approaches are varied and wide-ranging. This natural experiment could, potentially, give us the data we need to consider what the "essential ingredients" for making healthcare work for care home residents.

A new NIHR-funded project, the Optimal study, led by Prof Claire Goodman at the University of Hertfordshire, will look at several of the approaches in detail and will hopefully generate robust data on what does, and does not, work in which context. We hope to report on this as the study starts to provide answers.

**Adam Gordon**
Honorary Deputy Secretary

# A tribute to Professor John Brocklehurst
## from Hong Kong

***In the last newsletter, we published Professor John Brocklehurst's obituary. Here, Dr Tak-kwan Kong from Hong Kong shares his memories of the great man.***

I was awarded the Commonwealth Medical Fellowship by the Commonwealth Scholarship Commission of the British Council for training in geriatric medicine. The University Hospital of South Manchester (UHSM, also known as Withington Hospital) was chosen as the training centre by the Commission out of the three regions of the United Kingdom that I was asked to indicate on my application. Manchester was my preference because of the favourable feedback from my senior geriatric colleagues on their experiences with the one-week course "Advances in Medicine of Old Age" at Manchester and because of the admirable works of a textbook and an atlas on geriatric medicine by Professor John Brocklehurst from that city. So, in April 1988, I left Hong Kong with my new wife and started my one-year Commonwealth Medical Fellowship in the Department of Geriatric Medicine in UHSM under Professor John Brocklehurst.

By the time I left in 1989, John was retiring from the University. In his farewell lecture, John ended with a slide showing a photograph of two women, an older clothed one and a young nude model, looking at each other. John's vision was that young and the old would be able admire each other for their own unique qualities. Later, I learnt from John the old woman in the photo was the famed portrait photographer Imogen Cunningham, who continued to take pictures until shortly before her death at age 93. I returned to visit John in Manchester in 1994, 2004, and 2010. While intending to revisit him again in July 2013, I was sorry to learn of his passing.

John had been well known for his expertise on incontinence, a geriatric giant that impacts on elders and their carers. But he also had wide ranging interests in most areas of medicine in old age including instability and falls, fractures and bone disorders, strokes, rehabilitation, nutrition, hospital-home transition, geriatric day hospital, and medical screening before residential care. He had researched aids and equipment for helping older patients: bed-bars to facilitate transfer out of bed for those disabled by severe osteoarthritis, a reclining "relaxator" for elevating feet to drain postural oedema, and a urethral catheter designed to fit the natural contour of the female urethra. He recognised the need to widen the knowledgebase beyond geriatric medicine to biological gerontology and established a Unit for Biological Aging Research in 1974. He had always been a strong advocate for the practice of geriatric medicine as a specialty to improve the quality of care of older patients in hospital and to this end he emphasised the importance of organising hospital geriatric services into a continuum of progressive care from acute assessment to rehabilitation to long-stay wards, supported by geriatric day hospital and coordinated community geriatric services. I am glad that I was able to witness this A/R/L model of geriatric service being practised during my one-year stay in Manchester, in particular the optimistic and enthusiastic interdisciplinary teamwork in the acute and rehabilitation wards, as well as the homely environment of the long-stay

John Brocklehurst in his studio, aged 80

wards, named with different plant species, and enlivened by activities, including painting and music. Together with Keith Andrews, John completed a national survey of departments of geriatric medicine in UK in the 1980s, shedding light on the planning and development of geriatric services to meet the differential ageing demographic changes.

During my fellowship in Manchester, John asked me to join their undergraduate teaching in geriatric medicine. I was most impressed by their well organised and problem-oriented undergraduate teaching in geriatric medicine, which I tried to emulate on my return in Hong Kong. In a regional postgraduate clinical meeting in Hope Hospital, Salford, John introduced me the second Professor of Geriatric Medicine in the University of Manchester, Raymond Tallis, for whose intellect John had the highest regard. This paved the way for a steady series of Hong Kong doctors coming to Manchester for overseas training in geriatric medicine under Professor Tallis.

John was invited to Hong Kong as the Visiting Professor for the Hong Kong Geriatrics Society Annual Scientific Week in 1989. In between the tight schedule of his lectures, I showed him around Hong Kong. His keen sense of observation and inquisitive mind kept me very busy answering his many questions about the things he saw. While walking in a busy street, John observed an old woman and a young man (perhaps her son) struggling to push a heavy wooden cart of rubbish collections over a curb. John came forward to help (to the surprise of the old woman and the young man) and then asked me about the social welfare support system for the old in Hong Kong. John had been on the international board of Honorary Editors of the *Journal of the Hong Kong Geriatrics Society* since its inaugural issue in 1990, contributing to improving its contents through his review articles, critical comments on submitted articles, and constructive advice on the format and style of the Journal.

John remained active and productive after his formal retirement in 1989, spending another nine years as associate director of the research unit of Royal College of Physicians of London, where he was committed to setting standards of good geriatric practice and producing audit packages on geriatric day hospitals, long-term care, functional assessment scales, and continence promotion. He continued to write and talk on the history of geriatric medicine, biographies of pioneer geriatricians, as well as obituaries of his contemporaries.

When I visited John in his residence in Wilmslow in August 2004, he had just celebrated his 80th birthday with his family and was then mentally and physically well. He told me that despite Ferguson Anderson's saying that one should not give a lecture after the age 75, he would be delivering a lecture on history in a week's time. He kept the flowers in his garden and a pond full of blossoms. It was here that he led me to experience of lavender. He enjoyed having his grandchildren use his grassland as a playground. He regularly checked on e-mails from his children with his laptop. He maintained his interest in painting in his studio, which overlooked his garden. He showed me his collections of paintings displayed all over his home, explaining how these brought back fond memories of his youth: In 1948, John was one of

two house physicians (the other being Bernard Isaacs) in Stobhill Hospital, the cradle of geriatrics in Glasgow, under Stanley Alstead. Alstead, who succeeded Noah Morris as Professor of *Materia Medica and Therapeutics* in Glasgow University, continued Morris's interest in chronic disease and old age and promoted research in those areas. John won a gold medal and got his MD in 1950 from Glasgow University through his research on the effect of ephedrine on urinary incontinence. In 1955, John ventured to a missionary hospital in the remote area of Labrador, Canada, where transport and communication was underdeveloped. He had to travel by dog-carts and sometimes by planes to see patients. It was in Canada where he came to know a nurse Susan, who became his wife. He showed me his paintings of their honeymoon spent in France. He returned to England in 1957 at the age of 33. Hanging in his studio was a portrait of John in his early thirties done by his good friend while John was simultaneously painting a portrait of his friend's wife. After lunch, he talked about his health while walking around neighbouring houses. He asked me if I knew restless leg syndrome, and then told me his personal experience of this syndrome two years before, and how this uncovered in him iron deficiency anaemia and early stage caecal cancer, for which he was operated, followed soon by another surgery for prostate. Despite these, he outlived both the cardiologist who advised coronary bypass surgery and the cardiothoracic surgeon who did the surgery for him while he was in UHSM. (I recalled that he used stairs rather than lifts in UHSM, which would contribute to his coronary fitness).

In September 2010, when I visited John again, he told me, "At the age of 86, I am now having an accumulation of pathologies. My memory has been fading. I have had a few TIAs, am a bit unsteady and have fallen a few times. I have installed a handrail on the staircase outside the entrance to my house to help me negotiate the steps safely. Four years ago, I had a blackout while driving and collided with two cars. Since then, I was put on a pacemaker, and have not been driving. My wife, disabled by her back problem, has been spending most of her days in hospital. One of my sons has returned to Manchester. So, I have been eating out more frequently than before. But usually I prepare and cook my own meals at home. I go out shopping once a week for simple essential things. Since I don't drive, I have to rely on public transport. In this country, bus is free for all elders. But the bus service can be irregular and waiting for buses in cold weather can be quite chilly so I have been calling a taxi driver to drive me to town for shopping once a week, help me with carrying the things I have bought, and drive me back home. I am now wearing a safety alarm with me all the time so that I can call for help when the need arises." Nevertheless, he was still actively painting in his studio then. He showed me his mandolin which he had been playing instead of the violin, because of experiences of transient hemianopia while he grripped his violin between his neck and left shoulder. Opening his bookcase, he showed me the first edition of his textbook published in 1973 and the subsequent editions. He was glad to see that the textbook had survived to its 7the edition in 2010.

It was by no means coincidental that John excelled in both portrait painting and geriatric medicine. To quote from Dr Therese Southgate, "In the end, both art and medicine are about seeing: one looks first with the eyes of the body, next considers with the eye of the mind, and finally if one has been attentive enough, one begins to see with the eye of the soul." Good practice of geriatric medicine requires seeing the person inside the geriatric patient. John will be remembered for his endeavour to portray geriatric medicine through his clinical practice and research, publications and presentations, teaching and advocacy, survey and audit of practice, and lastly writing history of his predecessors and obituaries of his contemporaries.

His "being good" and "doing good" was manifested in an unconditional love for his fellow human beings irrespective of age, race and belief without any expectation of a heavenly reward. In his last words to his wife, he said, "I am going to die… Where will I go? I will go to nowhere." In the eyes of those colleagues and friends who bid him farewell at his funeral on 11 July 2013, he is a "humanist, pure geriatrician, great geriatrician, non-judgmental, 'colour-blind,' …" His humanistic spirit will continue to live forever and inspire and influence many to follow him as role model.

**T K Kong**
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