards poverty and unemployment started to change at the end of the nineteenth century and this lead to the reviewing of the deterrent aspects of the workhouse for those who were helpless and vulnerable. Certainly by the end of the century the majority of inmates were old people.[7] This aspect was addressed by the Royal Commission on the Aged Poor in 1895. Their recommendation was that old people should not be sent to the workhouse if they were able to look after themselves; but if they were admitted, the conditions should be better than if they remained in their own homes. These changes suggest that, generally there had been a notable shift in attitudes to the delivery of care of old people in the workhouse since 1834.

As less able-bodied people were using the workhouse, leaving old people as the main group of inmates using it, a deterrent admission policy was not as significant or appropriate.[8] Booth's survey had highlighted the fact that poverty increased with age, creating an extra dimension towards the moral categorising of the deserving and

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[6] Crowther, Workhouse, p. 54.
[7] Ibid, p.73, the author cites Booth's statistics indicating that of those persons aged between 70 and 75, approximately 9 per cent were in the workhouse.
[8] S. and B. Webb, English Poor Law History: Part II: The Last Hundred Years, Vol I (London, 1910), p. 360.

undeserving poor.[9] Society increasingly recognised that elderly poor people who were in dire financial circumstances were not entirely responsible for their situation. This recognition did present contradictions for the poor law guardians, as groups of the 'deserving' and 'undeserving' poor were mixed together in workhouses. Crowther suggests that in the late 1890s, the LGB was impressed by public opinion on the need to 'dispauperise' old people. In essence, wherever possible outdoor relief was to be given to old people, and institutional accommodation made more attractive for them. However, practical difficulties arose in applying this practice. For example the master of the workhouse was responsible for determining whom he deemed deserving and undeserving. Distinguishing between these two groups appeared to have been made on a personal basis and in the absence of any national criteria. Consequently the classification created two tiers of aged poor inmates, thereby creating divisions, resentment and inconsistency. Despite these changes in lessening the deterrent aspects of the workhouse no alternatives were provided.[10] As "managers" of workhouses were able to determine which were the 'deserving' and 'undeserving', inconsistencies in the delivery of relief undercut the original aims of the 1834 New Poor Law.

Important steps were taken at the beginning of the twentieth century marking policy changes to help poor old people. The introduction of old age pensions in 1908 effectively provided outdoor relief to elderly people and contributed to a reduction of old people's admissions to workhouses.[11] This coincided with the Royal Commission on the Poor Laws. Both the Majority and Minority Reports, recommended changes to the distribution of welfare. The implications of these landmarks have been discussed in Chapter One, but significantly the First World War impeded any further development and the depression then followed. Both of these events had economic effects in the distribution of poor relief in general. However, against the backdrop described above, in 1913 the LGB changed the name of workhouses to Poor Law Institutions. This was probably an attempt to reflect the changing nature of the institutions and Crowther suggests that this provided a more acceptable option to poverty stricken families who had helpless relatives, particularly for the "feeble-minded". At this time reformers

[9] See P. Thane, Old Age, pp. 173-77, who outlines the role of Booth in his contributions to highlighting poverty amongst old people and the need for pension provision. The author cites his work, The Aged Poor in England and Wales (London, 1894, reprinted New York 1980).
[10] M.A. Crowther, 'The Later Years of the Workhouse,' in Pat Thane (ed.), The Origins of British Social Policy (London: Croom Helm, 1978), pp. 36-55.
[11] Crowther, 'Later Years.'

considered that good specialised institutions were better than a bad home. Implicit in the name change was a recognised need that old people needed care not the punishment associated with a workhouse. In Oxford the workhouse changed its name in 1921 to the Cowley Road Hospital.[12] Some cities, particularly in the industrial north of the country, had already established these institutions as semi-almshouses for old people without stigma attached to them.[13] By the late 1920s the workhouse can be seen as a state institution that provided care for the helpless and hopeless. The nature of the care varied and was dependent on regional and personal managerial influences. Some workhouses were better than others and had made conditions better for old people.

In 1929 the Local Government Act (effective from 1930), was introduced, and transferred power from the board of guardians to the public assistance and public health authorities. A further act, the Poor Law Act 1930, identified the administrative changes arising from the Local Government Act 1929. This legislation also reaffirmed that relatives of poor near relations were liable for their relief and maintenance, and allowed outdoor relief and restricted admission to the workhouses for the aged and infirm. The Act stated: "It shall be the duty of the father, grandfather, mother, grandmother, husband or child of a poor, old, blind, lame or impotent person, or other poor person not able to work, if possessed of insufficient means, to relieve and maintain that person."[14] Implicit in this extract is the state's position on family responsibilities under the Poor Law. Families had the ultimate responsibility to support and provide for their relatives. In practice when families applied for relief, this legislation would be applied by the appropriate local administrators. According to Crowther this interpretation did not give national uniformity and whilst the household means test was strictly applied in the 1930s (it was stopped in 1941), the definition of family responsibility was unclear. As the twentieth century progressed the state began to take more responsibility for the helpless. Consequently the definition of family responsibility became inconsistent, the impact of poor law policy was softened, but legally the two policies co-existed.[15] A

[12] Annual Report of the Guardians of the Poor Within the City of Oxford With Statement of Accounts to March 31 1921, p. 4. lists the official title and address of the institution as being Cowley Road Hospital, Cowley Road, Oxford. Previously this institution was officially known as The Workhouse at the same address. Other indicators confirm the name change, such as the list of employees at the hospital, an account of births and deaths and supplies for the hospital pp. 5 & 10. No explanation is given for the name change.

[13] Crowther, 'Later Years,' pp. 37-55.

[14] Poor Law Act 1930 Chapter 17 15 (1) (b).

[15] A. Crowther, 'Family Responsibility and State Responsibility in Britain before the Welfare State,' Historical Journal, 25:1 (1982), pp. 131-145.

double message was therefore being given to people, and combined with the already disparate local and regional state provision this would have created even more inconsistencies in the delivery of welfare. The outbreak of war in 1939 meant more changes were made and contributed further to the management of the state institutions.

Notwithstanding the changing legal position it is probable that there was little difference in practice in the administration and facilities for old people in public assistance institutions after 1930. Little action was taken to implement the classification for old people in institutional care and it is unlikely that this change in administration did anything much to improve care for them.[16] In fact most of the inherited poor law buildings were considered grim and unsuitable for caring for old people, as the better more modern hospitals were turned into municipal general hospitals.[17] Nonetheless the reality of the situation was that elderly people occupied most of the public assistance institutions including hospitals. Dr Marjory Warren identified the practical problems this posed in her articles in medical journals in the mid 1930s, and other doctors followed suit. Thus this marked the beginning of the professional lobby to create a speciality for geriatric medicine discussed in Chapter Four. Doctors working in the 1930s and 1940s highlighted the conditions in which old people were cared for during this time. Parallel to the medical developments improvements were being made in the training of Poor Law staff and these employees were becoming more professional.[18] Adam's perspectives add to the general picture of the developments of the public assistance institutions, that changes were being instigated on various levels. Effectively professional challenges were being made to the established poor law system, at the same time as some of those working within it were experiencing the contradictions and inadequacies of the structure.

There are gaps in information on the public assistance institutions during this time as most studies are focussed either on the establishing of the Poor Law or the introduction of the welfare state. This time from 1930 to 1948, can be divided into three periods, before, during and after the Second World War. Initially in the early 1930s the effects of the 1929 Local Government Act were being tested. Experiences of the early

[16] See C. Webster, 'Elderly', pp. 165-193.
[17] Seebohm Rowntree, Old People, p. 57.
[18] J. Adams, 'The Last Years of the Workhouse, 1930-1965', in J. Bornat, R. Perks, A. Thompson and J. Walmsley, (eds.), Oral History, Health and Welfare, (London: Routledge, 2000), pp. 98-118. His work traces developments in the professionalisation of public sector employees. The author illustrates how activities before the welfare state influenced post welfare state professionalisation.

pioneers of gerontology suggest that changes were beginning. However, in the latter part of the decade impending war halted progress as the country prepared for war and subsequent military and civilian casualties. Once war was declared emergency infrastructures were established and hospitals were needed for war casualties. As a result, any developments would have been put on hold. But from the early 1940s, the advent of the welfare state influenced future planning of welfare. Plans were underway for welfare reforms and the introduction of the NHS at the beginning of the 1940s, as the Beveridge Report indicates.

Alternatives to the workhouse existed. Old people with good financial means could be accommodated in nursing homes but there were relatively few of these and many old people were unable to afford the fees. In 1891 there were approximately 9500 nursing homes and convalescent beds in England and Wales, 13000 by 1911 and by 1921 26000. These homes would look after a variety of cases such as maternity, medical, surgical, convalescent, senile and chronic cases. There was no official regulation of establishments that were run on a commercial basis. Fees were varied, as were standards of care. Most of the homes were run by unqualified staff. It was not until 1927 that the Nursing Homes Registration Act gave powers to local medical officers to inspect the homes.[19]

One of the first steps to providing alternative help for elderly people was the introduction of old age pensions in 1908, and undoubtedly many pensioners who were unable to work benefited from this. But priorities for health care were focussed on maternal and child welfare and conditions such as venereal diseases, tuberculosis, cancer, mental illness and mental handicap, rather than welfare improvements for older people.[20] In fact during the 1914-1918 war the death rate for older people rose but little was done about this.[21] Priorities for old people's care were also undercut during the Second World War as an unofficial priority system had been developed by hospital staff whereby servicemen were considered first, then air-raid casualties, war-workers, women and children and lastly the aged and chronic sick.[22]

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[19] H. Bartlett, Nursing Homes For Elderly People: Questions of Quality and Policy (Singapore: Harwood Academics, 1993), pp. 2-7.
[20] Webster, 'Elderly', pp. 165-193.
[21] M.A. Crowther, British Social Policy 1914-1939 (London: Macmillan, 1988), p. 28.
[22] B. Abel-Smith, The Hospitals 1800-1948 (London: Heinemann, 1964) pp. 431-435. Two categories of concern were highlighted, the civilian vulnerable old people and the chronic sick (mostly made up of old people) who were occupying hospital beds. Old people in London were using air raid shelters and this

To summarise: old people living in England and Wales in the 1930s and 1940s and needing help had four options. First, if they had enough money they could contract in private care or go to a nursing home; secondly, if they had family support they could either live with them or remain in the community with shared care; thirdly, if there were no resources available to them they could be admitted to the "workhouse"; or fourthly, they could remain at home regardless of their physical, social and financial conditions. Sometimes, when old people became ill their families could not provide for them so admission to a public assistance institution was the only solution for accessing medical care.

Voluntary hospitals were reluctant to admit chronically sick patients so the only alternative if medical care was needed was in a public assistance institution. An increasing proportion of old people were admitted and this meant that more medical care was needed.[23] Consequently the medical staff had a more defined and homogenous group of inmates to care for.[24]

Family responsibilities

Whilst acknowledging the various historical interpretations on the role of the family over the centuries, for the purposes of this study the focus will be in family responsibilities during the twentieth century.[25] At the beginning of the century, people of any age who were vulnerable, and without family or financial support, could be accommodated in the workhouse. As described previously conditions were not pleasant in these institutions. If a family member had to enter into a workhouse it was widely perceived as a shameful experience that reflected a poor social position. Therefore many old people lived with their families, or alone, in sometimes awful conditions. There was a general expectation that families looked after their elderly relatives.

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was causing problems from moral and health perspectives thus the Ministry took financial responsibility to accommodate those old people found in shelters in reception centres and transferred the chronic sick to the country.

[23] S. and B. Webb, Poor Law History, p. 333, quote an inspector of workhouses Hervey who stated in 1903: "The workhouses of a past and bygone age are no longer refuges for able-bodied; but are becoming every day more of the nature of state hospitals for the aged, sick and infirm. As such they should be furnished with the very best nursing procurable."

[24] Crowther, Workhouse, p. 186, comments that by the 1920s the workhouse doctor was able to concentrate more on patients as the able-bodied had been removed from the workhouse.

[25] See for example, Laslett, Household and Family, Thomson, Welfare of Elderly, also Thomson, 'Decline', and D. Thomson, 'Welfare and the Historians' in L. Bonfield, R.M. Smith and K. Wright (eds.), The World We Have Gained: Histories of Population and Social Structure (Oxford: Blackwells, 1986), pp. 364-378.

According to Finch relatives felt duty bound to give care, therefore less state provision was necessary. Her analysis considers that relatives' decisions to offer a home to an old person were affected by what "acceptable alternatives" were available. For many, as illustrated above, the only alternative was the workhouse or later public assistance institutions. Finch explains how social policy in the nineteenth century developed and capitalised on the situation: ".....By making the workhouse the only alternative to family care and then deliberately creating conditions in workhouses which were both undesirable in terms of physical conditions and also reinforced a sense of shame, so that any relative who could be considered available would feel obliged to offer support." The above quote explains the reasons why conditions in the workhouses were so bad in order to put pressure on families to care for their relatives. This attitude was inherited through to the twentieth century and Finch considers that this situation continued to keep a "strong hold on British social policy."[26]

Co-residence, or living with family members, was not uncommon in working class communities. Roberts identifies a variety of reasons for co-residence, for example, old people needed care, young married couples needed accommodation and children cared for by the extended family. She also suggests that people cared for relatives (all ages) because it "was assumed that that was what one did" and it "was the right thing to do." Not doing the right thing could result in social disapproval and gossip. However, Roberts is sure that "their conviction they were doing the right thing was reason enough," inevitably people felt a strong sense of obligation to care for their relatives and there was affection for them. Besides this there was an element of mutual reciprocity in co-residency, for example, a home was offered in exchange for caring for an old person.[27] Other studies reveal examples of co-residence for instance three generations of families lived together. Combinations included widowed and non-widowed parents lived with children, unmarried old people lived with other people or as lodgers, or older parents would live with an unmarried daughter.[28] Although some of these studies were carried out on the cusp of the time covered for this chapter, that is

[26] Finch, Family Obligations, p. 82.
[27] See E. Roberts, Women and Families: An Oral History 1940 – 1970 (Oxford: Blackwells, 1995), pp. 175-198. Roberts elaborates on complications in the dynamics of kin relationships and discusses exploitation vis a vis self interest in the context of the extended family.
[28] See Seebohm Rowntree Old People; Sebohm Rowntree and GR Lavers, Poverty and the Welfare State, A Third Social Survey of York Dealing only with Economic Questions (London: Longmans Green, 1951), and Townsend, Family Life, for detailed accounts of these surveys.

during the mid to late 1940s, in all probability, the living practice of the families reflects patterns from the previous decades.

With the reminder of the powerful influence of the inherited social policy of the nineteenth century in mind, the chapter will now proceed to uncover how a local community cared for its old folk.

What happened to old people in Oxford?

By 1771 a union, comprising of the eleven chief parishes, had been formed in the city. The union established rating and administrative business, thereby creating increased funds to build a new workhouse. A new mixed workhouse for two hundred inmates in Oxford was completed in 1772 on Wellington Square and this was administered by a Board of Guardians. Following criticisms in the 1790s about the conditions in the workhouse and an investigation by Sir Frederick Eden, a nursery was added and wards for aged and infirm paupers. Able-bodied inmates were kept occupied by various activities such as oakum picking, women nursed the poor in the parish, or they worked on the Board of Guardians small mixed farm (which functioned until 1865). But by 1848 there was still overcrowding and a need for more accommodation. A site for a new workhouse was found on the Cowley Road and the building for 330 inmates was completed in 1865. [29] An architect's impression of what CRH was to look like was published in the Builder in 1864, (See Figure 3.1.)

[29] K. Morrison, The Workhouse, a Study of Poor-law Buildings in England (English Heritage, 1999), p. 53, by 1841 320 new workhouses had been built arising from the 1834 Poor Law Act; see also chapters 5 and 6 where the author describes the architectural features and differences of the work houses built between 1835-1840,1840-1870 and 1860-1918. Morrison identifies the political reasons behind the designs. Crowther Workhouse, p. 58, refers to professional journals such as, The Builder, who published plans of these institutions, thus creating a greater uniformity of style.

Figure 3.1: Architect's view of Cowley Road Hospital

Some of the pressure on accommodation in the workhouse was relieved in 1855 when the Poplars, an industrial school for children, was opened in Cowley. The Anti-Mendicity Society (a similar organisation to the Charity Organisation Society) opened a hostel for vagrants in Castle Street in 1844 which also helped to relieve the pressure on the workhouse. Once the new workhouse was up and running vagrants were accommodated in casual wards. Oxford had another workhouse, later known as the Laurels, which was built by the Headington Poor Law Union (established in 1834) in 1858 for 250 inmates. However, most of the parish of Headington (approximately 1529 people) was incorporated into Oxford City in 1928 under the Oxford Extension Act.[30]

In 1848 the Poor Law Commissioners ordered that all relief should be given in the workhouse. Previously out relief had been given by the guardians to aged people and those seasonally unemployed. Established links between the local Charity Organisation Society (COS) and the Oxford Board of Guardians were made by 1873, resulting in arrangements between the two organisations for the distribution of relief in the city. Two of the main aims of the COS were to reduce pauperisation and help the 'deserving' poor. The COS philosophy was to distinguish between the 'deserving' and

[30] See M. Lobel, (ed.), The Victoria History of the Counties of England, A History of Oxfordshire Vol V, A History of the County of Oxford, Vol V Bullingdon Hundred Dawson for the University of London, (Institute of Historical Research, 1957) p.157.

'undeserving' poor and their intervention had an influence on state provision.[31] In Oxford, the COS reduced the amount of relief given by the guardians and gradually took over most of the work. For example, in 1898 the guardians provided 17 per cent of out-relief compared to 65 per cent in1872, indicating that the COS contributed to the reduction of out relief. By the early twentieth century the role of the COS had changed, partly because of the introduction of old age pensions, and low unemployment in the city. Out relief was mainly given to widows, old people and the sick.[32]

By 1930, the administration of the two workhouses in Oxford the CRH and the London Road Hospital had been transferred from the guardians to the public assistance committee. As the Radcliffe Infirmary was a voluntary hospital that did not accept chronic cases, CRH was the place where the old, ill people were referred. In addition old people who were without financial or social resources, vulnerable and needing care in Oxford would often have no alternative but to be admitted to the CRH but there was reluctance to do this.

In July 1930 the local newspaper reported on the public assistance committee meeting, the headline read: **"OXFORD WOMAN HONOURS DEATH BED PROMISE."** The article goes on to describe how a blind woman refused to go to the workhouse following her husband's death as she had promised him she would not go into the workhouse. Neighbours and a relieving officer were concerned about her welfare but could not persuade the woman to go to the CRH and her wishes were respected.[33] Why was this woman reluctant to go into the CRH? Did her attitude reflect those in the wider community? Newspaper reports at a later date illustrate two different types of care for older people. The results of four inquests on Oxford women reported in the Oxford Times demonstrate this. In 1944 two women fell (in separate incidents) and injured their legs necessitating admission to CRH where they subsequently died.[34] Later in 1948 two other inquest results were reported. These concern women who lived in the more affluent area of the city, north Oxford. They also broke their legs. Both

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[31] See K. Woodroofe, From Charity to Social Work, in England and the United States (London: Routledge and Keegan, 1971), pp. 25-55, who describes the role of the COS and local Poor Law Guardians and the impact that this had on paupers. Effectively the COS introduced casework into the distribution of poor relief and used their own criteria to determine payments prior to decisions made by the guardians.

[32] VCH, Oxford, pp. 349 state that the COS dealt with eighty six per cent of the 357 cases referred in 1898.

[33] Oxford Times, July 25 1930.

[34] Oxford Times, 21 July 1949.

were nursed and cared for at home where they subsequently died.[35] This fragmentary evidence tentatively suggests that old people with financial resources would avoid admission to the workhouse because of its associations.

Admission to a workhouse was perceived to be a shameful experience, as having to resort to public relief was a statement that individuals were incompetent at providing for themselves or their families. In the nineteenth century the deterrent policy of the workhouses had had a humiliating effect on inmates and their treatment, once admitted, furthered the humiliation. This legacy remained into the twentieth century as the cases of the women with private resources suggests. The examples also corroborate and illustrate Spicker's assertions on the stigma of admission to the workhouse: "In practice, stigma became the principal method by which deterrence was maintained." By having personal resources these two old people avoided the shame of admission.[36] Thus the workhouse was seen as less of a social and more of a penal institution. Although the deterrent policy relaxed somewhat towards the end of the century, and gradually old people were considered the 'deserving poor', the disgrace of claiming poor relief lived on after the 1930 Local Government Act when public assistance committees took over from the poor law guardians and institutions became public assistance institutions. Renaming at this stage did not remove the stigma. Staff, buildings and policies from the poor law still remained and retained the former images of the workhouses.

What infrastructures were available to support old people before the inception of the welfare state in Oxford? Obviously the main formal system of help came from the public assistance structure with some support from charitable organisations. The next sections will examine how this worked in more detail based on information from professionals and relatives. Evidence from their oral histories will reveal how old people managed.

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[35] Oxford Times, 28 June 1948 and 5 July 1948.

[36] See P. Spicker, Stigma and Social Welfare (London, 1984), pp. 6-23, where the author charts the evolving of the stigma of the Poor Law.

The professionals' perspectives on health and social care provision for old people in the community pre-NHS

A GP practising in the east of the city considered that older patients neglected themselves and were distrustful of hospitals and doctors.[37] It is quite likely that charges for visits to the doctor were prohibitively expensive for many elderly people.[38] Possibly by neglecting their care, old people exacerbated existing conditions, then when they became sick or incapacitated as a result of this neglect this would mean admission to CRH. As this was still considered a workhouse by the majority of the community there would be resistance to admission. Admission to the CRH was not always initiated through a medical referral as the need for care could well be a social need. Mr JW was a community policeman during the 1930s and 1940s and his descriptions of his work indicate that he acted as a social worker in many ways. He was often the first port of call for the public when they were concerned about an old person's welfare. Mr JW would investigate the situation and then call on the appropriate agency, usually the doctor. In cases when no relatives were available to provide care the old person was taken by Mr JW to the CRH. He made numerous trips escorting old people to the CRH and recalls that sometimes people were reluctant to be admitted to the institution. He went into many homes of old people, some in the heart of the city, such as the slums in St Ebbes. He contextualises the care provided for old people by acknowledging that conditions of CRH would not be acceptable today, but for many people living then, there was no alternative. As Mr JW had much contact with the general public he was able to remember general attitudes to the CRH and considered that many people disliked the CRH.[39] Furthermore Mr JW recollects his colleagues' attitudes to the CRH and concluded that many of them did not have much confidence in the CRH.

Medical professionals seemed to have limited knowledge of the CRH. Mrs VE worked as a nurse at the RI in the 1940s and had little to do with the CRH but was aware of the need for accommodation for old people then as shown in the following extract:

> ...[it]was there and of course lots of these places were in the thirties, the Poor Law institutions and a lot of the elderly went there.... It was somewhere that took you in, certainly you know when you were in need and of course if you couldn't afford anything in the way of a private place and that was really all.

[37] Dr DL OX48, 18/01/00, p. 5.
[38] See Webster, 'Elderly', pp. 165-193.
[39] Mr JW OX23, 25/4/97, pp. 4 & 10.

> There weren't so many private homes about. But then there weren't so many elderly people you see these have grown as the population of elderly people have grown.[40]

Mrs MF, an occupational therapy student in the mid 1940s, found CRH quite a frightening place when she went there in 1946:

> I remember the Cowley Road workhouse I had to go in there once ..... and I can remember walking along past all these old men's beds and you see I wasn't there long enough to see how they were treated. One of the men shouted out at me to take his bottle and I was absolutely horrified that I would have to go and take his bottle because I wasn't a nurse or anything...but I didn't I went and told somebody but they were....it seemed a difficult place to be... a bit frightening ...all these men in bed because they were bedridden...[41]

Local authority community services were not provided at this stage. When patients were discharged from hospital some junior nursing staff were not aware of what facilities were available for old people in the community as the senior nurse took this responsibility.[42]

Professional staff saw CRH as a workhouse which was the only facility for poor vulnerable people. Not all of the professionals had first hand experience of the CRH and some formed their opinions on hearsay and rumour. There appears to have been little professional dialogue regarding the situation at CRH, which meant they were unable to comment on important issues. This could be interpreted as silences. Gittins suggests that: "Silences are thus created consciously, unconsciously, and at a number of levels, not just within individuals but among the collective generally. Silences are, in the widest sense political."[43] Her perspective being that silences are deliberate, and therefore in this context professionals were not discussing conditions at the CRH, possibly because they did not want to discuss or confirm any rumours or hearsay. Testimonies from a retired nurse and a retired policeman illustrate a similar silence.[44] Neither of these professionals who worked and had contact with colleagues in CRH were able to remember any professional discussions on CRH. Consideration has to be given to other possibilities; that this aspect of care was unrelated to their work at the time or they were relatively newly qualified, and their overall experience of old people was limited.

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[40] Mrs VE OX51, 14/2/00, p. 8.
[41] Mrs MF OX7 8/7/98, p. 2.
[42] Mrs VE OX51, 14/2/200, p. 3.
[43] D Gittins , 'Silences: The Case of a Psychiatric Hospital' in (eds.), M. Chamberlain and P. Thompson Narrative and Genre (London: Routledge, 1998), pp. 46-62.
[44] Mrs MA OX1, 15/7/981, and Mr JW OX23, 25/4/97.

Mr JW considered that the people in the community that he dealt with did not like going into CRH. He was unsure why but offers his analysis:

> I don't know the word CRH used to get their back up "Oh no I'm not going in there" ...but I don't know it had this sort of fear to them they didn't want to go into CRH, they felt it was the end of the road for them ...but a lot of them probably had no dependants at all.....and the doctor would say I think that the best place for this person is CRH and he would arrange for him to be taken but not against their will. If there was no mental disorder and she didn't want to go then you had no right to remove her but you could persuade her... "in your own interest you've got nobody to look after you my dear the best thing is for you to go to hospital." *You wouldn't say CRH you'd say hospital.* (my emphasis) [45]

This implies that professionals were aware of the community's attitude to the CRH, and without statutory powers to remove vulnerable older people they had to become manipulative in order for them to be safely accommodated. Once ensconced in the CRH it would be difficult for an old person without resources to leave. On the other hand, according to Mr JW's testimony, there does seem to have been a general concern for the welfare of old people and their need to be protected. Gittins suggests that fear, pain and shame influence repression of memory, so maybe some respondents did subconsciously block out memories because in today's context some philosophies of practice in caring for old people could be considered scandalous. Recalling the practice may have made them think they were condoning the philosophy.

Evidence from professionals indicates that prior to the inception of the welfare state admission to the CRH was a last resort for those old people without means. None of the professionals interviewed made overt criticism of the CRH. However, implicitly they compare contemporary standards and use their own knowledge of being old today in their contributions. In reviewing the problems of oral history Portelli acknowledges that the person recalling events today is not the same person who took part in events recalled. He considers that: "there will have been many changes in personal subjective consciousness as well as in social standing and economic conditions which may induce modifications, affecting at least the judgement of events and the "colouring" of the story."[46] Indeed the respondents had become older, gained more personal and professional experience and were therefore able to contextualise their memories in the way Portelli describes.

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[45] Mr JW OX23, 25/4/97, p. 7.
[46] See A Portelli, 'The Peculiarities of Oral History', History Workshop, 12 (1981), pp. 96-107.

In summary, most of the professionals interviewed were realistic about CRH facilities and services and contextualised this. Respondents were very aware that there was nowhere else for old people in dire straits to go, and they recognised that CRH provided shelter and care with appropriate standards for the time.

Relatives' perspectives on conditions for old people in the community

A high proportion of the oral respondents had grandparents alive before 1948 therefore giving a broad experience of caring for old people during the time. Eighty-one per cent (36 people), of respondents had grandparents that were alive when they were children. Within this group, 25 people had a maternal grandmother alive, 17 people had a maternal grandfather alive, 18 people had a paternal grandmother alive and 21 people had a paternal grandfather alive.

A large proportion of respondents (71 per cent) had contact with their grandparents and the majority of grandparents lived in the same town. (The grandparents died between 1894 and 1957.) Help in the home was given to 16 grandparents, and 17 grandparents went to live with the family, most commonly the maternal grandmother. (Some of these grandparents may have been looked after in their own homes too). Few grandparents went into an institution, 7 in total; of these 4 were maternal grandmothers, 1 paternal grandmother and 2 paternal grandfathers.

There was thus, overwhelming evidence from oral histories that grandparents, parents and other older relatives were cared for by their families. The reasons that families looked after their older relatives can be divided into the following categories. First, there was an expectation that this was what society expected you to do, a duty to look after your parents. Families were bigger then as was described by the following relatives:

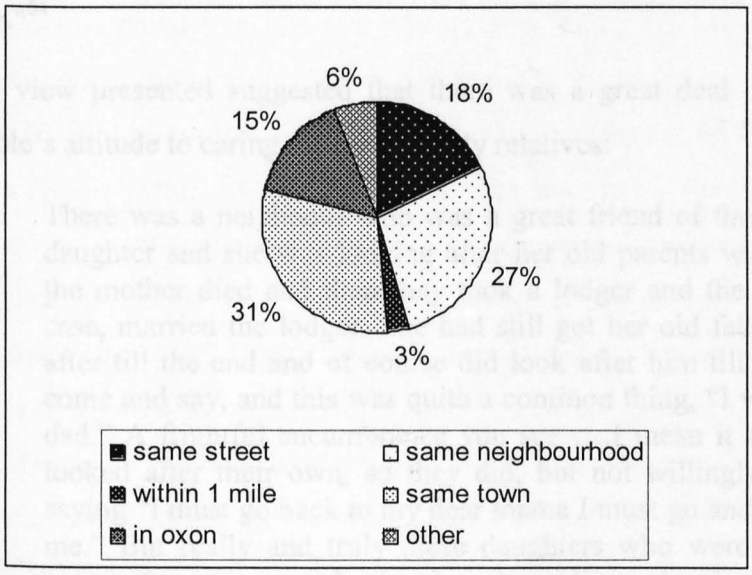
> They looked on it as their duty simple as that....well it was accepted as part of your duties...[as] the children .....[they] had brought you up and looked after you and it was your duty to look after them.[47]
>
> ...the families used to look after them then...the girls the daughters would look after the mothers and fathers.....well the boys took their share.....I mean they were big families in those days anything from five, to six, seven, nine people in the family you see.[48]

[47] Mr HC OX44, 13/12/99, p. 6 & p. 12.
[48] Mr EB OX49, 25/1/00, p. 6.

Mrs IM recalls that her paternal grandfather lived into his 80s and had 15 children to look after him: "remember there is 15 of them so they could take it in turns quite easily to look after them."[49] And Mr JB adds: "...the sons and the daughters of the parents it was their job to look after them to the best of their ability."[50]

Another significant factor was that families lived nearer to each other at this time. The families interviewed in this study revealed that nearly half (48.5 per cent) lived within one mile of their grandparents, and nearly four fifths (79 per cent) lived in the same town as their grandparents. Living in close proximity may well have made caring easier for families.

Figure 3.2: Where respondents' grandparents lived



Source: oral histories

Secondly, on a similar theme, the families did not consider any other option than to look after their older relatives, it was instinctive and done unconditionally as explained very clearly by a daughter:

> I really don't know what would have happened it never entered our heads there were three girls to look after mother and daddy until they died... I hate the word expected it was their life we didn't dream of not doing it.....I mean my sister who lived eventually at Leeds would come home to see us and spend the day washing if necessary to help one of us....[51]

[49] Mrs IM OX57, 30/3/00, p. 7.
[50] Mr JB OX3, 7/10/97, p. 2.
[51] Mrs SS OX40, 10/11/99 p. 13

Thirdly, there was fear of social disapproval if an older relative was admitted to the workhouse as illustrated by the following memories:

> ...Oh yes many of them never did marry because there was a moral obligation to stay if you did not look after your old people you were condemned by other people.....Oh that was common enough in fact ....they'd say "do you think she actually put her old mother in the workhouse?" that kind of remark but it was a dreadful.... ...if you didn't do your duty by them....[52]

Another woman supplied the thought that there was gossip in the community if an older relative was admitted to CRH. People asked "why did they let him go?"[53] A minority of people thought it was not the children's responsibility to care for their parents and considered that looking after the immediate family was enough: "No it wasn't their business to do so really.....I mean they had mum and dad with two children to look after."[54]

One view presented suggested that there was a great deal of hypocrisy attached to people's attitude to caring for their elderly relatives:

> There was a neighbour who was a great friend of them and she was the only daughter and she was looking after her old parents with whom she lived. And the mother died and then they took a lodger and the daughter as often is the case, married the lodger. She had still got her old father there and she looked after till the end and of course did look after him till the end and she used to come and say, and this was quite a common thing, "I wish the Lord would take dad." A frightful encumbrance you see ....I mean it sounds as though people looked after their own, so they did, but not willingly .....they put on an act saying "I must go back to my dear mama I must go and put her to bed she needs me." But really and truly these daughters who were left sometimes married more often than not, because mothers disapproved of any men friends, they were resentful of the fact that fate landed them with this.[55]

Relatives put forward a variety of practical reasons why their older relations would need to be looked after. These being: old people had financial problems and were unable to manage on the limited money they had; accommodation problems arose due to the inability to pay rent following retirement and having a reduced income, or the loss of tied accommodation after retirement; after the death of a spouse the surviving partner needed help; and if an older person could not cope financially or practically there was nowhere else to go except the CRH and the family did not want this.

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[52] Mrs RB OX38, 23/7/99, p. 10.
[53] Miss BH OX39, 13/10/99, p. 14.
[54] Mr HC OX44, 13/12/99, p. 3.
[55] Mrs RB OX38, 23/7/99, p. 4.

Several main motivations were influential in families providing care for elderly relatives. First, there was an emotional driver; some families had strong emotional bonds with their parents and considered they had no other option but to care for them as they got older. Provided there were no other barriers such as physical disability or illness then this was often quite a clear-cut option. There was fear of community disapproval if elderly relatives were not cared for by family members. This was also a finding by Roberts who suggested, as we have seen above, there was "a desire 'to do the right thing' and this was sometimes reinforced by a fear of gossip and social disapproval if an 'incorrect' course of action was taken."[56]

Who did the caring and why in families?

Care can be divided up into two aspects, first, fairly limited practical support given to an old person in their own home, and secondly more intensive help for the homeless, poor, ill, frail and vulnerable. Women did most of the caring for older relatives. This is in accordance with findings by Parker who analysed a variety of aspects of care and found that, on the whole, elderly people who needed care were cared for by daughters or daughters-in-law. In her review Parker refers to the surveys by Sheldon and Townsend who found that daughters and daughters- in-law were more likely to help with household tasks than sons.[57] Most of the respondents were under the impression that daughters were responsible for providing the care. Explanations for this were limited, but there was an assumption that men had different roles to fulfil in their own families, and that daughters-in-law did not have any responsibility in the situation as they were expected to care for their own parents. The following excerpts illustrate these two points: "well no the boys didn't so much it was the girls that looked after him.....well they were all busy ...." [58] Inherited Victorian values seem to have been an influence in determining who cared as Mrs RB recalls: "But my mother was the only

[56] See Roberts, Women and Families, p. 180.
[57] G Parker, With Due Care and Attention, a Review of Research on Informal Care (London: Family Policy Studies Centre, 1990), pp. 43-44. In this review Parker draws attention to the surveys carried out by Sheldon, Social Medicine and Townsend, Family Life in 1948 and 1957, respectively. Furthermore relatively contemporary research in the 1980s found that there was a systematic process regarding decisions in care giving and there was a "hierarchy of expectation or obligation: spouse, daughter, daughter-in-law, son, other relatives, non-relatives." This assertion does fit with similar patterns presented by the oral respondents. However, Parker does state that there have been shifts in gender aspects of caring particularly in relation to informal care by male spouses, therefore some caution must be given to this finding in this context. Research into caring patterns during the 1930s and 1940s is generally limited.
[58] Mrs IM OX57, 30/3/00, p. 7.

daughter ten years younger than her youngest brother and like all Victorian daughters of the ones at home she was saddled you might say with looking after her hypochondriacal and hysterical mother."[59]

Miss BH had a similar interpretation in that attitudes towards women caring were inherited from the previous century:

> ....It was always the woman, the daughter, that was expected to do this the sons weren't expected to do it at all even by sort of you might say authorities especially a single one in the family it was her duty to look after her parents..... what was expected by society in general was that women the daughters of the family were responsible for their elderly dependents. [60]

Mrs LW's younger brother wouldn't go to live with his father when he became ill, or have him to live with his family either, because it wasn't fair on his wife as it was "only her father in law"[61] Mrs IM elaborates further: "No I don't think so they all had their own families four or five or six children....well I suppose they had their own families...the daughters were expected to do it in those days but not the daughters in law...cos you see quite probably they had their parents their mothers to look after you see"[62] Mrs DB considered:

> It's not quite the same daughter in law looking after you as your daughter I suppose.....I can't imagine Mum having him along to live with grandfather, you see he was lucky.....he'd got the two daughters one not married, one not married living with him and the other one married living next door so he was very lucky...because they had bigger families in those days there was always one old maiden aunt.[63]

But some daughters-in-law did assist, one helped during the war when there were no other family members to fall back on.[64] Another daughter-in-law cared for her father-in-law because all his daughters had young babies, but the daughters did come and help clean the house once a week in turn.[65] Mrs MC's paternal grandmother lived with them and was nursed by her mother when he was very ill and subsequently died.[66] On the other hand, examining the role of sons-in-law indicated that they were generally

[59] Mrs RB OX38, 23/7/99, p. 1.
[60] Miss BH OX39,13/10/99, p. 4.
[61] Mrs LW OX33, 17/5/99, p. 8.
[62] Mrs IM OX57, 30/3/00, p. 7.
[63] Mrs DB OX41, 29/10/99, p. 10.
[64] Mr WL OX56, 30/3/00, p. 3 during the war his wife looked after his mother as everybody had left home.
[65] Mrs DB OX41, 29/10/99, p. 5.
[66] Mrs MC OX5,17/2/98, p. 2.

supportive. Mrs DC recalls how her mother was finding it difficult to manage on her pension so "..my husband had her to live with us."[67] For one son-in-law although his wife's mother was particularly demanding and needed to live with them for long periods of time, he agreed to have her to stay in consideration for his wife: "I had to for my wife's sake you see really."[68] He is insinuating that this arrangement was stressful for him, but he overrode his personal feelings in deference to his wife. As he was the only son-in-law to articulate comments of this nature it is not possible to suggest that this was a usual or unusual situation, but it does fit in with other oral evidence claiming arrangements were stressful for families.

Respondents gave examples of how female relatives helped to care for their old folk whilst still living independently in the community. Help was provided in a variety of ways by daughters such as bringing food; a son-in-law arranged for his elderly mother-in-law to live next door while the daughter helped in the house; daughters remember their mothers doing their maternal grandmother's shopping and housework, and when illness struck they would visit and help accordingly. If daughters lived near the parent then for practical reasons, they assumed the caring role. [69]

When a parent needed more help and support and had to live with relatives they usually went to live with a daughter. Relatives recall numerous examples of this.[70] But there seemed to be quite a lot involved in deciding which daughter provided the care. There were several different scenarios presented. Firstly there was shared care by the family (mostly daughters) and the relative lived with family members on a rota basis.[71]

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[67] Mrs DC OX34, 14/6/99, p. 7.
[68] Mr BH OX42, 22/11/99, p. 4.
[69] Mrs OA OX55, 12/5/00, p. 1, remembers her aunts bringing her grandparents food; her grandmother had six daughters and a son, the daughter who lived nearest did the caring for practical reasons.; Mrs MP OX45, 6/12/99, p. 4, her father arranged for her widowed maternal grandmother to live next door and her mother cared for her "she lived on her own and she used to look after herself I think my mother did a bit for her but she always came in and had tea with us." Mrs KP OX17, 16/3/98, p. 3. Mrs MD OX6, 9/7/98, p. 6, used to go and visit her mother and help her with jobs around the house. Mrs OH OX11, 9/6/98, p. 5, when her mother was ill she would visit her mother everyday after she suffered her stroke in 1929 and her aunts and her father helped to nurse her. Mrs MC OX5, 17/2/98, p. 2, her mother looked after her mother in the 1930s when she was ill.
[70] Mr RH OX30, 23/2/00, p. 2, remembers his next door neighbour who was nearly 100 years old in 1922 and her daughter and son in law lived with her. Mrs DC OX34, 14/6/99, p.8, her mother came to live with her when she was getting old and unable to manage on her pension, both of these are typical examples.
[71] Mrs MG OX31, 14/6/99, p. 11, her mother and her two sisters took turns to have their older mother living with them; her godmother had eight children who all took it in turns to have their mother.

Secondly unmarried daughters were expected to care for the elderly parent.[72] Thirdly sometimes daughters would give up their home and move their family to live with an ailing parent.[73]

How the care was negotiated within the family is not clear. Many of the respondents were children at the time their grandparents needed help and support, therefore it was highly unlikely that they were actively participating in decision making of this kind. This is supported by Mr HC who thinks that the arrangements for his grandmother to go to live with her son must have been discussed as a 'family concern ' with his father and uncles but he was only 15 and not involved.[74] But there are some illuminating perceptions of how care evolved within the family, particularly in relation to the roles that women took on. Mrs RB describes how her mother ended up looking after her own mother:

> .... But two of them *[brothers]* did live with her after her husband died and my mother and these two made themselves scarce in a way because they weren't going to be left, and eventually their wives had nothing to do with their mother-in-law they weren't going to be saddled ....so my mother was the one left to hold the fort ..... because she was the only daughter and was the youngest.[75]

Mrs RB considers this situation happened a lot and Mrs MP provides another view that illustrates how things seemed to "happen". She considers that the person who did the caring was the person most able: "I take it would be the person who was most able to. I mean my mother had brothers, I mean my grandmother had sons in Bristol and a daughter I suppose it was just worked out that she came to my mother and that was it." Mrs JT gives an explanation as to why unmarried sisters in her parent's families ended up caring for her grandparents. She describes her perception of why the eldest daughter (out of three daughters and five sons) cared for the mother (paternal grandmother) and considers she was: "Not forceful enough you know not sort of pushing enough personality to want to leave home....I believe she was engaged to be married at one stage but it fell through..." She also describes why she thinks her mother's youngest

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[72] Mr HC OX44, 13/12/99, p11, his sister who was unmarried left her job in service to come and look after her mother who was ill with heart disease she then stayed on to look after her; Mrs DB OX41, 29/10/99 p.2 her mother was the eldest daughter and when her mother died when she was in her mid 30s she looked after her father; after she married her younger sister looked after their father until he died. Mrs DB lived next door to her father and sister. Mr ML OX15, 24/6/97, p. 2, his grandmother lived with her three unmarried daughters.

[73] Mrs LW OX33, 17/5/99, p. 8, gave up the tenancy of her own place to return to live with her father when he was widowed in 1944; she had an older sister who had four children and some problems.

[74] Mr HC OX 44, 13/12/99, p. 4.

[75] Mrs RB OX38, 23/7/99, p. 4.

sister cared for her mother: "She had a good job, she had been engaged but it fell though and she'd got a good job and she lived at home...you did in those days you know it was cheaper to live at home and also this grandmother had dreadful ulcerated legs and she treated her legs for her every morning before she went to work..."[76]

Respondents' testimonies are suggesting that unspoken or sub-conscious, but often self-interested decisions, were made in families and frequently the youngest or the unmarried sister left at home drifted into, or was expected to do the caring. Being an unmarried female sibling at home seemed to lead to being a carer for elderly parents. If siblings were married then more complex influences were involved.

One gentleman did remember getting together with his wife's family and discussing the arrangements for his mother in law to live with the family on a three monthly rota basis.[77] This could suggest that caring was seen as a less than optimal role and the reasons the care was shared could have been financial, practical or emotional. There may not have been enough money for caring for an extra adult, or family members may have experienced relationship or practical problems arising from the arrangements. Sharing the care of an elderly relative by families could mean that there were a variety of reasons why this happened. It could be that there were financial problems in the family and therefore this agreement was mutually beneficial. Likewise if family dynamics were upset by caring for an elderly relative sharing the care may have been helpful as this distributed the problem and did not leave one family member with the onus of care. Two other more positive reasons should also be considered. Family members may have all been eager to help their parent, or the parent wanted to spend as much time with all his or her children. Reasons for the rota based care were not explored in depth as this was not a common occurrence amongst the respondents. The above analyses are based on respondent's diverse contributions regarding their attitudes and experiences to caring for their elderly relatives, and have ranged from positive attitudes to resentful or dishonest ones.

So far the discussion has focussed on daughters but there is evidence to suggest that some sons did help their elderly parents in different ways. Sons who were only children would take responsibility and sons who came from big families would also help out. But these appear to have been exceptional. The following are examples of this. Mr WL

[76] Mrs JT OX37, 20/11/99, p. 5.
[77] Mr BH OX42, 22/11/99, p. 4.

helped his mother out, as did his sister, but his brothers didn't and he describes this: "Well it was the habit in those days brothers weren't expecting it you see....it all had to be the girl. Only in my house I was the "girl" [chuckles].[78] Mr HC's grandmother went to live with her son although there was a daughter. The daughter was in service as a cook and housekeeper and so could not help.[79] However Mrs RB thinks that it was usually the youngest son or daughter who was expected to care for the parent. She raises the gender aspects associated with this situation and suggested that, if the son was helping out, then people would praise him for being a wonderful son, implying that it was taken for granted that daughters would help.[80] It seems that in general men would help more with financial and organisational aspects of caring.

When old people lived with family members this could cause problems. Understandably life could be very difficult if there were space problems and three generations lived in the same home. For one family where each of the families had their mother to stay with them every three months, relationships broke down between the son and his mother when his daughter got fed up with sharing a bedroom with her grandmother. [81] Mrs RB draws attention to the fact that children and old people could be quite difficult in these situations and underlying the arrangements was a complex of family tensions and conflicting responsibilities:

> ..... But you see old people were a terrible nuisance. First of all they were always there sitting in their favourite chair then there were their various illnesses ....they coughed or they snuffled or they hacked...had hacking coughs or they were incontinent they were a frightful nuisance sometimes they were treated with jocularity you know "don't tell the old man" or "that'll amuse the old girl" something of that kind. They weren't treated with much respect I can tell you. Although the idea it might be put about outside the family 'I loved them I had tender feelings towards my old mother or father', but really and truly the underlying feeling was resentment, and since the old mother and father, as long as they had enough energy, would fight hard against the daughter marrying or the son marrying, sometimes that would mean they would take them away or have other demands so very often some of these girls, Victorian girls and they were still alive...their parents were still alive they were born in Victorian times would be very resentful because mother had refused to [allow] any boy brought into the house any boyfriend brought into the house saying I won't allow it or I shall stop it or something ...oh yes many of them never did marry because there

[78] Mr WL OX56, 30/3/00, p. 4.
[79] Mr HC OX44, 13/12/99, p. 4.
[80] Mrs RB OX38, 23/7/99, p. 16.
[81] Mr BH OX42, 22/11/99, p. 4.

> was a moral obligation to stay. If you did not look after your old people you were condemned by other people.[82]

Echoes of Roberts' research can be heard in the last sentence of this testimony, in her assertion that if family members did not care for their relatives then there was social disapproval in the community. Mrs RB narrows down this disapproval to unmarried women and suggests that there was a great expectation for them to care. This effectively placed a value on the role of single women which might help shape their life course. She also describes some of the children's relationships and attitudes towards old people:

> And then there were the children who could be a nuisance and you had to keep the children quiet well you didn't but you can't say...you can't keep the children quiet because it disturbs the old lady and then the teenagers absolutely hated them ....the teenagers would play away ...the 15 year old boy would say I'm not coming anywhere I'm staying here. Well they hated...they took against the old people - I know there was a story but like the relationship with grandchildren, the old people might try very hard and a lot of small children are fond of the grandparents, but not when they get a bit older and when they get to their teens.[83]

Power balances in the household were identified as a source of tension by some respondents. For example, if the house was in the parent's name, then apparently the adult children could not take out hire purchase agreements without written consent from the house owner, and this could cause friction.[84] In another situation where the family moved in with the husband's mother, her daughter thinks that the mother-in-law took over the running of the household, and the daughter-in-law had to be very diplomatic, which was stressful for the marriage.[85]

While some had problems with parents living with them others didn't. There doesn't appear to be a pattern to suggest why this should or shouldn't be a problem, but inevitably living space and resources would have been influential as, were the dynamics within the family. Families responded differently to this situation. Often the arrangements were of mutual reciprocity, for example a married granddaughter moved in with her grandmother, which solved her accommodation problems and provided the grandmother with care.[86] Other elderly relatives also lived with the family, for example, aunts and uncles. Sometimes unmarried siblings would live together and the

[82] Mrs RB OX38, 23/7/99, p. 16.
[83] Mrs RB OX38, 23/7/99, pp. 10-11.
[84] Mrs RB OX38, 23/7/99, p.13.
[85] Mrs KP OX17, 16/3/98, p. 1.
[86] Mrs DB OX41, 29/10/99, p. 10.

sister would be the housekeeper. Another example of co-residence was when outsiders of the family moved in to the home. An elderly woman rented part of her house out to a poor family in return for them keeping an eye on her, and another woman took in lodgers who helped her with practical tasks.[87] Besides this there was an element of mutual reciprocity in co-residency; for example, a home was offered in exchange for caring for an older person.[88]

Old people did not necessarily want to be dependent on their families and developed strategies for coping financially, by having lodgers, growing produce on their allotments, working part-time or taking in laundry. It was usually when these arrangements broke down that help was needed. If there was no family available then the alternative for people without financial assistance would have been to use the public assistance institutions. Evidence suggests that old people living alone got some support from their communities. This support was manifested in a number of ways ranging from sharing allotment produce, helping with shopping or household tasks, keeping company with a lonely old person, preparing meals and distributing Christmas goods.[89] Shopping was not too demanding a task as communities would have local traders nearby. Clearly there were some gendered aspects to caring that were in part dependent on the family composition, but also on society's expectations of men and women. (These aspects will be discussed more in Chapter Six). Respondents' considered that the reasons why an old person would have been admitted to the workhouse were as follows: first there was nobody to look after them, particularly a daughter; secondly, relationships with their families had been destroyed; thirdly poverty and homelessness; and fourthly because the family could not cope with the demands of an old person's illness.

Perception of the CRH and service users

Crowther explores the complex reasons why the workhouse has engendered such a "peculiar revulsion".[90] It was an institution that had an extraordinary dual role. On one hand the workhouse provided institutional regimented care for helpless and abandoned

[87] Mrs RB OX38, 23/7/99, p. 8; Mr HB OX27, 14/4/98, p. 4.
[88] See Roberts Women and Families, pp. 175-198. Roberts elaborates on complications in the dynamics of kin relationships and discusses exploitation vis a vis self interest in relation to reciprocity.
[89] Mrs MQ OX53 p. 5, Mrs RS OX43 p. 7, Mr DB OX36 p. 3, Mrs LW OX33 p. 12, Miss ME OX32 p. 12, Mrs KP OX17 p. 4, Mrs MH OX p. 10, Mrs MW OX25 p. 3, Mrs SH OX9 p. 7, Mr RT OX22 p. 6, Mr BB OX27 p. 8 all these respondents recall the incidents described.
[90] See Crowther, Workhouse, pp. 267-272.

people, children and elderly persons; on the other hand it was a deterrent for the able bodied-poor. This combination of deterrence, institutionalisation and destitution, created a powerful perception in society. Alongside these perceptions other fears were prevalent. Suggestions have been made that old people also feared the workhouse because of rumours of 'body snatching'.[91] Respondents were not directly asked about 'body snatching' and they did not raise the subject during interviews. It is not possible to draw any conclusions from this other than there were no significant memories amongst those interviewed.

Several of the respondents had visited the CRH because they were entertained residents or visited relatives. Local school children, church groups and drama groups would provide entertainment for residents. Most commented on the drab décor of the CRH, Mrs LW visited a friend of her mother's in the CRH and remembers: "It was all very dark green and you went along these long passages you know it was quite cold"[92] Another visitor Mrs SH remembers the CRH as: "Being a terrible place for somebody to have to go to....it was a great big ugly stone building ...there was no separate room they were all so ugly and bare and great big windows."[93] But a different view is recalled by Mrs VG who visited her friend's father who had suffered a stroke in the early 1940s she remembers the coal fires and she thought it was "cosy and homely"[94]

[91] S. Hussey, 'An Inheritance of Fear: Older Women in the Twentieth-Century Countryside', in, (eds.), L. Bothello and P. Thane Women and Ageing in British Society Since 1500, (Harlow: Longman, 2001), pp. 186-207. Hussey refers to research by Ruth Richardson, on the Anatomy Act in 1832 which gave permission for poor law institutions to supply anatomical schools with unclaimed pauper corpses.
[92] Mrs LW OX33, 17/5/99, p. 10.
[93] Mrs SH OX9, 26/6/97, p. 5.
[94] Mrs VG OX8, 9/6/98, p. 3.

Figure 3.3: Southwell Workhouse

This picture of Southwell workhouse (Figure 3.3) illustrates the décor characteristic of these institutions at this time. The colour schemes also fit with the descriptions by respondents, dull, dreary shades.[95]

[95] The National Trust restored Southwell workhouse to nineteenth century conditions but left some rooms as they found them. This room has been left as it was found.

Figure 3.4: Interior of Cowley Road Hospital circa 1950s [96]

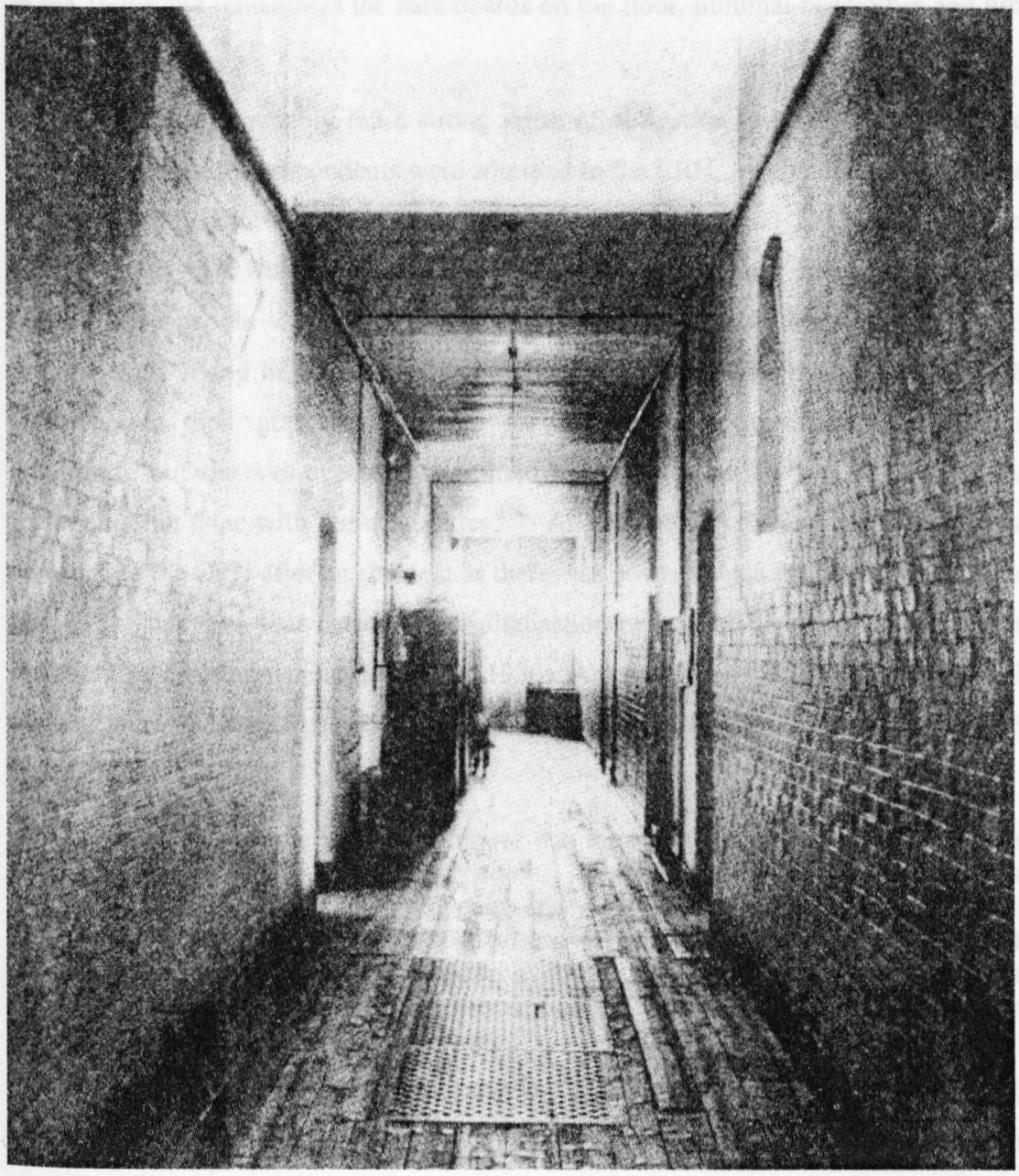

Figure 3.4, a photograph from 1959, is of the inside of the CRH and shows the long corridors that respondents who had visited the hospital described.

There was an overall impression from the respondents that the majority of inmates were old people although some tramps also used the CRH. A visitor to the CRH in the 1930s recalls that men and women were separated, and that this was difficult for married couples. She also recalls that there was no therapy of any kind, patients waited for their

[96] S. Shatford and T. Williams, The Changing Faces of St Clements and East Oxford, Book Two (Witney: Robert Boyd, 1998), p. 73. Reproduced by permission of S. Shatford.

meals and were told when to go to bed.[97] Mrs ST visited her grandmother in the CRH in the 1920s and remembers the bare boards on the floor, minimal bedclothes and little food for inmates.[98]

Although people inevitably felt a strong sense of obligation to care for their relatives some relatives of the respondents were admitted to the CRH. A grandfather of 83 years old was admitted to the public assistance institution in the mid 1940s. He had lived alone for ten years with family help but became incontinent and they could no longer cope.[99] Old people were being cared for in some deplorable situations, and some families were living in extreme poverty. One large family who lived in the slums of Oxford with their grandmother cared for her for many years despite appalling conditions, but she was eventually admitted to the CRH, as she was so crippled that they could not cope with her disabilities.[100] Another elderly father aged 84 years was admitted to the CRH after an accident as there was nowhere else for him to go.[101] In her account of her four year period of hospitalisation in London poor law and voluntary hospitals, as a young woman in the late 1930s, Aronvitch sums up reasons why elderly patients were admitted to hospital. She also highlighted attitudes towards admission by old people:

> Not to have to die in the workhouse was the unspoken prayer and greatest wish of many aged, working-class people. The family of the aged did their best, often in the face of unemployment and great poverty. Having nursed an aged person for a long time, the difficulties towards the end became more than the ordinary family could cope with, so it was that many of these old folk were finally brought into hospital, literally dying. Sometimes they would last a few weeks, whilst others died overnight.[102]

Aronvitch's first hand observations reiterates local experiences on admission to the CRH by elderly people, it was often a last resort because alternative care was not available. But there remained a stigma about admission to the CRH summed up by Mrs VG: "I don't know when it became a hospital .....there was always that stigma. If ever I met anybody and they'd got an ageing parent they would say "oh I'm not letting my

[97] Mrs RB OX 38, 23/7/99, p. 9.
[98] Mrs ST OX21, 9/5/97, p. 2.
[99] Miss BH OX39, 13/10/99, p. 3.
[100] Mrs ST OX21, 9/5/97, p. 2.
[101] Mr BB OX4, 6/7/98, p. 4.
[102] B. Aronovitch, Give it Time (London: Andre Deutsch, 1974), pp. 66-67.

dad or my mum go into that old workhouse"...it still had....it still had a workhouse stigma attached to it [even] as a hospital."[103]

It is pertinent to note that relatives of those admitted to the workhouse did not apparently share this opinion. Miss BH did not think it was a disgrace for the family to have an older relative go into CRH as it was the only place that could look after older people in those days: "It wasn't an unprecedented thing neither was it a disgrace it was where they were looked after sort of thing at the end of the day..." [104] Additionally Mrs DB considered that her grandfather was so ill when he was admitted to the workhouse that he didn't really worry about where he was.[105] In fact other testimonies also concurred with this as people thought that if you were sick you were thankful to be cared for. Examples of this were: "I suppose in those days you were just grateful for it,"[106] and: "...She just had to put up with it poor old soul you didn't have choice with anything in those days she'd got no money."[107] And Mrs HH thought that people had little choice in what facilities were given and could not grumble.[108] These extracts could well be interpreted as a defensive rationalisation for letting relations be admitted to a public assistance institution, or they could be considered pragmatic responses to the situation at the time. In reality there were no options for a poor sick old person when the family could not help any further, be it for practical, emotional or financial reasons.

Grandparents may well have feared the CRH, although direct evidence for this is lacking, because of the shame of having to go into the workhouse, which was an indication that you had nobody to care for you. The institution was also seen as a place for people who were incurable. Childhood memories had also influenced respondents' views of the workhouse and these can be separated into three areas. First, as children they were brought up to believe that admission to the workhouse was a disgrace. Therefore their attitudes will have been determined by long term parental and peer group influences and stigma. These will undoubtedly have been formed and passed down through generations dating back to the previous century. Secondly, it was seen as a punishment and used as a threat. Mrs SH remembers her mother saying: "If you do anything wrong you'll go to the workhouse". Combined with this were rumours that the

[103] Mrs VG OX8, 9/6/98, p. 4.
[104] Miss BH OX39, 13/10/99, pp. 5-6.
[105] Mrs DB OX41, 29/10/99, p. 5.
[106] Mrs SH OX9, 26/6/97, p. 5.
[107] Mrs ST OX21, 9/5/97, p. 3.
[108] Mrs HH OX13, 23/4/98, p. 5.

workhouse staff were cruel and conditions inside were grim.[109] Thirdly, there was fear of the unknown. For example Mrs RB's mother used to say: "Oh heavens I can see my self going up the Cowley Road," or: "If you take me up the Cowley Road I shall jump over Magdalen Bridge into the water," or: "You ought to have been a workhouse matron...or you have a workhouse matron manner."[110] Most of the respondents were small children in the 1920s and 1930s. It is unlikely that many had first hand experience of the CRH, as orphaned children tended to be sent to the Poplars, the industrial school in Cowley.[111]

Three key points have emerged from the residents' testimonies. The first point is that old people wanted to remain independent in the community and tried to maintain this for as long as possible. Secondly, there was a strong sense of family obligation to care for elderly relatives partly because of the fear and stigma attached to admission to the workhouse, and also due to the genuine love and desire to care for them. However, stress and strain on the family was not uncommon and probably not talked about. Thirdly, admission to the workhouse was usually because the family could not provide for the elderly relative. Housing was poor then and some people did not have an indoor toilet, or bathroom. Housework was more laborious as modern conveniences were not readily available. Neither were there many support services from the local authority. Offsetting these negative perceptions was a realisation by some that, despite the fears and hatred of the "workhouse" old people who were admitted to CRH were well cared for.

Official information on the conditions for old people from 1930 -1948

Poor Law records on the CRH and the Laurels were deliberately burnt before the start of the welfare state, but no reason has been discovered for this action. Speculation suggests that this was a physical gesture to signify the end of the poor law, or it could be to hide incriminating evidence.[112] In view of this alternative information has been

[109] Mrs SH OX9, 18/5/98, p. 6.
[110] Mrs RB OX38, 23/7/99, pp.8 & 11.
[111] I have interviewed two people who lived in The Poplars during the 1920s who had little contact with CRH who confirm this. Families would go to the Laurels or CRH. Unless the family had cause to be admitted to either the Laurels or CRH then direct experience of these institutions was limited
[112] Personal discussion with Elizabeth Boardman, Oxford Hospitals Archivist who believes that the CRH records before 1948 were burnt in a bonfire. No date has been established when this happened. There are no records available for the Laurels either.

collected from Oxford City Council Minutes and Reports. It is very probable that the destroyed records held more detailed information.

As we have seen earlier, when the workhouse was built in the nineteenth century the intention was to provide a mixed workhouse for 330 inmates. But from 1930 the following groups were accommodated in the CRH, maternity cases, (until 1946), children, TB patients, chronically sick, old people and vagrants. Records from the city council archives show that the highest number of inmates during the 1930s was 217 people in 1933, and the lowest was 182 in 1930. Of the 217 inmates in 1933, 18 were men, 72 were women and 27 were children, but no more detailed breakdown of the composition of these inmates is given.[113]

In 1933 the city council were concerned about the potential lack of accommodation at the CRH and wanted to remove the casuals from the CRH to increase space.[114] However, records indicate that only 217 beds out of the available 330 were occupied, therefore there were 113 unused places. It is a mystery why there was such a large number of unoccupied beds when there was an official recognition that more accommodation was needed. One conclusion that can be drawn from this information could be that there was not enough space for the increasing number of old people needing accommodation in the wards allocated for them. Removing casuals may have created extra space for this group.

The next chapter discusses the effects of the increased older population in public assistance institutions in relation to the development of geriatric medicine. From 1939 to 1945 the CRH was requisitioned for the Emergency Medical Service (EMS). Part of the hospital was actually used for the EMS but 220 geriatric beds and 15 maternity beds were left for public use. Arrangements were dependent on local needs. For example, in London some institutions evacuated elderly patients because of the anticipated attacks on the capital and the need for hospital beds for casualties.[115] Oxford City was not

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[113] City of Oxford Council Reports 1934, Public Assistance Committee 14/12/33, p. 93.

[114] City of Oxford Council Reports 1933, Public Assistance Committee 6/10/33, p. 833. The hospital management sub-committee reported that "the hospital sub-committee wish to represent to the Public Assistance Committee the difficulty of finding accommodation for the increasing number of inmates. If it were possible to remove the casuals from the Cowley Road Hospital, the day rooms now occupied by them would be a welcome addition to the available accommodation." (It is not specified whether the 'casuals' were the 'in-and-outs' amongst the local poor or the 'casual poor'). The Public Assistance Committee were then authorised to make enquiries as to the cost of a new casual ward site.

[115] Abel Smith, Hospitals, pp. 424-439. This chapter overviews national hospital arrangements made during the Second World War. Within this chapter the problem of the aged and chronic sick in hospital and the evacuation of old people from hospitals are addressed.

bombed during the war and the EMS left a fair proportion of beds for old people, but in light of the registered previous concern about adequate places in the CRH this may still have left a gap. This shortfall was not addressed in the reports and no mention is made of alternatives for old people in the city.

Evidence from the council reports suggests that old people were reasonably well provided for in the CRH within the context of the time. Inmates were given treats and entertainment at both the CRH and the Laurels.[116] Personal interest was taken on occasion. For instance, one inmate of CRH was sent congratulations on reaching her 100th birthday by the public assistance committee in 1930. Open Days were held at the CRH and the Laurels in 1934 which indicates a sense of honest administration.[117] Inspections were carried out and noted by the public assistance committee.

Reports from the housing committee provide evidence of the general state of housing in Oxford and the need for slum clearance but do not detail conditions for old people.

There were no local authority support services in the community that would have enabled old people to be able to maintain their independence at home. Consequently the CRH was the only resource provided by the local authority for them. The CRH provided basic nursing care and elderly residents were given extras, thereby acknowledgement was made by the city council that old people did have special needs. In 1935 the public assistance committee passed a resolution to convert CRH into a home for aged and poor persons with an infirmary for the bedridden. This suggests that there had been public discourse on the welfare of old people that was not recorded in the official minutes.[118] Whilst the Second World War obstructed any possible progress or developments for old people's welfare there were beginnings of change immediately after the war. The public assistance committee in conjunction with the city estates department and the housing committee started to address community accommodation needs for old people.[119] This initiative was a response to national policy developments introduced by the Labour administration.[120] A further indication that national changes

[116] Oxford City Council Reports and Minutes 1930-1939, make references to the extras given to inmates and note the entertainments.
[117] Oxford City Council Reports 1934, Public Assistance Committee 5/10/34, p. 913.
[118] Oxford City Council Reports 1935, Public Assistance Committee 9/7/35, p. 796.
[119] Oxford City Council Reports 1946, Public Assistance Committee, 2/4/46, pp. 373-374, and Housing Committee 23/5/46.
[120] A change in philosophy and policy towards welfare for the poor had been instigated by the Labour Government and new guidelines were being distributed to local authorities particularly in relation to the NHS Act 1946 and the National Assistance Act 1948.

were having an impact locally was the fact that Oxford City Council sent delegates to national conferences on old people's welfare.[121] At this stage Oxford City Council appears to have been neither negligent nor progressive in the care and welfare of old people but mainstream.

Conclusion

Not all the needs of old people were met, financial problems featured as a key factor in determining adequate care. This combined with the lack of local authority community resources placed an onus on families to support their elderly relatives. Societal pressure undoubtedly played a big part in family decisions to care for their elderly parents. Living with relatives, however did not always solve the problem and created stress for some families. Families had to cope with this stress without state support systems in the community. Sometimes, despite the well intentioned motives by a family to provide care to avoid a relative's admission to an institution, if this care broke down, the public assistance institution was the only other option.

Attitudes to the CRH seem to have been based on hearsay rather than actual experience. Data collected for this thesis has not produced any objective evidence to suggest that the CRH was a particularly dreadful place for old people from 1930 to 1948. The CRH did provide a service for old people in Oxford but to have been admitted to this hospital was considered shameful, second rate and terminal by both professionals and relatives. Inevitably previous attitudes influenced opinions but nothing extraordinary was revealed from the respondents. Apart from the humiliation attached to admission to CRH fear of the institution seems to have been based on folklore.

This chapter has explored the political and social background to the CRH, charted the particular local developments leading to the provision of welfare services between 1930 to 1948, and established community perspectives on the institution during this time. What has emerged is a general acceptance that the institution did provide essential care for old people who were without financial and social resources, but that most would not use it as revulsion out-weighed benefits.

In the next two chapters developments in geriatric medicine will be analysed to show how these influenced changes from 1930 to 1960. Chapter Six will examine how and

[121] Oxford City Council Reports 1945-1946, Public Assistance Committee 19/11/1946, p. 42. A delegate from the council was sent to the NOPWC conference in London.

whether the attitudes towards the workhouse identified in this chapter carried on in the community after these radical changes.

CHAPTER FOUR

Changing attitudes to old people within the medical profession

It is dangerous to be in any way lavish to old age until adequate provision has been assured for all other vital needs, such as the prevention of disease and the adequate nutrition of the young. Sir William Beveridge 1942 [1]

This chapter will examine whether there were significant changes in attitudes and practices towards old people before, and for twelve years after, the inception of the welfare state. Some of the main concerns of the medical professionals regarding old people's health and welfare before 1948 will be identified from original sources, to establish whether there was a link between these concerns and the development of state provision for elderly persons. Explored in this chapter is the development of the policy framework for the care of old people, supported by the emergence of a new speciality and detailed policies to sustain them in their communities. As professional expertise developed, more diverse aspects of old people's care were identified. These ranged from mental health, to housing needs and community resources. The conclusions of this part of the investigation will construct a national framework within which local provision and developments for old people post-welfare state can be contextualised later in this thesis.

Since the beginning of the twentieth century there had been a steady increase in the population of people over 65 years and, generally speaking, improvements in social and health conditions played a major part in this rise. Local age profiles are given in Chapters One and Seven, Figures 1.1, 1.2, 1.3, and Table 7.1. Jefferys and Thane remark on the changing age structure in relation to the falling birth-rate and decline in mortality rates amongst old people.[2] Table 4.1 charts the changing ageing profile on a national level.

[1] Social Insurance and Allied Services, Report, HMSO 1942, p. 92.
[2] See Thane, Old Age, p. 332, for a detailed account of the implications of the ageing population.

Table 4.1: Age proportions at successive censuses, 1901-1961, per 100,000

	1901	1911	1921	1931	1951	1961
0-14	32420	30637	27715	23830	22145	22958
15-64	62914	64154	66237	68754	66828	65121
65-84	4517	5031	5848	7175	10575	11267
85 and over	149	178	200	241	452	655
Males						
0-14	16187	15334	13950	12037	11308	11765
15-64	30135	30787	31172	32668	32212	32052
65-84	1977	2181	2522	3108	4368	4364
85 and over	55	63	65	77	139	196
No of males per 100000	48354	48365	47709	47890	48027	48377
females						
0-14	16233	15303	13765	11793	10837	11193
15-64	32779	33367	35065	36086	34616	33069
65-84	2540	2850	3326	4067	6207	6903
85 and over	94	115	135	164	313	459
No of females per 100000	51646	51635	52291	52110	51973	51624

Source: Census of England and Wales, 1901- 1961.

As discussed in the previous chapter health care for old people without financial resources from 1930 until 1948 was mainly in the public assistance institutions. Despite overall social improvements, many old people were probably still in a bad condition due to physical, social and economic factors. Seeking the help of a doctor in the community to rectify health problems was expensive for people living on limited finances. Geriatricians interviewed by Jeffreys recall how many old people in public assistance institutions were not examined properly during the thirties and forties, consequently erroneous diagnoses were made.[3] It is probable that even though the majority of inmates in public assistance institutions were elderly, good practice in the care of old people was a lottery depending on where you lived and whether the doctor in the establishment had a specific interest in geriatrics. One other point to note is that many of the public assistance institutions had part-time medical officers who, for practical reasons, would not have had much time to devote to the patients.

Older people in 1948 had lived through two world wars and the depression. Neglected obstetric care for women contributed to their pitiable general health.[4] Working class women married in their teens or early twenties in the 1890s; they averaged 10 pregnancies, and spent 15 years in pregnancy and nursing compared with an average of

[3] Jeffreys, Geriatrics, Thomas Rudd, C512/21/01, p. 3.
[4] Webster, 'Elderly,' p. 167.

4 years spent by their counterparts in the years following WWII.[5] Older women with this obstetric background would most probably have been in a very poor physical state in the late 1940s. There is little exact information about old people's health but general suppositions have been made. Webster, for example, describes the general health of old people when the welfare state was introduced. He believes that they were physically run down, and most likely living in inadequate housing which made running a home very hard physical work. Furthermore, he suggests that many people had lost their teeth, glasses would be purchased from Woolworths for sixpence, hearing aids were difficult to obtain and people who had mobility difficulties had little assistance. Regular contributions to Friendly Societies (private insurance schemes) were also financially prohibitive for many old people; consequently many older people neglected their health.[6] Old people were obviously more prone to the slower moving kind of illnesses than younger people and were labelled the "chronic sick." As discussed in Chapter Three, poverty, combined with ill health, poor accommodation and no family resources would often mean admission to a public assistance institution.

The demand for beds during war time prompted the government to survey hospital services. Old people were evacuated to make room for casualties. This exercise revealed that old people were often being cared for in appalling conditions.[7] About the same time, within the medical community a minority of physicians working in hospitals began to be concerned about the care of, and attitudes towards older people. Articles raising these concerns starting appearing in the medical press in the 1940s.

Webster has charted changes to the national age profile as the population of those aged over 65 years increased from 4.6m to 5.3m in the first ten years of the NHS. In particular more people were surviving over the age of 75 years (this had increased from 1.5m to 1.9m) and this put more strain on the existing services.[8] However, 95 per cent of old people were living at home, and most wanted to retain their independence for as long as possible.[9] These situations inevitably posed two problems for the government; first, how to manage the increased population in the hospitals, and secondly, in order to avoid more admissions, how to make improvements in the community to enable the

[5] J. Lewis, Women in England 1870 – 1950 (Sussex: Wheatsheaf, 1984), p. 23.
[6] See Webster, 'Elderly', pp. 165-187.
[7] G. Bennett and S. Ebrahim, Essentials p. 59; Lord Amulree and AL Sturdee, 'Care of the Chronic Sick and the Aged', BMJ, I (1946), pp. 617-9.
[8] Webster, 'Elderly', pp. 165-187.
[9] Boucher, Survey, p. 30.

majority of old people to remain independent. In order for this plan to work an adequate community care policy had to be in place. Community care was a relatively new concept in the 1950s and needed detailed planning with adequate finance. The lack of the development of a properly resourced community care policy in the 1950s contributed to the insufficient development of residential and domiciliary services.[10] Webster considers that although a good start was made in the hospital services and a framework for comprehensive community care established, transformations did not materialize because of inconsistencies and contradictions within the infrastructure: "For reasons of inertia within the system the policies pursued were often inconsistent with the broader objective of community care."[11]

The Beveridge extract at the beginning of this chapter is from a significant government report in 1942, and must have sent a strong message to the nation on the future low priority of old people's health and welfare.[12] Prior to this time much of the lobbying for developments in old people's welfare had been centred on pension improvements. During the 1940s concerns broadened out, and voluntary groups were established and campaigned on behalf of old people.[13] There were several types of pressure groups representing, lobbying and negotiating on behalf of older people since 1916. These included the National Conference on Old Age Pensions (NCOAP) (1916), the National Spinsters Pensions Association, (NSPA) (1935), the National Federation of Old Age Pensions Associations (NFOAPA) (1938), the National Old People's Welfare Committee and the National Corporation for the Care of Old People (NCCOP) (1947). All these groups had different roles within the lobby for older peoples' needs, some were promotional and others representative. Research on old age began to attract writers from the social sciences and medicine after Seebohm Rowntree's report in 1947. When the trend towards community care began to evolve in 1953, NCCOP policy switched to providing support for domiciliary projects for older people such as

[10] See Means and Smith, Development, pp. 121-166.
[11] Webster, 'Elderly,' pp. 165-187.
[12] C. Boucher, Social Insurance and Allied Services, Report (HMSO, 1942), this report was used as a basis for the welfare state provisions.
[13] J. Macnicol and A. Blaikie, 'The Politics of Retirement', in M. Jeffreys, (ed.), Growing Old in the Twentieth Century, (London: Routledge, 1989), pp. 25-30. The authors outline the different roles of the pressure groups and the labour movement in relation to policy development from 1908 - 1948 in detail. In this context it is necessary to acknowledge that there is a difference between 'promotional' groups which act on behalf of a body and 'representative' groups which are composed of interests. To be effective as a promotional group the support is needed of the people the group represents. The groups claiming to speak on behalf of their membership do not have a representative membership.

giving priority to schemes supporting older people to remain in their homes rather than be hospitalised.

The NOPWC, (founded in the mid 1940s by Miss Keeling and Miss Rathbone, a leading philanthropist), was a national body but had local groups and convened annual conferences with impressive speakers. This organisation was concerned with disseminating information to older people to inform them of benefits and other welfare rights as well as highlighting the problems faced by old people.[14] Conference speakers ranged from Dr Marjory Warren, Nye Bevan, Dr Trevor Howell to Sir William Douglas (secretary to the Minister of Health in 1949). Topics covered were wide ranging, addressing concerns on institutional and hospital care, family expectations, accommodation needs, or the work of the Society for Medical Care for the Elderly. Delegates to conferences were from government departments (local and national) and voluntary organisations. Sir Fred Messer, chairman of NOPWC, was a Labour MP in the early years and helped publicise the plight of old people.[15]

Old people were (and still are) removed from the workforce. They consequently had little bargaining power and were minimally represented. Pressure groups campaigning for improved services for old people had limited political influence even though there were significant influential figures supporting the work and aims of groups.[16] These pressure groups acted as watchdogs and could use the media to generate public interest and support. Although there was a difference between the NCCOP and the NOPWC the two organisations linked together. Doctors from the Medical Society for the Care of the Elderly worked with both of them. These organisations and medical professionals were key players in promoting the cause of old people.

Evidence from testimonies and writings from medical professionals working with old people from the 1930s to 1960, illustrate their role and influence in developments in their care before and after the inception of the welfare state. A collection of oral histories from professionals working with old people was carried out by Jeffreys during 1991.[17] A total of 72 people (all born before 1921) were interviewed. They qualified before or during the Second World War and worked in geriatric medicine in the 1940s,

[14] See NOPWC conference reports 1946, 1947, 1948, 1949, and 1950.
[15] Jeffreys, 'Geriatrics' interview Marjorie Bucke, ref 305C512/62/01-02, 1991, p. 11.
[16] Lord Amulree, Trevor Howell and others from the Society for the Medical Care for Elderly People worked with the NCCOP and NOPWC.
[17] Jeffreys, 'Geriatrics'.

1950s and early 1960s. For the purposes of this study the oldest contributors who were practising in the 1940s and 1950s were selected. Respondents' testimonies recalled their own and national experiences of the development of gerontology. This cohort of geriatricians revealed career routes, the background to the development of geriatric medicine as a speciality, the treatment of old people and the future of geriatric medicine.[18] Thane also covered the development of geriatric medicine by using two testimonies from this oral history collection alongside documentary sources. She outlines the influences of the Second World War, the NHS, social medicine, community care policies and opposition to the specialism.[19] Whilst Thane has used the NSA collection, this thesis has reviewed thirty testimonies of the older geriatricians from the archives, and drawn together collective conclusions from this source. Martin has also focused on post-war medical attitudes to the development of geriatric medicine and used medical literature to illustrate her points. In her study she reviews the arguments presented on the development of geriatric medicine in relation to old age being a social rather than a medical problem. She draws out the combination of the social and medical aspects associated with old age, and suggests that detailed environmental factors affected the process of ageing. Within this work she contextualises the post 1948 medical debate on old age into the economy of the early NHS.[20] Although Martin used medical literature from the late 1940s and early 1950s for her work, she focuses mainly on the post-war period. My investigation uses medical literature from before and after the inception of the NHS to illustrate how doctors contributed to post war changes. Furthermore, it is the combination of oral sources and early medical articles that provide a perspective from the professionals themselves. Webster writes of the failure of the early NHS to provide adequately for old people and identifies the influences behind this.[21] Bridgen covers the period of time from 1946-1976 examining how the early cultural and political context, particularly in the early

[18] M. Jeffreys, 'Recollections of the Pioneers of the Geriatric Medicine Specialty,' in J. Bornat, R. Perks, P. Thompson and J. Walmsley, (eds.), Oral History, Health and Welfare (London 2000), pp. 75-97. Jeffreys used her oral history collection 'Geriatrics as a Specialty', for this project.

[20] Martin, 'Medical Knowledge', pp. 443-461.
[21] Webster, 'Elderly', pp. 165-193.

post war period, affected the long term policy on the care of old people.[22] Medical professionals have also written on the history of geriatric medicine.[23]

Through Jeffreys' oral history collection and medical literature pre-1948, this part of my investigation has primarily used sources which reflect the professionals' point of view. The chapter builds on previous work but triangulates evidence from oral, documentary and administrative sources to draw out professional views about the process of change.

The main concerns identified by medical professionals before 1948

To discover the major concerns of medical professionals before 1948, medical literature and an oral history collection of early geriatricians has been scrutinised. One of the obvious main problems of reading existing oral histories was not being able to direct the questions or to ask subsidiary questions. There is also a difference in reading a transcript "second hand" as the reader misses out on the atmosphere created by the interviewer and interviewee. Dates and times were sometimes quite vague and recollections could have been between the 1950s to the 1970s.

By using Index Medicus, (a directory that lists all articles published on medical matters), 131 articles concerning old age between 1920 and 1948 were identified. Clinical papers on specific pathological issues such as tuberculosis in older people were not included. Publications were multi-national, but mostly American and British. The journals covered a wide variety of medical specialisms ranging from military surgeon to medical insurance and health conservation. Public health journals also published occasional articles on old people's circumstances.

A total of 44 different journals were listed. These journals included medical, scientific, public health, medical insurance, occupational therapy and nursing publications. The main journals in the United Kingdom reporting on older people's needs were the Lancet, Practitioner, Medical Press and Medical Officer. From 1920 to 1929, 11 papers were published; 24 papers were published between 1930 to 1939; and 96 papers published between during 1940 to 1948. The increase in papers over these three

[22] P. Bridgen, 'Hospitals, Geriatric Medicine, and the Long-term Care of Elderly People 1946-1976, Social History of Medicine, 14:3 (2001), pp. 507-523.

[23] See for example, J. Brocklehurst, 'Geriatric Medicine in Britain – The Growth of a Specialty,' Age and Ageing, 26, (1997), pp. 5-8; Grimley Evans, 'Geriatric Medicine'; Bennett and Ebrahim, 'History of Geriatric Medicine'; and J. Williamson, 'Three Views on Geriatric Medicine: 3, Notes on the Historical Development of Geriatric Medicine as a Medical Specialty,' Age and Ageing, 8 (1979), p. 144.

decades indicates that the health and welfare of old people was generating more interest amongst professionals. However, given that there were thousands of medical papers published over this time, comparatively little attention was given to old people. This is supported by a medical officer of health in the 1940s, Walker, who states: "It is a matter of common knowledge that, until now, old age as a special subject of study has received little attention from the medical profession."[24] Walker also considers that although there is a "considerable bibliography" available, most writings on the subject of old people are of American origin. Dr Sturdee a principal MOH at the Ministry of Health, agreed with this when he quoted from an article on classification of the chronic sick by Marjory Warren in 1943: "It is noteworthy that geriatrics has received more attention in America than in this country and much of the literature on the subject has emanated from American writers."[25] Two new publications were established in 1946, the Journal of Gerontology and the Journal of Geriatrics. The Journal of Geriatrics was the official journal of the American Geriatric Society, with contributions mainly from American practitioners, although a few British doctors had papers published in it, and two were associate editors of the publication.[26] The Journal of Gerontology was also an American based journal which featured international papers.

The papers used for this chapter were chosen following two criteria. Firstly, the articles had to address generic issues regarding old age, that is domiciliary and hospital care in Britain. The second criteria was accessibility, since unfortunately, some journals were not available. Using these criteria, 29 papers covering the generic care and welfare of older people were examined. This section will now focus on the content of the articles. In the British medical press, case studies were available from a variety of towns ranging from Aberdeen, to Worthing. Provision for old people was described in at least thirteen towns and cities. Issues concerning older people's welfare concentrated on physical and social needs with much attention being given to the link between social conditions and poor health. This was illustrated in the reports of surveys carried out by medical officers in Glasgow,[27] Wolverhampton[28] and Ramsgate.[29] All of these papers made very

[24] J.V. Walker, 'The Welfare of Older Persons,' Medical Officer, 77 (1947), pp. 87-88.
[25] E.L. Sturdee, 'Care of the Aged and of the Chronic Sick in Great Britain, Geriatrics, (1947) pp. 359-365.
[26] T. Howell and E.L. Sturdee were two Associate editors in 1947.
[27] M. Curran, J. Orr, J. Hamilton and E. Thomson, 'Care of the Aged: Observations Based on Experiences in Glasgow Outdoor Medical Services,' Lancet, I (1946), pp.149-152, and Thomas Ferguson, 'Aged Sick Nursed at Home', Lancet, I (1948), pp. 417-419.
[28] J.H. Sheldon, 'Some Aspects of Old Age', Lancet, I (1948), pp. 621–624.

clear the need for domiciliary care in a generic context. Seebohm Rowntree's major national survey in 1947 was also reviewed.[30] He outlined the services provided for old people from a non-medical perspective. Medical opinion was consistent in recognising the intrinsic need for adequate living conditions for older people and health care. Some papers concentrated on specialist areas such as the different types of housing needed for older people. The physical ailments of old people were addressed in relation to the community and hospital care. A review of care for chronically sick older people identified problems with the existing systems, ranging from attitudes to old people in hospital, to their special needs when hospitalised. Different models of hospital care were discussed and the need for physiotherapy and occupational therapy was introduced. Another pertinent publication called for the establishing of an institute for gerontology which could combine research and practical help.[31] Links were also made with the need to work in a multi-professional environment. Reference was made to impending legislation, the National Assistance Act, the National Health Service Act and how these would be effective in providing changes in care for older people. Given the limited amount of publications, there were a wide range of issues concerning the welfare of old people covered in these papers.

As time drew nearer to the inception of the welfare state, administrators began to take more interest in the needs of old people. Walker suggests that the reason for this increased interest was due to: "...An economic need to make the best possible use in society of persons in the later age groups."[32] Several district medical officers for the city of Glasgow in 1946 described their experiences in Glasgow outdoor medical services.[33] This article outlined the national significance of the ageing process. They believed that there were different reasons for becoming interested in old age: economic, philanthropic and professional. In their view the increasing older population meant that caring for old people formed a substantial part of their work. They were therefore in a favourable position to: "Investigate and procure data about living conditions of older people." They hoped that their findings would contribute to an understanding of the national situation regarding the development of care for older people.

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[29] JV Walker, 'The Old at Home', Medical Officer, 78 (1947), pp. 169-174.
[30] Seebohm Rowntree, Old People, was a significant national social survey that highlighted conditions for old people in the country and received much publicity.
[31] T. Howell, 'Organisation for Old Age: An Institute of Gerontology,' Lancet, I (1947), pp. 264-265.
[32] Walker, 'Old at Home'.
[33] Curran et al, 'Care of the Aged'.

The beginning of change and the instigators of change

In 1947 the Lancet carried a special series on old people's care. The editor noted the increasing concern about the neglect of old people but acknowledged that some professionals, institutions and voluntary bodies were making progress in caring for old people. Recognising that these attempts were beginning to address the welfare of older people the editor commented:

> None of these homes or hospitals claim to have achieved perfect care of the old; but in all of them those in charge have grasped that their task is active not passive; they have shaken off inertia, and whatever the frustrations and handicaps, are set on steady advance. We hope that they will infect others with their discontent.[34]

Similarly the Medical Press carried a report of a Symposium on care for old people in 1948 with the aim to:

> Combine to point out the urgency of better care for old folk and to suggest some improvements in present methods of treatment.....Let us hope that this Symposium and the work of the new Medical Society for the Care of the Elderly will help to arouse interest in the problems of those forgotten men and women, the aged.[35]

The major concerns highlighted in the journals centred on medical care for old people, notably hospital provision, treatment plans and health care in the community, but the articles also focussed on aspects of social care particularly housing provision. This part of the thesis will explore the development of geriatric medicine and the beginning of a change in medical attitudes towards older people from the 1930s to 1948.

Whilst in general terms there was a developing interest in improving old people's care, this may well have been for pragmatic reasons given the steady increase in the numbers of older people. Within the medical profession, Howell considered that there was limited interest in the development of geriatric care: "[the] Greatest obstacle of all is lack of interest in geriatric medicine and the general feeling that nothing can be done for old age."[36] The first paper in the Lancet series Modern Care of Old People in 1947 begins by stating that: "Neglect of the old in institutions is the rule rather than the exception."[37] Thus we can assume that care for old people was rather minimal in the majority of establishments, but there were medical practitioners who had begun to see

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[34] 'Proper Care of the Old', Lancet, I (1947) p. 760.
[35] Editorial, Medical Press, 219 (1948), p. 383.
[36] T. Howell, 'Social Medicine in Old Age,' BMJ, 1 (1946), pp. 399-400.
[37] 'A New Outlook in the Wards,' Lancet, I (1947), pp. 760-761.

the need to improve the care for old people. Marjory Warren, deputy medical director of West Middlesex County Hospital in Iselworth, appears to have been one of the first doctors who provided practical and medical changes for old people. Her peers unreservedly recognise her as the pioneer of geriatric medicine and the following quotations are examples of how her contribution to the development of the speciality was seen by her contemporaries:

> ...But of course, the real key to what happens to the chronic sick was Marjory Warren.....the patient investigation and rehabilitation of the rather slower moving kind of illness that was so common in older people, wasn't really attempted until Marjory got it on the road...Marjory was way ahead but there were others beginning to come up...[38]
>
> She had transformed the West Middlesex Poor House part; people had gone out, for the first time in their lives walking instead of in a box to be quite blunt.[39]

She was certainly an inspiration to some of her contemporaries[40] and geriatricians practising today credit Marjory Warren as the "mother of geriatrics."[41] Her work at the West Middlesex Hospital was discussed in the first article in the Modern Care of Old People series in the Lancet. A description of the changes made since 1935 were listed and credited Dr Warren as the architect of the ventures. These changes were made in an old hospital with limited financial and practical resources. Her creativity, enthusiasm and commitment were apparent.

In one of her earlier articles on the long-term care of old people in Britain, Dr Warren reviewed care for chronic older sick people and argued for changes in attitudes and in professional care.[42] Warren highlighted the issue of "bed blocking" and suggested that special units would solve this problem. She categorised different groups of dependent old people and identified specific needs for them in hospital. She felt that the increase in the population of old people was due to progress in preventative medicine and a fall of the birth rate. Warren's opinion was that geriatrics had to be seen as a specialty (like paediatrics) which would raise standards, and provide the opportunity to undertake research. She stressed the need for proper facilities and a stimulating atmosphere for diagnosis and treatment for proper rehabilitation and care. Previously these cases had

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[38] Jeffreys, 'Geriatrics', interview with George Godber, 512/28/01, pp. 8-9.
[39] Jeffreys, 'Geriatrics', interview with Sir Professor William Fergus Anderson, ref 106 C512/20/01, p.16.
[40] Many of the professionals interviewed in the above collection recall Marjory Warren inspiring them in their career.
[41] See Grimley Evans, 'Geriatric Medicine', and T. K. Kong, 'Dr Marjory Warren: The Mother of Geriatrics, Journal of the Hong Kong Geriatrics Society, 10: 2 (2000), pp. 102-105.
[42] M. Warren, 'Care of the Chronic Aged Sick', Lancet, I (1946), pp. 841-846.

received little priority; some hospitals had refused to take cases, whereas others had given little or no treatment. Rehabilitation was a key issue for Warren, and with optimism and hope, she considered this a preventative action, along with multi-professional teams. New and extra equipment for geriatric wards was necessary in order for her plans to be put into operation. Warren thought it was important for medical students to observe the management of old people as they would be responsible for the future care. Specialized care also provided learning opportunities for nurses. Warren suggested that the medical profession needed a change of attitude towards the care of the chronic, often elderly, sick people. Furthermore, she was convinced that a positive attitude would be engendered in nursing and other hospital staff; that a higher standard of care and a great deal more work was still needed in the care of the chronic sick; and that the creation of a speciality for geriatrics would stimulate better work and initiate research.

In a later paper Warren described the evolution of a geriatric unit and argued that this was a more efficient way to treat older people. She stated her hope to convince the: "More conservative sections of the medical and nursing professions, proving itself to be an invaluable and practical department in the hospital, enjoying the prestige and dignity which it has earned." Warren considered that medicine had responsibilities to old people and this was the way forward.[43] Dr Cosin, later a key figure in Oxford, also supported the need for geriatric departments and expressed his views on the subject in the British Medical Journal.[44] His work and contribution to geriatric medicine nationally and locally is discussed in detail in Chapter Five.

Another Lancet article contrasted methods of care in two hospitals, one in Orsett (Essex) and others in Gloucestershire.[45] Orsett hospital care (under the medical supervision of Dr Cosin) was based on advanced physiotherapy with a minimum of ordinary nursing care. Gloucestershire hospitals had achieved adequate nursing staff by specific recruitment projects since these inevitably involved more patient care.

Practitioners were keen to promote smaller hospitals for old people. One article describes Morningfield Hospital which had 104 beds, in Aberdeen.[46] This hospital was much in demand for its limited beds, but there was a six to twelve month waiting list

[43] M. Warren, 'The Evolution of a Geriatric Unit' Geriatrics, (1948), pp. 42-50.
[44] L Cosin, 'Organising a Geriatric Department' BMJ, 2 (1947), pp. 1044-1046.
[45] 'A Contrast in Methods', Lancet, I (1947), pp. 840-842.
[46] 'Integrated Services at Aberdeen', Lancet , 2 (1947), pp. 106-107.

for places in 1947. Medical staff consisted of two visiting physicians from the Royal Infirmary at Aberdeen which provided a beneficial close link between institutions and easy facilitation for transferring patients from one hospital to the other. The article illustrated bed shortages, noted the local authority's intentions to develop the building but hoped to maintain a hospital: "Small enough to avoid danger of institutionalisation, but allowing for close and effective co-operation with the key hospital of the area." Inadequate provision was flagged up. The accommodation for chronically sick and old people in Aberdeen was provided by the local authority and voluntary organisations, with further beds provided by the religious community. Attention was drawn to a hospital survey in the North East region which suggested the possible bed places needed would be 1:5 beds per 1000 for the chronic sick. Therefore the Aberdeen population of 165,000 would only need 250, which was considered inadequate. The author estimated a more accurate figure to be 2:2.5 per 1000 but acknowledged that a true figure could only be decided by a thorough survey. Effectively this article challenged official calculations for old people's provision.

A contentious debate amongst the medical profession concerned the benefits of geriatric units being established in acute hospitals. In one of the papers featured in the series 'Modern Care of Old People' the debate favoured not having specialist annexes for old people. The reasons for this position were along the lines that treatment of the aged was not only a speciality, but also part of the general body of "internal medicine", and that being specialist would only:

> Divorce still further the treatment of the aged from general medicine...This divorce is so complete in many teaching hospitals that most consulting physicians have no experience and there is no interest in the problems of ageing; while students who later, in practice, must remedy the ills of the aged are never trained for this task.[47]

This opinion was contrary to those of Dr Warren and Dr Cosin who felt that gerontology should be considered a speciality on the same basis as paediatrics. It seemed that both models could work. The ultimate test would have been in the delivery of patient care. In this respect it appears that the success of each model was dependent

[47] 'A City's Problems', Lancet, I (1947), pp. 879-881.

on practice, and the skills of the physician were paramount. This aspect is discussed later in the chapter.

Christopher Rolleston, a local MOH, suggested that when old people were ill and admitted to chronic hospitals due to sudden illness, they received inadequate treatment as there were no opportunities for consultation with specialists, and treatments such as massage and physiotherapy were lacking.[48] Therefore old people were nursed but not treated, patients became demoralised as they had no alternative to hospital and remained bedridden until they died.

Howell, one of the founder members of The Medical Society for the Care of the Elderly, addressed the training of geriatric physicians. He did not think that major training in gerontology could be gained in a hospital in a few weeks. To him it was important to observe old people in health as well as sickness. In his opinion, the best person to understand the old person was the general practitioner who saw the gradual onset of infirmity, and was able to see an older person in a holistic context.[49] Howell's model was effectively branching into the idea of social medicine. His ideas were based on preventative primary care in the community. He was acknowledging that old people were not always ill – getting old did not always mean illness. GPs were in a prime position to monitor the health of elderly patients, and were able to take other factors into consideration such as family support and environmental influences. Such factors contributed to the well-being of older people.

As there was no free health care before 1948, ailments were usually dealt with by over the counter remedies, or else neglected, particularly so for old people. One survey in Ramsgate found that: "Many old people with marked and well recognised complaints did not seek any medical advice, but preferred to suffer in silence."[50] Physicians such as Howell welcomed the new approach to health care for old people and saw the development of gerontology as exciting. He specified that treating old people needed time, and that the patient as well as the disease had to be treated. Howell felt it was important to treat a relatively minor ailment before it turned into a major complaint, immobilising the patient and therefore necessitating long term treatment.[51] Links were made between a lack of out-patient clinics and "bed blocking". One solution on how to

[48] C. Rolleston, 'Services for Elderly Persons', Medical Officer, 79 (1948), pp. 25-26.
[49] T. Howell, 'The Training of a Geriatric Physician', Geriatrics, (1947), pp. 280-282.
[50] Walker, 'Old at Home', pp. 172.
[51] T. Howell, 'The New Approach', Medical Press, 219:18 (1948), pp. 387-389.

reduce "bed blocking" by old people was to introduce an out patient geriatric service where treatment and investigations could be undertaken.[52] It was envisaged that this service would be multi-agency based and provide "medico-social aid," extending to home visits and needing multi-agency co-operation.

Sheldon's local survey in 1948 identified specific risk factors for old people. He suggested that they were more susceptible to falls due to a variety of medical reasons, but by providing hand rails for the stairs falls could be avoided.[53] According to Sheldon, only 2.5 per cent of old people were confined to bed in the home, and 66.5 per cent were capable of full mobility. In order to maximize the enjoyment of old age mobility should be encouraged. There appeared to be universal medical agreement that institutionalisation of old people should be avoided as much as possible, and that the longer people remained in their own homes the more self-respect they maintained. Additionally, not admitting older people to hospital for social reasons enabled beds to be used for more urgent cases.[54] In order to achieve this it was acknowledged that more community support had to be provided such as domestic help. Free access to a medical practitioner was seen as fundamental in maintaining old people in their own homes. Some concern was expressed that old people should be aware that this service was not charity, but available by right.[55] Sheldon estimated that the proportion of older people spending their last years at home was rarely less than 95 per cent.[56] Like Howell he thought that the general practitioner was crucial in the care of old people and insisted that social care in the home was as important to study as medical care.

Walker wrote about a creative project - the establishment of an elderly persons' clinic in Ramsgate in Kent - where the aim was to give advice on health to old people on a similar par with the infant welfare clinics. This particular project was not successful, but Walker argued that older people should have clinics arranged on the same premise as the infant welfare clinics, that is, regular clinics with specialist geriatric advice. He suggested that elderly person's welfare schemes should be established in each county

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[52] E.B. Brooke, 'The Place of the Out-Patient Department in Caring for Older People', Medical Press, 219 (1948), pp. 400-402.
[53] J.H. Sheldon, 'The Care of Old Age in the Home', Medical Press, 219 (1948), pp. 398-400.
[54] Howell, 'Social Medicine', gives the example of old people suffering from recurrent disorders such as urinary tract infections which could be treated at home if more domestic support was available. Furthermore he points out that old people are reluctant to go into hospital and hospitals do not like admitting patients in these circumstances
[55] Curran et al, 'Care of the Aged'.
[56] Sheldon, 'Care of Old Age'.

and the clinic would be an important feature of this scheme. To support the clinics Walker proposed a "closely linked" health visitor service where staff would have strong liaison with all the departments and organisations concerned with older people's welfare.[57] This innovative scheme did not appear to have much support nationally, as there is no evidence of other similar projects. There is no evidence to deduce if this project failed through lack of resources.

Despite such debates and innovations there is much evidence to suggest that little was being done for elderly patients written off by the medical profession. Dr Rudd went to Devon after being demobbed and took over a country practice. He was also responsible for the public assistance hospital and compared the treatment of the patients in voluntary hospitals with those in public assistance institutions:

"..the standard of medicine there was so completely different from what I was doing for many instances of the same group in the voluntary hospitals. And in the voluntary hospitals people were treated in accordance with their needs whatever investigation – whether xray or pathology – they needed was given for them treatment was prescribed,...he then went back to his home or his job. In the public assistance institutions the opposite happened."[58]

Information gathered from Jeffreys' oral history collection indicates that many old people may not have been properly diagnosed. One doctor did a survey of 400 chronic sick patients and discovered that their records were out of date. This doctor transferred the patients from the chronic sick wards, prescribed treatment and discharged them home. Another doctor had similar experiences. He was told that the patients who could not sit up had arthritis of the spine but found that they had bed sores and were completely malnourished.[59] Further corroboration was provided by Dr Rudd: "Nobody was examined, no medical case notes were taken, no investigation was done, necessary operations were not carried out and everyone, nearly everyone seemed to be kept in bed between cot sides with their bowels completely neglected so, of course they just went into a state of physical and emotional decline." [60] Dr Agate recalls his experiences as a medical student in London during the war. He was instructed by his seniors:

> We know you are not qualified but we reckon you are intelligent enough to look after patients already, so will you take it on? We will cover you from a legal point of view. If there are death certificates to write we will write them and if

[57] Walker, 'Welfare'.
[58] Jeffreys, Geriatrics, Thomas Rudd, C512/21/01, p. 3.
[59] Jeffreys, Geriatrics, Joseph Mellor Greenwood, 112 C513/31/01 p.8 1991 and Wilfred Fine 214 C512/17/01-02, p.6 1991.
[60] Jeffreys, Geriatrics, Thomas Rudd, C512/21/01, p. 1.

> you want to prescribe drugs we will sign them. But you look after the patients and find out what's wrong with them' And in each of these hospitals – there were about 9 or 10 of them that lived in for short periods - they shoved me in charge of what they called 'chronic sick' wards. And these were mostly fairly elderly people, not always because some had multiple sclerosis and were younger but they were people about whom they said 'we can do no more for him or her – she's just got to exist there until she dies' so I saw rank upon rank of chronic sick wards in East London with people lying in bed all the time. They never had day rooms, they had occasionally a chair beside their bed, they had minimal facilities and they were just waiting for the end.....I had early experiences of the chronic sick wards which were filled with elderly people with absolutely nothing going on and no comforts and no activities and no physiotherapy and nothing of that sort. But since there were no physiotherapists, occupational therapists and very few actual nurses about there wasn't very much we could do and there certainly wasn't the chance in the middle of the war to build any day rooms and things like that. So I thought this is a pretty gloomy prospect but there it was.[61]

One doctor stumbled upon the chronic sick quite accidentally in 1946. He heard a message on the tannoy for a request that a doctor urgently visit the chronic sick ward in the next fortnight. He thought this a strange request and went to discover the chronic sick ward, and describes this:

> ...found the most remarkable place. There were all sorts of people for all sorts of reasons; some of them needed to be there, some didn't, none of them had been properly diagnosed and very few of them had any sort of meaningful treatment. So I looked around this and found all sorts of things, discharged a few people and put others on treatment and generally took an interest in this place...[62]

These experiences show the low priorities accorded towards old people and reflect invidious attitudes towards them inside institutions.

Even in areas where there was progressive care for elderly people, the Second World War inevitably halted some developments, as medical care for casualties was of greater national importance. Hospitals in London cleared wards to make way for impending casualties and many of those discharged were old people. Ironically this time also brought about some positive changes for old people. First, because government surveys carried out prior to the inception of the NHS highlighted the fact that most hospital beds were occupied by old people who were being kept in unsatisfactory conditions.[63] A major national survey concluded "the majority of the hospital stock occupied by the

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[61] Jeffreys, Geriatrics, John Agate, C512/8/01-02, pp. 3-4.
[62] Jeffreys, Geriatrics, Ronald Dent, C512/63/01, pp. 5-6.
[63] Webster, 'Elderly', reviews some of the surveys which described conditions in hospitals.

elderly was unsuitable for future use by the NHS".[64] This was certainly borne out by some of the doctors interviewed by Jeffreys. They described some dreadful circumstances they were working in across the country. Secondly doctors were assigned to public institutions in anticipation of war casualties and one doctor, Lionel Cosin, placed at an Essex hospital, fortuitously spent his time at the beginning of the war, developing care for old people, who occupied most of the beds.[65]

Although there were changing attitudes towards caring for old people, these were not universal so that a medical officer of health could describe the care of old people as "arduous, monotonous and, at times revolting"[66] Indeed, caring for old people was not a glamorous occupation and very hard work especially as there were few modern labour saving inventions. Boucher's survey in 1957 revealed some of the primitive conditions in antiquated hospitals accommodating old people and described the inadequate amenities which resulted in extra work for nurses and ancillary staff such as the sluicing of soiled linen in patient's baths.[67] Extra heavy tasks associated with caring for old people did not make the task of caring for old people attractive, especially compared to the progress of acute medicine and surgery.

Increasingly, writing on the overall holistic care of old people incorporated their social needs. Environmental factors were identified as a problem and accommodation needs were featured in the medical press. Articles on housing focused on two aspects: first, the need for specialist independent accommodation in the community, and secondly, the need for residential accommodation. Case studies of local projects included: special council housing for older people in rural areas, planning of accommodation (including sites and house designs and the criteria for applicants), advantages of particular sorts of accommodation, the need for multi-agency working, the links between public health and housing, local authority provision, housing conditions and the role of the local medical officer of health. Different types of accommodation were identified and divided into the following categories: privately rented property, specially designed council rented property, small group homes run by charities/voluntary agencies, colonies/communities for older people with a variety of housing available run by local authorities and voluntary agencies, municipal institutions and hostels

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[64] Domesday Book of the Hospital Service (HMSO, 1947).
[65] Jeffreys, Geriatrics, Dr Cosin, 512/41/10-04 1A, p. 11.
[66] See T. Howell, 'Geriatrics – The New Approach', Medical Press, 219:18, (1948), pp. 387-389.
[67] Boucher, Survey, pp. 16-18.

As the medical professionals were effectively "front line" workers in caring for old people it is not surprising that housing conditions were seen as so important in their publications. A survey carried out in Glasgow in the mid-1940s described the conditions that old people were living in. The authors considered that old people had: "Passed from temerity of youth, through the disillusionment of mid age to the timidity of old age and are now afraid to tackle life in new surroundings; they have about them friends and neighbours they have known for many years." [68] Furthermore the authors suggest that: "Economic factors and infirmities of age had blunted their perception towards general comforts of life and have unfortunately led to their acceptance of their present state....if in a previous life they had a higher standard of living they would now consider their circumstances terrible." These excerpts suggest that old people had become passive, subservient and resigned to their fate but at this stage the organisations to represent and lobby for better conditions for old people were still in embryonic stages.

Various types of accommodation needed for old people were outlined in a paper in the Lancet in 1947 which also described the provision in Glasgow. Glasgow's population of 1,000,000 included a large proportion of older people (120,000). The city provided hostels for elderly persons, and pioneered new projects for older people's welfare. It was the centre of an industrial area and therefore had special problems for poorer people living in such an area "said to age more rapidly than those elsewhere." There was a heritage of slums and overcrowding; 60 per cent of the population lived in one or two roomed dwellings and welfare authorities had to "balance claims of the aged against the equally just demands of the young." The local authority was aware that some older people lived in houses too large for them but these were suitable for families who were confined to tenement dwellings. A plan was made to help both "by decanting old wine into newer and smaller bottles." New housing estates were to have a proportion of houses especially suitable for old people but the progress for this project was expected to be slow. Welfare and public health departments began to establish improvements for old people and studied their needs and identified two groups of old people, well and fit people who were capable of living alone, (or with family), but who

[68] Curran et al, 'Observations'. The authors carried out a survey in Glasgow in 1946. This survey of 1729 people over 65 years illuminated daily living standards of poor older people in industrial areas and focussed on living conditions arising from inadequate housing. All respondents were visited in their homes by a doctor to collect the information for the survey.

needed suitable housing; and the ill, feeble, infirm and the ailing who were able to look after themselves with a little help.[69]

Other community housing needs were identified in the journals such as the necessity to review placements in council housing in order to balance accommodation for older people and young families. Links were made between poverty and the effects this had on the ageing process, essentially poverty accelerated ageing. Local councils were beginning to build and develop special housing for old people and learning from their experiences.[70] Residential homes were becoming increasingly popular as accommodation for active and independent old people who were unable to cope with living alone. There was a general consensus that it was not necessary for old people to be hospitalised if they were still independent.

Small group homes appear to have been introduced from about 1935. In 1947 the Ministry of Health endorsed the principle of group homes and circulars were issued to local authorities urging them to establish small homes for thirty to thirty five people in suitably adapted houses.[71] An article in the Lancet in 1947 described a successful experiment conducted by a public utility society known as Hill Homes Limited in Highgate who established a home in 1935.[72] Other homes developed out of this project and small homes were run on behalf of the Ministry of Health with help from Hornsey Borough Council. A group of vulnerable older people were identified from the Hill Homes project, those with "small means" who were often in great need of help and had no provision made for them. The project management intended to develop this facility, but progress was impeded by the lack of suitable houses and labour to convert them.

These homes were considered an excellent example of care for old people and the writer expressed the opinion that smaller homes with twenty-five to forty residents were happier, as there was a more intimate atmosphere than in a larger institution. Suggestions were made to develop these schemes nationally as small group homes were seen to provide for specific aspects of more independent old people's needs. Other similar homes run by voluntary agencies elsewhere in the country were also described in the journals such as the one established by the Linen and Woollen Drapers

[69] 'A City's Problems', Lancet, 1 (1947), pp.879–881.
[70] 'Independent Dwellings', Lancet, I (1947), pp. 921–922. In Trowbridge, the council modified the design of old people's house specifically to integrate them more into the community.
[71] Ministry of Health Circular, 49/1947.
[72] 'Living in a Small Group: Hill Homes Highgate' Lancet, I (1947), pp. 800–802.

Institution and Cottage Homes established a community in 1898. This community accommodated residents aged over sixty years. Residents were sponsored by some person well known in the textile industry. Understandably there was a great demand for places and a waiting list. Residents paid nothing for medical and nursing attention but if they moved into the nursing cottage the charge was fifteen shillings a week for board. Old people unable to care for themselves lived in the rest home and were given a complete service. This community seemed to have been quite an unusual venture and very supportive of ex-employees: "They have worked in the industry and now receiving due." Mr Donald Cave, secretary of the institution, suggested that the example of the Linen and Woollen drapers should be followed by other industries then: "if each took care of its own, much distress among old people could be prevented."[73] His words suggest dissatisfaction that old people were being neglected by commercial agencies and more could have been done to support old people by industry.

Municipal institutions for old people were also recognized for their contribution in providing accommodation for old people, as were charity homes.[74] Hostel accommodation was featured in the medical press but there does seem to be an overlap between small group homes and hostels. Glasgow's experiences of hostels for old people run by caretakers had not been positive. The authorities decided not to extend this scheme and instead took over larger dwellings to convert into small separate dwellings.[75] A description of hostel services in Aberdeen was given in an article on 'Integrated Services at Aberdeen'.[76] When the Old People's Welfare Council was founded in 1945 one of the main objects was to provide a hostel or hostels for elderly infirm needing domestic care rather than hospital care. There were many applications for this accommodation indicating the need for more hostels.

These articles demonstrate that the medical practitioners considered that there was a clear need for able-bodied old people's accommodation in the community. Connections were made between the social needs in the community and inappropriate

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[73] 'Living in a Small Group'.

[74] 'Municipal Institutions: Birmingham's Example', Lancet, (1947) pp. 30-31. In Birmingham there were four large houses (831 places) administered by the public assistance committee for older people who did not require medical care. The homes were self-supporting and residents were charged according to their means. Those who had means, regardless of how small kept a small amount for pocket money. There were two homes for men, two mixed and one for women.

[75] 'A City's Problems'.

[76] 'Integrated Services'.

hospitalisation. Good community resources enabled old people to live comfortably in the community, ultimately relieving pressure on the busy hospitals.

Psychiatric developments

Felix Post had been working in psychiatry since 1941 and became interested in the mental health needs of old people after reading the results of a survey in the Sociological Review in 1943.[77] This survey apparently found that many old people with mental health problems were staying in hospital for social reasons rather than medical ones. He described the developments regarding older people's psychiatric care and referred to his work with Dr Cosin at CRH.

Another doctor, Dr Kay, who worked with old people with mental health problems and was involved in clinical research, suggested that there wasn't psychiatry of old age in the early years. He credits work being done by Roth and Morrisy, who in 1952 highlighted the importance of depression in old age and high rates of suicide. This work evidently led to the distinguishing of depression from dementia and other causes of dementia. At this time physicians and neurologists had limited understanding of dementia.[78]

Dr Agate, who worked with old people, would see patients suffering from psychiatric disorders as well as geriatric physical disorders in a Bradford hospital in the 1950s. He talked of a positive practical developing relationship he had with the psychiatrist where they had weekly meetings to discuss arising problems and describes the process:

> Where new admissions to psychiatric hospital were reviewed, and if physical illness mental illness at the root cause, then guaranteed to sort them out physically and he guaranteed to take ambulant demented patients who'd had a long history of mental disorder. First example of psycho geriatric cooperation between a perfectly straightforward psychiatrist and a perfectly straightforward geriatric physician trying to do a bit extra for doubtful cases in middle. [79]

This system established a basic form of liaison between departments and probably benefited both patients and the hospital management.

Responsibility for the provision of accommodation for people with dementia and the role of local authorities was addressed. Homes such as Hill Homes could not

[77] Jeffreys, Geriatrics, Felix Post, C512/103, p.13.
[78] Jeffreys, Geriatrics, David Kay, C512/45, p.12 & 19.
[79] Jeffreys, Geriatrics, John Agate, 512/8/01-02, p. 13-14.

accommodate residents with "dementia, delusions and persecutions." [80] However it was recognised that a proportion of residents would eventually become "incapacitated in these ways" and that the local authority would have the ultimate responsibility to help find other placements. Problems occurred when residents with dementia continued to stay in the homes as this meant the character of the homes would change, and concern was expressed in the article at these implications: "Instead of offering congenial surroundings for sane and active old people they will become like the poor law institutions, a limbo for those beyond all hope and understanding." Although local authorities were identified as the agency to find suitable alternative accommodation this arrangement did not work out satisfactorily as the paper highlighted and described the problem for Highgate local authority: ".....But arrangements for care of old owing to lack of buildings and staff is defective... so far ineffective in finding sufficient places for old people who deteriorate."

Placements for old people with mental health problems posed a national problem. Often old people with mental health problems were inappropriately placed in institutions that accommodated them rather than provided for their needs. In the absence of alternative accommodation there was an inappropriate use of psychiatric beds.

The emergence of a new speciality

Advances were being made in medicine for old people, and doctors in hospitals and in the community (GPs) were beginning to observe these changes. Alongside this there were also impending administrative changes arising from the advent of the NHS.[81] Inevitably these developments would have had an impact on services in the established institutions and challenged customary practice. Inherited from the poor law was an expectation that old people, particularly the infirm and senile were to be cared for in institutions. Crowther suggests that there was a societal dependence on institutional treatment. Combined together with and parallel to the progress in medicine and NHS changes this had an influence on the care of old people during the 1940s. In Crowther's opinion, as medicine became more sophisticated, specialist caring for geriatrics was

[80] 'Living in a Small Group'.

[81] See for example, Abel Smith, Hospitals,; A. Digby, The Evolution of General Practice, 1850-1948, (Oxford, OUP, 1999), pp. 325-342 discusses the historical role that GPs played in shaping the new health service; J. Stewart, The Battle for Health: A Political History of the Socialist Medical Association (Aldershot: Ashgate, 1999), pp.152-179, outlines the Socialist Medical Association's contribution to the establishment of the principles of the NHS.

less interesting, and as nurses became more qualified, nursing old people became to be seen as inferior. Another point to consider was the doctor and patient relationship in public assistance institutions. Crowther thought that by the twentieth century the role of the workhouse doctor had changed, but medical staff saw patients as cases and were separated by "social class and professional mystique."[82] For old people bereft of health and social status this could only contribute to their humiliating situation, perpetuating demoralisation.

Alongside these general changes was the development of professionalisation in relation to the provision of hospital services. Whilst multi-professional work was being advocated there is little evidence of inter-agency systems developing at this stage. One of the problems that medical staff encountered was persuading nursing staff of the benefits of changes in the methods of treatment for older people. During the 1940s, in many hospitals for the chronic sick, it was normal practice to nurse old people in bed, but the early gerontologists had realised the need for patients to be mobilised as soon as possible. The nursing staff found it easier to nurse the patients in bed as they didn't fall and fracture their limbs and then become more dependent.[83] Dr Agate felt that the younger nurses were more appreciative of the new treatments.[84] When one doctor took up a new position just before the introduction of the welfare state the matron resigned on his arrival as she was aware new methods were going to be implemented.[85] In some institutions the change in attitudes by medical staff may well have been threatening to nursing staff who had probably had more control in previous times.[86] Dr Mellor Greenwood recalls the philosophy and practice: "..If you were old you were regarded to be sick, and if you were sick and old, you were to be nursed." His statement suggests that, in some institutions, old people were considered ill just because of their age. He remembers having to convince a nursing sister that patients could get up out of bed and reduce the bed numbers. Some doctors considered they had no recruitment problems,[87] but others thought there were staff shortages and that the nurses were overworked.[88] Nurses were also working with antiquated equipment, which made caring for old

[82] Crowther, Workhouse, pp. 188-189.
[83] Jeffreys, Geriatrics, Dr Thomas Wilson, 512/2/01, pp. 8-9.
[84] Jeffreys, Geriatrics, John Agate, 512/8/01-02, pp. 11-12.
[85] Jeffreys, Geriatrics, Thomas Rudd, 512/21/01, p.4.
[86] Personal conversation with Dr Helen Sweet, who is of the opinion that nurses found it easier to nurse patients in a regimented way during this time.
[87] Jeffreys, Geriatrics, Dr Joseph Mellor Greenwood, 513/31/01, pp. 8 & 9.
[88] Jeffreys, Geriatrics, John Wedgewood, 512/12/01-01 p.4. Wilfred Fine, 512/17/01-02, p.6.

people an even more physically demanding job. Generally, within the hospital service, there were problems with nursing recruitment even before 1930, which inevitably spilled over into the next decade and, women volunteering for war work during the 1940s must have stretched the resources.

The Glasgow survey featured in the Lancet in 1946 began to highlight the plight of old people in working-class areas in relation to the gate-keeping role of the medical practitioner.[89] As older people were living longer, GPs were undoubtedly having an increased case load of elderly patients. In the lead up to the NHS, this was an opportune time to establish the role of primary health care. Digby has studied aspects of the historical gate-keeping function of GPs and outlines how significant environmental factors influenced this in local communities.[90] Common themes in the poor social conditions for old people were being identified by medical professionals, (including inadequate housing) and the general opinion was that improvements were crucial in providing basic welfare for old people. Ultimately, unless social conditions were improved medical treatment was effectively squandered. If people's houses did not have adequate sanitary provision and were disorderly due to the old person's disposition then the healing process was impaired. This example reflects the opinion expressed by many of the contributors in this medical literature for professionals to work together to improve the situation of old people. Professional opinion was united in proposing that adequate housing, sanitation, home helps and medical care were all needed to improve primary conditions for older persons living in their own homes. Social medicine gained momentum in Britain from the early 1940s, marked particularly by the establishment of the Institute of Social Medicine at Oxford University, headed by John Ryle as the chair, in 1942. Underpinning the concept of social medicine was the belief that preventative medicine and the preservation of health needed to be developed. This aspect of medicine extended beyond the medical domain as it involved environmental factors such as housing, sanitation, occupational health and poverty. The Institute served as a research and teaching establishment. Major research projects were carried out, ranging from child development to occupational diseases. A holistic approach generally towards medicine was developing.[91] This synchronised with

[89] Curran et al,'Care of the Aged'.
[90] Digby, Evolution, pp. 247-255.
[91] D. Porter, Health, Civilization and the State, A History of Public Health from Ancient to Modern Times (London: Routledge, 1999), pp. 294-296.

developments in geriatric medicine and was beginning to have an impact on thinking, but resources lagged behind such thinking.

One of the greatest achievements which grew out of the medical profession's concerns must be the development of the new speciality - geriatric medicine. Old people were labelled the "chronic sick" and this group of people had occupied a large number of hospital beds since way before the inception of the NHS. Marjory Warren had set some professional precedents. Sir Fergus Anderson believed that the only way to protect the elderly was to create special units so they did not have to compete with the younger patients and explains this in his interview with Jeffreys:

> ....And it became apparent to me having heard of the work of Dr Marjory Warren that the only way to protect the elderly was to give them special entry to a unit so they didn't stand in line with the young, because if they stood in line with the young they would never get in. And that was human justice. But the elderly deserved justice too. So in my view it wasn't at the beginning that I thought that would get to know more about geriatric medicine from a specialised geriatric unit, it was because they simply had to have beds reserved for their own use.[92]

Sir Fergus Anderson also remembers how Dr Warren inspired him by recognising the holistic aspect of older people's health. However, changes in the way older people were treated did not simply depend on the influence of Dr Warren. For example one progressive doctor had not heard of Dr Warren when he was responsible for the local public assistance institutions in the mid 1940s. He appears to have challenged the customary practices inherited from the poor law regarding health care for older people and worked on "first principles", for example by operating on hernias. After reading an article in the Nursing Mirror suggesting that that the administration of barbiturates increased the amount of people who fell out of bed, he stopped prescribing them.[93]

Following a circular sent to all the local authorities by the Ministry of Health in 1946 requesting them to assess the public assistance institutions, a senior physician in Cornwall, Charles Andrews, carried out a survey of the patients in his area. With help from his registrar he examined every patient (about 6-700 in total) in seven public assistance institutions. He then consulted Dr Warren and came up with a recommendation to the local authority to appoint a consultant geriatrician along with an occupational therapist, physiotherapist and social worker. This recommendation was

[92] Jeffreys, Geriatrics, Sir William Fergus Anderson, 512/20/01, p. 15.
[93] Jeffreys, Geriatrics, Thomas Rudd, 512/21/01, p. 6.

agreed by the local authority and Dr Wilson was appointed in 1948 just months before the inception of the NHS. An advert was sent to the British Medical Journal in 1947 but did not appear. The county medical officer rang up to enquire why this was so. He was informed that the British Medical Journal did not know what a geriatrician was as this position had never been advertised before and the advert had to be submitted for approval. Dr Wilson believes that the local authority approved the recommendations as they were just months away from the establishing of the NHS and the authority were aware that the financial responsibility for the institution would be taken over by the NHS after a few months.[94]

By 1949 one doctor considered that "people [were] beginning to have a conscience about geriatrics in those days."[95] He was requested to do a study of the local authority infirm wards to investigate whether the modern methods of treatment for older people could be used. This doctor found the work extremely challenging and used the opportunity to provide more resources for this under resourced group.

In the 1950s there was a general move towards gerontology with a multi-disciplinary holistic approach. Sir Fergus Anderson reports how important this was and links in the development and significance of the domiciliary visits instigated by Eric Brooke.[96] These visits were seen as "absolutely necessary" because relevant information on the patient's circumstances was obtained, and this cut down the work for the hospital staff. This approach was also adopted by Dr Agate who used domiciliary visits to cut his waiting list.[97] In fact management of the waiting list was of fundamental importance to the gerontologist. Interesting points are made by one physician working in Liverpool where there were long waiting lists of 400-500 people.[98] Patients were accepted without any assessment and there was no out-patients department. Many died in their homes whilst waiting for admission in dreadful isolating conditions. He tackled this problem by acknowledging the role of the GPs and establishing liaison. Further investigation of the waiting list revealed that some patients had got better, some were inappropriately on it and some patients were irredeemable but would not have been so if admitted earlier. Priority was eventually given to patients living alone.

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[94] Jeffreys, Geriatrics, Thomas Wilson, 512/5/01, pp. 5 & 7, and Mabel Andrews, 512/6/01, p. 6.
[95] Jeffreys, Geriatrics, John Wedgewood, 512/12/01-01, p. 4.
[96] Jeffreys, Geriatrics, Sir William Fergus Anderson, 512/20/01, p. 20.
[97] Jeffreys, Geriatrics, John Agate, 512/8/01-02 1B, p. 10.
[98] Jeffreys, Geriatrics, Wilfred Fine, 512/17/01-02, p. 1-2.

The introduction of physiotherapists and occupational therapists onto the wards complemented the multi-disciplinary approach, and helped to occupy and rehabilitate patients. Articles in the medical press in the late 1940s and early 1950s suggested that this was due to the new changes adopted in the management of older people's care,[99] but doctors also highlighted the benefits of an integrated approach for the patients.[100] Multi-disciplinary case conferences were beginning to be held in some hospitals, signifying that doctors appreciated the input of other professionals.[101] Social workers/almoners were not highlighted in the articles, but Boucher acknowledged the essential contribution this profession could make in assisting the work of the geriatrician. His survey noted the lack of almoners.[102] The survey also stated that professional liaison in the community combined with an assessment of patients' domestic circumstances were considered helpful in facilitating discharge. In some areas health visitors took on some of these roles. Local authorities had not yet developed specific departments to work with old people.[103]

Convincing the managers of the hospitals of the needs of old people became an essential job for the early gerontologist. One doctor described how he wrote to "every conceivable committee" to portray the conditions of the wards. As they were so terrible something had to be done and he managed to get significant improvements. [104] Several of the doctors talk about the dreadful conditions of the hospitals. Boucher's survey in 1955 also described the state of some of the former public assistance buildings and the appalling conditions for the patients: "Some particularly in rural areas, were so poor that it is doubtful whether it would be economically sound to raise them to an adequate standard.....there was often evidence of overcrowding with consequent lack of space for rehabilitation and the general conditions were such that it proved difficult to recruit staff."[105]

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[99] A.N. Exton Smith and G.S. Crockett, 'The Chronic Sick Under New Management, Experiences in Starting a New Geriatric Unit,' Lancet, I (1949), pp. 1016-1018.
[100] M. O'Sullivan, 'The Problem of the Aged Sick as seen by the General Practitioner', BMJ (1953), pp. 1297-1298.
[101] Jeffreys, Geriatrics, John Wedgewood, 512/12/01-02, p. 9-10.
[102] Boucher, Survey, p. 30.
[103] See E Younghusband, Social Work in Britain: 1950-1975, A Follow Up Study, (London: George Allen & Unwin,1978), for further discussion on the development of the local authority and medical social work department services.
[104] Jeffreys, Geriatrics, John Wedgewood, 512/12/01-02, p.5.
[105] Boucher, Survey, p. 18.

The doctors working with old people had to have a high degree of commitment. This work was tiring but the doctors also had to battle with authorities to improve situations. Identifying and challenging previous practice and assumptions were all part of the early work. Looking at falls in hospital was a contribution by one doctor. In a paper he wrote in 1959 he suggested that bed needs and ward design should be considered in efforts to prevent falls. He also thought that patients were often confused due underlying medical conditions, for example, cardiac problems or medication.[106] There was a belief that in the early days of gerontology that geriatricians were mostly practical physicians through necessity, and that there wasn't much time for the academic side.[107]

Ronald Dent in his work as a consultant in Manchester, found that older people as patients had low expectations.[108] Similar views were expressed by two of his colleagues who wrote on patients' reaction to the changes of a new management:

> Most of them were thoroughly despondent; perhaps they remembered previous experiences during evacuation; and they assumed they would have no choice about their future disposal. Their pessimism seemed to arise largely from a dislike of any change, however trivial, and from the fact that many seemed to have resigned themselves long ago to staying in the "chronic wards" of the same hospital permanently. It was this tacit assumption of the hopeless progress by patients, relatives and staff that most impressed the newcomer.[109]

There was no indication how these doctors approached this problem and if a resolution was found. The sentiment of the extract does present a passive picture of disempowered old people, who were resigned to their fate which was effectively determined by others, the professionals.

Teaching hospitals took a while to appoint geriatric physicians. Dr Amulree at University College Hospital in London, and Dr Cosin in Oxford were amongst the first to be appointed in the 1950s. Initially there were few doctors interested in geriatric medicine but it had the fastest growing number of consultants, and was the fastest growing speciality in the 1950s.[110] This was probably because the increased older population generated a need for more doctors and geriatric medicine was beginning to have a significant profile. Geriatric medicine was the new term given to the chronic

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[106] Jeffreys, Geriatrics Wilfred Fine, 512/17/01-02, pp.7 & 14.
[107] Jeffreys, Geriatrics , John Wedgewood, 512/12/01-02, p. 28.
[108] Jeffreys, Geriatrics, Ronald Dent, C512/63/01, p. 8.
[109] Exton Smith and Crockett, 'The Chronic Sick'.
[110] Jeffreys, Geriatrics, George Godber, 512/28/01 1A, p. 16.

sick which had become anathema to many of the early pioneers. According to one doctor, introducing the term geriatrics was considered by some to still carry the same meanings, "but to general physicians and in the USA geriatrics and chronic sick were synonymous.[111] Writing in the Lancet, Boucher articulates his strong views on the term geriatrician:

> The term "geriatrician" is unfortunate and should be discarded; it is an unattractive word; the first part of which in spite of its Greek derivation, conjures up different images in the minds of different people, while the second part suggests that the problem of the elderly and chronic sick is solved when the medical treatment is completed, which of course is incorrect.[112]

There was limited training for gerontologists, Dr Agate, for example applied for a job in Bradford in the early 1950s without having any formal training in geriatric medicine. He makes the point that it was impossible to get any training in this field, or to know where to get it and there were no senior registrars or registrars in gerontology. Marjory Warren had earlier raised this issue. In 1949 two doctors commented on the first geriatric unit in the country (in London), soon after the hospital administration was taken over by the NHS. They suggested that a doctor's training would be improved if medical students spent several months in a geriatric ward playing an active role in the patients' care, stressing that this would be particularly beneficial for future general practitioners as many of their patients were elderly.[113] Dr Agate requested time off from his new post and went to see the key players such as Amulree, Cosin, Howell, Warren and Wilson who were extremely helpful to him. Lord Amulree helped Dr Agate appreciate the need for providing statistical information to local health authorities to develop services, which he considered of fundamental importance for planning.[114] These pioneers of geriatric medicine were keen to impart their knowledge to their peers to expand and improve care for old people.

Respondents recognized that there were mixed attitudes in the medical profession towards the status of geriatricians. This is also borne out in Boucher's survey which states: "Geriatricians were regarded as medical practitioners of a clinical calibre who could not always claim equality with other consultants."[115] Some were of the opinion that becoming a gerontologist was a back door to consultancy as the following quote

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[111] Jeffreys, Geriatrics, George Adams, 512/19/01-02 1B, p.1.
[112] C. A. Boucher, 'A Plan for the Aged', Lancet, I (1949), pp. 745-746.
[113] Exton Smith and Crockett, 'The Chronic Sick'.
[114] Jeffreys, Geriatrics , John Agate 205 512/8/01-02, p.7.
[115] Boucher, Survey, p. 24.

illustrates: "But I must be honest about this, people were being made consultants in geriatric medicine if there was literally nothing else they could be a consultant in at the time."[116]

George Adams puts forward an interesting perspective that geriatricians in the USA were mostly refugees – often highly qualified doctors from Nazi Germany. He suggests that they took up their positions because looking after the chronic sick was not an attractive job and was therefore all that was available to them:

> Because the predominant numbers and this is the kind of comment that I suppose is fair comment but might offend some people's susceptibilities, but most geriatric medicine in the USA at that time [early 1950s] had been practiced by expatriots, Middle European doctors who had been driven out of the country by Hitler and the Nazi progress over there – come to the USA and found in this area of practice which nobody else wanted to have anything to do with – looking after the chronic sick didn't appeal to anybody very much – and that was they way it was looked upon.[117]

Working with older people appeared to be seen by some people as second rate. One senior gerontologist was not personally concerned with this as he felt confident in his qualifications, but understood the prejudice as outlined in the following excerpt:

> ...I think there was a wee bit of prejudice against people working with old folk. I think that the temptation was to regard, it crept in later on, to regard anybody who worked with the elderly as some way being second rate. I was so privileged, I had my honours MD my fellowship and things like that came and I could cock a snoop or whatever you call it,....I wasn't worried by that.[118]

Another doctor refers to an earlier time of working with old people and sums it up as facing: "...certain snobbery because you were doing work with the poor ..."[119] The misunderstandings of opponents to geriatric medicine were expressed by one physician:

> ...One that general physicians felt that this was a back door into general medicine for people who weren't so highly qualified as they were and there was a grain of truth in this but not very much. And I think the geriatricians felt that the general physicians were concentrating on a disease rather that the person....good general physicians have always been good geriatricians and good geriatricians have always been good general physicians.[120]

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[116] Jeffreys, Geriatrics, Samuel Vine, 512/68/0-02, p.8.
[117] Jeffreys, Geriatrics, George Adams, 512/19/01 1B, p.1.
[118] Jeffreys, Geriatrics, Sir William Fergus Anderson, 512/20/01, p.17.
[119] Jeffreys, Geriatrics, Thomas Rudd, 512/21/01 1B, p. 4.
[120] Jeffreys, Geriatrics, John Wedgewood, 512/12/01-02, p. 24.

This perception sums up the suspicions very well. Others recounted how they cultivated relationships with their medical colleagues to develop systems to enable old people to receive treatments in specialist fields such as psychiatry.

The significant BMA Committee on the Care and Treatment of the Elderly and Infirm made formal proposals on the development of a geriatric service in 1948. This committee made links with bed blocking and efficiency, thereby setting the scene for change in a political context. Many of the views expressed by medical professionals during the previous decade had consolidated by the time of this committee.[121] Opportunities for change were also favourable due to the recent inception of the welfare state. However, Martin points out a major contradiction of the time, that on the one hand that there was a debate arguing that there was no need for a geriatric speciality, and on the other a debate on the need for geriatric units in the late 1940s early 1950s. Martin summarises the major objections to the establishment of specialist units. First, that these units could cause isolation from mainstream medicine. Secondly, that the character of hospitals would change and effectively become chronic sick hospitals similar to the old public assistance institutions. Thirdly, that a trend could develop not to treat old people alongside others in curative medicine. Finally, those involved in social medicine considered that this speciality would detract from developing environmental aspects that improved the welfare of old people.[122] As illustrated above, similar concerns were echoed in the medical testimonies of 1940s. One of the biggest concerns was that old people should not be in hospitals as they were inappropriate establishments to provide for their care and this could lead to a change in the character of general hospitals. Those in favour of the development of a geriatric speciality were of the opinion that there were specific needs attached to the physiology of old age and these would be overlooked in mainstream care. This difference of opinion presented practical problems that were difficult to resolve and created national inconsistencies.

In response to growing concern about old people accessing hospital beds and the continuing increase in the older population, an important committee to survey services for the chronic sick and elderly was set up by the Ministry of Health in 1953. Boucher, a medical officer in the Ministry of Health chaired the committee, known as the

[121] See Webster, 'Elderly', pp. 165-189. Webster presents his analysis on the influences on delays in establishing adequate services for old people.
[122] Martin, 'Medical Knowledge.' Martin identifies the salient objections and objectors on the development of the specialty and examines attitudes expressed in medical journals of the 1950s to explore the "inconsistencies in the arguments for improved medical care for elderly people."

Boucher Committee. The committee recommended that domiciliary services should be improved to enable old people to stay in their homes, so that admission to hospital would be the last option. A BMA Committee came up with similar conclusions.[123] Surprisingly the Boucher Committee concluded that there was no need for increased hospital provision. A bed norm was subsequently established, which effectively reduced the number of hospital beds for old people. As a result this put pressure on to the local authorities and GPs. Bridgen has examined the Boucher Report in detail and considers the conclusions and recommendations inconsistent with the evidence. He also points out that there was an overlap in members of the BMA Committee and the Boucher Committee which could have influenced the conclusions. Furthermore, he asserts that the bed state was wrongly calculated and the bed norm was implemented without finance for greater domiciliary and residential support.[124] The committee did acknowledge the confusion over the possible creation of geriatric medicine as a speciality, but no solution was offered. Underpinning the report was the philosophy that medical intervention would enable old people to become independent, and this would best be achieved in geriatric units run by geriatric consultants. It was apparent that specialist units alone were not working. The Boucher Report found that the physicians in charge of many geriatric units were not particularly interested in old people, and there were staffing problems.[125] By the mid 1950s, Regional Health Boards had limited beds for the chronic sick to 1.2 beds per thousand population. Two other significant reports, by the Phillips Committee and the Guillebaud Committee, carried out in 1954 and 1957 respectively, drew similar conclusions. The Phillips Committee concluded that:

> Old people should as far as possible continue to live as members of the community. With this end in view, we consider that it is important that special housing of varying types, adapted to the needs of old people but not isolated from the rest of the community, should be provided. The necessary domiciliary services should be developed and coordinated with the general practitioner and geriatric services.[126]

The Guillebaud Committee endorsed this conclusion.[127]

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[123] Supplementary Report of the Council, BMJ, Supplement 23 April 1955, pp. 181-9.
[124] Bridgen, 'Hospitals'.
[125] Boucher, Survey, p. 53.
[126] Report of the Committee on the Economic and Financial Problems of the Provision for Old Age, Cmd. 9333, (HMSO, 1954), p. 54.
[127] Report of the Committee of Enquiry into the Cost of the National Health Service, Cmd.9633, (HMSO, 1957).

In theory it seemed as if there was political agreement about the needs of old people in the community. But, as Martin rightly asserts, additional problems were created because the administrative structure of the NHS could not define whether old people's welfare came under the auspices of social or medical remits. Also, whilst local authorities were providing some services in the community to support old people living in their own homes, the lack of a coordinated community care policy did not offer a safety net when support systems broke down. Without adequate support systems in the community, ranging from housing to housework, old people would have to be admitted to hospital, effectively undermining the policy.

Doctors working in the care of old people were struggling with practical problems as well as inconsistencies within their profession on the status and future of geriatric care. In the early 1950s, the medical profession seemed to have been resistant to accepting gerontology as a specialism. Some physicians were employed as general physicians and others as geriatricians. A part of the developing work as a gerontologist was promoting the specialism within the medical profession in addition to improving the medical care for old people. In some hospitals the benefits of the gerontologists' philosophies and practices were acknowledged because beds were cleared. Admittedly there was also a vested interest here from a clinical and management perspective.

Despite, or perhaps because of these problems, some doctors working with old people began to make informal links with each other and shared professional concerns. It is impressive to note the networking and links between these doctors. Eventually, the Medical Society for the Care of the Elderly was formed. The name was apparently carefully chosen as Lord Amulree was opposed to the word geriatrics.[128] Dr Wilson remembers eight doctors at the inaugural meeting held at St John's Hospital in 1947. These were Lord Amulree, Lionel Cosin, Trevor Howell, Marjory Warren, Eric Brooke, Alfred Mitchel, EL Sturdee and himself. Trevor Howell became the treasurer and Lord Amulree became the president. George Adams joined later.[129] Sam Cieman is also mentioned as one of the original founders.[130] The organisation had representations from the department of health, clinicians and some administrators.[131] In 1959 the Society changed its name to the British Geriatric Society (BGS) because other countries

[128] Jeffreys, Geriatrics, John Agate, 512/8/01-02 1B, p. 18.
[129] Jeffreys, Geriatrics, Thomas Wilson, 512/5/01, p. 13.
[130] Jeffreys, Geriatrics, Ronald Dent, 512/63/01, p.7.
[131] Jeffreys, Geriatrics, John Agate, 512/8/01-02 1B, p. 18.

were developing geriatrics and having academic societies to support them (such as the French Geriatric Society and the Italian Geriatric Society) and it seemed a logical progression. Scotland had its own branch of the Medical Society for the Care of the Elderly. Sir Fergus Anderson thought that it was easier to operate in Scotland as it was a smaller country; the doctors all knew each other, and before going into geriatrics, had been well-trained physicians.[132]

Establishing a journal on geriatrics presented a problem. Dr Agate remembers going to discuss the possibility of a journal on geriatrics with some of his colleagues and the BMA journals committee in the mid 1950s. The committee refused the request as this was a new specialism. Following this decision a publishing company in Switzerland was approached and Gerontologica Clinica was launched in 1957 and became recognised as the official journal of the Medical Society for the Care of the Elderly.[133]

One of the Medical Society for the Care of the Elderly's achievements in the recognition of gerontology and development of standards was to ensure that no geriatric hospital could be properly called so unless there was footing in a general hospital where full investigations could be done. The British Medical Journal and the Lancet would apparently not advertise for geriatric consultants posts unless it was acknowledged that there would be an acute assessment ward in a general hospital.[134] Certainly the founding of the Medical Society for the Care of the Elderly was a major development in the care for old people. A professional organisation was established with influential members such as Lord Amulree, Dr Warren and Dr Cosin, all of whom had links with the government. By forming this organisation the profile of old people was raised both professionally and politically. Members of the society received peer support, and were less isolated.

Conclusion

By using the testimonies from the pioneers of gerontology within the context of contemporary medical literature an overall national picture has been constructed. Sources complement each other by presenting a detailed perspective from professionals

[132] Jeffreys, Geriatrics, Sir William Fergus Anderson, 512/20/01 1B, p.2.
[133] Jeffreys, Geriatrics, John Agate, 512/8/01-02 1B, p. 18, the editorial of the first edition of Gerontologia in 1957 published in Basel establishes that "This new journal is intended to be of service to all those who believe that experimental research can lead us to a better understanding of the process of ageing."
[134] Jeffreys, Geriatrics, John Agate, 512/8/01-02 1B, p. 10.

directly working in front line services, describing the problems they encountered and the responses from the authorities. Previous studies of the development of geriatric medicine have not included professional perspectives in this level of detail.

An expanding interest in the welfare of older people in the 1930s and 1940s was reflected in the increased number of publications in medical journals written before the inception of the welfare state. Those who wrote in the journals were from two groups of medical professionals; clinicians already interested in the welfare of older people, or senior medical officers. Trevor Howell had five papers published and Marjory Warren had three. Other doctors had more than one article published. The limited number of contributors indicated a general lack of professional interest in older people; caring for older people was not seen as glamorous within the profession. This mirrors society's attitude to old people at the time, for they were not seen as a priority group, as was evident in Beveridge's statement in 1942.

The fine dividing line between social needs and health care is demonstrated by the fact that several articles focusing on the housing needs of older people are featured in the medical press. Local MOHs and GPs were obviously concerned at the social conditions that many older people were living in. Statutory social services departments had not been established; most social work with old people was effectively on a voluntary basis. In the light of this, medical practitioners were the main professionals directly working with older people. Some cities had extreme poverty which medical practitioners reported on. This explains the intense interest in housing, as doctors were able to make the obvious links between the need to improve standards of living and to improve health care. A holistic approach was advocated by many of the writers, as they considered the importance of the well being of the whole self was crucial to the welfare of an older person. Thus the interest in occupational therapy, physiotherapy, chiropody, clubs and other activities that would occupy and benefit older people.

Hospitals in this period were full of older people in varying degrees of illness and incapacity. The contention regarding specialist geriatric units versus integration into mainstream medicine indicates the complex debates amongst the medical profession on old people's care. Those doctors in favour of geriatric medicine becoming a speciality had a struggle convincing the wider medical profession of its benefits. This is another

example confirming that within the medical profession older people's care was not considered a priority. Hospital care in general terms was subject to local resources, as well as to individual commitments and philosophies. Dr Warren is an example of a doctor who managed to effect great change in the quality of care for older people, despite working in difficult conditions, that is, antiquated "poor law" institutions. The literature is from self selected contributors so we do not know how old people were treated by those practitioners not pro-active in the care of old people and/or not in favour of the speciality. Their treatment could have been equally commendable, negligent or unremarkable, but statements such as "neglect of the old in institutions is the rule rather than the exception," in the Lancet in 1947 give a strong indication that in all probability the care was at best unremarkable and at worst negligent. However, it is likely that there were hospitals where doctors did not have an interest in geriatrics as a speciality but gave old people the best care that was available at the time and in the circumstances. Geriatric medicine was also developing internationally, international conferences were being held and some of the pioneers were involved in this.

Evident in the medical literature was a strong move to get rid of the stigma of the institutional care of the public assistance era. This involved creating smaller establishments where residents were able to wear their own clothes, a "family life" atmosphere was created, for example small dining tables, cosy chairs, light décor, constant warmth, activities, mixed sex groups and facilities for married couples.

However, in general whilst advances were being made in the development of geriatric medicine, there was concern over the hospitalisation of older people. Consequently bed shortages led to more pressure on the welfare departments of the local authorities who were already struggling to provide services with inadequate resources for older people. It is my opinion that there was an economic influence underpinning the interest in older people's welfare. Medical practitioners, particularly those based in hospitals, understood the implications of the need to improve and develop systems for old people, otherwise services for the rest of the population would be jeopardised for example by bed blocking. This was happening at the same time as the debate about the development of geriatric medicine. Evidence from the doctors suggests there was a current of thinking that considered that creating the speciality would marginalise old

people and their needs would not be met. Thane explores this further and explains how some social scientists considered that this contributed to the "medicalization of old age."[135] It is impossible to know what would have happened to old people without the efforts of the early pioneers. There can be no doubt that old people have benefited from their interventions and from the commitment of gerontologists to their work. The next chapter will illustrate the efforts and enthusiasm of one such doctor and examine how this affected the local community both professionally and socially.

[135] See Thane, Old Age, pp. 436-457.

CHAPTER FIVE

The influence of an individual, Dr Lionel Cosin, on the Cowley Road Hospital in the 1950s

His work was very very remarkable and it too good to let it fall into forgetfulness. The work won't be forgotten but the contribution he made certainly should be remembered.[1]

While the previous chapter presented a picture of the development of geriatric medicine from a medical professionals' perspective, this chapter will focus on an individual, a pioneer of gerontology, Dr Lionel Cosin. Dr Cosin was part of a wider national movement of early pioneers in geriatric medicine that included Marjory Warren and others (outlined in Chapter Four). But because Dr Cosin was based in Oxford and was one of the leaders of his time, and a founder member of the Medical Society for the Care of Elderly People, his position at CRH has a particular relevance to this thesis. Another doctor was appointed to CRH in 1952, Dr Bedford, who also played an important part in the local development of geriatric medicine but unfortunately he died in 1962. This chapter will address a number of key questions about the role of Dr Cosin. These include: how significant were Dr Cosin's background and philosophies in the development of national gerontology? How was his work seen by other professionals locally, nationally and internationally? Did his appointment at Cowley Road Hospital in 1950 affect the care and welfare for older people in Oxford; and was this in line with national developments?

The information for this chapter has been collected from oral histories from local professionals working in the care for old people between 1930 and 1960, testimonies from the early specialists working in care for old people carried out by Jeffreys[2] in 1991, historical texts, interviews with Dr Cosin's son and daughter, medical literature and Dr Cosin's private papers.

Oral history methodology has been discussed in Chapter Two. For the purposes of this chapter the testimonies of local respondents who had professional experience of Dr Cosin, either directly or indirectly, are used. The national collection of oral histories by Jeffreys is discussed in more detail in Chapters Two and Four. This chapter has used the collection to discover further information about Dr Cosin. By selecting the oldest

[1] Jeffreys, 'Geriatrics', Thomas Rudd, 512/21/01 p. 10, speaking about Dr Cosin in his interview.
[2] Jeffreys, 'Geriatrics'.

contributors who were practising in the 1940s and 1950s, I have extracted their memories of him. Additionally, within this collection is an interview with Dr Cosin himself. This related to the 'fit' of the data being used throughout my thesis as discussed in Chapter Two in the methodology section.[3] In conjunction with my discussions with his children, Dr Cosin's papers were able to give biographical details and were used to map his medical career.[4] With regard to information supplied by Dr Cosin's children there may be possible bias in their assessment of their father. This could be due to several reasons, but mainly because of restricted perspectives and family loyalty. The chapter aims to provide a profile of an eminent doctor that demonstrates his influence in geriatric medicine locally and nationally.

Early career

Dr Lionel Cosin was born in London on 8 November 1910. He attended Westminster City School, and then went to medical school at Guy's. Dr Cosin qualified as a doctor in 1933, and gained his professional qualification as a surgeon aged twenty-six. After qualifying, he took up a post as a junior doctor, working in surgery at the Prince of Wales Hospital, then he worked at the Royal Northern Hospital. Both of these hospitals were in London. He studied obstetrics at the City of London Maternity Hospital in 1936. From 1937 until 1939 he worked as a GP in Hampstead Gardens. In 1939 Dr Cosin applied to be a first assistant in a neurological team for war work at London Hospital. He was successful in his application but in the meantime received government instructions to proceed to Orsett Lodge.

On 1 September, 1939, Dr Cosin went to Orsett Lodge in Essex. In his oral history with Jeffreys he described the set up when he arrived. He was: "One of five surgeons (with surgical teams), along with two or three physicians, some junior staff (not many) and a medical superintendent." Orsett Lodge was a public assistance institution and according to Dr Cosin had: ".... Five hundred beds in all sorts of places and states, plenty of room there and a well built maternity department." Dr Cosin held the view that he and other medical personnel were sent to Orsett because the government anticipated that there would be many war casualties. Orsett Lodge was assigned to deal with such events. He explained the initial outcome of the government action: "[It was]

[3] Elliot, 'Growing Up'.

[4] I am indebted to the generosity of Pippa and Ben Cosin who donated their father's papers to me. These papers are now held at Oxford Brookes University and provide a rich source of information that covers a wider time span than that covered in this thesis.

Ministry of Health decision that there would be a quarter of a million casualties in and about London in the first two weeks of the war. There were none, so staff were "twiddling their thumbs" but could not return to their practices as they had been disrupted."[5]

It was at Orsett Lodge that Dr Cosin first began to be interested in rehabilitation, an interest which was to have such a positive result at CRH. According to his daughter Pippa, Orsett Lodge was very disorganised and her father was a pragmatist. She recalls an example of his skills. Orsett Lodge had a single front gate and ambulances delivering patients to hospital had to turn around in a very complicated way causing jams. Dr Cosin noticed a back gate and arranged a one way traffic system for the ambulances to increase efficiency. Another improvement was his introduction of the triage system for admissions. All patients were given a different coloured blanket depending on their priority. Dr Cosin was surprised that nothing had been designed by the existing staff.[6] Here, he developed a system of 'progressive patient care' that concentrated on rehabilitation and preparation for discharge from the hospital once acute treatment had been given.[7]

During this time he was waiting to hear if he would be called up. In late 1941 he was appointed medical superintendent. Orsett Lodge was also caring for civilian patients, some of whom Dr Cosin described as "chronically neglected patients" who were never discharged. However, within this group he discovered there were patients able to feed themselves and walk, and who, in Dr Cosin's opinion, needed little nursing care. In conjunction with the physiotherapist at Orsettt Lodge, Dr Cosin, concentrated on daily living activities, and categorised patients into the following groups, "bedfast", "ambulant" and "frail ambulant."[8] Dr Cosin's rehabilitation treatment had left the hospital with, unusually, many empty beds. According to Burrough, the historian of the United Oxford Hospitals, Dr Cosin was intrigued as to why a chronic sick hospital had so many beds[9] and suggested a statistical survey be undertaken.[10] This survey, carried out over eighteen months from 1947 to 1948, found that (a) the death rate was 37 per

[5] Jeffreys, 'Geriatrics', Dr Cosin, C512/41/10-04 1A, p. 11.
[6] Taped interview with Pippa Cosin, 11 November 1999.
[7] Thane, 'Old Age', p. 443.
[8] Jeffreys, 'Geriatrics', Dr Cosin, p. 12.
[9] Burrough, Unity, p. 208.
[10] L. Cosin, in Proceedings of the Royal Society of Medicine, 'A Statistical Analysis of Geriatric Care', May 1948, vol 41, pp. 333-336.

cent, (b) nearly all deaths took place within the first 30 to 60 days after admission, (c) a large number could be discharged within 60 days, and (d) those remaining could be rehabilitated for a further 30 to 40 days. Dr Cosin introduced a rehabilitation programme for bedfast patients at the acute stage of illness and worked to get them back to their own homes.[11] One of his major achievements at this time was demonstrating that chronically sick patients could be rehabilitated. His Orsett Lodge experiences could therefore be interpreted as a pilot project for his later years at CRH.

About this time Dr Cosin was becoming well known in the field of gerontology. Lord Amulree, the Medical Officer of Health visited Orsett Lodge and discussed geriatric care. Dr Cosin was also attending medical superintendents' meetings and met up with Dr Brooke from Carshalton. His fame was spreading and, in early 1947, he and three other early geriatricians Boucher, Brooke and Warren were invited by Whitehall to attend "a little committee on the chronic sick." The committee was in fact, a very important committee that met with government representatives to review care of older people, and to design new systems for old people under the newly established NHS. This committee met for approximately seven months and recommended, (a) that departments of geriatric medicine be established (which was accepted by Nye Bevan), and (b) that medical direction of superintendentship be part of the NHS (which was not accepted by Bevan).[12] These and other recommendations contributed to government policy on care for older people under the NHS. This was provided in the Report of the Committee on Care and Treatment of the Elderly and Infirm. Dr Brooke, Mr Cosin and Dr Warren are credited for their contributions to the Committee based on their long experiences of working with the chronic sick. The following extract illustrates the extent of their involvement: "...this section is based on a draft which was written primarily by them, primarily with a view to publication in the medical press, and which, somewhat modified in the light of the Committee's discussions, is likely to appear in print (with the full concurrence of the Committee) in advance of this report."[13]

Dr Cosin wrote articles to illustrate his work at Orsett Lodge and demonstrated that the average length of stay in hospital could be reduced (mainly for elderly chronic sick

[11] Burrough, Unity, pp. 206-208.
[12] Jeffreys, 'Geriatrics', Dr Cosin, 512/41/10-04,1A, pp. 13-14.
[13] 'Report of the Committee on Care and Treatment of the Elderly and Infirm', Appendix I, Supplement to the BMJ, June 21, 1947, p. 134.

patients).[14] The national average was 260 days,[15] and at Orsett Lodge, Dr Cosin brought this down to 52 days.[16] Within these articles he outlined the necessary ingredients needed to improve the care of the aged sick. Firstly, a geriatric department had to be established; second, rehabilitation of older people must be prescribed; thirdly, a more optimistic approach by the medical staff towards older people would encourage more nursing staff to work with old people; and fourthly, medical staff must design more therapeutic approaches to "economise nurses' time." Dr Cosin was of the belief that this would effectively reduce the maximum amount of time spent nursing the sick and thus hopefully decrease the "unpopularity of this work."[17] As a result of the introduction of these programmes, Dr Cosin managed to reduce the amount of time that old people stayed in hospital.[18]

Professionals tended to give little priority to the care of older people, and many considered that "sickness in old age could not be cured or treated."[19] This form of care came to be seen as 'warehousing'.[20] Both Dr Cosin and Dr Warren worked in institutions where chronically ill patients were accommodated in this fashion. As discussed in the previous chapter these doctors, and others, such as Brooke, Howell and Boucher, were instrumental in changing the philosophy and policy in national treatment and care for older people during the 1940s. Their professional contributions paved the way for the 1948 changes in medical care for old people. Dr Cosin was also prominent in the establishment of the Medical Society for the Care of the Elderly. He described to Jeffreys how in the early years of the development of gerontology, networking was important. He and his contemporaries, such as Howell, Wilson and Adams (who worked in Belfast), met regularly and were frequently "swapping experiences." Dr Cosin held the opinion that the founding of the Medical Society for the Care of the Elderly "put geriatric medicine on the map" especially as it grew and became a political

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[14] For example, see L Cosin, 'Organising a Geriatric Department, BMJ, II (1948), p. 1014; Aids to Hospital Care of the Elderly, Medical World, January (1948); ' Modern Methods in the Care of the Aged', Journal of the Royal Institute of Public Health and Hygiene, (1948), pp. 133-135; 'Rehabilitation of the Chronic Sick', Nursing Mirror, November & December (1948), January (1949); 'Geriatric Rehabilitation', British Journal of Physical Medicine, November & December (1949).

[15] Webster, 'Elderly', p. 177.

[16] Cosin, 'Statistical Analysis'; see also Thane, 'Old Age', p. 443, where the author refers to a taped interview between Jeffreys and Dr Cosin confirming these figures.

[17] Cosin, 'Organising', pp. 1044-1046.

[18] Jeffreys, 'Geriatrics', Dr Cosin, p.11.

[19] Jefferys, 'Pioneers', p.77.

[20] Jefferys, 'Pioneers', p. 94, refers to the term "warehousing" coined by E.J. Miller and G.V. Gwynne in a study of residential care.

force. [21] This formal and informal networking would have enhanced and reinforced their professional identity.

In 1948, Dr Cosin was invited by the medical administrator of the North East Regional Hospital Board to be the medical officer at Langthorne Hospital for the Chronic Sick. Langthorne had 900 patients and had been partly demolished by bombs. (By contrast, Orsett had been a more general hospital.) On his arrival at Langthorne, Dr Cosin was told by the matron when doing his initial rounds that some of the patients had cancer. He disputed this and considered that further examinations were necessary and "demanded" that a junior doctor should be appointed to attend to this aspect. (Similar experiences of mis- or non-diagnosis were described by his colleagues in Chapter Four.) Some patients, approximately 100, had been in Langthorne hospital for 5, 10 and 15 years. Dr Cosin wanted to get them up and moving around. A physiotherapist and psychiatric social workers were employed probably as a result of Dr Cosin's influence. Some patients were able to be sent home. He also introduced day care for the mentally confused.[22]

During Dr Cosin's time at Langthorne he was contacted by John Ryle from the Department of Social Medicine at Oxford University, who held weekly medico-pathological conferences. John Ryle had been a consultant physician at Guys Hospital and Dr Cosin had been his clerk. Dr Cosin was invited by Professor Witts, at the RI, also formerly a ward clerk at Guys, to give a talk to the medico pathological conference on "medical rehabilitation." Subsequently he received a letter from John Ryle inviting him to apply for the post as medical director at CRH. One factor influential in his decision to move, was Dr Cosin's view that there were more opportunities at CRH, he thought there was "only a certain amount you could do there [at Langthorne]."[23] An impression is given that even before he arrived at CRH he had plans and ideas for change.

Cowley Road Hospital

When Colin Share took over the administration of CRH in July 1948 he described it as being "an awful shambles" and raised this at the end of the first board of governors' meeting. It was at this meeting that the board made an "inspired" decision to prioritise

[21] Jeffreys, 'Geriatrics', Dr Cosin, pp. 13-14.
[22] British Geriatrics Society Annual Report, 1996/97, p. 24.
[23] Jeffreys, 'Geriatrics', Dr Cosin, pp. 13-14.

the practice of geriatrics and elderly care in Oxford.[24] Burroughs suggests that this decision by Oxford academics, at the beginning of the life of a new medical school, with fashionable new specialisms developing, was remarkable. It is not clear exactly who was on the board of governors at this meeting, but prestigious personnel were present, such as Sir Hugh Cairns (who proposed the decision), and Leslie Witts, (Nuffield Professor of Medicine), who took on the task of investigating improvements for CRH. A house physician was appointed, Dr Morag Insley, the only physician at the CRH. Dr Cosin was appointed as consultant physician and medical director at CRH on 1 May 1950. It is pertinent to note that he was appointed to a position as a consultant physician, not as a geriatrician, although working in a hospital designated specifically to care for old people. This anomaly reflected the attitude of the medical profession with regard to recognising the specialism. Prior to taking up his appointment, Dr Cosin had visited the CRH on a number of occasions, and started to make some changes with advice from the architect's department at the Ministry of Health. He visited this department every two months for several years to report on progress at CRH. Dr Cosin wanted to reorganise the CRH in line with his previous experience at Langthorne and Orsett and needed £50,000. He went along with the general move towards gerontology having a multi-disciplinary, holistic approach. When he arrived at CRH, there was a waiting list of 200-300 people, and he was offered 100 extra beds, but he refused this.[25] Dr Cosin's objective was to reduce the length of time old people stayed in hospital, as he felt that rehabilitation was the way forward for old people. Before Dr Cosin was appointed at CRH, the average length of stay for patients was 290 days and by 1956 he had reduced this to 42 days.[26]

In the early 1950s, Dr Cosin developed and introduced a day hospital at CRH. This provided an innovative form of care for older people in the community and helped to release beds. After patients were discharged back into the community, Dr Cosin arranged for them to be sent to the day hospital for treatment in the resettlement programme. Initially after discharge patients had maximum attendance at the day hospital - four days a week. The plan was to gradually reduce each individual's attendance down at the day hospital, so that more people could benefit from the service. As out-patient care had released beds, this eventually gave Dr Cosin an opportunity to

[24] Burrough, Unity, p.205.
[25] Jeffreys, 'Geriatrics', Dr Cosin, pp. 13-14.
[26] Webster, 'Elderly', p. 177.

be more creative with the "extra" beds. One of his ventures was the provision of a "floating bed" scheme. Between three to eighteen patients at a time received this service, each staying as an in-patient for a fortnight on a regular basis. Dr Cosin's practice reflected his philosophy, for he strongly believed in integrating patients back into their community. Treatment programmes for ex-patients also reflected his understanding of the problems for old people in the community. Support needed to be provided for them and their families post-discharge, and the day hospital and floating beds helped to bridge the gap between home and hospital.

Dr Cosin was a member of the Advisory Council of the National Corporation for the Care of Old People (NCCOP) between 1951 and 1958. This organisation developed an overview on the national situation for elderly people. Mike Simson, the secretary of the NCCOP, outlined one of the major problems facing old people needing residential accommodation: "....Institutions provided this *[accommodation]* and when demolished problems of infirmity got bigger. Nobody seemed to have a policy and the only policy was to shift responsibility from one to the other."[27] The NCCOP started to address this gap. Simson recalls that a gift of £170,000 came from South Africa (the rationale for this donation is not provided) and these funds were used to fund four new accommodation projects. The NCCOP felt that these new homes provided by this donation should have "financial creativity". These "Rest Homes" were located in Stanmore, Glasgow, Belfast and at CRH (Hurdis House) in Oxford. Mike Simson is of the opinion that these homes terrified the local authority as they [NCCOP] had control over home and hospital and explains why: "all these homes worked in a way but they did not necessarily achieve the objective of getting the local authority and hospital to work closely together. They were miles apart in thought and always suspicious of each other."

The NCCOP had strong views on the ill-defined areas of responsibilities between health and social care agencies, and thought that geriatricians should determine whether hospitals or local authorities should take responsibility. Local authorities did not accept this proposal, but it is not apparent where these discussions took place, who was involved in them, and whether they were taken at formal meetings. In practice local authority homes catered for fit people, but when residents became ill, the paradox was that hospitals did not want them. Some of the problems between the agencies are

[27] Jeffreys 'Geriatrics', Mike Simson, C512/22/1-2, pp. 16-17.

reflected in the example of Hurdis House. According to Dr Cosin the NCCOP ran Hurdis House, a "halfway house" in the grounds of CRH, for two years. There were enormous difficulties with United Oxford Hospitals relating to financial responsibilities for local authority patients, exactly as Mike Simson had described.[28] After four weeks in Hurdis House, the local authority were requested to assess for Part III fit (an assessment to ascertain whether a patient would be able to transfer to a local authority home, which required residents to be of a certain level of fitness) and availability of beds in the OPHs. Both authorities were loath to accept patients. (Chapter Eight looks further into the role of the local MOH in the development of services for old people and the relationship with the health authorities.)

The influence and effects of Dr Cosin and Dr Bedford at Cowley Road Hospital

Local professionals involved in the care of old people between 1930-1960, and whom I interviewed, saw Dr Cosin as instrumental in changing the care for older people from 1950. Some remembered Dr Bedford, a colleague of Dr Cosin's at CRH as equally significant in the changes at the CRH during the early 1950s, but his impact was less than Dr Cosin's as he died in 1962.

Dr Philip Bedford graduated from Leeds University Medical School in 1939. Following his graduation he held the posts of house-surgeon, house physician and resident medical officer at Halifax General Hospital. He then served as a medical officer in the RAF until 1946. After the war Dr Bedford spent three years as a medical registrar at the General Infirmary in Leeds. Prior to his appointment as a registrar at CRH, he spent six months study leave at Guys Hospital. He was appointed as a consultant at CRH in 1954. During this time he was also appointed clinical lecturer and tutor in medicine to Oxford University. In 1958 he was honorary secretary of the Section of Geriatrics at the Annual Meeting of the BMA. Dr Bedford was 48 years old when he died. His colleague, Dr Cosin contributed to his obituary, praised his professional practice and teaching skills. Professor Witts, also contributed to Dr Bedford's obituary, and wrote: "It is tragic that who had done so much to promote the longevity of others should himself have been cut off prematurely."[29]

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[28] Jeffreys 'Geriatrics', Dr Cosin, pp. 13-14.
[29] Obituary, BMJ, 2, 1962, pp. 124-125.

One local GP, practising on the outskirts of the city centre and St Clements, recalls how Dr Cosin and Dr Bedford started to change the treatment for older people by investigating the cause of illness rather than treating the symptoms: "[they] tried to do something for old people other than getting them symptomatic treatment...this was the great change that they gave them physiotherapy, they gave them antibiotics and they fully investigated them."[30] As previously outlined, there was ambivalence amongst the national medical community with regard to these new methods of treatment for older people. Dr DL corroborates this on a local level. He recollects that while some of his colleagues were glad to see something was being done about old people, others considered that limited resources should not be devoted to people nearing the end of their lives and should be used for younger people; the old had had their lives and treatment was "unwarranted interference with nature."[31]

Mr MG a physiotherapist working at CRH in the 1950s remembers Dr Bedford's input as challenging the system for inappropriate referrals to the CRH:

> The patients that were sent to Cowley Road were sent there to die oh nothing to do with anything else ..... he [Dr Bedford] was a brilliant consultant in old age and he was the only doctor that I've seen that would write on the patients notes 'this is an entirely erroneous diagnosis when this patient dies I will carry out the post mortem to substantiate these findings PD Bedford'.[32]

Dr FC was a senior house officer at CRH in the mid 1950's and considered that Dr Bedford was particularly outstanding as he had "clarity of thought" and could see things that others could not see themselves, and "he tried as far as he could to introduce scientific methods to the care of the elderly."[33]

Dr FC also corroborates the testimony of Mr MG. He remembers Dr Bedford's concern at the wrong diagnosis given by doctors at the RI; this practice indicated to him that the patient had not been looked at properly. He explained why there were concerns as at this time "[it] was not realised that the way you had to go about things was different" [for old people's examinations]. The reason why an examination should be different for older people was explained "it was not appreciated, just a touch different and ordinary methods of history taking and examining were not adequate." There were often problems with a "misleading history" (taking details of a patient's medical

[30] Dr DL OX48 18/01/00, pp. 10-11.
[31] Dr DL OX48 18/01/00, pp. 10-11.
[32] Mr MG OX16 4/03/98, p. 2.
[33] Dr FC OX6112/12/01, p. 1.

history), if one was obtained at all. Doctors at the CRH considered that correct history taking was essential in establishing the diagnosis and if possible involved talking to the relatives. Busy doctors in an acute hospital rarely acknowledged this.

According to Burrough, Dr Bedford was a general physician who applied his clinical knowledge of general medicine to geriatric care, and linked it very closely with social care. He considered that Dr Bedford recognised that older people suffered from multiple conditions and: "Therefore of multiple physiological disturbances which were often inter related and were an important cause of disability. He recognised that treatment by drugs was often responsible for producing effects which were sometimes worse than the disease so that many patients became practically intoxicated by them."[34] Burrough also credits Dr Bedford with being an excellent teacher. He related how popular he was amongst the post graduates and undergraduates as he was able to persuade medical students to come to the CRH to "think about the problems and work them out for themselves." A former post graduate taught by Dr Bedford in the early 1950s, who then became a SHO at CRH in the mid 1950s, pays tribute to Dr Bedford as "the best teacher of medicine in place"[35] Dr Bedford was effectively another pioneer of gerontology; his insight and practice reflected his commitment to old people.

In the early days of the NHS the CRH had two progressive doctors working to improve the conditions for old people, but Dr Bedford's premature death in 1962 left Dr Cosin to take forward the initiatives. The strong personal philosophical views that Dr Cosin and Dr Bedford held on old people's treatment clearly had an impact on local professionals. On a personal level Dr Cosin and Dr Bedford appeared not to have had an easy relationship. Dr FC could "only sense problems between them." He thought Dr Bedford felt Dr Cosin was "too clever by half", and was glad when he went away (Dr Cosin did go away a lot in 1956) as he was always interfering.[36] This does suggest that staff were aware of tensions between the two consultants, though there is no evidence to assess whether this relationship had any significant effect on patient care.

Contributions from a former employee who worked for the local Old People's Welfare Committee (OPWC) in the early 1950s recalls how Dr Cosin turned the CRH around and contrasts his methods of treatment with previous practices:

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[34] Burrough, Unity, p. 213.
[35] Dr FC OX61, 12/12/01, p. 1.
[36] Dr FC OX61, 12/12/01, p.1.

> One of the things I did was to visit CRH, and I was absolutely appalled by that because there were people in CRH who were perfectly capable of coming out into the community but were bedridden - that was the idea, an old person went into hospital perhaps if they were unwell at some time - and they never came out you know. And then of course they weren't got up - when Dr Cosin arrived - and he said they would be up in two days, you know he would only keep them in two days, that was quite a culture shock for them.

Ms ASP remembers how people who were "compos mentis" were left in bed and this was changed by Dr Cosin.[37]

Ultimately Dr Cosin wanted older people rehabilitated to become incorporated back into the community, a reversal of previous practice. To him this was best done in a multi professional environment and needed back up resources in the community. GPs were informed of his treatment plans, and were able to visit their patients in the CRH. Once discharged back into the community, then the GP had overall responsibility.[38] When Dr Cosin was asked if he thought that old people were neglected by their families during the time of his early career, he responded, "I think that inevitably neglect developed but the neglect was really from the services not the relatives."[39] This strong, and significant statement, suggests that Dr Cosin's opinion was that old people were not being appropriately provided for by the state, and their needs were overlooked. Through his experiences nationally, and within the Medical Society for the Care for the Elderly, he had good grounds to make this assertion.

A nurse who trained at the RI in the 1950s returned to work at CRH in the early 1960s. She realised that changes in the philosophy of and policy in medical treatment for old people had occurred, and considered there was a radical change from past practice:

> By this time Lionel Cosin had been appointed and been working there for some years and so there was an accent then on rehabilitating people. He had realised that in fact people had just been treated through the various conditions but, if you looked at the whole person and all the needs they had, you could probably improve their lot and rehabilitate them to be moved to either an OPH or in lots of instances to an old home. So that was a bit of a culture shock. And the other thing I discovered was that they were doing actually acute work there, and that people were being admitted with conditions, whereas when I had been at the RI doing my nurse training I was totally unaware they may have been doing it then. I don't know but in the interim I hadn't realised that there was this change. There was an operating theatre there and operations were being undertaken, in the evening after the surgeons had completed their work in the general hospitals,

[37] Ms ASP OX19, 4/06/97, pp.3 & 7.
[38] Dr MB OX 46, 12/01/00, p. 9, was a GP in East Oxford and had patients discharged by Dr Cosin from CRH.
[39] Jeffreys, 'Geriatrics', Dr Cosin, p. 2.

> and people were admitted with acute illnesses, chest infections, diabetics. When I first went there on nights we often had emergency admissions. I went there totally unprepared in fact.[40]

Mrs SB's reaction to the "culture shock" indicates how radical the change must have been during the 1950s. Furthermore, her comment that she was "unprepared" for the progressive changes could indicate that she was complacent about old people's care and did not expect these alterations. This attitude could well reflect other professionals' expectations too. The above extract sums up the changes in the 1950s, expectations of the professionals were challenged by Dr Cosin's holistic treatment and rehabilitation programme. In addition, more resources were being put into the CRH, for example, surgery was now being carried out on old people, and acute admissions were received at the hospital. The day hospital, floating beds and active rehabilitation involving a range of health professionals were also part of the changes at the CRH.

Interestingly, although gerontology was a new developing field in the early 1950s there seemed to have been little professional discussion about it. Mrs VE trained as a nurse in the 1940s and she and her husband were good friends of Dr and Mrs Bedford. She cannot recall any local professional discourse about the development of gerontology and, in retrospect, is surprised that there was none.[41]

Psyscho-geriatric units began to be developed in the 1950s. Around this time Dr Cosin became particularly interested in elderly confused patients in Oxford. In his opinion, there were problems with this group of patients in Oxford, partly as a result of Littlemore hospital, (one of the local mental health institutions) restricting admissions. The day hospital at CRH took on some older people with mental health problems and Dr Cosin had the major responsibility for them. From Dr Cosin's perspective Littlemore Hospital and Warneford Hospital did not provide much help with dementia patients. Dr Cosin considered that patients needed music, art, occupational therapy and physiotherapy. He apparently designed an "endless corridor" built for elderly confused patients. This was a corridor in which patients could safely walk round and round.

Dr Cosin's interest in dementia led to him running a research project funded by the Nuffield Provincial Trust. The project, headed by Felix Post, undertook an evaluation of elderly, confused, demented patients for two years. Subsequently papers were written but no national recommendations on psycho-geriatric units followed. This may

[40] Mrs SB OX29, 31/03/99, p.3.
[41] Mrs VE OX51, 14/02/00, p.8.

have been disappointing for Dr Cosin.[42] Psychiatric developments on a national basis have been discussed in the previous chapter but, generally speaking, the service was very much in its infancy in the early 1950s.

In an initiative by Dr Cosin in 1957, local mental health officers were invited to CRH out patient clinics as a step towards supervising certain senile patients in their own homes. The MOH reports this progress:

> It is thought that extra support and advice given to these patients and looking after them (in addition to that often provided by the health visitor) might prevent or postpone complete breakdown. The beneficial effects seem to occur in the mental functions and attitudes of certain confused old people attending the CRH day hospital have been encouraging and also to be remembered is the mental and physical relief afforded to friends and relatives by having a senile dependant taken off their hands once or twice a week.[43]

The local MOH seemed to have been impressed with Dr Cosin but there was no evidence to suggest if this initiative was taken forward. It is not clear how much, or if at all, there was further liaison between the MOH and Dr Cosin. One could make the assumption that given Dr Cosin's professional merits, he would have been forthcoming with his ideas for progress and developments for CRH. Obviously, there must have been some communication, but the particulars of the professional relationship are not explicit.

Local, national and international influences

Many of Dr Cosin's local appointments were made at the beginning of his career. Five of them were in 1950/51 very soon after his appointment at CRH. Four of these were in the health care arena and the other was as a lecturer on geriatrics for the city and county councils. In 1960 Dr Cosin was appointed as a university lecturer in geriatric medicine in Oxford. We can assume that this was the first appointment at Oxford University Medical School, as geriatric medicine was a new speciality, and there was resistance to its recognition. The appointments held by Dr Cosin ranged from advisor to lecturer to committee member to clinical director and all reflect his interest in geriatrics. (See Appendix C for further details of Dr Cosin's positions)

Dr Cosin's national appointments were significant although minimal. As a member of the BMA Committee on Geriatrics he had been an initiator and influencer of change

[42] Jeffreys, 'Geriatrics', Dr Cosin, pp.13-14.
[43] OxMOH Report 1957, Old Age and Mental Illness, p. 124.

and policy in post-war care for older people. He obviously contributed to the development of gerontology at an opportune time. His membership of the Advisory Council of the NCCOP in 1951 coincided with his membership of other national committees, such as the Executive Committee of the Medical Society for the Care of the Elderly. Chapter Four explored aspects of the work of some of these committees and the input from other medical professionals. At this time, early in the 1950s, there were a limited number of people working in the promotion of welfare for old people on a national basis. This small network of medical professionals inevitably would have overlapped in their work, thus linking the various national committees together.

Dr Cosin held prestigious international positions ranging from those in the USA, to Israel and to Scandinavia or Morocco, and mirrored his work nationally and locally. The positions were divided into three groups visiting lecturer, consultant and advisor (or expert advisor). He held three positions in Canada, eight in Australia, six in the USA, twelve in Europe, one in Israel, one in Morocco and two under the World Health Organisation umbrella. Many visitors came to CRH from as far afield as Eastern Europe and the Middle East. Two senior social workers, from Israel who worked with elderly Jews visited the CRH, and as a result of this Dr Cosin and a colleague, Bill Schmit from Harvard University went to Israel to assess the situation there.[44] It is likely that so many visitors were attracted to the CRH because of Dr Cosin's international profile and connections. Word had spread about his work at the CRH, and professionals were keen to see the theory being put into practice. In fact visitors were restricted to one day a fortnight and Dr Cosin had to limit the time he spent with them.[45]

Dr Cosin's international positions are impressive, particularly so, considering the limited communication technology and air transport available at the time. Furthering these connections must have been a dedicated and time consuming task in order to promote his work. I would suggest that his international role is indicative of somebody who believed in what he was doing, and also that there was a reciprocal respect. As demonstrated in Chapter Four, others involved in geriatric medicine also took on

[44] Jeffreys, 'Geriatrics', Dr Cosin, pp. 13-14.
[45] M. Jeffreys, 'Lionel Cosin (1910-1994): A Pioneer Geriatrician Who Thrived on Controversy', Generations Review, 4: 3 (1994), pp. 2-4.

international work, undertook major research and wrote articles. Dr Cosin was part of a wider group which gained international recognition.[46]

Dr Godber explains why he thinks that Dr Cosin persuaded the Oxford hospitals to take on a geriatric physician in 1950:

> The other teaching group that did take this on board Oxford CRH, which was then a Poor Law institution was part of the teaching hospital and then recruits Lionel Cosin from Orsett where he had already demonstrated that he could do a great deal more for the chronic sick than had been done so far....but his was an active interventionist unit and he was to go on to be the first person who really recognised that there was a psychiatric component. In this because he recruited the help of one of the psychiatrists – this was some years later as the thing developed.[47]

Dr Godber considered that Dr Cosin had obviously persuaded the management that his philosophies and practices were of fundamental importance in medical teaching. Lord Amulree, an administrative medical officer, and Dr Cosin were successful and others weren't because the hospitals that appointed them were more progressive, and had high profiles. Lord Amulree originally worked at the Ministry of Health when the NHS was being founded, and was so impressed with the work of Cosin and Warren that he left the Ministry to work as a consultant post in geriatric medicine at University College Hospital in London.[48] Although Dr Cosin was appointed as a physician not as a geriatrician, Dr Godber's point is still valid as he was appointed to run the CRH which was designated specifically for geriatrics within the United Oxford Hospitals group. Dr Cosin's publications were innovative. They covered different aspects of gerontology including statistical and economic perspectives, physiological issues, rehabilitation ideas, psychological care, mental health developments and the need for interprofessional care. His writings were published nationally in the medical press such as Lancet, British Medical Journal and the Practitioner. They were also published in specialist medical press such as Journals of Radiology, Public Health, Psychiatry and Nursing Times. He also had papers in international medical journals. Between 1947 and 1965, only one article was published in a non medical publication.

Dr Cosin's international appointments seem to outweigh his national and local appointments. There are some questions to consider: did he feel content to work in

[46] The NSA collection Geriatrics as a medical speciality, does document individuals career paths and contributions to the development of gerontology.
[47] Jeffreys, 'Geriatrics', George Godber, C512/28/01 1A, pp. 14-15.
[48] Jeffreys 'Lionel Cosin'.

three prestigious committees and promote within these arenas and locally? Was there prejudice regarding his professional capacity in this country as his daughter Pippa suggests he felt? Or did he feel that Great Britain was not creative with resources for older people and he felt it more personally fulfilling to challenge his energies into developing international contacts? I will address these points.

His daughter suggests that her father felt "very isolated and on his own" and did not feel included as part of the medical establishment. She considers that this could have been because geriatric medicine was not fashionable. He enjoyed going to the USA as people were interested in his work. In England he always seemed to be "fighting for resources," his work did not have the same recognition and he was not invited to speak so much. Pippa Cosin does not know why her father was interested in geriatric medicine but he was appalled that people should be "tucked up in bed" and forgotten until they died. He was interested in the welfare state and making it work.[49] It is not surprising that Dr Cosin felt professionally isolated as this aspect of medicine had a low status and the medical profession were divided on whether there should be a specialism in geriatric medicine.

As early as 1947 his work was shown public respect by specialists in his profession. Dr Greig Anderson, chairman of the BMA Committee on Care and Treatment of Elderly and Infirm, paid tribute to the work already being done at West Middlesex Hospital by Dr Warren, Dr Brooke and Dr Cosin.[50]

There was much retrospective respect emanating from the testimonies collected by Margot Jeffreys in 1991 regarding Dr Cosin's contribution to the development of gerontology.[51] One colleague rates his contribution as equivalent to that of his Scottish colleagues. (Dr Vine was of the opinion that Scotland was more advanced in the development of gerontology). Many gerontologists seem to have been physicians and acknowledgement is given to the fact that Dr Cosin was a surgeon.[52] However, one colleague George Adams felt that credit for the development for the day hospitals was "erroneously given to Dr Cosin" as he thought that Dr Eric Brooke was the real

[49] Taped interview with Pippa Cosin, 11 November 1999.
[50] 'Working Together for Old People's Welfare, Report on Second National Conference on Care for Old People', 14th/15th November, (1947, NOPWC), p. 13.
[51] National Sound Archives collection C512 Oral History of Geriatrics as a Medical Speciality 1991; this collection has 73 interviews with geriatricians discussing the evolution of geriatric medicine as a medical speciality after the Second World War. I selected the oldest interviewees and read 30 of these testimonies to form this opinion
[52] Jeffreys, 'Geriatrics', Samuel Vine, C512/68/0-02, p. 16.

innovator of the day hospital.[53] Dr Fine had a different memory of Cosin and recalls how he influenced his own practice:

> He was always forward thinking and all his discoveries were original. They were mostly in the organisational field, not much in the clinical field. His approach to rehabilitation was strictly organisational again....he influenced my work mainly in his work on the day hospital because he introduced the germ of the idea which I elaborated. [54]

At the Third National Conference of the National Old People's Welfare Committee in November 1948, Dr Howell addressed the conference, and paid tribute to the work of Dr Cosin:

> ...The results of his work were that many who were sent into his hospital to die eventually walked out on their own feet" [refers to Orsett Lodge and the treatment of fractured thighs] and attributes his [and Dr Warren's] work leading to the formation of geriatric units now in Liverpool and Leeds, Glasgow and one was being established in Nottingham.[55]

Historiography and Dr Cosin

Jefferys used oral histories from the early pioneers of gerontology to chart the progress of the development of geriatrics as a speciality from the late 1930s. By using twenty three oral history interviews of the "earliest cohort of geriatric consultants" she explored the influences behind their decisions to become geriatricians. Jeffreys considers that very few of the doctors had decided which branch of medicine to specialise in post qualification. She qualifies this by suggesting this was understandable for those who completed training just before, or during, the Second World War, because they put career plans on hold in case they were required for military service. However, she does suggest that even those who qualified prior to this time did not pursue a structured career path. Jefferys considers that these doctors became geriatricians by default: "But even those who had qualified well before 1939 seem to have drifted rather aimlessly after their initial posts as dressers in hospital or assistants to general practitioners, rather than follow certain well defined objectives."[56] She describes the career path of one such doctor, and suggests that the reason he did not continue as a surgeon was because the competition was too great. The doctor she describes fits the profile of Dr Cosin. Jefferys also highlights the career of Dr Warren

[53] Jeffreys, 'Geriatrics', George Adams, C512/19/01-02 1B, p. 16-17.
[54] 'Problems and Progress in Old People's Welfare, Report on Third National Conference on Care for Old People', November 1948, NOPWC, pp. 23-27.
[55] 'Problems and Progress', address by Dr Howell, pp. 23-27.
[56] Jefferys, 'Recollections', pp. 79-80.

and refers to her as the pioneer of geriatric medicine as a specialism.[57] The interviewees were asked about their opinion of Dr Warren. Dr Cosin's comments about his colleague: "I think because of her status of starting geriatric wards (she was) somewhat rigid and authoritarian. I think that's all one can say." These comments are considered by the author as "reflecting a certain amount of rivalry."[58] My own interpretation of his comments regarding her professional behaviour is that, whilst he saw Dr Warren as the most experienced gerontologist amongst them, he was critical of aspects of her professional practice.[59] In a later article Jeffreys compares the treatment of old people today with that pre- NHS and in the early years of the reforms. Jeffreys uses Dr Cosin's professional career to illustrate the work of early geriatricians by using the interviews she carried out in 1991. She identifies professional criticism of his care and treatment plan but concludes that: "Yet, even the most critical were fulsome in their praise, recognising that his drive and enthusiasm had helped to raise high on the agenda of health authorities the issues associated with the medical care of older people."[60]

Dr Cosin is credited as being one of the original pioneers of geriatric medicine by current practitioners such as Dr Grimley Evans, a professor in the Nuffield Department of Clinical Medicine at Oxford University,[61] and Dr Kong, consultant-in-charge of the geriatric unit, at Princess Margaret Hospital in Hong Kong.[62] Whilst working at the Research Unit at the Royal College of Physicians in London, Professor Brocklehurst draws attention to the skills and creativity in providing for elder people's health care by the first generation of geriatricians including Dr Cosin.[63] The Annual Report of the British Geriatric Society in 1997 celebrating it's fiftieth anniversary lists Dr Cosin and four other doctors as the early pioneers of modern geriatric medicine.[64] Webster, the official historian of the NHS, credits Dr Cosin for his innovative work developing day

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[57] Other writings also refer to Warren as the pioneer of geriatric medicine see Grimley Evans, 'Geriatric Medicine: A Brief History', BMJ (1997), pp. 1075-1077 refers to Marjory Warren as the mother of geriatrics; Bennett and Ebrahim, 'History', pp. 58-59; Helen Evers identifies Marjory Warren's contribution to the development of gerontology in 'The Historical Development of Geriatric Medicine as a Speciality', in J. Johnson and R. Salter (eds.), Ageing and Later Life pp. 320-323, (London: Sage, 1993); Kong , 'Dr Marjory Warren'; Adams, 'Last Years', p. 111; Welshman, 'Growing Old', pp. 74-89; M. Martin, 'Medical Knowledge'; Webster, 'Elderly'; and Brocklehurst, 'Geriatric Medicine in Britain'.
[58] Jefferys, 'Recollections', p. 86.
[59] Jeffreys, 'Geriatrics', Dr Cosin, pp.13-14.
[60] Jeffreys 'Lionel Cosin'.
[61] Grimley Evans, 'Geriatric Medicine'.
[62] Kong, 'Dr Marjory Warren'.
[63] Brocklehurst, 'Geriatric Medicine', pp.5-8
[64] British Geriatrics Society, Annual Report 1996/97 p. 24, acknowledges the following as early pioneers of gerontology, Dr Warren, Dr Tom Wilson, Dr Trevor Howell and Dr Eric Brooke.

hospitals and rehabilitation at the CRH, and stresses the impact of these innovations locally and nationally,[65] as does Burrough.[66] Dr Cosin was seen to be an important geriatrician in the history of development of gerontology by, amongst others, eminent historians and medical professionals.[67]

There is a consistent and undisputed view by clinicians and historians that Marjory Warren was the earliest geriatrician. This is based on her work during the 1930s and 1940s, when she was deputy medical superintendent at a poor law infirmary, combined with her philosophy that the treatment of older people should be regarded as a speciality. However, accounts of who were the other significant key players are not so clear. More explicitly Dr Cosin is not mentioned in some writings. The reasons for such omissions are unclear, but in the context of a doctor working in a prestigious city where the hospital board of governors had actively pledged to improve the care of old people, this poses further questions. Was Dr Cosin excluded from the medical fraternity because he was not a traditional Oxbridge professional? Or was it because, despite the Oxford medical connections, working in geriatrics was not considered a progressive field? Did being Jewish influence his professional status? Or was it a combination of these reasons? Unfortunately the available evidence does not allow us to reach conclusions on these issues. Although his work was held in high regard in the USA in the 1950s, Dr Cosin felt that in this country he was not acknowledged in the same way.[68]

On examining the texts of major contributors on the development of geriatric medicine I found that there was no consistent evidence to form a pattern. For example, on a local level Parfit does not highlight him in the context of describing the development of local geriatric care in hospital and in the community,[69] yet Burrough described his work at Orsett Lodge and CRH in great detail.[70] Thane contextualises the position of older people during the war and suggests that very few old people had the benefit of such progressive treatment as Dr Cosin's, (implying that he was innovative, if not perhaps

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[65] Webster, 'Elderly', p. 177.
[66] Burrough, 'Unity', p. 205.
[67] For example, Evers, 'Historical Development of Geriatric Medicine', acknowledges the significance of Dr Cosin's treatment philosophy that also aimed to incorporate older people back into the community, as does Martin in 'Medical Knowledge', when she refers to his practice and work in the BMA.
[68] Taped interview with Pippa Cosin 11 November 2001.
[69] Jessie Parfit, The Health of a City: Oxford 1770-1974 (Oxford: Amate Press, 1987), p. 123.
[70] Burrough, 'Unity', p. 205.

influential).[71] Thane also documents his role in the development of geriatric medicine by describing how his continuing innovatory methods contributed to him becoming an internationally respected geriatrician.[72]

Dr Cosin had a variety of experiences during his post qualification training. The war seems to have interrupted his career plans, although he is not clear what they would have been otherwise. It appears that his choice of gerontology as a career was coincidental. This is a similar interpretation to that of Jeffreys who formed the opinion that the early geriatricians she interviewed in 1991 (which includes Dr Cosin), had not made any career plans and felt that the competition was too high to pursue careers in surgery or general medicine. She does acknowledge that the war did interrupt and influence opportunities at a crucial time. My own interpretation of Dr Cosin's career development is that he deliberately sought a variety of post-qualification work. In his interview with Jeffreys he explained that he wanted an obstetric training to "round off his career." Then after two years as a GP, he applied to become part of a neurology team, but was directed to go to Orsett Lodge and so put his plans on hold.[73] As outlined in the previous chapter, it is quite apparent that there was a current within the medical profession which considered geriatricians to be a "second best". Attitudes towards the status of gerontology were mixed and ambivalent, the current of thinking that becoming a gerontologist was a back door to consultancy did not enhance professional confidence.

It seems that Dr Cosin probably made the best out of his position at Orsett. Being the pragmatic person he was, he probably enjoyed the challenge of designing systems that he hoped would improve the quality of life for the chronic sick patients, whilst at the same time he had to address management issues, such as bed blocking. His enthusiasm was expressed in his publications. Early networking led him to become involved in a high profile government committee at a crucial time when the welfare state was being designed, and care for older people was being established. His creativity in the treatment of older people gave him an early reputation in his field.

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[71] Thane, 'Old Age', p. 439. Thane addresses the problems faced by 140,000 patients, mostly old people, who were discharged from hospitals two days after the outbreak of the second world war to make room for war casualties. Some of these patients were discharged to public assistance institutions such as Orsett Lodge where Dr Cosin was working and received the benefits of his treatment methods.
[72] Thane, 'Old Age', p. 443.
[73] Jeffreys, 'Geriatrics', Dr Cosin, p.11.

Conclusion

Dr Cosin's specialist philosophies appear to have arisen out of his employment during the war at Orsett Lodge public assistance institution, where the majority of his patients were the chronic sick. He became an innovator in rehabilitation care, learnt from physiotherapists, and considered multi professional practice to be essential in working with older people. His treatment methods were probably considered radical at the time, but, when placed alongside other early geriatricians, reflected the developing professional specialism, with theoretical and medical qualification. It is without doubt that care for older people in Oxford was improved once Dr Cosin was appointed to the CRH. Changing from treating individual symptoms in isolation, to investigating and holistically treating old people, improved and extended their quality of life. Furthermore, his commitment to working towards patients returning to live in the community acknowledged the value of their lives. Many practitioners accredit his work and contribution in literature and in practice. His publications were delivered and read internationally, and he developed many international contacts ranging from across Europe to the USA and Israel.

Combined with his professional initiatives and reputation, Dr Cosin's personality influenced changes. He was enthusiastic, energetic, creative and challenging. Examples of these characteristics are reflected in his on going developments at CRH, the introduction of the day hospital, constant international positions and papers and his belief that older people should be treated equally. His colleagues' testimonies about him reflect the respect he gained within the medical profession regardless of any personal criticism. These ingredients were necessary to fight for a minority cause.

At a national level, Dr Cosin was undoubtedly one of the earliest geriatricians in the country, but there were an increasing number of doctors beginning to specialise in gerontology in the early 1950s. Evidence suggests that immediately after the establishment of the NHS, old people's services were quite limited nationally. Initially, improved conditions for older people appear to have been determined by whether a specialist doctor was appointed, and how vociferous he/she was. There seems to have been a paucity of specialists interested in geriatric medicine, and there was inconsistency in the medical profession in recognising the need for the speciality to develop. Inevitably this influenced the treatment of and provision for older people. Health care services for older people varied throughout the country and, as Townsend

demonstrated, older people's residential and health establishments were usually old public assistance institutions inherited from the poor law.[74] Dr Cosin's work does not seem to be unique, but he was in a minority. Other early geriatricians also made significant changes in their areas and thought along similar lines to Dr Cosin. Additionally each local area had individual characteristics so it is impossible to gauge individual contributions. Unless similar studies were carried out in different localities, it is impossible to measure the individual impact of each of these early pioneers. It is difficult to compare Dr Cosin's contribution to gerontology to that of his early colleagues as each contributed something different to further the cause of geriatric medicine. Undoubtedly, however, he played a major role, alongside colleagues, in contributing to the development of geriatric medicine.

Working in government committees, a professional society, national pressure groups, and through international connections meant that Dr Cosin had a capacity to further the interests of old people. His ability to thread them together benefited elderly people. For example, he could use information from the USA for the benefit of elderly residents in the United Kingdom; his presence on the NCCOP may well have resulted in the establishment of Hurdis House in Oxford; sharing knowledge with his colleagues in the Society for the Care of the Elderly enhanced his national understanding of the progress in care and treatment for old people, and he could also take and share his expertise in other countries. I would argue that Dr Cosin was a crucial figure nationally at a significant time in the development of geriatric medicine, and that his innovatory insight (along with others), was responsible for changing attitudes, both locally and nationally.

Dr Cosin spent the majority of his working life at CRH and played a leading role in the development of local services. Oxford was, (and still is) an academic centre for medicine, which utilised Dr Cosin's skills. Dr Cosin also had a good team of people, including Dr Bedford, who shared his philosophies at the CRH, and whom he relied on to run the hospital when he was away. It may have been that if Dr Bedford had lived for longer there may have been a different career course for Dr Cosin. Interestingly Dr

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[74] See Townsend, Last Refuge, Townsend provides detailed statistical analysis of public assistance institutions that were taken over by the local authorities and regional hospital boards (some for joint use) for long term care for older people, pp. 16-18. This indicated that conditions were still deplorable. Also Webster, 'Elderly', p. 167, refers to surveys where the conditions of the hospitals for old people were considered unsuitable for future use.

Cosin stayed at CRH until he retired in the 1970s, possibly because he wanted to develop his practices and, as his daughter pointed out, he had a strong commitment to the welfare state. CRH was effectively his project, created through the establishment of the NHS. Many of his innovatory achievements were made in the early part of his career, when he participated in developing a new speciality, both nationally and locally. Ultimately older people in Oxford benefited from his position. As well as his rehabilitative treatment programme, he made significant physical changes in the CRH. He improved community facilities by liaising with the local MOH to utilise the local authorities responsibilities under the NHS Act, promoted multi-disciplinary teams, addressed the needs of older people with mental health problems and continued to raise the profile of older people's needs in the city.

The next chapter will investigate whether residents in the city saw any change in the CRH after the appointment of Dr Cosin, as well as other changes made since the inception of the welfare state.

CHAPTER SIX

Changing social attitudes

There is another category of persons for whom we shall have to accept an even larger measure of responsibility than we have had in the past and these are old persons... Aneurin Bevan opening speech on the second reading of the National Assistance Bill 1947[1]

The previous chapters have presented an emerging picture of change in health care for older people from 1930. Once the welfare state was established, not only was health care free and accessible to old people, but other services were also available. This part of the thesis will identify the development of these services, by examining how local residents perceived the Cowley Road Hospital for the first twelve years after the inception of the welfare state, and by seeking to establish whether there were any significant changes towards the institution in the light of developments in welfare provision. Take up of services will be addressed in Chapter Eight as part of the case study.

Awareness of social need was developing in the 1930s influenced by the economic slump, which caused a review of policies.[2] Between 1919 and 1939 there was a growing feeling that the poor law was outmoded, and there was debate about what would replace it. The Second World War was probably the final contributing factor which led to the complete development of the welfare state.[3] Foundations for this were laid in 1942 with the publication of the Beveridge Report.[4] The welfare state was to provide a safety net for the public and society's expectations of provision rose. Lowe suggests that this commitment laid many future expectations for the public:

> All citizens were effectively guaranteed, for the first time in British history, equal welfare rights; and it was on the basis of such a guarantee – reflecting, so it was believed, a heightened sense of community during the war – that many came later to argue, more contentiously, that the essential objective of the welfare state was the creation of a more equal and altruistic society.[5]

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[1] Hansaard 444 col 1609, November 24, 1947.
[2] Thane, Foundations, p. 288-297, details the significant political and economic developments during this time.
[3] B. Gilbert, British Social Policy 1914-1939 (London: Batsford, 1970), p. 308, considers that a public social policy evolved between 1919-1939 and by the time of the Second World War a "consensus on social responsibility had appeared." This provided the policy of commitment to maintain British citizens that Gilbert considers was "....evolved, like the British empire, in a fit of absence of mind."
[4] Social Insurance and Allied Services Cmd. 6404, 1942.
[5] R Lowe, The Welfare State in Britain Since 1945 (Basingstoke: Macmillan,1993, 1999), p. 283.

One of the most important changes arising from the inception of the welfare state was the passing of the National Health Service Act 1946 which established a free comprehensive health service to people in England and Wales. A new administrative structure was created for hospital management. Hospitals were transferred to the jurisdiction of the Ministry of Health and regional hospital boards. Teaching hospitals were managed by boards of governors, and others by hospital management committees. Although the Act was established in 1946 it became effective from July 1948 alongside other prominent welfare legislation. Free prescriptions, glasses, dentures and hearing aids improved the quality of life for many old people. In conjunction with the NHS Act local authorities were to play a major part in service development for older people by having the responsibility for planned, local health centre programmes, and for providing health visitors and home nursing services. The home help service, originally designed to help expectant mothers, expanded to support the growing older population remaining in their own homes. Health visiting and home nursing services also increased. These services had a wider client group than just old people, and there was pressure on limited services. Webster considers that these services were inadequately resourced, and in general local authorities neglected their responsibilities towards old people. Some authorities provided more for old people, which Webster links with local pressure group activity and efforts from voluntary agencies.[6] It was during the war that domiciliary help for old people began to be highlighted as a problem. The shortage of domiciliary workers during and after World War II led to more inappropriate hospital admissions of affluent middle class older people. This issue was raised in parliament as the situation caused particular concern because there was an exceptional need for hospital beds during this time. One explanation for the increased hospital admissions for old people suggests that prosperous old people in the middle classes, who traditionally employed domestic help, found it difficult to recruit staff as many men and women of working age were involved in war work. Voluntary agencies were aware of the domiciliary needs of old people and played some part in getting these services for older people included on the statute.[7] During the war, the Women's Voluntary Service (WVS) had played a large part in providing help to old people and undoubtedly local authorities capitalised on the existing voluntary arrangements already in place.

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[6] Webster, 'Elderly', p. 184.
[7] Means and Smith, Development, pp. 87-104.

The National Assistance Act (1948) was another significant piece of legislation essential in the creation of the welfare state. It enabled the provision of services for old people with limited resources, and ensured that local authorities had a duty to provide welfare accommodation for elderly persons. There were other obligations arising from this legislation, such as the inspection of residential establishments. Part of this act also made it possible to remove old people to places of safety when there was concern about a person's ability to cope. Some services such as meals on wheels, old people's clubs and chiropody were not a statutory provision and so were provided by voluntary agencies such as the WVS and the Red Cross. Local authorities subsidised some of these activities. In his survey, Seebohm Rowntree had identified that some old people were very isolated, and he considered that loneliness was a particular problem for old men living on their own. Different clubs for old people were seen to be a helpful solution to combat loneliness.[8]

Housing legislation of 1936 and 1949, in conjunction with the Local Government Act 1948, addressed the provision of special housing for old people. Seebohm Rowntree raised the issue of housing for old people in his survey, and described some of the poor housing conditions of older people. These included, shared bathroom and toilet facilities (often on another flight of stairs or outside toilet), no bathing facilities, water obtained from a well or communal stand pipe, communal drains, damp and disrepair.[9] His report also identified different types of housing needed for older people and suggested where homes would be best placed. Some ten years later Townsend's survey in Bethnal Green highlighted the importance of an established housing policy for older people. This he considered as being essential in addressing the needs of carers. Townsend also linked inappropriate hospital admission of older people with their preference to remain in their own homes.[10] Special housing schemes in the community were introduced for older people in the 1950s. The case study in Chapter Eight examines local housing conditions and developments, and their implications for old people in Oxford.

[8] Seebohm Rowntree, Old People, pp. 52-54.
[9] Seebohm Rowntree, Old People, pp. 30 -38.
[10] Townsend, Family Life, p. 230.

Professionals were generally optimistic that the welfare state legislation would remove most social problems by providing better education, health, housing and social security, alongside full employment.[11] Social work services for older people, which seemed to be non-existent before 1948, started to develop after then. There were, however, still expectations that families and charity should resolve problems, and this philosophy underpinned national and local policies.[12] Boundaries between the so-called 'deserving' and 'undeserving' poor were reviewed, and social workers began to question professional practice and methods. Younghusband stated that some groups, such as deprived children and young chronically sick and disabled people, generated more public interest than others during the first two decades of the welfare state, "but the old, one parent families, the homeless, prisoners and their families, the chronic poor and young people adrift only passed fitfully across the stage. Services existed for them and knowledge about them but the necessary quality, universality and drive was lacking except in some voluntary organisations."[13]

Voluntary organisations had a key role in the provision of services under the welfare state. Beveridge, its chief architect, had accounted for this in his Memoranda from Organisations, which he submitted as evidence with his own Report on Social Insurance and Allied Services.[14] Explicit in Beveridge's supplementary report in 1948 was the expectation that voluntary work with old people would continue, and expand as indicated in the extract below:

> Although at the present moment probably as much as being done by voluntary organisations as by public authorities to meet the urgent needs of old people – even in respect of accommodation for the able-bodied – in time it seems clear that public authorities (through the operation of housing schemes, of the NHS, and under the powers likely to be conferred by the National Assistance Bill) will play an increasingly large part. On the distant view it is not possible to see the exact field for voluntary enterprise, but all the same there seems to be no reasons to expect the exclusion of voluntary organisations from this side of social provision. For those who believe that voluntary enterprise is not a luxury but a vital necessity in a democratic society-a complement to State action, making for vigour and progress – the pressing problem is to find means whereby voluntary organisations, while adapting themselves to changing

[11] E Younghusband, Social Work, p.21.
[12] R Lowe, Welfare State, p. 263 identifies the reasons why the personal social services were neglected between 1945and 1975.
[13] Younghusband, Social Work, p. 25.
[14] Social Insurance and Allied Services Report, HMSO 1942.

> conditions, continue to have effective opportunities and power to make their contributions to the life and thought of society.[15]

With this strong directive local authorities and voluntary agencies developed their services. However, voluntary organisations tended to carry out a lot of duties that some considered to be the responsibility of local authorities.[16] For example the WVS had taken the lead for organising the meals on wheels service, and locally the Red Cross started up old age pensioners clubs and chiropody clinics. This confirms Younghusband's view that voluntary organisations provided the impetus for services for the overlooked groups. Additionally, she states that: "In the mid-1950s, 83 per cent of local authorities co-operated with voluntary organisations in providing services, for example old people's welfare committees, the British Red Cross Society and various religious bodies."[17] The work of the NCCOP and the NOPWC brought together a variety of different agencies and professions from statutory and voluntary sectors and highlighted the needs of old people. However, social work with old people developed slowly, was mostly unrecorded, and little was done to identify special social work needs.[18] Although Beveridge saw the work of voluntary organisations as a positive entity in its own right, it is also possible that he was influenced by other pragmatic factors. An explanation of his reasons for promoting voluntary agencies is given by Jose Harris in her biography of Beveridge. She suggests that as well as having a political motive for writing this study, Beveridge was concerned at the decline in "religious conviction", and felt voluntary organisations may have mistakenly held the belief that the state was in the process of meeting all material and social needs. By raising the different areas of social need (such as chronically sick and disabled persons, housing for old people, and prisoners) which were not included or "glossed over", in his report on social insurance, Beveridge hoped to show the need for voluntary work.[19] Nevertheless, Beveridge had clearly established priorities towards younger people in his social insurance policies and, in the light of limited finances, it was logical that he promoted voluntary organisations. Voluntary work was more economical to administer and provided a political solution. But because the voluntary sector supplied some services to old people, this may have meant that the statutory agencies were not

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[15] Beveridge, Voluntary Action, A Report on Methods of Social Advance (London, 1948), pp. 161-162.
[16] Means and Smith, Development, p. 287, refers to Townsend and others contributions on this debate.
[17] Younghusband, Social Work, p. 197 the author refers to the Younghusband Report 1959.
[18] Younghusband, Social Work, p. 195.
[19] J. Harris, William Beveridge A Biography (Oxford: Clarendon Press, 1977), pp. 458-459.

encountering the full extent of the problems faced by old people. In a political context local authorities did give financial support to voluntary agencies, which effectively was a contribution towards the services, in difficult financial circumstances.

In the early years of the welfare state, old people's domestic and family circumstances were similar to those in the preceding years. Some old people were unable to live with their families, and if unable to manage were probably admitted to an institution; other families continued to provide some form of care, either by having an older relative to live with them, or helping them out in their own homes, so that they could remain independent. Caring for older relatives was associated with women. Previous studies of working-class women indicate that there was a gender aspect to caring which is associated with economic, demographic and social factors.[20] (This was discussed in Chapter Three). Parker takes up the issue of gender analysis on caring responsibilities, and refers to Townsend's study in 1957. [21] His study found that female relatives were more pro active in care giving, notably daughters and daughters-in-law.[22] In view of this and the caring patterns shown in Chapter Three, an assumption can be made that there were parallels between 1948 and 1960, that historically women provided the majority of caring. Roberts' study of women and their families also examined gender aspects of caring in relation to changing social expectations. She found no evidence that even in a changing society, women put their jobs before caring for their relatives. Instead they developed a fine balancing act between kin and work.[23]

Before 1948, old people's expectations of welfare were usually associated with deterrent and punitive institutions inherited from the poor law. When introduced in 1908, pensions reduced the need for institutional accommodation. However, the pension was small and older people often had to work to supplement their income. Health care needs for old people had been neglected, housing was poor, and older people were living longer. The declining birth rate caused concern for the post war government, which anticipated that in order to provide for the growing number of old

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[20] See M. Spring Rice, Working Class Wives: Their Health and Conditions (2nd edn., London: Virago, 1989); E. Wilson, Only Halfway to Paradise: Women in Post War Britain 1948 - 1968 (London: Tavistock, 1980); J. Lewis, Women in England 1870 - 1950 (Hemel Hempsted: Harvester Wheatsheaf, 1984); E. Roberts, A Woman's Place: an Oral History of Working Class Women 1890 – 1940 (Oxford: Blackwells, 1984), these works describe working class women's life which provides a context for the caring role.

[21] Parker, With Due Care, pp. 43-44.

[22] Townsend, Family Life, pp. 43-53 and p. 228 describe kinship and gender patterns.

[23] Roberts, A Woman's Place, pp.197-198.

people, financial demands on the rest of the population would be high. Services were designed for old people but there was criticism that this provision was not enough. A survey by Townsend and Wedderburn in 1962 questioned the provision (including financial) for old people, and the take up of services in relation to future planning strategies.[24]

Previous chapters have outlined medical influences in shaping post-1948 services, and identified the need for old people to have financial independence and security. Once the welfare state was up and running, old people were entitled to a pension, access to free medical care, and could apply for special housing, or have community support services to help maintain them in their home. Alternatively they could take a place in an old people's home should they need it. The basic retirement pension per week for a man in 1962 was £2 17s 6d, (£2. 75p in today's currency), and for a couple £4 12s 6d (£4. 62p). In 1962, the income (not wage) comparison with the population as a whole, was calculated at £7 6s per week (£7.30p) based on one measure. Inland Revenue data for the same year indicated a median income of £7 10s (£7 50p). Overall, Townsend's study concluded that "on the most conservative basis 1 ¾ million men and women aged 65 or over had total incomes of less than £4 a week, and 400,000 couples had total incomes of less than £6 per week."[25] These figures indicate the financial problems of old people compared to the rest of the population. Amongst other conclusions the authors of the survey considered that, "old people had income levels a half or more below the levels of younger persons in the population." Women were worse off than married couples and single men. Over two thirds were dependent on the state, their median income was only half that of couples and a considerable number of the poorest lived with their relatives or alone. The survey also examined distribution practice for national assistance benefits, and concluded that there were approximately three quarters of a million old people who were not receiving the benefit, and that their level of income was no higher than those who were eligible.[26] A picture emerged of some very poor old people, most living in the community as the following table demonstrates.

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[24] P. Townsend and D. Wedderburn, The Aged in the Welfare State, The Interim Report of a Survey of Persons Aged 65 and Over in Britain, 1962 and 1963 (London: Bell and Sons, 1965), pp. 21-22.

[25] Townsend and Wedderburn, Aged, pp. 75-95. National assistance rates did change during the period of their study (they were raised in 1962) but this was considered "scarcely detectable" in their overall analysis. The authors provided a detailed analysis and breakdown of the financial positions of old people in various circumstances.

[26] Townsend and D Wedderburn, Aged, pp. 134-139

Table 6.1: Estimated number of persons aged 65 and over living in different types of accommodation; Britain, mid-1963

Type of accommodation	Number	%	
Residential homes	105,000	1.7}	
Psychiatric hospitals and nursing homes	60,000	1.0}	4.5
Other hospitals and nursing homes	115,000	1.8}	
Hotels, boarding houses, hotels, common lodging houses, etc	95,000	1.5}	
Private households	5,825,000	94.0}	95.5
Total	6,200,000	100.0	

Source: Townsend [27]

†see note

Table 6.1 shows that the norm was for old people to remain in the community. Although Townsend's survey was carried out in the early 1960s, his findings are also applicable to conditions for old people at the end of the previous decade. This survey, carried out fourteen years after the inception of the welfare state, established some national base lines on poverty, family help and general services available for old people. It suggested that certain poorly co-ordinated community services needed to be improved. Some conclusions related to specific groups of older people and were quite detailed, but Townsend presented evidence for a more general need to expand social services to provide for an increasingly ageing population. Therefore a conclusion can be drawn from his research - although the welfare state had brought improvements for older people on a national basis, there was still inadequate provision.

Within a slowly improving social, political and medical context, the next section will examine how and why old people in Oxford used the CRH and whether there were any significant factors influencing their use. Oral histories were the primary sources used to compile this section. During interviews, respondents were asked about their experiences and perceptions of the CRH after 1948. Their responses have generated the structure of this part of the chapter. (Please see Appendix B for template of questionnaire.) This information, consolidated in the following section, will be compared with professional experiences and perceptions later in the chapter.

[27] Townsend and D Wedderburn, Aged, p. 23.

†Note: The definitions were used by the Registrar General and the estimates are based on data from the 1961 census, brought up to date by information supplied by the Ministry of Health and the Scottish Home and Health Department.

Were there changing attitudes by residents to the CRH after the inception of the welfare state?

Oral respondents were recalling a period in history when their parents or other relatives were ageing, recollecting specific times and events particular to their own circumstances. Some respondents had first hand experience of the CRH, but others didn't. Regardless of whether they had any direct experience of the CRH, respondents also had their own perceptions of whether there had been any changes, and contributions were sought from both perspectives.

There was an opinion from respondents that 1948 was the time when the institution changed from being a workhouse to being a hospital. Mrs MQ identifies this significant change: "I suppose that's why some of the old folk had to go into CRH when they were poorly I mean it was a hospital then it wasn't a workhouse."[28] Her interpretation that the institution had changed to a hospital possibly provided some justification for families to use it for elderly relatives; a hospital was a respectable place, the workhouse was not. But the institution had actually changed its name in 1921, from the workhouse to the Cowley Road Hospital. Within Mrs MQ's excerpt is an indication that the change over to public assistance administration in 1930 did not change the local community's perception - the institution was still seen as a workhouse. There was still a strong image of the CRH as a workhouse in 1948 (as explained in Chapter Four), and this lived on for longer. In 1960, when Mrs DB's mother was ill she was admitted to the CRH. Mrs DB remembers her mother's fears at having to go to the CRH when she became ill:

> ....So she had to go to CRH and she knew she was going to CRH and this worried her to death because in her mind from way back if you were going to CRH you were going to the workhouse....and in her mind it was still – you know CRH, it was a sort of, bit of a disgrace if you see what I mean, you were going to the workhouse sort of thing.[29]

Mrs DB qualifies why in her opinion CRH was not a workhouse then: "CRH wasn't a workhouse at all you know it wasn't that sort of thing it was a proper hospital which had a geriatric sort of department..." Her statement is very similar to Mrs MQ's - CRH was a respectable hospital that cared for old people. She also suggested that, although

[28] Mrs MQ OX53, 3/4/00, p.8.
[29] Mrs DB OX41, 29/10/99, p. 7.

her generation (she was in her seventies) still remembered the workhouse connotations, they had had time to adjust to the new CRH. However, for older people it was probably difficult to associate a positive change, especially when the same building had been used as a workhouse as she explains: "Well I suppose we'd got used to it having its different status but my mother I suppose being old and still had it in the back of her mind ..." Mrs MQ had a like minded view and thought that the younger generation did not see CRH as a (previous) workhouse.[30] Another respondent bears out these views as she felt that, although it had the stigma of the workhouse, people were glad to have it there if relatives needed it.[31]

These experiences and views suggest two main things, first that older people were finding it difficult to let go of the image of the workhouse, and secondly, that by 1960 younger people were beginning to change their views about the CRH. The CRH was beginning to be acknowledged as a respectable community resource that provided for old people. However, tensions between older and newer perspectives resulted in a complex, sometimes contradictory, layering of perceptions.

Negative perceptions of the workhouse were sometimes inter-connected with negative perceptions of geriatric institutions. Some respondents were quite specific in making the distinction between pessimistic geriatric care and the workhouse. People thought that the CRH "became a geriatric place." This had gloomy undertones. One woman who visited relatives in the CRH thought that it still had the workhouse image, was the "dumping ground for geriatrics....the last call before the undertaker," and little money had been spent to improve the hospital.[32] In addition, there was a view that the CRH took an overflow of long term patients from the acute hospital the RI.[33] Mr B corroborates this by suggesting that after the transfer to the welfare state only terminal cases were admitted to CRH "...they just had to be in bed and looked after but they didn't really need any medical attention and they just wanted nursing until it was time to go..."[34]

Mrs IM explains why some respondents would never have sent their parents to the CRH, and also links in the negative perceptions of the workhouse: "We, the children,

[30] Mrs MQ OX53, 3/4/00, p.10.
[31] Mrs KP OX17, 16/3/98, p. 4.
[32] Mrs RB OX38, 23/07/99, p. 14.
[33] Mr HC OX44, 13/12/99, p. 13.
[34] Mr BJ OX14, 24/04/98, p. 3.

would have got them into a nursing home, they would never have allowed them to go there ....ooh the reputation it had." She considered attitudes did not change after 1948, ".....it always had that stigma it was a terrible place."[35] Miss ME, whose relatives were admitted to the CRH, also felt that the CRH was seen as a workhouse in the 1950s and that people would do anything to avoid admission "....they still called it the workhouse, they were almost ashamed to go in."[36] Mrs MQ's aunt was admitted, and her daughter was "ever so ashamed," and collected her from the hospital.[37] On a similar theme, Mrs IM considers that there was never anything good said about CRH post-1948, and remembers people saying, "we never heard anything good of it ever, 'oh god' they'd say, 'not that place, I'm not going in there.'" [38] Mr HC thought that local people had a very low opinion of the CRH and that the patients were neglected and did not get the care and attention they needed.[39]

There were also some positive views about the development of CRH in the 1950s by some respondents. One respondent considered there was "less of a stigma" after the CRH was taken over by the NHS as it was brought up to date.[40] Another person thought it brightened up and became more of a hospital.[41] Mrs RB visited relatives in the hospital pre-and post-1948, and noticed that the distemper on the walls had been replaced by paint by the time of her later visit, and the "smell" had gone.[42] According to Miss ME the CRH changed into "something special," where you went for "special treatment", not available at the general hospital, the RI.[43]

Nevertheless, negative comments on the changed CRH outweighed the positive comments. In general terms, the attitudes expressed fit with previous claims that the old workhouses and public assistance institutions, which were full of infirm and sick old people became geriatric units. This perpetuated the image that once elderly people were institutionalised they had limited quality of life and little time to live. Some respondents made positive and negative statements about the CRH, which possibly reflects a more general ambivalence felt towards the institution. It was also quite

[35] Mrs IM OX57, 30/03/00, pp. 12-13
[36] Miss ME OX32, 10/05/99, p. 10.
[37] Mrs MQ OX53, 3/04/00, p. 7.
[38] Mrs IM OX57, 30/03/00, p. 13.
[39] Mr HC OX44, 13/12/99, p. 13.
[40] Miss BH OX39, 13/10/99, p. 14.
[41] Mrs LW OX33, 17/05/99, p. 13.
[42] Mrs RB OX38, 23/07/99, p.14.
[43] Miss ME OX32, 10/05/99, p. 11.

unlikely that the majority of residents in the community would have had any knowledge of the work that Dr Cosin was doing at the hospital. People with relatives in the hospital were more likely to know about these developments than those who had no contact with the CRH. However, what is unclear is whether negative perceptions were historic ones associated with the workhouse, or ones arising from geriatric care, or a combination of both.

There was a general expectation that the welfare state would mean the end of the workhouse, and there would be new facilities for old people. Essentially there was not enough money to carry out modernisation quickly and old people were not a priority. Means and Smith have analysed the role of the government and reasons why so many old institutions continued to be used for geriatric units.[44] In the meantime there was an urgent need to accommodate old people and, whilst in many respects inadequate, old public assistance institutions provided accommodation and solved an immediate problem. Opportunistic rhetoric by the Labour Party during the 1945 election campaign suggested that public ownership of the economy would benefit the people.[45] Future priorities for a Labour administration in 1945 were listed as nationalisation, education, health care and welfare. Opinion polls carried out at the time discovered that a majority of people supported these policies.[46] Inevitably people were full of hopefulness about the initial changes to a welfare state, and this combined with peace time probably enhanced optimism. Webster draws attention to the continued optimistic political rhetoric that disguised an under-funded and under-resourced health care service in the post war era.[47] In all likelihood many of the population would not have been aware of shortcomings if they were not using the services. Old people have been identified as major service users but, as highlighted in Chapter Four, they had no official mouthpiece to articulate their concerns or dissatisfaction with the system.

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[44] Means and Smith, Development, pp. 167-239, Townsend, Last Refuge, also provides an analysis on the history of institutional care for old people pp. 17-39.

[45] See S. Brooke, Labour's War, The Labour Party During the Second World War (Oxford: Clarendon Press, 1992), pp.323-327. Brooke relates the economics of public ownership to the Labour Party election campaign, compares the campaign policies to rhetoric before the coalition and suggests that in general social policy discussion had a low profile during the campaign though promises for better housing, education and pensions were highlighted.

[46] P. Addison, The Road to 1945, British Politics and the Second World War (2nd edn., London: Pimlico, 1994), pp. 263-264. Addison also analyses the other political parties election campaigns in relation to the 1945 Labour Party campaign.

[47] C. Webster, The National Health Service, A Political History (Revised edition, Oxford: OUP, 1998, 2002), p. 35.

Why old people were admitted to the CRH

Two main reasons were given by oral history respondents as to why people were admitted to the CRH during this period. Firstly, there was no family support, either because family members were not available to help, or because family tensions prevented them from helping. Mrs MQ outlined her reasons why family members were not available to help: "The families had gone down you see, the lads some of them had been killed...the women had to work if they'd got a family so they weren't able to sort of look after the older ones so much so grandma had to be looked after somewhere else..."[48] What Mrs MQ describes is her memory of many young men having been killed in the war, leaving women alone to bring up their children, and therefore unable to help look after their elderly relatives, unlike before the war. She elaborated further "...they used to visit them I think and it was still in their minds that it wasn't the place to be at all," thus suggesting that these women felt guilty at not being able to care for their relatives but did visit them in the CRH. Another significant factor to add to Mrs MQ's perception of changes in family structure was the social mobility of families post war, which affected contact opportunities.

Tensions in the family could also bring about admission to the CRH as Mrs HH related. Her mother-in-law who was in her 80s went into the CRH in the late 1940s as there was friction in the family and nobody was able to care for her.[49] It was not appropriate, or possible, to unpick the circumstances further to discover exactly what caused the friction, but obviously family dynamics could have influenced available accommodation within families, similar to those described in Chapter Three.

The second major reason why old people used CRH was because they were very sick. Relatives pointed out that even when patients who had financial resources to go elsewhere were admitted to CRH, they did not move because they were sick, too ill to make alternative arrangements. Examples of relatives with terminal cancer, strokes and pneumonia were given as serious illnesses. Supplementing this observation, there was a further belief that patients had no choice in the decision of where they were hospitalised, as there was no room or appropriate treatment available at the RI.

[48] Mrs MQ OX53, 3/04/00, p. 10.
[49] Mrs HH OX13, 23/04/98, p. 5.

Two groups of patients emerge from the descriptions respondents give of how their relatives reacted to their admissions. The first group has already been described as those being so sick they were not in a position to request changes; by contrast, the second group were vocally quite unhappy about their admission. On occasions when an old person was aware of their surroundings and realised where they were, and then persuaded their relatives to take them home. Examples of this are given from Mrs RB and Mrs KP. Mrs RB whose aunt was ill with cancer when in her 70s in the 1950s, "hated the CRH" so much, she thought it was "dreadful that I actually have to come to this terrible place." She was eventually taken home with a housekeeper.[50] Following a stroke, Mrs KP's father was admitted to CRH, but he was very unhappy and pleaded with his family to take him home. He was eventually discharged home after the doctor apparently cleared it with the family that they would be able to cope.[51] This example of one family's perception illustrates a particular dilemma in oral history. In reality, other criteria were probably used by the doctor when he discharged the patient. The point here is that the attitude of the family was probably only one of a number of factors influencing the doctor's decision. Oral histories do provide perspectives that can usually be measured against other sources. In this case, however, medical notes were not available therefore the doctor's view is not presented as to why he discharged the patient.

Admissions to the CRH changed after 1948 once health care was free, so that it was not necessary for affluent families to contract in private care as they had to before 1948. As a result, CRH had a more mixed clientele. It appears that some of the more wealthy patients were not happy with their admission, and considered it an affront to their dignity to have been taken to the CRH. For some, paying for private care was preferable to staying in the CRH, as in their eyes stigma remained.

Respondents also discussed how change within the welfare affected old people. In general, respondents considered that people were not left in poverty, and had a better quality of life. Mr WL thought that people "didn't want for much." He thought that the new system provided much more for old people.[52] Mr RH thought that one of the outcomes of the welfare reforms meant that the poor law was abolished: "All of these organisations that existed, poor law institutions, they were all swept aside by the

[50] Mrs RB OX38, 23/07/99, p. 14.
[51] Mrs KP OX17, 16/03/98, p. 8.
[52] Mr WL OX56, 30/03/00, p. 6.

welfare state they weren't needed anymore. The welfare state was saying 'look if you are in need we will give you money to live in your own home.'"[53] There is an element of truth in the first part of Mr RH's extract, as one of the major aims of the reforms, in theory, was to get rid of the poor law, but in practice the fact that some public assistance institutions (previously poor law establishments) remained, presented a contradiction. The second part of the extract from Mr RH, implies that there was recognition that older people did not have to be institutionalised any more when financial and social resources collapsed. His interpretation that money was given to old people to remain in their own homes is probably based on the fact that more substantial pensions were introduced, and community support services were provided such as home helps and meals on wheels.

A belief that old people were not served as well as young people was expressed. Mr DB recognised the feeling of egalitarianism associated with the creation of the welfare state, but considered that old people were not affected by the changes as much as younger people. Comparisons have been made in previous studies which suggest that children's services were developed with greater priority than those for old people. [54] This theory is also borne out by the quote at the beginning of Chapter Four from Beveridge, who explicitly stated that old people would not get as much as young people in the construction of the welfare state.

Pension improvements were seen as one of the most significant changes for old people in the establishment of the welfare state. Increased financial provision enabled old people to live more comfortably in the community. Several interviews grouped together the new pension system, access to a doctor and free medical care as being the most important changes for old people. There was no doubt that access to free medical care was a significant change, as the following excerpt indicates, "but when the welfare state came and you went to hospital you got free treatment that was the difference."[55] One gentleman was the husband of one of the first home helps in Oxford; he was therefore attuned to this angle of welfare provision, and saw the introduction of home helps as significant in helping old people, but this was an unusual association.

Not all respondents were aware of wider developments associated with the welfare

[53] Mr RH OX30, 23/02/00, p. 13.
[54] Means and Smith, Development, pp. 154-155.
[55] Mr BH OX42, 22/11/99, p. 11.

state, but saw developments in health care as one of the major changes. These included being able to see the doctor more often, improvements in the health service and free medicine and treatment. Access to free medical care was considered to have made a difference for people as the following extract shows: "I suppose you had the doctor, I suppose came free didn't he?.... because in my parents house you were very careful if you had bills to pay and as I say you wouldn't go to the doctor unless it was really urgent... necessary." [56] People, particularly old people had become accustomed to only seeing the doctor when it was absolutely essential, especially as they were unlikely to have had health insurance and had limited financial resources. However, despite positive transformations, Mr EB thought that the NHS did get abused after a few years, "but when you could get free dental treatment, free glasses and everything everybody went silly didn't they ....?"[57] His comments insinuate that people were taking advantage of the facilities of the NHS. Webster annotates the uptake of services, such as dental and optical treatment, prescriptions and hearing aids, in the first years of the NHS and considers that the crisis in service provision resulted in the introduction of prescription charges. This action penalised the poorer sectors of society, including pensioners.[58]

Amongst some of the health developments, a respondent noted that she thought that larger geriatric units were created, and old people "still lived out their days in them."[59] Her view implies that she thought these institutions were replacing the previous public assistance ones, and effectively nothing substantial in the way of services had changed. In her view, old people were still admitted to long term institutions and their quality of life was limited. At this stage she spoke in general terms, rather than from a particularly local perspective, and elaborated on expectations and effects of the welfare state:

> We were told you see that there would be a secure decent pension and that if you needed to go into a nursing home it would be a proper nursing home not a workhouse....the word was eliminated from the vocabulary. If you went into an old people's home it would be run like a proper nursing home from the cradle to the grave... we expected the welfare state to provide for everything we would no longer have to consider whether we could afford doctors fees....that was another thing of course people couldn't afford doctors fees and often didn't send

[56] Mrs MP OX45, 6/12/99, p. 7.
[57] Mr EB OX49, 25/01/00, p. 9.
[58] Webster, 'Elderly', pp. 165-193.
[59] Miss BH OX39, 13/10/99, p. 6.

> for a doctor when they should have done so although the doctors were very cheap. And .....I knew a friend I knew, who was... who lived in Birmingham in a poor part of Birmingham when she was young, and she said that she knew that you wouldn't go to a doctor because they would be ashamed for the doctor to see that their underclothes were patched and darned....that they were afraid to go to a doctor not only because they couldn't afford to pay a doctor's fee but also because they were ashamed of their underclothes.[60]

Highlighted in the above extract are the expectations of the welfare state, in relation to the problems facing old people, ranging from financial and social to medical needs. Mrs BH also identified the indignities and effects of poverty for both old and young. Other oral respondents also felt that the welfare state had improved life for old people. They considered two main aspects as particularly significant, pensions gave more financial security, and the NHS gave free, comprehensive health care. There was an impression that poverty would be eradicated by the welfare state, and that the workhouse image would go. Respondents had minimal knowledge of other welfare services that were available such as OPHs and community services. Not surprisingly, if there was any knowledge of services it was usually because of personal use or relatives worked in the system.

Stigma was certainly an issue influencing admission to the workhouse and public assistance institutions before the welfare state (as outlined in Chapter Three). Some of this stigma may well have been carried over, as it took time for the effects of change to be absorbed; especially since poor law philosophies had been ingrained in society for well over a century. Spicker's analysis on stigma can certainly be applied to the early years of the welfare state; the stigmatising of claimants of welfare was still a deterrent.[61] Earlier shifts in attitudes towards receiving welfare were noted by Roberts.[62] Her study of working class women, covering the period 1890 to 1940, found that there were changes in attitudes towards welfare provision during the latter part of her investigation. She noted that these co-existed with changes in the ideals of self-help, and paying for benefits through insurance. As already pointed out in earlier chapters, at this time there was a government drive to improve maternal and child health. There is a possibility that this promotion may have influenced changes in attitudes to receiving welfare for this cohort of people. However, there was not the equivalent promotion of health and welfare of old people at the time. Consequently, old

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[60] Mrs BH OX38, 13/10/99, p. 12.
[61] Spicker, Stigma, pp. 6-23.
[62] Roberts, 'Recipients,' pp. 203-226.

people would perhaps have inherited a long-standing reluctance towards receiving stigmatising public help, such as local authority welfare assistance, without any offsetting positive messages on take-up. Reinforcing this were messages given by Beveridge on the need to prioritise younger people. Old people would have found it difficult to be pro-active in establishing welfare entitlement in this ideological climate.

Memories of how change brought about by the welfare state affected the CRH revealed that respondents considered that excess patients at the RI (caused by access to free health care), resulted in CRH providing an overflow to reduce bed pressure in the acute hospital. This suggests that people saw admission to the CRH as second rate, and corroborates a "dumping" perspective, already prevalent in testimonies. It also perpetuated the previous pre-welfare state ideas about an inferior CRH being used for old people, at a time when the prospects of treatment and life expectancy were limited. The general hospital had a better image and was probably seen as more modern in treatment and care, as it was associated with a younger client group. This put the CRH at a disadvantage in public perception.

Some respondents were unaware of any changes made at the CRH following the transfer to the welfare state. Several explanations can account for this, including their not living in the area, their parents or grandparents needing institutional care either pre- or post-1948, or their ignorance of the implications of the welfare state. Changing from the workhouse/public assistance image to that of the NHS took some time. Mr RH's testimony indicated how the workhouse image still stood despite major government reorganisation: "Well it changed anyway, it changed see, it slowly phased out if you recall...they slowly phased out the workhouse atmosphere....whilst it was there it was a reminder of what things were like."[63] Another respondent recalls how difficult it was to recall when change actually happened: "I couldn't give you a proper date it mingled with the workhouse to the hospital and it didn't become a hospital for quite a few years, its only after the war it came to the hospital"[64] Both of these testimonies illustrate perceptions of the gradual changing of the role of the CRH, it was not something that automatically, or instantaneously happened on the 5 July 1948.[65] However, one of the

[63] Mr RH OX30, 23/02/00, p. 13.
[64] Mr HB OX27, 14/04/98, p. 4.
[65] This date is known as the Appointed Day when administration of health and welfare services was transferred to the state.

limitations of oral history is that precise dating can be difficult for some people as the second testimony illustrates. Chapter Two addressed this issue in more detail.

The CRH was grounded in poor law history and the removal of this image took time, as did adapting to changes made in welfare provision after 1948. These processes may have been difficult for older people, as they were used to previous practices in welfare distribution, and were probably wary of new changes. For old people, the relevant changes were in the nature of institutional care, and free access to the medical profession, but there were grounded fears about both these aspects. The CRH was known to almost all old people as the former workhouse, and in view of previous inaccessibility to health care, medical care for some, could have been an unknown quantity, and possibly was still viewed with some suspicion.

Professional attitudes to the inception of the welfare state and the CRH

In the previous chapter, professionals identified changes made to the CRH once Dr Cosin was appointed. They also spoke about more general changes associated with the welfare state. These views are significant in relation to the collective view of the CRH by the community. Furthermore, by virtue of their positions, professionals were well placed to influence attitudes in the wider community as they had direct contact with patients and potential patients of the CRH and their relatives.

Health and welfare agencies were the main organisations that had to make changes following the inception of the welfare state. As outlined earlier, under the NHS Act local authorities had to provide associated services such as home helps and district nurses. The oral respondents interviewed worked in several professions and covered a range of experiences in hospitals, GP surgeries and in the city council. (See Appendix A for description of respondents). Nothing remarkable was remembered about the 5th July 1948, the official day of the change over - there was no dramatic change. Three key themes emerged from discussions on the change to the welfare state, these being: the medical profession's perception of the change, patients' responses to the establishment of the NHS and the city council's changes.

Medical professionals' perceptions of the change

Two respondents recall particular conversations on the lack of change on 5th July. Mrs AP started work as a medical social worker on the 5th July and recalls her colleagues'

discussion with a senior physician, "Well here it is, it's come, I can't see any difference it's just an ordinary working day." He said "you wait my girl" or words to that effect".[66] Mrs VE, a nurse at the RI, remembers a strikingly similar experience:

> That fateful day came and I remember it was a Dr Cooke's out patients and the next day was his and he sat down and he said "well (I've forgotten what date it was) .....the 5th of July has come and its gone and we're still here" [chuckles] I said "yes we don't seem to have changed very much" he said "you wait we will.

She also had the impression that the doctors were unhappy that the state were taking over.[67] A local GP thought that the politicians failed to ask the right questions pre- 1948 and should never have introduced a free NHS. He used the imposition of prescription charges early on in the NHS as an example of problems caused by attempting to provide such a vast service, and considered that politicians wanted to bribe the electorate. It was his opinion that people were worried about paying for health care and thought this option would solve the problem. This doctor was aware that his senior colleague was displeased about having his private patients "taken away from him."[68]

Health workers interviewed to commemorate fifty years of the NHS presented similar views on the initial transition. Peggy Nuttall, a nurse at the time commented: "....From my point of view, working at the London Hospital, it was the same as the day before and just the same the day afterwards..."[69] Another nurse interviewed recalls that: "On the whole the changes were gradual and it took time for retrospective reflection to highlight the changes."[70] Ms Nuttall was also of the impression that noticing effects of the immediate change over was a secondary concern for busy practitioners. However, she makes a salient point regarding her significant memories from that time, "The Appointed Day is to me only a hazy memory, whereas those of World War II are never to be forgotten."[71] Powerful memories of the war could well have obscured some of the initial changes to the NHS. Nevertheless, it seems that many practitioners were preoccupied with their work and there were no immediate noteworthy changes.

Digby's study of GPs reflects a national perspective on how one group of medical professionals viewed the change to the NHS. In this study, the author identifies

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[66] Mrs AP OX52, 1/03/00, p. 4.
[67] Mrs VE OX51, 14/02/00, p.7.
[68] Dr DL OX48, 18/01/00, pp. 5 and 13.
[69] P. Nuttall, 'Remembering 1948' International History of Nursing Journal, 3:3 (1998), p.57. This edition has special articles celebrating the NHS and covers a range of experiences from professionals who worked in medical care during the change over to the NHS.
[70] M. Crompton, 'Remembering 1948' International History of Nursing Journal, 3:3 (1998), p.52.
[71] Nuttall, 'Remembering'.

generational issues as a marker in terms of responses to the change. Older doctors who had built up their practices based mostly on private patients took longer to respond to the changes, whereas newly qualified younger doctors tended to identify more with the ideals of the NHS. Some doctors were relieved not to have to treat private patients as they were aware of the difficulties some people had in paying the bills. Other doctors were realistic about how the demands of their patients would exceed the service provided by an NHS GP, and some moved into private practice.[72] The medical professionals interviewed for this thesis, were in the age cohort of relatively newly qualified practitioners, and related similar views. Therefore, it would be reasonable to suggest that they too identified with those of a similar age in Digby's study. However, they also reflected some perspectives that represented their senior colleagues' views which had echoes of those from Digby's work.

Medical workers' views on patient's response to the establishment of the NHS

Local doctors thought that most of the patients were no trouble at all but that some patients took advantage of the free service. [73] A doctor's wife who was very active in the administration of the practice prior to 1948 recalls:

> In some cases some people became much more demanding....people expected to have something for nothing in a curious sort of way. I remember I think I was taking the parish magazines round and I met an old man who was a patient and I asked him how he was ....he was in quite a rage he had to have some special boots because he's got deformed feet and he said " this NHS they've asked me to pay something towards my boots I thought we were expecting...we were told we would get it for nothing" you know they expected such a lot and in some cases the night calls became more frequent for a while ....people weren't paying anymore and they thought they were getting everything for nothing and they thought they could have more and they seemed to be more demanding. It died down.... It died down because people just sort of realised that they were getting a lot for nothing and the doctors couldn't do more than a certain amount.[74]

In contrast Mrs SB, a nurse at the RI, remembers patients being very grateful for their care.[75] Mrs MA another nurse at the RI considers that older people became healthier once the welfare state was established.[76]

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[72] Digby, Evolution, pp. 333-334.
[73] Dr DL OX48, 18/01/00, p13, and Dr MB OX46, 12/01/00, p. 8.
[74] Mrs RS OX43, 30/11/99, p. 9.
[75] Mrs SB OX29, 31/03/99, p. 10.
[76] Mrs MA OX1, 15/07/98, p. 14.

Medical workers' testimonies emphasised three aspects of old people's responses to the welfare state. First, some old people were initially not demanding of the NHS and were very grateful for the service received. Secondly, others, probably a minority, had high expectations of what could be provided. How this expectation developed could be explained by the rhetoric and propaganda delivered by the Labour Party. Thirdly, there was a general view that free access to medical care for old people would help them become healthier. However, it would seem expectations of the service ran ahead of the service's ability to deliver and the medical professionals witnessed this. Perceptions by the medical professionals do fit in with political analysis on initial failings to fully resource the NHS, particularly in respect of older people.[77]

City council changes

Mrs ASP was a member of the city council in 1957 and served on the welfare committee. She was also an administrator for the local branch of the NOPWC from the early 1950s. The welfare committee met once a month in rotation at the OPH's. Mrs ASP recalls that the city was building old people's homes and the policy of the time was to:

> "...put people away and not to help them stay in their own homes, so if somebody came along who perhaps had been in hospital, or had been in long term care in Cowley Road Hospital, which was the traditional way for anybody who was ill even if they hadn't got a terminal illness or something that couldn't be cured. They could sometimes be bedridden and a lot of those were eventually discharged and could go back to Old People's Homes; then there were people from the Poor Law Institutions who went into OPHs when that was all abolished. So in a way they were getting something better for those people the bedridden the people in the hospital and the Poor Law people were getting something better, in fact they were quite proud of the OPHs. Some of them didn't have any property to bring with them. Then there were the people in the early years who needed to be housed because of slum clearance....and so often there was nothing for them. They weren't provided with another house or flat, there were no houses, there was no sheltered housing in those days, so it was often thought that if someone was 65 or 70 plus they could go into an OPH. They didn't need to be in an OPH, in later years of course the average age of OPH was nearer to 85 than it was to 65 or whatever but, in the early days people were quite young by our standards who went into OPH, so there was quite a demand for them ... they were built for 4 bedded rooms and they called them beds, they didn't call them residents they said about Barton End this is going to be about a 40 bedded home and Townsend House and Shotover View.... and so

[77] See Webster, 'Elderly', pp 165-193

> it was always thought that beds were the most important thing where of course it wasn't really quality of life was more important....[78]

In her testimony Mrs ASP tracks the city council's policies and practices on residential care of old people from the beginning of the welfare state. She identifies some important points, particularly that old people were institutionalised, rather than cared for in the community. This she links this with previous practice, lack of resources and possibly lack of creativity and long term planning. Mrs ASP also raises the issue of the new OPHs and stresses how accommodation was perceived as "beds." This suggests a bureaucratic approach to the care of old people that was more concerned about the disposal of a short term problem rather than finding a long term solution. Another significant point made by Mrs ASP was that old people needed accommodation at a much earlier age than today. Possibly, due to the lack of previous welfare facilities, they had little resources to enable them to retain their independence in the community, or may have been in poor health and therefore more vulnerable. Mrs ASP makes a moving point, that when existing residents of the old public assistance institutions were transferred to the new OPHs, they had no belongings to bring with them which reflected their impoverished past. However, Mrs ASP acknowledged that the OPHs were an improvement on former institutions and that there was a great demand for places.

Oxford City Council progressed with slum clearance after the war, and Mrs ASP remembers that these projects were not discussed with residents. Council records do not suggest that there were any consultation processes with residents. The council made the decisions and some elderly people apparently had their houses purchased for very small amounts. Mrs ASP considers that these transactions caused problems as the old people were then homeless, and the only alternative was for them to go into an old people's home. Slum clearance projects solved one problem by modernising and updating homes, but it seems that existing residents' (including old people) needs were not addressed or given consideration.

Ambivalence and apprehension about the establishment of the NHS was evident in the professionals' testimonies. These attitudes, which were probably representative of a national picture, must have prevailed for some time after 1948, and initially influenced professionals' approaches towards patients. But most of the cynicism seems to have

[78] Ms ASP OX19, 4/06/97, p11

been engendered towards politicians. A more compassionate attitude was adopted towards old people, possibly because, as Dr MB acknowledges, they did not present in the surgery as often. At first, old people may have found the concept of free health care difficult to grasp, and were suspicious of the medical profession. Surveys on the general practitioner service and on the consultation rates for old people were carried out in the late 1950s and early 1960s. According to Webster, these surveys revealed that: "The elderly made appreciably more use of general practitioner services than the fittest age groups, but there is no evidence to suggest that their demands were excessive."[79] Some older people were obviously visiting their GPs and benefiting from the new service but there were others who were not. Reversing ingrained attitudes to welfare was probably quite difficult for old people.

The local authority's immediate response to the change appears to have been circumstantiated, providing accommodation solved the problem. By examining the MOH reports in the 1950s there is some evidence that attitudes towards the care of old people were changing. For example, in 1955, a statement was made by the Chief Welfare Officer on the policy of the welfare section with regard to work with older people:

> ...That the aged and infirm should be encouraged and assisted to remain in their own homes for as long as possible, and that removal to a home should only be effected when adequate care and attention is not otherwise available. A most important part of care and attention is not, perhaps, readily associated with the words alone, and it is a principle that happiness of the individual is an essential part of "adequate care and attention." All too often one hears of old people being "put" into homes or institutions. Except in very rare cases when Section 47 of the Act has to be used, no person is "put" into a home, and as long as they remain in a home the individual is free whenever he or she desires to leave. Admission to a home is by application from the individual; once the application is made then it is our duty to admit a person only when it is absolutely clear that adequate care and attention us not available from any other source.[80]

Obviously changes in attitudes were influenced by practical and financial circumstances and demand for residential places in Oxford was increasing (this will be described and discussed in Chapter Eight). A significant change since the inception of the welfare state was the reference to old people's wishes to remain in their homes. Despite the sentiment of the MOH report, there seems to have been inconsistency in attitudes towards accommodating old people. Given the evidence of Mrs ASP, did the

[79] Webster, 'Elderly', pp. 165-193.
[80] MOH Report 1955, Section VIII Welfare Services, pp. 110-112.

managers of slum clearance projects liaise with the CWO or was this overlooked? It is fair to say that there were fewer public consultation processes within society at this time than later on. There is no detailed evidence to suggest, either, that there was any liaison. Reports of the council meetings would not necessarily reflect that consultation had taken place, and professionals interviewed do not indicate that there was any liaison with other departments. The situation described above illustrates one of the challenges of the welfare state; housing was to be improved, but by carrying out these policies some "casualties" occurred. On the evidence presented by Mrs ASP, in this instance it was old people being made homeless and institutionalised. The city council may have felt that providing cash incentives for property purchases was adequate and the department was fulfilling its obligations, but possibly to the detriment of old people. Changing attitudes and policies brought anomalies too.

Establishing liaison between different departments may have been quite a complex task immediately after 1948. A new local and national administrative structure had been created with the inception of the welfare state, expectations and bureaucratic procedures were inevitably in their infancy, and priority was given to statutory requirements. Secondly, interdepartmental liaison within this new structure would have taken some time to establish, although there was no evidence of this in documentary sources examined. Thirdly, voluntary organisations were providing a fair degree of services to older people and had their own structures of accountability. Fourthly, there was no old people's committee to provide a focus point for all the agencies involved in old people's welfare to discuss the problems encountered, progress and future projects.

Professionals' perceptions of the community's view of CRH after 1948

There was a distinct view amongst professionals interviewed that patients still saw the CRH as the workhouse after 1948. A GP in East Oxford thought that old people dreaded being sent to the CRH as they regarded it as the old workhouse.[81] Dr MB, another local GP, corroborates this and thinks that the community's attitude was "never all that good because lots of people in those days remembered it as the workhouse, you know it was the last resort until we had this new attitude to the care of old people....they made it clear they just didn't want to go there."[82] Mrs ASP remembers people's attitudes to CRH when the CRH took over: "'Oh that's the old poor law place

[81] Dr DL OX48, 18/01/00, p. 6.
[82] Dr MB OX46, 12/01/00, p. 10.

we're not going in there to die' and oh yes tremendous resistance"[83] Miss JA qualified as an almoner in 1939 and started her first job on the day the Second World War broke out in September 1939, in a Birmingham hospital. She was head almoner at the CRH from 1950 to 1956, and went out on home visits with Dr Cosin to assess people. Miss JA would also see patients in hospital, or in the OPD and recalls reactions to admission:

> Looking back poverty was much more evident than it is today.....There was still a fear of being sent to a geriatric hospital and when mentioned people thought they were being "banished to the workhouse" even though they ceased in 1929. It should be remembered that many of these old buildings were still in use so the change was not always apparent.[84]

Her perceptions which are based on a good deal of professional experience of old people, sum up the situation very well, and confirm theories that the inherited poor law buildings did influence attitudes to the institutions allocated to old people.

Another professional, Mr MG, who worked in the CRH in the 1950s, reinforced these views. He too thought that some patients were reluctant to come to the CRH as they knew it was the old workhouse. However, he makes an important point about changing patient attitudes which emanated from staff attitudes. He recalled a patient saying to him: "I like coming to your department because everybody treats me as a human being."[85] This statement encapsulates the change in treatment by the medical profession and the patient's expectations of it. Clearly things had begun to change; Mr MG and his colleagues' professional approaches were starting to have an impact. What is notable about Mr MG's recollection is that as a physiotherapist he was in a position to talk to patients in a different and possibly more relaxed way whilst carrying out their treatment. He also worked in the community, and was therefore able to see both in-patients and out-patients, thereby giving a broad range of contacts across classes. Mr MG recalls treating all classes of people at the CRH and makes the point that the process of ageing does not acknowledge class distinctions, it affects everybody regardless of class, gender or wealth. Another interesting point made by Mr MG was that in his opinion "...when they *[patients]* got there it was not as bad as they thought it would be..."[86] These statements by Mr MG imply that patients were influenced by previous community attitudes to the CRH, that it was the workhouse and associated

[83] Mrs ASP OX19, 4/06/97, p. 7.
[84] Miss JA OX 58, in a letter written to me on 28/4/2000.
[85] Mr MG OX16, 4/03/98, p. 3.
[86] Mr MG OX16, 4/03/98, p. 8.

with poor treatment for old people. As the head of his department Mr MG was responsible for staffing. Initially the CRH had difficulty recruiting staff as it was associated with the workhouse, a further indication of community influences. Mr MG employed some creative recruitment strategies by employing married women on a part time basis (which fitted in with school hours), with a career structure. His view was that a stable, committed, staff group contributed to the changing perception of CRH. Given his wide experiences with old people from all classes and backgrounds at the time of transition to the NHS, he was well placed to make these observations.

Professionals thought that local people continued to see the CRH as the old workhouse, implying that they found little change after the Local Government Act in 1929, when the institution was renamed Cowley Road Hospital. The professionals indicated that they had sympathy with the general public's perception of the CRH – a former workhouse, and implied no criticism. As well as being professionals they were also members of a wider community, having both a professional and a personal identity. Being members of the local community probably enabled them to relate to some of the comments made about the CRH.

Family responsibilities

Families did help out their elderly relatives to enable them to remain independent in their own homes. Respondents gave examples of how they would do shopping, laundry, cleaning, and on occasions, other heavier tasks to help their older relatives remain in their own homes. Three reasons were given by relatives as to why old people would need to have more care, these being illness, widowhood, financial necessity and/or a combination of all three. When illness occurred that either needed treatment, and/or disabled a person, then hospitalisation was likely to be a necessity, depending on the diagnosis or prognosis. But some families would have their older relatives to live with them when a serious illness was diagnosed, and nurse them at home.[87] No specific reason was stated as to why these decisions were made, but an impression was given that families wanted to care for their parents themselves at the end of their lives rather than have them die in a hospital. Mrs DB's family turned their dining room into a bedroom for her terminally ill widowed father. Prior to his illness Mrs DB had done her father's laundry and cooking. Obviously some families were unable to have their

[87] Mrs DB OX41, 29/10/99, p. 9 & Mrs HH OX13, 23/04/98, p. 4. Both gave examples of older relatives going to live with their children following the diagnosis of a serious illness.

elderly relatives to stay, and the circumstances under which illness developed also influenced things. For example, Mrs OH's father was suddenly taken ill with a stroke and rushed to the RI in the early 1950s. Her father was transferred to the CRH soon after admission to the RI as he was classified as "terminally ill." He died several weeks after the transfer to CRH and, as she had just had a baby, Mrs OH was unable to be very proactive in her father's care.[88]

Who did the caring?

There were many examples of women providing care for their elderly relatives. These range from giving up a home to go and live with parents,[89] visiting to help a parent care for a sick spouse,[90] having a parent to live with them,[91] and providing relief care for the sister who had taken the parent in.[92] One sister used to cycle at least five miles a day to care for her terminally ill father.[93] Sons did do some of the caring and their contributions ranged from regular visiting,[94] vacuuming[95] and heavier tasks and eventually living or staying with them.[96] There was no pattern associated with the care giving from sons. Some would be from large families, others from smaller families, but sons that had a parent living with them (usually a mother) were either unmarried, or an only child. For example, Mrs AP's brother never married and he remained in the family home, and Mr BJ was an only child and had his mother to live with him.[97] Mr RH expressed a view that suggested that daughter-in-laws were not expected to take much of a role, as he did not consider it was his wife's job to look after his mother.[98] A similar attitude was held by another brother of a respondent. Mrs LW asked her brother if he could care for their father and later on help with relief care. Her brother considered that this would not be fair on his wife. Although Mrs LW pointed out that it

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[88] Mrs OH OX11, 17/7/97.
[89] Mrs IM OX57, 30/03/00, p. 11, one of her sisters gave up her home to move into the top floor of her parents house when they became old and frail.
[90] Mrs KP OX17, 16/03/98, p. 9 would regularly visit her mother who lived nearby, to help her care for her sick father.
[91] Miss BH OX39, 13/10/99, p.10, had her mother come to live with her when she was widowed in 1956.
[92] Mrs OA OX55, 12/05/00, p. 3, her mother would come and stay once a year for a fortnight so that her sister could go on holiday.
[93] Mr MH OX26, 18/05/98, p. 2.
[94] Mr WL OX56, 30/03/00, would visit his mother at least three times a week.
[95] Mrs IM OX57, 30/03/00, p. 11 came from a big family and one of her brothers would go and do the vacuuming for his mother.
[96] Mr BJ OX14, 24/04/98, p. 2 did heavy tasks for his mother until she came to live with him; Mrs KP OX45, 16/03/98, p. 3. Her brother had their widowed mother live with them for three months.
[97] Mrs AP OX45, 6/12/99, p. 3 and Mr BJ OX14, 24/04/98, p. 2.
[98] Mr RH OX30, 23/02/00, p. 7.

was equally not fair on her husband this contradiction was not resolved. The brother wanted their father to be admitted to an institution.[99] Interestingly, another gentleman considered that his parent's needs were attended to because his sister-in-law was very pro-active, she organised and found a suitable nursing home for his frail parents.[100] According to Miss BH, who was a single woman, on the whole, unmarried single women had to take the brunt of care, even when there were married brothers to help share the responsibility. She recalled examples of her unmarried female friends' brothers' attitudes to caring for older parents. One friend had to cancel a holiday as the brother would not help and told her "I've got my family, Mum's your responsibility". Another friend's brother left his mother after a fall when his sister arrived, and said "you're here now so I can go."[101] With regard to her own circumstances, Miss BH felt that it was her duty to care for her own mother, not because she was pressurised by society, but as an only child there was nobody else to do it. Her experiences substantiate earlier views, that daughters-in-law played a minimal role in caring for parents-in-law, and also highlights expectations that a single woman would have the ultimate responsibility of caring in a family. Mrs MQ suggested that after the war there was a change in culture as there were more women going out to work, and therefore unable to provide care for elderly relatives.[102] Mr NS's sisters lived with his parents for a while but this did not work out as one had family and the other a career therefore they "had their own lives to pursue."[103]

What seems to have happened was that when parents started becoming frail, then most family members would help out in some way regardless of gender. Arrangements for caring did not generally seem to be negotiated within the families, they just seemed to evolve without discussion. When one or both became sick it was usually a daughter that helped out, unless there was an unmarried adult child still living at home. If a parent or parents needed to have more supervision then a daughter would either move back home, with her husband if married, or have the parent(s) to live with their family. However, if there was only one male child in the family, he would provide care for his parent(s) and should there be unmarried children, a female would be expected to do the caring. But expectations were beginning to change, particularly as women were taking

[99] Mrs LW OX33, 17/05/99, p. 10.
[100] Mr NS OX18, 8/07/97, p. 4.
[101] Miss BH OX39, 13/10/99, p. 10.
[102] Mrs MQ OX53, 3/04/00, p. 10.
[103] Mr NS OX18, 8/07/97, p. 4.

up work outside the home. The experiences described by relatives synchronise with other historical analysis on gender and demographic influences in caring. Parker reviewed gender expectations of caring and, by using Halsey's demographic analysis, elaborated on assumptions made about women's role in caring. She asserts that, after economic factors, demographic factors were the most powerful influences on policy formation:

> It was assumed that single women would continue to be available to care for elderly dependents at a time when the proportion of single people in the population had already been declining for 50 years. Post-war social security legislation also assumed that the majority of women would marry and be financially dependent on their husbands, thus misjudging the scale of change both in married women's labour market participation and in divorce.[104]

Parker is making the point that anticipated and ongoing demographic shifts were ignored by policy makers determining post-war social legislation; this led to a crisis in caring provision. Another point to consider in relation to gendered aspects of caring is how women made the decision to be carers. According to Lewis, these decisions were made because of assumptions that caring was primarily women's work and should take precedence over any other types of work. In the 1950s there were more rigid expectations of women's roles within the home than today. These expectations were inherited from previous generations, and would have influenced the decision making process.[105]

Oral history respondents have described the process of change and the beginning of the shift in attitudes towards caring during the early days of the welfare state. In the early 1950s there were few OPHs for Oxford residents and the Laurels was overcrowded. More accommodation was being planned but had not yet alleviated the situation. Opportunities for old people's residential care were limited and the testimonies suggest that few families considered using this option. Hospitalisation for sick old people was becoming more acceptable, but the concept of residential care was still in its infancy.

Conclusion

Returning to the question posed initially, was there a change in the perception of the CRH pre-and post-1948? It can be argued that during the initial transfer over to the welfare state there was no change. Following the appointment of a dynamic clinical

[104] Parker, Due Care, p. 15.
[105] J. Lewis, B. Meredith, Daughters Who Care, Daughters Caring For Mothers At Home (London: Routledge, 1988), pp.4-5.

director (Dr Cosin) in 1950, there were considerable alterations in treatment and systems for older people within the hospital. This gradually extended into community resource provision. Professional opinion on the role of CRH appeared to have changed quite quickly. The community's perception of the CRH was more gradual. Several significant factors influenced this transformation.

By the end of the 1950s, after twelve years of welfare state provision, it appears that it was more acceptable for ageing parents to be admitted into the CRH. Residential care (OPHs) did not feature as an option, possibly because the older relatives of the respondents needed medical care, and therefore this was not appropriate. With regard to class differences, none of the respondents from north Oxford (the more affluent area of the city) had any personal use of CRH. Nursing homes were a significant option for the more wealthy people in the city. I therefore assume that the stigma of the workhouse was still associated with CRH amongst the affluent whose choices were more plentiful.

The work of the professionals began to filter through to the community. The listed benefits for relatives of patients of the day hospital in 1958 were listed as: ".....free time is made available for shopping, occasional recreation time and even part time work."[106] This statement, in conjunction with other listed benefits of the day hospital, certainly indicates a shift in policy for caring for old people on a local level. It is not clear how the community was made aware of the changes in CRH, but I suspect that the medical professionals in the community such as GPs and district nurses were responsible for passing on this information. An Oxford Times article featured the role of the CRH Almoner in the 1950s and described many of the benefits of the CRH, for example the day hospital, physiotherapy and occupational therapy.[107] Undoubtedly this positive media profile would have helped to enhance the reputation of the CRH at this time.

The respondents' testimonies suggest that family relationships were stronger in the past. However, the view that there was a "golden age" in which "family responsibilities were stronger than they are today," is challenged by Finch. She suggests that industrialisation and urbanisation transformed their character "which continues to

[106] Head Occupational Therapist at Cowley Road Hospital notes of 1958.
[107] Oxford Times extract forwarded by Miss JA OX58 who is featured in the article and contributed to the piece. She cannot recall the date of the newspaper except it was in the 1950s. The feature is part of a series titled "Other people's jobs: 24 hospital almoner."

change and suit the particular circumstances in which individuals find themselves."[108] This is particularly pertinent after 1948, when radical changes had been introduced and people were also adjusting to post-war society. Most of the respondents interviewed did not want their relatives admitted to the CRH at this time, but empirical evidence post-1948 suggests that there was a high demand for residential beds in Oxford in the 1950s.[109]

One explanation for the high demand for residential care could be because requests came from old people without a spouse, or dependants, or who lived away from their families. In his national study of residential care for older people in the early 1960s Townsend found that in institutional care, "nearly two-thirds of the elderly men and women are unmarried or have no surviving children. Many others have been separated from their children by migration or divorce and the great majority are of poor social status."[110] Given Oxford's demographic profile (synchronised with a national one), it is probable that these characteristics of the older population can also be attributed to Oxford City. However, in the light of the oral evidence I would also suggest that there was a shift in familial expectations. People were beginning to use state facilities more, particularly at the end of the 1950s, and this was also influenced by demographic factors, professional changes and expectations.

Thane states that: "a mass of evidence showed with striking consistency between 1945 and the mid 1990s that it was extremely rare for families to provide the whole support of older people."[111] She is referring to studies carried out by Townsend and Sheldon (in the 1950s) and others later, who concluded that older people preferred to live alone and were supported by their families who lived close by. Old people had become more independent since 1945. Pension provision underpinned this independence and with more people living longer, expectations of a third age rather than an early death began to surface.

Time lags are an important element to consider in this study and, by examining the sequence of events and the links between them, the significance of these can be identified. Certainly time lags existed between older images and perceptions of the

[108] Finch, Family Responsibilities, p. 85.
[109] Oxford City Council minutes and reports record the increased demand initially for the Laurels in the 1950s and then subsequently expanded provision.
[110] Townsend, Last Refuge, p. 107.
[111] Thane, 'Family Lives', p. 206.

workhouse and the new CRH which was supposedly representative of the new welfare state. People were still referring to the CRH as the workhouse in the 1950s. Given that the name changed in 1921 and public assistance committees took over administrative responsibilities from the poor law guardians, this is a clear example of how public perception lagged behind social policy change. Respondents' attitudes to CRH continued to contain images and connotations of the workhouse, despite the changes instituted there in the decade after the inception of the welfare state. The intention of the welfare state was to bring about radical change in social welfare, but as the rate of new build was slow, poor law buildings thus remained, a constant reminder from earlier times, thus perpetuating historical images. In addition, there was a shortage of new services so that families continued to provide the majority of care for their elderly relatives.

The following chapter will present a case study of how the city of Oxford adapted to changes spearheaded by successive governments. It will incorporate the social developments outlined in this chapter to further illustrate the relationship between local perceptions and national policy for provision for old people.

CHAPTER SEVEN

A Case Study of Oxford City, Part 1

The case study of Oxford is in two parts; the first part in this chapter, will present a demographic and health profile of residents aged over sixty years, who were living in Oxford from 1930 to 1960. Part 2, in Chapter Eight will focus on the impact of chronological changes arising from legislation on older people in the city. Information for this chapter has been collected from documentary and oral sources, and will be used to make national comparisons. The profile will provide a means to frame and measure local provision for old people before and after the establishment of the welfare state. Evidence on some aspects of old people's lives was obtained through national surveys, carried out in the 1940s and 1950s. Some of the conclusions from these surveys will be compared with evidence gathered from the oral respondents, to gain a comparative perspective of the lives of old people living in Oxford during the time of this study.

Age profile

Evidence presented for the demographic profiles has been collected from the census data. Two points can be made in relation to this profile, first no census was carried out in 1941 because of the war. Secondly, for the period under review for this study the census was not carried out in term time and therefore students were not included. However, the census was delayed in 1921 and carried out close to the end of the summer term. This may have a minor effect on the proportion of those aged over 65 years in Oxford for 1921, however, it is not possible to quantify this.

Local and national age profiles were presented in Chapter One. Evidence suggests that Oxford's age profile followed a national trend. Figures 1.1 – 1.3 illustrate this.

Also evident from the national census data was a proportionately larger increase in the numbers and percentage of people over 70 years, than those in the 65 to 69 year old group. In addition, this shows that the rate of increase is even more for the older year groups, for example even those in the 80 to 89 year old group increased by approximately two times, and 90 years and over by three times from 1921 to 1961. The table below illustrates these points.

Table 7.1: Age groups for those aged 65 and over in Oxford 1921-1961

		%		%		%		%
age last birthday	1921	1921	1931	1931	1951	1951	1961	1961
all ages	57036		80539		98684		106291	
65-69	1796	3.15	2671	3.32	3961	4.01	4224	3.97
70-74	1335	2.34	1862	2.31	3094	3.14	3405	3.20
75-79	834	1.46	1214	1.51	2149	2.18	2425	2.28
80-84	404	0.71	606	0.75	1148	1.16	1484	1.40
85-89	161	0.28	234	0.29	508	0.51	653	0.61
90-94	29	0.05	60	0.07	130	0.13	194	0.18
95 + over	5	0.01	9	0.01	15	0.02	41	0.04

Source: Census of England and Wales, 1921, 1931, 1951 and 1961.

Additional demographic information is provided in Chapters One and Four where different aspects of demography have been presented.

Epidemiological profile

A profile of the main illnesses causing the deaths of Oxford residents aged over 65 years from 1930 to 1960 has been compiled by using data from MOH reports which record causes of death for different age groups. The readings have been taken at the beginning of each decade - 1930, 1940, 1950 and 1960. Each report was accompanied with relevant information by the MOH. For example, in 1930 the MOH explained the method for classification of causes of death which had been adopted on the recommendation of the Registrar General. This was based on international criteria explained in the MOH report for 1930: "The method followed is that outlined in the "Manual of the International List of Causes of Death" in which definite rules are laid down for the selection of one or more jointly stated causes of death."[1] As definitions were changed throughout the decades covered, this gave way for some inconsistent comparisons, which was acknowledged by the MOH. Seasonal diseases such as bronchitis, pneumonia and influenza have been included in the construction of the profiles as they were a particular cause of death for this older age group, especially before the development of penicillin. Traffic accidents, and all other accidents, were included as new categories from the 1940s. Age grouping in the MOH reports also changed over the decades. Initially over 65 year olds were grouped in two categories, 65 - 74 year olds and those aged over 75 years. This age classification changed in 1940 and was then re-introduced in 1950 and 1960. In the light of this there is no more

[1] City of Oxford Annual Report of the Medical Officer of Health for the Year 1930, p ix (hereafter known as OxMOH).

detailed break down of age groups for these profiles, thus the information is based on people aged over 65 years.

Table 7.2: Major causes of death for over 65 year olds in Oxford 1930-1960

Disease	1930	1940	1950	1960
Heart disease	124 (15.4%)	227 (18.9%)	307 (29.2%)	303 (28.8%)
Malignant disease	72 (9.0%)	81 (6.7%)	98 (9.3%)	129 (12.3%)
Cerebral haemorrhage	43 (5.4%)	80 (6.7%)	116 (11.0%)	139 (13.2%)
Bronchitis	23 (2.9%)	70 (5.8%)	35 (3.3%)	36 (3.4%)
Pneumonia	17 (2.1%)	54 (4.5%)	22 (2.1%)	45 (4.3%)
Influenza	2 (0.2%)	32 (2.7%)	5 (0.5%)	
Other	70 (8.7%)	56 (4.7%)	39 (3.7%)	37 (3.5%)
Total of over 65s	351	600	622	689
Total number of deaths of city population	803	1203	1051	1053
Total city population	73810	96570	108200	104490

Source: Oxford City MOH reports 1930-1960.

Bronchitis, pneumonia and influenza are included in 1940 as there was a significant increase since 1930 when only 23 people aged over 65 years died from bronchitis, 17 from pneumonia and 2 from influenza. In 1930 the MOH remarks on the low death rate for the year, "The fall in the death rate is attributable in part to the mildness of the weather throughout the year and the consequent fall in incidence of the respiratory diseases, and the absence of an influenza epidemic."[2]

Although there have been adjustments to the ways in which causes of death are categorised across the period of the study, a health profile of older people has emerged. Heart disease, malignant disease and cerebral haemorrhage were the chief causes of death. It is difficult to compare this on a national basis as age profiles are not consistent during the period under review. Seasonal diseases such as bronchitis, pneumonia and influenza were seen to be dependent on the weather and influenced the death rate. The 'other' category included accidents and unspecified causes of death.

Table 7.3: National and local death rate for all ages 1940 – 1960

	Local	**National**
1940	12.70	12.50
1950	9.71	11.80
1960	10.08	11.50

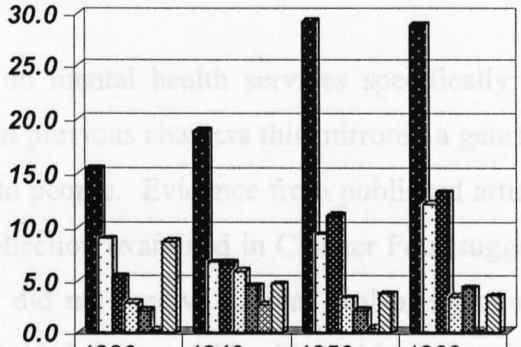
Source: Oxford City MOH reports 1940 -1960.

The 1940 death rate was marginally higher than the national rate, whereas later the local death rate was lower than the national one. No consistent pattern was established

[2] OxMOH, 1930, p ix.

regarding the seasonal diseases. Deaths from the other diseases steadily increased over these decades as is shown in Figure 7.1.

Figure 7.1: Total deaths by disease of people aged 65 and over in Oxford



	1930	1940	1950	1960
heart disease	15.4	18.9	29.2	28.8
malignant disease	9.0	6.7	9.3	12.3
cerebral haemorrhage	5.4	6.7	11.0	13.2
bronchitis	2.9	5.8	3.3	3.4
pneumonia	2.1	4.5	2.1	4.3
influenza	0.2	2.7	0.5	0.0
other	8.7	4.7	3.7	3.5

Source: Oxford City MOH reports 1930-1960.

When respondents recalled the health of their parents and grandparents, their accounts confirm that heart attacks, strokes and malignant disease were the main cause of death. There was an inference suggesting that relatives were often very well and active until just before they died, some being in their eighties and nineties. However, some relatives did suffer from other chronic ailments such as varicose veins and arthritis, which affected their quality of life. Sensory disabilities, particularly deafness, contributed to this, as for example, hearing aids were not as developed as today. Several respondents remembered that their relative's appliances did not work efficiently - consequently, they became socially isolated. Broadly speaking, relatives' health could be divided into two groups, those who were well and lived active lives, and those who suffered from ailments associated with ageing, for which treatment was limited. Those who were well came from across the city and from different social backgrounds. Access to health care as discussed in Chapters Three and Six, was dependent on a variety of influences but, as mentioned earlier, and in general, old

people during the time of this study did not visit the doctor very often. This was related to financial and social reasons originating before the existence of the welfare state and continuing after.

Mental health

There is little documentation on mental health services specifically for old people before 1948. As demonstrated in previous chapters this mirrored a general limitation in health care developments for old people. Evidence from published articles in medical journals and the oral history collection examined in Chapter Four suggests that mental illnesses amongst older people did not receive a great deal of attention before 1948. Social advances probably highlighted the mental health problems for older people. For example the development of small group homes (discussed in Chapter Four) drew attention to problems which arose when residents started to suffer from dementia. Clarifying areas of responsibility became a pressing issue to address, especially as the older population was increasing - this magnified the problem. Alongside this a more understanding approach was being adopted towards old people, with the result that attempts were being made to address some of their needs. The increased older population meant that there were more patients with mental health problems. This presented practical problems for the health and welfare authorities, at a time when interest in older people's health in the form of gerontology was developing. With this national backdrop the next section will illustrate how Oxford City responded to old people's mental illness and developed its services and policies.

Mental health admissions in Oxford rose in 1948, then remained constant for three years. There was an increase in admissions to mental hospitals for older people suffering from degrees of senile dementia. In 1951, for example 65 people over 60 were admitted compared to 19 in 1947. The CMO remarked on the national situation regarding the treatment and care of old people with mental illness in 1950, and acknowledged that there were more hospital admissions than before the war.

Table 7.4: National breakdown of the number of elderly patients resident in mental hospitals 1930-1950

	1/1/1930		1/1/1948		1/1/1949	
	Males	Females	Males	Females	Males	Females
Total patients resident in health service mental hospitals	59,668	74,977	55,620	74,232	56,790	75,800
Of the total, those aged 65 years and upwards	9,139 (15.3%)	15,576 (20.8%)	10,673 (19.2%)	20,607 (27.8%)	11,221 (19.8%)	22,187 (29.3%)

Source: Annual Report of the Chief Medical Officer of the Ministry of Health for the Year 1950.[3]

The above table illustrates the CMO's point that there was an increase in admissions to mental institutions for elderly people (particularly older women) over the twenty years which spanned the pre- and post-welfare state period. He drew attention to the fact that this group of elderly people had always "presented special difficulties," and expressed his concern that compulsory admission (through legislation) was inhumane, distressing for the patient and their families, and inappropriate. This statement suggests that nationally, a compassionate approach was now being adopted towards old people with mental illness. Suggestions for arrangements to address some of these problems were made to regional hospital boards and management committees. However, the CMO admitted that "the present financial stringency will limit the extent to which regional boards will be able to initiate action on these lines." But he stressed the practical benefits relating to easing the pressure on mental hospital beds.[4] This must have presented a confusing message to local MOHs as the crisis of beds in mental hospitals was recognised, older people were seen to be inappropriately occupying some of these beds, and changes needed to be made but there was not enough money to carry out these. Policy was being established, but, this was not able to be carried out in practice.

Locally the MOH, Dr Warrin echoed the CMO's sentiments and comments on compulsory admission and treatment of elderly people in Oxford, which he found inappropriate:

> This policy although unavoidable at the moment is most unsatisfactory and in many cases, is particularly harsh treatment in that as a result of the general overcrowding, senile patients have often to be treated alongside psychotics of all ages. New residential units for dealing with this problem of old age are urgently required, and could be provided either by local authorities or hospital boards. One advantage of provision by the local health authority would be the

[3] Annual Report of the Chief Medical Officer of the Ministry of Health for the Year 1950, p. 71.
[4] Annual Report of the Chief Medical Officer of the Ministry of Health for the Year 1950, p. 72.

> avoidance of certification which is a distasteful procedure in a person who is really only suffering from one of the effects of old age. [5]

Nearly all the 33 old persons in Oxford certified as insane in 1951 and admitted to a psychiatric hospital were suffering from senile dementia. Admission to a mental hospital was not considered an appropriate solution, but remaining in Part III (Old People's Homes) and wards for the aged sick, was not appropriate either. This situation needed to be addressed. Providing separate units by local authorities to accommodate senile dementia patients under either Section 28 of the NHS Act 1946 or Section 21 of the National Assistance Act, was suggested as a solution to this problem. These units would provide supervision and general care, but not skilled nursing, and hence relieve the critical nursing position in mental hospitals. Another suggestion was for special annexes to be attached to mental hospitals. The deputy MOH stated that the favoured option was a special home for older people suffering from these mental health problems.[6]

In 1952, the introductory letter from the Medical Officer of Health referred to the continuing problems of admission to hospital of the aged and confused and the need for a solution. There had been no progress in providing alternatives. Later in the report the point was made that old people admitted with senile dementia "do not die soon after admission but spend their last years treated as psychotics." Concern was expressed that this was an indefensible situation and needed addressing urgently. The idea of special accommodation was strongly recommended.[7]

In 1954 there was a slight decline in admissions of older people with senile dementia. The existence of the day hospital at CRH was seen to have removed the "burden of care from the family for periods during the week."[8] Although in 1955 there was an increase to 65 people admitted to hospital over 60 years of age there was a fall in the number of those certified.[9] In 1956 the number of admissions increased again but efforts were made to keep cases of senile mental deterioration at home and close liaison between

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[5] OxMOH, 1951, Introductory letter, p. 6.
[6] OxMOH, 1951, Section VII, Mental Health, report by JB Davies, deputy MOH, Old age and mental illness, pp. 90-91.
[7] OxMOH, 1952, Introductory letter p. 5, and Section VII, Mental Health, Old Age and Mental Illness, p. 102.
[8] OxMOH, 1954, Section VII, Mental Health, Old Age and Mental Illness, p. 105.
[9] OxMOH, 1955, Section VII, Mental Health, Old Age and Mental Illness, p. 105.

CRH, Littlemore and the welfare department helped to avoid unnecessary certification.[10]

In 1957 Dr Cosin invited mental health officers to CRH out-patient clinics as a step towards supervising certain senile patients in their own homes, rather than resorting to hospital admission. The MOH outlined the aims and the benefits of this approach and gave his approval:

> It is thought that extra support and advice given to these patients and looking after them (in addition to that often provided by the health visitor) might prevent or postpone complete breakdown. The beneficial effects seem to occur in the mental functions and attitudes of certain confused old people attending the CRH day hospital have been encouraging and also to be remembered is the mental and physical relief afforded to friends and relatives by having a senile dependant taken off their hands once or twice a week.[11]

By 1960 a trend in the admissions indicated a lower rate of patients being admitted to mental hospitals. This was attributed in part to the willingness of the CRH in accepting patients who were suffering from senility and confusion. The MOH acknowledged the importance of the liaison of the consultant staff: "The transfer of patients between this hospital and Littlemore Hospital, in either direction, is greatly facilitated by the close liaison of the consultant staff concerned."[12]

Since 1948 services had been developing in the community and the previous three chapters have outlined the history and background to them. Effectively these services were the beginnings of community care; alternatives were provided to avoid institutionalisation for vulnerable old people, including elderly mentally confused persons. As suggested earlier, initial plans for hostels and other residential accommodation for older people did not address the needs of elderly mentally confused people. The needs of this group of people were seen to be different and in 1960 the MOH report highlighted the problem that care was: "....directed towards only maintaining in hospital those patients actually needing treatment or the special care and services available there, has resulted in a number of old people being discharged to the care of relatives or friends or otherwise being helped to support themselves in the community." The other remaining patients would have been able to be admitted to Part III accommodation as long as the numbers of those "showing any obvious mental

[10] OxMOH, 1956, Section VII, Mental Health, Old Age and Mental Illness, p. 150.
[11] OxMOH, 1957, Section VII, Mental Health, Old Age and Mental Illness, p. 124.
[12] OxMOH, 1960, Section VII, Mental Health, Old Age and Mental Illness, p. 128.

abnormality" were limited.[13] This was a similar problem to that experienced in the small group homes described in Chapter Five. If residents in this sort of accommodation were suffering from mental health problems this would change the nature and characteristic of the homes. Admissions were to be carefully selected for each home and observed during a trial period, giving an opportunity to assess for underlying mental health illness.

Very few of my oral respondents had relatives who suffered from mental health problems, but this could be explained by a reluctance to volunteer such information, as there was, and still is, a stigma attached to mental illness. Additionally, there may have unwittingly been an acceptance and stereotyping of old people becoming senile and confused in the past. Of those whose relatives had mental health illness, two were admitted to Littlemore Hospital, [14] two to the Warneford,[15] and one to CRH.[16] Only one respondent recalled a grandparent's experience before 1948. The post-1948 accounts describe their parents' experiences, who demonstrated signs of dementia and anti-social behaviour. One gentleman was compulsorily admitted to Littlemore. Another gentleman who was quite ill with a mental health condition received ECT. According to his daughter he was wrongly diagnosed with mental illness. This she discovered when after his death, several years after his admission to hospital, she received his death certificate, which seemed to indicate that he suffered from a physical illness which affected his brain. No treatment for his physical condition was apparently available at the time.

What is pertinent about the experiences of these relatives is that they describe some rather traumatic events and that there was no support for them. Their recollections correspond with the MOH reports and illustrate that there were no alternatives other than hospitalisation for older people with mental health problems. Indeed, none of the respondents' parents had a psychiatric social worker, who would have been able to carry out home assessments, and liaise between home and hospital. One of the respondents recalled how difficult it was caring for her mother-in-law, indicating that if there had been a domiciliary assessment, help in the home may have been more

[13] OxMOH, 1960 Section VII, Mental Health, Old Age and Mental Illness, p. 128.
[14] Miss BH OX39, 13/10/99, pp. 8-9, and Mrs LW OX33, 17/5/99, p. 9.
[15] Mrs RB OX38, 23/7/99, p. 1, and 4, and Mrs RS OX43, 30/11/99, pp. 6-7.
[16] Mr RH OX30, 23/2/200, p.7.

appropriate than hospitalisation at that stage.[17] Another notable aspect regarding these experiences is that within this relatively small group of old people with mental illness, they were sent to three different hospitals. Having at least three consultants in different institutions dealing with older people's mental health problems must have caused inconsistencies in treatment, especially at a time when the medical profession were themselves developing strategies for this condition. Chapter Four identified some of the innovatory treatment plans by doctors, but also highlighted difficulties faced by the medical profession on a national basis. Dr Cosin did have a special interest in mental health and his expertise inevitably benefited patients that came under his care. However, not all patients were sent to CRH and there were probably professional differences amongst the medical profession (similar to those described in Chapter Four) which did not help the situation.

Locally the recognition of the specific needs of older people with mental health problems gained momentum after 1948. This is probably because of administration changes and criteria for admission in residential provision. CRH was effectively for old people who were physically ill, other accommodation such as Part III catered for the more independent elderly people. One of the most notable developments was a humane policy in addressing the very complicated needs of this vulnerable group of people because compulsory long term admission to a psychiatric hospital was not appropriate. Creative ideas were proposed but the finance was not forthcoming to support the proposals. These innovations possibly arrived at a time when the welfare state began to feel the financial penalties of a free service and budgets had to be curtailed. The three different institutions and professionals working with older people with psychiatric illness probably all had their own identities and perhaps also their rivalries.[18] It appears that the issues regarding older people's mental health were kept in the medical domain and there were limited multi-professional links. According to evidence from the oral histories[19] this was similar to the national picture.

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[17] Mrs RS OX43, 30/11/99, pp. 6-7.

[18] See Davies, 'Narratives Beyond the Walls: Patients' Experiences of Mental Health and Illness in Oxfordshire since 1948', Oxford Brookes University, 2002, unpublished thesis, pp 3-5. The writer contextualises the two local psychiatric hospitals, the Warneford and Littlemore since 1948 and describes the complex professional changes instituted. As the CRH also admitted patients with mental health problems this establishment must be included too.

[19] Jeffreys, 'Geriatrics'.

After 1948 one of the common features between mental health illness experiences and physical illness experiences amongst older people was their occupation of hospital beds. Many doctors considered that these hospitalisations were inappropriate, but overall, beds were being blocked, and this caused general concern in medicine and in the psychiatric services. Local MOH reports imply that attempts were made to release beds in the hospitals by encouraging GPs to use community resources, such as the district nursing service in order to relieve pressure. It is unclear whether or not this was taken up by the GPs. Apart from reference to Dr Cosin's initiatives between psychiatrists, the CRH, and the welfare department, co-ordination between the MOH and other practitioners in this respect was ill-defined.

Links between hospital and home

One of the earliest links between hospital and home was made by the hospital almoner, whose main task was to collect money from patients as a contribution towards their care in hospital. Traditionally almoners were women, and referred to as the 'lady almoner'. The Royal Free Hospital in London appointed one of the first almoners in 1895, and her salary was paid by the Charity Organisation Society (COS). By 1903 seven London Hospitals employed almoners and their salaries were also initially paid by the COS. From 1911 the almoners had to obtain a certificate in sociology from the London School of Economics and do 'practical work' with the COS. At first there was no specific 'referral process' and this caused quite a lot of controversy. Patients who had joined special schemes considered that this paid for their hospital treatment, therefore did not need to be "interrogated" by the almoner. Consequently, complaints were made by patients, which raised further issues about financial arrangements concerning specialists and GPs, so that the referral system had to be reviewed.[20] Notwithstanding this, the job of the almoner was to investigate the financial circumstances of patients to assess contributions towards their care.

Locally, a lady almoner was appointed to the Radcliffe Infirmary in 1910. She described her work in the Annual Report as to:

> ...investigate and test each case as to its suitability for hospital treatment, and thereby to co-ordinate private medical attendance upon the wage earners outside, and the medical and surgical attendance for them in the hospital, in

[20] Abel-Smith, Hospitals, pp. 174-176. The author suggests that before 1895 officers had carried out similar tasks. See also, E Moberley Bell, who provides a history of the Almoners in The Story of Hospital Almoners, The Birth of a Profession (London: Faber and Faber, 1961).

> order to reduce the abuses of the voluntary system of hospital practice to a minimum. [21]

She clearly spells out her role in keeping costs down for the hospital, and her job as to follow up patients who were potentially financially unreliable. Details of the work of the almoner during the earlier years of the twentieth century are documented in the Radcliffe Infirmary Annual Reports. Generally, it seems that most of the work was directed to younger people. This comprised of visits made to families, and letters written on behalf of patients to charities (including the COS) and other professionals. Acknowledgement of poverty was made by the almoner and she was enthusiastic about the development of social work. Her work brought her into contact with other agencies but there is no reference to any liaison role.[22] In 1942, the Oxford City Council Establishment Committee agreed to the recommendation from the public assistance committee and made a decision to appoint an Almoner to CRH, but this never happened.

Later, professionals recollected the work of local almoners. Mrs VE, a nursing sister, recalls the almoner seeing every new patient that came into the out patients department; she is of the opinion that the almoner: "Looked into their background and if it was alright then they didn't seem to be in there pretty long but of course there were some patients that needed more attention than that and [I] presume they looked into their home conditions..." [23] Dr DL was of the opinion that the lady almoner would assess patients who could pay for treatment in hospital: "When people went into the RI if they were uninsured they had to pay. What happened in practice was that people called the Lady Almoners came round and assessed which the patients what they could afford to pay ..."[24] Mrs MA recalls the Lady Almoner but she had no contact with her: "They came to see patients to see how they could help in any way but it was usually private wasn't it? It was private you know between the social worker and the ....I mean we didn't know all that went on between the social worker." In her opinion the almoner would try to arrange things for patients before they went home.[25] These recollections indicate that there were assumptions made on the role of the almoner, probably based on experiences and professional discourse.

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[21] Report of the Committee of Management to Governors, Almoners Report, Radcliffe Infirmary Annual Report, 31 December 1910, p. 11.
[22] Report of the Committee of Management to Governors, Almoners Reports, 1910-1921.
[23] Mrs VE OX51, 14/02/2000, p.3.
[24] Dr DL OX48, 18/01/200, p. 2.
[25] Mrs MA OX1, 15/07/98, p. 7.

Transfer to the NHS brought about changes to the role of the almoners. Mary Kennedy started work as an almoner at the Nuffield Orthopaedic Centre in 1941 and sums up the change, "I regard those as the bad old days and 1948 was a revolution for me and the patients. It was an enormous relief not to have to handle money."[26] Obviously the focus of work on collecting money from patients stopped once the NHS was established. Miss JA was an almoner at CRH during the early 1950s and worked with old people and their families to improve the quality of life for them.[27] There was now a different role for almoners, who eventually became known as medical social workers. Miss JA suggests that working with the families was an important part of her work, but as Younghusband stated, social work for old people developed slowly and their specific needs were unidentified for some time.[28] Perhaps working in a specific unit for old people like CRH gave a different focus for social work especially working alongside Dr Cosin. As the clinical director he was able to direct the work, and his philosophies in maintaining old people at home would have been paramount.

Previous chapters have discussed the importance of the family in the central caring role for old people. The underpinning professional theory that developed during the 1940s was that as far as possible old people were better off in their homes and to a certain extent this depended on support systems available particularly in the family. This next section examines local kinship clusters and their influence.

Kinship clusters

Three significant national surveys investigating the lives and social conditions of older people were undertaken between 1947 and 1957. These surveys identified living conditions for older people in various areas of Great Britain. In his national survey in 1947 Seebohm Rowntree found that quite a high proportion of pensioners lived with others.[29]

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[26] M. Kennedy, Public Health in Oxfordshire: The Past (Oxfordshire Health Authority, 1998), p. 39.
[27] Letter from Miss JA describing her work as an almoner with old people at CRH, and excerpt in the Oxford Times circa 1956.
[28] Younghusband, Social Work, p. 25
[29] Seebohm Rowntree, Old People, p. 22.

Table 7.5: Percentage of persons of pensionable age living with their children or lodgers, or living as guests of their children

Area	%
London Boroughs of Wandsworth and St Pancreas	46
York	62
Wolverhampton	60
Oldham	53
Mid-Rhondda	75

Source: Seebohm Rowntree.[30]

Another survey carried out about the same time by Sheldon in Wolverhampton found that: 4 per cent of older people had children living next door; 6 per cent had children living not more than three houses away; 10 per cent had relations in the same street; and 20 per cent had relations within half a mile; in total 80 per cent of older people had "relatives living near."[31]

Later in the early 1950s Peter Townsend conducted a survey of 203 old people in Bethnal Green. He discovered that amongst this group: 25 per cent lived alone, 29 per cent lived in married pairs, 38 per cent lived with married or unmarried children, and 8 per cent lived with other others. Townsend compared his findings to national findings from the census in 1951 which concluded that, 12.5 per cent of people aged 60 and over lived alone, 28-29 per cent lived in married pairs, 58 per cent were living with people other than a husband or wife (nearly all with relatives), and 40 per cent of people were living with children, unmarried, married or both unmarried and married.[32] The information from these surveys indicated that there were important regional variations in the living circumstances of old people.

As well as Rowntree, Sheldon and Townsend, there have been other studies carried out on old people during the time covered by this thesis. Two such examples are those done in Sheffield and Liverpool. Hobson's survey in Sheffield addressed medical, social and nutritional needs of older people and is discussed in Chapter Eight.[33] The Liverpool survey had four main objectives: first, to discover whether elderly people were isolated from friends and relatives, or whose social contacts were so tenuous that remaining alone placed them in danger of being uncared for if they got ill; secondly, to find out if there were old people not taking up services provided by statutory or

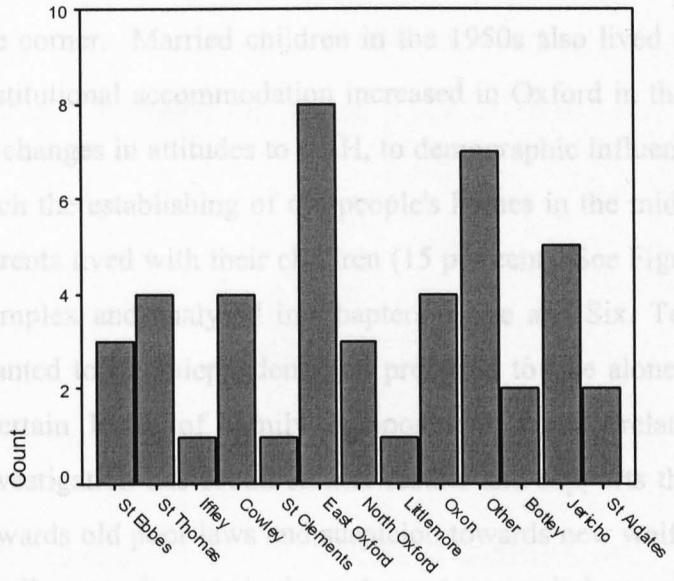
[30] Seebohm Rowntree, Old People, p. 36.
[31] J Sheldon, 'Aspects of Old Age' Lancet, I (1948), pp. 621-4.
[32] Townsend, Family Life, pp. 21-22.
[33] W. Hobson, The Health of the Elderly at Home: A Medical, Social and Dietary Study of Elderly People Living at Home in Sheffield, (London:, 1955).

voluntary agencies, and the reasons for this; thirdly, to assess how these difficulties could be overcome in order to enable older people to become more integrated into community life; and fourthly, to establish whether additional services, from either the voluntary or statutory sector were still needed and if so, how these should be developed. The survey found that the majority of the respondents were not isolated as 82 per cent were living with relatives, including spouses, but this did not always mean that they were not lonely or unhappy. Recommendations were made to improve services to help combat the loneliness of old people in the community. Amongst the recommendations was the need for increased domestic help, a need to address problems with coal deliveries, a call for voluntary workers to ensure old people were registered with a GP, the need to review housing exchanges for elderly residents and to improve general leisure facilities and the visiting service.[34]

Information gathered from oral respondents in Oxford has been used to provide a profile of kinship clustering. Whilst direct comparisons cannot be made as the information was not collected as part of a survey, and is not intended to be statistically robust, it does give a snapshot of kinship patterns.

[34] Liverpool Personal Service Society, Social Contacts in Old Age; Report of a Survey Undertaken, (Liverpool: Liverpool University Press, 1953).

Figure 7.2: Respondents' childhood home[35]



Source: oral histories.

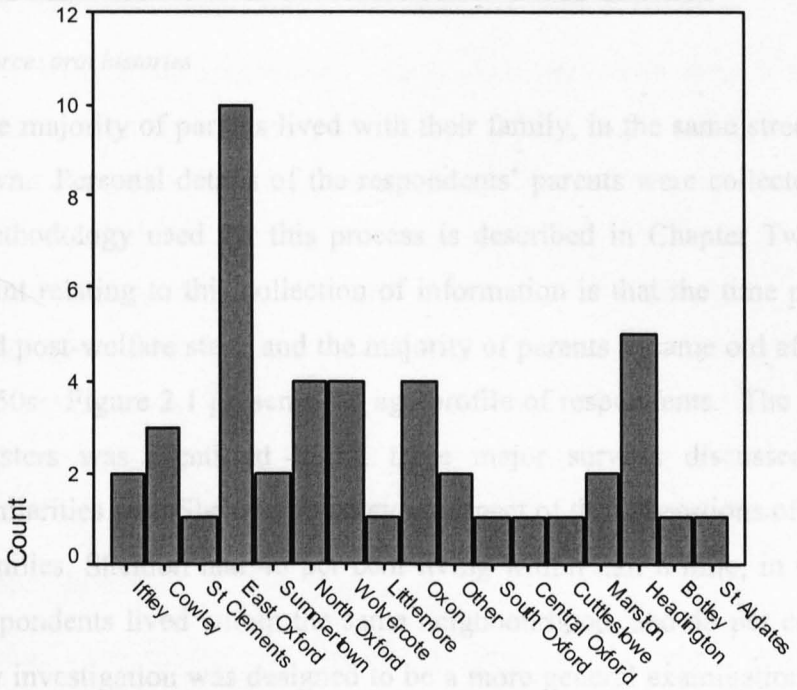
Figure 3.2 shows where respondent's grandparents lived in relation to their families from the early 1900s onwards. As can be seen, the majority of grandparents (79 per cent) lived in the same town. Within this group 45 per cent lived either in the same street or same neighbourhood, and a further 3 per cent lived in the same town thereby suggesting that families continued to live near each other. This would inevitably make caring for older relatives easier. It also suggests that if other families followed similar patterns, communities would have become quite established with several generations of families within it. Migration patterns were not examined, but, during the period under review, major slum clearances were concentrated in St Aldates and St Ebbes from the 1930s and later (after the war) in Jericho. Inevitably these housing projects would have disrupted some of these communities, but for the rest of the city there was some degree of stability.

The data relating to grandparents in Oxford (pre-1948) indicates that the majority of grandparents lived near their children, and that a high proportion lived with family

[35] Figure 1.1, the map of Oxford identifies the wards in Oxford City at the time of the census in 1951. Sub-districts are not included in this map; boundaries and wards have been extended and added over the years in the city. St Ebbes, St Thomas, St Clements, St Aldates, Jericho and East Oxford (this describes a particular district of the city) would be considered as working-class areas. Iffley, Botley and Littlemore were more rural areas. North Oxford (this describes a particular district of the city) was a middle/upper class area. Even within deprived areas such as St Ebbes and affluent areas such as North Oxford there were diverse family circumstances

members. Similar characteristics to Sheldon's survey can be found, for example, two generations of families lived in the same street in some cases next door or just round the corner. Married children in the 1950s also lived near their parents. Demand for institutional accommodation increased in Oxford in the 1950s.[36] This could be related to changes in attitudes to CRH, to demographic influences, or to the increased facilities such the establishing of old people's homes in the mid to late 1950s. A proportion of parents lived with their children (15 per cent). See Figure 7.3. The reasons for this are complex and analysed in Chapters Three and Six. Townsend asserts that old people wanted to be independent, and preferred to live alone after the death of a spouse but "certain kinds of family compositions favour relatives living together."[37] My investigation has found similar results and supports this assertion. Historical attitudes towards old poor laws and suspicion towards new welfare systems seemed to influence family commitments in the early post war period.

Figure 7.3: Respondents' adult home

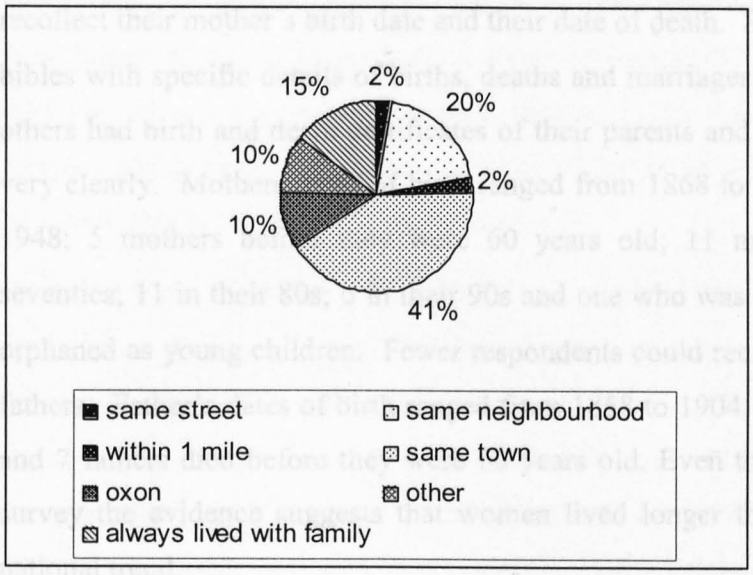


Source: oral histories.

[36] Oxford City Council Minutes and Reports from 1948 constantly monitored the demand for residential accommodation and update on the progress of new developments.
[37] Townsend, Family Life, p. 28.

The above table shows where oral respondents mainly lived as adults during the 1940s and 1950s. Respondents were relatively evenly distributed throughout the city, but there was a higher concentration in the eastern areas.

Figure 7.4: Where respondents' parents lived



Source: oral histories.

The majority of parents lived with their family, in the same street, area or in the same town. Personal details of the respondents' parents were collected from oral histories. Methodology used for this process is described in Chapter Two, but the significant point relating to this collection of information is that the time period spans both pre- and post-welfare state, and the majority of parents became old after 1948, that is in the 1950s. Figure 2.1 presents the age profile of respondents. The importance of kinship clusters was identified in all three major surveys discussed above. There are similarities with Sheldon's survey in respect of the proportions of those living near their families. Sheldon had 40 per cent living within half a mile; in Oxford 45 per cent of respondents lived within the same neighbourhood, and 48 per cent within a mile. As my investigation was designed to be a more general examination of old people's lives, identical criteria and survey methods were not applied when interviewing respondents. However, comparisons have been made and there are parallels with the national picture. What has emerged from the analysis of data is the overlap between pre- and post-welfare state, the cut off time is not simply defined. Patterns of caring did not change significantly. Parents may have presented with problems of ageing in the later years of

the poor law, but statutory help was not available until after 1948. Families may not have been aware of the availability of services in the early years of the welfare state.

Within the group of respondents many had experiences and powerful memories of older relatives living within their community. Altogether 45 respondents were able to recollect their mother's birth date and their date of death. Some respondents had family bibles with specific details of births, deaths and marriages entered on the initial pages; others had birth and death certificates of their parents and some remembered the dates very clearly. Mothers dates of birth ranged from 1868 to 1906, 9 mothers died before 1948; 5 mothers before they were 60 years old; 11 mothers in their mid to late seventies; 11 in their 80s; 6 in their 90s and one who was 101. Two respondents were orphaned as young children. Fewer respondents could recall similar details about their fathers. Father's dates of birth ranged from 1858 to 1904, 13 fathers died before 1948, and 7 fathers died before they were 60 years old. Even though this is not a statistical survey the evidence suggests that women lived longer than the men, supporting the national trend.

Over half of the respondents helped their parents in their home, and this help was usually given by all family members. Of the total number of respondents 21 had a parent or parents (including one mother in law) to live with them. Most parents went to live with their children after the age of 70 years. Fourteen parents were admitted to institutional accommodation and this was in the following establishments, general hospital, psychiatric hospital, old people's homes, private nursing home and CRH. As this profile covers pre-and-post welfare state there were different reasons and variables influencing why parents went to live with their children and why they were admitted to institutions, the reasons for this are referred to in Chapters Three and Six.

Conclusion

Oxford was neither unusual or untypical in its demographic and health profile. Comparisons on a range of demographic and epidemiological profiles for those aged 65 years and over during the period under review, indicated that Oxford was generally in line with national averages. Oxford's age profile for the over 65 year olds was broadly similar to the national average. In addition the gender mix had the same pattern for this age group. Health statistics and epidemiological information revealed the city's profile was comparable to national trends.

Oxford City was probably relatively advanced in its provision for old people. Evidence for this can be seen in relation to medical innovations such as the day hospital and floating beds introduced by Dr Cosin (discussed in Chapter Five). Undoubtedly his management and practice in the CRH had a knock on effect for old people in the community. Day care and relief care for patients gave support to relatives and would have improved access to medical care for old people. As discussed in earlier chapters GPs carried out a gate-keeping role; they were the main link between community services and old people and their families. This group of professionals were aware of how to access health and welfare resources.

Evidence from relatives of old people who suffered from mental health problems in Oxford has given an insight into how limited resources affected families. Although progress in mental health developments for old people was slow, the MOH does indicate his concern on this and attempts to address alternative solutions to inappropriate hospitalisation. But a lack of national direction contributed to the lack of a coordinated policy on care for old people with mental health problems. Exactly how people accessed these few available services is unclear, there seemed to be no established procedure.

The national surveys carried out in the 1940s and 1950s identified similarities in kinship cluster patterns between Oxford and other towns, in particular with Wolverhampton. The local profile of kinship patterns, albeit of a small group of people, gives insight into how family life was for some.

Having established a demographic profile and an overview of the broader health issues facing the older population, the second part of the case study will examine administrative and practical changes for old people in the city.

CHAPTER EIGHT

A Case Study of Oxford City, Part 2

There are three aims to this part of the case study; the first is to map the changes made by Oxford City Council in response to legislation, government guidelines and local need in relation to old people. Secondly, services provided will be measured against oral respondents' perceptions of provision. The third aim is to investigate Oxford within a national context in order to establish similarities and differences. Mapping the administrative changes will be achieved by using material from local and national Medical Officer of Health reports and Oxford City Council reports. The evaluation of provision for old people will also use these reports in conjunction with the oral sources to assess any discrepancies. This will provide a more intricate study, expanding on some of the welfare issues concerning old people on a local level specific to Oxford.

Institutional provision for old people and the changes made by the Local Government Act 1929

The city council had a complex structure including university representation and an aldermanic system. Effectively this meant that out of the 68 members of the council, only 42 were elected; the council did not necessarily reflect the voting patterns of Oxford's constituents. Analysis of the political implications of this is discussed by Waller who suggests that the council's structure influenced some aspects of social development in the city, particularly in terms of town planning.[1]

Oxford City's MOH's annual report in 1930 reviewed the Local Government Act 1929 in relation to the previous legislation and the local implications of the new system. He considered that the Act was designed to remedy defects in the existing local government legal framework, these being:

(1) The inconsistency of Poor Law and Local Government systems
(2) The inequitable distribution of the burden of road charges
(3) Insufficient power to review and modify areas of Local Government
(4) Defects in the existing rating machinery
(5) Impairment of local independence caused by percentage grant system.

[1] See R. Waller, 'Oxford Politics 1945-1990', in R. Whiting, (ed), Oxford, Studies in the History of a University Town since 1800, (Manchester: Manchester University Press, 1993), pp. 167-189. The author gives a detailed historical description of the composition of Oxford City Council.

Furthermore, the MOH stated that there was (general) criticism that the Poor Law system had not incorporated local government into the system, and there was, in some circumstances, a duplication of services. This particularly applied to those with physical and mental conditions, who were then considered destitute, a group which would have included old people. The MOH summed up the significant changes of the Act as such:

(1) Local Authorities are made responsible for vaccination and infant life protection
(2) They are made responsible for the collection of the fundamental vital statistics
(3) They are made responsible, severally or jointly, for the provision, maintenance, and management of all public institutions for the cure or mitigation of physical or mental disease.[2]

The major change arising out of this legislation regarding old people's welfare was the transfer of the administration of former workhouses to public assistance committees. In Oxford there were complications with the transfer from the poor law, due to the fact that there were two boards of guardians, one for the Headington Union and the other for the Oxford Incorporation. These two organisations oversaw the city workhouse (this became CRH) and the London Road Institution (which became the London Road Hospital and later the Laurels). Headington Union and a large part of Headington area was outside the city boundaries (even after the extension of the city in 1929). However, agreement was made with the county council that the London Road institution and staff be transferred to the city council. Oxford City Council considered either handing both institutions over to the public health committee (known as declaration), or defining one hospital as being a "public health committee" hospital and have the other one administered under the poor law (known as appropriation). In the end the decision was made that the public assistance committee: "....would make some agreement with the Public Health Committee that the latter would take all the sick poor in need of medical treatment and skilled nursing and that these cases would have first call on the Hospital services."[3] The Cowley Road institution came under the jurisdiction of the public assistance committee and the infirmary within was to be used for people who were not in need of constant medical treatment, but who "require only kindly supervision, general care and the more homely atmosphere that they would obtain in an institution of this sort." If a resident suffered from an acute illness then they would be transferred to the City General Hospital. Able-bodied, aged people and those unable to provide economically for

[2] OxMOH 1930, Section I, General provision of health services in the area, p. 11.
[3] See OxMOH 1930, Section I, General provision of health services in the area, pp. 11-16.

themselves were to be accommodated in the "House" portion. The MOH concluded that: "...The Cowley Road Institution would be the City Almshouse, and the public assistance committee would have the right to send their inmates who required constant medical care to the City General Hospital." This enabled admission to the City General Hospital (RI) to be on medical grounds alone and application did not have to go through the poor law staff. But if the RI ever became full, there was the possibility to appeal to the public assistance committee for extra accommodation at the Cowley Road. Plans were being made to enlarge the London Road Hospital when funds became available "so that there would be no likelihood of an appeal to the public assistance committee, and this would be the appropriate time to make a declaration that all medical treatment should be given under the Public Health Acts, and not under the Poor Law." [4] Efforts were made by the city council to ensure that the administration of health care in their institutions was kept under one umbrella. Oxford City thus had two public assistance institutions, one in Headington and one in East Oxford (CRH). It seems that the London Road Hospital served Headington and the surrounding areas and CRH served the rest of the city. Maintenance costs of the inmates at these institutions were met by Oxford City Council. Inspections were made at the institutions and reported to the public assistance committee meetings of the council. Oxford City Council had three committees where issues relating to old people's welfare would usually be addressed, the public assistance, public health and the old age pensions committees.

An interesting aspect of the MOH's 1930 report was his suggestion that the CRH could be used as an overspill for the Radcliffe Infirmary (RI). Distinguishing which patients should be sent to the CRH would have been an exercise that raised many conundrums for the governors of the RI and the city council. Records do not reveal whether this arrangement had to be put into practice, or if it was, what criteria were adopted for referring a patient for transfer. As the RI was an acute hospital, which accepted patients for treatment under prescribed conditions, if there were any transfers then these would have involved chronically sick people that would have been transferred to the CRH.

Private and voluntary provision was also important. Old people with financial resources, who were infirm, or unable to continue living alone had the choice of living in a private or nursing home. These were homes that were run for profit and not necessarily registered, which meant it was difficult to calculate exactly how many old people were

[4] OxMOH 1930, Section I, General provision of health services in the area, p. 16.

accommodated in these establishments. There were several nursing homes in Oxford.[5] In many cases the homes took other patients as well as old people so specialist care was not necessarily provided.

In addition in Oxford there were several voluntary homes including St Basil's Home in Iffley Road and St John's Home in St Mary's Road. St John's Home was founded in 1873 for people with lingering sickness or other curable diseases, and was later taken over by the Anglican Society of All Saints Sisters of the Poor. The sisters lived in one half of the house, and 40 elderly residents were housed in the remaining half. Admission to St John's was probably dependent on religious connections. One oral respondent's grandfather was admitted to St John's Home; he had previously been employed in a local religious establishment.[6] Nazareth House in Cowley Road (on the same street as the CRH) was originally a large private house, Charnwood Lodge. It was purchased by the Congregation of the Poor Sisters of Nazarath (a Catholic order) in 1875 to provide care for children and elderly people.[7] Only one of the respondents had experience of Nazareth House.[8] Voluntary homes did not seem to have been used by respondents possibly because of the need for religious connections for admission and restricted places. A minority of respondents had elderly relatives who were admitted to private nursing homes.

Almshouses were available in Oxford and the most prominent during this time was Dr Stone's Almshouses situated in St Clements. These almshouses were founded in 1700 by the Reverend William Stone. The following inscription is still on the front of the building, "This Hospital for ye Poor & Sick was founded by The Reverend Will Stone Principal of New Inne Hall In Hopes of thy Assistance AD 1700." Legacies from benefactors financed the almshouses. In 1835 the eight women who resided there were each given 20 pounds a year (paid quarterly), an additional 10 shillings (from a benefactor Richard Curtis) and were provided with coal for their fires. Administration of the almshouses during the early part of the twentieth century cannot be clarified, but by

[5] Oxford Kelly's Directory 1932. This directory lists establishments such as these amongst other useful business information.
[6] Mr HB OX27, 14/4/98.
[7] See S. Shatford and T. Williams, The Changing Faces of St Clements and East Oxford, Book Two (Witney: Robert Boyd, 1998), p.29.
[8] Mr BJ OX14, 24/4/98; his grandmother was admitted to Nazarath House for a short period of time before 1948.

the 1950s, the residence was run by the Trustees of the City of Oxford. [9] None of my oral respondents had either professional or personal experience of the almshouses.

Thus Oxford City Council was the major agency responsible for welfare from 1930 to 1948, and was most affected by any changes imposed by the 1929 Local Government Act. According to the city council records, little change was effected for old people during this time. This fits in with previous assertions that old people were not a priority during this time; precedence was given to maternal and child welfare and fighting diseases such as tuberculosis. The Oxford workhouses were renamed as hospitals and admitted mostly chronically sick patients, many of these being elderly people. Acute illness was treated at the RI, and GP services were available if they could be afforded. Evidence from residents documented in Chapter Three suggests that little change in services for old people was apparent locally after the introduction of the 1929 Local Government Act. Despite the remarks of the local MOH in 1930, major changes affecting welfare services for old people were not implemented.

The inception of the welfare state and afterwards

The key Acts of Parliament affecting old people after the inception of the welfare state were the National Assistance Act 1946, National Health Service Act 1946 and the National Insurance Act 1946. Each act had a different focus but they were effectively interdependent. For local authorities the main administrative concern was the National Assistance Act.

On 5 July 1948, when the National Assistance Act came into effect, the local health authority's functions under the Act became the responsibility of the city council's health committee. A welfare services sub-committee was established to undertake duties on their behalf. Initially, the sub-committee was constituted solely of members of the local authority, but plans were made to co-opt members who had specialist knowledge in the area.[10] The MOH had responsibility for the general administration of the local health authority. A welfare services section was established within the health department and a chief welfare services officer was appointed along with a part time assistant welfare

[9] MNE Tiffany, The History of the Rev. Mr William Stone and His Hospital, Together With That of Other Almshouses in Oxford (privately published by Tiffany Arts Oxford, for the City of Oxford Charities, 2000), p. 39 and 46. This booklet provides a history of Stone's Court and details the financial arrangements and management of the almshouses. Also included is a history of other almshouses in the city.

[10] OxMOH 1950, Section VIII Welfare Services, p. 90. The chief welfare officer reports that there are 11 members on the welfare services sub-committee.

officer and support staff.[11] Section 21 of the National Assistance Act deemed that the local authority should provide:

> (a) Residential accommodation for persons who by reason of age, infirmity or any other circumstances are in need of care and attention which is not otherwise available to them;
>
> (b) Temporary accommodation for persons who are in urgent need thereof, being need arising in circumstances which could not reasonable have been foreseen or in such other circumstances as the authority may in any particular case determine

New administrative arrangements for residential provision for old people were now effective in the city. Following national legislation, different committees had been established, but no specific committees were introduced for the welfare of old people. Having a special committee for old people could have led to more local coordination and uniformity with regard to welfare provision. There were two major areas of need for old people that the local authority had to address, residential provision and support in the community. Establishing the need for residential accommodation was based on empirical evidence of numbers of old people, but assessing the need for community support services, and the implications of the lack of provision was more complex. Local people were probably suspicious, reluctant to ask for help and unaware of what was available. Inherited attitudes towards state help on various levels may have been difficult to redress, and promoting new services posed a problem, in as much as communication was less sophisticated than today. Many of the services were relatively new and monitoring processes were basic; consequently there are some unanswered questions. The next section charts the developments of residential and community services from both documentary and residents' perspectives and identifies disparities between them.

Residential provision in Oxford for old people, 1948-1960

CRH was transferred to the jurisdiction of the NHS in 1948 and the London Road Hospital, renamed the Laurels, and managed by the city council welfare services sub-committee in a special house section.[12] The Laurels admitted old people who were vulnerable but did not need hospitalisation. At this time the Laurels was the only local authority residential provision for old people, but by 1950 the city council started to plan to increase this kind of accommodation as it was insufficient. The CWO remarks that the

[11] OxMOH 1948, Section VIII Welfare Services, p. 86.
[12] OxMOH 1950, Section VIII Welfare Services, p. 90.

Laurels staff were subjected to "considerable stress" in 1950, as they were coping with larger numbers than the home was intended for.[13]

Table 8.1: Distribution of inmates in voluntary homes in Oxford in 1949

Home	Males	Females	Total
St Basils, Iffley Road	0	26	26
St John's, St Mary's Road	0	60	60
Nazareth House, Cowley Road	9	22	31
Council of Social Services Home, Banbury Road	0	17	17
Elizabeth Nuffield Home, Banbury Road	0	24	24
British Red Cross Society's Home, Banbury Road	-	-	20

Source: Oxford City Council Reports.[14]

Table 8.1 shows the distribution of residents in voluntary homes and, where known, the gender breakdown. Women occupied more places than men, but no age categories were available. Explanations for the higher proportion of women than men could be related to a variety of factors ranging from the selection of residents by the home's managers, criteria for admission, more women being referred to the homes, or that women lived longer. Only one home (Oxford Council for Social Services) had accommodation for married couples in 1948, and there were twenty such residents.[15] By 1952 three small homes had been registered, each accommodated five residents.[16] The NCCOP initiative in 1950, Hurdis House, increased provision for frail and ambulant old persons.[17]

Nationally on 1 May 1946, 62,957 aged people, or 1.16 per cent of the total population of pensionable age, were living in public assistance institutions or in homes run by local government bodies.[18] In 1948 the CWO wrote in his Oxford report that:

> Additional Part III accommodation for approximately 100 persons is much needed. Every endeavour has been made to obtain suitable properties in or near the city for conversion into homes for the aged and infirm, but so far it has been impossible to purchase any property at a price satisfactory to the district Valuer.[19]

At this time, there were 272 residential beds in the city for old people, and the demand for the places in the homes was exceeding the supply. Frilford House, a converted old house in the country was purchased by the council in the early 1950s, to accommodate old people but it was not a successful venture. It was too far out into the country,

[13] OxMOH 1950, Section VIII Welfare Services, p. 91.
[14] City of Oxford Council Reports 1949, Health Committee, p. 106.
[15] OxMOH 1948, Section VIII Welfare Services, p. 87.
[16] OxMOH 1952, Section VIII Welfare Services, p. 108.
[17] OxMOH 1950, Section VIII Welfare Services, p. 91.
[18] Seebohm Rowntree, Old People, p. 55.
[19] OxMOH 1949, Section VIII Welfare Services, p. 84.

isolated residents and their families from each other, staffing was a problem and the building was not suitable for infirm old people. This situation of inadequate provision in Oxford mirrored the national picture. Townsend was of the opinion that, although the provision of accommodation for old people increased after 1948, given the rising population of old people and compared with the developments in education, health and housing, the history of institutional provisions was not impressive.[20] Table 8.2 illustrates the limited national provision of new buildings for old people's accommodation from 1948 to 1960. Local authorities had to rely on converting old institutions for residents. If old workhouse buildings were used to accommodate old people, then undoubtedly this would have reinforced the belief by some people that OPHs were just renamed workhouses, and explained old people's reluctance to be admitted to them. For residents who remained in these institutions before and after the transfer to the welfare state, little change may have noticed by them. Parallels can be made with the CRH when it changed to a hospital. Inherent attitudes towards the former workhouse influenced residents' perception of the CRH after the management had been transferred to the NHS.

Table 8.2: Homes opened for old and handicapped persons in England and Wales 1948-60

Year	No of homes opened	Of which newly built
1948	97	0
1949	103	0
1950	138	1
1951	112	5
1952	130	5
1953	119	17
1954	99	15
1955	57	13
1956	73	22
1957	72	29
1958	53	26
1959	55	27
1960	76	47
Total	1184	207

Source: Townsend[21]

The above table shows that there were more homes for old (and including handicapped) people opened from 1948 to 1954. There was an increase in the proportion of newly

[20] Townsend, Last Refuge, pp. 37-39 Townsend refers to Government reports and Circulars between 1953 - 1960 identifying the problems of acquisition of suitable property and the problems of residential homes converted in inappropriate areas; this led to several re-thinkings of the design of OPHs.
[21] Townsend, Last Refuge, p. 37. It must be noted that the homes were not exclusively for old people.

built homes after 1954, rising to 54 per cent between 1958 to 1960. Nevertheless, in total, only 17 per cent were newly built establishments.

Table 8.3: Number of places in Oxford City Old People's Homes 1949-1960

	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960
Laurels	116	140	140	143	133	130	124	125	118	117	70	30
Frilford House				26	26	27	27	27	26	27	26	26
Barton End					26	26	26	40	40	40	40	40
Townsend House											60	60
Shotover View											60	60
Marston Court												60
Total	116	140	140	169	185	183	177	192	176	184	256	276

Source: Oxford City MOH Annual Reports.

(The Laurels was a former PAC institution; Frilford House and Barton End were converted homes; Townsend House, Shotover View and Marston Court were newly built homes)

In a national survey, Townsend refers to areas where there were a "relatively large number of old persons in new and converted Homes [*Oxford is one the nineteen areas mentioned]*... These tend to house a relatively small proportion of people in former public assistance institutions and a relatively large proportion in new purpose-built premises." Evidence from Table 8.3 illustrates how the council was running down admissions to the Laurels (the former public assistance institution) and using the newly established homes. However, until 1959 there were only three OPHs. One of these was a former public assistance institution, and the other two were converted old houses with inadequate ground floor facilities. It was not until 1959/1960 that three new purpose buildings were built and were up and running in the city. These were Townsend House, Shotover View and Marston Court. Townsend praises 13 areas for their initiatives in residential provision and Oxford is included in this.[22] Between 1959 and 1960, the city had built 4 per cent of all the new homes in England and Wales, indicating that they were in advance of much of the country. Indeed Oxford had plans for several more OPHs in the city, which were built in the 1960s. The long term plan was to close the former Headington workhouse, once all the new premises were up and running.

Very few of the oral respondents had experience of the OPHs during the period under review. There was awareness of the existence of OPHs, but this was more than likely

[22] Townsend, Last Refuge, p. 49.

due to the fact that they had been established for nearly five decades at the time of the interviews. The relatives of the respondents interviewed mostly expressed attitudes that their families wanted to provide care for their old folk outside institutions.

There was an obvious need for increased residential provision illustrated by the MOH's regular reports. In 1959 reference was made to the increasing ageing population, in particular to the rising number of people over 85 years (See Table 7.1). The CWO applauded the city council's anticipation of this problem and thought that the OPHs helped to provide a solution. A further suggestion was made that the authority should develop special homes for the very infirm. There was still a shortage in provision of accommodation, and only the most needy cases were admitted. The average age of residents in the homes was over 83 years (and considered to be rising).[23] However, the homes did accommodate a small percentage of residents who were "severely handicapped persons between the ages of fifty and sixty five years." One or two residents admitted to the new homes, who were more or less bedridden, became more ambulant as a result of the design of the home, indicating that there was some therapeutic value in the homes. Comments were also made on the improved personal appearance of residents in the homes which was considered a result of well being in the residents themselves. However, because more old people lived longer, there was a larger group whose physical condition deteriorated and were therefore unable to live in the community, either alone or with their families, so they needed more appropriate accommodation to cater for their needs. Some housing conditions were still quite inadequate and this was inevitably influential in circumscribing care for old people.

Support systems for old people in the community

Parallel to the developments in residential care, concern was also focused on the need to support old people in their own homes as this was where the majority of elderly persons lived. Towards the end of the 1950s the Oxford MOH emphasised the need to focus on domiciliary care, particularly as 97 per cent of pensioners remained in their own homes. In order for them to survive in their homes he considered they needed warmth, adequate diet, freedom from worry and good health and welfare services. The amount of old persons who received domiciliary care from the welfare department was 800. A further 500 persons received help from home helps, friendly visitors and health visitors. In

[23] OxMOH 1960, Section VIII Welfare Service, p.133 states that the average is nearly 85 years in the homes "a figure which is one of the highest averages in the country."

addition, short stay admissions to OPHs, which were a relatively new venture, were considered of positive value to the relatives.[24]

Support systems for old people living in the community were the responsibility of Oxford City Council but, as indicated earlier, there were overlaps with the NHS. Statements by the MOH illustrate that there was a commitment by the local authority to maintain old people in their homes. Initiatives were taken by the council to provide new services in the community, chiropody, meals on wheels, occupational therapy and old people's clubs. Amongst all the services provided, a division can be made between those associated with health, and those associated with general welfare. A further division can be made with regard to those provided on a statutory basis and those on a voluntary basis.

District nursing

Prior to 1948, domiciliary nursing was provided by the Oxford, Headington and Marston Nursing Associations. The Headington and Marston Associations also provided midwifery services for which they received a grant. Nearly 60,000 visits were carried out by these associations during the year.[25] In 1946, the Oxford District Nurses Association was responsible for all domiciliary nursing services in the city. The Association was paid a grant of £200 per annum by the City Council, comprising of £100 for maternal and child welfare services, and £100 for home nursing of "aged and infirm and necessitous patients who are the responsibility of the Public Assistance Committee."[26]

The NHS Act 1946 stipulated that the local health authority be responsible for the provision of a home nursing service. Oxford District Nurses Association was charged with this responsibility. Four members of Oxford City Council's Health Committee and the MOH were members of the District Nurses Association. From July to December in 1948 the number of cases attended was 1,154, and 27,667 visits were made. Sixteen full-time nurses were employed, including one male nurse, and one part-time nurse.[27] District nurses had an increased number of cases in 1950; 2,153 cases were attended,

[24] OxMOH 1959, Introductory letter, p. 8.
[25] OxMOH 1930, Section I, General provision of health services in the area, p. 1.
[26] OxMOH 1946, Section II, General provision of health services in the area, p. 17.
[27] OxMOH 1948, Section III, General health services, p. 31.

compared to 2,073 in 1949. Visits were also increased; there were 54,735 home nurse visits in 1949 and 58,690 in 1950.

In 1955 the home nursing service was taken over by Oxford City Council. Out of the total number of referrals for district nursing (3,201) 91 per cent came from GPs.[28] Concern was expressed by the MOH in 1959 at the lack of referrals by hospital staff to the home nursing service. 31,592 visits were made to patients aged over 65 years (60 per cent of all visits) in 1959.[29] Out of 2,127 referrals only 73 were made by Oxford Hospitals. Dr Warrin was of the impression that more hospital beds could be freed to relieve this pressure:

> ...One cannot help wondering whether the hospital service in this city is making the best use of the district nursing service. Could not more patients be discharged earlier to care of the GP and the district nursing services? With proper liaison between hospital and district nursing services it should be possible to arrange for the earlier discharge of more patients and so make a valuable contribution to the relief of the very heavy pressure on hospital beds.[30]

This concern was repeated in 1960 indicating that there had been no change during the intervening year.[31]

Administration of the home nursing service became the responsibility of the local authority under the post-war welfare reforms. The steady increase of patients requiring home nursing raises questions. Was this because patients wanted to be at home, or because hospital beds needed to be freed? The MOH seemed to have an understanding of the need to release hospital beds, but was this discriminating against old people or families? He suggests that there was unnecessary bed blocking and more use could be made of community resources. Liaison between hospitals and community services appeared to be limited, but it is not clear whether the MOH did anything to improve this. Within the NHS Act, the dividing line between determining health and social needs was unclear, demonstrated by the local authorities having responsibility for some health services. This structure specified different levels of administrative decision-making and finance in two separate agencies which would inevitably present difficulties. Even today, this continues to present problems.

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[28] OxMOH 1955, p7 & Section III, General health services, p. 40.
[29] OxMOH 1959, Introductory letter, Section III, General health services pp. 34-36.
[30] OxMOH 1959, Introductory letter, p. 5.
[31] OxMOH 1960 Introductory letter, p. 5.

Oral respondents had a limited experience of the home nursing service; very few of the families had help from a district nurse either pre-or post-welfare state. Those who had visits from a district nurse had long term illnesses such as Parkinsons' disease, cancer or a stroke. On the other hand, there were other families whose relatives had similar diseases, and did not receive help from a district nurse. Thus access to the service was not automatic and there were some obstacles in the delivery of home nursing.

Home Helps

Nationally the home help service was originally established under the Maternity and Child Welfare Act 1918 and incorporated into the Public Health Act 1936. This service was primarily to help mothers in their lying-in period. Duties for home helps were generally of a domestic nature such as cleaning, cooking, washing and child care. In 1944 this service was extended to frail and older people. It appears that the Minister of Health was concerned at the number of sick and infirm people who were unable to get hospital beds or help in the home.[32] Inevitably many of these people were old and unable to pay for the service. Attitudes towards the institutionalisation of old people began to change during the Second World War, partly for practical reasons (beds were needed for war casualties) and because of the development of geriatric medicine. There was a developing policy that sick and frail old people should remain in their own homes. It is possible that the service was extended to older people because the hardship being caused to families without domestic help was demoralising for civilians during the time of war.[33]

Domestic help was reduced during the war due to men working in the forces, and women working in related industries, or taking other employment. An attempt to redress this was made in 1942 by making domestic work a more significant contribution to war work. Local authorities were informed that the Minister of Labour and National Service had agreed that home helps employed under their maternity and child welfare scheme were doing "work of national importance." Women over 40 years were to be encouraged to

[32] Ministry of Health Circular 179/44.

[33] Means and Smith, Development, p. 88, quote from DHSS 99063/8/1A Social Welfare: domestic help to householders, letter from the MOH to Joint Committee 14 June 1944, ".... the Minister of Labour and our own Minister are concerned about the hardship which is arising owing to lack of domestic help in private households where there is sickness or where there are aged or infirm persons and the deleterious effects which this may have on service and civilian morale."

take up this work and the need should be made known to the Labour Exchange and the WVS. (Circular 2729).[34]

An influenza epidemic in 1943 established some new coordination procedures. The St John's Ambulance Brigade, the BRCS and the WVS responded to the crisis following a request from the Ministry of Health. In view of some successful local schemes run by the volunteer agencies there were expectations that the service could be managed by them. Requests were made by senior officials at the Ministry of Labour and National Service that the home help service be extended to include sick and frail older people. There were already problems providing the service to meet the needs of expectant mothers, and extending the scheme posed further problems. Discussions between the Ministry of Labour and the Ministry of Health led to a compromise to extend the service for older people if local authorities found the staff. The Defence (General) Regulations were amended to incorporate the changes. Circular 179/44 Domestic Help was issued in November 1944: domestic help could be given in the following circumstances:

1. Where the housewife falls sick or must have an operation.
2. Where the wife is suddenly called away to see her husband in hospital and arrangements have to be made to look after the children.
3. With elderly people who are infirm, or one of who suddenly falls ill.
4. Where several members are ill at the same time for example during an influenza epidemic.

Nationally there were variations in establishing the scheme, but Oxford (where the WVS organised the scheme), was praised by the Ministry of Labour early in 1945, and held up as an example of good practice to follow. With the introduction of the NHS 1946 Act the scheme became part of the NHS.[35]

By 1948 the administration of the home help service was properly established in Oxford. Amongst the medical cases were, those who been injured by accidents, long term chronic sick and aged and infirm people, and tuberculosis patients. Patients were financially assessed for contributions towards their care, in order to avoid hardship for those in lower income groups. Home helps were encouraged to attend courses in order to broaden their knowledge. Lectures were given on subjects ranging from hygiene in the home, first aid, avoiding infection, the role of the health visitor and cookery. Home

[34] Means and Smith, Development, pp. 90-91.
[35] See Means and Smith, Development, for further discussions on the political aspects behind the development of this service, pp. 87-89.

helps could also study for a related diploma, the Diploma of the National Institute of Houseworkers.[36]

Table 8.4: Staffing levels and requests for home help in Oxford 1947-1950

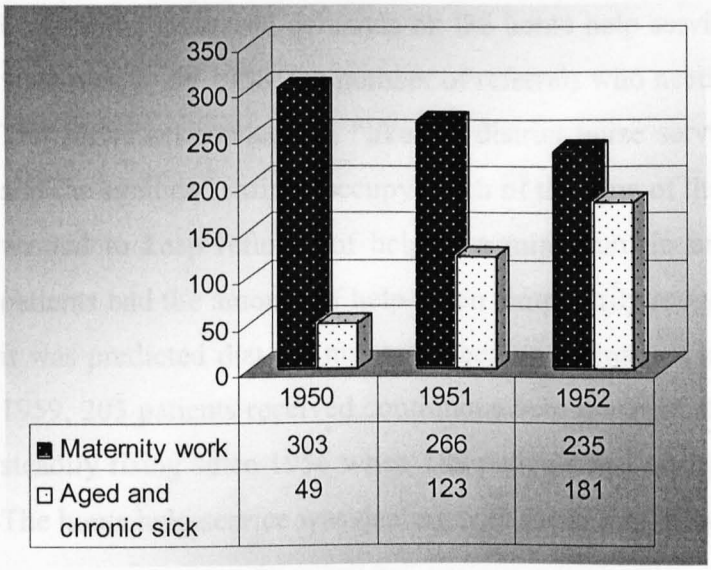
Number of home helps employed by council	1947	1948	1950
Part time	18	-	-
Full time	41	-	-
Total number of home helps	59	-	81
Requests for help	687	830	-

Source: MOH reports 1947-1950

Illustrated in the above table is the rise in requests for help in the city between 1947 and 1950. Seasonal illnesses created more demand for the service which peaked in March November and December. Evident in the reports was the increased need to provide for people needing continuous help for "months even years." [37]

In 1952, the home help service had a staff of an organiser, deputy organiser, finance clerk, shorthand typist and over 80 home helps. Home helps were mostly married women "who are capable housewives and mothers, selected on the basis of suitable experience and attitude to their work," and became an established group of experienced home carers. At first recruitment was not a problem. Maternity work had decreased and work for the aged and chronic sick increased as shown in the table below.

Figure 8.1: Numbers of help requested from the two client groups 1950-1951



Source: Oxford MOH reports 1950-1952

[36] OxMOH 1948, Section III, General health services, p. 34.
[37] OxMOH 1950, Section III, General health services, p. 28.

Requests for long-term help had also increased. Priorities were beginning to be established in the service. In 1953, the MOH made clear his concerns about family responsibilities towards their elderly relatives: "The tendency of families to reject their old people, noted in 1952, increases. The high cost and restricted staff of the home help services means that help must be given first to old people who have no relatives in the city." [38] In this statement he is making known the need to ration services by introducing eligibility criteria. His reference to families rejecting their "old people" was not qualified with evidence or explanations. It is not clear if, and how many old people were rejected by their families. However, the increased pressure on the developing services may have influenced the MOH in his opinion.

By 1954, the home help service was beginning to identify serious problems with workload and future service delivery. The increase in care needed for old people had formed 50 per cent of the workload, compared with 21 per cent in 1951. (The definition of aged was those over 75 years of age.) It was considered that people aged between 60 and 75 years made an adequate recovery, but those who become sick in their mid 70s, never regained full independence. Once on the list for help it was not possible for the service to remove them, consequently there was a large demand for continuous help to a "solid block of elderly people." There was little change in their conditions and this made it hard for the service to take on new cases.[39]

Despite the increased demands on the home help service all the requests for home help were met.[40] By 1958, the number of referrals who needed continuing help had increased. The MOH acknowledged, "like the district nurse service the needs of the chronic sick and the aged and infirm, occupy much of the time of the NHS."[41] Staff in the department wanted to keep refusals of help to a minimum. In order to do this less incapacitated patients had the amount of help given temporarily reduced. Given the ageing population, it was predicted that the numbers needing permanent help would continue to rise.[42] By 1959, 205 patients received continuous help throughout the year. This number had been steadily rising since 1956 when 189 patients had continuous help throughout the year.[43] The home help service was dealing with more long-term cases in 1960, and nearly half of

[38] OxMOH 1952, Section III, General health services, p. 33.
[39] OxMOH 1954, Section III, General health services, p. 35.
[40] OxMOH 1956, Introductory letter, p. 5.
[41] OxMOH 1958, Introductory letter, p. 6.
[42] OxMOH 1958, Section III, General health services, p. 38.
[43] OxMOH 1959, Section III, General health services, p. 32.

these required some degree of continuous assistance. By the mid 1950s the plight of old people and the demand for services was becoming more of a national concern. A Ministry of Health Circular 14/57 requested "information of any special ways in which it may have been found possible to strengthen the domiciliary health services (including the home help service) provided for the elderly and infirm." The MOH considered that the statistics available on home help for older people demonstrated that in Oxford the home help service made a major contribution to the domiciliary service.[44]

The development of the home help service, indicated the commitment (and changes in philosophy) towards helping older people to remain in their homes for as long as possible. Home help contributed to maintaining old people in their homes, as reflected in Dr Warrin's report in 1960, when he remarked that the service was "making a substantial contribution towards retaining elderly persons in their homes for as long as possible."[45] However, there are indications that it was not always possible to provide an adequate service. Staffing shortages resulted in people being refused a service and priorities had to be made. Thus the service was not sufficient to cope with the demand and eligibility criteria must have been established at some stage. Furthermore, as old people were living longer they needed help for longer. It is interesting to note that the service was only provided to people over 75 years of age; perhaps this was one of the eligibility criteria adopted. There are unanswered questions about how people between 65 and 74 years coped when they were ill. (This group made up the majority of the over 65 year olds, as noted in Table 7.1 in the previous chapter.) Inevitably there will have been many people in this age group who were frail and vulnerable especially in view of their previous lack of access to health services and poor social conditions.

Only one of the oral respondents mentioned the home help service, probably because he was attuned to this facility as his wife worked as a home help. A number of the descriptions of domestic circumstances of the respondents' elderly relatives suggest that there was a considerable need for help in the home. This can be construed as another indicator that there was unmet need in this area. Other cities provided similar structures for their home help service, one such example being Leicester. Some aspects of Oxford's home help service can be compared with those in Leicester, in as much as this city established their service in 1946, and this expanded quickly. Attempts were made to

[44] OxMOH 1958, Section III, General health services, p. 39.
[45] OxMOH 1960, Introductory letter p. 6.

improve the service in a variety of ways such as providing training courses for the workers, as in Oxford.[46]

Meals on wheels

In 1943 concern had been expressed by local residents regarding old people's nutrition. Requests were made for old age pensioners to be given reduced charge midday meals at municipal restaurants. At this time there were 1,250 non- contributory old age pensioners in the city. This request was not granted as there were problems with administration, distribution and space.[47] Requests of this nature continued to be presented to the council, such as the possibility of other users of the restaurants effectively subsidising pensioners' meals. A request from the Communist Party to address the city council on the subject of cheap meals for pensioners, was initially turned down in May 1944. The week before this refusal by the council an open air meeting held by Oxford Communist Party in St Giles, had announced that it hoped to arrange for a deputation to meet with the city council in connection with provision of cheap meals at municipal restaurants for old age pensioners. One of the speakers, Mrs E Smith, said that the cost of living had been going up steadily since the war and pensions for old people, even with supplementary ones granted were not comparable with the increase in cost of living.[48] A deputation sponsored by the Oxford Branch of the Communist Party, eventually addressed the council on 5 June 1944. Various trades unions branches and other societies sent letters supporting the delegation.[49] In 1951 there was a request for pensioners to have reduced half price midday meals in municipal restaurants which was also refused.[50]

The Meals on wheels (MOW) service was developed nationally in the 1940s and the Ministry of Health were of the opinion that voluntary agencies should run this scheme. Old people's welfare committees did run lunch clubs and a mobile service, in some areas, in the 1940s. There is a dispute as to who actually initiated this service, whether it was

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[46] Welshman, 'Growing Old', pp. 74-89.
[47] Oxford City Council Minutes and Reports 1943, Full Council 6/3/43 Paragraph 710 referred to Emergency Committee 15/3/43; amendment to full council 3/4/44 resulted in a review of the situation.
[48] Oxford Times, Friday 19 May 1944, p 8. The paper reported the open air meeting, the result of the council decision on accepting the delegation and listed the members of the deputation. These were, Mr Cameron Tudor, Oxford University Socialist Club, Mr Alan Gibson, Oxford University Liberal Club, Dr Maurice Stein, Socialist Medical Association, Mr C Squire, District Secretary AEU, Mr N Brown, Shop Steward, Mrs J McLaren, housewife, Mrs E Smith, Communist Party, Mr E Keeling, Communist Party.
[49] Oxford City Council Reports and Minutes 1944, p. 329, p. 353 and p. 389 refer to the Emergency Committee Reports; and p. 394. The Catering Officer had reviewed the situation and deferred the decision until number of meals served each week dropped to a level which made it practicable to consider extending specific services.
[50] Oxford City Council Reports and Minutes, p. 825.

the OPWC or WVS. However, the WVS did provide a lot of meals and also had been involved since the beginning of the war in their distribution. The Ministries of Health and Food held a conference and invited representatives from the National Old Peoples' Welfare Committee (NOPWC), the Women's Voluntary Service (WVS), British Red Cross Society (BRCS), National Federation of Women's Institutes and the National Union of Townswomen's Guilds to identify ways whereby old people could access non-rationed food. Several of the organisations were already providing meal schemes. Documentation provides evidence that the voluntary agencies took their role in this service provision very seriously. Legislation (the National Assistance Act 1948) enabled local authorities to provide grants to agencies providing this service. Means and Smith are convinced that the MOW service grew from concern about how older people coped with the rationing, but underlying this was the "impact that suffering might have on the perceptions of others."[51] Effectively this goes against some previous assertions that considered that old people's needs were often neglected when compared against children's needs. This suggests that old people's predicaments in some circumstances were a concern in their own right.

A MOW service organised by the WVS and BRCS, was established in Oxford City in 1947. Meals were provided from two city municipal restaurants and, at that stage, it was impossible to provide more than 100 meals. Assessing the total need for the city was difficult, but it was suggested that between 200-500 cases would benefit if the service was extended.[52] By 1950, 85 people were having meals on wheels twice a week. The meal cost ninepence (c 4p). Oxford City Council paid for the transport of the meals at sixpence a mile (2.5p), and the food was supplied by the catering department of the city.[53] The MOW service was extended in 1959. Meals went up to a shilling (5p) and the cost to the council was one shilling and sixpence (7.5p). This led to greatly improved meals and more demand. New equipment was purchased adding to the quality. Over 100 people received the meals three times a week.[54] By 1960, 2,000 meals a month were being served.[55] Information regarding the total amount of MOW supplied does not make it clear exactly how many times a week people received meals. Obviously this service

[51] Means and Smith, Development, pp. 99-104, provide archive material from some of the agencies detailing instructions from head offices to the provinces on the importance of their help
[52] OxMOH 1948, Section VIII Welfare Services, p. 91.
[53] OxMOH 1950, Section VIII Welfare Services, p. 97.
[54] OxMOH 1959, Section VIII Welfare Services, p. 125.
[55] OxMOH 1960, Section VIII Welfare Services, p. 145.

was necessary and welcomed, and the increase in take up of the meals illustrates this. The administration of the scheme mirrored national developments.

Pressure from the community on the council highlighted the nutritional needs of old people. Membership of the deputation to the city council demonstrated the cross section of people concerned about old people's welfare and the strength of local feeling. Although MOW was undoubtedly a useful resource for old people who were housebound, there were also wider nutritional needs associated with poverty. Writing up his Sheffield survey results in 1955, Hobson drew attention to the importance of adequate nutrition for old people. Hobson contrasts the addressing of children's malnutrition against that of elderly people, and expresses his concern at the repercussions of poor nutrition for them. Indeed, we must be reminded here of the previous quote from Beveridge "it is dangerous to be in any way lavish to old age until adequate provision has been assured for all other vital needs, such as the prevention of disease and the adequate nutrition of the young."[56] In contrast, Hobson considered that severe malnutrition (caused by ignorance, poverty and apathy), amongst old people was responsible for hospital admissions in big cities.[57]

Clearly the issue of MOW (and older peoples' nutrition more generally) had wider implications, particularly of a preventative nature. Oxford City Council seems to have established a reasonable MOW service within the confines of resources, but there are indications that there were old people that did not receive this service. Inevitably, gender and social isolation contributed to the nutritional routines of old people. Old men living alone who had been dependent on a female spouse or other relative for meals were probably more vulnerable than old women. In fact, admission to institutions by men has been attributed to their inability to care for themselves. Women were seen to be able to maintain themselves for longer in the community, and admission to an institution was usually at a later age, usually due to physical deterioration. In her survey of Oxfordshire in1938, Bourdillion acknowledged this fact: "The smaller amount of women than of men in the group 65-70 [*entering institutions*] is due to the fact that women can look after themselves better than men; this is still true of people over 70, but since women live longer than men, this counteracts the smaller number of women entering institutions."[58]

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[56] Social Insurance and Allied Services, Report, HMSO, 1942.
[57] W. Hobson, The Health of the Elderly at Home: A Medical, Social and Dietary Study of Elderly People Living at Home in Sheffield (London: Butterworth, 1955), p. 196.
[58] Bordillion, Social Survey, p. 101.

Consequently, the population of women in institutions would be older and higher as they also lived longer. Lyon and Colquhoun have shown that "evidence from different decades shows that lone older people are not only more economically disadvantaged than other sections of society but also they are faced with a greater struggle in daily living, in comparison with contemporaries living with partners or children."[59]

In view of this conclusion, Oxford's elderly residents living alone were probably no different in their nutritional practice to others in the rest of the country. However, the local community response during the war concerning the nutritional needs of old people is extraordinary. It is difficult to explain why this issue generated so much political reaction compared to other concerns for old people such as home help provision. Linked to this local concern was the national concern raised by Means and Smith suggesting that during the war authorities were concerned about the effect of old people's nutritional deprivation on the country's morale. Obviously this aspect of old people's welfare was extremely sensitive and aroused people's consciences. Maybe it was purely an emotional reaction. All of the population existed on limited diets, and there could have been a strong identification with vulnerable old people on this issue.

Chiropody

A further development in terms of health and welfare services for older people in the community was chiropody. Townsend outlined the relevance of chiropody in relation to the development of geriatric medicine. In this context, Townsend presented the rationale for general specialist help to go into old people's homes to carry out specific medical treatment, such as injections. He considered that some tasks were difficult or impossible for families to carry out, so that specialist care was needed to complement family care. However, if older people were living alone, then some tasks carried out by specialists such as district nurses effectively substituted family care. Writing in 1965, Townsend recognised that the standards of care for old people had probably been raised through public education and media interest. As a result, he considered this meant that families were more aware of the needs of their older relatives, and doing more for them than previous generations had. At this time chiropody was a relatively new development and not seen as a key preventative measure. The benefits of healthy feet in old people and the specialist nature of chiropody were beginning to be appreciated, but this was taking

[59] Lyon and Colquhoun, 'Home, Hearth', pp. 53-67.

time to disseminate. In the absence of chiropodists, families attended to relatives' feet.[60] Below is a table demonstrating the results of a national survey carried out by Townsend in 1962, which included the care of old people's feet. Information in the table indicates that elderly persons were having trouble with their feet and had to rely on others to help them. Relatives obviously played a key part in foot care, therefore if relatives were not available the task was not done.

Table 8.5: Percentage of persons being unable to care for their feet even with difficulty who received help with such care from different sources; Britain 1962

Source of help	Persons being unable to cut their toenails		
	Men (%)	Women (%)	Men & Women (%)
Spouse	33	8	15
Child in household	17	13	14
Child outside household	4	7	7
Relative in household	2	3	3
Relative outside household	0	3	2
Others in household	2	1	1
Friends and neighbours	2	2	2
Social service	23	29	27
Private domestic help	-	-	-
Others outside household (including private chiropodist)	11	28	23
None	5	6	6
Total	101	101	101
Number of persons	185	504	689
Number of replies	186	509	695

Source: Townsend [61]

In 1953, OCSS, the umbrella group for voluntary agencies, sponsored a chiropody service and chiropodists visited the nine old people's clubs.[62] One of the oral respondents, Mr MG, a physiotherapist at CRH realised that there was a limited podiatry service in the community and trained as a chiropodist. He subsequently visited old people's clubs in the city, and Dr Cosin gave him time off to deliver this service.[63] Mr MG also worked as a chiropodist two evenings a week. Oxford City Council introduced a new chiropody scheme in 1959 in conjunction with the OCSS. Transport was provided for old people who couldn't get to the old people's clubs and took them to the Laurels where a weekly chiropody clinic was held. Approximately five or six people attended this clinic each week. A number of them were able to walk after treatment and attended the old people's clubs for further treatment. [64] By 1960, Marston Court was used for

[60] Townsend and Wedderburn, Aged, p. 34.
[61] Townsend and Wedderburn, Aged, p. 38.
[62] OxMOH 1953, Introductory letter, p. 8.
[63] Mr MG OX16, 4/3/98, p. 10.
[64] OxMOH 1959, Section VIII, Welfare Services, p. 125.

chiropody clinics on the same basis. In October 1960, the city council took financial responsibility for the service and records show that there was a considerable take up of the service in the first three months.[65]

Chiropody provision in the city indicates that old people's needs continued to be identified and provided for, in conjunction with the development of other services in the community. However, it is notable that the chiropody service was not fully publicly funded. Leicester had similar arrangements for chiropody and became involved in discussions with the Ministry of Health for developing new schemes. Despite evidence supplied by a local medical doctor on the benefits of regular chiropody treatment for old people, particularly those suffering from diabetes, the Ministry were initially opposed to this but did change their mind several years later. Welshman uses this example to show how delays in policy affected service delivery.[66] There are no indicators as to whether or not there were similar problems in Oxford from the documentary sources studied, but evidence that there was a considerable take up of the service indicates the need. Additionally, Townsend's national survey identified that old people did rely on others for foot care, and this was a growing need, related to more old people living longer and remaining in the community.

Clearly the experiences of Oxford and Leicester show that there were benefits of chiropody for old people and these could possibly be seen as pilot projects. Notwithstanding the fact that chiropody was a new specialism, the arrangements of the chiropody service reflect the priority given to old people, and signify the limited connections made by policy makers between prevention and economics. Chiropody treatment offered more than just cutting toenails. The neglect of an old person's feet could lead to them becoming less mobile, then more incapacitated through lack of mobility, and ultimately, more dependent on other resources, leading to more financial outlay. Chiropody treatment must have been a relatively minimal outlay compared to the problems created by neglect of foot care.

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[65] OxMOH 1960, Introductory letter p. 6 & Section III, General Health Services, p. 45. At 7 Old People's Clubs 187 persons received 238 treatments at 45 sessions; at 6 OPHs with accommodation for approximately 300 residents 339 treatments were given in 48 sessions; at Marston Court Clinic 46 persons received 73 treatments at 13 sessions; 19 domiciliary treatments were given.

[66] Welshman, 'Growing Old', pp. 74-8.

Occupational Therapy

Occupational therapy was a relatively new profession established in the 1940s. In Oxford the occupational therapy service was established in 1951 with one full-time therapist and a part-time assistant. A domiciliary occupational therapy service was in operation by 1955. Weekly occupational classes were available for ambulant patients at the Laurels on Wednesday afternoons. Residents continued to have occupational therapy services for part of the week.[67]

In 1960 the service was moved to the sheltered workshop in Woodstock Road, and weekly sessions were held at three OPHs, the Laurels, Townsend House and Shotover View. The average age of patients seen was over 80 years. Miss Targett, the head occupational therapist, considered that the benefits for the residents were largely psychological, but the service needed to expand in order to cope with the increased demand created with the development of OPHs.[68] Records indicate that priority for this service was initially given to young physically disabled people, under 60 years of age. However, as the profession developed and the provision of residential accommodation increased, the needs of old people were identified, with an expansion of the service to residents in OPHs. Professional assessment of the occupational therapy services was one of optimism and encouragement. One respondent who trained as an occupational therapist in the mid 1940s recalls the aims of occupational therapy at that time: "...You helped people to get well through occupational therapy but you also in those days there was enough time to pass the time....so that you gave them things to do so they didn't get bored so mainly we were going in to help them not get bored...give them something to do...."[69] Occupying sick people for a long period of time was obviously a challenge and the dual purpose of occupational therapy was spelt out in the above testimony. Extending the service to the OPHs where old people were still ambulant and independent undoubtedly began to address the monotony for residents, especially in the days when acquisition of television sets was not so common. The benefits of occupational therapy were already well-known at CRH, particularly in the day hospital. There is no evidence to suggest that the practice in the CRH day hospital was copied throughout the city, but it could have been influential in the development of the service.

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[67] OxMOH 1955, Section III, General Health Services, p. 46.
[68] OxMOH 1960, Section III, General Health Services, pp. 42-44.
[69] Mrs MF OX7, 8/7/98, p.1.

Old People's Clubs

By 1949 there were twelve clubs for old people in different areas of the city. Six were run by the BRCS, five by the WVS and one by the Women's Electrical Association. The clubs were open one afternoon a week, tea and cakes were sold for a nominal sum, and social activities such as outings and whist drives were also organised. Average attendance at the clubs was between 80 to 100 people.[70] By the 1950s more clubs had been established - Mrs ASP an organiser for the local OPWC raised interesting points about the management and membership of the clubs:

> .....We did a bit of research on what people did when they went to old people's clubs. Old people's clubs were a great thing, there were 20 to 25 old people's clubs in the city; some run by the Red Cross, some run by the WRVS some independent some community centres, and we serviced them. We gave them all the information and I used to visit and talk about what was available and we did a little survey. We knew it wasn't very professional but it was quite interesting we had a questionnaire asking people about their lives and what their hobbies were. Of course they were mostly women, the men hadn't survived, and I suppose that 10 per cent men or even less than that as a man would go and find there was only one other man and they'd go. And this was for anybody over 60. And they were run often by a volunteer. I remember one lady she was over 80 and she talked about her elderly people you know and a lot of them who were born in the 1890s did age quite quickly, so it was quite easy to see a lively 80 year old who'd had a privileged existence running this club with people in their 60s who seemed older than she was. And they would be very bossy and tell them where they were going for the outings and things. I mean later we tried to have a little bit of training for club leaders to sort of suggest that they should sort of discuss it. And I remember that one club there was an elderly gentleman who was a little bit it was a class thing then people who came to old people's clubs tended to be what was known as working class but there were some people who were a little.....perhaps who'd been tradesmen or run a shop and so on, and I remember one man I think it was the Cuttleslowe one where he did enter the discussion and suggest they should go somewhere and he was put down by the others 'no no no you shouldn't interfere leave it to the leader' I mean this was often the way they liked to be led .....[71]

Mrs ASP provides a very illuminating picture of the clubs highlighting the significance of class and gender. Affluent, assertive, middle class women often older than the attendees of the club were volunteers. They ran the activities, more women than men attended, presumably because women tended to outlive men, and the users were from different social backgrounds to the volunteers. According to Mrs ASP loneliness

[70] OxMOH 1949, Section VIII Welfare Services, p. 88.
[71] Mrs ASP OX19, 4/6/97, p. 6.

featured as a prime reason for attending the clubs. This fits in with national views on the benefits of such clubs as expressed in Seebohm Rowntree's survey.[72]

Social work and general welfare

There was no evidence from the council reports before 1948 of any community or general welfare social work for old people at a local level. A welfare department was established in Oxford, as a result of the new administration in 1948. In 1952 the visiting staff section was enlarged and a system was introduced whereby older people on the waiting list for residential accommodation were visited on a routine basis. Liaison was established between the welfare department and the voluntary services that provided community services such as meals on wheels to ensure that "everything possible is done to encourage old people to lead an independent life." The CWO noted that the community resources relieved the pressure on overcrowded Part III accommodation (Part III accommodation was the provision of old people's homes).[73] In 1953 the Chief Welfare Officer reported, "wherever possible, a regular visiting service has been maintained to known cases of aged persons living alone."[74]

The visiting service was extended due to the increase in the numbers of welfare officers. A re-arrangement of work enabled a welfare officer who was also a trained nurse, health visitor and qualified sanitary inspector to follow up cases, particularly those who had been or were patients at the CRH. "By early knowledge of these cases, it is possible by the use of the home help and other local authority health services, together with voluntary effort, to prevent a deterioration in the home circumstances and thus enable the person to remain in their own home for as long as possible"[75]

What is unclear from council reports is how this process was effected. The earlier CWO's reference to "known cases" do not explain how an old person became "known". Where did the process of referral begin? Once on the waiting list for residential accommodation an old person was visited by a welfare officer, but it is not apparent how a person got on the list in the first instance, and who "owned" the list. Staffing of this department had been increased and the ultimate effect of the service kept people in the community and relieved pressure on the residential accommodation. However, was the

[72] Seebohm Rowntree, Old People, p. 102.
[73] OxMOH 1952, Section VIII Welfare Services, p. 109.
[74] OxMOH 1953, Section VIII Welfare Services, p. 111.
[75] OxMOH 1954, Section VIII Welfare services, p. 115.

increase in staff a response to the increased need for help, or was there a proactive policy to discover more cases? Interlinked to this aspect is the question of how cases were brought to the attention of the welfare department in the first instance. Links were made with follow up patients from CRH so some inter agency liaison was in operation. Implicit in the CWOs statement was a suggestion that there was a mixture of both previously known patients at CRH and those older people who were unknown to agencies. If this was the case, and in view of the increased older population, then thresholds of eligibility criteria would have been established to meet the demand. No evidence as to how this was put into practice was discovered during the study, but these decisions may not be in the public domain.

Under Section 47 of the National Assistance Act of 1948, the local authority had the power to remove vulnerable older people from their own homes, if necessary against their wishes. The first Oxford person to be removed under this legislation was documented in 1952 and described below:

> The person concerned was a lady of over 90 years of age, living in a ground floor flat without any means of artificial lighting other than candles. She had completely refused offers of Part III accommodation throughout the year, but was assisted by the Home Help Service until her condition deteriorated to such an extent that she constituted a danger to herself and other persons living in the block of flats.
>
> Action was accordingly taken and it was certified that she then in need of nursing treatment and removal to CRH was effected. Once the removal had taken place, it was not found necessary to extend the order as the lady became amenable to her new surroundings and did in fact voluntarily relinquish the tenancy of her flat.[76]

Another case was recorded in 1954:

> Aged over 90 years and suffering from a chronic illness and was not receiving adequate care and attention. During the preceding period she had persistently refused help from local health and welfare authority and when her condition began to deteriorate, it was considered necessary to enforce her removal to hospital. Again it transpired that her objections had diminished by the time of the arrival of the ambulance and she then entered hospital voluntarily. The disease was unresponsive to treatment and she died within the statutory period of the order.[77]

In 1960 an aged woman was living alone. She was infirm and physically incapacitated and in need of continuous help. Her GP had requested assistance in providing for her care and, as she was unwilling to accept help voluntarily, she was removed under order

[76] OxMOH 1952, Section VIII Welfare Services, p. 114.
[77] OxMOH 1954, Section VIII Welfare Services, p. 120.

to CRH where she later died.[78] These examples of how old people were found to be neglecting themselves and then followed up by the welfare services do suggest that there were beginnings of a safety net for elderly persons; but it is not apparent how these persons came to the attention of the local authority in the first instance. Balanced against this legislation must be the human rights aspects of such action; similar parallels can be drawn with mental health sectioning. The MOH and the CMO, had previously made clear their concern about old people being committed inappropriately to mental hospitals when they were suffering from dementia (discussed in the previous chapter) but there were no comparisons with this legislation. However, it is evident that this action was used on a minimal amount of occasions, and this may well reflect reluctance on the part of the welfare officers to use this section of legislation.

A review of 10 years of the National Assistance Act was provided by the CWO in 1958. The CWO reviewed the intention of the Act in relation to the provision of Part III accommodation. He identified two "fallacies" regarding Part III accommodation. Firstly, these were homes where people of pensionable age could live in comfort and retirement; and secondly they were places where younger persons could put unwanted relatives. The CWO clarified the situation; the homes were intended for the aged and infirm who were in need of care and attention not otherwise available to them. Furthermore he commented that as a result of these misunderstandings, problems had arisen between health and welfare departments concerning:

> ....[the] indecisive border line between infirmity and sickness, where these few border line cases arose, and it must be clearly understood the border line cases are very few, there was a tendency for dispute between hospital and local authority as to whose the case was. This was a most unfortunate development and one for which there was no real excuse. The division of responsibility between hospital and local authority is logically sound, and it is the responsibility of the local authority to provide suitable care and attention for a case that the medical and hospital authority decide is not suitable for hospital admission. It is the duty of the welfare authority to provide suitable accommodation for those persons with whom it has to deal and not set itself up as an arbiter.[79]

This statement by the CWO described the problems resulting from unclear boundaries between health and social care that had arisen over the 10 years since the inception of the welfare state. Disputes between health and welfare departments had occurred in these

[78] OxMOH 1960, p. 26.
[79] OxMOH 1958, Section VIII Welfare Services, pp. 126-128.

years, and whilst the CWO was clear on the majority of cases that needed local authority provision, he noted it was only a minority of cases that were borderline. Nevertheless, this was an acknowledgement of problems caused by the legislation that were not easily resolved; and these difficulties have been carried over to today.

In the opinion of the CWO, Oxford had vigorously followed national policy in the provision of residential accommodation. This was illustrated by the number of new homes opened, which was significantly higher than the national average. A new specially designed home for the more infirm was completed in 1958 and a second home was underway, together these two homes provided 120 places. (See Table 8.3) Acknowledgement was made by the CWO that, as the majority of all persons of pensionable age lived in the community the development of domiciliary services needed to be addressed.

Approximately 10 per cent of the people receiving help from the welfare department were also having out- or in-patient treatment at CRH. Over 650 aged and infirm persons were in regular receipt of some form of domiciliary welfare. Consequently liaison between one of the welfare officers and the medical social workers was established. Another problem was identified, that of the need for liaison between hospital and welfare departments. Breakdowns in the systems were identified in 1952, when the home nursing team were not informed of a patient's discharge until after the event; as a result patients were left without care.[80] Discharge from hospital had not always been co-ordinated with the community teams. Although nursing was essentially a health provision the service was administered via the city council and linked in with other welfare services which came under the general supervision of the MOH. These identified gaps were essential in forming an early coordinated community care policy. It is also likely that there were some discharge procedures in existence in order for follow up in the community, such as home nurse visits, to take place.

In the 10 year review of developments, the CWO recognised that much could be done towards making home conditions more tolerable for old people. Different aspects of assistance such as home help, MOW, chiropody, welfare visits and volunteer visiting had all contributed to improvements. A scheme of respite care in Part III accommodation initiated in Oxford was followed by other authorities and subsequently became the

[80] OxMOH 1952, Section III General Health Services, p. 36.

subject of a government Circular. The philosophy of the CWO was that "prevention of distress is better than any remedy of a crisis."

In 1959 the CWO applauded the city council's prediction that more people over 85 years of age were going to need help in the future. He remarked how the OPHs helped to provide one solution to this problem. There was still a shortage in provision of accommodation and only the most needy cases were admitted. The average age of residents in the homes was over 83 years (and considered to be rising).[81]

Volunteers worked in the welfare department and in the OPWC. Community centres were encouraged to implement a service to old people living in the area. Rose Hill Community Centre pioneered a service and worked closely with the welfare department "in providing a community service for the elderly which is second to none." Plans were made to employ a welfare assistant to work in the area and provide a co-ordinating link between the voluntary and statutory services. Other community centres also wanted to take up this idea. It was the hope of the CWO that this domiciliary service in Oxford would be the "envy of the country" in a few years time. Welfare officers made 6,943 visits during the year and there were several hours of follow up work co-ordinating services.[82]

By 1960, there were 276 people in OPHs, 100 on the urgent waiting list, and 628 aged, infirm and handicapped people receiving domiciliary care in their own homes through welfare officers, home nursing, chiropody, home helps, meals on wheels, recreational facilities, aids in the home and a friendly visiting service. This was approximately 8 per cent of the city's population over 65years, and within this group only people aged over 75 years were receiving home help services. Special housing was to be built close to the OPHs so that older people could receive any help needed from the home. The Rural Community Housing Association completed a block of old people's flats at Rose Hill and included a neighbourhood community room for old people. Volunteers from Rose Hill Community Centre helped to open this room.

Welfare officers made 8,471 visits during 1959; many were made outside office hours "to ensure as far as possible the greatest amount of help in the quickest time." But many old people lived in older houses with a lack of modern facilities which made the duties of

[81] OxMOH 1960, Section VIII Welfare Services, p.133, states that the average is nearly 85 years in the homes.
[82] OxMOH 1959, Section VIII Welfare Services, pp. 114-116.

the social worker inside the home more difficult. The National Assistance Board officers were acknowledged by the CWO, as being very helpful in supporting older people in their own homes. A philosophy was developing that old people's lives should "become a happy existence rather than a monotonous burden."[83] Emphasis on the psychological well being of old people was a new aspect introduced by the CWO.

It is apparent that a great deal of thought was being put into the development of the welfare services for old people during the 1950s. Services provided good support systems in the community, but inevitably more demands were made on these services as the population of old people increased in the city. Furthermore, the professionals were learning more about the heterogeneous needs of old people as this new service developed. Supporting people in the community must have been cheaper than hospitalisation? But unfortunately, after 12 years of the welfare state, the innovatory ideas and plans began to exceed budgets. Webster notes that: "The performance of the NHS was further depressed by the unremitting regime of retrenchment taking effect in the 1950s. Because of their inferior status, services for elderly were disproportionately affected by charges and cuts."[84] He also points out that Titmus concluded that "there had been a decline in resources available to community care since the beginning of the NHS." As earlier evidence has indicated local services were being stretched and rationed. Given this situation, it would have been difficult for the local CWO's philosophical aims to be put into practice. Practitioners in local authorities were working within a newly established institution, the welfare state, and were beginning to accumulate expertise and skills. It was probable that in the initial years after the inception of the welfare state, practitioners were nevertheless immersed in pragmatic responses to demands for services. During this time the psychological aspects of welfare for older people would have been a secondary concern, which only fully emerged when the services were up and running .

The MOH made the following points in his 10 year review of the relationship between local authority, health and welfare services in 1958. Firstly, in Oxford, the health department had worked closely with the developing geriatric services at CRH. Secondly, OCSS had their main office headquarters conveniently sited within the welfare section of the health department, and gave considerable help with the domiciliary care of old

[83] OxMOH 1960, Section VIII Welfare Services, p. 134.
[84] Webster, 'Elderly', p.188, see also Townsend, Last Refuge, p.339.

people. Dr Warrin summarised "...fair to say that in this area the "tripartite" health service is functioning as a whole and is very strongly supported by voluntary effort."[85] His observations emphasise how the developing infrastructures were working together, as he made the links between the health and local authorities and the voluntary sector, in line with Beveridge's recommendation. Dr Warrin was well placed to make these observations as his position as MOH enabled him to have an overview of the situation. However, pressures on services were noted and supply was not matching the demand, particularly for residential accommodation, home helps and MOW. Oral respondents had minimal experiences of these services for their elderly relatives. Was this because that by providing support they were outside the eligibility criteria, or was it because they did not ask for help or even know about it? The answers to these questions probably lie in a combination of all three factors. But if this group of people did not get help then there must have been others in the same position too. Given the limited and stretched resources some informal rationing must have been enforced. This is alluded to in the MOH reports. For example, home help care was only given to people over 75, and the MOH outlined the principles for admission to residential accommodation. Documentary sources do not indicate if, and how, any eligibility criteria for services were applied, but it is probable that thresholds were introduced and not necessarily made public as they were influenced by financial constraints. What is not answered is how the local authority interpreted need, and associated with this, how they made policy decisions on service distribution. One conclusion that can be drawn from welfare provision from 1948 is that services were built around existing resources rather than around defined eligibility criteria or clear new principles. An example to illustrate this point would be the development of OPHs. Initially old people were accommodated in an existing public assistance institution before demand for places required provision to be reviewed and increased. These issues appeared to be governed by pragmatism rather than by policy.

Housing

Housing conditions were described in more detail than welfare provision by oral respondents. Not surprisingly they lived in a variety of circumstances in different areas of the city. Many respondents lived in rented property at this time and made the point that house ownership was more unusual then. One respondent remarked that St John's

[85] OxMOH 1958, Ten year review of the relationship between the local authority, health and welfare services and the other branches of the national health service, pp. 12-15.

College, owned much of the property in the Jericho area and most of their houses were rented out on a short lease basis.[86] Washing was usually done in a copper, and for some, the facilities were shared with others. One woman and her family, including her aged grandmother, lived in small rooms with inadequate cooking and heating facilities during the 1920s and 1930s. She described the facilities for washing: "...There was this wash house with two coppers in and you each had a day to do your washing you couldn't do it any day you wanted to and if you missed your day you couldn't do it till next week again..." [87] Respondents also recalled having to use outside lavatories, which were sometimes shared with other tenants. As described by Mrs MC who lived in St Ebbes as a child: "...they were little one up one down little places with loos at the bottom of the garden and wash houses at the bottom of the garden and maybe a water pipe for several houses..."[88] Many families and their older relatives did not have bathrooms either and Mr RT also recalls having to share sanitary facilities:

> ....You'd have to bath in front of the fire. The running water was in a washhouse, what was called a washhouse which was about ten....fifteen yards up. It was a communal thing you see. Everybody had to go over there with jugs and buckets and those sort of things. It's where those enamel jugs come from those days. Community washhouse toilets shared, five toilets between one, two, three, twelve families.[89]

Other respondents also recalled minimal washing facilities in their own or their elderly relatives' homes and most washed in tin baths by the fire. Mr MW would regularly go to the local baths which cost sixpence a time but he didn't think old people used this facility.[90]

For families that experienced poverty life was very hard especially if there was an elderly relative to care for. The following extract reveals just how difficult the combination of poverty, poor housing, ill health and lack of welfare resources were for the whole family in the late 1920s:

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[86] Miss BH OX39, 13/10/99, p. 8. See also T. Hinchcliffe, 'Landownership in the City: St John's College, 1800-1968' in RC Whiting, (ed) Oxford, Studies in the History of a University Town Since 1800, (Manchester: Manchester University Press, 1993), pp. 85-109.
[87] Mrs ST OX21, 9/5/97, p.1-2.
[88] Mrs MC OX5, 17/2/98, p. 2.
[89] Mr RTOX22, 30/4/97, p. 2.
[90] Mr MW OX25, 26/8/97, p.2. See also A. Crossley, (ed), A History of the County of Oxford, Vol IV, The City of Oxford (Oxford: OUP 1979), p. 363. A Scheme to provide wash house and baths for the industrious classes was launched in 1850. The corporation opened baths in 1923 in Paradise Square, slipper baths and swimming baths in Merton Street (leased from university) from 1924-1938; and slipper baths and showers in Albert Street, Jericho in 1952, Catherine Street in 1954, and Lake Street in 1961. Paradise Square closed 1965 and Lake Street in1966.

> But she couldn't get up stairs you see we'd only got one room downstairs so every night I can remember my brother and I used to have to go up to the top of the house to fetch the bedclothes for her to make up a bed on the sofa I feel terrible when I think of it now because we used to argue and the poor old soul was waiting to get to bed and we were arguing over which one's turn it was to fetch the bed clothes down for her. We had no bathroom we had to wash everything in a bowl and boil water on the fire. Nobody realises today. And another thing we were often hungry cos there wasn't the food for you then.... my mother used to boil little tiny... pig potatoes we used to call them, we used to have that for our dinner sometimes and a slice of bread and we were rationed with bread and when we went to school .....my mother used to ration us and we had our slice of bread left out on the table there. If I was late getting home from doing the shopping Jim had eaten mine and I didn't get anymore and had to go hungry....cos there wasn't the money you see. [91]

When illness or disability incapacitated an older person living in these conditions were even more difficult; for example, Mr RH's elderly father was terminally ill and his house had an outside lavatory and no bathroom.[92] Although the descriptions of the housing circumstances are from relatives of old people they do give a general picture of the conditions some people lived in. Legitimate inferences can therefore be made, that a number of old people lived in similar circumstances. Although expectations and standards of sanitary arrangements were different in earlier times, nevertheless it must have been very difficult and uncomfortable not to have an inside lavatory and washing facilities especially for old people, who were becoming more disabled through the ageing process. Oxford was not bombed during the Second World War, this meant that the city did not have major housing reconstruction projects to address in the immediate post-war period. Bad housing conditions in Oxford were not on as big a scale as other larger cities where there were more slums and war damage.

Following the Housing Act 1930 all urban local authorities with a population exceeding 20,000 had to undertake a special housing review, plan how to deal with local housing conditions and identify future provision of housing accommodation. Underpinning the Act was the aim of clearing slum areas and preventing new slums being created by "stopping the deterioration of other areas (Improvement Areas)." Financial assistance was available in the form of an Exchequer Grant. These monies were to assist local authorities with rehousing.[93]

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[91] Mrs ST OX21, 9/5/97, p. 2.
[92] Mr RH OX26, 18/5/98, p. 2.
[93] OxMOH 1930, Appendix, Report C (Housing Act 1930 submitted to the Public Health Committee November 17 1930), p. 97.

Areas designated for clearance and development were identified in the reports, but the slum clearance programme was halted because of the Second World War. One noteworthy factor which influenced Oxford's housing development was its geographic composition, with a lack of land within the city, because of the many areas of historical interest.[94] In 1950 the sanitation department of the city council considered that, in line with national concern regarding the domestic circumstances and care of aged and infirm people, an investigation should be carried out in Oxford. The chief sanitary inspector reported: "The ever present and growing problem of the domestic conditions of aged and infirm persons was also the subject of special consideration and a survey of related sanitary circumstances was undertaken with a view to securing improved conditions where neglect was apparent, close cooperation being maintained with the home help service."[95] A survey of the domestic circumstances of aged and infirm persons known to the department, through association with food parcels or other 'post-war' activities, was carried out by the "qualified lady member of the staff." Out of the 893 cases visited, few needed intervention. The following table summarises the results of the survey.

Table 8.6: Results of Oxford survey into the domestic circumstances of aged and infirm people in 1950

	No
Total number of old people visited	893
Total number of visits paid during the year	2144
Relatives asked to help improve insanitary conditions	19
Home help referrals as no relatives to help	16
Old people admitted to an institution	22
Treated at cleansing stations	2
Died since visitation	21
Males lived alone	14
Females lived alone	106

Source: OxMOH Report [96]

The proportion of old people visited amongst the over 65 year old population was approximately 8 per cent. There seem to be a relatively small number of outcomes for the large scale multiple visits carried out. Explicit in the report is that some system of liaison was in operation in terms of referrals to institutions and the home help department. Furthermore, it seems that relatives were contacted to help clean up the house. The treatment at cleansing stations involved a rather undignified process for an old person to undergo. The survey continued into 1951, and 588 cases were visited with a

[94] See Waller, 'Oxford Politics', pp. 167-189. Waller details Oxford's housing problems in relation to overall redevelopment.
[95] OxMOH 1950, Section IX Environmental Hygiene, p. 101.
[96] OxMOH 1950, Section IX Environmental Hygiene, p. 101.

total of 1,535 visits being made. Again, significantly more females than males were found to be living alone (78 females, 8 males). The home help service helped to deal with nineteen cases. [97] Reports made to the MOH stated that close co-operation continued with the welfare section and assistance was provided when necessary.[98] The surveys do not define how old the respondents were. In view of the fact that the home help service was provided for those over 75 years, it may be that this was the definition of aged and infirm for the survey. Although oral respondents described the housing conditions of their grandparents and parents, in general, little comment was made about them.[99]

Slum clearance resulted in families being rehoused on new estates mostly situated on the eastern areas several miles out of the centre.[100] Little mention is made about the rehousing of old people and whether, in cases where extended families were co-residing, the whole family was rehoused, or the family was broken up. The momentum for the slum clearance programme picked up in the mid 1950s when the plan was to clear 700 homes in six years, and clearance areas were identified in St Ebbes.[101]

Conclusion

This chapter has discussed the provision of services administered by Oxford City Council before and after the inception of the welfare state. A picture has developed of how Oxford City responded to change imposed by legislation, underpinned by a changing culture from the poor law to the welfare state. Evident in the documentary sources is the shift in attitudes towards old people's care, particularly after 1948. There is no doubt that this was generated by the demands of legislative changes; prior to 1948 very little reference to old people was made in the MOH reports. An assumption can be made that, as the administration had to make statutory provision for old people, then addressing their needs engendered changing attitudes. Financial constraints were also evident and illustrated by waiting lists for services, such as residential accommodation and under resourced departments like the home help section. Another factor pertinent to the economic situation is the extent to which preventative measures such as chiropody, old

[97] OxMOH 1951, Section IX Environmental Hygiene, p. 99.
[98] OxMOH 1956, Section IX Environmental Hygiene, p. 150.
[99] Many respondents recalled that the homes were without inside toilets and bathrooms, and coppers were used for laundry.
[100] See Waller, 'Oxford Politics', pp.167-189. He outlines Oxford's housing shortages, the progress of the developments and some of the problems related to the new estates.
[101] OxMOH 1956, Introductory letter, p. 5.

people's clubs and MOW were effectively provided by voluntary agencies. These important preventative services were not provided through legislation though to an extent subsidised or financed by the city council, thereby reducing costs. As the government considered partnership between local authorities and the voluntary sector was positive and necessary for service delivery, the evolution of some such services was logical and desirable.

It is clear that Oxford City's health and welfare authorities were relatively advanced in their provision for old people. Outlined in previous chapters was the contribution that Dr Cosin made towards the advancement in care for older people in the city. Further evidence of the progressive approach towards old people can be found in the provision of residential accommodation. Two examples confirm how Oxford was held up as a national example, Townsend's praise of the city building new OPHs and the introduction of respite care in these establishments. Despite constant demands on the service, the home help department had been up and running effectively and identifying need since soon after 1948. An understanding of the need for old people to remain in their own homes with good community support, prevalent in the MOH reports, must have given leadership to employees working in the welfare departments. In 1960, the MOH revealed that the aim of the council was "to have a home in as many sub-districts as possible, to enable old people requiring admission to live in their own locality."[102] Compared to 20 years beforehand this was quite a progressive turn around in philosophy and policy.

Nevertheless, infrastructures for liaison seem to have been under-developed. The testimony from Mrs ASP, an experienced councillor and voluntary worker, suggests that there were gaps in communication. Service provision under the welfare state on such a large scale was a new venture, so it is not surprising that systems, infrastructures and policies were not well developed or explicit. There was a lot of learning to do in a reversal of culture. Leadership was provided by the MOH and also the CWO; both were vocal in their analysis of problems and future plans. According to their reports both of these professionals had strong opinions on desirable care and on existing gaps in health and welfare provision for old people. Expectations and statutory obligations had to be balanced against available resources, and the gaps identified were symptomatic of this

[102] MOH 1960, Introductory Letter, p. 8.

conundrum. There does not seem to have been a clear process for debate on the implementation of policy into local practice.

Oxford does appear however to have been advanced in health and welfare provision for old people. It was not only the work of Dr Cosin and his team at the CRH that helped to improve the facilities for old people. Similar acknowledgement should be given to Oxford City's MOH and the CWO, who together launched and improved services for old people. Their interpretation of welfare legislation resulted in a positive approach to provision for old people.

CONCLUSION

The intention of this thesis was to discover the role of the CRH and whether the local population perceived any changes in it before and after the inception of the welfare state, in the context of a wider exploration of growing old in Oxford during in this period. This thesis has demonstrated that there were shifts in perceptions of the CRH from 1930 to 1960, and that these were influenced by many factors. Shifts in perceptions of the CRH ultimately themselves affected the care of old people on different levels, for example in family care and services in the community. The study has explored different layers affected by shifts in perceptions, identified underlying influences, and in the process has contributed new perspectives on the history of ageing. Identifying local change and community responses to this, against a backdrop of national transformation has provided an insight into the interaction of local and national factors. Similarly, this detailed local case study has created the opportunity to examine more intricate effects of changes that could be overlooked in a larger national investigation of the health and welfare provision for old people.

During the period 1930 to 1960 there were some remarkable changes for the British population; older people certainly benefited from these, and their quality of life was improved. Key factors included a questioning of the poor law system in the 1920s and 30s, social pressures highlighting the plight of older people, medical advances and the presence of a dedicated group of individual doctors challenging inherited practice for older people. Political change in the 1940s enabled the creation of a state welfare structure. The Second World War had a pronounced effect on this development as did rhetoric from politicians; both led to generally raised expectations of provision under the new welfare state. In reality, there were gaps between policy intentions and the delivery of services.

Highlighted within this thesis has been the unique contribution that oral history would bring. Throughout this thesis oral histories have featured as an important component in discovering the work of practitioners and the care of relatives. Testimonies from the early pioneers of geriatric medicine in the NSA collection uncovered a professional experience of how doctors worked in former workhouses like CRH, how this affected their practice, and ultimately the patients. Documentary and oral sources have balanced and reinforced each other providing a more rounded view of Oxford's past. For example council records provided an official perspective on the housing situation,

whilst oral history accounts of personal experiences of the conditions in which old people lived, and the difficulties experienced, complemented the picture.

The central theme of the thesis has been the relationship of one of the city's workhouses to the care of old people. General historical studies have discussed the fear of the workhouse. Chapter Three focussed on local attitudes to the workhouse or public assistance institution (CRH), from 1930 to 1948, and examined any influences that this may have had on families providing care for old people. Respondents with a wide variety of experiences talked about their perceptions of the workhouse, and the fear and the stigma attached to admission. This was something I was generally aware of, and wanted to discover some actual incidents that made the fear of the workhouse more tangible. In view of this, respondents were closely questioned to give examples of the cruelty that some claimed occurred in the workhouse. My own view prior to carrying out this thesis, was that appalling things had occurred in the institution, and that this was an opportunity to open up some memories of the past. In fact, little horror was revealed, and a contrary picture has emerged. Respondents could not identify any examples of dreadful practice or incidents to suggest that this was a place of terror. Inmates seemed to be comfortable and appreciative of the care they received. Of course, the environment, inherited from the nineteenth century poor law, was gloomy and drab, and practice in general was not as it is today. But within the context of time, the standards and practice appear to have been acceptable. Without this accommodation it is quite likely that vulnerable old people would have been in a worse predicament because, as the evidence clearly suggests, admission to the workhouse was a "last resort".

Today, discussion of standards of care for old people in poor law or public assistance institutions probably conjures up punitive, harsh images as the following incident demonstrates. In 2002, an old couple in Oxfordshire needing residential care were placed in separate OPHs. National and local press followed the story. One local paper the Oxford Mail took up this case and published this piece headed "Callous Priorities":

> We believed the days when couples were separated because of infirmity and old age were gone with the repeal of the Poor Law and the closure of workhouses.
>
> It is hoped that the elderly Banbury couple who have been forced to live apart for three months will be re-united today.
>
> But it is scandalous that Gordon and Nora Watts should have been separated in the first place. No amount of excuses that there was insufficient money in the

> social services purse to keep them together is acceptable. A county council spokesman said there was a need to prioritise. The Oxford Mail agrees, but if caring for the old, infirm, the young and the needy is not a priority, then what is?
>
> The time has come for a thorough investigation into the way the county's social services department is run.
>
> If the county council is prepared to live with 19th century standards of care, we are not. Leader Keith Mitchell and his executive team had better take that on board now.[1]

I would suggest that, if the above commentary from the Oxford Mail is read by historians in 50 years time, they may well consider that the residential conditions for old people in 2002 were terrible, especially so if examined alongside some present day scandals of nursing homes and abuse of old people. As society advances our expectations are raised and those of today are as different to those 50 years ago as those of the future will be looking back to today. It is easy to be disparaging out of context.

This thesis would not want to suggest that old people in public assistance institutions were all comfortable and well cared for, as this was clearly not the case. Medical professionals have revealed that old people's health was neglected during this time. Chapter Four illustrated how the pioneers of geriatric medicine worked hard to transform this situation, and to raise the profile of old peoples' health and welfare, which were interlinked. It is apparent that doctors were among the main instigators in promoting improved welfare for old people. However, as government departments had made it quite clear that old people would not be a priority in the welfare reforms, this led to a paradox. On the one hand, renowned doctors were supplying information to the government in order to develop policy to improve the health and welfare for old people; and on the other hand the government was asserting that only limited finances would be available as the priority was to be younger people. Well intentioned professionals with progressive ideas were handicapped because of unclear boundaries in this legislation. Throughout the 1950s, growth in the older population and demand for services increased pressure on professionals working within limited and ill defined institutional contexts.

Perhaps the absence of pro-active government support for the care of old people was responsible for Dr Cosin's individual approach. Chapter Five demonstrated how a young enthusiastic doctor worked to change conditions for old people on local, national

[1] Leader, Oxford Mail, 8 November 2002.

and international levels. Having been involved in a crucial national committee to establish policy at the beginning of a new era, and enthusiastic about the potential for improving the care of older people, he must have been demoralised by the limited outcomes and effects of legislation. Consequently I would speculate that he concentrated on local developments (along with international ones), and played a minimal national role in contrast to before 1948. His local work at the CRH turned the institution around and raised the profile of old people in Oxford. Testimonies by his contemporaries have shown how significant his work was, and how highly he was regarded amongst professionals.

Following the Local Government Act of 1929, some changes were made to the delivery of welfare. These were effectively mainly administrative, but there were some policy implications arising from this legislation. Respondents did not acknowledge any difference in welfare services at this time, as relief was still considered to be under the poor law. Significantly CRH was still referred to as the workhouse despite the formal name change. On a local level, transfer to the welfare state from the poor law did not generate any immediate practical changes in 1948 and most alterations were in administration. The significant 'Appointed Day' seemed to have passed by like any other. (Given that the 'Appointed Day', was a historical land mark, it is somewhat disappointing to discover that locally there was no outstanding significant event to remember it by.) The effects of the change would not have been experienced immediately, instead it was a slow process. Whilst the anticipation the welfare state provoked enthusiasm, access to information for many people on the transfer would have been limited, as there were not the same mediums of communication as today; radio and newspapers were the main channels for distributing information. Although free access to health care and increased services were available, it appears that, in the main, most old people did not immediately use the new services. By the end of the 1950s however, many people would have had some experience of use.

Evidence revealed that the stigma attached to the workhouse affected and influenced families' attitudes to providing care for their older relatives before the inception of the welfare state. Chapters Three and Six drew out other complex elements to this issue, including family dynamics, accommodation conditions and older relative's health. Whilst many families wished to care for an older relative, there were situations where it was just not possible to provide it, mostly for practical reasons. Prior to 1948, families

with relatives who needed care outside the family faced community disapproval, and negative attitudes towards admission to institutions for older relatives were still prevalent in the 1950s. There did seem to be the beginnings of additional shifts by the end of the decade, as some relatives of respondents were using OPHs. Community resources were effectively rationed by the welfare department, giving priority to old people with urgent needs. Essentially this reinforced the concept that residential accommodation reflected a poor social situation. This notion is carried over today by some older people. A short while ago a friend's 83 year old mother had to go into a nursing home to convalesce after a hospital admission. She was mortified and remarked to her daughter, "What will people think, they know I have two daughters?" Her attitude is reminiscent of her age group and may well be shared by others. Admission to an institution is still humiliating for some old people and indicates that your family do not want, or care for you. Will there be any change in attitudes by the following generations who have grown up in a different culture with different expectations?

Following the progress of Oxford City Council during the transition to the welfare state from the poor law, has produced important empirical data to illustrate the limited available resources for old people's services, notably the Meals on Wheels, home helps and residential accommodation. Demand therefore outweighed supply. The case study gave the opportunity to uncover the nature of this unmet need. One outstanding area was a lack of care for old people with mental health problems, particularly dementia. As this is flagged up in both national and local oral collections, and the MOH reports, the inference must be that there was little understanding of the condition. Attempts were being made to redress this, indicated by Dr Cosin's innovatory research into the condition along with that of his colleagues.

Whilst there was a shortage of resources, Oxford City was quite advanced in understanding the needs of old people. Progressive policies from the health and welfare agencies combined together to improve the lives of old people. The newly established Department of Social Medicine at the university, under the leadership of John Ryle played a part in the appointment of Dr Cosin. Dr Cosin's approach to geriatric care was in line with the aims of social medicine and ultimately influential in policy development. Financial restraints undoubtedly played an important part in the actual delivery of services, but explicit in the evidence is the clear intention of the local

authority to provide for old people in the community in innovative ways. Both the health and welfare departments were working together to improve the development of service provision in the city.

It is pertinent to note the community's changing attitudes towards the CRH over five decades. In the 1930s and 1940s there was hatred for the CRH from the community; in the 1950s ambivalence; and in the 1960s and 1970s enthusiasm. The 1950s was the beginning of a change in attitudes by residents towards using the CRH, and accepting help from statutory agencies. I would hypothesise six reasons for changes, in the community's attitudes. Firstly, that a good service was offered by the hospital and that professionals had a good understanding of older people's and carers' needs; secondly, there was an economic interest by management in improved services, which meant consistency in Dr Cosin's treatment strategy; thirdly professionals had confidence in their work which was reflected in the way patients were treated; fourthly, word spread round the community on the changing nature of the hospital; fifthly, older people and their relatives wanted more independence and so took advantage of the CRH facilities such as the day hospital and relief care beds; and finally, the improved regime at the CRH did not now mean that older people went in to die. Receiving care from the state began to be acceptable because the stigma had been removed, individuals realised that the benefits of treatment were real and professionals delivered the service in a different kind of therapeutic context.

What of the later history of the CRH? By the mid 1970s CRH had become a well established geriatric hospital in Oxford. Despite this, following much discussion in 1981 CRH closed. The general reason for closure by the Oxfordshire Area Health Authority (AHA) was considered to be economic.[2] CRH buildings were old and outdated and a new hospital the John Radcliffe II, was about to be opened. It was thought that this new hospital, in conjunction with other local hospitals would be able to provide for older people in the area. CRH was closed despite a Trades Union Council Inquiry, which felt that CRH should remain and be updated, as this would be in the interests of older people as geriatric care could continue to be centralised in one place. The inquiry heard from nursing staff at the CRH that, 'the "old workhouse" image is

[2] See Oxford and District Trades Union Council, Cowley Road Hospital: The Case Against Closure: First Report of the Trade Union Inquiry into the Provision of Services for the Elderly in Oxfordshire (October 1979).

now a very secondary consideration and one that vanishes when a patient is admitted.'[3] Financial arguments were challenged by the inquiry and by Oxfordshire Community Health Council (CHC) and alternatives were suggested. These were proposed to the AHA but rejected. Despite demonstrations and lobbies from the labour movement the hospital was closed. The public response to the closure of an institution that was once a workhouse was impressive. The AHA, a statutory body, had used the inherited stigmas of the old workhouse as one of the reasons for closure of CRH, yet the public and other bodies felt that this was outweighed by the interests of patient care. Clearly the perceptions of the local population had changed as can be seen by the ways the staff of the CRH and the community were united in defending the institution. It is an interesting paradox that in the late 1970s and early 1980s it was the management that wanted to close CRH on the grounds that it was an old workhouse, outdated and uneconomic, whereas the community and some professionals fought to save the hospital. Citizens had begun to have a voice and attempted to reclaim "the workhouse," now perceived as a hospital which was useful to the local community.

[3] Oxford and District Trades Union Council, Case Against.

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Appendix A
Personal details of oral respondents

Relatives

Identification	Study Reference	Year of Birth	Personal experience
Mrs AB	OX2	1924	Worked in service to an older lady in North Oxford during the 1930s; and family experience of older relatives post-1948.
Mr JB	OX3	1920	Grandparents lived nearby pre-1948; experience of older parents post-1948
Mr HB	OX27	1917	Experience of grandparents pre-1948; and parents post-1948
Mr BB	OX4	1916	Had first hand experience of living in a poor law institution as a child
Mrs MC	OX5	1929	Grandparents were ill pre-1948; and parents post-1948
Mrs MD	OX6	1913	Experience of ageing parents in the 1950s
Mrs KE	OX28	1919	Experience of ageing parents in the 1950s
Mrs VG	OX8	1908	Experience of ageing parents in the 1950s
Mrs OH	OX9	1910	Mother was ill pre-1948; father lived with family post-1948
Mrs SH	OX11	1907	Grandparents lived with family pre-1948; mother lived with family post-1948
Mr RH	OX30	1910	Elderly parents pre-1948; mother admitted to CRH in 1949
Mrs MH	OX10	1918	Had experience of older people in the community pre-1948; worked as a carer for an older person in the late 1940s and early 1950s
Mrs IH	OX12	1918	Had first hand experience of living in a poor law institution as a child
Mr MH	OX26	1915	Experience of grandparents; father was ill pre-and post-1948 and nursed at home
Mrs HH	OX13	1910	Experience of older mother-in-law pre-1948; and father post-1948
Mr BJ	OX14	1913	Experience of grandparents and parents pre-and post-1948
Mrs KP	OX17	1922	Experience of grandparents and parents pre-and post-1948; entertained residents of the CRH as child
Mr MW	OX25	1915	Elderly father lived with him pre-and post-1948
Mr NS	OX18	1914	Grandparents lived until their late 80s and 90s; parents aged post-1948
Mr ML	OX15	1915	Lived with grandmother as a child; had experience of older relatives pre-and post-

Identification	Study Reference	Year of Birth	Personal experience
			1948
Mr RT	OX22	1918	Grandmother lived with family pre-1948; older parents post-1948
Mr MT	OX20	1911	Lived with grandparents as a child; pre- and post-1948 experiences of older relatives
Mrs ST	OX21	1913	Experience of grandparents pre-1948; and parents post- 1948
Mrs MG	OX31	1911	Had father and mother-in-law to stay for long periods during 1940s and 1950s
Miss ME	OX32	1916	Grandparents pre-1948; cared for parents pre-and post-1948
Mrs LW	OX33	1914	Cared for her father post-1948
Mrs DC	OX34	1902	Experience of grandparents and parents pre-and post-1948
Miss BW	OX35	1901	Experience of elderly father pre- and post-1948
Mr DB	OX36	1919	Experience of grandparents pre- and parents post-1948
Mrs JT	OX37	1915	Experience of grandparents pre-1948
Mrs RB	OX31	1911	Pre- and post-1948 experience of grandmother and parents
Miss BH	OX39	1919	Experience of grandparents and parents pre- and post- 1948
Mrs SS	OX40	1916	Pre- and post-1948 experience of a sick mother
Mrs DB	OX41	1920	Experience of grandparents pre-1948; and post-1948 experience of other relatives
Mr BH	OX42	1909	Pre- and post-1948 experience of mother and mother-in-law
Mr EB	OX49	1923	Had grandparents and parents living locally pre-and post-1948
Mr HC	OX44	1916	Pre- and post-1948 experience of grandparents, parents and parents-in-law
Mrs MP	OX45	1916	Post-1948 experience of elderly mother
Mr WL	OX56	1909	Experience of grandparents and parents pre- and post- 1948
Mrs IM	OX57	1906	Experience of grandparents and parents pre- and post- 1948
Mrs MQ	OX53	1921	Experience pre- and post- 1948
Mrs OA	OX55	1907	Experience of older relative pre- 1948

Professionals

Identification	Study reference	Year of Birth	Professional experience
Mrs MA	OX1	1913	Nurse at RI in the 1930s
Mr MG	OX16	1921	Physiotherapist at CRH from 1950
Mr JW	OX23	1913	Community policeman from 1930-1960
Dr MB	OX46	1926	GP in East Oxford from 1950
Dr DL	OX48	1922	GP in Oxford from 1950
Mrs EB	OX47	1928	Trained as a nurse at RI in 1946; experience of pre- and post-NHS
Mrs EL	OX50	1923	Trained as a nurse at the RI in 1942
Mrs AP	OX52	1921	Trained as an almoner in London 1947-1948; worked at the RI during the transition to NHS
Mrs UH	OX60	1907	Worked as a psychiatric nurse pre- and post-1948
Mrs VE	OX51	1923	Trained as a nurse at the RI in 1942
Miss SW	OX24	1914	Professional social work experience pre-and post 1948 in the voluntary sector
Mrs ASP	OX19	1925	Had political and voluntary work experience in 1950s
Mrs MF	OX7	1926	Trained as an occupational therapist in 1944; had a placement in the London Road Hospital
Miss JA	OX58	1913	Trained as an almoner pre-1948; worked as a social worker at CRH in the early 1950s
Mr FC	OX61	1928	Worked as a junior doctor at CRH in the 1950s
Mrs SB	OX29	1933	Trained as a nurse at the RI in the early 1950s

Some respondents (both relatives and professionals) who were interviewed did not want to be taped. Their details are not included.

Appendix B

Questions for Respondents.

What year were you born in? or How old are you now?

How long have you lived in Oxford?

With whom did you live?

Can you describe your life with them?

Did you pursue a career?

What experience did you have of Grandparents/old people?

Where did they live?

Who looked after them when they became unable to live alone?

Do you have any memories of CRH or the Laurels?

Did you know any people who went into them and for what reason?

Did you go into these places?

Did you encounter any problems for old people in your job?

Have you any particular memories about the lives of old people?

Before starting the interview a few minutes would be spent engaging with the respondent. Questions were not necessarily asked in the sequence above. Respondents could give much information in response to one answer. Answers generated more questions and were particular to each respondents experiences. Professionals were not asked about family details but some volunteered them and did not mind them being used for the study.

APPENDIX C

Dr Cosin's Profile

This profile has been compiled by using information from Dr Cosin's Curriculum Vitae written (approximately) in 1983. Dr Cosin held numerous positions during his career. I have only identified those he held at the beginning of his career until 1965.

Local positions
Clinical Director, Geriatric Unit Rivermead Rehabilitation Unit Oxford Regional Hospital Board (1956-1968)
Chairman Geriatric Medicine Committee, Oxford Regional Hospital Board (1951-1967)
Member Oxford Regional Hospital Board Physical Medicine Committee (1951-1973)
Advisor, Oxford Regional Hospital Board on Geriatrics (1951-1972)
Lecturer on Geriatrics, Oxford City and County Councils (1950-1976)
Member Medical Advisory Committee, Oxford Regional Hospital Board (1951-1967)
Member, Oxford Disabled Persons' Committee, Ministry of Labour (1960-1968)
University lecturer, Geriatric Medicine, University of Oxford Magdalen College (1960-1976)

National positions
Member British Medical Association Committee on Geriatrics (1948-1949)
Member Executive Committee, Medical Society for the Care of the Elderly (1948)
Member, Association for Research on Ageing (1951-1970)
Late Member, Advisory Council National Corporation for the Care of Older People (1951-1958)

International positions
Visiting Lecturer, United Kingdom Information Service Canada (1951)
Visiting Fullbright Fellow, Division of Gerontology, University of Michigan (1951)
Consultant Bureau of Medical Care and Hospitals, Maryland State Public Health Department (1951/1955)
Visiting Consultant, New York State Mental Health Commission (1951/55/57)
Visiting Fellow in Physical Medicine, New York University (1951-1952)
Consultant in Charge, Reorganisation of Chronic Sick and Geriatric Programmes, American Joint Distribution Committee in Israel (Malben Programme) (1954)
Consultant, Onandago County, New York State, USA, Chronic Sick and Geriatric Care Programme (1955-57)
Visiting Consultant, Public Health Department, California, USA (1955/57/58/60)
Visiting Lecturer and Consultant Veterans' Administrations, USA (1955-1960)
Advisor on Geriatric Care to Community Studies, Kansas City (1956-1958)
Consultant on Geriatric Care, American Joint Distribution Committee, Belgium and Holland (1956)
Visiting Lecturer and Advisor, Department of Veterans' Affairs, Canada (1955-1956)
Expert Advisor on Geriatrics, World Health Organisation, Kenigswinter, West Germany (1959)
Consultant on Geriatrics, World health Organisation, Oslo, Norway (1959)
Visiting professor University of Saskatchewan Canada 1960
Advisor, Hospital Charities Commission, Victoria, Australia (1961)

Advisor Ministry of Health, Queensland, Australia, (1961)
Advisor, Ministry of Health, Tasmania, Australia (1961)
Advisor Ministry of Health, Western Australia (1961)
Advisor, Ministry of Health, South Australia (1961)
Lecturer of Geriatrics, Tubingen University, West Germany (Department of Psychiatry) (1962)
Lecturer of Geriatrics, Brussels University (1962)
Lecturer of Geriatrics, University of Berne (1962)
Advisor, Dusseldorf Town Council, Geriatrics and Chronic Sick Care (1962)
Advisor, West Berlin City Council, Geriatric Care (1962-1967)
Advisor Morrocan and British OSE on Geriatric Organisation, Morroco (1963)
Visiting Consultant, Special Staff on Ageing, Department of Health, Education and Welfare, United States government (1963-1967)
World Health Organisation Expert, Brussels, Conference on Occupational Medicine (1964)
Advisor, Ministry of Health and Social Welfare, East German Democratic Republic (1964)
Advisor, Malamo County Council, Sweden (1964)
Lecturer of Geriatrics, University of Florence (1964/1966)
Lecturer of Geriatrics, University of Lund, Sweden (1965)
Fourth International Medical Rehabilitation Council, World Health Organisation (1965)

Publications

Dr Cosin's curriculum lists ninety two publications between 1940s and 1979. His articles were published in national and international journals. Only papers published until 1965 have been included in this appendix due to their relevance to the period under review for this thesis. Dr Cosin's curriculum vitae does not give full details of his published works.

1947

'Organising a Geriatric Department', BMJ, 2 (1948) p. 1014.
Art in Geriatric Rehabilitation

1948

'Aids to Hospital Care of the Elderly', Medical World January (1948).
Proceedings of the Royal Society of Medicine 'A Statistical Analysis of Geriatric Care', (May 1948), pp. 333-336.
'Some Observations upon the Radiology of the Small Intestine in Old Age', (with HJ Jungmann DMRE) British Journal of Radiology, June (1948).
'Window on the Wall', Lancet (1948).
'Modern Methods in the Care of the Aged', Journal of the Royal Institute of Public Health and Hygiene, (1948) pp. 122-135.
'Rehabilitation of the Chronic Sick', Nursing Mirror, November and December, (1948).
'Geriatric Rehabilitation – The Contribution of Physical Medicine', The British Journal of Physical Medicine, November/December, (1948).
'Geriatric Rehabilitation', Lancet, (1948), p. 804.

1949

'Rehabilitation of the Chronic Sick', Nursing Mirror, January, (1949).
'Geriatric Rehabilitation', British Journal of Physical Medicine, November/December (1949)
'The Psychological Significance of Geriatric Rehabilitation', Journal of the Royal Institute of Public Health and Hygiene, (1949).

1950

'The Need of Emotional Adjustment in the Elderly', National Council of Social Service, (Inc) May, (1950).

1952

'Physiotherapy in Geriatric Rehabilitation', Permanent Foundation Medical Bulletin, (1952).
'A Statistical Analysis of Geriatric Rehabilitation', Journal of Gerontology, (1952).
'Physiotherapy in Geriatric Rehabilitation', Proceedings of International Congress of Physical Medicine, (1952), pp. 37-144.

1953

'Geriatrics', in W. Donohue, (ed) Rehabilitation of the Older Worker
'Geriatric Rehabilitation: textbook on physical medicine (edited by B Kiernander)
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