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The birth of British geriatric medicine and its struggle for survival as a medical specialty

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Abstract

Geriatric medicine in Britain was born in the setting of a former poor law workhouse in London. Its early pioneers developed models of geriatric services and instigated research into the diseases pertinent to older people. Government initiatives championed the establishment of geriatric units but denied geriatric medicine the status of a clinical medical specialty. Despite an unfavourable image within the medical profession, medical services for older people flourished under the National Health Service to become one of the largest groups of medical specialties. The development of the specialty is traced from its origins in the care of chronically sick patients through to its greater involvement in the medical care of a wider spectrum of older people.

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Introduction

The discourse surrounding the medical care of older people from the classical period to the time that Marjory Warren took charge of wards in West Middlesex County Hospital in London, which housed several hundred patients with chronic disease who were mostly old and bedbound in 1935, has been explored.[1] To understand how Warren came to be in this position we need to take a step back to the practice of medicine in the context of the English poor law system in the nineteenth century. It played a seminal role in the nature of the development of the new specialty of geriatric medicine that arose from Warren's initiative and in the relationship that came to exist between the specialty and general medicine throughout the second half of the twentieth century. The division that took place between general and geriatric medicine will be illustrated by the developments that took place within the institutional poor law medical service in Birmingham Workhouse and Infirmary towards the end of the nineteenth century. The progress of geriatric medicine after Warren's initiative and its struggle to be recognised as a specialty within medicine will be analysed.

English poor laws

Poor relief in England and Wales was governed by the Acts for the Relief of the Poor of 1595 and 1601 (collectively known as the Old Poor Law). The system of relief was based on the parish as the unit from which the poor law levy was raised and through which relief was distributed. Help for paupers living in the community, so-called outdoor relief, could be given as money, food, clothing, bedding and payment for a variety of medical expenses. Institutional care, known as indoor relief, was available but unusual as the buildings were usually small. The Poor Law Amendment Act in 1834, known as the New Poor Law, attempted to abolish all outdoor relief except when given for medical assistance. The only relief available to able-bodied persons and their families was to be indoor relief in a well-regulated workhouse. As a result, the erection of large, general mixed workhouses gradually spread across the country. Sick wards were provided in early workhouses for inmates who became sick, but by the 1860s a dedicated infirmary building separated from the main workhouse became necessary as increasing numbers of paupers were admitted because of illness. As workhouses came to cater for paupers with chronic illness on a long-term basis, larger infirmaries containing 600 beds to over 1,000 beds were required by the end of the century. The number of sick inmates they could accommodate dwarfed that of the local voluntary hospitals. By 1861, poor law institutions provided 81% of the country's hospital beds, and they became England's first public hospitals.[2]

The Metropolitan Poor Act of 1867 established infirmaries in London for sick paupers geographically separated from workhouses. They were managed and funded by the Metropolitan Asylum Board rather than by local boards of guardians, and thus created a centralised hospital system. In the same year provincial poor law authorities were empowered, rather than legally obliged, to establish separate institutions for the sick, but progress was slow. Nevertheless, a process of taking hospitals out of workhouses had begun, albeit slowly. These separate infirmaries began to be selective in admitting only those with acute illness,

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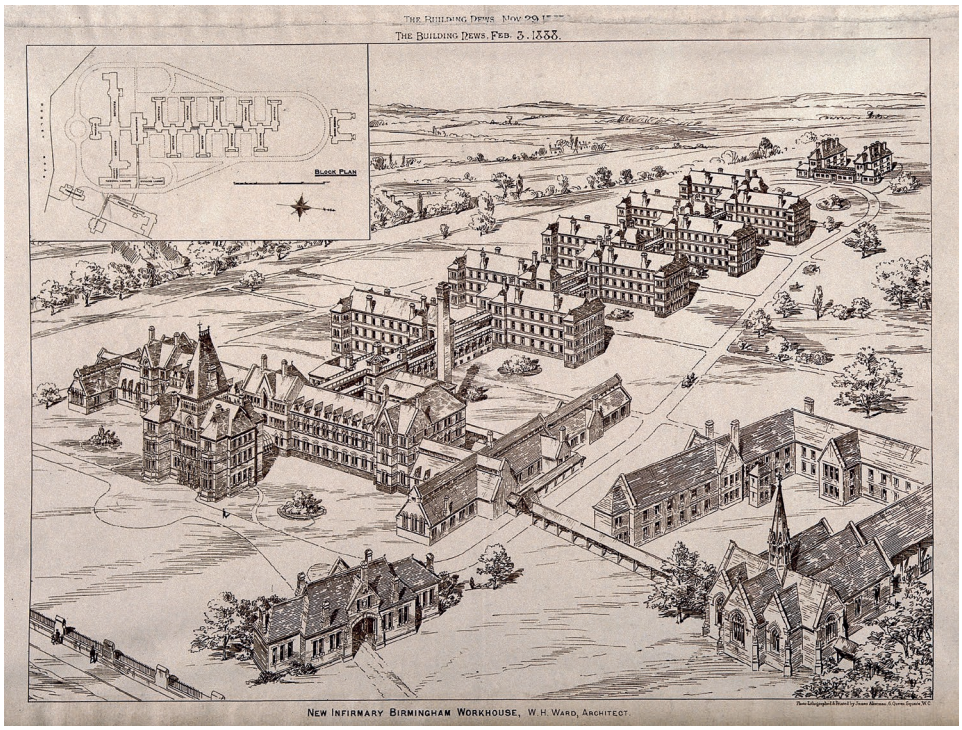

Figure 1 Bird's eye view of the Birmingham Workhouse infirmary with a key. Lithograph by J. Akerman. Image courtesy of the Wellcome Collection, London (CC BY 4.0). Part of Birmingham Workhouse can be seen on the right of the image.

leaving the workhouses to accept the remainder, who were predominantly the chronic sick. The Local Government Act of 1929 abolished poor law authorities and transferred services to public assistance committees of local authorities. It also enabled local authorities to appropriate workhouses and infirmaries as municipal hospitals. Where this was not taken up, workhouses became public assistance institutions.

Birmingham Workhouse and Infirmary

The situation that developed in Birmingham is a good example of how the division between acute medicine and the care of the chronic sick arose. It was not until 1889 that Birmingham guardians opened an infirmary with 1,665 beds that was separately managed from the workhouse with its own master and matron (Figure 1). The adjacent workhouse, which had opened in 1852 to accommodate over 1,600 inmates, had an integral infirmary that had become overcrowded. Efficient workhouse administration depended on classification of paupers, with subsequent strict segregation of classes of inmates within dedicated wards. Most workhouses had specific wards for the 'aged and infirm' class, but Birmingham also had wards that were designated as 'bedridden wards' for more physically dependent inmates, the vast majority of whom were old. Almost one-third of older inmates were sufficiently disabled to need to be accommodated in these wards at any one time.[3] Prior to the opening of the new infirmary, the board of guardians decided that those in the bedridden ward should not be transferred from the workhouse as they were 'not classed under head[ing] of sick, many are simply cases of senility and require mainly good nursing'. Three years later, the guardians decided that those inmates who never or only occasionally required medication should be retained within the workhouse wards as they were not thought to need medical attention. In the 1890s, patients in the infirmary who could not be discharged because of severe disability began to be transferred to the workhouse wards, with the result that by the second decade of the twentieth century the chronic and convalescent wards 'were practically the same as the bedridden wards'. Indeed, the levels of dependence had by then increased significantly, with 102 women out of 106 in the female bedridden department described as 'actually bedridden'.[3]

Transfer arrangements between the two institutions led to considerable disagreement between medical staff in both locations. Infirmary medical officers complained about the large number of cases of mild illness, for example bronchitis and diarrhoea, being admitted daily from the workhouse. In November 1893, a great many cases were passing between the two institutions, some 'going backwards and forwards the same day'. On the other hand, the workhouse medical officer complained that patients were transferred inappropriately from the infirmary to the workhouse before they had sufficiently recovered.[4] The process of patient transfer from the infirmary was formalised by Dr Frederick Ellis following his appointment as medical superintendent of the workhouse and infirmary in 1913. He considered it essential for the economic administration of the infirmary that 'chronic cases' not requiring medical or nursing skill should be removed to the workhouse. If, after a 'fair length' of treatment in the infirmary (he reckoned several months), it was clear that patients would remain 'chronic cases', he proposed they should be moved to the workhouse wards.[3] After the Local Government Act, Birmingham Council took over the management of both the workhouse and infirmary as municipal institutions. By that time the infirmary had become an acute general hospital (later Dudley Road Hospital) and the workhouse's role was cemented as a provider of care for chronic illness and disability. The Chief Medical Officer at the

time suggested that the continued presence of these patients in a hospital would lower medical and nursing standards throughout the institution.[5] In 1948, the workhouse became a geriatric hospital. It was renamed Summerfield Hospital and at that time nearly half of the male patients and just below two-thirds of female patients were bedridden.[6] When Warren took over the wards in the former workhouse, she resisted the practice that had previously existed of general physicians transferring to the wards older patients in whom they had no interest. She would only accept those patients she considered would benefit from further treatment.[5] However, this practice continued in many hospitals and, in the author's experience, the expectation within the acute hospital sector that patients would automatically be taken over on request by a geriatric department continued well into the 1980s.

This dichotomy of care between the workhouse and its infirmary and the division of patients according to the nature of their illness continued due to the increasing reluctance of infirmaries to admit patients with chronic disability. Thus, acute medicine took precedence over the needs of older and chronically ill patients and hampered the later development of care for a number of disadvantaged groups, but especially those requiring long-stay care. The eminent medical historian George Weisz argues that in the 1940s former poor law institutions were seen as 'a dumping ground for indigent elderly and chronically ill people' and that many within them were kept bedridden.[7] It was into such a situation that Marjory Warren was pitched when she became responsible in 1935 for wards for patients with chronic disease in an ex-poor law institution. If she had responded with the indifference that others had shown, perhaps the specialty of geriatric medicine may never have seen the light of day.

The beginning of modern geriatric practice

Marjory Warren (Figure 2) was born in London in 1897, educated at North London Collegiate School and studied medicine at Royal Free Hospital, London, from which she qualified with LRCP, MRCS in 1923. She held junior posts at Queen's Children's Hospital, Royal Free and Elizabeth Garrett Anderson Hospitals before being appointed as assistant medical officer at Isleworth Infirmary (also known as West Middlesex Hospital) in 1926. The focus of her training had been in surgery, and at Isleworth she performed over 4,000 operations. Her appointment met with considerable resistance from male colleagues as hospital medicine was largely a male preserve at that time.[8] Despite this, she became deputy medical superintendent within five years of her appointment. After the Local Government Act of 1929, Middlesex County Council took over responsibility for Warkworth House, Brentford Union's workhouse, as a public assistance institution and the adjacent Isleworth Infirmary as a municipal hospital. The combined institutions were renamed West Middlesex County Hospital. It was at this point that Warren became responsible for the medical management of the former workhouse and took over the care of around 700 patients who were mostly old and bedbound.[9]

Figure 2 Dr Marjory Warren CBE MRCS LRCP (1897–1960): the mother of British geriatric medicine.[5] Reprinted by permission of SAGE Publications Ltd.

It had been usual for these patients to be ignored by the physicians responsible for their care, as they were felt to be incurable and uninteresting. The appalling conditions in the drab wards repelled many doctors from going back after their first visit but stirred Warren to action. She described the typical 'untreated case':

> Having lost all hope of recovery with the knowledge that independence has gone, and with a feeling of helplessness and frustration, the patient loses morale and self-respect and develops an apathetic or peevish, irritable, sullen, morose and aggressive temperament… Still, alas, in this miserable state, dull, apathetic, helpless and hopeless, life lingers on sometimes for years.[10]

She instituted rehabilitation as a team function and assessed all patients' state of disability, identifying those who had potential for recovery even if it was only to a limited degree. She believed 'much can be done even when full rehabilitation is impossible'.[10] She classified patients into five groups: chronic up-patients who get up part or whole days and can get about with some help; chronic, continent bedridden patients; chronic incontinent patients; senile, quietly restless and mentally confused or childish patients, but not noisy or annoying to others; and senile dementia patients, requiring segregation from other patients.[11]

This classification enabled her to move those of a similar classification and stage of illness onto the same wards, allowing care to be more focussed on their needs. Dedicated wards were provided for initial assessment and treatment. She initiated discharge planning by discussing arrangements for possible care at home with patients' relatives. As a result, about 200 patients were able to leave hospital, some to live with their families and some to residential homes. At the end of two years, the number of beds had been reduced to just over 200.[8]

She identified many of the principles behind the practice of geriatric medicine today, including the involvement of the multidisciplinary team, the presence of multiple conditions in older people and the interplay of physical, mental and social components of their illness. She lectured and published widely promoting the establishment of geriatric units to protect the care of older people from medical neglect. It was important to her that these should be 'in specially built and equipped blocks of a general hospital' rather than, as was the case at the time, in isolated chronic hospitals with limited facilities for diagnosis, treatment and research.[10] For her work in instigating modern geriatric practice she has been designated the 'mother of geriatrics'.[12]

Although Warren did not claim to be a specialist, she considered 'There is much to recommend geriatrics as a specialty comparable to paediatrics.'[10] She felt the position with care of the chronic sick was similar to that of ill children who at that time were usually admitted to adult wards and cared for by junior members of clinical staff. The creation of a specialty would stimulate interest, raise standards of care and aid the inclusion in the training programmes of medical and nursing students. She concluded that 'until the subject [geriatrics] is recognised as a special branch of medicine in this country it will not receive the sympathy and attention it deserves.'[11] Recognition of her work was widespread, including from the Ministry of Health, and many came to visit her unit, usually with a view to providing a similar service in their own locality. Most were inspired to do so. However, there were others working at the same time who independently contributed to the establishment of the specialty.

One of those was Lionel Cosin who qualified from Guy's Hospital and initially trained and practised as a surgeon. After junior posts at Royal Northern and Prince of Wales Hospitals, he took up a post at Littlemore Mental Hospital to enable him to study for and pass the Fellowship of the Royal College of Surgeons. At the outbreak of World War II, he was due to start a surgical appointment at London Hospital, but instead was drafted to Orsett Lodge Hospital in Essex as a general surgeon. Orsett Hospital had previously been run by Essex County Council as a public assistance institution, with beds for 300 chronic sick patients, but was converted to an Emergency Medical Service Hospital at the outbreak of war. The main focus of his work was treating wartime casualties, and it was not until he succeeded the retiring incumbent as medical superintendent of the hospital towards the end of the war that he became responsible for chronic sick patients. He was as shocked as Warren by the conditions on the wards. Like her, he introduced rehabilitation, with increasing bed turnover which reduced the average length of stay for patients from 286 days in 1947 to 51 days in 1951.[8] He began operating on older women admitted with fractures of the femur, a procedure that was previously not usually performed because they were thought to be too old for surgery. He introduced early rehabilitation postoperatively to restore their mobility and is reputed to have coined the phrase 'bed is bad'.[12] In 1950, he was invited to establish a geriatric unit at Cowley Road Hospital in Oxford, where he re-organised the department into an acute ward for investigation and different types of long-stay wards. He pioneered day care, opening the first geriatric day hospital to enable diagnosis, treatment and rehabilitation to be carried out without a stay in hospital but with the same multidisciplinary approach.

Another was Trevor Howell, a general practitioner in Worthing. He came across many older patients in Worthing, something he had not experienced while working in hospital. When he was drafted to the Royal Hospital, Chelsea, he began examining the Chelsea pensioners and uncovering chronic diseases. This survey formed the basis of his first book, *Old Age, Some Practical Points in Geriatrics*. He began a programme of research and, following his appointment as consultant physician at St John's Hospital in Battersea, he formalised it by establishing a geriatric research unit. He also set up an active service department following a visit he made to Marjory Warren. This integration of research and practice was unusual in England within geriatric medicine, and he drew attention to the fact that research was rarely carried out in hospitals for the chronic sick.[12] His written contribution to the specialty consists of over 300 papers and four textbooks. Despite this huge output, he thought of geriatrics as 'more a state of mind than a branch of medicine'.[13]

The work of Warren, Cosin and Howell, plus that of Eric Brooks at St Helier Hospital, Carshalton, where he had set up a domiciliary service providing a multidisciplinary team to manage older people in their homes, came to the attention of Dr Sholto Mackenzie (Figure 3). Following clinical training, Mackenzie joined the Ministry of Health in 1936 and was given responsibility for the care of chronic sick patients and for former poor law institutions. Determined to reverse the neglect of these patients, he used his influence in the House of Lords, after he succeeded to the title of 2nd Baron Amulree in 1942, to bring the care of older people into the public domain. In 1949, he was appointed physician in charge of a newly established geriatric unit at University College Hospital, London, although based at St Pancras Hospital, a former workhouse.

Howell saw the need for a medical society covering the field of old age and, at his instigation, a meeting was arranged in 1947 of those with an interest in chronic sick patients, including Warren, Cosin and Brooks. It was agreed to form the Medical Society for the Care of the Elderly, with Howell as Secretary and Lord Amulree as President. In 1959, the name was changed to British Geriatrics Society. Amulree served as

Figure 3 Basil William Sholto Mackenzie, 2nd Baron Amulree, President Medical Society for the Care of the Elderly and British Geriatrics Society, 1947–1972. Image courtesy of British Geriatrics Society, Library and Archive, London.

Figure 4 Professor Sir Ferguson Anderson, first professor of geriatric medicine in the UK. Image courtesy of University of Glasgow Archives and Special Collections, University Photographic Collection, GB248 Ph/PR2668.

president of both societies for over 25 years and is credited with inventing the maxim 'Adding Life to Years' to highlight the aims of geriatric medicine.[8] With other members of the society, he participated in the British Medical Association working party which produced a report in 1948 on *The Care and Treatment of the Elderly and Infirm*. Its recommendations included the establishment of coordinated medical services based in general hospitals with facilities for comprehensive assessment and rehabilitation.[9]

The other important publication relating to the care of older people in 1948 was the seminal text *The Social Medicine of Old Age* by Joseph Sheldon, a consultant general physician in Wolverhampton. It was the first study of older people in the community, defining older as men aged 65 years and over and women aged 60 years and over. The 477 participants in the medical arm of the study were visited at home by Sheldon himself. He was impressed that 63% were independently mobile outside their home and only 29% were in poor health.[14] He identified many of the special problems of old age, especially falls for which he later carried out further research. He stressed the importance of the family in helping to maintain older people in their own homes. In 1950, he was invited to lecture to the Royal College of Physicians in London on *The Role of the Aged in Modern Society*, and in 1954 he became President of the International Association of Gerontology.[15]

The early pioneer in Scotland was Sir Ferguson Anderson (Figure 4), who was appointed in 1952 as a consultant physician and advisor on diseases of old age and chronic sickness in Glasgow. He set about establishing geriatric units throughout Scotland, where geriatrics was more readily accepted, to provide older people with easy admission to a unit dedicated to their care as there was resentment to admitting them to acute hospital beds.[9] With a colleague, Nairn Cowan, he established the Rutherglen Health Centre to which general practitioners could refer older patients not requiring a hospital referral. This gave the opportunity to study apparently healthy subjects, leading to the identification of unreported medical needs. The research led to a series of publications, but Anderson also published widely with contributions to around 25 books. He stressed 'that geriatric medicine started with the concept that old age is not a disease; this led to the conclusion that accurate diagnosis of illness in older people is essential'.[16] His appointment to the chair of geriatric medicine in Glasgow in 1965 was the first in the United Kingdom. In England, the first three chairs were not appointed until the early 1970s and were important in giving the specialty academic credibility. One of those appointed was John Brocklehurst at the University of Manchester, and a few years later Bernard Isaacs was appointed to a chair at the University of Birmingham; both of them had trained under Anderson in Glasgow.

Geriatric medicine in the National Health Service

At the start of the National Health Service (NHS) in 1948 there were no clear guidelines for the treatment of older people.[9] Charles Webster, one of the most prominent historians of the health service, considered they had a great deal to gain, particularly in access to consultant services.[17] Despite a good start in modernising hospital services, the chronic sector received relatively less than the acute sector in resources, with budget cuts affecting chronic hospitals more severely.[17] Concern at the 220% increase in the number of people aged 65 years and over from 1901 to 1954 led to the publication by the Ministry of Health in 1957 of *Survey of Services Available to the Chronic Sick and Elderly 1954–1955,* commonly known as the Boucher report.[18] It reported diverse views regarding geriatrics as a separate specialty and doubted that disease in 'the elderly' had any special features, although it found that the possibilities of rehabilitation were not well recognised. It commented that geriatrics was not a clinical specialty demanding clinical knowledge denied to other hospital staff, but that it was concerned primarily with degenerative changes and long-term illness. Nevertheless, it admitted that where geriatric units existed, providing skilled medical and nursing attention to the chronic sick patient, results were good. It was in no doubt that the 'modern geriatric approach' would be the normal practice in the future in most hospitals.[18] The report was extremely important as it provided justification for policy developments in hospital geriatric care for at least the next two decades and assisted in establishing units under the charge of a specialist physician.[19]

A further stimulus took place in the 1970s when the provision of geriatric units was given special priority under the government's hospital development plans to ensure comprehensive hospital geriatric services existed throughout the country.[20] Consequently, the number of consultant geriatricians, which had risen from 97.7 in 1963 to 213.9 by 1971, almost doubled to about 500 by 1983.[19,21] However, the inpatient facilities for geriatric services that were set up were nearly always in buildings separate from the district general hospital and very often in former poor law or public assistance institutions.

Local initiatives also took place after 1948. Professor Sir Arthur Thomson, Chairman of Birmingham Regional Hospital Board, instigated a regional survey of chronic sick hospitals. The pilot study at the largest of these in Birmingham, Summerfield Hospital which was the former Birmingham Workhouse, formed the basis of his Lumleian Lectures to the Royal College of Physicians in which he described his 'most vivid impression … is of an atmosphere of profound apathy'. But he found the medical treatment surprisingly good.[22] As a result, more consultants in geriatric medicine were appointed in the region. Yet Thomson, who strongly urged the establishment of wards in general hospitals, would still say, 'Some assert that it is necessary to develop another specialty in the shape of geriatrics. I do not share that opinion.' But he was also of the opinion that 'Medicine today … breeds too many specialties', reflecting on the current attitude in Britain at the time of rejecting medical specialisation.[22]

The 1970s saw moves to increase the involvement of geriatricians in the acute care of older people, along with attempts to establish facilities in general hospitals. However, there was dispute within the specialty as to how this was best achieved. The two most favoured models were the 'age defined', where all patients above a certain age were admitted to the care of geriatricians, and the 'integrated', where a geriatrician worked alongside general physicians taking responsibility for the acute care of adults of all ages.[23,24] The next significant modification to geriatric services took place in April 1993. As allowed by the National Health Service and Community Care Act 1990, local authorities began funding care for patients in private nursing homes, and many hospitals took the opportunity to close long-term care wards. This had the effect of withdrawing consultant medical supervision from chronically ill patients, the very ones the specialty had set out to rescue from neglect by doctors with no interest in their care. Following the proposals in the *National Service Framework for Older People* in 2001 for rehabilitation facilities to be provided in community settings rather than be hospital based, the medical responsibility for some patients undergoing rehabilitation also passed from consultants to general practitioners.[25] Conversely, by this time most consultant geriatricians had become involved in the emergency medical admission of adults of all ages in the acute hospital, as well as providing specialist services for older people, such as falls clinics and stroke care.

Should geriatric medicine exist?

Despite the huge growth in geriatric services in the preceding sixty years, historian Pat Thane has drawn attention to the dilemma that 'the emergence of geriatric medicine over the twentieth century has been accompanied by a debate, which is still unresolved, as to whether it should exist'.[9] According to Moira Martin, the policy advocated by the Ministry of Health by 1957 was that while there was no basis for a new clinical specialty of geriatrics, there was a need for medical staff who were prepared to specialise in the medical care of elderly people. She points out the illogicality of this position because if disease in older people was not significantly different from younger adults, why should they be segregated in separate wards?[26] Of the early pioneers, only Marjory Warren publicly supported the specialty position. Others, like Sheldon, felt that the adoption of a special title for the study of old age was premature as it was 'staking out of a claim for a field that is almost untilled'.[14] The opposition to specialty recognition needs to be set against the background of a time when there was a lack of enthusiasm for creating medical specialties. George Weisz, a historian of social medicine, has pointed out that medical specialisation occurred in Britain later in the twentieth century than in other nations and that even those with international recognition in, say, cardiology did not consider themselves specialists. In the early twentieth

century, the typical consultant was a generalist and the British clung to the concept of the general physician within the Royal College of Physicians until the 1960s.[7]

A number of formal challenges to geriatric medicine came in the mid-1970s, most notably *Can Geriatrics Survive?* by J. C. Leonard in the *British Medical Journal*. His main argument was that geriatrics should be abolished as it had failed to attract sufficient staff to enable it to clear 'blocked' medical beds.[27] His proposition that chronically ill patients could be returned to general physicians who could do the job better, does lend weight to Evans' assertion that the real motive behind it was a contest over resources.[12,27] Geriatrics was criticised for having no unique clinical processes or techniques and lacking definition as it was unclear at what age geriatric care takes over. As Leonard puts it, geriatrics 'shades off imperceptibly into general medicine'.[27] Numerous replies flooded the letters column of the journal over the following month and several points were made in favour of the specialty. Although geriatricians admitted that the clinical processes were the same as general medicine, they claimed physicians outside of geriatrics did not have sufficient knowledge about elderly ill patients to manage their care properly and maintain a high bed turnover. They pointed to their special skills in managing specific conditions prevalent in old age in a holistic manner and to their commitment to running rehabilitation wards effectively by coordinating the work of the multidisciplinary team. However, according to Margot Jefferys writing in 1993, 'the arguments both for and against the perpetuation of a medical specialty of geriatrics are nicely balanced'.[28]

Leonard put the unpopularity of the specialty down to the fact that relatively few doctors wanted to confine their clinical attention solely to elderly patients.[27] This reflected the negative view of old age prevalent in society in general and within the medical profession, as well as the widespread hostility towards the medical treatment of elderly people.[8,19] Moreover, geriatrics continued to carry the stigma of workhouse medicine as second-rate.[9,26] As Thane points out, 'the interest in (ill) health of older people has always been a marginal and unfashionable enterprise among medical specialists'.[9] Despite this perceived unpopularity, growing numbers of trainees continued to enter the speciality.

The debate over its existence surfaced again in *British Medical Journal* columns in 2008: *Head to Head: Should geriatric medicine remain a specialty?*[29] Its proponent pointed to its strengths in providing well-organised multidisciplinary care within a 'whole systems approach', that ensures any individual is receiving the appropriate form of care within the total health and social care system in their locality. Randomised controlled trials had shown that this approach benefits patients in terms of their health and ability to function. The case against centred around the argument that all generalists must practice in a similar way to geriatricians and so there is no need for geriatric physicians.[29] To argue a return to generalism is anachronistic, as medical specialisation now appears inevitable and is 'a fact of life in all Western nations'.[7] Finally, the argument for the need to incorporate the lessons of these pioneers in aged care into everyday clinical practice would suggest the need for the specialty to exist rather than for its abolition.

Concern has also been expressed around the legitimacy of health service provision on the basis of chronological age and the issue of generational equity.[28] Has geriatric medicine helped to define older people as a separate and marginalised social group 'the elderly' by segregating them in special wards and medicalising old age? Thane suggests that the opposite is the case; that by improving the lives of older people it is likely to bring them in from the margins of society.[9] The tension between providing age-blind and age-defined services was brought to the fore following the Department of Health's *National Service Framework for Older People* in 2001 which sought to discourage age discrimination. Some providers were of the opinion that the provision of specialist services for older people would constitute discrimination, while for others it represented a positive development in combating barriers to access to medical treatment due to ageism.[30] The differing interpretation of the focus of the framework arose from a failure to distinguish between negative and positive ageism and a realisation that the former continues to be documented in health contexts worldwide.[31] In the United Kingdom, the Equality Act 2010 made it unlawful to discriminate against users of public services solely on the basis of age, and this would include hospital care. However, the current pandemic with the virus SARS-CoV-2 has again highlighted the issue of ageism in a number of ways, not least in access to treatment and the perception by the public that the virus is really an older adult problem.[32]

These arguments become less pertinent as the specialty moved in the late twentieth century from an age-based model to focus on the concept of frailty. Although it has no exact definition, frailty is seen as a state of increased vulnerability to poor resolution of homeostasis following a stress, and it manifests as a reduced physiological reserve. A number of tools have been developed to measure frailty in patients in different clinical settings.[33] The majority of such patients will be older, but those who would benefit from the skills of geriatricians can be identified. It counters the criticism that geriatric medicine is no longer appropriate since older people are generally fitter and healthier in the twenty-first century.[28]

Conclusion

The specialty of geriatric medicine did not embed itself firmly in the ranks of medical specialties until the late twentieth century. It was born in the United Kingdom out of a humanitarian concern for chronically sick older people. It flourished within the setting of the NHS where a standardised practice of geriatric medicine across the country was given government support because of its ability to make efficient use of resources. Indeed, Martin maintains that it is unlikely geriatrics would have developed if it had not offered increased bed turnover.[26] The specialty emerged to protect older people from exclusion from medical care and has succeeded in both enhancing the standards of their care and the quality

of their lives. The contradiction between the official policy of appointing consultants to run geriatric units and the denial that the medicine they practised was a specialty in its own right has prevailed throughout most of its history. Geriatric medicine has adapted to the changing demands of medical care in the twenty-first century, and many geriatricians are now involved in front-door frailty and acute stroke services. They continue to be involved in rehabilitation services for older people, but long-stay care, where the specialty originated, is no longer within their remit as it has been redefined as social care.

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