Bureaucracy, Benevolence and Medical Innovation

Cecily Hunter

Introduction

In 1956, Graeme Larkins, the first doctor appointed to the position of 'geriatrician' in Victoria, gave his first public address on the topic of geriatric services.[1] He began by saying that there was nothing new about the methods to be used in the purpose-built unit then under construction at Mount Royal Home and Hospital for the Aged (hereafter Mount Royal) at Parkville. The restorative treatment to be provided in this novel hospital setting was new only in the sense that it was to be used for old people whose disabling conditions had previously been treated by putting the afflicted person to bed.[2] What Larkins did not mention was that the introduction of geriatric services also entailed establishing a new type of medical role and definition of sickness. Unlike the other medical roles Victorians had come to expect in their hospitals, the role of 'geriatrician' (a title not then in common use in either Australia or Britain which provided the model for the geriatric service) focused not on the cure of specific disease conditions, but on minimising and preventing disability in patients who could not be cured and who, in their dependence, relied upon publicly funded institutions.

John Lindell, first medical chairman of the Hospitals and Charities Commission (HCC), outlined the purpose of the geriatric units, that were to be situated in the benevolent institutions, at a meeting in 1954 of representatives both from Mount Royal and from the Queen Elizabeth Home in the provincial city of Ballarat.[3] The units were to be centres for geriatric services, each serving a specific region, from which a medical practitioner appointed as 'geriatrician' would classify patients referred from the public hospitals and from the surrounding community, assessing the potential of each individual for rehabilitation.[4] This medical practitioner would then oversee the provision of appropriate restorative treatment by nurses and therapists, followed by discharge to an environment judged, with the assistance of a social worker, to be the most appropriate to that person's needs. Ideally, he or she would then be supported in this environment by com-

munity-based welfare services. The geriatric units were also to play a part in developing a knowledge base for this work, to educate professionals and to inform local communities.[5] In the environment of the geriatric service a socio-medical definition of *sickness* related to social competence would replace the prevailing charitable assessment of *need*.

Geriatric services were part of the plan for a regional system of hospital services devised by Lindell who, influenced by developments in the discipline of social medicine in postwar Britain, wanted to reconnect hospital services and medical care with local communities.[6] The geriatric service was intended to carry 'the assault on disease' into the community, by establishing 'chains of care' extending from the acute hospital, through a geriatric unit, into every home. It aimed to 'docket every old person in the region… to know their condition' so that no one would be 'declared a chronic' and sentenced to institutional life without the chance to return to the world of everyday life.[7] Medical treatment in the geriatric service focused on the patient's capacity to participate in the social world rather than the restoration of norms of physiological function.

The purpose of this article is to examine the process through which a small group of doctors, the voluntary committees of management of the benevolent institutions and the State's hospital bureaucracy cooperated to 'reframe' the poor and infirm 'old person' as a 'sick man'.[8] Overall, this attempt to establish a medical role in relation to problems of sickness, for which episodic, hospital-based treatment was inadequate, through a revival of community responses to the needy and infirm aged was unsuccessful. Nonetheless, this narrative of frustration and disappointment is valuable for its insights into the social context of definitions of sickness and meanings of old age.[9] The role of 'geriatrician' and the definition of the 'geriatric patient' in 1960s Victoria may more fruitfully be seen not as the result of a failed enterprise, but rather a positive response by representatives of the community and medical practitioners to the challenges posed in this process to existing social interests, to the demands of establishing a medical career and to public and professional understandings of illness and old age.

Geriatric services—A community enterprise

The role of geriatrician was introduced in circumstances where the principal sponsors of the project, the Hospitals and Charities Commission and the committees of management of the benevolent institutions, were united in the aim of improving conditions for a neglected segment of the Victorian community. This unanimity of purpose, however, obscured the complex territory that pioneer 'geriatricians' would have

to negotiate if they were to be successful in replacing a charity model of 'care' with a medical model of 'service'.

When John Lindell was appointed chairman of the HCC in 1953 he was already involved, as medical superintendent of the Royal Melbourne Hospital (RMH), in a project directed towards the needs of 10 per cent of patients treated at the RMH who could not be discharged because they had nowhere to go.[10] Prior to taking up this appointment he had visited Britain where he met Marjory Warren, Lionel Cosins and W. F. Anderson (later Sir William), the doctors who developed the geriatric service as a practical response to the demand for institutional care in their own municipal hospitals.[11] On his return, Lindell initiated discussions with nearby Mount Royal for the purpose of establishing a geriatric unit that would be situated at Mount Royal but managed jointly by the two institutions. Committee of management members at Mount Royal were ready to cooperate, as their manager, Colonel Robert Elliott, had recently recommended the introduction of rehabilitative treatment following his own trip overseas.[12] As HCC chairman, Lindell incorporated the geriatric service into his plans for a regional system of hospitals to meet the needs of a growing postwar population in Victoria.

Lindell, who was described by an obituarist as a personable and clever man, confronted the task of organising a fragmented and unevenly distributed system of hospital services with limited financial resources.[13] His first report to the Victorian Parliament noted two pressing problems—the provision of acute hospital beds and the development of services for the chronically ill.[14] Lindell's approach exhibited the characteristic combination of local ideas and practices with British and American influences that had shaped the Victorian hospital system.[15] In drawing on a model for regional hospital services that had been developed in the US, Lindell reinforced the voluntary element so fundamental to the provision of hospital and welfare services in Victoria, while at the same time extending the scope for professional expertise in service provision and management.[16] His emphasis on the treatment of the 'whole person' in community-based hospitals, and the provision of preventive and restorative medical services in his regional system, came from Britain: firstly, in the practical example he found in the geriatric service; and, secondly, in the theoretical model developed by John Ryle, Professor of Social Medicine at Oxford from 1942 to 1949. Ryle was one of a small group of prominent physicians in Britain who wanted to equip doctors to deal with the chronic conditions for which curative medical services offered little. He hoped to establish the discipline of social medicine as a 'social biology' in which the sick person was presented in his or her natural environment—the home and the community—in contrast to the unnatural environment

of the hospital where all human attributes were obscured in the focus on physiological disturbance.[17]

Lindell's enthusiasm for introducing social medicine into the organisation of Victoria's hospital services was shared by a few of his colleagues. Eric Saint, for example, introduced social medicine to his students at the Clinical Research Unit attached to the Walter and Eliza Hall Institute and the Royal Melbourne Hospital.[18] In 1953, Saint published a study of elderly patients at the RMH that exemplified the social medicine interpretation of disease as a reflection of the 'cultural structure of society and the occupational pursuits of its members'.[19] Minutes of meetings held at the University of Melbourne's Faculty of Medicine in the early 1950s record an intention to appoint a lecturer in social medicine, while Joseph Silver Collings set up general practice in Richmond to provide socio-medical services similar to those found in the geriatric service.[20] Social medicine was also promoted in the newly established Mental Health Authority (MHA) under the direction of Dr E. Cunningham Dax.[21] Overall, however, mainstream medicine showed little interest in these projects. Collings' enterprise foundered for lack of financial support, Eric Saint moved to Perth to establish the medical school at the University of Western Australia and a lecturer in social medicine was never appointed.

Even in the administrative structure supporting the geriatric service, an area where Lindell had direct influence, there was an element of ambiguity that made the task of pioneer 'geriatricians' more difficult. Lindell established a special geriatrics division in the HCC but instead of appointing a medical practitioner to head the division he put a nurse, Elizabeth Johnson, in charge.[22] Given the limited influence of the nursing profession over medical matters it is hard to see how this division could provide adequate support for doctors introducing a new medical service. In Queensland, New South Wales and Western Australia, steps were also taken in the late 1950s and early 1960s to establish geriatric services. In contrast to Victoria, however, the medical practitioners involved were appointed as directors of geriatric services within the responsible government departments in these States.[23] While straitened finances may have accounted for this economy in Victoria, it is also possible that Lindell may have believed that he, as HCC chairman, would provide sufficient medical support for the doctors who took on the work of establishing geriatric services. The problem was that he was also the principal source of support for the committees of management and the interests of Lindell's proteges did not always coincide, although both groups acknowledged the value of his support.[24]

Where Lindell may have seen the geriatric service as an early step in introducing social medicine, the committees of management which were to establish these services saw the project in terms of providing

for the infirm aged. They were ready to cooperate with the HCC because they received funding that their institutions had badly needed for many years, and because the addition of special medical services promised to enlarge their activities. Their commitment found disciplinary support in the postwar proliferation of literature on the 'problem of old age' from social scientists, policy makers and welfare providers in Britain and America.[25] This emerging discipline of gerontology promised to foster an existing disposition in the Victorian community to focus its charitable energies on needy and infirm old people.[26]

The doctors who took on this work were in a similar position to those who had introduced medical services into the voluntary hospitals, in that they gained community support for the practices associated with modern medicine and surgery, and wrested the requisite authority from their committees of management as they went along. It appears that 'geriatricians' were expected to do likewise; their situation, however, was somewhat different. From the beginning there were grounds for common interests between the committees of management and the doctors in the voluntary hospitals: firstly, in the desire to maintain a turnover of patients; and, secondly, in that once surgery became safer, the benefits of such medical services were clearly apparent to both parties. It was not too long after the voluntary hospitals were established that a medical diagnosis of physiological pathology replaced the charitable assessment of need, albeit not without disagreements along the way.[27] The successful establishment of a geriatric service, on the other hand, depended on a total shift in the culture of the benevolent institutions. An efficient geriatric service would generate a turnover of patients, with only a residual group requiring institutional care. This threatened to undermine the need for institutions with hundreds of beds, the clearest possible evidence of a community's care for its infirm old people and the mark of a successful committee of management.

Medical innovators

In Victoria, the doctors who took on the task of establishing geriatric services only came into the picture after the HCC and committees of management made the decision to establish such services.[28] In this, their position contrasted both to that of their British counterparts and to that of Dr Richard Gibson who established a geriatric service at the Royal Newcastle Hospital (NSW) in the mid-1950s. In Britain the geriatric service was developed by hospital-based doctors with administrative responsibilities that made them aware of the demand for long-term care, to which they responded by developing specific services.[29] In the provincial Australian city of Newcastle, Gibson, a hos-

pital-based physician, instigated the process together with his medical superintendent Dr C. J. McCaffrey. McCaffrey believed that restorative treatment should be routinely included in services provided in the general hospital.[30]

In Britain, and in Newcastle, geriatric services were on the margins of mainstream medicine, but the position of the Victorian doctors appointed to establish geriatric services was even more marginal. This was clear from the beginning when the travelling scholarships that were made available for those doctors appointed to develop geriatric services were justified on the grounds that doctors needed encouragement to take on work so clearly outside mainstream medicine.[31] The scholarships were funded by three philanthropic businessmen[32] and awarded to three of the first doctors appointed—Cecil Ashley, David Wallace and Robert Butterworth—all of whom spent time travelling in Europe, Britain and the US inspecting provisions for infirm old people before taking up their appointments.[33] In comparison, P. G. Livingstone, the doctor appointed to establish a geriatric service at the Princess Alexandra Hospital in Brisbane, was sent to work with Marjory Warren at the West Middlesex Hospital where he qualified as a physician.[34]

Although the ‘geriatrician’ represented a significant innovation in medical services, the doctors who took on this work were slotted into an existing space in hospital positions occupied by the convalescent medical officer in outlying institutions attached to the public hospitals. The convalescent medical officer emerged in the 1920s when wards at the Repatriation Department Hospital at Caulfield were first taken over by the State government, principally for the use of the RMH but also the other teaching hospitals.[35] These wards accommodated patients who could not be discharged home but nor did they need acute hospital services, and the institution was then named Caulfield Convalescent Hospital.[36] The medical officers who staffed theses wards were responsible only for the day-to-day care of their patients. The overall medical management of these people remained the responsibility of the consultants in charge of the department in the originating hospital.[37]

The ‘geriatrician’ was thus lodged in a confined and, given the existing pattern of medical work in Victoria, inconsequential space bounded by that of the consultant specialist in the acute hospital on one side, and the general practitioner in the community on the other. The marginal position of these early ‘geriatricians’ was reinforced by Lindell’s insistence that the position be a salaried one.[38] A salaried position set this group of practitioners apart both from the honorary consultants in the teaching hospitals, who occupied a position at the top of the medical hierarchy, and from the fee-for-service, entrepreneurial medical practice that prevailed elsewhere. In the view of many Australian doctors, salaried work implied a close association between

the medical profession and the State, an association they believed to be inimical to good medical practice.[39]

Those doctors prepared to take on the task of establishing geriatric services were a diverse group. Both Graeme Larkins, in charge of the geriatric unit at Mount Royal, and David Wallace were younger men who had recently returned to Melbourne after gaining postgraduate qualifications in Britain.[40] Larkins must have had a special interest in the medical care of elderly people because on his way to study in England he had visited both the Institute of Gerontology and Endocrinology and the Maimonedes Hospital for the Aged in San Francisco.[41] His postgraduate training also included a stint in Marjory Warren's department at the West Middlesex Hospital. Wallace, a Sydney-trained doctor appointed to establish a geriatric service at Greenvale Village (in accommodation no longer needed for tuberculosis patients), undertook his training at the Postgraduate School at the Hammersmith Hospital in London.[42] No doubt both he and Larkins hoped to integrate their work in developing geriatric services into their overall objective of establishing themselves as consultant physicians.[43]

Many of the older men in the group, general practitioners well on in their careers, were motivated by more personal desires. Collin Robjohns was appointed medical superintendent at the Queen Elizabeth Home in Ballarat, specifically to introduce rehabilitative treatment. Previously, local medical practitioners had provided palliative medical care for the 600 inmates of the institution on a sessional basis. Robjohns had been in general practice in South Australia when he applied for the Ballarat position, after a stint in medical practice in China with the London Missionary Society. Life as a GP had failed to provide the satisfaction he sought and he felt he had lost the sense of vocation that had imbued his work in China. The challenges he faced at Ballarat soon revived that sensation.[44] There is no record of why Cecil Ashley took on the work of establishing a geriatric unit in the infirmary wards of Caulfield Hospital, and no indication of E. A. Eddy's motivation in taking on a similar task at the Cheltenham Old People's Home (later the Kingston Centre).[45] Horace Tucker, however, a golfing friend of Eddy's and a local GP, found it increasingly difficult to cope with a busy general practice because of the after-effects of war service. When Eddy suggested he join the medical staff at Cheltenham, Tucker accepted. The work gave him a new lease on life, despite the disparaging remarks of his friends, and he was proud of his early involvement in developing medical services for a neglected segment of the population. In time he, too, was appointed medical superintendent.[46]

John Shepherd, another general practitioner, was employed as a full-time medical officer at Heidelberg's Repatriation General Hospital (RGHH). His ambition to work in general practice in the country had

been frustrated by illness, and the new era beginning at Mount Royal offered him an opportunity for a hospital-based career at a time when general practitioners were increasingly excluded from employment in hospitals, including at the RGHH.[47] Shepherd was ready to take on the position of Rehabilitation Medical Officer when Graeme Larkins' sudden and untimely death in 1959 left it vacant. Larkins had relinquished his position in charge of the geriatric unit at Mount Royal shortly after the unit opened but maintained his connection with the hospital. Shepherd's experience at RGHH meant he was familiar with the restorative regime being introduced at Mount Royal.

In the early 1960s when Dr Alan McCutcheon retired after three decades as medical officer at the hospital, John Shepherd was elevated to the new position of medical superintendent.[48] In the meantime Robert Butterworth, an English-trained doctor with an MD qualification in physiology, was appointed in charge of the geriatric unit. The reasons for Larkins' resignation prior to his death can only be a matter for speculation but it is likely they were related to restrictions imposed on developing a career as a consultant physician by full-time employment at Mount Royal, an institution without any standing in mainstream medicine. Butterworth, an outsider in the parochial world of Melbourne medicine and coming from the salaried medical practice of the National Health Service, may have been more inclined to be satisfied with the appointment, which he held until his own untimely death early in the 1970s.[49]

Reordering old age infirmity

Between the late 1950s and the mid-1960s any contradictions between the objectives of 'geriatricians' and those of their committees of management were overlaid by a general enthusiasm for the project of establishing geriatric services. Those doctors who took positions as 'geriatricians' came into contact with a range and depth of old-age infirmity that few of their colleagues saw in their everyday work. Collin Robjohns was surely not alone in feeling a revived sense of vocation as he confronted the task of introducing a treatment regime. This is not to suggest that the inmates of the benevolent homes were exceptionally badly treated. The institutions were certainly drab, shabby and overcrowded but there is no reason to believe that the inmates—like their counterparts in the Public Assistance Infirmary when Marjory Warren first encountered them—were not, in general, well fed and clean according to contemporary standards.[50] These standards and the ethos whereby the poor infirm aged had to be grateful for what they were given were, however, challenged when an active medical role led to

the introduction of specific techniques of treatment and standards of accommodation and nursing care.

Beginning in the mid-1950s, the committees of management of the homes introduced facilities to provide restorative treatment as they saw fit, within the limits of the subsidies provided by the HCC.[51] In all the homes, to varying degrees, new accommodation was added and old wards renovated.[52] The annual reports of these institutions show that wards previously distinguished according to whether the inmates were bedridden or ambulant were now designated according to treatment regime. There were geriatric units or rehabilitation wards where patients underwent straightforward restorative treatment with the expectation of discharge; wards for long-term rehabilitation; assessment wards where newly admitted patients were examined prior to being allocated to the appropriate section; and wards where long-term care was provided. In addition, all the institutions continued to provide for 'well' old people in hostel- or dormitory-style accommodation. Day hospitals were also established to provide restorative treatment on an outpatient basis, making it possible to treat without admission and to maintain post-discharge supervision.[53]

The subsidies provided by the HCC brought a degree of standardisation into the institutions and it was on this basis that they were, in due course, reclassified as Special Hospitals for the Aged and became known as Geriatric Hospitals.[54] Only two 'geriatric units' had a close association with an acute hospital: Mount Royal with the RMH, and the unit at Caulfield Hospital with the Alfred Hospital, Prahran. Ballarat's Queen Elizabeth Home was notable for the domiciliary service it introduced to assist applicants for institutional care to remain at home.[55] The combination of hospital and community-based services that made up a geriatric service required a degree of cooperation between State and municipal bodies, and between the providers of hospital and welfare services, that was unknown in Victoria at the time. With the exception of Ballarat, none of the institutions overcame this hurdle.[56]

In the reconfigured 'benevolent' setting, medical practitioners laid the foundations for a form of medical expertise related to the management of old-age infirmity. Larkins pointed out that there was nothing new about the methods used in treating disabled old people; the novelty lay in providing this treatment with the aim of keeping them 'active and healthy functional members of the community instead of merely providing them with comfortable custodial care'.[57] Nevertheless, it would have come as a shock to the first patients admitted for rehabilitation treatment to find themselves the objects of such intense attention. All their experience would have led them to expect that to have a stroke, to fracture a hip joint, to be diagnosed with Parkinson's Disease, or to be afflicted with the crippling and debilitating pain of

arthritic joints would mean spending the rest of their days confined to bed or, at best, a wheelchair. The prospect for those without any resources was grim.[58] They faced the ignominy of going into 'a home', to see out their days in the dreary routine of bed-care provided by overworked attendants in wards shared by forty or more of their peers, many of whom would have already sunk wordlessly, others more raucously, into an indeterminate condition between life and death.

By contrast, in the geriatric unit at Mount Royal these infirm individuals found themselves in the hospital version of a domestic setting.[59] Beds were arranged in small units of four or six, with cupboards nearby for the everyday clothes that patients were expected to wear during their stay. Bathrooms were close by, in which, depending on their disabilities, they would relearn the art of bathing and dressing. In yet another section, there was a dining room where patients were expected to take their meals and engage in the sociable interaction that was so essential in maintaining a mental orientation towards community life. In addition, there were specified areas for occupational therapists and physiotherapists to assist patients in developing the skills needed to undertake these activities within the limits of their disability.

For those whose lives had already been reduced to the confines of bed, the dissection of every aspect of their disability must have been a confronting experience, possibly a mixed blessing in view of the efforts they were required to make if they wished to alter their bed-bound condition.[60] On admission to the geriatric unit at Mount Royal, each patient became the focus of attention as physician, social worker, therapists and nurse attempted to gain 'full knowledge of the patient, his nutrition, his environment, his aspirations and the foundation of residual capability' on which to base restorative treatment. Not surprisingly, it was often difficult to motivate patients who '… when first seen are lacking hope: they feel that nothing can be done for them and must be convinced that attempts at improvement are worthwhile'.[61] Group therapy was particularly helpful in assisting patients to see that what could be done for others may also be done for them. It was, therefore, especially important to provide rehabilitative treatment in an area well separated from the wards where long-term care was provided in order 'to concentrate the thought of the patient on the idea that they can and will get well'.[62] This emphasis on separating the rehabilitation unit from the long-term care wards indicates the extent to which the introduction of restorative treatment for infirm old people contested prevailing ideas about what it meant to be old and disabled.

There may indeed have been 'nothing new' about the rehabilitative techniques used in the geriatric units. However, they entailed a complete reversal in the prevailing view that bed rest was the most appropriate response to old age, sickness and disability. The effects of bed

rest on the aged body in compounding existing infirmities and promoting additional deformity and disease were described by Marjory Warren in the late 1940s. Put to bed the patient 'rapidly loses morale and self–respect', it being clear that there is no hope of recovery and all independence gone. Their temperament becomes 'apathetic or peevish', even aggressive, and 'laziness and faulty habits' develop, perhaps even incontinence. Confined to bed the inactive aged body undergoes changes that are difficult to reverse—bed sores, postural deformities, contractures, and 'disuse atrophy of the lower limbs'.[63] Where the objective of rehabilitation treatment for younger adults was to restore their capacity to work and a stable level of independence, for the infirm elderly it was related to the capacity to participate in everyday life: to get about, to feed oneself, to wash, dress, and be sociable. In addition, restorative treatment was provided from a perspective that recognised that this capacity for participation was likely to change from time to time as new illnesses or injuries were superimposed upon existing ones. Recognition of the importance of activity in maintaining well-being in infirm old people underpinned John Lindell's ideal of 'docketing' each vulnerable individual in the region served by a geriatric unit.[64]

Bodies paralysed by stroke were inspected closely by geriatrician and physiotherapist to identify unimpaired muscles that might be strengthened through exercise in order to reinforce those affected by injury or disease.[65] Others long confined to bed, having lost strength and the capacity for balance, had to learn anew how to move about, beginning by rolling from side to side on the floor and crawling, until gradually reaching the point of being able to remain upright with the assistance of technical aids. When individuals had been confined to bed or chair for a protracted period and inactive limbs had contracted, it took a while to distinguish between damage associated with neurological malfunction and that arising from disuse, and even more time needed to strengthen long-unused muscles.

Elderly amputees also found themselves the objects of unexpected attention as doctors, technicians and therapists focused their efforts on devising ways of making them mobile.[66] It had long been presumed in the general hospitals that the poor peripheral circulation that made amputation necessary would also make it unlikely that an artificial leg could be successfully attached. In addition, the expense of these prostheses (around £100) did not allow for experimentation. In the new geriatric setting, however, doctors, therapists and technicians tackled this problem with enthusiasm. Lighter, temporary prostheses were developed for a cost of between £15 and £20, which allowed the patient to become accustomed to the experience without great expense. Other solutions were cheaper; £2 or £3 could provide a bucket and peg leg,

and double amputees whose stumps were too short for prostheses could be prepared, with 'considerable time and effort', to use 'rockers' that were suitable for indoors and were supplemented outside the house by a wheelchair.[67]

The cooperation evident in the treatment of amputees was an integral component of the rehabilitative process. Robert Butterworth acknowledged this in his first presentation at the third Geriatrics Conference in 1958, when he brought along his co-workers to speak about their contributions.[68] Overall, as Graeme Larkins stressed in his outline of the rehabilitative process, it was the work of nursing infirm old people that was transformed. Where the measure of care provided by untrained attendants was how much they did for their charges, in the restorative environment care was measured in terms of how much the nurse was able to encourage each patient to do for themselves.[69] Nurses needed to understand the contributions of the various therapists so they could reinforce this work in their everyday dealings with patients. Even in the long-term care wards an element of technical expertise was introduced with the treatment of incontinence through routine measures, the avoidance of pressure sores, and the attention given to nutrition and fluid intake.[70] The importance of the nurses' contribution was marked by the award of a travelling scholarship to Ray Tabbner, deputy matron at Mount Royal, similar to the ones given to the first 'geriatricians'.[71] The geriatric hospitals became training schools for nurses aides to replace the untrained attendants who previously staffed the wards, and a postgraduate training program for nurses began in the late 1960s.[72]

In the restorative regime that emerged in benevolent institutions in the late 1950s and early 1960s, sophistication and homeliness were combined in both techniques and the physical environment. In some cases it was sufficient to encourage the bed-bound to get out of bed (not always an easy task), to wash and dress in everyday clothes, and perhaps to perform simple exercises at the foot of the bed.[73] In other cases, as the foregoing paragraphs indicate, techniques were more complex and required professional expertise. Time was also an important factor in the process, to allow for patients' lack of confidence to be gradually replaced by the 'realization that some independence was possible'. Mental confusion in a newly admitted patient could not immediately be attributed to permanent changes; it was likely to clear given time, as 'often apparent poverty of intellect is due mainly to loss of hope and will improve rapidly with active attempts to help'.[74] This tolerance of mental confusion, however, was based on a selective process through which patients whose 'poor intellectual capacity, undue loquacity, inability to concentrate, (and) spatial disorientation' had already ensured they were considered unsuited for restorative treatment.[75]

Victorian 'geriatricians' did see a role for themselves in providing services for elderly individuals whose mental state had deteriorated. At the 1961 Geriatrics Conference John Shepherd claimed that up to 30 per cent of potential patients for the services offered at Mount Royal suffered in this manner. The problem he faced in making services available to all old people who could benefit from them was that he could not admit patients immediately, as his institution continued the practice of admitting patients on the basis of their position on the waiting list.[76] The reforms introduced in the mental hospitals when Cunningham Dax became head of the MHA in the early 1950s also included attempts to introduce the geriatric service into MHA hospitals.[77] The only reason for establishing two forms of the same type of service at this time was the customary division in hospital services according to whether they dealt with physical or mental disease and the administration of these services by two different authorities. G. V. Davies, a MHA psychiatrist, published a study in 1961 suggesting that many problems attributed to the intractable difficulties of old age were due more to the organisation of hospital and medical services. He called for closer links between geriatrics (care of the aged), general medicine and psychiatry to address these problems, a call that remained unheard until the 1980s.[78]

The geriatric patient

The 'geriatric patient' was defined at the annual Geriatrics Conferences as representative patients were brought along to illustrate the principles of rehabilitation. Depending on the skills of the doctor presenting these living examples, the appearance of rehabilitated patients was both an illustration of the possibilities of restorative treatment and an opportunity to teach the principles of an active approach to the medical care of elderly patients. David Wallace, in his account of restoring mobility in eighty-three-year-old Miss B whose leg had been removed because of arteriosclerotic gangrene, was thus able to show the need for vigilance in the prevention of bedsores.[79] As Miss B had been confined to bed for some time before her admission to Greenvale, a sore had developed on the heel of her remaining foot. In noting this point Wallace took the opportunity to discuss methods of preventing and healing such sores. He went on to say that when Miss B was admitted she had lost all interest in life, 'she was old, she'd lost her leg, attempts had been made to get her on her feet, they'd been unpleasant to her and she'd given up hope'. She was prepared to spend what little time she had left sitting in bed waiting to die.

Had a rehabilitative approach been established practice in the public hospitals, Miss B may not have experienced this degree of despair.

At Greenvale the concerted efforts of therapists and nurses encouraged her to make the effort required. An artificial limb was devised—'nothing much to look at'—but she walked on it and 'she'll walk off with something that's well, quite passable for an artificial leg'.[80] Once she had gained some independence at Greenvale Miss B was transferred to a half-way house where, having got to the stage where she was looking after herself to a certain extent in an institutional setting, she could try herself out in a more domestic environment.[81] The hope was that she would return to her little house in inner-suburban Richmond after it had been checked by a social worker to see what alterations were necessary to enable her to manage.

The rehabilitated patients exhibited at the Geriatrics Conferences were, however, a minority in the day-to-day work of geriatricians. Generally, patients referred to them were candidates for long-term care not rehabilitation followed by discharge. The foregoing account of innovative techniques, the inventive fabrication of aids and the air of optimistic cooperation among medical practitioners, nurses, social workers and therapists, presents a somewhat idealistic picture that was, at best, characteristic of the years immediately after the reclassification of the benevolent homes as geriatric hospitals. By the mid-1960s the impetus of this early period had faded. In institutions that retained many of the marks of their nineteenth-century origins, the 'geriatric patient' in Victoria was barely distinguishable from the impoverished benevolent home inmate. David Wallace made the association between geriatrics and poverty clear when he defined 'geriatrics' as the medical management of old people who, in addition to physical and mental afflictions, suffered from 'social infirmity'. That is the combination of

> lack of money, lack of friends and relatives who can or will care for the patient… and general frailty which makes it hard for an old person to continue to battle on leading an independent existence.[82]

Professional failure—institutional success

In Victorian teaching hospitals throughout the 1960s, medical work became increasingly defined in terms of specialised services for which postgraduate and college-accredited courses of training were required.[83] In contrast, the 'geriatrician' in Victoria was confined to overseeing the welfare of long-term care patients in institutions that, in the eyes of the community and the medical profession, were 'old folks homes'. This is not to deny the gains that were made during this period. The changes that took place in the benevolent institutions set standards

for the long-term care of infirm old people that had not existed before, a considerable achievement that extended into the institutions run by the voluntary agencies.[84] Nevertheless, the position of 'geriatrician' in Victoria in 1970 had less in common with contemporary hospital-based doctors than, for example, with the institutional psychiatrist of nineteenth-century Britain. There also the number of doctors increased and institutions became more numerous but, as in the geriatric hospitals, the principal medical career was that of medical superintendent. The prospects of medical officers who filled positions lower down the career ladder were limited, their role being confined to easing the burden on the superintendent.[85]

How did it happen that John Lindell's attempt to minimise institutional care by introducing a form of hospital provision based upon a socio-medical interpretation of illness resulted in the expansion of institutions, and a medical role defined not in terms of service provision but of institutional setting? There is no doubt that from the beginning those doctors who took on the task of establishing geriatric services were at a disadvantage in relation to their colleagues, in being slotted into the space occupied by the convalescent medical officer from whom little was expected other than the day-to-day supervision of patients. The position of nascent geriatricians in providing a socio-medical service was made even more difficult as mainstream medicine in Victoria showed no support for such a service.[86] This was not because the Victorian medical profession refused to acknowledge the contribution made by social factors to sickness and disability. It did so by accepting the social worker into the hospital and by defining the role of the general practitioner in terms of that doctor's individualised knowledge of each patient.[87] There was no support for a hospital-based medical role in the provision of socio-medical services.

Generally, the doctors who took on the work of establishing geriatric services were in no position to promote the provision of socio-medical services with their hospital-based colleagues, although Graeme Larkins might have been able to do so but for his untimely death. For while David Wallace and Robert Butterworth may have had the formal qualifications to engage with their hospital-based colleagues, they were outsiders in the parochial Melbourne medical world.[88] Nor do these two practitioners appear to have been equipped with the personal characteristics to overcome this hurdle. Not long after Butterworth was appointed to Mount Royal he had cause to question the judgment and good will of the doctors at the Royal Melbourne in referring patients to the geriatric unit. At a meeting of the consultative committee formed to oversee the operation of the unit shortly after it opened, he noted 'the slight tendency for RMOs to dump patients on us'. He followed with the sad observation that 'we appear to be

getting many decrepit cases referred for admission… not all rehabilitation cases attend the weekly (Outpatient) Clinic'. The moderate tone of these remarks suggests he may have been ill equipped to make a forceful defence of the treatment principles he sought to implement. As for David Wallace, he resigned in the face of the obstacles presented by the obstructive approach of his committee of management and the frustrating delays in the workings of the HCC.[89]

The general practitioners who worked to establish geriatric services were in no better position; they had no standing in the teaching hospitals and their colleagues in the community showed little interest. Some GPs attended the lectures and demonstrations provided by Robert Butterworth in his unit, and a special interest group was formed within the Victorian branch of the British Medical Association in 1961. However, there is no record of any activity by the group.[90] Nor did GPs show any interest in joining the Victorian branch of the Australian Association of Gerontology when it was formed soon after the national body had been established in 1965.[91] Lloyd Jago, geriatric medical officer and medical superintendent at Cheltenham's Kingston Centre in the 1970s and 1980s, accounted for the lack of interest on the part of GPs by pointing to the general tendency to exclude these practitioners from the teaching hospitals. There may, however, have been more to the reluctance of GPs to acknowledge the 'geriatrician' as a provider of medical services. In the early 1970s when Malcolm Scott was establishing a geriatric service at Mount Eliza, he placed a short note describing the service in the *Monthly Paper* issued by the Victorian branch of the Australian Medical Association. The mollifying tone of Scott's emphasis on the role of the general practitioner as a provider of medical services for 'the elderly and chronically ill' suggests the existence of some degree of antagonism on the part of GPs.[92]

The position of Victorian 'geriatricians' in relation both to their medical colleagues and to their patients was very different from that of Richard Gibson at the Royal Newcastle Hospital. Gibson, a physician at the hospital with all the rights regarding treatment and admission that go with such a position, was able to arrange with local doctors that if any of the patients seen in his geriatric service required admission to hospital, that the doctors would contact him directly.[93] Within the hospital, his own position and the support of his medical superintendent ensured that candidates for the geriatric service were admitted to his care. In Victoria, even if a GP with a patient who had suffered a stroke or whose arthritis was making mobility increasingly difficult did recommend admission to a geriatric hospital for restorative treatment, the proposal was likely to be received unsympathetically. The view expressed by the friends of Horace Tucker when they asked him why he was getting involved with 'those dreadful old people' was most

probably representative of the general community view of the geriatric hospitals.[94] It highlights the point that those who did benefit from restorative treatment were generally people who had no choice because they occupied a public hospital bed and had nowhere else to go.

Even in their own hospital environment Victoria's nascent geriatricians were not able to establish their authority to the extent that they controlled admission policy. Had they been able to do so, their colleagues both in the hospitals and in general practice may have been encouraged to take their work more seriously. However, ten years after the reclassification of the benevolent homes as 'special hospitals', patients continued to be admitted according to their position on a waiting list. The inexorable growth of these indisputable demonstrations of need for long-term care fuelled demands for funds to support institutional expansion. At the Kingston Centre in the early 1970s, the committee of management harboured an ambition to reach the 1000-bed mark.[95] The building virus also infected the committee of management at the Queen Elizabeth Centre in Ballarat, notwithstanding its early commitment to provide domiciliary services to enable frail old people to remain at home. Collin Robjohns resigned before his contract expired rather than appear to condone by his presence a fund-raising drive by a committee of management intent on institutional expansion.[96]

Why were these doctors in this position? It might be expected that the Association of Geriatric Medical Officers would work to raise the status of its members, but after a few years of activity in the early 1960s the association appears to have lapsed. It must be acknowledged that those doctors who established the role of 'geriatrician' would have found it difficult to develop any form of collegial association. They were few in number and based in institutions located at considerable distances from each other. Furthermore, each institution was responsible for a very large area. In addition to the work involved in transforming a custodial care environment into a treating one, even in relation to individuals requiring long-term care, travelling to examine patients referred for admission could take up a large part of a doctor's working day.[97] In comparison to their teaching hospital colleagues, and even the psychiatrists who also faced enormous problems in establishing geriatric services in the 1960s, 'geriatricians' were isolated from the professional support that others took for granted.

Isolation and lack of numbers do not, however, entirely explain the failure by 'geriatricians' to wrest the necessary authority from their respective committees of management, and the associated failure to shift the community view that the provision of beds was the most appropriate response to old-age infirmity.[98] Indeed, it seems that the doctors who persevered in working in the field of geriatrics throughout the 1960s were those who—by virtue of age, gender and/or dis-

position (for there were plenty of opportunities in other areas of medical practice)—shared the same conservative outlook as their committees of management.[99] It was a conservatism characteristic of a period of social and economic change in which ‘standards of social responsibility’ appeared more vulnerable. While technical innovation was lauded it was accepted through an accommodation with prevailing attitudes and practices.[100] The doctors who developed the role of ‘geriatrician’ were thus satisfied with a position of some standing as medical superintendent, and prominence in the field of activity that emerged throughout the 1960s around the provision of care for old people in the State geriatric hospitals and voluntary agency homes.[101] The ‘field of aged care’, based on increased government spending, perpetuated an ethos in which care provided in institutions was paramount. In part this was a response to demand, and in part a response to the interests that found their justification in this ethos.

Elderly individuals also played their part. A short film made by the Kingston Centre at Cheltenham to advertise its facilities illustrates the attitude underlying the practice of well, old people applying for institutional care. It begins with a view of an elderly but fit man walking through the gates and down the drive, dressed in his best clothes and carrying a small suitcase. The accompanying commentary describes his situation. After a life-time of hard work and being alone in the world, he is, although still well and able to work, approaching the time when he may not be. In preparation for this day he has taken the wise step of applying for admission to the centre and can now enjoy the security of knowing he has somewhere safe for the remainder of his life.[102]

The field of care for the aged that emerged in the 1960s was pervaded by an ethos of ‘care’, reflecting the community’s view of appropriate provision for aged adults. In the process of making a place for themselves in this field, medical practitioners took on this ethos as they attempted to deal with the problems that confronted them while, at the same time, making the most of the opportunity to develop a hospital-based career as general practitioners. This alliance is illustrated in John Shepherd’s response when he accompanied the manager of his hospital, M. E. Atkinson, on a visit to Richard Gibson’s geriatric service at Newcastle.

The conditions Shepherd worked in were very different from those Gibson had to deal with. He had no control over the referral of patients or admission policy, his hospital was responsible for a large area of a capital city and many applicants for admission could not be kept at home because they had no home. Nevertheless, it is notable the extent to which his response concurred with that of Atkinson rather than Gibson’s. The two Victorians agreed that patients in Gibson’s service appeared to be discharged ‘somewhat ruthlessly’, often to conditions

they believed were 'well below standard'. Gibson had countered their reservations with the comment that patients were used to these conditions and the close supervision provided by the service made it possible to act quickly when problems arose.

The difference between Gibson's approach and Shepherd's was most evident in their responses to the provision of long-term care. Gibson refused to offer this, although the beds were available, because he did not want to discourage relatives from accepting the principle of patients being returned to their own homes, even when in practice this meant nursing homes in the community. Shepherd, on the other hand, was prepared to accept involvement in long-term care, thereby emphasising his alignment with his institutional manager. To some extent this response was a matter of necessity. The people who were admitted to Mount Royal were very likely not to have a home. However it also illustrates the positive reaction of Victorian 'geriatricians' to the circumstances in which they found themselves. They established their role through combining a medical orientation towards old-age infirmity with the community ethos of care, because it made sense from the perspective of the doctors who persisted in the work (those who were satisfied with the solid, but limited power of the institutional medical superintendent) in relation to the actual problems they confronted. It was not simply the result of unpropitious circumstances that, at a conference on the topic of 'Clinical Problems amongst Aged Patients' held at Lidcombe Hospital in New South Wales, the Victorian contribution by John Shepherd dealt with the provision of long-term care.[103]

None of the obstacles to developing the geriatric service in Victoria and establishing the role of 'geriatrician' as service provider were seriously confronted, because of a measure introduced by the Federal government. In an amendment to the *Hospital Benefits Act 1951* that came into effect early in 1963, the Commonwealth provided a subsidy for long-term care, entering a field that had previously been the sole responsibility of the States.[104] As most of the beneficiaries of the subsidy were infirm old people, in taking this step the Commonwealth also increased its contribution to age-related welfare measures. This contribution began with the passing of the *Invalid and Old Age Pensions Act 1908,* and it progressively relieved the State government of a significant expense. The subsidy for long-term care arose not out of a desire to address the needs of infirm old people, but from the necessity to make workable the system of voluntary hospital and medical insurance that the Menzies' government had introduced in 1951. A condition of eligibility for the subsidy was registration with the Commonwealth Department of Health, so the measure had the effect of gathering together a motley collection of provisions for long-term care into a new category of hospital bed—the nursing home bed.[105]

The nursing home subsidy meant that the HCC had even less control over provisions for the care of infirm old people, because the subsidy was paid directly to providers. Private businesses took advantage of the subsidy to enter the field of long-term care, and charitable bodies found a new avenue for institutional funding. Necessity may have forced mainstream medicine to reconsider whether old people at risk of custodial care did, in fact, receive appropriate care in hospital, but this impetus was removed with the proliferation of nursing homes that provided an outlet for the 'disposal' of the 'bed-blockers' in the public hospitals.[106] Victorian 'geriatricians' were further marginalised with this development. If this form of hospital provision was associated with any segment of the medical profession at all, because no medical authority was required for admission, it was with general practice. This association, however, was purely incidental, arising out of the distinction made in medical practice between the acute hospitals and the community. GPs may finally have been given their own particular form of hospital service but it was one that they used as individual practitioners tending to their individual patients. There was no attempt on their part to establish standards of treatment and accommodation similar to those associated with medical care in the general hospitals.

Why did the HCC not intervene to ensure that a medical assessment of need was the principal factor in the operation of the geriatric hospitals? First, it did not have the authority to compel an institutional committee of management to take any particular course of action. Second, the commission did not have the political clout to ensure that decisions that may have been unpopular with committees of management were immune from political interference. Bridget McCoppin noted in her early 1970s study of the HCC that the health portfolio ranked low among ministerial offices. In the long reign of the Liberal Party that began shortly after Lindell was appointed, the position of Minister for Health was a reward for political service not an indication of interest in health services.[107] Had Lindell wished to contest the authority of committees of management, he did not have a strong minister to back him. However, Lindell's belief that 'a community's hospital resources can be planned best by the people who conduct hospitals', suggests that he would not have sought direct intervention in this matter.[108] The development of the geriatric hospitals and the role of 'geriatrician' in this environment, as overseer of the welfare of the institutional population, reflected the response of the people who conducted the institutions—their voluntary committees of management and their medical practitioners.

University of Melbourne

1. 'Geriatric service' was the term used by the English doctors who established hospital-based, age-related services; see P. Thane, *Old Age in English History: Past Experiences, Present Issues*, OUP, Oxford, 2000, ch. 22.

2. G. Larkins, 'Modern Methods of Rehabilitation', Geriatrics Conference 1956, *Geriatrics Conference 1956–1966,* Hospitals and Charities Commission (HCC), Melbourne, n.d., pp. 23–6. These annual conferences were instigated at the suggestion of Elizabeth Johnson, first executive officer of the newly formed Geriatric Division in the HCC in the mid-1950s. The conferences were sponsored by the HCC and organised, in turn, by the geriatric hospitals. They provided a valuable meeting place for the widely dispersed and isolated Victorians and their counterparts in the other States. The HCC published proceedings in two volumes, *Geriatrics Conference 1956–1966,* and *Geriatrics Conference 1967–1977.* Copies of these are held in the library at Melbourne Extended Care and Rehabilitation Service.

3. Victorian Public Records Series (VPRS) 4523/P2/947/72/2. The institution was later given the title of 'Centre' to denote the change in function from the provision of institutional care to the provision of services. For an account of the place of the HCC in the structure of Victorian health services, see R. Inall, *State Health Services in Victoria*, Occasional Monograph No. 4, Department of Government & Public Administration, University of Sydney, 1971, also B. McCoppin, The Hospital System of Victoria: Administration and Policy Making, MA Thesis, La Trobe University, Melbourne, 1974. The circumstances which the position of chairman became vacant are described in H. W. Nunn, *A Most Ingenious Hospital: A History of Sandringham and District Memorial Hospital, 1940–1990,* Sandringham and District Memorial Hospital, Melbourne, 1990, pp. 79–80.

4. Details of the classification of 'geriatrician' and 'geriatric medical officer' were outlined in the HCC Circular No. 22/1961, VPRS 4523/P2/961/183–1.

5. *Annual Report*, Hospitals and Charities Commission, 1956.

6. 'Report on Third Australasian Medical Congress, Melbourne, 1968', *Medical Journal of Australia (MJA)*, vol. 2, 1968, p. 87.

7. Lindell qualified for Fellowship of the Australian Institute of Hospital Administrators with the thesis 'A Regional Plan for Hospital Development', *Australian Modern Hospital*, no. 5, 1954, pp. 32–3; see also J. Lindell, 'A Regional Plan of Hospital Development', *MJA*, vol. 1, 1950, pp. 619–22; VPRS 4523/P2/947/72/2. The benevolent homes subsidised by the State government included institutions at Bendigo, Castlemaine, the Old People's Home at Cheltenham (formerly Melbourne Benevolent Home), Mount Royal at Parkville, the Queen Elizabeth Home at Ballarat, and the Ovens and Murray Home at Beechworth, *Annual Report,* HCC, 1955; Lindell, 'A Regional Plan of Hospital Development', 1950, pp. 619–20; J. Uhl, *Mount Royal: A Social History*, Mount Royal Hospital, Melbourne, 1981, pp. 177–8.

8. C. E. Rosenberg, 'Framing Disease: Illness, society, and history', in C. E. Rosenberg & J. Godden (eds), *Framing Disease: Studies in Cultural History*, Rutgers University Press, New Brunswick, NJ, 1992, pp. xxviii–xxi.

9. C. E. Rosenberg, 'The Aged in a Structured Social Context: Medicine as a case study', in D. Van Tassel & R. N. Stearns (eds), *Old Age in a Bureaucratic Society*, Greenwood Press, Connecticut, 1986, pp. 232–3.

10. Younger adults, incapacitated through injury or chronic illness, were also included in this category, but because infirmity increases with advancing age, older people were more prominent. *Annual Report Royal Melbourne Hospital*, 1954; RMH Archives/Minutes of Committee of Management Meetings/vol. 25. Lindell also instigated the establishment of two small rehabilitation hospitals, see L. Wedlick, 'Development of a Rehabilitation Centre', *MJA*, vol. 1, 1961, pp. 338–40 and S. Steele, *A Road to Rehabilitation*, North Eastern Health Care Network, Melbourne, 1996.

11. Personal communication from Mrs Marion Shaw, 18/2/1997. For a general account of the development of geriatric services in England see Thane, *Old Age in English History*, ch. 22; for Scotland also see ibid., and Sir W. F. Anderson, 'Geriatrics', in G. McLachlan (ed.), *Improving the Common Weal, Aspects of Scottish Health Services 1900–1984,* Edinburgh University Press, Edinburgh, 1987.

12. Uhl, Mount Royal.

13. 'Obituary', *MJA*, vol. 2, 1973, p. 984; Lindell, 'A Regional Plan of Hospital Development', 1950; *Annual Report*, HCC, 1953–54. Victorian hospitals suffered from neglect during the depression and World War II. Financial stringency prevailed even in the more prosperous 1950s because the reimbursement grants provided by the Commonwealth

to Victoria (to compensate the States when they relinquished the power to levy taxes on income to the Commonwealth in 1942), were based upon the parsimonious spending of the Dunstan Country Party government during the interwar years, A. F. Davies, 'The Government of Victoria', in S. R. Davies (ed.), *The Government of the Australian States*, Longmans, London, 1960, Appendix A, p. 235; see also Nunn, *A Most Ingenious Hospital*, pp. 61ff.

14. It is not clear whether demand for long-term care for infirm old people had increased. There are indications that it may have. Although the proportion of people over the age of sixty-five years in the Victorian population was negligible in the 1950s, absolute numbers had increased, A. Howe, 'Report of a Survey of Nursing Homes in Melbourne', *Working Paper No. 10*, Mount Royal National Research Institute for Geriatric Medicine and Gerontology, 1980, p. 18; see also H. O. Lancaster, 'Aging in the Australian Population', *MJA*, vol. 2, 1954, pp. 548–53. Reports of the medical superintendent of St Vincent's Hospital in the 1940s note patients 'appeared more elderly than before', B. Egan, *Ways of a Hospital, St Vincent's Hospital Melbourne, 1890s–1990s*, Allen & Unwin, Sydney, 1993, p. 178. And the inclusion of a session on the medical care of the aged in the proceedings of the 1952 Melbourne Congress of the British Medical Association, suggests older adults were prominent in doctors' everyday work, *MJA*, vol. 2, 1952, pp. 489–91. On the other hand, the stock of infirmary beds had not increased over the previous sixty years according to the manager of Mount Royal Home and Hospital for the Aged, VPRS 4523/P1/260/2242. Bertram Hutchinson's comment that long-term beds had been converted to acute beds suggests the overall number had diminished as well, B. Hutchinson, *Old People in a Modern Australian Community*, MUP, Melbourne, 1954, p. 157. The Austin Hospital, originally intended to accommodate the terminally ill and the incurable patients who were not wanted in the other voluntary hospitals, provides an example. When R. A. Willis was appointed medical superintendent in the late 1920s, he began to differentiate between incurable patients and moved those whose afflictions could be more readily attributed to 'old age' rather than specific pathologies, out of the hospital to the Cheltenham Old People's Home. See R. A. Willis, 'Recollections of Medicine at the Austin Hospital: Heidelberg in the 1920s', *MJA*, vol. 1, 1979, pp. 15–17.

15. K. S. Inglis, *Hospital and Community: A History of the Royal Melbourne Hospital*, MUP, Melbourne, 1958, pp. 180–3.

16. Lindell, 'A Regional Plan of Hospital Development', 1950, pp. 619–22. When the Victorian Parliament legislated to replace the Charities Board with the HCC in 1948, all parties were congratulated by The Age newspaper for combining the 'spheres of activity and service', Coppin, 'The Hospital System of Victoria', ch. 2. Under Lindell's direction the HCC developed a role in educating hospital professionals by providing, scholarships for postgraduate training for medical practitioners and other staff, studentships for potential student nurses and social workers, and it established the Mayfield Centre to provide short training courses. The Geriatrics Conferences were part of this educative role, see FN 2.

17. J. A. Ryle, 'Social Medicine: Its meaning and its scope', *British Medical Journal*, vol. 2, 1943, pp. 633–6; D. Porter, 'Changing Disciplines: John Ryle and the making of social medicine in Britain in the 1940s', *History of Science*, vol. xxx, 1992, pp. 138–40; see also G. Rosen, 'What is Social Medicine', in *From Medical Police to Social Medicine: Essays in the History of Health Care*, Science History Publications, New York, 1974, pp. 64–8.

18. R. B. Lefroy, *On Good Doctoring, Eric G. Saint, Foundation Professor of Medicine, The University of Western Australia*, privately published, Perth, 1998, Intro.; F. M. Burnet, *Walter & Eliza Hall Institute, 1915–1965,* MUP, Melbourne, 1971, pp. 40–2, pp. 148–9.

19. E. G. Saint, H. F. Albrecht & C. N. Turner, 'Old Age: A clinical, social and nutritional survey of seventy patients over sixty-five years of age seen in a hospital out-patient department in Melbourne', *MJA*, vol. 1, 1953, pp. 757–64; E. G. Saint, 'Social Perspectives in Medicine', *MJA*, vol. 1, 1955, pp. 161–2.

20. University of Melbourne Archives/ Minutes Meeting Faculty of Medicine 1953–56, Minutes Meeting, 18 September 1952; R. Petchey, '"A Man Ahead of His Time"—Joseph Silver Collings (1918–1971)', *Individuals and Institutions in the History of Medicine*, Conference Proceedings, 6th Biennial Conference of the Australian Society of the History of Medicine, Occasional Papers in Medical History No. 9, University of Sydney, 1999.

21. The Mental Health Research Institute, established by the Mental Health Authority in the 1950s, fostered research from a social medicine perspective, J. Krupinski, A. Mackenzie

& R. Banchevska, *Psychiatric Research in Victoria*, Mental Health Research Institute & Health Commission of Victoria, Special Publication No. 9, Melbourne; see also A. Westmore, Mind, Mania and Science: Psychiatry and the Culture of Experiment in Mid-Twentieth Century Victoria, PhD Thesis, University of Melbourne, 2002.

22. Johnson was the first of a sequence of registered nurse divisional officers, VPRS 4523/P2/947/71/2. She completed general nurse training at the Children's Hospital then gained additional certificates in midwifery and infant welfare, Your Hospitals, vol. 1, no. 4, 1951.

23. For Qld and NSW, see Geriatrics Conference 1962, for WA see Geriatrics Conference 1964, in *Geriatrics Conference 1956–1966*.

24. Transcript, Oral History of Kingston Centre, Ref. 19/92, interview with Dr David Quinn, member of the committee of management in the early 1970s. Quinn records the committee found, in general, that 'a lunch with Lindell' would reliably result in his support for whatever project it promoted. Personal communications Dr John Shepherd, 23 February 1998 and Dr M. Scott, 18 December 1997, both acknowledged Lindell's support for their work.

25. See N. Shock, *A Classified Bibliography of Gerontology and Geriatrics, Supplement One, 1949–1955,* Stanford University Press, California, 1957, and *Supplement Two, 1956–1961,* 1963. It was a coincidence that the development of geriatric services at some municipal hospitals in postwar Britain coincided with the publication of J. H. Sheldon's text, *The Social Medicine of Old Age*, Nuffield Foundation, OUP, London, 1948. The introduction to Sheldon's study shows it as a rare example in which the growing body of knowledge about the lives of (mostly) poor old people was allied with the social medicine perspective associated with John Ryle.

26. The establishment of the Old People's Welfare Council in Victoria in the early 1950s was a direct imitation of a British model. See A. Norris, *Champions of the Impossible, A History of the National Council of Women, 1902–1977,* The Hawthorne Press, Melbourne, 1978, pp. 95–8.

27. C. Walker, The Emergence of the Hospital System in Melbourne: 1846–1975, PhD Thesis, La Trobe University, Melbourne, pp. 45–52, pp. 128ff.

28. There may have been informal discussion between John Lindell and the doctors who were interested because when he announced his plans at the meeting in 1954 he noted that he knew of three doctors who were prepared to take on this work.

29. This distinction is not quite as clear cut as it appears here. The British doctors who developed the geriatric service did so in municipal hospitals, some of them former Poor Law Infirmary institutions that may not have been so very different from the benevolent homes. The difference was that doctors like Marjory Warren, Lionel Cosin and Eric Brookes were able to integrate their work with infirm old people into the operation of an acute hospital, albeit one low in the hospital hierarchy. In addition, the activities of local authorities in providing both hospital and welfare services offered an administrative basis for the development of the geriatric service that was absent in Victoria. The importance of local control and local administrative structures for the effective operation of geriatric services is shown in Charles Webster's chapter, 'The Elderly and the Early National Health Service', in M. Pelling & R. Smith (eds), *Life, Death and the Elderly: Historical Perspectives*, Routledge, London, 1991, pp. 175–6. Webster maintains that the introduction of the National Health Service in 1948, with its centralised control and separation of health and welfare services, impeded the effective development of geriatric services.

30. M. Henry, 'Pioneering in Geriatrics: The Newcastle Experience', in H. Attwood & R. W. Home (eds), *Patients & Practitioners & Techniques*, Second National Conference on Medicine & Health in Australia, 1984, Medical History Unit & Department of History and Philosophy of Science, University of Melbourne, Melbourne, 1985. The Newcastle service did not begin as a geriatric service but a general domiciliary service. See R. Gibson, 'The Royal Newcastle Hospital Domiciliary Care in the Newcastle District', 1959, held in the library of Melbourne Extended Care and Rehabilitation Service. The social worker who worked with Gibson described this development as a 'natural progress', as '[t]hey looked at problems as they developed and developed a program as they went along', from Henry, 'Pioneering in Geriatrics', p. 56. McCaffrey did not see any need for age-related services. In his view a general rehabilitation service should be part of the services provided by all general hospitals, 'Geriatric Care in the Newcastle Hospital', *Geriatrics Conference 1956–1966.* McCaffrey's career is described by R. G. Evans, 'A Professor 'Honorarius': An Australian

experiment in medical administration 1939–64', *Health and History*, vol. 5, no. 1, 2003, pp. 115–38.

31. *Annual Report*, HCC, 1956. Scholarship holders were required to work in approved Victorian institutions on their return. Only three doctors were awarded scholarships although there were plans to extend them to country appointments.

32. The donors were: Sir Edward Hallstrom, a benefactor of Mount Royal (see Uhl, *Mount Royal*, p. 230); James Ross, a member of the committee of management of Mount Royal (ibid., p. 181); and Sir Herbert Olney, former Chairman of the Charities Board, Member of the Legislative Council (Victorian Upper House), and President of the Committee of Management of Mount Royal. Olney is described in Uhl, as 'that staunch worker for the sick aged, and better known as a philanthropist than as a businessman', p. 180. The geriatric unit at Mount Royal was named in his honour.

33. Cecil Ashley described his tour at the Geriatrics Conference 1957, *Geriatrics Conference 1956–1966*, p. 31. Wallace's account was published under the title 'Geriatrics Overseas', *MJA*, vol. 2, 1959, pp. 40–2.

34. R. B. Lefroy, 'The History of the Geriatrics Society of Australia', in J. C. Wiseman (ed.), *To Follow Knowledge, A History of Examinations, Continuing Education & Specialist Affiliations of the Royal Australasian College of Physicians*, The Royal Australasian College of Physicians, Sydney, 1988, p. 60.

35. VPRS 4523/P1/51/475; A. M. Mitchell, *The Hospital South of the Yarra: A History of the Alfred Hospital Melbourne from Foundation to the Nineteen-Forties*, Alfred Hospital, Melbourne, 1977, FN 61, p. 272.

36. In the late 1940s Caulfield passed into the control of the Alfred Hospital and wards at the Infectious Diseases Hospital at Fairfield were made available to the Royal Melbourne.

37. B. Ford, *The Wounded Warrior and Rehabilitation*, The Alfred Healthcare Group, Caulfield General Medical Centre, Melbourne, 1996, pp. 88–9.

38. RMH Archives/Committee of Management Minutes/vol. 26.

39. J. A. Gillespie, *The Price of Health: Australian Governments and Medical Politics 1910–1960,* CUP, Cambridge, 1991, ch. 11.

40. Larkins' appointment set the pattern for the position of 'geriatricians' within the medical hierarchy in Victoria but it was an exception in that it was approved by the Medical Advisory Committee of RMH. With the exception of the geriatric unit at Caulfield, the other appointments were not overseen by the medical staff of an acute hospital but were approved by the institutional committees of management, possibly also depending on approval by the HCC.

41. Larkins had gone to England to gain higher qualifications, as many Australian doctors did at the time, after spending the years immediately following graduation (and one year as RMO at the Alfred Hospital) in general practice. His passage to a higher degree was probably delayed by the war. These details are taken from the *cv* Larkins submitted when he applied for the position of geriatrician, RMH Archives/Chairman's Correspondence/ no. 1/Medical Matters/vol. 15.

42. 'Obituary', *MJA*, vol. 1, 1980, pp. 40–1. Hammersmith Hospital was a fitting background for a doctor to develop an interest in sickness in old people as it had evolved from a workhouse infirmary. See R. Stevens, *Medical Practice in Modern England: The Impact of Specialization and State Medicine*, Yale University Press, New Haven, 1966, p. 107.

43. Wallace wrote some years later that his ambition was to be a consultant physician in a provincial city. He achieved this after leaving Greenvale and moving to Goulburn, NSW. See D. Wallace, *Joseph Coles: A Country Doctor*, n.d., no publisher, p. 91.

44. C. Robjohns, *My Several Lives*, H. C. Robjohns, Marrayatville, SA, 1988, pp. 88–95.

45. *Annual Report*, Alfred Hospital, 1956; S. Forster, '*A Place of Love', Kingston Centre—A Living History*, n.d., Kingston Centre, Melbourne. There may have been an association between Ashley and Eddy as this Alfred Hospital report notes that Eddy took Ashley's place while he was away on his travelling scholarship.

46. Forster, ibid. When Horace Tucker told friends about the change of direction in his work they responded with remarks along the lines of: 'What... are you doing out there?… getting mixed up with those dreadful old people…', Transcript, Oral History of the Kingston Centre, Ref. 3/93, 12 May 1993.

47. Personal communication from Dr John Shepherd, 23 February 1998. Shepherd came to Mount Royal from the Repatriation General Hospital at Heidelberg at a time of change

in that institution. Up to this time the Repat. had been staffed by general practitioner medical officers, with visiting consultants providing specialist services, but changes were underway to establish a medical staff similar to that of the teaching hospitals where most of the everyday medical work was done by trainee specialists. See G. Hunter-Payne, *Proper Care, Heidelberg Repatriation Hospital, 1940s–1990s*, Allen & Unwin, St Leonards, NSW, 1994, pp. 81ff. For Shepherd the changes planned for Mount Royal opened up possibilities for a general practitioner that were being closed off at the Repatriation Hospital.

48. For an account of Dr McCutcheon's career at Mount Royal see, A. B. McCutcheon, 'Retrospect', *MJA*, vol. 1, 1958, pp. 273–5. In 1959, the report submitted by J. V. Dillon on the terms and conditions of medical appointments in the State's hospitals noted the emergence of the position of medical superintendent as a specific medical career with the appropriate skills and training program. The HCC responded by providing scholarships to enable doctors to gain these qualifications and John Shepherd benefited from this. The only institution providing such postgraduate courses was the University of New South Wales. This institution had been founded in 1950 with the title New South Wales University of Technology with the objective of establishing a link between university level training and industry and commerce, a relationship that was seen to be a necessary basis for Australia's developing role as an industrial nation. The medical administration course was one of a number of specialised graduate courses. In 1958 the institution's title was changed, possibly as part of an attempt to restore its image following criticism in relation to its performance as a university. This was part of a broader discussion in postwar Australia in which the role of the universities in national development was examined. See N. Brown, *Governing Prosperity, Social Change and Social Analysis in Australia in the 1950s*, CUP, Melbourne, 1995, pp. 222–7.

49. Butterworth had applied for the position of geriatrician at Greenvale when it was first advertised but was passed over. He was also a relatively young man when he died in the early 1970s. See Uhl, *Mount Royal*, p. 182.

50. 'The Care of the Chronic Sick', a talk given by Dr Marjory Warren to the Medical Women's Federation in February 1946. See *The Lancet*, vol. 2, 1946, p. 83. For a picture of the local benevolent home environment during the war see F. Finnie, *Don't Stand on the Grass*, Vista Publications, Melbourne, 1996, chs 2 & 3.

51. Some of the problems encountered in converting a custodial care mentality to a treatment-oriented approach can be discerned in the comment noted in the record of a meeting of the consultative committee overseeing the planning and building of the geriatric unit at Mount Royal, that the plans submitted by the superintendent of Mount Royal, Colonel Elliott, showed an inadequate understanding of the requirements for a treatment setting. See RMH Archives/Manager's Correspondence/Medical Matters 1/vol. 15; and VPRS 4523/P1/260/2242.

52. New buildings were erected, possibly depending on the resources individual institutions were able to call upon in addition to the subsidies provided by the HCC. However, new buildings existed alongside some very old and dilapidated ones. The HCC, in the interests of economy, encouraged the use of existing buildings wherever possible. See *Annual Report*, HCC, 1953–54.

53. D. H. Blake, 'A Day Hospital for Geriatric Patients: The first twelve months', *MJA*, vol. 2, 1968, pp. 802–04.

54. VPRS 4523/P1/382/3167. Conditions included: the provision of daily medical attention, and specialist geriatric medical attention when required, trained senior nursing staff available day and night, chiropody services and the appointment of occupational and physiotherapists.

55. I. M. Dicker, 'Home-Help Scheme', Geriatrics Conference, 1958, *Geriatrics Conference 1956–1966,* pp. 25–8.

56. The HCC did not have the authority to overcome this problem as it was authorised to deal only with subsidised institutions. The Department of Health was responsible for subsidising services such as home delivered meals and the Elderly Citizens' Centres that were established at the behest of the Old People's Welfare Council.

57. Larkins, 'Modern Methods of Rehabilitation', p. 23. He was correct in saying there was nothing new about the rehabilitative techniques used for infirm old people. Many of them were developed to enable maimed service personnel to return to civilian life. See Ford, *The Wounded Warrior*, and C. Lloyd & J. Rees, *The Last Shilling, a History of Repatriation in Australia,* MUP, Melbourne, 1994. Even in relation to old people restorative methods had a longer history as G. F. Adams notes in his text, *Cerebrovascular Disability and the*

Ageing Brain, Churchill Livingstone, Edinburgh, 1974, p. 6. Sir Richard Gowers, an English physician, described methods similar to those promoted by Marjory Warren in his textbook published in 1888, *A Manual of Diseases of the Nervous System*. Adams writes that these principles were lost sight of in the first half of the twentieth century as 'palliative treatment of the residual disabilities of cerebrovascular disease became less important than the dramatic successes of curative treatment…'.

58. Hutchinson found in his survey that lack of family support was crucial in the demand for publicly funded care. See Hutchinson, *Old People in a Modern Australian Community*, p. 143. For a contrasting example of a man whose family, although not wealthy, were able to pay for twenty-four hour care by untrained attendants, see Finnie, *Don't Stand on the Grass*, pp. 38–40.

59. My emphasis on Mount Royal in this account may contribute to the situation, often regretted by other institutions, where their achievements were overlooked because Mount Royal assumed, and was generally granted, precedence. Mount Royal is prominent in this account simply because the doctors who developed the role of geriatrician there were more inclined to document their work in journal articles and in presentations at the Geriatrics Conferences. Robert Butterworth, in particular, published several articles in the *MJA*, and other journals, describing the techniques and devices he developed. See *Annual Report*, Mount Royal, 1963.

60. L. Yapp, 'Physiotherapy', in R. F. Butterworth, 'The Geriatric Unit at Work', Geriatrics Conference 1958, *Geriatrics Conference 1956–1966,* pp. 13–24.

61. Butterworth, ibid.

62. ibid.

63. M. Warren, 'Activity in Advancing Years', *The Lancet*, vol. 2, pp. 921–2.

64. VPRS 4523/P2/947/72/1.

65. L. T. Wedlick, 'Physical Therapy in Geriatrics', Geriatrics Conference 1957, *Geriatrics Conference 1956–1966,* pp. 13–14; Yapp, Physiotherapy', pp. 15–16.

66. See Geriatrics Conferences 1958, 1959, *Geriatrics Conference 1956–1966.*

67. ibid.

68. Geriatrics Conference 1958, *Geriatrics Conference 1956–1966.*

69. Larkins, 'Modern Methods of Rehabilitation', p. 24.

70. R. Tabbner, 'Geriatric Nursing', Geriatrics Conference 1960, *Geriatrics Conference 1956–1966,* pp. 75ff.

71. Uhl, *Mount Royal*, pp. 185–6; Tabbner reported on her tour at the Geriatrics Conference 1959.

72. For the introduction of nurses aides see J. & B. Bessant, *The Growth of a Profession, Nursing in Victoria, 1930s–1980s*, La Trobe University Press, Melbourne, 1991, pp. 71–3. J. Uhl, historian of Mount Royal Hospital, dates the first postgraduate course in geriatric nursing in the 1980s. However, Marion Shaw, the English nurse who came to Melbourne in the late 1960s and went on to become an officer in the Geriatrics Division of the HCC, says she participated in a postgraduate course at Mount Royal in the geriatric unit, beginning in April 1969. See personal communication from Mrs M. Shaw, March 1997.

73. Collin Robjohns recalled how he promised some long-bedridden ladies in the Ballarat home that if they would agree to get out of bed, they would be moved to a new wing. He also notes that the use of simple exercises at the end of the bed developed strength. See Robjohns, *My Several Lives*, p. 89.

74. Butterworth, 'The Geriatric Unit at Work'.

75. Larkins, 'Modern Methods of Rehabilitation', p. 24.

76. Geriatrics Conference 1961, *Geriatrics Conference 1956–1966,* pp. 97–8.

77. The mental hospitals were the last resort for old people who had nowhere else to go and who other institutions refused to accept, regardless of whether they needed the type of medical care provided in these institutions. See J. F. J. Cade, 'Beattie Smith Lecture', *MJA*, vol. 2, 1951, p. 218.

78. G. V. Davies, 'The Relation of Physical and Mental Disease in Later Life', *MJA*, vol. 2, 1961, pp. 152–4.

79. Case presented by Dr David Wallace at Geriatrics Conference 1960, *Geriatrics Conference 1956–1966.*

80. Wallace, 'Geriatrics Overseas'.

81. Greenvale had a half-way house at Clayton, a considerable distance from the hospital. Graeme Larkins discussed the importance of the half-way house in restorative treatment in his first contribution to the Geriatrics Conference in 1956, 'Modern Methods of Rehabilitation', *Geriatrics Conference 1956–1966,* p. 25.

82. Wallace, 'Geriatrics Overseas', pp. 40–2.

83. R. B. Scotton, *Medical Care in Australia: An Economic Diagnosis*, Sun Books, Sth Melbourne, 1974, pp. 76ff.

84. In the mid-1970s when a Diploma of Geriatric Medicine was introduced, the institutions run by the large voluntary agencies were accredited as training institutions for candidates. This suggests a degree of cooperation between doctors in the geriatric hospitals and the voluntary agency institutions. The record of the annual Geriatrics Conferences, and the meetings of the Australian Association of Gerontology, show a growing field of activity related to 'care of the aged' undertaken by State hospitals and voluntary agencies.

85. A. Scull, C. Mackenzie & N. Hervey, *Masters of Bedlam, The Transformation of the Mad-Doctoring Trade*, Princeton University Press, Princeton, NJ, 1996, p. 269.

86. Overall the Australian medical profession showed little interest in socio-medical services. In NSW the doctors who were interested were more numerous and were able to make some headway in organising services. Naomi Wing, for example, became director of a rehabilitation centre established at the Royal South Sydney Hospital in the early1950s. See N. M. Wing, 'Medical Rehabilitation', *MJA*, vol. 1, 1955, pp. 705–14. The Australian Association for Physical Medicine was formed in the mid-1940s and five years later the word 'Rehabilitation' was added to the title. The association supervised a postgraduate diploma of which the first part was done in Australia with candidates going to England to complete the second part. See L. T. Wedlick, 'Physical Medicine and its Place in the Rehabilitation Programme', *MJA*, vol. 1, 1966, p. 514. Doctors who had experience of working in the rehabilitation services for service personnel in World War II were prominent among those interested in socio-medical services. Some insight into how doctors were developing a special medical role related to rehabilitation may be gained from the report of the Section of Rehabilitation and Physical Medicine, at the Australasian Medical Congress 1955, *MJA*, vol. 2, 1955, pp. 531–73; see also, G. G. Burniston, 'Rehabilitation in Australia', *Postgraduate Medicine*, vol. 25, no. 1, 1959, pp. 49–55. It needs to be stressed that the concern here is with the emergence of a special medical role in the provision of rehabilitative services. Therapists and social workers in the 1940s and 1950s were already involved in providing such services, often under the auspices of voluntary agencies. See F. H. Rowe, 'Rehabilitation in Australia', *International Labour Review*, vol. LXXVII, no. 5, 1958, pp. 461–75; also J. Tipping, *Back on Their Feet: A History of the Commonwealth Rehabilitation Service, 1941–1991,* Commonwealth of Australia, Canberra, 1992. Doctors may have had a part in supervising the work of therapists, but they did not have treating authority.

87. C. Rosenberg, *The Care of Strangers, The Rise of America's Hospital System*, Basic Books Inc., New York, 1987, pp. 312–13; Inglis, *Hospital and Community*, pp. 85–7; L. O'Brien & C. Turner, *Establishing Medical Social Work in Victoria*, Department of Social Studies, University of Melbourne, 1979; R. Winton, *A 'Body's Body, The First Twenty-One Years of the Royal Australian College of General Practitioners*, Royal Australian College of General Practitioners, Sydney, 1983.

88. The existence of only one medical school in Melbourne until the 1960s meant that doctors trained in Victoria were a particularly close-knit group compared with, for example, British doctors. See T. S. Pensabene, *The Rise of the Medical Practitioner in Victoria*, Australian National University, Canberra, pp. 53–4.

89. S. Wickham, Greenvale from Isolation to Centre: A History of Greenvale Centre, unpub. ms held in the library of Melbourne Extended Care and Rehabilitation Service.

90. *Annual Reports*, Mount Royal, 1959–63. This special interest group was formed just as the Australian Medical Association was registered in Canberra in 1961. See Pensabene, *The Rise of the Medical Practitioner in Victoria*, p. 168.

91. Notes re inaugural meeting of the Geriatric Study Group, Victorian Faculty of Royal Australian College of General Practitioners, 14 May 1969. From Dr John Shepherd's Papers, in his personal possession.

92. AMA (Victorian Branch), *Monthly Paper*, no. 110, June 1972, p. 4.

93. R. Gibson, 'A Comprehensive Geriatric Service', *The Lancet*, August 1965, pp. 284–5.

94. See FN 45.

95. Interview with Dr David Quinn, member of the committee of management at Kingston in the early 1970s, Transcript, Oral History of Kingston Centre, Ref. 19/92. In the early 1970s the Kingston committee investigated its waiting list to find that 500 applicants had died, 500 did not reply to the questionnaire, and thirty applicants needed admission for long-term care. See Minutes Meeting Medical Superintendents and Managers, and HCC Officers, 12 March 1975, from Dr John Shepherd's Papers.

96. Robjohns, *My Several Lives*, p. 94.

97. The region allocated to the Cheltenham Old People's Home (Kingston Centre), situated in the south-east of Melbourne, extended north-east to Lilydale, then across country to Springvale and back to Moorabbin. In one day, assessing likely candidates for admission, Lloyd Jago set off from Cheltenham in the morning, travelled to Box Hill Hospital, on to other hospitals in the area around Doncaster, ending up near Lilydale at 6pm. See Oral History of Kingston Centre, Ref. 21/93, 2 February 1994.

98. Committees of management resisted medical involvement in institutional policy making, citing an institutional by-law that prevented employees of the institution from participating in committee of management activities. See, for example, Mount Royal Committee of Management, VPRS 4523/P2/8283. Medical practitioners attended committee meetings on invitation and may or may not have been able to remain at the meeting after presenting their report. Medical men were members of committees but they appear to have shared the conservative views of their lay fellows. For example, Dr Alan McCutcheon, medical officer at Mount Royal, was a member of the committee of management at Greenvale. Speaking at a session on the medical care of the elderly at a British Medical Association conference in Melbourne in 1952 he made it clear that he believed care of the infirm aged was a 'social problem' requiring community action to provide more beds. See *MJA*, vol. 2, 1952, p. 489.

99. Expansion of the hospital system in Victoria during the 1950s and 1960s provided more positions for doctors, and these were incorporated into training programs for the various specialties that proliferated in this period. See Scotton, *Medical Care in Australia*, pp. 76ff. Also, since the introduction of the system of voluntary hospital and medical insurance by the Menzies' government in the early 1950s, plus the Pensioner Medical Service to provide federally funded medical services for eligible pensioners, remuneration for GPs improved.

100. S. Alomes, M. Dober & D. Hellier, 'The Social Context of Postwar Conservatism', in A. Curthoys & J. Merritt (eds), *Australia's First Cold War, 1945–1953,* George Allen & Unwin, Sydney, 1984, pp. 6–14, pp. 27–8.

101. While the State government increased its spending in developing the geriatric hospitals, the Federal government also contributed through the subsidies provided following enactment of the *Aged Persons Homes Act 1954,* subsidies that made it possible for the voluntary agencies to establish a role in providing institutional care.

102. This film made in the late 1960s or early 1970s, is kept in the Archives, Kingston Centre, Cheltenham. It is likely that provision of funding through the *Aged Persons Homes Act 1954,* and the resulting growth of institutions, fostered a demand for such accommodation. See Australian Government Social Welfare Commission, *Care of the Aged*, (M. Coleman, Chairman) Part 2, 1975, p. 41.

103. *Newsletter of the Australian Association of Gerontology*, vol. 1, no. 2, 1965, p. 5.

104. T. H. Kewley, *Social Security in Australia 1900–72,* 2nd edn, Sydney University Press, Sydney, 1973, pp. 353–8.

105. Provisions that included the infirmary wards of the geriatric hospitals, the infirmary beds in voluntary agency homes and the private hospitals, convalescent and rest homes that were found around the more affluent suburbs of Melbourne. See Kewley, *Social Security in Australia 1900–72,* pp. 536–46.

106. A. Howe, 'Report of a Survey of Nursing Homes in Melbourne', pp. 11–13.

107. McCoppin, *The Hospital System of Victoria*, p. 95.

108. Inglis, *Hospital and Community*, p. 206.