Dr Marjory Warren CBE MRCS LRCP (1897–1960): the Mother of British Geriatric Medicine

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Summary: Dr Marjory Warren was a remarkable, formidable physician who reversed the neglect of chronic sick patients and brought their treatment into the modern era. She advocated the creation of the specialty of geriatric medicine with units based in district general hospitals, and that medical students and nurses should be taught about the diseases of old age. She treated the whole patient, applied advances in medicine and therapeutics, devised new techniques and equipment to assist disabled elderly stroke and amputee patients, and made great improvements in the ward environment. She emphasized the importance of the patient's social background, and electrified both staff and patients with her drive and enthusiasm. Many patients were treated successfully and discharged. Bed requirements were reduced and vacated wards allocated for other uses. She wrote extensively and lectured across the world to national and international approbation.

Introduction

Dr Marjory Winsome Warren (Figure 1) was born on 28 October 1897 in Hornsey, London, and was the eldest of five daughters of Walter Richard Warren, a barrister who died in 1930.[1–4] One sister, the formidable Enid Charis Warren (1903–80), became an eminent and influential almoner.[5] All were educated at the North London Collegiate School. Marjory later studied at the London Hospital School of Medicine, qualifying in 1923 as LRCP and MRCS. Her early appointments were at the Royal Free and the Elizabeth Garrett Anderson Hospitals, and later at the Queen's Children's Hospital in Hackney. In 1926 she was appointed Assistant Medical Officer at the Isleworth Infirmary. This appointment placed her in a previously exclusive male preserve and she was viewed askance by her new colleagues: 'she endured the disapprobation of one Dr Cook, who told her "I'll have you know that I in no way approved of your appointments".'[6] Initially her main interests were surgical – she performed over 4000 major and minor operations and gave some 3500 anaesthetics. Within a few years she was appointed Deputy Medical Superintendent. In 1949, with the inauguration of the National Health Service (NHS), she was recognized as a Consultant Physician. She was appointed an examiner for the General Nursing Council and was an ardent supporter of the London Association of the Medical Women's Federation.

In 1935 Isleworth Infirmary took over the adjacent workhouse, Warkworth House, creating the West Middlesex County Hospital. Marjory Warren was assigned the task of assessing the residents in the workhouse. This duty transformed her career and brought national and international acclaim and the status of 'The Mother of British Geriatric Medicine'. She published extensively on the modern treatment of the chronic sick and presented many papers at international meetings. She was appointed Secretary of the International Association of Gerontology and planned its third meeting, held in London in 1954.

She was tall, thin, red-haired and freckled with a determined looking jaw. She was always warm in her welcome and hospitality which she and her sister offered at their home in Highgate, London. Her charming, cheerful vitality and drive endeared her to many, especially her patients. She had simple tastes and took great pleasure in the colours of the sea, flowers and the countryside. She was always a good listener, enjoyed lively conversation and gave freely of her time and knowledge.

She was a keen and inveterate traveller. Between 1927 and 1935 with her sisters and sometimes her mother she went abroad on what might be described as grand tours exploring Belgium, Holland, the Channel Islands, Germany, Spain, Austria, France, Norway, Sweden, Ireland, Italy, Canada and the UK.[7] During a visit to Australia she had a swimming accident from which one of her sisters had to rescue her. This convinced Marjory that she was living on borrowed time.[8] However, the apogee of the visits was to the USA which she explored on three occasions before the war. She was taken round several hospitals including the New York City and John Hopkins Hospitals and the Mayo Clinic. In 1951 she returned to the USA for a fourth time at the behest of the Macy Foundation to speak at conferences.

Marjory Warren died in 1960 following a road traffic accident in Metz, France when driving across Europe to

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Figure 1 Dr Marjory Warren CBE MRCS LRCP

Baden-Baden to give a lecture at the Medical Women's International Association. Her companion suffered only minor injuries. Friends said she tended to pay more attention to her passengers and the exposition of her ideas than to the road conditions. Her body was cremated in Strasburg and a memorial service was held on 1 October 1960 at St Pancras Church, London. Dr (later Professor) George Adams, a friend and admirer, gave the Memorial Address. A memorial fund was set up in her name to promote medical, nursing and social aspects of care and treatment of older people.[9] She was unmarried.

Setting the scene

Before the inception of the NHS, care of the chronic sick was almost entirely custodial. Patients and relatives expected admission to hospital to mean a 'bed for life'. Families were all too often pleased to be relieved of the responsibility of care. The buildings to which patients were admitted were large, unattractive, poorly decorated, overcrowded, with drab wards and day rooms, poor ventilation and lighting, and stone stairs. The walls were often unplastered brickwork and painted a dark green. Doorways were narrow and floors highly polished. Beds were low, black and old fashioned, arranged in neat rows in perfect line with each other and invariably tidy. Bedside lockers were not always provided and flowers were forbidden. Sanitary arrangements were often inadequate and inconvenient. Equipment was lacking and access to specialist consultants and ancillary services limited. Student nurses were not trained on these wards.

The medical profession as a whole was unenthusiastic about treating sick older people because they had multiple pathologies frequently associated with social problems that required extra time and patience, took longer to recover from illnesses, blocked beds and provided little opportunity for private practice. Patients' illnesses were not properly classified or investigated. Treatment was often limited to nursing care. Medical notes were of poor quality. Many patients were confined to a bed for years on end with little prospect of recovery. Community care was hampered by lack of housing and limited local support services. Family support was inhibited by decreasing family size with younger relatives going out to work. Private care was expensive.

Warren emphasized that medical care of the aged presented a major problem with considerable economic and social implications.[10] She berated the medical profession for being 'so long awakening to its responsibilities towards the chronic sick and the aged'.[11] A *Lancet* editorial in 1949 concluded: 'the plight of old people is one of the biggest and most embarrassing problems facing the National Health Service'.[12]

Philosophy

Warren's philosophy developed as her experience grew. The word *geriatric*, which was coined by Dr Ignatz Leo Nascher (1863–1944) in America in 1909, was little known in the UK in the 1940s. Warren maintained *geriatrics* derived from *geros* meaning old age and *iatrikos* pertained to a physician and had come to mean the medical treatment of elderly people.[13] *Gerontology* meant the study of all problems of ageing. She believed the term *chronic sick* should be abandoned because it was old fashioned and without precise definition and that *long-term sick* should be used instead. She decried the term *senile* in its secondary and derogatory sense as if it applied to all elderly people.[14] She deplored the fact that in 1946 the UK lacked a specialist medical journal devoted to the diseases of old age although the Americans already published the *Journal of Gerontology*.

In her view chronological and biological ages should be differentiated. Old age need not normally be associated with general physical frailty, gross mental deterioration, disability and dependence. Mental failings of old age could be temporary and due to physical illness including dehydration, infections, anaemia and drug therapy. Good management lay in early diagnosis, appropriate treatment, adequate hydration and minimal sedation. She believed children should be taught to respect old age and to regard older people as the heads of the household for as long as possible.[15]

Warren argued that geriatric medicine was essential to raise standards of medical care of the elderly. Staff of a geriatric unit should be specially trained to get the best results for patients. Consultant Geriatric

Physicians should have both a broad training and empathy with the elderly. Medical students and nursing staff should be taught about the diseases of old age. The geriatric service should be a new medical department in modern well-equipped accommodation within the district general hospital, backed up by a separate long-stay annexe and locally based residential homes. Good liaison with the Regional Hospital Board and the local authority was essential. The service would treat those aged more than 60–65 years and improve staff training in the diseases of old age.[16] The aim was not to prolong life but to make it easier.[17]

Patients should be treated as individuals and not as diseases. Special attention should always be paid to care of the feet, teeth, eyes, ears, clothing and diet. Patients should have ready access to all specialist professions but should not be admitted to general acute wards because they might not get proper attention and treatment. Modern geriatric units should discharge about one-third of patients back to the community or a home, about a quarter would require long-term care while about 40% would die. Relatives should not be over indulgent and should not persuade elderly people to take more rest and to do less for themselves. Her *cri de coeur* was that 'nothing the patient could do for himself should be done for him'.[18] Large separate chronic sick hospitals without facilities for diagnosis, research and treatment should no longer exist.

Warren knew her patients, always had a cheerful word for them, applied a kindly discipline from which all unnecessary red tape had been removed and treated them with an intelligent understanding as individuals. So-called incurable patients needed patience, tact and quiet energy from an understanding staff in order to achieve improvements. Long-term sick patients required guidance towards a slower tenor of life. Tightly made beds and prolonged time in bed should be eschewed because the one inhibited leg movement while the other had horrific consequences.[19] She insisted that every patient had to be got out of bed before her ward rounds and this proved difficult in the days before hoists. She encouraged patients to take an optimistic and creative interest in their progress, play a part in their recovery and help other patients. Relatives were encouraged to expect elderly patients would be discharged home with the necessary home support.

She believed geriatric medicine helped to prevent the exclusion of older people from medical care but until it was accepted as a specialty it would not receive the sympathy and attention it deserved. Her ethos was to maintain patient independence, allowing the majority of elderly people to live at home and enjoy a happy, constructive and successful old age.[20] When they became sick and required hospital treatment, speedy admission should be arranged. After discharge patients should be followed up in the outpatient department.

Reversing custodial care

When the Isleworth Infirmary took over the adjacent workhouse in 1935, Warren was charged with assessing and raising the standards of care of the 874 residents. Her initial review showed the total included 16 maternity patients, mothers with infants and about 144 'mental observation' patients, all of whom were transferred to appropriate departments. Assessment of the remaining 714 patients revealed that the same ward could contain young and old, senile dements, restless and noisy patients in cot beds, incontinent patients, elderly sick patients who were treatable and others who were relatively healthy. She wrote:

> 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 ... temperament, which leads to laziness and faulty habits, with or without incontinence. Lack of interest in the surroundings, confinement to bed ... soon produces pressure sores ... inevitable loss of muscle tone make for a completely bedridden state ... [leading to] disuse atrophy of the lower limbs, with postural deformities, stiffness of joints, and contractures ... in this miserable state, dull, apathetic, helpless, and hopeless, life lingers on, sometimes for years.[21]

She classified the patients into groups: chronic but relatively mobile; chronic, continent but bedridden; chronic and incontinent; senile but quietly restless; and senile dements who required segregation from other patients.[22] The great need was for accurate diagnosis that would point to appropriate drug therapy.[23] An editorial in the *Medical Officer* expressed delight at her intentions but thought there were so many difficulties to be overcome that it would take a long time to achieve success.[24]

Warren found that 200 of the 714 patients were destitute, able-bodied workers who did not need to be in hospital and she arranged their transfer to another institution.[25] The remaining 514 patients were examined between June 1935 and March 1936. None had previously been classified and many had been bedridden for long periods. A nurse who worked on these wards during the Warren era described the scene.[26] The low beds, with which wards were then equipped, made nursing care of the patients very difficult. Screens on wheels provided the only privacy. Southey's tubes were used to drain oedematous legs because organomercurial diuretics were only just coming into use. Patients with fractured femurs were not treated surgically but were nursed using Balkan Beams. Nurses were taught to apply leeches and poultices. Trained nurses, physiotherapists and occupational therapists thought it unimportant and beneath their dignity to work on geriatric wards.

Warren placed patients with the same conditions and at the same stage of illness together in one ward. This new arrangement allowed some wards to be used for assessment, investigation and treatment, with others reserved for female patients whose main or only disability was incontinence of urine or faeces. Mobile patients awaiting discharge and those requiring nursing or medical supervision were placed in separate wards.

She improved the ward environment. Entrances were enlarged, obstructions removed and swing doors provided. Lighting was upgraded with individual indirect

lights.[27] Walls were repainted with cream colours. High nursing beds in light pastel shades with adjustable backrests replaced low old-fashioned ones. Each bed was provided with a modern locker, a bed table, a pair of headphones, bright red top blankets, light coloured bedspreads and patterned screen curtains. Wards were equipped with modern clinical aids, handrails and suitable armchairs. Floors were no longer highly polished and steps were avoided. Special chairs, walking frames and walking sticks with rubber ferrules were provided for arthritic and heart patients. Non-institutional clothing was introduced and shoes were adapted to the patients' needs.[28] Heating was evenly spread across the ward – cold toilets discouraged use. Her treatment of elderly patients was broadly based with emphasis on the care of the feet, teeth, eyesight, diet, sleep and the prevention of chronic disabilities.[29]

Warren really got going in 1945. She developed rehabilitation as a team function involving medical and nursing staffs, physiotherapists, occupational therapists and almoners (later medical social workers). All had interest, patience and sympathy for old people.[30] She was totally loyal to her staff who were frightened of her but if 'she did get on with you, she would go a long way out of her way to be helpful'. She valued team members' views and when one of them said a patient was not ready for discharge, or the home arrangements were not yet satisfactory, that view was accepted and discharge postponed. However, working with her must have been difficult at times. She would be on the wards at 11 pm at night, perhaps even carrying out a ward round at that time. She slept in the hospital much of the time since she was frequently on call. On the other hand her staff were young and found the work exciting and there were opportunities for international contacts.

Specific treatments

Warren developed special techniques to rehabilitate hemiplegic, single and double amputee patients. Previously stroke patients were regarded as irremediable, causing the paralyzed limbs to become stiff and contracted.[31] Often the good leg also contracted. She advocated that stroke patients should be examined fully on admission and given active treatment and rehabilitation to prevent pressure sores and stiff joints. Those who were unconscious required correct nursing to prevent sores, attention given to bladder and rectal function, hydration maintained and sedatives avoided. While the patient was in bed the bed linen should not be tucked in tightly to prevent leg movement. Special exercises were devised to assist mobilization. Dysphasic patients were given special care. The patients' morale was maintained by being dressed properly. She produced a film demonstrating these techniques.

She devised specific treatments and exercises particularly for double amputees, who had previously only received bed rest.[32,33] Before amputation she assessed and educated the patients about the implications of the operation. Patients were taught care of the amputation stump and provided with the necessary aids and pylons. Special bed-end exercises and shuffleboards were developed to assist them to get in and out of bed and on to a wheel chair. She worked closely with the Roehampton Limb-Fitting Centre and advised on modification of their prosthetic devices for older people.

She reviewed recent literature, drug treatments and physical agents including clothing, heating and aids in the treatment of chronic patients.[34–36] She published prudent advice on drug therapy for older people which the Royal College of Physicians echoed years later.[37] It was essential to establish the correct diagnosis. Compliance problems were likely since the elderly frequently had multiple pathologies for which several drugs were prescribed. Medication regimens should be kept simple and the number of drugs reduced. Patients should be warned about adverse drug reactions and sedatives used with caution.

Achievements

Warren was the first geriatrician to publish statistical data to demonstrate the work of her unit.[38] These showed that between 1944 and 1946 she discharged approximately one-third of her patients. Good nursing and teamwork cured incontinent patients and many were able to return home which raised patient and staff morale. Local general medical staff acknowledged that their 'chronic sick' elderly patients actually did better on the geriatric unit than their wards.[39] She became successful in extracting funds from a Board usually better known for skinflint attitudes to infirmaries.[40]

She accepted for transfer only those patients she considered would benefit from further medical treatment on her wards: other consultants could not expect her to take all their 'unwanted' patients. This put her at odds with colleagues who without consultation were used to moving their patients to elderly care wards. Those patients she did accept made considerable progress. One woman of 62 years who had been an inpatient for nine months was transferred from an unnamed London hospital because the physicians considered they could do nothing for her. Within one month of routine treatment she was walking in the ward.[41] In 1950 she took 50 hand-fed, incontinent and bedridden patients who had been in that state for at least two years.[42] After three months 20% were ambulant, independent and had returned home while a further 30% were up dressed and partly independent. In 1955 she accepted a 74-year-old woman from another unnamed hospital where she had been an inpatient for 20 years and bedridden for a considerable period although she wanted to get up.[43] The patient mobilized herself, was given clothing and special footwear, and surgery helped for her deformed left foot. After 30 weeks of rehabilitation she was discharged to a welfare home.

These achievements allowed her to vacate three wards. One of 45 beds was made available for TB patients and another of 22 beds allocated to dermatological patients. A third ward was used to create a small gymnasium and a second X-ray unit.[44] She was even able to allocate some beds to a newly-arrived

consultant general physician who had not been allocated any.[45] Thus, her geriatric unit slimmed down from 514 to 200 beds and she had two full time house physicians to assist her. She thought this bed number was adequate for her purposes provided they were used correctly. Her successes must have been recognized locally because later she was asked to take care of 200 more patients in a local residential home!

Her publications and clinical successes claimed the attention of Drs Banks, Sturdee and Boucher and of Lord Amulree at the Ministry of Health. They realized her achievements in discharging patients and emptying beds could alleviate pressure on the embryonic NHS. Sturdee was instrumental in persuading geriatricians to form The Medical Society for the Care of the Elderly. Its first clinical meeting was held in Warren's unit at the West Middlesex Hospital in 1948.

Warren served on some 20 national and international committees and was a member of the British Medical Association Committee on Care of the Elderly.[46,47] Its first report was issued in 1947 and a supplement followed the next year. She lectured across the world including in Australia, Canada and America. In 1959 she was appointed Commander of the Order of the British Empire for distinguished services. The London Association of the Medical Women's Federation elected her as its President but unhappily this was only just before her death. Her unit received many visitors. One of the earliest, Dr Charles Andrews from Cornwall, came away with a clear idea of what was required to correct the problems in his local institutions.[48] Adams in his Memorial Address said that it was given to few to arrive at journey's end with work complete and as well done as hers.[49]

However, she was not without her critics. Lionel Cosin (1910–94), a contemporary geriatrician based in Oxford, visited her at the West Middlesex Hospital.[50] He thought she was rigid and authoritarian and that he learned little from her. He was shocked to see wards of doubly incontinent patients and he thought she changed her treatment of the care of these patients in view of his comments. He maintained that she only discharged 10% of her patients while he discharged 40%. Alice Sheridan, Warren's Almoner, considered Cosin was 'an awkward cuss' and was not in the main stream of geriatric medicine like Lord Amulree and Professor Exton-Smith.[51–53] She thought that Warren placed most emphasis on hospital management of the sick elderly and did not develop strong community support services although she appreciated the value of home nursing. This contrasts with Dr Eric Brooke who managed a geriatric service at Carshalton in Surrey with very few hospital beds and had of necessity to develop neighbourhood services, including home helps, meals on wheels, district nurses, laundry services and occupational therapists.[54]

Warren makes little mention of an external waiting list unlike many of her contemporaries who had hundreds of elderly people awaiting admission.[55,56] Her forthright nature did not enamour her to colleagues, upset by her attitude to taking transfer patients and the fact that she never gave an inch when fighting for her corner. Sheridan detected an implied criticism that she was a woman, was not a proper physician or fully qualified because she had not passed the MRCP examination.[57] Sir William Ferguson Anderson (1914–2001), a Scottish geriatrician, found her inspiring, brilliant and hard working but thought she was not well regarded locally because she was very plainspoken and worked with the elderly, and local doctors lacked insight into her abilities.[58]

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GLIMPSES

Dr Henry Crawford MacBryan aka Sir Roderick Glossop (PG Wodehouse's 'well known loony doctor')

Avid readers of *Plum* will be familiar with Sir Roderick Glossop, school friend of Lord Emsworth and Society Psychiatrist who treated the aristocracy. A teetotaller with a morbid fear of cats, Glossop is convinced by Jeeves that Bertie Wooster is mentally unstable and fortuitously sunders Wooster's hasty engagement with daughter Honoria. What is not so well known is that Wodehouse often based the details of his characters, the places they visit and even their adventures upon real life examples.

The young Wodehouse (1881–1975) stayed frequently with his maternal grandmother and her four unmarried daughters (no doubt explaining his continued aversion to aunts) at Cheney Court, situated in the village of Box in Wiltshire. Dr MacBryan LRCS, described as having an enormous bald head and bristling eyebrows, ran a private mental home a short distance away at Kingsdown House. Clearly he had an effect upon the boy since Dr MacBryan became the model for Sir Roderick.[1]

Records concerning the doctor are scarce and so we cannot be sure how much of the original made its way into the literary character. Dr MacBryan made application to run a private asylum in West Derby in Lancashire, and also appeared on the staff list of the Hanwell County Asylum in 1884.[2] His name is given at the quarterly meeting of the Medico-Psychological Association of Great Britain and Ireland that attended at 11 Chandos Street in May 1906.[3] In the early 20th century the establishment at Box was recorded as being well run with 43 patients who were charged between two and five guineas per week.[4] This would have helped to send his son Jack to Cambridge where he became a cricket blue, later capped for England and went on to win a hockey Gold Medal at the 1920 Olympics. Dr MacBryan is known to have written to Jack when he was incarcerated in a prisoner-of-war camp at Magdeburg and it may be the name of another son, Edward, that is recorded on the Box War Memorial as having been killed in action in 1917. The gates of the former mental home are thought to have become the entrance to the Swindon Borough Council Crematorium.

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