DR. MARJORY WARREN: THE MOTHER OF GERIATRICS

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"Things are always at their best in their beginning,"- Pascal

"Medical history teaches us where we came from, where we stand in medicine at the present time, and in what direction we are marching. It is the compass that guides us into the future," Henry E. Sigerist

Summary

Marjory Warren (1897 - 1960) was a person with innovation and dynamism. Her work was missionary and her proposals visionary. She was a surgeon to start with, and yet she created geriatrics out of medicine. She advocated practising geriatrics as a specialist, and yet she emphasized the importance of generalist training. She argued for having separate wards with environment and caring process appropriate for elderly patients, but she insisted that these wards should be an integral part of a general hospital with equal access to diagnostic and therapeutic facilities. She was thankful that she was not distracted by fame during her early endeavours so that she could quietly build up this special branch of medicine. Her concern for human life, not only for the unwanted and unfittest elderly patients but also for her passengers, ended up in her tragic death in a car accident at the age of 62. Her work continues to influence and inspire those who share her conviction that elderly people deserve the best care.

Introduction

Although it has often been quoted that geriatric medicine in Hong Kong follows a British model, the pioneer work of Dr. Marjory Warren in British Geriatrics is not as widely appreciated locally. A review of the work and writings of Marjory Warren will inspire many to take up the challenge of geriatric medicine and throw light on the development of this speciality in Hong Kong.

A non-physician: from a surgeon to a medical superintendent to a geriatrician

Born in London in 1897, Marjory Winsome Warren was the eldest daughter of a barrister. She qualified from the Royal Free Hospital School of Medicine in London in 1923. After house appointments, she became an assistant medical officer in 1926 at the West Middlesex County Hospital, where her primary interest was in surgery, performing four thousand operations[1]. In 1931, she became Deputy Medical Superintendent. Her career took a turning point in 1935 when the nearby Poor Law Infirmary was annexed into the West Middlesex Hospital, and she was given overnight the medical responsibility for 714 new patients, who were chronically ill, primary elderly patients labelled as "incurable". She attributed the high number of elderly bedridden chronic sick in this Infirmary to poor diagnosis, a lack of medical supervision, insufficient treatment, a lack of multidisciplinary teamwork and an absence of rehabilitation. She accepted this new challenge by creating the first geriatric unit in the United Kingdom, based upon comprehensive assessment and early rehabilitation of the patients by a multidisciplinary team[2]. Her innovative work led to the publication of the British Medical Association Report on the Care and Treatment of the Elderly and Infirm[3] in 1947, and the initiation of comprehensive geriatric medicine service by the National Health Service Act in UK in 1948. In 1947, she became a founding member of the Medical Society for the Care of the Elderly, the forerunner of the British Geriatrics Society[4]. She was appointed as one of the first consultant geriatricians in the United Kingdom in 1949.

It is of interest to note that Marjory Warren was not a physician to start with, but a surgeon. This allowed her to take a fresh and unbiased look at the problems and needs of those elderly patients thought to be having a "disposal problem" only; and to conceive the idea of creating geriatrics as a specialty. Another example of a non-physician becoming a geriatrician is Lionel Cosin. Lionel Cosin was an orthopaedic surgeon who became a pioneer geriatrician and a founder member of the British Geriatrics Society[5]. He established an early model geriatric unit in Oxford and developed the first

purpose-built geriatric day hospital in Cowley Road Hospital in 1958.

Marjory Warren's early experience as Deputy Medical Superintendent was to her benefit in helping her to gather a multidisciplinary team and developing the organizational skills central to the development of geriatrics. As Professor John Brocklehurst has put it, "Geriatrics is an organizational speciality in which the geriatrician provides a care complex whose primary objective is to meet and overcome breakdown in independent living among old people."[6]

A humanitarian: respect and concern for human life

In the year of 1935 when Marjory Warren took over the care of 714 chronic sick patients, it was a time when chronic ill elderly patients became fixed with the poor and institutionalized in what were then known as Poor Law Infirmaries. She described the situation as "ill-assorted dumps ... large wards which are devoid of any signs of comfort or interest."[7] Her Infirmary was filled with chronic ill, bedbound, and neglected elderly patients without proper medical diagnosis or rehabilitation. Nursing care kept the patients alive, but lack of diagnostic assessment and rehabilitation kept them disabled.

She wrote of "the untreated case": "…only those who have had charge of such patients can know anything of their misery and degradation.... Having lost all hope of recovery, with the knowledge that independence has gone, and with a feeling of helplessness and frustration, the patient rapidly loses morale and self-respect and develops an apathetic or peevish, irritable, sullen, morose and aggressive temperament, which leads to laziness and faulty habits, with or without incontinence. Lack of interest in the surroundings, confinement to bed, and a tendency to incontinence soon produce pressure sores, with the necessity for more nursing of a kind ill appreciated by the patient. An increase in weight, especially in the anterior abdominal wall, or an inevitable loss of muscle tone make for a completely bedridden state. Soon the well-known disuse atrophy of the lower limbs, with postural deformities, stiffness of joints, and contractures, completes the unhappy picture of human forms who are not only heavy nursing cases in the ward and a drag on society, but also are no pleasure to themselves and a source of acute distress to their friends. Still, alas, in this miserable state, dull, apathetic, helpless and hopeless, life lingers on sometimes for years, while those around them whisper arguments in favour of euthanasia."[8]

She made an effort to examine all the 714 patients personally, assess and classify them systematically according to their mobility, continence and mental states. She introduced modifications of the dull and custodial ward environment to promote rehabilitation, reduce handicap and to stimulate interest and morale. To rehabilitate these patients, she gathered a team of staff whose central theme is optimism and hope. This team included nurses, occupational therapists, physiotherapists and social workers. As a result of her innovations, about 35% of these "incurable" patients were able to return home or go to a home for the aged, so that she eventually reduced the beds in her geriatric unit from 714 to 200 beds. In the beginning, "the geriatric unit was regarded by most of the medical staff as a convenient place to dump all their unwanted patients, medical and surgical, old and young, and usually without consultation. This old tradition has died slowly…"[9] In the beginning, only those with poor prognoses were sent to the unit. Gradually, as a result of her endeavors and success, all medical and surgical patients aged over 60 years, except those in acute emergency or immediately postoperative, came under geriatric unit supervision.

She advocated a holistic approach and cautioned dehumanizing life as numbers. She wrote, "in modern medical practice, suffering tends to be reduced to a mathematical equation. We speak of morbidity and mortality rates, incidence of disease, and survival time. Assessment of disease in these terms gives direction to further study and indicates its urgency. But there is a danger of mistaking a calculated solution for a remedy, forgetting that finally we are treating not a disease, but a person."[10] A kindly discipline from which all unnecessary red tape has been removed, and an intelligent understanding of, and interest in, them (elderly sick) as individuals, will do much to create a receptive background, without which much medical and nursing treatment will fail to be effective."[8]

Writing in 1946 in Lancet, Marjory Warren expressed surprise "…that the medical profession has been so long in awakening to its responsibilities towards the chronic sick and the aged, and that the country at large should have been content to do so little for this section of the community,"[8] a sentiment again sounded by Professor Robert Butler[11] in the United States in 1975.

A Specialist and a Generalist

Despite of her pioneer work, Marjory Warren humbly wrote in 1943, "Although I do not claim to

be a specialist in geriatrics I have for several years been much interested in the problem."[12] In two seminar papers,[8,12] Marjory Warren advocated creating a medical speciality of geriatrics: "...until the subject is recognized as a special branch of medicine in this country, it will not receive the sympathy and attention it deserves. Only in comparatively recent times has paediatrics really been fully appreciated as a speciality — and certainly in my student days children were too often nursed in adult wards, and too often junior medical and nursing staff were considered all that was necessary for their care. To-day much the same attitude is shown towards the care of the chronic sick — a class which includes the majority of elderly folk — and very frequently they receive but scant attention."[12] "There is much to recommend geriatrics as a speciality comparable to paediatrics. The creation of such a specialty would stimulate those with a leaning to this type of work and raise the standard of the work done. This branch of medicine forms an important subject for the teaching of medical students and should form part of their curriculum, and the care of chronic sick patients should also be an essential part of the training of student and assistant nurses. Research into the diseases which accompany advancing age should be encouraged and undertaken."[8]

Marjory Warren believed that geriatric medicine must remain closely linked to general medicine. She demanded careful attention to the patient's overall medical condition and correction of systemic illness before attempting rehabilitation. She held that a geriatrician must be a broadly trained physician because of the diverse skills required for proper management of all the needs of elderly people.

The publications of Marjory Warren reflect her wide interest in the medicine of old age, covering subjects on rehabilitation, physical medicine, home nursing, strokes, amputees, arthritis, mental confusion, and drug treatment. Since the 1940s, many geriatricians and gerontologists have contributed to expanding the world's medical literature on geriatric medicine and gerontology; and the number of scientific journals devoted to different aspects of ageing[13] have grown to a recent figure of 116.

A Separatist and an Integrationist

Marjory Warren advocated that chronic sick patients should be treated in a special block in a general hospital because of four reasons: "Geriatrics is an important subject for the teaching of medical students and should form part of the curriculum. It should comprise an essential part of the training of student nurses. The full facilities of a general hospital are necessary for correct diagnosis and treatment. Research on disease in old age can only be undertaken with the full facilities of a general hospital."[12]

"The proper care of the aged chronic sick requires knowledge of the elderly and sympathy with their particular requirements — and most classes of these patients should be treated in blocks as part of a general hospital. It is quite as unsuitable to treat these patients in wards for acute cases as it is to relegate them, often unsegregated, to institutions for the chronic, where facilities for diagnosis, research, and treatment are unobtainable. In the former case (acute ward), these worthy people, whose lives have been every whit as useful as we should like to believe our own, are ill-housed with younger folk who are irritated by them and in turn annoy them, and usually the staff has neither time nor facility for treatment. In the latter case (chronic institutions), there is usually a lack of attention and of facilities should an acute condition supervene — moreover, the 'chronic' institution tends to attract a less good medical and nursing staff."[12] This view has recently been echoed by the President of the British Geriatrics Society, " Hospital diversion usually means poorer care for vulnerable people."[14]

So, while she argued for having separate wards with environment and caring process appropriate for elderly patients, she insisted that these wards should be an integral part of a general hospital with equal access to diagnostic and therapeutic facilities. "For the proper care and rehabilitation of these (chronic sick) patients, the full facilities and stimulating atmosphere of a general hospital are necessary both for the establishment of a correct diagnosis and for full treatment.... It is not enough that medical students should merely be shown chronic patients; they should see them under treatment and watch their seniors manage such cases from the beginning to the end. Without such tuition there is no hope that future generations will be any more knowledgeable in the care of these patients than is the average doctor today. While such cases, still needing treatment, can easily be transferred to an institution, there is no incentive on the part of the physician to treat them. The lack of facilities in the institution render full treatment there impossible — and so another bed becomes blocked by a treatable patient."[8] "The inclusion of the geriatric unit in a general hospital, with all modern facilities and the necessary staff for

investigation, consultation, and treatment, would raise the standard of work done, shorten the time of stay in hospital, and avoid the unnecessary blocking of beds by patients who could be treated sufficiently to return to their own homes or enter a home (for the aged)."[8]

On Home Care and Institutional Care

Marjory Warren recognized that most elderly patients prefer to be treated at home and tend to recover more rapidly in familiar surroundings. "Whenever possible, they should be retained in, or returned to, their own homes, provided there is sufficient help for their comfort and welfare, and that the home conditions are suitable."[8] She stressed the need for improvement of home nursing: "Home nursing is therefore an absolutely essential part of the health scheme and must be recognized as such....If this service fails, then all other services will collapse."[15] For those who cannot remain at home, she advocated careful pre-admission assessment and treatment before considering long-term institutional care. "Only after all possible treatment has been given, and the social background carefully studied, should a patient be admitted to a home (for the aged chronic sick)." She was keenly aware of the importance of social network to an elderly person when she wrote, "Elderly chronic sick patients needing... a long stay in hospital should be treated in a hospital serving their own district and not, as has sometimes been advocated, in quieter or more remote districts.... it is important that there should be easy access for visiting, particularly for their contemporaries, who are often the visitors most wanted."

A tragic end

At the height of her productive career, Marjory Warren died in a car accident in Germany in 1960 at the age of 62. Her accompanying passengers were only minimally injured. It was reported that she was known to pay more attention to her passengers than to the road ahead.[16]

Figure 1. Dr. Marjory Warren. Copyright Adams 1961 (Ref.1)

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