History of the Cornwall Hospital: the development of geriatrics in New Zealand

by J.L Newman

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In 1981 I had occasion to take a walk over the site formerly occupied by the Cornwall Hospital. Not a trace of it remained. There was nothing to indicate that the site had ever been anything but a part of Cornwall Park, indistinguishable from the rest of it.

Perhaps, I thought, a brief account of the geriatric hospital and the part its staff played in establishing geriatric medicine in New Zealand should be written. I began to draw on my own memory of that part of its performance with which I was myself concerned. There were many gaps, so I called at the Hospital, Board offices to refer to the reports which I had submitted to Mr Selwyn Kenrick, the Superintendent-in-Chief. Alas; they too had vanished. The orily record I could find that the Cornwall* Hospital had ever existed was one file containing some rather irrelevant contemporary memoranda and the Superintendent-in-Chief s Annual Report to the Board for 1950.

What follows is therefore a personal account: it lacks the objectivity of a real history. I have drawn on the recollections of several of my colleagues, but their numbers have inevitably shrunk and their memories, like mine, are only too fallible. It can only be said that, in spite of its imperfections, this account of the Cornwall Hospital is the most complete that can be put together under the circumstances. One general comment remains, Cornwall was a happy hospital. Its whole staff worked together with dedication in a real conviction that the work they were doing was of vital importance.

According to the story current at the time, when I went to Cornwall Hospital as Medical Superintendent in 1952, the Hospital had been offered to the Hospital Board as a going concern, complete with theatres, pharmacy, radiology and so on when it was vacated by the US forces as the US 39th General. But the Board had refused to accept it and the contents were disposed of. It was not long before the Board found itself forced to look for more accommodation. The old - one could scarcely call them geriatric - patients in other institutions were delaying development, but - most important - the success of Dr Doris Gordon's appeal-*- for the.money to launch a National Womens Hospital placed the Board in a position which made a take-over of the empty Cornwall wards essential. So it came about that the National Womens Hospital were allotted the rear half of the buildings, including the theatres and x-rays, and the far, and larger, half became available for occupancy by the geriatric patients. Every few years the lease of the buildings from the Cornwall Park Trustees ran out, and every few years the Board would plead necessity for staying, a plea that was regularly granted with the proviso that this was for the last time. The supposedly imminent dissolution of the hospital was always the reason given for leaving it as it was. No additions were allowed and alterations were frowned on and achieved only with difficulty.

Structurally the buildings stood up remarkably well. They had been run up in a great hurry at a time of shortages of all sorts. Apart from the asbestos cement roofing the whole structure was of wood, even the gutters and down-pipes. One day an old man in Ward 5 tossed a lighted cigarette butt out of the window and it landed on a horizontally projecting ledge. By one chance in a million it got blown along the ledge to rest against a downpipe and it burned its way through one side. The fire, gently smouldering, spread up the pipe from which, and from the adjacent sheets of roofing, smoke poured. The alarm was raised and the old patients were prepared to walk out of the other end. I was observing the situation from the Sister's office adjacent when Ian Parton rang up from the Auckland Hospital to discuss a urological case. After we had been talking for a while I said 'You must excuse me if I ring off now. The ward's on fire'.

That was the only such alarm, which was lucky seeing that some of the men had an irresistable urge to smoke in bed. There were some narrow shaves, but only shaves.

When the geriatric programme got under way I was able to get the Board to agree to a very minor modification of each ward. The far three or four beds were removed and the space turned into a dining

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1 The appeal was Doris Gordon's but the concept of a post-graduate school of obstetrics and gynaecology was said to have been John Stallworthy's.

and sitting area. The change gave a boost to the morale of the patients and saved a good deal of nurses' work in having meal service centralised instead of individual.

The only major structural change was a day-room that filled the gap between the parallel Wards 5 and 7 occupied by ambulant men. They had had nowhere to sit except beside their beds and the Board Office saw at once how great was the need. So we got our sitting room. The House Manager, Mr Syms, arranged to draw on a more-or-less forgotten fund for the provision of ameneties. With it we bought some items beyond basic furniture, including pictures. We tried to get the City Art Callery to provide them but perhaps the idea was rather too novel and we had to buy some ourselves. Miss McCullogh, then an Assistant Matron, went with me to the city art shops and debated what kind we ought to hang for a clientele that included all types from ex-schoolmasters to ex-wharfies - old masters? Picasso? We played for safety and ended with some rather conventional but colourful scenes of yachts keeling over before the wind, farmyard scenes and so on.

The only other structural change, a minor but significant one, was the adaptation of what had been a National Womens canteen into the first hospital's post office, another step in the campaign to get rid of a hospital environment and to bring the other world into the geriatric.

Today, in 1981, there remains no trace of the Cornwall Hospital of 1951. You may enter by the gate just on the Great South Road side of Cornwall Park entrance and find yourself confronted by meadows. The one on the right, between the entrance road and the pohutukawas of the park, is now dotted with trees. Then it was full of huts, the Cornwall Geriatric Hospital Nurses' Home, with a large recreation hall in the middle.

As you went up the road you were confronted, where it divided, by the first of a series of weather-board and asbestos huts, a part of the National Womens Nurses Home. On your right was a long border planted with gazanias; up to a round-about with a large concrete static water tank on the near side and a flag pole in the middle. From the pole we used to fly a Union Jack on June 18th to celebrate Waterloo, an event lost on the natives, and on April 23rd (nominally St George's Day but really for my birthday, an event Mrs Williams never failed to celebrate), besides the more recognised occasions.

On the left at the round-about was the first building of the Cornwall Geriatric Hospital. This was a short one for the offices of the administration. A path ran from its back in the open to the spinal corridor of the National Womens Hospital past another large hall, the main part of which was used for films and various meetings, with the associated rooms being the X-ray Department under Dr A Crick and then Dr John Stewart. Next to this was one standard hut that housed the Path. Lab under Dr John Burton with John Sullivan at first as a registrar.

Beyond the Cornwall Geriatric Hospital administration building was the hospital's main entrance in a similar one linked to the spinal corridor by another. The National Womens Hospital administrative offices were on the left. On the right successively were our Staff Clinic and the Pharmacy. Mr J Hargraves and R C Laurie, pharmacists. Turning to the right into the main spinal corridor you had the National Womens Hospital theatres on the right and soon reached the beginnings of the Cornwall Geriatric Hospital - Occupational Therapy on the right and Physiotherapy under Mrs Boyd on the left. Behind you on her side (the left) were the lower kitchen, the main one, with a dining room annexed and a succession of National Women ward blocks. Then came three geriatric wards on either side.

At the far end of this section of the main spinal corridor you turned right for a short stretch, with various short buildings in the line of the main corridor before you turned left and continued in the original direction. These short buildings were a variety of store houses for Hospital Board equipment. I long had my eye on these for a central office and sitting room for the RMOs who had a long way to come from their hut; they would be much more likely to spend time in association with the wards if they had somewhere to spend it. But it was only shortly before I left that this dream was realised.

Reverting to the main spinal corridor you went' up a slope in it and then levelled out to more ward huts on the right and left. After three of these there was the upper kitchen and dining room on the left and the staff tea room on the right. The upper kitchen catered for all the ambulant patients. You might meet them a good hour before a meal-time struggling painfully along the corridor with the help of a handrail fixed to the wall. The staff tea room was the focal point of the morning's activities. To it came the doctors and the matron and her assistants. The Matron, Miss Vi Hyde, presided at the teapot and the meeting reviewed all manner of problems, mostly clinical, but by no means entirely. There were few current topics, whether of local, hospital, or international interest, that were not discussed and the level of conversation was pretty uniformly high for the participants represented the best of the younger doctors in Auckland.

Beyond the kitchen were Wards 5 and 7 on the right (used by ambulant men), Ward 3 (later to be taken over by Dr Bruce Cain, a lot of very smelly animals, and a chemical research lab where Cain explored the native flora for pharmacological properties) . There was a large hall used as a salvage store with the Cornwall Geriatric Hospital Library in the associated smaller rooms and at the far end the male nurses' quarters where they lived their own lives undisturbed by supervisory visits.

Continuing a stroll round the hospital the road rounded the end wards and then ran along the east side from south to north with the

wards on the left (west). First, on the right, came the incinerator then a medley of huts, used as RMO quarters, some stores, a large social and recreation hall with a stage etc like the others and a group of huts occupied by the Treasurer's Department of the Hospital Board (Mr John Gage, Treasurer) , until room could be found for them in the city with the rest of the Board's administrative staff. The huts here were notable for an annual re-growth in the strips alongside them of cocktail tomato and swan plants. Beyond the huts was a large Dutch barn for the vehicles (motor mowers etc) and, at the very end, a small hut for the mortuary and postmortem room.

Most of the male nurses lived out. I never knew which for, indeed, I had too little to do with them as a group. They were, in fact, quite an interesting lot. There was the chief, Mr Willis, highly efficient but I never saw him smile. Mr Evans was a remarkable character. He had spent his life as a farmer but when he passed 60 he thought he ought to do some really useful work and what could be more worthwhile than nursing. So nursing it was and he went on until he was not far short of 80, one of the gentlest attendants imaginable. John Harrison was another dedicated worker. He always looked cadaverous and ill - he had a duodenal ulcer and asthma which eventually killed him in 1980 - and he was married by, and to, a woman in the non-hospital setting (was it from the canteen?). Miss Hyde said she'd got an eye on his money and it would never last. She was quite right. Harrison eventually became Chief Assistant to the Auckland Old Peoples' Welfare Council (I was able to further his cause by being a leading member of its council when the Chairman was Dr Roy McElroy) . Everyone always thought he was so ill - 'Poor Mr Harrison' - but I knew he'd always been like that. He seemed never to be so happy as when he had sleeves rolled up cleaning out a neglected tenement and re-establishing its broken-down occupant. There was one very odd member of the male nursing staff, Mr Rupe. I was struck when I examined him by the odd smoothness and softness of his skin. He was a very good nurse but I was not surprised to find, years later, that as a transvestite he was a well-known character owning a rather doubtful night club in the capital city under the name of 'Carmen'.

The other nurses were first class. Once the atmosphere of stagnation had been ended they all, from the elderly sisters - and many of them were pretty old for active nursing - £o the beginners, threw themselves into the service with alacrity. They hadn't the educational background that the pupil nurses in the other hospitals had, but they were excellent nurses. I could not have wished for better had I been a patient.

The high quality of the nursing must have been largely due to the personality of Miss Vi Hyde, the Matron. She set high standards but took a personal interest in the girls and was an approachable human being.

An American visitor was struck by the small numbers of nurses on a ward. 'But how do you manage with tube feeds and antibiotics?' he

asked. 'I never use tube feeds and scarcely ever give anti-biotics' I replied. 'We use both' he said, 'My people are paying good money and they expect it'.

The Sistc were all fully trained RNs, but the ambulant men in Wards 5 and / ■ supervised by Nurse Allen, a rr/ddle-aged nurse aide who controlleu ..in-., cared for them with what could only be described as devotion. lhe-ₑ was one Maori Sister, Jane Clarke, and very good too, and one wi>u '?-d been on the staff of Oakley psychiatric hospital whose ability to handle, and to advise on the care of, disturbed patients was very valuable.

When the hospital was first established it shared a Superintendent with the National Womens Hospital in the person of Dr Oddie, a young English doctor recently demobilised. He had no clinical duties but was a vigorous advocate of the needs of the aged. He enlisted the help of Dr R G McElroy, a prominent solicitor (and later a mayor) and they founded the Old Peoples' Welfare Council. Tills consisted of representatives of the interested philanthropic bodies such as St John and the Salvation Army, of the Health Department and Social Security and of the local City and North Shore Borough Councils (Takapuna originally until they had their own OPWC under Mr Reg Powley, the Health Inspector there). Oddie also enlisted the interest of Sir Robert Kerridge and they made a film to show the plight of many pensioners. -I tried to trace it years after but failed. We worked in close association with the Auckland OPWC who had as their first officer a Mr Tilby who was winkled out of a post as sanitary inspector to the city and became an interested social worker, able to prove helpful to the Cornwall Geriatric Hospital and vice versa.

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After a few years Oddie went back to England and became Regional Medical Officer to the Oxford region. His place was taken by Dr Worseldine, an officer in the RAMC who liked nothing better than to lie on his back in the grounds and listen to the tuis - which suited others too.- The care of the patients was in the hands of Dr Valentine, an elderly GP in the Manukau Road - half a GP to 300 patients! No wonder the hospital was half dead. He had the help of two RMOs who could be prevailed on to spend three months in geriatrics only on the understanding that by doing so they would get the next three on the staff of National Womens. I too had two RMOs but by the time I left there was no need to lure them to the CGH. It was the most popular 'run' in the Board's service and I had the choice of seven applicants for each job.

The method of selection of house officers was that a meeting of medical superintendents was •convened for the purpose, and each in turn picked a quota until in the course of several rounds they were all allocated. Whichever Medical Superintendent had the first choice one time «'ould have the last next, and so on, so that every hospital would get a first choice in rotation. The junior doctors themselves put down their own choices and as far as possible their wishes got the first priority.

Sometimes the choice was blind. Sometimes a previous report would be very influential. In my first year I selected Ray Windsor on the strength of his having sung the part of Polyphemus in a Choral Society's production of Acis and Galatea in the Town Hall.

They all did well later, indeed they might be described as a very distinguished lot - with the exception of Joan Casserley of whom I wrote in my report to the Superintendent-in-Chief 'I failed to interest this young woman in geriatrics'. But I believe she was in love. A list of their names and eventual status shows how good they were as doctors (Appendix A). They were a pretty distinguished lot - eventually eleven Fellows of Surgical Colleges, sixteen Members of College of Physicians; one MRCOG; two Fellows of the Faculty of Radiology; two of the Faculty of Anaesthetists RCS, four leaders in the field of general practice and four in senior administrative posts.

I felt particularly gratified when Alan Clark, to whom I had written congratulations on his Otago Chair of Surgery, replied that he looked back on his months at Cornwall as the most rewarding of his 'runs' as an RMO in Auckland.

The routine was a round with each on alternate days, seeing the sick and the new cases first and any the House Physician wanted to refer. He was expected to carry out a check on every patient during his three month run. He would give me his notes and I would reqd them myself because I'd noticed at Green Lane Hospital that House Physicians questioned the trouble they had taken with their notes only to have the chief ignore everything but the GP's letter nf introduction (no doubt from the geese that laid the golden eggs). Then there would be the physical examination in which we tried to catch each other out by meticulous accuracy: I always wrote my own appraisal and expected the House Physician to do the same. That was the best way of demonstrating the fallacies of prognosis. They were also expectsi to draw what was going to be seen on the chest x-ray and the use of the laboratory was discouraged although a blood urea, WR and Hb were always obtained. Eventually I dropped a routine chest x-ray because we never found an abnormality on a woman's and practically never on a man's that we did not suspect on clinical grounds. All the defects found were listed (I think they averaged about 3.5 per patient - or was it 4.5?) and a plan of treatment worked out leading straight on to rehabilitation.

An electrocardiography, though, was a welcome and indispensible diagnostic weapon which became almost a routine. In addition we would obtain the advice of any member of the Board's staff by filling in a yellow reference form. This was invaluable as we had repeated problems of eyes, orthopaedics and urology and the expert opinions we got so readily added enormously to the clinical interest and speeded up treatment. Dr Rowat Brown, the specialist in Physiotherapy, paid a weekly visit to the Department under Mrs Boyd so that consultation with him could be easily arranged and was a regular feature.

Having the laboratory and the x-ray so near (one actually walked past them very often on the way to the wards) was of the greatest value. Personal contacts added flavour to the coloured slips of paper to be stuck into the case notes.

If the patient died, as many of them did, we always tried to get a post mortem and we always attended it, unpleasant though I still found them. I ought to have supervised the completion of the notes and the coding according to the international Classification of Diseases! but I did it myself in the afternoons, together with writing to the GP because i did not realise how badly it was usually done until I saw the notes of other physicians' patients at Green Lane Hospital.

I should also have ensured that the House Physician accompanied me on the times when I discussed a patient's illness with the patient. But I did this in private conversation as it was some time before I worked out a system. When I did it was always to tell the truth and to call a spade a spade so far as the term 'spade' was comprehensible to the patient. Thus 'I think your trouble is cancer. Mark you, I think, I've been wrong before but that's what you ought to know I'm going to treat you for. We shall get the best advice if I think there's any more that someone else has to offer. But in any case my job will be to see that you don't suffer'. I found the nervous system degenerations more difficult to explain, partly because they mean little to the un-initiated and when they did mean something (as with Sister Campigne's motor neurone disease) it was the possibility of a spontaneous remission that I tried to leave in mind. Rarely I might be asked 'Am Ingoing to die?' and I would say 'Yes. And so am I but I don't know when with either of us. Only that I shall be here to look after you and see that you don't suffer'.

And they didn't/ I don't remember any patient dying in pain, nor did I give large doses of analgaesic. I used to give Tinct. of Opium by mouth if possible and combine it with the new drug chlorpromazine. Sometimes we had to resort to injections of morphine. After a time I read a paper by tWo Australians on com-bining an opiate with its antidote amiphenzole to cut out the nausea and depression and, on their lines, we could find out how many milligrammes it took to keep a patient comfortable for 24 hours and then divide it into two or three, keeping the amiphenazole at a constant level (20 mg). It worked very well.

These developments were late. At the time of my arrival the general atmosphere was one of passive acceptance of disability and all that went with it. In justice to the staff I must say that this was reluctant and that when the lead had been given they threw themselves into the programme of active treatment and rehabilitation with zest. Not so some of the relatives. When I said 'He'll be fit to come home in a week or so' the reaction was one of shocked

surprise. They would answer 'But I thought this was an old men's home!'.

On the general question of admission policy I did my best to avoid segregation or the allocation of particular types of patients to particular wards. This was with the object of spreading the case load and avoiding the possible stigma that might have become attached to particular wards, as the one where they go to die or the one for the mental cases. When we got a phychiatrically trained sister she took the same cases as did the others but her experience could be utilised without filling her ward with the 'difficult' cases. The only kind of segregation of patients was that the ambulant ones went to the far end (Wards 5, 6, 7 and 8) from which access to the top kitchen and dining room was easy and the patients on the more active physio and occupational therapy programmes were in Wards 21 and 19 at the other end of the corridor.

At first we were faced by three major problems - incontinence, bedsores and contractures. At the end 1 was still faced by incontinence but I think not to the same extent. Pondering on it I had come to the conclusion that much of it was due to mis-handling . I wrote an article on it for the BMJ, 'Old folk in wet beds' (BMJ 1962-1-1824) and although this appeared some time after I had left it embodied ideas I had been incubating for some time, ideas that became forumulated particularly in the light of Sargent's book Battle for the mind. This concept was widely accepted and was still being quoted at the present time (1981).

Bedsores we treated with all sorts of things - saturated urea solution, egg white, flavine in paraffin, and eusol which was perhaps the best. It was only later that I learned that an impending break-down begins deep down and should be identified by a feel of subcutaneous tissues before the skin gives way. By then bedsores were becoming unusual, thanks to the fact that few patients were fully bed-fast and fewer left immobile.

The same applied to contractures. They were grotesque at first and the result of immobility. Limbs in use don't get stuck. But all sorts of nervous system paralyses and joint affections had ended up by being frozen in positions that made use impossible and thus interfered with movement in other joints. I never found a satisfactory cure. Prevention became the objective and I tried to encourage nurses to move the limbs, for all their reluctance to do what some sisters regarded as the business of 'physio'. Removal of cot sides helped to encourage mobility. Adjustable high-low beds would have done even more bur I was too economy-minded and it had to be left to R A Barker to persuade the Board to provide them.

Some individual patients stand out in my memory. The worst cases I think were two old men whose faces were being slowly destroyed

by rodent ulcers that began near the side of the nose and destroyed the nose, ate through into the maxillary sinus and, one case, destroyed the floor of the orbit. They were positively repulsive but they were cared for with extreme devotion by the male nurses in Mr Willis' Ward 19, notably by Harrison and Evans.

In Ward 21 were two pathetic younger cases. Miss Margaret Knight, a school-teacher was blinded and rendered helpless in bed with rheumatoid arthritis. Joan Barr, in her early 30s perhaps, had never known real life. She was hopelessly incapacitated by spastic diplegia and from time to time she would lose all control and scream and storm at the nurses out of pure frustration. All you could do was screen her off till she'd cooled down and give her a little barbiturate.

Nellie Spicer was an elderly woman with osteoarthritic knees who had taken to a wheeled chair which she parked in the upper corridor. She had grown fat and resented any attempt to change her life - which probably wouldn't have succeeded anyway. I remember her because when I went to the San Francisco Conference I wrote in her notes 'Famous last words - Charles II on his deathbed and JLN on departing for the USA, "Let not poor Nellie starve"'',

There were some interesting cases of cancer that stand out. A middle-aged man came in with cancer of the stomach on regular and frequent injections of morphine; wasted, vomiting and a shocking dirty colour. I noticed that he had constricted pupils, so I rather boldly (and rashly) stopped the morphine. He stopped vomiting, did not need narcotic pain relief and within a week-I told his relatives that he would be fit to go home in a day or two. 'But, Doctor, he's dying of cancer', they said. 'Not quite' I replied, 'I'd rather he lived with it'. I didn't see him again.

Another middle-aged woman came with a note from Fishponds Hospital, Bristol which said that they had opened her and found her too full of malignancies to be operable. 'You don't need me' I said. 'Go and make the best of things and if there's anything I can do, come back'. She didn't. But she was admitted to Green Lane for gall-stones and when they opened her there wasn't a trace of cancer.

An old lady came in with a fungating cancer of the breast. She had had it for 18 years! Originally she had responded to a publicity campaign by going to a clinic at the Auckland Hospital, but they felt it and said 'Hm, ha, we'll send for you'. But not a word of explanation, and she went home and had a good cry and decided to give doctors a miss. I wondered if that was why she had lived so long, considering the widespread recurrencies we so often saw in operated cases.

Another who was admitted as a case of cancer proved to have megaloeystic anaemia and she went home surprised and gratified.

Then there was poor old William Sparrow from Ward 19 who for years was unable to take a proper breath.

One cantankerous old man in Ward 17 found fault with all we did for him (which may not have been much, as his peripheral arteries were not much good). I suspected he might cause trouble and so I got Dr Michael Gilmore, the Medical Specialist to Auckland Hospital to see him. The verdict was that he had no more to suggest. After he died his daughter found a diary in which he vented his spleen and she gave it to Truth which published an article, without reference to me, accusing Cornwall Hospital of 'shocking neglect'. As the Cornwall Hospital meant me, I took a serious view of this and appealed to the Medical Protection Society and to the Board to look into the accusation, but the legal opinion was that as I had not been named I could not demand redress, and the Board was for letting sleeping dogs lie if they would. And there it ended.

I had not been working at Cornwall Geriatric Hospital long before I recognised that the social work was shockingly inadequate. We depended on as much of Sister Spensley's time as she could spare from responsibility for the other hospitals. ' So I got the first Social Worker appointed to a particular hospital. I had just attended a notable national conference in Wellington (under Ralph Hanan, the Minister of Health) where 1 had met Professor Minns and Mr McCreary of Victoria University School of Social Science. I hoped to get one of -their graduates, but they were all snapped by the Public Service. Miss Avis Jones came to me from a nursing position. Like the rest of us she had to play it by ear and she made a good job of it. Later she became head of the Board's Social Worker Service.

The waiting list was a bane of administration because people judged the service by the length of the list. So I went out myself to see what the need for admission was, and on some of these expeditions I took an RMO to introduce him to social conditions. (Dykes got a bit carried away by the sight of a case of Paget's disease in a Newton street and urged me to run him down and 'get him in the bag'.) Conditions were often shocking. Newton Gully was full of bad housing (eg Manning Street, now lost to the motorway) and Vincent Street of mens' rooming houses that emphasised the need for a housing policy as a basis for preventive geriatrics, a theme that I enlarged on at several conferences. In order not to show prejudice or to overlook, under the impact of a recent shock, needy cases of standing, 1 introduced a system of points assessment. The patient got so many points for pain, so many for immobility, and so on.

The attendant got points for lack of relief, for incontinence etc. More were given for inadequacy of facilities and accommodation. The

form on which the findings were recorded gave a valuable picture of the chances of success after discharge, and the totals scored were an unassailable challenge to critics.

It was soon clear that I could not handle the outdoor work and the care of over 300 patients myself and I had no difficulty in convincing Selwyn Kenrick, the Superintendent-in-Chief, that the appointment of a Registrar was a necessity. I had five in succession: Nils Theilman, Neville Hogg, Roger Maxwell, Elizabeth Bowie and Larry Brett and very good ones too. Miss Jones would visit prospective patients and assess the social need, then the Registrar would look into the medical need as a matter of functional capacity without the niceties of diagnosis. If an old man couldn't walk It was our job to admit him whether his disability was the result of arthritis or nervous disease. Of course eventual full examination often revealed remediable defects that would never have received attention outside. An unexpected aspect of the light that came to be shed on a case was the domestic situation that sometimes was brought out when you could really talk to a relative. There were some shocking stories of cruelty. One old woman who would not yield any freedom to her elderly daughter 'cooked pounds and pounds of it' (I forget what) 'and I hate the stuff. Another daughter, whose matrimonial prospects had been blasted by her mother years before, had a little dog as the only object of her devotion. When she'd gone into town to work her mother rang up the RSPCA to have them kill it. When the daughter found out where the dog was she rang up in the hope of being in time but was told that the lady had specially asked for the job to be done immediately.

It became clear that-- in many cases it was the next-of-kin whose needs could be met by admission no less than the patients. So I instituted a 'short stay' system based on two beds for men and two for women. They were to be in for a month and then go back on to the waiting list - all good in theory but in practice the next-of-kin too often went back on their side of the bargain. I tried getting them to sign an undertaking to take the patient home provisionally 'whether relieved or not'. But not even this would work. Some people would do anything to shelve their responsibilities. Later I found that Dr Delargey at Leytonstone was running a similar scheme that he called 'six weeks in and six weeks out' in which his hospital and the relatives shared the burden of care. He told me it worked without any hitches. The short-stay system had very beneficial effects for the patient. It allowed a much more thorough diagnostic review to be made and for the services of physiotherapy (Mrs Boyd) and occupational therapy (Miss Smythe and Miss Trotter) to be brought to bear in the hope that they would be continued after discharge. Soon after my successor (R A Barker) took office the National Womens Hospital vacated their wards for the new building in Claude Road and he was able to get one of them for a day ward in which he was able to do all that I had done, or more, in my few beds.

As the turn-over increased so did the need for more medical help. The Board accepted this and appointed Donald Cash. I made him

responsible for definite beds and then kept out of the picture except that we invited one another to one's beds pretty often. I didn't like his style of medicine, the American system of avoiding any possible suggestion of negligence by asking for every kind of lab test and then trying to add them up to a clinical picture with little reference to the patient. He was not particularly interested in geriatrics, rather in getting an entree to the Board's visiting staff, and as soon as he could he moved to Middlemore.

On looking round for a successor I approached Ron Barker who had his MRCP and was in a flourishing general practice in Dominion Road. He applied and got the job and proved a very interested and valuable colleague (who eventually succeeded me).

After I had left some relief was provided by an appointment of an out-door physician to do the assessment of the need for admission. Dr Jameson, a retired CP, was the first person to do this.

One of the reasons that impelled me to ask for visiting physicians was to stop ourselves becoming 'egg-bound' by lack o£ external contacts. The mere interchange of house officers every three months ensured some new ideas. More were qbtained through the Clinical Society which did me the honour of electing me Chairman. There were abundant cases of interest to bring before the Society (I was a fairly frequent participant) and I did my best to get my juniors to do the same. This showed that geriatric medicine was something more than the custodial care of dead-beats, but our successes in what might be described as bread-and-butter geriatrics didn't see any publicity - such as the rehabilitation Of hemi-plegics at which we became much more efficient. It has always been a regrettable feature of our hospital service that knowledge of success in a particular field percolates into others so slowly. So a doctor at Green Lane might know more about what a special department was achieving at the Middlesex Hospital than what a corresponding department at the Auckland Hospital was doing.

There were useful contacts with other centres that made me aware of possible lines of progress and that helped to put Cornwall on the map. The first of these was a national conference convened in Wellington by the Hon Ralph Hanan, a very effective Minister of Health, attended by Dr McElroy as Chairman of the Old People's Welfare Committee and myself as vice-chairman. At this I made contacts with the Health Department, particularly with Mr Tasker who organised the meeting .brilliantly, with the sociologists of Victoria University, with other interested doctors such as H R Donald of Christchurch at a time when the struggling speciality of geriatrics was not fully recognised. The following year I was awarded by the Ford Foundation a ticket to the International Gerontological Society's Conference in San Francisco (by piston-engined aircraft - as if there was any choice. I went by Electra

to Fiji and Boeing 707 to San Francisco). There I presented a paper on my method of choosing who to take into hospital (which was quite well received) and I met many leaders in the international field who were to prove very helpful when I did a round-the-world gerontological tour soon after leaving Cornwall Geriatric Hospital. All this helped to put the care of the elderly, and the Cornwall Geriatric Hospital on the map, as did my attendance at conferences in Hamilton, Rotorua, Hastings, New Plymouth and at meetings of Old Peoples Welfare Committees and with local physicians at Wellington, Christchurch and Dunedin. At many of these there were hints to be picked up which helped to raise the standards of old people's care, especially in the preventive environmental aspects.

As a step towards arousing interest in the sociological aspects of ageing I tried to get a properly designed retirement dwelling erected. It would have embodied all the recognised (but neglected here) features to make for safety and easy living. These were to include low level shelving (nothing over six feet), shallow steps with handrails, grab bars in bathroom and toilet, toilet doors with an outward swing, an orderly sequence of surfaces in the kitchen, lever-type door handles and taps and so on. Mr Keith Hay showed interest and would have built it at no expense to the Hospital Board. But the project foundered on the undertaking not to put up any more buildings on the Park trustees' land.

The administration of the Cornwall Hospital ran very smoothly, seldom harassed by the intervention of the Board.. We saw nothing of them except for a goodwill round on Christmas Eve, and all they knew of us was the simple statistical return and my annual reports which, Selwyn Kenrick laid down, were to be purely factual and to contain no controversial material. The quiet behind-the-scenes efficiency of the secretary Nita Williams was largely responsible for the smoothness. As Medical Superintendent I kept the documentation up to date. A discharge letter was written as soon as a bed was vacated and the carbon copy was filed alphabetically and the diagnoses in the form of International Classification of Diseases numbers written in the top right-hand corner. With this file on a shelf beside my desk I could answer about any patient immediately. Mrs Williams maintained a tallyboard with a visiting card made out for each in-patient and these were slotted into grooves ward by ward so that it was possible to tell at a glance what beds were occupied by whom and where and, after the prime assessment, what the diagnoses were. The case notes were brought to the office after death or discharge and the ICD code numbers entered, so that there was available a very complete and accurate register of all diseases. It might have been the subject for an interesting research but it was a matter of some regret that the output of original work was nil.

A very good feature of the administration was a weekly meeting, in the Medical Superintendent's office, of the Medical Superintendent, Miss Hyde as matron, Mr Mills the House Manager, Mr Marson the linen keeper. Jack Lindsay the head orderly sometimes attended. These

meetings were chiefly useful by bringing other aspects than the medical nursing into the picture. A variety of topics were discussed and it was sometimes precisely the non-professional members whose comments were interesting.

One non-geriatric activity of Cornwall Hospital is worthy of record. A Boy Scout Jamboree was held in Auckland at the Epsom Show Grounds at which were contingents from all over the country, from Australia and the Islands. Mr McCormick, FRCS and ex-Brigadier ADMS, was in charge of the medical arrangements which consisted mainly of a first-aid centre. No special preparations had been made when flue struck and the boys went down like ninepins. Somehow word reached me that they were lying all around the Cornwall Park School, where they had -been housed, with a bare minimum of attendance or care. I went over the road and found that this was indeed so. So I mustered the Cornwall Geriatric forces and they sprang into action with enthusiasm. Miss Hyde reorganised the nurses to provide cover for two wards, Mr Sims, the House Manager, cleared a ward that had been in use as a store, Mr Marson the linen keeper produced bedding from nowhere, Mr Lindsay, the head orderly had his men at the ready, Miss Donnelly the Dietician laid in the food, Mr Laurie the Pharmacist the medicines. In a matter of hours we were ready. Elizabeth Bowie undertook to see that clinical care was provided by herself and the two House Physicians while I did the routine ward work. I'd not been able to consult old McCormick, perhaps fortunately, but when it was all in action I reported to him and the Superintendent-in-Chief what was afoot. Again, fortunately, it was approved. The nurses loved it, and so in a few days did the boys who regarded it as a great joke being in a.geriatric hospital.

This response was typical of the enthusiastic and happy staff of the Cornwall Hospital. I moved to Green Lane because the Board's retention of the hospital had been repeatedly challenged, repeatedly renewed by the Park Trustees under protest and at last seemed likely to be terminated,. Moreover, Green Lane, with a national reputation (thanks to the cardio-surgical service of Sir Douglass Robb and Dr E H Roche), offered a much better platform for spreading the geriatric gospel than did the Cornwall Geriatric Hospital. Two years later I got my sabbatical leave and a round of visits to geriatric hospitals in the USA, several countries of Europe (Italy, France, England, Scotland, Holland and Scandinavia) left me satisfied that we were in no way lagging behind. Indeed, had the hospital not been on the wrong side of the world, it might have attracted visitors in its own right.

Geriatrics is really a minor aspect of the care of old people. Matters of pensions, housing, retirement, bereavement and so on are of great importance. So after my return from San Francisco at which all these were represented, I started a 'Society for the Study of Ageing' (gerontological is an ugly word). We hoped to get the University involved but the membership was never large, though it remained interested. It went into abeyance after Barker left the

Hospital and finally re-surfaced as a contributor to the National Gerontological Society based in Wellington. Our local group did some good by bridging the gap between Cornwall and the private geriatrics and perhaps encouraging higher standards.

(Signed)
J L Newman

APPENDIX A

Allan, Brian 1958	
Abrahamson, Irene 1954	Became Dr Valentine but never got over Nazi persecution.
Archibald, Robert 1959	In USA.
Bowden, Bernard 1954	Occulist to Northland Hospital Board. President NZMA - died 1980.
Bowie, Elizabeth 1958	Renal Physician AH : Phys to Carrington Hospital.
Cameron, Alan 1953	Physician (gastro-enterology) GLH
Casserley, Joan 1953	
Caughey, David 1957	Phys rheumatology Middlemore and Auckland Hospital.
Clark, Alan 1958	Prof of Surgery, Otago.
Clay, William '1952	Pharmaceutical industry.
Commons, John 1957	GP - Rotorua.
Conyngham, Bruce 1952	Obstetrician _NWH
Craw, Margaret 1958	Anaesth. ma. in Philadelphia.
Dignan, Peter 1958	
Dodd, Geoff 1955	Radiologist MH
Doak, Peter 1958	Phys nephrology AH
Dykes, Peter 1952	Phys Birmingham UH
Earnshaw, Roy 1958	Oculist Exeter Oxford
Feeney, Denis 1952	MO Dept of Health Wn
Greenhough, Roger 1957	Dep. Med. Supt. AH (ex MO New Hebrides)
Frazer, Peter 1955	FRCS
Hall, John 1954	DHM Dep. Dir. Psy. Med, Health Dept
Hay, Donald 1955	Urologist Wn
Howie, Ross 1952	Paediatrician NWH
Irvine, Robin 1954	Chairman UGC ex Prof. Medicine, Dunedin
Kay, Ronald 1954	FRCS AH and Ass. Prof, of Surgery
Kerkin, Ed 1953	In UK
Lamb, Geoff 1957	FRCS Orthop. Surg. MH
Lawrence, R 1954	MRACF GP Te Aroha
Lindsay, Peter 1953	MOH, Gisborne
Liley, Margaret 1954	(Lady M L) Phys. NWH
McKenzie, Ray 1953	GP Wellsford - now in USA
Mayo, Ken 1955	Radiologist MH
Meffan, Margaret 1956	
Meffan, Peter 1955	Surgeon Nelson
Menendez, Ramon 1954	GP Auckland
Molloy, Pat 1953	Prof. Thoracic Surg. Otago
Montgomerie, John 1959	MRACP in California
Moore, Ross 1957	MRACP Phys. Palm. Nth. H
Morris, John 1958	FRCS Orthop. Surg. MH Died soon after introducing Charnley's hip operation.
Neutze, John 1959	Cardiologist GLH
Nicholson, Gordon 1958	Physn. gastro-ent. GLH
Perrett, Tony 1959	MRCP in Truro
Richards, John	Ass. Prof. Comm. Med. Akd

Riordan, Teresa 1952	Anaesth. AH
Scobie, Brian 1952	FRACP Phys, gastro-ent. Hutt.
Scott, P J 1956	Ass. Prof. Medicine AH
Seddon, John 1953	MRCGP in Cambridge
Spencer, Pat 1959	
Taylor, Alan 1956	DP M Psychiatry
Tucker, Wm 1956	ENT Surg. GLH
Williams, Leon 1953	CP in Avondale.
Williamson, Chas 1956	GP North Shore
Wilson, Ian 1952	•ENT Surg. GLH, died 1979
Windsor, Ray 1952	FRCSE Surg. Ludhiana Mission Hospital

REGISTRARS

Theilman, Nils	Anaesthetist A Hosp
Hogg, Neville	GP Dargaville
Roger, Maxwell	Later Med. Supt. North Shore Hospital
Bowie, Elizabeth	Later physician to AH Renal Service
Brett, Larry	Med. Supt. Tokanui Psy. Hosp.

MEDICAL STAFF

Pathologists (with National Womens)

John Burton	(Returned in 1952 - Stephen Williams having been in temporary charge)
John Sullivan	

Radiologists

A Crick
J Stewart

APPENDIX B

NURSING STAFF

Matron	Miss Vi Hyde
Deputy	Miss E Orr
Chief Assistants:	Miss McCulloch Miss Guthrie - later Matron Mdmre Miss Jeffries Miss Murphy
Sisters:	Compigne (night) Copsey Duggan Forsyth Fullerton Grayson Hanning Jones Kennard O'Meara Russell Stubbs Sythes Thomas Tully
Registered Nurse Aide:	Allan
Male Nurses:	Willis Evans Rupe

Mrs Anderson, Mayoress of Mt Albert recruited staff for one ward. Other voluntary workers did nursing duties generally. It was at the Cornwall Hospital that such help was first used.

This list is incomplete, but many of the names above were recalled by Miss Hyde in 1981.

APPENDIX C

OTHER STAFF

Engineer ; Kronfeld

Grounds : Farnell, Supervisor for the Board, a national figure in the hybridisation of gerberas.

Groundsman : Davis

Sam Thomas kept the surface of the paths and driveways in repair. He referred to himself as the 'parkologist'. He always appeared exactly the same, pushing a wheel-barrow at a steady plod with a can of tar on it, wearing tar-stained gumboots and apron, looking just the same on Monday as when he went off on Friday.

Linenkeeper : Mr Marson

Orderlies : Jack Lindsay (Head Orderly)

House Managers : 1 Mr 0 Mills t
2 Mr A Syms until 1971
Mr Metje (later the Manager), Assistant

Storeman : Fred Angus

Clerical : Joyce Dwyer
Dorothy Manning

Painter : Mr Tobin

Carpenter : Mr Whitman

Fitters : Mr McQuoid
Mr Holmes