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ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
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THE PROBLEM of THE AGED, THE INFIRM and THE AGED SICK: A SOCIAL STUDY of 550 INSTITUTIONAL CASES

INTRODUCTION

The study was conducted at Stobhill Hospital, the Western District Hospital, Crookston Home for the Aged, together with the Crookston Cottage Homes.

Stobhill Hospital and the Western District Hospital are general hospitals. At the former, cases in the medical wards only were selected for investigation but in the latter the cases investigated were in both the medical and the surgical wards.

Crookston Home, an old poor law institution, was reconstructed in 1933 and, since that date, has provided accommodation for aged and infirm persons - approximately 300 in number. It comprises a three storey building with a central administrative block and separate wings for male and female residents. On each floor of the wings are the dormitories, together with a recreation room and a dining room. In each wing there is a lift which can accommodate a wheel-chair or a stretcher but it is used mainly as a goods lift to convey food from the centrally placed kitchen on the ground floor. The old persons have to use the stairs. The bedfast patients are accommodated chiefly on the top floor. There is on the ground floor a very fine central hall where the old people meet periodically for concerts, film displays and parties.

In association with Crookston Home, the Corporation of Glasgow established in 1938 the Crookston Cottage Homes, comprising 72 single and 28 double cottages capable of accommodating 128 persons. These cottages - which,

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in this thesis, will hereafter be termed "The Cottage Homes" - are situated in the grounds of Crookston Home. They are self-contained flats built in units of eight in a block and are especially designed either for single persons or for married couples. Each cottage contains a living-room with a bedroom annexe, a kitchenette and a bathroom. The house is heated by means of a coal fire in the living-room. The bedroom annexe, opening off the living-room, has a window which provides good lighting and ventilation. The kitchenette is well appointed, has built-in cupboards and an electric cooker; it has all the labour-saving devices. The bathroom has a low bath safe for use by old persons. Each cottage has a front and a back door, and the old persons can, if they choose, sit in seclusion on a sheltered verandah. Some of the cottages are single-storey buildings but the majority are built in two storeys, the approach to the upper cottages being by means of a broad stair common to the block. Grass plots and flower beds add to the attractiveness of the cottages. Fuel and food are supplied to the residents who cook their own breakfast and supper. One well-cooked meal per day is essential to health and this is prepared for them and partaken of in a small communal dining-room which serves each group of cottages. This dining-room also functions as a community recreation room where the old people can enjoy whist drives and where they can meet their relatives and friends. Whilst the old people resident in the cottages lead independent lives, a nursing sister supervises their health and welfare.

The total number of cases investigated was 550 and the distribution of cases in the different institutions is as follows:-

Table 1/

TABLE 1.

Institution	Males	Females	Total
Stobhill Hospital . .	86	106	192
Western District Hospital .	22	19	41
Crookston Home . .	129	88	217
Cottage Homes . .	13	87	100
TOTAL .	250	300	550

The cases under review constitute women of 60 years and over and men of 65 years and over. The choice of the ages of 60 for women and 65 for men was not an arbitrary one for these are the ages in the respective sexes at which, under statute, contributory pensions become payable. The cases investigated were divided into age-groups of five-year periods from 60 to 84 years with a composite group of those aged 85 years and over.

The distribution of cases by age and sex in the different institutions is set forth in Table 2:-

TABLE 2.

Institution	Age and Sex													
	60 - 64		65 - 69		70 - 74		75 - 79		80 - 84		85 & over		TOTAL	
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
Stobhill	-	18	47	23	20	23	12	22	7	15	-	5	86	106
Western District	-	3	11	4	8	4	3	5	-	1	-	2	22	19
Crookston Home	-	9	14	10	33	18	46	22	24	20	12	9	129	88
Cottage Homes	-	7	-	11	6	26	6	27	1	12	-	4	13	87
TOTAL	-	37	72	48	67	71	67	76	32	48	12	20	250	300

The/

The cases are classified in relation to the state of general health into four categories, viz., able-bodied, frail, chronic sick and acute sick. The able-bodied are those who are physically fit and capable of undertaking a modified amount of work. They are free from disabilities which might prevent them from looking after themselves. The frail are the infirm aged who, although able to do much for themselves, require some measure of assistance from others. The chronic sick are bedfast patients in need of nursing care and for whom there is no prospect of permanent betterment. The acute sick are the old persons who are suffering from critical illnesses from which recovery may take place: they will, in the event of recovery, return to the categories of able-bodied or frail.

The number of persons who fall into these categories in the various age groups is given in the Table below:-

TABLE 3.

General Health in the various Age Groups

State of Health	Age in years						
	60-64	65-69	70-74	75-79	80-84	85 & over	TOTAL
Able-bodied	5	18	49	52	29	5	158
Frail	14	42	46	54	27	19	202
Bedfast or Chronic Sick	9	30	25	34	22	7	127
Acute Sick	10	29	18	3	2	1	63
TOTAL	38	119	138	143	80	32	550
		295			255		

Inspection/

Inspection of the foregoing Table reveals that the majority of cases fall into the able-bodied and frail classes numbering 158 and 202 respectively, these together representing 65.5 per cent of the cases reviewed. The bedfast or chronic sick number 127, representing 23 per cent of the cases. Only 63, or 11.5 per cent of the cases, are designated as being acutely sick.

It is also recorded in Table 3 that the number of able-bodied persons is as large in the oldest age-group as in the youngest and that there are more chronic sick in the youngest age-group than in the oldest. As the numbers in each group are small, an arbitrary division was made and the cases grouped into those under 75 years of age and those aged 75 years and over. In the first group there are 295 cases and in the second 255 cases. The total number of able-bodied in the younger age-group is 72, or 24.4 per cent, as compared with 86, or 33.7 per cent in the older age-group. The chronic sick in the younger age-group number 64, or 21.7 per cent, while in the older age-group the number is 63, or 24.7 per cent. It is thus apparent that the state of health of the old persons has no definite relationship to age.

The distribution of old persons according to their state of general health in the several institutions is shown in Table 4:-

TABLE 4.

General Health

Institution	Able-bodied	Frail	Bedfast or Chronic Sick	Acute Sick	TOTAL
Stobhill	3	78	63	48	192
Western District	1	11	14	15	41
Crookston Home	72	95	50	-	217
Cottage Homes	82	18	-	-	100

From the above Table it will be seen that, in respect of the hospital cases, there are 4 able-bodied and 89 frail persons, 77 chronic sick and 63 acute sick cases. It is apparent that the able-bodied and the frail, together representing 40 per cent of the aged persons reviewed in the hospital series, did not require to occupy hospital beds which could be more profitably allocated for the use of sick patients. The list of sick persons awaiting admission to hospital is huge and there can be no justification of a system which denies skilled medical and nursing care to those actually in need of it and at the same time provides medical attention for the able-bodied and frail whose physical and mental well-being is undoubtedly jeopardised by prolonged residence in close proximity to the sick.

It is also shown in Table 4 that in the Cottage Homes 82 persons are able-bodied and the remaining 18 are frail. There are no sick persons in the Cottage Homes as it is the practice to remove the old people from the Cottages to the central Home if they fall ill. In Crookston Home, 72 persons are able-bodied and 95 are frail; these two groups represent 77 per cent of cases in the Home, the remaining 23 per cent of cases being composed of 50 bedfast patients.

It thus became evident at the outset that the question of the adequacy of the provision for old people called for a close investigation, and it occurred to the author that such a study presented many interesting aspects for consideration. It seemed to necessitate not only the assessment of the physical and mental state of the old persons and their prospect of life in relation to their condition, but also the determination of their capabilities for work and recreation and the ascertainment of their interests and social activities/

activities. It would appear that proper provision for old persons cannot be achieved without the knowledge and full appreciation of their educational and social background.

It was felt that the assessment of these factors would throw light upon the problems of the aged healthy, the aged infirm and the aged sick who are in institutions and that thus it might be possible to devise those measures most likely to promote the welfare and happiness of the old.

In the conduct of this investigation, a personal approach was made by the author to each old person in order to gain a full and detailed history of the individual prior to admission to the institution. The mental and physical state was thereafter assessed, and, in the light of these findings, the old person's future was planned. The investigation resolved itself into three main parts, the first of which follows.

PART I/

PART I.

FACTORS CONTRIBUTORY TO ADMISSION TO INSTITUTIONS

Part I deals with those factors which were mainly responsible for the admission of the old persons to institutions, and these factors are analysed under the following eight headings:-

1. Age at which the old person became resident in Glasgow.

2. Education and training.

3. Employment:
   (a) Occupation
   (b) Number of employers
   (c) Unemployment and its causes
   (d) Age at which old person ceased work

4. Married State.

5. Residence prior to admission:
   (a) Place of residence
   (b) Situation and type of house
   (c) Size of house
   (d) Sanitary and other facilities
   (e) Assistance in the home
   (f) Reasons for giving up house

6. State of health prior to admission:
   (a) Predominating major illnesses
   (b) Previous admissions to hospital
   (c) Domiciliary medical care

7. Residence in other institutions.

8. Main reasons for admission to the institution.

It became abundantly apparent that not one but many factors led to the admission of the individual to the institution. The factors were diverse, embracing social, physical, educational, economic and moral influences. Where possible the author traced the life history of the individual from birth until/

until his admission to the institution. Enquiries were pursued into his upbringing in early childhood, his education and occupational training, his health, the condition of employment during his working years, his marriage, family and home life, together with the forces which rendered necessary admission to the institution.

1. Age at which the old person became resident in Glasgow. Enquiries were instituted regarding the place of birth and the age at which the old persons became permanently resident in Glasgow. The majority, 296 in number, had lived in Glasgow all their lives while a smaller number, 77 cases, had come to Glasgow in early childhood and had thus a life-long association with the City. An appreciable proportion, 130 cases, had left their country homes to seek employment in the big City. This migration to the City usually took place during adolescent years and early manhood. The attachments made in the City by these persons were so strong that they had no desire in their old age to return to their native haunts. This investigation definitely shows that people are not in their advancing years attracted to the centres of population. Once a person reaches maturity he tends to remain in the place where he has made his home. In old age the need for security is keenly felt and there is no tendency to change the usual place of residence. In Table 5 the birthplace and age in years at which the cases became definitely resident in Glasgow are recorded.

TABLE 5/

TABLE 5.

Age, in years, at which old persons took up residence in Glasgow

Birthplace	0-5	6-10	11-20	21-30	31-40	41-50	51-60	61-70	70+	TOTAL
Glasgow	-	-	-	-	-	-	-	-	-	296
Scottish Towns near Glasgow	8	9	10	8	4	3	1	-	-	43
Scottish Towns further afield	3	8	13	10	6	1	1	-	-	42
Scottish country districts	8	12	16	11	12	3	-	1	-	63
Highlands	-	4	8	5	2	-	-	1	-	20
England	3	4	9	8	6	1	-	-	-	31
Ireland	10	7	17	14	2	1	-	-	1	52
Abroad	-	1	1	-	1	-	-	-	-	3
TOTAL	32	45	74	56	33	9	2	2	1	550
		77		130				3		

In only three instances had persons after having attained the age of 60 years taken up their residence in Glasgow. In each case, the person was strongly motivated to change his or her home. The details of these three cases are as follows:-

(1) A woman of 85 years had come to Glasgow from Ireland/

Ireland 13 years previously to look after her nephew on the death of his mother, but when her own health began to fail she found that he no longer wished her to reside with him.

(2) The second case is that of a man of 80 years who had lived all his life in the country working as a jobbing gardener. His cottage was under a restrictive lease whereby it returned to the laird at the end of a 99-years' period. At the termination of the lease he was homeless and his niece who lived in Pollokshields invited him to stay with her but she tired of the responsibility when he became frail and arranged for his admission to Crookston Home.

(3) An elderly Highland woman of 68 years had worked as a domestic servant in various parts of Scotland. She developed rheumatoid arthritis and came to Glasgow in order to obtain treatment. She has marked deformity of the hands and it is with difficulty that she manages to wash and dress herself. She gets up every day, but, as she cannot hold a stick in her painful and deformed hands, walking is difficult. She has been two years resident in hospital.

2. Education and Training. The general level of education of the cases under investigation is certainly not high. Only 33 persons continued their schooling beyond the age of 14 years. It is noteworthy that many left school at the very early age of ten years; those who were in their tender years precipitated into the vortex of industry were deprived not only of schooling but of happy childhood. Some seventy years ago, there was in vogue a system of part-time education and school children were employed in the mills, the potteries, the bleach fields, the foundries and the mines. The following two cases are typical illustrations of the unhappy conditions prevailing/

prevailing in the last quarter of the 19th century:-

> (1) A woman, aged 84 years, said that her childhood had been cruel and harsh. Her father drank and her step-mother had little affection for her. At the age of nine she was put to work as a "half-timer" in the bleach fields. She spent alternate weeks in school and factory. Her factory wage was 1/11 per week. What possible happiness could such a childhood hold?
>
> (2) The second case is that of a man, aged 73 years. He was one of a family of nine. His father, a quarryman, died at the age of 48 and his mother worked in the mills to support the family. At the age of ten, he became a "half-timer", spending three hours daily at school and five or six hours in the woollen mills. There were alternate shifts. One week he went to school from 9 a.m. to 12 noon and to the mills from 1 p.m. to 6 p.m. The other week he worked in the mills from 6 a.m. to noon and went to school from 1 p.m. to 4 p.m. His average earnings were only 2/- per week.

The number of persons who served an apprenticeship or had undertaken special training is 96, representing 17.5 per cent of the cases under review. Many persons, however, had undertaken skilled work although they had served no apprenticeship; these numbered 39 and the occupations followed were exceedingly varied; they included those of brass worker, designer of cotton goods, shoemaker, gardener, French cook and pastry maker, silk and carpet weavers, valuator of furs and jewellery, steel plate examiner and clothes cutter. Dressmaking was the only trade to which women were apprenticed and this occupation was commonly followed on a part-time basis after marriage.

3. Employment.

(a) Occupation. In order to obtain a concise and informative picture of the work undertaken by the old persons, occupations were grouped into eight/

eight categories. The normal occupations of the cases under review are, in accordance with this classification, recorded in the following Table:-

TABLE 6.

Normal Occupation	Number Employed
Professional	7
Skilled (manual)	115
Unskilled (manual) ..	205
Sedentary	13
Distributive	30
Housework in own home ..	140
Personal service	32
Service in H. M. Forces ..	5
None	3
TOTAL ..	550

These who had entered the professions number only seven, six women and one man. Four of the women had been nurses, one a missionary and one a head-mistress of a residential school. The male representative of the professions was a musician. Manual work was the chief occupation of the men of whom 115 undertook skilled and 205 unskilled tasks. The skilled workers included engineers, civil and marine, cabinetmakers, joiners, painters, glaziers, blacksmiths, stonecutters, etchers, platers, basketmakers, rivetters, a compositor and a Swiss embroiderer. The unskilled workers were/

were chiefly labourers who found employment in many fields of industry. The sedentary occupations usually carried special responsibility for the workers and in this category were found cashiers, clerks and insurance agents. In the distributive class were shopkeepers, commercial travellers, vanmen, carters, porters and pedlars. Women were occupied for the most part in the performance of household duties, the few skilled workers being dressmakers and cooks. Many women had undertaken unskilled work and found employment as domestic servants and daily cleaners. Personal service is a category reserved for those employed in a capacity such as housekeeper, ship steward, lady's maid and nursery governess; it does not include the general domestic worker who is included in the unskilled manual class. An additional category comprises three men who had served as soldiers in the regular army.

Economic or personal factors frequently prevented the old persons from pursuing their usual occupations. The following case histories are typical:-

> (1) A man of 69 years stated that he was a pianist. He had formerly been employed to provide the musical accompaniment to the silent films, but, on the introduction of the sound film, his means of livelihood came to an end. His only earnings during the past thirty years had been derived from concert parties at seaside resorts during the summer months.
>
> (2) The second example is that of a man of 67 years. He stated that he was a labourer but, on being questioned, it was revealed that, on account of a grave cardiac lesion, he had been unable to pursue such employment for 16 years.

In order to obtain a picture of the working life of the old persons enquiries were made as to the number of employers they had served under, the periods/

periods of unemployment, and the reasons for such unemployment.

(b) Number of Employers. Table 7 shows the number of employers for each of the occupational categories:-

TABLE 7.

Number of Employers

Normal Occupation	None	One	2 - 5	6 - 10	10+	Self Employed	TOTAL
Professional	-	1	3	2	1	-	7
Skilled (manual)	-	9	54	24	23	5	115
Unskilled (manual)	-	4	50	52	99	-	205
Sedentary	-	3	8	1	1	-	13
Distributive	-	4	9	8	6	3	30
Housework at home	7	36	87	8	1	1	140
Personal service	-	-	12	9	7	4	32
H. M. Forces	-	1	-	3	1	-	5
None	3	-	-	-	-	-	3
TOTAL	10	58	223	107	139	13	550

There are 58 persons who stated that they had had only one employer. This number includes 36 women who had married at an early age and had not engaged in employment after marriage but there still remain 22 persons who throughout their working life had had but one employer. It is of interest to record in passing that such faithful service carried no monetary reward

on/

on retirement. Cases illustrating long and loyal service to one employer are given below:-

(1) A man, aged 82 years, had worked with one firm for sixty years as a steel plate examiner. Although the nature of his work exposed him to the elements, he continued to work until the age of 77 years. His services were dispensed with two weeks after the appointment of a new manager.

(2) The second case is that of a labourer employed as a cleaner and greaser. He worked for forty-eight years with one firm and had, during that period, only a break of one week consequent upon injury arising from a quarrel with a fellow workman. He was retired at the age of 65.

(3) The third case is that of a man admitted to Crookston Home at the age of 71. He stated that he had been employed as a ship's draughtsman with one firm until the age of 70. This man was interviewed within two weeks of his admission to the Home and the author was struck by his distressed and agitated state of mind caused by the fact that he did not have the coppers to buy a newspaper. In his case the arrangements for the payment of weekly pocket-money had not yet been completed.

(4) Another typical example is that of a blacksmith, aged 82 years, who had worked for sixty years with one firm. He retired at the age of 75 without a pension from his employers. He had lived in respectable lodgings since the death of his wife twenty-seven years ago, but, on his retirement, he was unable to pay for good lodgings and applied, at the age of 76, for admission to Crookston Home.

(5) The fifth case is that of an employee of a Railway Company. He had worked from 1892 to 1945, a period of over fifty-three years, as a machineman. As he was not a superannuated worker, he retired at the age of 69 without a pension.

Reference to Table 7 also shows that 223 persons, representing 40.5 per cent of cases, had from two to five employers. In the case of skilled workers a total of 63 persons had fewer than five employers; this represents/

represents 54.8 per cent of the skilled workers. The number of skilled workers who had ten employers or more is 23, representing 20 per cent. In contrast, it is found that among the unskilled manual workers there are 54 persons, or 26.3 per cent of cases, who had five or fewer employers, while 99 workers, or 48.3 per cent of cases, had ten or more employers. Training, therefore, would appear to be a stabilising factor in employment. The skilled worker shows less tendency than the unskilled to change his employer. There is, however, a wide range of work open to the unskilled worker, who turns from one employer to another in an endeavour to improve his lot. In addition, the demand for unskilled labour is subject to considerable fluctuation from time to time.

(c) Unemployment and its causes. There are 327 persons who had never been out of work. Excluding the women who were occupied with housework in their own homes, the number of persons in full employment throughout life is 196, representing 47.8 per cent of cases. On the other hand, there are 170 persons, or 41 per cent of cases, who were unemployed for a period ranging from several years to almost life-long unemployment. In Table 8 is recorded the periods of unemployment in the different occupations:-

Table 8/

TABLE 8.

Records of Unemployment

Normal Occupation	Not Stated	None	Under 1 year	Several years	Predominating	Absolute	TOTAL
Professional	-	6	-	-	1	-	7
Skilled (manual)	-	56	17	25	17	-	115
Unskilled (manual)	-	89	20	58	37	1	205
Sedentary	-	9	-	3	1	-	13
Distributive	-	17	4	7	2	-	30
Housework in own home	5	131	-	-	4	-	140
Personal service	-	19	7	5	1	-	32
H. M. Forces	-	-	-	5	-	-	5
None	-	-	-	-	-	3	3
TOTAL	5	327	48	103	63	4	550

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The causes of unemployment were investigated and the findings are recorded in Table 9. There are 61 cases in whom ill-health or accident accounted for unemployment; 8 persons affected are skilled and 36 are unskilled workers. Although the numbers reviewed are small, it appears that the unskilled worker is more prone to incapacity through illness and accident than the skilled. The predominating cause of unemployment amongst both skilled and unskilled manual workers is the inability to find work.

Table 9/

TABLE 9.

Prolonged Unemployment

Normal Occupation	Not applicable	Ill-health	Accident	Inability to find work	Choice	Seasonal work	Instability of Temperament	TOTAL
Professional	6	-	-	1	-	-	-	7
Skilled - (manual)	73	7	1	32	1	-	1	115
Unskilled - (manual)	109	26	10	58	1	-	1	205
Sedentary	9	2	-	2	-	-	-	13
Distributive	21	1	-	8	-	-	-	30
Housework at home	136	4	-	-	-	-	-	140
Personal service	26	2	1	2	-	1	-	32
H. M. Forces	-	4	-	1	-	-	-	5
None	-	3	-	-	-	-	-	3
TOTAL	380	49	12	104	2	1	2	550

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From those engaged in the shipyards, whether as engineers, draughtsmen or platers, a repetition of the story of unemployment was elicited which dated back some thirty years to the period of trade depression following the First World War. For the older man unemployment continued from this time onwards. There are only exceptional cases in which the cause of unemployment can/

can be traced to a personality defect. The following case reports are illustrative of the tragedy of unemployment and its effects upon the old persons:-

(1) A baker, aged 71 years, was unable to secure employment after the age of 50. He was admitted as destitute to a poor law institution at the age of 60 and ten years later we find him still wishful to obtain employment; the strength of his urge is shown by the avidity with which he reads advertisements for work.

(2) A joiner, aged 69 years, had not worked at his own trade for twenty-eight years. After five years of unemployment he secured work as a labourer and was thankful to pursue this occupation as it provided steady employment.

(3) A man of 75 years, who had worked for fifty years in the pits, was dismissed along with other elderly workers on account of his age. He said he was strong and indeed he was, as was proved by the fact that he worked as a navvy in the dock yards until he was 73 years.

(4) When the question of unemployment was raised with a man of 72 years, he replied that he had "never been steady on the dole". The very words of that reply showed very clearly how resigned the worker was to a situation where unemployment rather than employment was the rule.

(5) A plasterer's labourer, aged 65, was in hospital suffering from cerebral thrombosis. Although his speech was impaired and he had only the use of one arm, he was a most friendly person, always anxious to assist his fellow patients. He had served in the First World War and was in receipt of a disability pension of 8/- per week on account of gun-shot wounds. He had never been able to secure anything but casual work, and had lived all his life in a common lodging house.

Elderly men experienced difficulty in securing work when for some reason they found themselves unemployed. It was only when the demand for labour/

labour was in excess of the supply that the older men could find employment.

(d) Age at which old person ceased work. The actual age at which men and women stopped working was investigated. Reference to Table 10 will show that 82 persons ceased their employment before the age of 60. The difference between that number and the total under survey, namely 468 persons, were working when they reached pensionable age. Ninety-three persons were aged 75 years and over when they stopped working; many of the women were occupied with housework at home, and, accordingly, were able to set their own pace of working. In industry, however, where the employer sets the standard and pace, the elderly have to compete with younger men. As regards those aged 75 years and over, there were 22 manual workers, nine of whom were undertaking skilled work at the cessation of employment.

TABLE 10.

Age at which stopped working

Occupation when ceased to work	Under 60 yrs.	61 - 64	65 - 69	70 - 74	75 & over	TOTAL
Professional	1	5	-	-	-	6
Skilled (manual)	14	15	33	12	9	83
Unskilled (manual)	35	55	62	31	13	196
Sedentary	2	1	6	2	-	11
Distributive	4	3	13	4	2	26
Housework in own home	15	14	32	54	63	178
Personal service	8	6	15	10	6	45
H. M. Forces	-	1	1	-	-	2
None	3	-	-	-	-	3
TOTAL	82	100	162	113	93	550

An/

An endeavour was made to ascertain the reasons for ceasing employment, and these are given in Table 11. It was found that most men and women chose to remain in employment for as long as they were able. In only three instances was employment discontinued through choice. The number who gave up work on account of ill-health, including those whom accident had rendered unfit, is 419. There remain, however, 49 old persons, representing approximately 9 per cent of the cases, who had been dismissed from their employment because they had reached the age at which contributory pensions were payable and not because they were unfit for their duties. Amongst the 115 skilled workers, 23 were dismissed on account of age. In other words, there is a loss to production of 20 per cent of the skilled workers. It is very common to find the skilled worker, on reaching the age limit for his trade, to be dismissed and thereafter to take up unskilled work, such as labouring, even with the same employer. This change from skilled to unskilled work is not satisfactory. It is with difficulty that elderly persons adjust themselves to a different type of work demanding usually more physical exertion than they can expend and working under conditions generally less favourable to their well-being.

A small number of persons, viz., 39, were working up to the time of their admission to the institution. The analysis of the reasons for the cessation of work is detailed below:-

Table 11/

TABLE 11.

Reasons for Ceasing Work

Normal Occupation	Unfit	Acci-dent	Dis-missed Age	Work ended	Unable to find work	Mar-riage	Choice	Adm. to Inst.	TOTAL
Professional	4	-	1	-	1	-	-	1	7
Skilled (manual)	70	2	23	7	9	-	2	2	115
Unskilled - (manual)	163	6	14	3	15	-	-	4	205
Sedentary	10	-	3	-	-	-	-	-	13
Distributive	20	-	6	1	1	1	-	1	30
Housework in own home	107	3	-	-	-	-	1	29	140
Personal service	26	1	2	-	1	-	-	2	32
H. M. Forces	4	-	-	-	1	-	-	-	5
None	3	-	-	-	-	-	-	-	3
TOTAL	407	12	49	11	28	1	3	39	550

419

4. Married State. In respect of married state the cases are divided into four categories, viz., single, married, widowed and separated. There are 160 single persons. The married persons number 85 and of these 28 are separated from their spouses. The largest category is the widowed which numbers 305.

These/

These figures show that it is the single and widowed persons who predominate in the institutions. Those who are happily married are apparently able to live in their own homes and to a much smaller extent have recourse to institutional accommodation. It is found that, where the attachment between husband and wife is strong and where illness necessitates the admission of the husband to hospital, his stay there is regarded as a temporary absence from the home. On his discharge from hospital he is welcomed back to his home to be cared for by his partner in marriage despite the fact that this imposes a heavy burden upon his wife. It was noted that many cases, but for the existence of a devoted helpmate, would have to remain in hospital until arrangements could be made for their admission to an institution which would provide for their permanent care. A few histories will illustrate these findings:-

(1) A man of 76 had worked for 40 years as a miner and subsequently as a watchman. He lived with his wife in a room-and-kitchen house, three stairs up. His present illness had a sudden onset and he was admitted to hospital suffering from acute pneumonia. The prognosis of this case is good and, on recovery, he will return to his home.

(2) A man, aged 74, has suffered from pernicious anaemia for a period of twelve years and has previously received treatment in hospital. He was employed as a joiner until the age of 65 when he was dismissed on account of his age. He lives with his wife and four children in a three-apartment house. His condition has improved since his admission to hospital and his wife and family eagerly await his return. Although he is not employed, he is fully occupied with his garden, newspapers and wireless. He plays bowls regularly and goes to the cinema once a week. He has been in hospital for ten weeks and is anxious to go back home.

(3) A man, aged 72, was admitted to hospital on account of inco-ordination, inarticulate speech and defective/

defective vision. His Wassermann reaction was positive. He has been three months in hospital but there has been little improvement in his condition. He wishes to return to his wife and son who are quite prepared to look after him.

In some instances, although the more able partner would willingly undertake the care of the sick spouse, this is a task beyond his strength and one which is relinquished only with reluctance. There are many cases where the sick persons require a high degree of nursing skill and in these it is not possible for the old persons to return to their own homes. Some typical cases are as follows:-

(1) A woman, aged 70 years, is suffering from rheumatoid arthritis and is bedridden. She lived with her husband in a one-apartment house. She has been resident in hospital for a year. Her husband is anxious to have her home but, since his wife's admission to hospital, he has had cerebral haemorrhage with impaired function of the right side. As he is therefore unable to give her the attention she requires, she has no alternative but to remain in hospital.

(2) A man, aged 73 years, was employed as a commercial traveller in whisky until the age of 71. His work had to be given up on account of his suffering from a rheumatoid condition of the knees and feet. Previously he had always enjoyed good health. In his work he had a wide area to cover and was only at home for a few days every few weeks. He attributed his illness to the fact that he was often wet through and had few facilities for drying his clothing. A heavy drinker, he consumed on an average six glasses of whisky per day. He has been twice in hospital. The application of extension to the lower limbs did not help the condition nor did two courses of gold therapy. He is completely bedridden and his hands have now also become affected. He can just manage to wash and feed himself. After three months in hospital he is exceptionally happy. Although he does not read much because of the difficulty of holding/

holding a book and turning pages, yet he enjoys the wireless and the companionship of his fellows. As he weighs more than 16 stones he cannot be nursed at home since the average person would be unable to lift him.

(3) A man, aged 65 years, developed cerebral haemorrhage and was nursed at home by his wife for four months, whereupon she complained that she could no longer continue to look after him. He is completely bedridden and mentally confused. He cannot feed or wash himself and urinary and faecal incontinence are present. His wife is 70 years of age. She visits her husband regularly and she states that she feels much better in health since her husband was admitted to hospital seven weeks previously.

On the other hand, where there is no deep and genuine affection in the marriage and when one spouse is admitted to an institution, it is evident that the other is glad to be rid not only of the burden of the sick person but also of his very presence. This is borne out by the fact that not a single visit is made to the sick spouse once he is admitted to the institution and the picture is one of complete abandonment. The following case histories are typical illustrations:-

(1) A man, aged 73 years, has been resident for six years in Crookston Home. He suffers from giddiness and has sustained many injuries as a result of falls. He is now practically confined to bed. Previously he resided with his wife in a one-apartment house. His wife is well and active but she has not visited him since his admission to the Home.

(2) A man, aged 77, had come from the Highlands to work as a gardener. He has been twice married. His first wife died twenty years ago. There are four children of this marriage, but they are all resident abroad. His second marriage at the age of 59 brought him no happiness. For some time past/

> past he has complained of pain and stiffness in the back. Eleven weeks ago he was admitted to hospital and has received treatment for osteo-arthritis of the spine, but the condition has shown little improvement. During the period he has been in hospital his wife, who is much younger than he, has paid only one visit to him, and on that occasion she informed him that she was going out to work for herself and that it was impossible for him to come home as she would not be there to look after him.

It has already been stated that there are 85 married persons amongst the cases reviewed. Further investigations reveal, however, that 28 of these old people, constituting almost one third of the married persons under review, are separated from their spouses.

At the present time, possibly no subject has had more attention focussed upon it than that of the "broken home". Many workers in widely different spheres - teachers, psychologists, magistrates, probation officers, doctors, ministers, children's officers and social workers - have directed their energies to finding a solution for the children of broken homes. It is rarely appreciated that the broken home produces other far-reaching consequences on the husband and wife who separate. Investigation of the histories of married couples who had separated, revealed that, on the break-up of the marriage, invariably one and often both of the partners never again were able to establish themselves in the security of their own homes. In the majority of cases, separation had occurred in early adult life, but, despite the fact that the man and woman at the time of the dissociation were at an age of physical and mental resilience, neither had been able to make a new start. The study of the cases shows that, where the husband deserted his wife, he drifted/

drifted from one employer to another and from one lodging to another until he reached a stage when he could only secure casual employment and could only afford to live in the common lodging house. Although no knowledge of the fate of the wives in these cases is forthcoming, the picture of the deserted wife is obtained from the case histories of those women in the series who had been deserted by their husbands. With the departure of the bread-winner the deserted wife found herself overwhelmed with debt and unable to meet her commitments. Evicted from her home she sought temporary refuge with her relatives When such shelter ceased to be available to her, she had no alternative but to seek admission to the common lodging house or the poor law institution. The following are typical histories of the results of separation:-

(1) A woman, aged 80, has been resident in the Home for six years. She has had a hard life and, after her marriage at the age of 19, worked in the Potteries. Her marriage was unhappy and, following a violent assault by her husband, she lost the sight of one eye. She left her husband, but, on account of her disability, was able to secure only casual work. Her home for many years was the common lodging house. She has never known either security or happiness in her whole life and now, at the age of 80, and after six years' residence in the Home, her restless spirit convinces her that she could make a living as a "tattie howker" and urges her to leave the shelter of the institution.

(2) A plater of 74 years has had two unhappy marriages. His first wife drank. His second wife tired of him and, in an endeavour to be rid of him, brought her daughter and her daughter's husband to live with her and he was thus driven from his home. He lived in lodgings, but, when he was forced to retire at the age of 65, he could not afford lodgings and went to reside in the common lodging house. Two years later he applied for admission to Crookston Home where he has now lived for seven years. He says that he is happier/

happier than he has ever been in his life. He is an active man and undertakes the purchase of cigarettes on a large scale for all the other inactive residents. This task, together with the work he undertakes in the ward, keeps him fully and happily occupied.

(3) A woman, aged 73, has been resident in the Home for six years. She left her husband as he was a heavy drinker and she was afraid of his exhibitions of violence. She lived for a time in the common lodging house, but, in later years, she was unable to obtain even casual work and sought shelter in the institution. Her health has improved since her admission and she is now able to undertake light tasks in the ward.

(4) A man, aged 70, had been separated from his wife for 30 years. He left her on account of her immoral conduct. He had formerly been employed as a clerk but for 17 years had been unable to secure work. He had never known any happiness in his life and he stated the constant struggle to keep body and soul together had worn him out. When at last he did obtain employment he was only able to work for a few months. At the age of 66 he sought in desperation admission to Crookston Home. Since his admission his health has improved immeasurably and his whole outlook has changed. He is a member of the Entertainment Committee and enjoys organising monthly whist drives and bowling matches for the residents in the Home.

It is apparent that, in each of the cases cited above, marital separation led not only to a worsening of financial and social status for husband and wife but also to a deterioration of their self-esteem.

There are relatively few married people residing together in the institutions. In the Cottage Homes series there are only 17 married couples. It was elicited that the old people had made application specifically for a Cottage. They had done so because they were strongly attracted to the Cottage/

Cottage Homes and they stated that they would not have applied for admission to an institution reserved for old people. Three examples illustrate this point:-

(1) A husband and wife, both aged 79 years, have been resident in the Cottage Homes for eight years. The man was a power-loom tuner and had worked for 42 years with the same firm, but, at the age of 64, he lost his job as the firm became bankrupt. As the couple found their savings rapidly dwindling they applied for admission to the Cottage Homes which they had seen illustrated and described in the newspapers. The old couple are very happy in their Cottage and have just celebrated their golden wedding.

(2) A husband and wife, both aged 75 years, have been in the Cottage Homes only for a few months. They lived in a two-apartment tenement house, three stairs up. Neither husband nor wife could negotiate the stairs and had not been out of doors in recent years. The wife had seen the Cottages during a visit arranged by the Co-operative Women's Guild several years previously and she was so enamoured of them that she persuaded her husband to make application for admission to this type of dwelling. After waiting for a period of five years, they obtained one of the Cottages and already they are feeling much better in health.

(3) A woman aged 75 and her husband aged 73 have resided in the Cottages for six years. The husband was a brass worker and was in full employment until the age of 67. They lived in a two-room and kitchen house, three stairs up. On the retiral of the husband they found they could not meet the rent of their house. The wife, who had been present at the opening ceremony of the Cottage Homes, persuaded her husband to make application for a Cottage. They are both very happy. She suffers from diabetes, is on a strict diet and is also receiving insulin therapy. Her husband is actively occupied as president of the Bowling Club and chairman of the Sports Committee.

There is, however, only a relatively small number of Cottages available/

available for married couples. Accordingly, if a married couple is admitted to Crookston Home at a time when there is no vacant Cottage, then the husband and wife must be segregated in the male and female wards respectively. In such cases the overwhelming tragedy of separation descends upon them as husband and wife can meet only in the corridors and in the grounds of the institution.

The lack of accommodation in the institution for married people is responsible not only for enforced separation of husbands and wives who reside in the same institution but it also frequently leads to one spouse only seeking admission, the other finding accommodation in the home of a relative. The pattern of events typical of many such cases is that of an aged couple who give up their home to reside with a son or daughter. After a time the son or daughter tires of the old people and stipulates that only one of the old persons can henceforth be accommodated. A daughter, while prepared to tolerate her mother on account of the services she can render, is not prepared to extend the same tolerance to her father who, too enfeebled to perform any useful tasks in the home, causes her considerable irritation by sitting about the house all day long. This rejection of the old person by his near relative, together with the enforced separation from his wife who has been his constant companion, produces such distress and bitterness that, when he finds himself within the institution, he is unable to adjust himself to his new environment. Illustrative case histories are given hereunder:-

> (1) A man, aged 82 years, had been resident for two months in Crookston Home to which he had been admitted from Stobhill Hospital, where he had been for eleven months. After the destruction of their home in the Clydebank "blitz", he and his wife took up residence with their married daughter. The man's health was shattered by the terrors of bombing. His/

His daughter insisted upon his admission to hospital and refuses to allow him to return to her home although she is prepared to keep her mother. The man is most unhappy. He continually frets for his wife, from whom he has never been parted. His only wish is for them to be together and he longs to live in one of the Cottage Homes.

(2) A man, aged 73, a retired baker, lived with his wife in a two-apartment house, three stairs up. He was active and undertook the shopping as his wife could not negotiate the stairs. Eleven months ago he collapsed in the street and was brought to hospital where he was found to be suffering from cerebral haemorrhage. He has only partially recovered the use of his left arm and leg and his speech is considerably impaired. While in hospital his wife went to live with their married daughter. The patient is now ready and anxious to leave the hospital but it is not possible for him to return to his home as his wife is unable to give him the attention he requires. It would be a good arrangement for him to join his wife in their daughter's home, in which there is ample accommodation, but the daughter states emphatically that she will not agree to this proposal. The man will now require to enter an institution for the aged. The future holds little prospect of the husband and wife being ever united again. In their present circumstances, both old people are acutely unhappy.

5. Residence prior to admission.

(a) Place of Residence.

Considerable diversity was encountered in the living conditions of the old people prior to admission. Many lived either in their own homes or with relatives. Others resided in lodgings, hostels, common lodging houses or in Homes for the aged. In Table 12 is recorded the type of residence in the four categories of the aged:-

Table 12/

TABLE 12.

Residence before Admission to Hospital or Institution

Classification	Own Home Alone	Own Home with Spouse	Own Home with Relatives	In Home of Relatives	Lodgings	Hostel	Common lodging house	Home of Friend	Voluntary Homes	TOTAL
Able-bodied	40	17	7	48	34	3	9	-	-	158
Frail	46	17	14	46	37	3	35	1	3	202
Chronic Sick	39	9	14	40	12	-	10	2	1	127
Acute Sick	9	22	9	8	5	1	8	1	-	63
TOTAL	134	65	44	142	88	7	62	4	4	550
		243					69			

Reference to the above Table shows that many of the old people lived in their own homes. Two hundred and forty-three, or 44 per cent of the cases, lived in their own homes but under different conditions. Living alone, there were 134; in 65 cases the old persons were married and lived in their own homes with their spouses, and, in the remaining 44 cases, the old persons lived in their own homes with sons, daughters or more distant relatives. The old persons also stayed in the homes of relatives and in the survey there were 142 persons, or 25.8 per cent of cases, who shared a relative's home.

There were 88 persons, equivalent to 16 per cent, who stayed in lodgings/

lodgings and 69, or 12.5 per cent, whose residence had been hostels or common lodging houses. Four persons had made their home with friends and four had come from voluntary homes for the aged.

When the previous residence in each category is examined, it is seen that the number of able-bodied who came from the homes of relatives comprise 48, or 30.4 per cent, of cases in that class. It is surprising to find that able-bodied persons who might reasonably be expected to share in the work of the home are apparently not acceptable to their relatives.

In the category of the frail, there were 35 persons living in common lodging houses; the frail persons represented 56.5 per cent of the cases residing in common lodging houses. It should be universally accepted that the common lodging house is primarily designed to provide accommodation for able-bodied working men; it is not intended to serve as a home for aged and infirm.

In respect of the chronic sick, 62 persons had come from their own homes. Practically one half of the chronic sick cases had been looked after by relatives. It is proposed to deal later with the reasons as to why the cases sought admission to hospital or institution.

(b) Situation and Type of House.

Enquiries were made regarding the situation and the type of houses in which the old persons dwelt. Particular attention was paid to the stairs which they had to negotiate in order to undertake shopping, walking and other journeys to and from their homes. The type of house was also investigated in order to ascertain whether to it was attached a garden which would provide facilities/

facilities for outdoor recreation with the least possible effort to the old person. In Table 13 is recorded the state of activity of the old persons in relation to the situation and type of house. The Table excludes 73 old people living in common lodging houses or in other institutions.

TABLE 13.

Type of House

State of Activity	Not Applic-able	Tenement					Cottage		Villa	TOTAL
		Ground Floor	1st Floor	2nd Floor	3rd Floor	Basement	Ground Floor	Upstairs		
Mobile with-out Ass-istance	40	59	72	53	33	1	11	3	6	278
Mobile with stick or crutch	6	12	16	17	7	-	2	-	2	62
Mobile with wheel-chair	3	1	-	2	1	-	-	-	-	7
Immobile	2	1	2	3	3	-	1	1	-	13
Bedfast	22	37	50	37	28	2	6	2	6	190
TOTAL	73	110	140	112	72	3	20	6	14	550
				437				40		

Most of the old people were found to be living in tenements. Only

110/

110 of the 437 tenement dwellers lived in ground floor houses. Only a small number, namely 40, lived in houses - cottage type or villa - with gardens attached; six of the cottagers dwelt on the upper floors of the dwellings, access to which was by means of steep stairs.

It will be seen from the Table how unsuited in many instances is the type of house to the needs of the old persons. Only those who live in ground floor dwellings could have unrestricted freedom of movement. The ascent and descent of even one flight of stairs present hazards to the infirm. Houses situated three stairs up virtually imprison old persons within the walls of their homes. In Table 13 the type of dwellings is studied in relation to the state of mobility of the old persons, but there are other factors which may affect their ability to negotiate stairs. Failing vision and impairment of balance, consequential upon old age, cause the old persons to stumble, particularly on badly lit, winding stairs with broken treads. Only the hale and hearty can climb to the top flat of a tenement without experiencing breathlessness. Climbing stairs imposes unnecessary exertion upon old people.

(c) Size of house.

The size of the houses ranged from single apartments to ten apartments. The two-apartment houses, numbering 163, comprised the majority of the houses. There were 135 three-apartment houses and thereafter the number of houses diminished as the size of the houses increased. There were 77 old people residing in single apartment houses. The size of the house is important, primarily in relation to the number of inmates and these facts are given in Table 14. Here again, the investigation was not applicable to the 73 common lodging house dwellers.

Table 14/

TABLE 14.

Number of Inmates

Size of House	Not Applicable	1	2	3	4	5	6	7	8	9 & over	TOTAL
Not Applicable	73	-	-	-	-	-	-	-	-	-	73
1 Apartment	-	62	15	-	-	-	-	-	-	-	77
2 Apartments	-	54	46	34	12	14	1	1	1	-	163
3 Apartments	-	16	20	40	20	28	8	2	1	-	135
4 Apartments	-	3	4	12	6	13	10	7	3	6	64
5 Apartments	-	-	1	-	2	5	-	2	4	4	18
Over 5 Apartments	-	-	4	5	1	1	-	3	1	5	20
TOTAL	73	135	90	91	41	61	19	15	10	15	550

It will be observed by reference to the above Table that, prior to admission to hospitals or institutions, a large number of the old people lived alone; these numbered 135, and, if we exclude from the series the cases living in common lodging houses and in other hostels as being inapplicable, then the old people who lived alone represented 28.3 per cent of cases. The old persons dwelt chiefly in one or two-apartment houses. There were 15 old people who shared the single apartment, usually with a near relative. The two-apartment houses were the most common; in 54 such houses the old persons lived alone and in 46 cases they shared the house with near relatives or sub-let one apartment to a single person. In many instances these two-apartment houses/

houses were grossly overcrowded as the old persons tended to sub-let one of the rooms to a family. Again, the old persons had gone to reside with married sons or daughters who were already overcrowded so that the number of inmates of the two-apartment house often exceeded the "permitted number" prescribed by the Housing (Scotland) Act, 1935. Similarly, in the three and four-apartment houses evidences of overcrowding existed.

(d) Sanitary and other facilities.

Living conditions were further investigated in respect of sleeping accommodation, bathroom and lavatory facilities.

There were 337 old people who had their own sleeping apartment. This was not necessarily a bedroom but very commonly the old person slept in a bed in the kitchen. There were 58 cases where the old person was required to share a bed.

The houses provided with a bathroom numbered 175, but in 12 of these there was only a cold water supply and hot water had to be heated on a gas stove and thereafter conveyed to the bath. There were 304 old people with no facilities for bathing. The standard of the lavatory provision was very variable, ranging from a water closet inside the house to one on the landing shared by as many as six different families, or to a water closet situated outside the building altogether. The lavatory provision was as under:-

Type of Sanitary Provision	Number of Cases
(1) W.C. inside individual house	327
(2) W.C. situated on stair landing for sole use of old person	19
(3) W.C. on landing or in back court and shared with other tenants	130
(4) Dry closet	1
(5) Not applicable (old persons in hostels or common lodging houses)	73
	550

The/

The inconvenience of an outside lavatory was keenly felt by the infirm persons and those who had the use only of the shared lavatory complained bitterly of the hardship occasioned thereby. Disfunction of both bowel and bladder are not infrequently attributable to the lack of adequate lavatory facilities.

(ë) Assistance in the home.

It has been shown that some old persons lived alone, some resided with relatives or friends and some lived in lodgings. It has been apparent that while some of the old persons were able to look after themselves in every respect, others required some measure of assistance in domestic cleaning, washing, mending, shopping, preparation of meals and in the management of personal affairs.

Enquiries were therefore pursued to ascertain to what extent the old people received assistance in their homes. The findings are recorded in Table 15 in which the nature of the assistance rendered is stated for the different places in which the old persons resided:-

Table 15/

TABLE 15.

Assistance in the home

Residence before Admission	Self	Husband/Wife	Relative residing with O.P.*	Relative non-resident	Neighbour	Friend	Landlady	Other	TOTAL
Own home alone	114	2	1	5	12	-	-	-	134
Own home with spouse	5	49	11	-	-	-	-	-	65
Own home with relatives	8	-	33	1	1	-	-	1	44
In home of relatives	5	-	137	-	-	-	-	-	142
Lodgings	26	-	1	-	-	-	61	-	88
Hostel	-	-	-	-	-	-	7	-	7
Common lodging house	3	-	-	-	-	-	59	-	62
Home of friend	-	-	-	-	-	4	-	-	4
Other	1	-	-	-	-	-	2	1	4
TOTAL	162	51	183	6	13	4	129	2	550

234

*O.P. = Old person.

There are 162 persons, or 29.5 per cent of cases, who, prior to

their/

their admission to the institution, did not receive any assistance but looked after themselves in every respect. Assistance was provided by relatives who resided with the old person in 234 cases, representing 42.5 per cent. In six cases only did a relative who was not resident with the old person provide any measure of help. It was commonly found that, even where the old person wished to reside in his own home and could have stayed there with assistance, that the relative, although not far distant, preferred to take the old person to reside with him as this was the easier course of action. Neighbours gave assistance in only 13 cases and all these neighbours devoted much time to the infirm old person. It is perhaps surprising to find that amongst so many tenement dwellers neighbourly help was lacking. It is found that neighbours willing to help in acute illness of short duration are not often prepared to give service for protracted periods. Furthermore, many old people of independent nature steadfastly refuse all neighbourly overtures of help; they fear that the neighbours may gossip about their affairs or attempt to manage their lives.

(f) Reasons for giving up house.

In most instances it was not a single factor which induced the old persons to give up their houses but rather a combination of reasons which led to this action. The giving up of house or home calls for much serious thought. The home, with its associated happy memories, extending, it may be, over a period of fifty years or more, has become an integral part of the individual's life. The chairs, tables, rugs, pictures, the furnishings down to the smallest "nick-nack", are all part of the vivid experience of living

and/

and become more precious with advancing years. It is with the greatest reluctance that an old person gives up his home; if he be faced with financial difficulties which he cannot meet, he still holds resolutely to the security of his home and must perforce lower his standard of living to enable him to do so.

It was found that in many cases the decision to give up the home was made by the old persons under the influence of family suasion. On the death of one of the partners of the marriage the surviving spouse may be induced to give up his house and go to live with a married son or daughter. Such a decision is made under powerful family pressure at a time when the old person is so stricken with grief that thought processes are numbed. These generous impulses are engendered in the presence of death. Could they be sustained at this high level then the old person would continue to live as a cherished member in the bosom of his family. Experience has shown that the decision of the old person to give up his home and take up his residence with a relative was almost invariably disastrous. Soon sympathy for the bereaved old person gives place to growing impatience at slowness, exacting ways and old fashioned standards and this may culminate in positive dislike of his very presence in the home, terminating in an ultimatum to the old person to find other accommodation. The following are typical examples of the circumstances which led the old person to dispose of his house:-

> (1) A woman, aged 87, on the death of her husband, eight years ago, was persuaded to give up her home and went to reside with her elder son who lived in a three-apartment house with his wife and two children, aged twelve and fifteen years respectively. As the daughter-in-law was not favourably disposed towards her/

her she left and went to live with her younger married son who had no family. But this arrangement did not prove a success, and she had no alternative but to enter an institution. She stated to the author that she very much regretted that she gave up her own home, and that she is very unhappy at the manner in which she will have to end her days. She is an active woman and could well have remained in her own home. The two sons are undoubtedly attached to their mother. They visit her regularly but neither of the wives is prepared to have the mother-in-law in their home.

(2) A man, aged 78, was employed as a mason's labourer until the age of 68. Following the death of his wife he lived alone for fifteen years in a one-apartment ground floor dwelling. Three years ago he felt he was failing in health, gave up his house and was admitted to Crookston Home. He, however, is unhappy. He says he has lived alone too long to mix with company, but he misses the companionship of his dog. He has never been taught to read. He used to enjoy going out walking, but his house was on the ground floor and in Crookston Home he lives three stairs up. He has a large family but all of them assert that they have no room for their father.

(3) A man, aged 78, had worked at many occupations. He stated that he was never idle; if he could not get the kind of job he wanted he just chose the first job which was available. He last worked as a packer but was dismissed when he was 62 years on account of his age. He lived in a village until the death of his wife, five years ago, when he gave up his cottage and came to Glasgow to reside with his daughter and her husband in a two-apartment house on the third floor. He has not felt well for some months and this he attributed to the climbing of the three flights of stairs and the loss of fresh country air. He previously lived an active life. He loves the countryside and spent much time walking and gardening. He was admitted to hospital suffering from pneumonia. He hopes to return to his daughter's home, but the daughter has indicated that she would prefer her father to find accommodation in an old people's Home.

(4) A woman, aged 76, has now been resident in Crookston Home for five years. On the death of her husband she was persuaded by her son to agree to the transfer of her two-apartment house to him. The son then married, brought his wife to the home and has/

has informed his mother that there is no longer accommodation for her. She is frail and uses a stick to get about on account of a chronic rheumatic condition. She has not been able to find any interests in Crookston Home. She dwells incessantly on the ingratitude of her son and his treatment of her.

6. State of health prior to admission.

(a) Predominating major illnesses.

The health of the old persons prior to admission was investigated in respect of the occurrence of major illness, previous occasions on which treatment in hospital had been received and the extent of domiciliary medical care. Major illnesses were classified into surgical, medical and gynaecological conditions. Serious accidents were also recorded. The findings are as under:-

TABLE 16.

Predominating Major Illnesses	Number of Cases
Medical	171
Surgical	40
Accidents	52
Medical and Surgical	26
Medical and Accidents	23
Surgical and Accidents	5
Gynaecological	13
None	220
TOTAL	550

Amongst the incapacitating illnesses, medical conditions predominated/

predominated and accounted alone for 171 cases. Associated with surgical conditions and accidents, medical illnesses take a prominent place producing conditions of ill-health in 220 cases under review. It is to be noted that 220 persons, representing 40 per cent of the cases, had had never a grave illness nor had met with a serious accident.

(b) Previous admissions to hospital.

The occasions on which the old persons had been in hospital are recorded in Table 17. Reference to hospital admissions in childhood has been omitted as these were found to be occasioned almost exclusively by the occurrence of the infectious diseases, especially scarlet fever and diphtheria, so prevalent in the last quarter of the nineteenth century. As the incidence and severity of these diseases have been greatly reduced in recent times it was felt that a better indication of the demand upon hospital services could be obtained by tabulating the data in respect of adult life.

TABLE 17.

Previous Periods of Residence in General Hospital during Adult Life

Previous predominating major illness	Nil	1	2	3	4	5	6	7+	TOTAL
None	214	5	1	-	-	-	-	-	220
Medical	47	73	25	15	3	4	2	2	171
Surgical	-	25	8	4	1	1	-	1	40
Accidents	8	34	7	-	2	-	-	1	52
Medical and Surgical	-	3	8	5	6	2	1	1	26
Medical and Accidents	-	2	12	6	2	-	-	1	23
Surgical and Accidents	-	-	3	1	-	-	1	-	5
Gynaecological	-	9	3	1	-	-	-	-	13
TOTAL	269	151	67	32	14	7	4	6	550

Reference to the above Table shows that 269 persons, representing 48.9 per cent, had never been in hospital. A further 151 persons had been in hospital on one occasion only. Thus, in the total 550 cases under review, for 420 persons it can be claimed that little or no demand had been made upon the hospital services. This fact is perhaps the more remarkable when one remembers that the persons in the survey are all over 60 years of age.

It will also be seen from inspection of Table 17 that a small number of persons had been many times in hospital. These occasions in hospital were found in some instances to be widely dispersed throughout life. On the other hand it was found that many persons had never been in hospital during their working lives but after retirement they had been in hospital on many occasions. Accordingly, it was decided to record the frequent admissions to hospital which had been repeated during the past five years. These findings are given in Table 18 hereunder:-

TABLE 18.

Frequency of admission to General Hospital during past 5 years

Previous predominating major illness	Frequent	Infrequent	TOTAL
None	4	216	220
Medical	47	124	171
Surgical	2	38	40
Accidents	3	49	52
Medical and Surgical	9	17	26
Medical and Accidents	11	12	23
Surgical and Accidents	1	4	5
Gynaecological	1	12	13
TOTAL	78	472	550

It/

It is confirmed by these figures that the vast majority of the old people, viz., 472, made no excessive demands upon the hospital services. There are, however, 78 persons, representing 14.2 per cent of cases, who had been repeatedly admitted to hospital during the past five years. A study of the individual cases in which frequent admissions to hospital had taken place during the past five years shows the demand for hospital treatment arose not primarily from the nature of the ailment itself but from the conditions of living which precipitated the illness. Where the old person on his discharge from hospital is received into the bosom of his family and receives all necessary care and attention, his restoration to health is assured but, if he is discharged from hospital to his own home where he lives alone or to the common lodging house, there is little possibility of improvement in health. On the contrary, such improvement as has been secured in hospital cannot be maintained and a return to hospital is inevitable. Amongst those admitted from the common lodging houses there was a well defined pattern of events. In succeeding years the admissions to hospital were more frequent, the period of treatment in hospital more lengthy and the time which elapsed between the admissions progressively shorter. A few typical case histories are given hereunder:-

(1) A man aged 72 worked as a labourer until the age of 62 when he had to give up his work on account of bronchitis. He has been in hospital repeatedly since then on account of his chest condition. X-ray examination reveals chronic bronchial changes but no evidence of a tuberculous lesion. He lived in a common lodging house and stated that his diet was poor, consisting chiefly of tea and bread. He has now been in hospital for eight weeks and, on his discharge which is imminent, he proposed to return to the common lodging house.

This/

This line of action will undoubtedly result in an early relapse. He will not consent to enter an institution for the aged, but states that he would like to live with his son or daughter, but neither of these persons has accommodation for him.

(2) The second case is that of a man aged 66 who was admitted to hospital suffering from myocarditis with congestive cardiac failure. He has been in hospital every winter for the past six years, and recently his admissions to hospital have become more frequent and his period of residence there more protracted. This year he was in hospital for a period of three months, and only two months after his discharge he was re-admitted on account of his cardiac condition. He lived in the home of his parents until their death some thirty years ago, when he went to reside first in lodgings and latterly in the common lodging house. He has not worked since the age of 60 because of his heart lesion. He is a decent man who found it difficult to mix with the other men in the common lodging house. The majority, he said, were "just animals", although he admitted that there were a few decent people amongst them. The state of the common lodging house he alleged to be filthy and most nauseating to him. His cubicle was dark and damp. Thieving, which was rife, was most distressing to him. He was unable to purchase the food he would have liked with the money granted by the National Assistance Board. He knew that he should rest as much as possible but this was denied to him in the common lodging house. He took a short walk daily to George Square where he sat on a seat for an hour or two before making the return journey to the lodging house. This man's condition has improved since he was admitted to hospital, but it will be impossible for the improvement made in hospital to be maintained if he returns to the common lodging house.

(3) Another example of repeated admission to hospital is that of a man aged 65 years who was admitted to hospital suffering from mitral incompetence. He began work as a "half-timer" in the mills/

mills at the age of nine and has worked hard all his life. He had to give up his work when aged 61 years on account of shortness of breath. He has received treatment in hospital on five different occasions for his cardiac condition. He lived in lodgings and paid 12/- per week for the share of a room. He found his own food and fuel. For some time prior to admission he had not been adequately fed. He has made good progress in hospital and would be very happy to remain there. This, he realises, he cannot do and he is apprehensive about the future for he knows full well that he cannot maintain his health in lodgings.

(4) The following case was treated in hospital on nine different occasions for the same disability. A man of 67 years worked for twenty-nine years on the Railway as a painter of the undercarriage of trains. He had not been able to work since the age of 58 on account of shortness of breath. The medical reason for repeated readmission to hospital is auricular fibrillation. He lived alone in a single apartment house, but has been unable to look after himself and his home for a long time. He said that he could not be bothered to cook, but admitted that if a meal had been prepared for him he would have enjoyed it. He has neither friends nor relatives and when not in hospital he is dependent upon the neighbours for help in respect of washing and shopping.

(5) The fifth case is that of a man, aged 79, who was employed as a miner until the age of 65 when he was dismissed as he had reached the age limit. On the death of his wife, nine years previously, he gave up his house and went to live with his sister in Dundee. The sister died shortly afterwards whereupon he went to reside with a married daughter in Glasgow. He became ill and was admitted to hospital, but, on his recovery, the relatives refused to have him back, and he was transferred to a poor law institution. He stayed there for seven months but, as he was most unhappy, he decided to live in a common lodging house where he has been for the past four years. He has been admitted repeatedly to hospital on account of bronchitis. He is a very decent/

decent man and is most grateful for the attention he receives from the nurses. He is a docile person and so helpful in the wards that it is difficult to understand the reluctance of his relatives to give him accommodation. Although he is 79 years old he refuses, on account of his previous unhappy experience of a poor law institution, to consider residence in a Home for the aged, fearing that in such a Home he will experience similar mental distress.

(c) Domiciliary medical care.

The incidence of illness amongst the old people was further studied by conducting enquiries into whether domiciliary medical treatment had been given during the period of five years prior to the admission of the old person to the institutions. In Table 19 are recorded the findings:-

TABLE 19.

Medical Care required at home during 5 years prior to admission to Institution

Previous predominating major illness	Domiciliary Treatment		TOTAL
	Given	Not Given	
None	50	170	220
Medical	111	60	171
Surgical	16	24	40
Accidents	14	38	52
Medical and Surgical	21	5	26
Medical and Accidents	21	2	23
Surgical and Accidents	3	2	5
Gynaecological	1	12	13
TOTAL	237	313	550

From/

From Table 19 it is seen that 313 persons, representing 56.9 per cent of the old people, have not been in receipt of medical treatment at home for a period of five years prior to their admission to an institution. It may thus be concluded that, generally speaking, the old persons constitute a healthy section of the community. Too often are old persons looked upon as potentially chronic sick persons likely to become bedfast and to make demands upon the hospital services. It was clearly demonstrated that many persons up to the age of 80 make few or no demands either on their family doctors or on hospital beds.

7. Residence in other Institutions. The question arose as to what extent the cases under review might have access to institutional care other than that provided by the general hospital. The findings in respect of residence in nursing homes, convalescent homes, eventide homes or local authority institutions are recorded in Table 20:-

TABLE 20.

Previous occasions in Institutions other than General Hospitals

Previous predominating major illness	Number of Admissions				TOTAL
	Nil	1	2	3	
None	219	1	-	-	220
Medical	163	7	1	-	171
Surgical	40	-	-	-	40
Accidents	52	-	-	-	52
Medical and Surgical	23	3	-	-	26
Medical and Accidents	21	2	-	-	23
Surgical and Accidents	5	-	-	-	5
Gynaecological	13	-	-	-	13
TOTAL	536	13	1	-	550

It/

It will be seen from inspection of the above Table that only 14 persons, representing 2.5 per cent, had previously been admitted to any institutions other than general hospitals. There was only one person in the survey who, after treatment in hospital, was transferred to a convalescent home and thence to a voluntary home.

8. Main reasons for admission to the Institution. It might be expected that the reasons necessitating the admission of the old persons to hospital would be very different from those leading to admission to a Home for old people. It cannot be presumed that in the case of persons admitted to hospital the determining factor in all cases is the need for treatment. While those who were acutely sick were in need of expert care, many chronic sick persons required care of a standard which could as easily have been provided at home. The admission of the latter cases to hospital came about primarily because there was no one to look after them, for example, where old persons lived alone or where they resided with relatives who were unable to provide the necessary care and attention.

It will be seen how varied are the factors which bring the old people into hospitals or Homes. Reference has already been made to illness. In some cases the old persons lived alone and were unable to look after themselves or undertake domestic duties. Some were homeless. Others experienced financial difficulties and through economic necessity sought admission to an institution. The unwillingness of the relatives to give shelter to the old persons was an outstanding factor in necessitating the admission of the old persons both to hospital and to institution. A certain number of old people applied of their own volition for admission to a Home. The part played/

played by each of these factors is brought out categorically in Table 21.

TABLE 21.

Predominating Factors determining admission to Hospital or Institution

Classification	No one to look after old person	Ill	No home	Financial difficulties	Unwanted by relatives	Volition	TOTAL
Able-bodied	4	5	16	35	52	46	158
Frail	26	86	13	23	43	11	202
Bedfast or Chronic Sick	29	67	2	2	27	-	127
Acute Sick	-	63	-	-	-	-	63
TOTAL	59	221	31	60	122	57	550

The reason why 158 able-bodied men and women should be resident in institutions calls for special comment. Approximately one-third of the able-bodied gave as their reason for admission to the institution the refusal of relatives to have them in their homes. While one can readily understand the reluctance of relatives to shoulder the burden of the sick and permanently bedfast, it is difficult to comprehend why so many sons and daughters refuse to look after their aged parents who have no disability other than the concomitants of old age. Forty-six able-bodied persons were admitted to a Home of their own volition. This number represents in the main old people who sought admission to the Cottage Homes and who would not have considered

residence/

residence in a large institution. Almost without exception the old person comes to the large institution with regret. His rooted dread of the old poor law institution with its regimentation and consequent loss of independence often delayed his entry to the Home until his physical condition had deteriorated to such a degree that life outside the institution was no longer possible. It may be recorded in passing that in many instances where the old person can bring himself to accept institutional accommodation his physical state improves immeasurably. In striking contrast are the old people who have been forced into the institution by their relatives. Such acute unhappiness has been inflicted that time cannot heal their wounds and even after five or six years a state of deep misery prevails. On entry to the institution the old person virtually stops living and merely exists. A small number of persons, admitted to hospital on account of illness, were unable on recovery to return to their homes which had been sold by their relatives, without their knowledge and consent. There were four able-bodied men who made application for admission to a Home on the death of their wives. Unaccustomed to looking after a home, they could not undertake shopping, cooking, cleaning and washing.

In the case of the frail, the predominating reason for admission to hospital was illness. Some of these frail people who had lived in their own homes never made sufficient recovery in hospital to enable them on discharge to return to their previous mode of living. In many instances, it was found that where the old person had formerly resided with relatives his illness had been seized upon as an excuse to secure his admission to hospital, and on his recovery/

recovery the relatives refused to have him back. There are twenty-six old persons who were admitted to the institution because there was no one to look after them. When the old person living alone finds he cannot look after his home on account of deteriorating health he reluctantly seeks admission to an institution for the aged. There were only eleven frail persons, representing 0.5 per cent of the frail cases, who came to the institution of their own free will.

In the case of the chronic sick, practically one-half had been admitted to hospital on account of illness, but in 27 cases the illness of the old persons was such that they could easily have been looked after by their relatives. The explanation of their presence in hospital lies in the fact that they are unwanted. In an almost equal number of cases, viz., 29, the old persons were admitted to hospital not because they required skilled nursing attention but because there was no one to look after them. They required a certain amount of care and attention which could very well have been provided in their own homes had there been relatives or friends available to provide such attention.

In the 63 persons who are acutely sick, it was illness alone which was the decisive factor in their admission to hospital.

A selection of cases is given below to illustrate the circumstances which led to the old person being admitted to an institution from his residence, whether it were his own home, the home of relatives, lodgings or the common lodging house:-

(1) The/

(1) The first case is that of a woman of 75 years who worked in a laundry until the age of 45 when she married and made her home in a two-apartment ground floor house. Since the death of her husband eight years ago she lived alone. For the past six years she complained of swelling and pain in her knee joints. The condition became progressively worse; she was unable to undertake her shopping and most of her household tasks. She was admitted to hospital for treatment. When seen, she had been in hospital for four months. Little progress had been achieved, and, as it is most unlikely that she will ever be able to return home, she will require to be transferred to a Home for the aged.

(2) A man, aged 83, was employed for forty years with one firm as a cashier, retiring at the age of 65. He did not marry as he was the sole support of his mother who lived until the age of 81. After her death, he lived for a time alone, but, as he was unaccustomed to performing domestic duties, his health deteriorated chiefly owing to lack of balanced diets, and, at the age of 70, he reluctantly applied for admission to Crookston Home and disposed of his house.

(3) There had been living in Crookston Home for three years a woman, aged 84 years, who had led a hard life, taking up work at the age of ten in a cotton factory where she earned 2/3d. per week. She was left a widow with a young family to maintain and she had a struggle to bring them up. Even at the age of 73 she was working in a laundry; she then developed bronchitis and was admitted to hospital. On her recovery she went to live with relatives but when she developed bronchitis a second time the relatives arranged for her admission to Crookston Home. She is very embittered at the treatment meted out by her family and cried bitterly as she told the author how much she had done for them in their youth and how now in her old age they would not raise a finger to help her.

(4) A single man, aged 76, has been in Crookston Home for five years. He was a carter but was practically continuously unemployed for the last 23 years. He gives as the reason for his unemployment the replacement of horses by mechanised transport. After/

After the death of his parents he went to reside with a married sister in a two-apartment house. She soon stated that she had no room for him as her two girls were growing up. In the Home, he is most unhappy. He feels that no one wants him and although he has been five years in Crookston Home he still is hopeful that his sister will relent and invite him again to stay with her.

(5) In a two-apartment house a woman, aged 86, had dwelt with her husband until his death thirty-seven years ago. On his decease her married daughter and her husband came to live with her. This daughter has now five children so that there were eight persons resident in the two-roomed house. Five years ago the daughter arranged, without the knowledge of her mother, that she would be admitted to Crookston Home. The mother suffers from rheumatoid arthritis and can only shuffle along with the aid of a stick, but she could have lived outside the institution if there had been someone to take care of her. The mother is most unhappy. She says her daughter has promised to take her home but after a lapse of five years this is not very probable. The daughter is going into hospital for an operation and on her last visit was full of remorse on account of her treatment of her aged mother. This case illustrates how very anxious to return to normal home life are those old persons who are forced into an institution against their will.

(6) The next case is that of a woman of 84 years who resided with her daughter to whom she is very much attached. The daughter, who is also fond of her mother, married and the latter went to live in lodgings. Unfortunately, the landlady died and, as the son-in-law refuses to have the old lady stay in his house, she was admitted to Crookston Home. She has never settled in the Home. She is restless and has lately become confused as to the reason for her being in the institution. Her daughter visits her twice a week. On each visit she begs her daughter to take her away and she frets on her daughter's departure and lives only for her next visit, but these are fruitless so far as the old lady's wish is concerned.

(7) A/

(7) A woman, aged 74, gave up her home on the death of her husband six years ago and went to reside with her married son, his wife and child in a two-apartment house. She said that it was made plain to her that she was in the way and her room was required for the grandchild. Accordingly she herself suggested that she should go into Crookston Home. She is active and enjoys reading, knitting and sewing, and undertakes many light household tasks. Indeed she is such a gentle, pleasant person that it is difficult to understand why she was unwanted by the daughter-in-law.

(8) There was admitted to hospital from the home of relatives a woman of 76 who suffered from rheumatoid arthritis. She has been a widow for thirty years and lived in a single apartment house but was persuaded, as the house was damp, to reside with her daughter at West Kilbride. After a short time in this home she went to reside with a son. She left his home and went to another daughter and finally she returned to the first daughter's home. Her son and daughters found that their mother required more and more attention and none was prepared to undertake to look after her. Although she is considerably incapacitated, she is light in weight and could easily have been nursed at home if her family had been sufficiently fond of her to undertake this task.

(9) A pathetic case was that of a labourer, aged 76, who was dismissed in 1926 as being redundant and, from that date he has never worked. He stated that he had never had a serious illness. He is a widower and lived with his son in a one-apartment house, but when his son went into H. M. Forces, he sold up the house. He has now been resident in the Home for five years but he has never settled there and bitterly regrets that he gave up his own home.

(10) A man, aged 75, was formerly employed as a despatch clerk and retired at the age of 68. For six years he has been resident in the Home to which he applied for admission on the death of his wife. He has a large family, three of whom are married, but he felt that it would be an intrusion on the members of the family if he went to stay with any of them. He felt that he could not live alone as he had no idea of how to run a home. He is an active man/

man and during the summer months is out all day long. He is cheerful and gracious but his family visit him but rarely and are not particularly interested in him.

(11) A caretaker of service flats, aged 60 years, was admitted to the hospital suffering from pneumonia. She gave up her own home to take this post when her husband fell ill and was unable to work. She resided with her husband in two small rooms. They had the use of a kitchenette and bathroom. She is very worried about the future. She says she will not be able to undertake the large amount of work involved as caretaker of the service flats and that they have now no home to which they can return.

(12) An unmarried iron turner of 74 years was employed until the age of 69. On the death of his mother he went to reside in lodgings and was with the same landlady for fourteen years. On his dismissal from work on account of his age, he lived on his savings for a year but found that he could not meet the cost of his lodgings and applied for admission to Crookston Home. He enjoys walking in the grounds but he suffers from varicose veins which prevent him from taking long walks. He is nicely dressed but complains that there is no place for him to keep his clothes. On taking off his coat it is rolled up and put into a pigeon-hole so that when he puts it on it is always crushed. He says he feels as if he "had retrieved it from the pawnshop".

(13) This is the case of a man, aged 77, admitted to Crookston Home from lodgings. On the death of his wife fourteen years ago, he gave up his home to reside in lodgings. The cost of his room was 17/- per week and in addition he had to provide his own food and fuel. As a young man he served his apprenticeship as an engineer but later worked at many occupations. He said that he took any job rather than be idle. At the age of 75 he was working as a skilled mechanic in a motor business. He developed bronchitis, was admitted to hospital and was soon discharged. The firm refused to re-employ him. He could not continue to live in lodgings when he was out of work and, his savings being exhausted, he applied for admission to Crookston Home. He is an intelligent man and although he would/

would like to have continued to live in lodgings he realises that this was not economically possible and that he will have to adjust himself to life in the Home. His only comment was "I am a young man and I find it strange to live amongst so many old people".

(14) A woman, aged 69, was employed as a clerkess until the age of 54. She gave up her employment on account of her suffering from rheumatoid arthritis. She lived with her mother and on her death she kept house for her brother until his marriage, whereupon she had to find lodgings for herself. She occupied a room in a three-apartment house for eight years. The other inmates were the landlady, her husband and two children. One day the landlady informed her that she required the room for her son who was growing up and that she would have to look for other accommodation. She has marked deformity of the hands and knees. She was rarely out of the house and for the most part sat in her own room. It is obvious that the landlady found her lodger required more attention than she was prepared to give.

(15) From a common lodging house was admitted a man of 65 years suffering from giddiness. He had worked for 35 years as a dock labourer and had not been well since he sustained injuries to his head in a street fight two years previously. For some time prior to his admission he has experienced a tendency to fall backwards. He has now been in hospital for one year. It is unlikely that he will be able to work again or that he will be fit to return to the common lodging house. Reluctantly he agreed to be transferred to a Home for old people.

(16) Also from a common lodging house was sent to hospital a man, aged 74; he suffered from cerebral haemorrhage which left him with a slight impairment of the function of the left side. He had worked as a carter for forty years and had only three employers throughout his life. At the age of 60 he was dismissed when an amalgamation of firms took place. He carried with him an excellent testimonial/

testimonial but this was of no use to a man aged 60 years seeking employment. He had lived with his mother until her death when he went to reside in a common lodging house. He is a decent man and realises that he can no longer live in the common lodging house and agrees to be transferred to a Home for old people on his discharge from hospital.

(17) The last case refers to a woman, aged 82, who was admitted to hospital on account of generalised weakness which caused her frequently to stumble and injure herself. She had worked hard all her life. She was never at school but worked from 6 a.m. to 6 p.m. in a cotton factory from an early age, earning 1/9d. per week. After her marriage she continued in employment as a ropemaker until the age of 70. Till a year ago she lived alone but on account of her debility she then went to reside with her daughter. Recently she has been confined to bed, and, as the daughter was unable to undertake her nursing care, she was admitted to hospital where she has been for four months. She is one of the few women in this survey who confessed that she drank in moderation. Her several falls may thus be attributed partly to her general weakness and partly to the effects of alcohol on an already debilitated constitution.

PART II.

THE STATE OF THE OLD PERSONS IN THE INSTITUTIONS

1. Duration of stay in the institutions.

2. The medical condition of the 550 cases:

   (a) Cardio-vascular diseases
   (b) Bone and joint diseases
   (c) Nutritional disorders
   (d) Respiratory diseases
   (e) Nervous diseases
   (f) Neoplasms
   (g) Anaemia
   (h) Diabetes mellitus
   (i) Other illnesses

3. Mental health.

4. The state of activity:

   (a) Degree of mobility
   (b) Bedfast patients

      (i) Feeding
      (ii) Washing
      (iii) Continence

5. The state of vision.

6. The state of hearing.

7. Recreational activities:

   (a) Physical
   (b) Cultural and aesthetic
   (c) Social
   (d) Handicrafts

PART II/

PART II.

THE STATE OF THE OLD PERSONS IN THE INSTITUTIONS

So far the survey has been concerned with the study of the old persons prior to their admission to institutions. An attempt has been made to obtain a picture of the social background of the old persons and to trace the main steps which eventually led to their admission to institutions. Armed with this knowledge one can approach with fuller understanding the problems of the aged. The importance of social influences in relation to sickness is now recognised and, in respect of the aged, special significance must be placed on social factors. The old persons, as we see them to-day, have been fashioned by their past lives and we must take stock of their past if we are to arrive at a true estimate of their present state. The second part of the investigation comprises the assessment of the old persons, both in sickness and in health. Their physical and mental states were examined and an opinion was formed of their character and temperament; their capabilities for work and leisure were also estimated; their habits and hobbies were observed. From the knowledge thus gained, it was possible to form conclusions as to whether the environmental provision was suited to the physical and mental condition of the old persons, whether it was such as to improve and maintain health and whether it provided, in full measure, facilities for the satisfaction of individual needs as regards work and leisure.

1. Duration of Stay in Institutions. The length of stay of the old persons in the various institutions showed great diversity. While, at the time of survey, some had been in the institutions for only a few days, others had lived/

lived there for as long as fifteen years. The duration of stay was considered as a force which might colour the individual's state of health and attitude of mind. Accordingly, the period of stay in the institutions was investigated and the findings are shown in Table 22 hereunder:-

TABLE 22.

Duration of Stay in Institutions

Institution	Under 1 month	1 - 6 months	7 - 12 months	1 - 2 years	3 - 5 years	6 - 10 years	Over 10 years	TOTAL
Stobhill	51	89	20	26	6	-	-	192
Western District	10	15	5	7	4	-	-	41
Crookston Home	19	29	14	52	53	40	10	217
Cottage Homes	6	9	6	24	21	34	-	100
TOTAL	86	142	45	109	84	74	10	550

From reference to this Table, it is evident that, in the hospital series of cases, the stay in hospital is in some instances of very long duration. There are 192 persons in Stobhill Hospital and 41 in the Western District Hospital, making a total of 233 cases, and, of these 33 persons had been in hospital for more than a year, and ten persons for periods ranging from three to five years. Such prolonged periods of residence in general hospitals can be justified only in very exceptional cases. Hospitals equipped with full diagnostic facilities must not be used for the retention of patients/

patients who, after clinical investigation, are found to have little hope of physical betterment. The present practice of nursing the chronic sick in general hospitals is not only wasteful of hospital services but is to be deprecated in the interests of the chronic sick themselves who undoubtedly would be much happier if cared for in premises apart from those in which sufferers from acute illness are also treated. Nor is it fitting that those who are acutely ill should be accommodated in the same ward as permanently bedfast patients who have a bad psychological effect upon persons who have passed from the acute phase of their illness to the stage of convalescence.

One reason for the retention of old persons in hospital beyond the period for which they have actual need of hospital services is the difficulty experienced in securing accommodation more suited for their needs. The dearth of Homes for the aged and infirm is responsible for the immobilisation of hospital beds by the homeless able-bodied and the frail who have recovered from acute illness. The following histories are typical of cases in hospital who could have been more happily and suitably accommodated elsewhere:-

> (1) A woman, aged 87 years, was admitted to hospital suffering from acute gastro-enteritis. She lived alone in a service flat but her sister-in-law decided that she was too old to live by herself, and, on her admission to hospital, disposed of the patient's flat and furniture. An active woman of cheery disposition, she rises each morning at 4 a.m. in order to make early tea for the other patients; in addition, she washes all the ward dishes. This patient has now been seven months in hospital. She is undoubtedly a great favourite with the nursing staff, but she could enjoy a much fuller life than the hospital can provide. She is so active that she would be able to find many interests in an Old People's Home, but it is lamentable to think that her sister-in-law should have disposed of her flat to which she could easily have returned, had a domestic/

domestic help been provided.

(2) A woman of 67 years enjoyed good health until eight years ago when she developed cerebral haemorrhage which left her with impaired function of the left side. Her sister, who volunteered to look after her, gave up her own house; but the sister wearied of her presence and the patient was admitted to hospital, where she has been for eighteen months. She is able to do much for herself but is afraid to walk on account of the highly polished floors and she simply sits on the chair at her bedside all day long. She is most unhappy as, apart from reading, she has little to occupy her mind. She, too, could live a more useful and full life in an Old People's Home.

(3) The third case is that of a woman, aged 84 years, who has been in hospital for four years. She has a left-sided hemiplegia of nine years' duration, and, for the past six months, she has been confined to bed. This woman is most unhappy. Intelligent and observant, she finds the days dreary and uninteresting. She longs to talk to someone and wishes she were in "Barnhill" (the Glasgow Poor-house) as she had heard that it was a cheerful place where the patients help each other. Much of the attention which this patient requires could be given by attendants rather than by trained nurses. All her food, given by means of the feeding-cup, consists of a monotonous diet of gruel, semolina and tea. She feeds herself and she has no difficulty in swallowing, but, if her food were more varied and if she had assistance in feeding, her meals would be much more palatable and appreciated. Her enforced isolation could be dispelled by bright companionship. Her only relative is a son, aged 50, who is at work all day and is unable to undertake the care of his mother.

(4) The next case is that of a woman, aged 81, who has been in hospital for eleven months. She was admitted to hospital from her own home as she had no one to look after her. She has a niece who visits her every week. She is most unhappy in hospital and says that she could sit up if only/

> only the nurses would help her. She dreads the frequent bathing to which she has not been accustomed, and on these occasions she is fearful of falling as she can do so little to help herself. Her chief distress seems to lie in the fact that no one has very much time to devote to her. She complains that the nurses just put the food down and disappear, and, as she is lying flat on her back, feeding is a difficult and laborious task. She is in an upstairs ward, from the windows of which she can see nothing but the sky. Her isolation and loneliness of spirit can be appreciated when she stated to the author:- "I couldna' thole being old and no' able to help mysel' if it were no' for the wee birdies - that I watch for - aye comin' keekin' in at the window".

Reference to Table 22 also shows that 50 cases, representing 23 per cent of the old persons resident in Crookston Home, have been there for a period of six years or more. In the Cottage Homes, 34 persons, equivalent to 34 per cent of the cases, have been resident there for a similar period. Such lengthy periods of residence clearly indicate that provision for the aged should be designed for long-term stay. Too often, the closing of the door upon the old persons when they cross the threshold of the institution is symbolic of the end of their active lives. Henceforth they may adopt the attitude of marking time until death supervenes. It was found that many of the old persons, although they have been resident for many years, still enjoy excellent health.

The duration of stay in the institution for the various categories of old people is recorded in Table 23, from which it will be seen that, of the 74 persons who had been living in the institutions for a period ranging from six to ten years, 43 are able-bodied; in their case, one should see the dreary institutional picture of enfeebled and melancholy old age awaiting a welcome release in death transformed into a scene of cheerful activity in which/

which hale and hearty old people are activated by a zest for living restricted only by the limitations of their advancing years.

TABLE 23.

Duration of Stay in Institutions

Classification	Under 1 month	1 - 6 months	7 - 12 months	1 - 2 years	3 - 5 years	6 - 10 years	Over 10 years	TOTAL
Able-bodied	11	26	11	38	29	43	-	158
Frail	37	54	16	39	28	21	7	202
Chronic Sick	13	34	10	31	26	10	3	127
Acute Sick	25	28	8	1	1	-	-	63
TOTAL	86	142	45	109	84	74	10	550

These stastistical findings, in respect of the large percentage of able-bodied persons living in institutions for long periods, reveal that many persons have spent a fifth or even a fourth part of their adult lives within the institutions, and show clearly the need for providing for the aged accommodation which has all the qualities of a real home.

The needs of the frail, so far as suitable environment is concerned must not be overlooked. Amongst those who had been resident in the institutions for more than six years there are 28 frail persons, seven of whom have been resident for more than ten years. The frail can also enjoy life and differ only from the able-bodied in that their mode of living is more restricted.

2. The Medical Condition of the 550 Cases.

The/

2. The Medical Condition of the 550 Cases. The health of the old persons was investigated and a medical diagnosis was reached in each case. Table 24 shows that in no fewer than 74 men and 100 women - 31.6 of the total - there was no evidence of any definite ailment.

TABLE 24.

Medical Diagnosis	Able-bodied		Frail		Chronic Sick		Acute Sick		Total		GRAND TOTAL
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	
Cardio-vascular disease	1	-	36	29	24	40	14	8	75	77	152
Respiratory disease	-	-	7	4	-	1	14	5	21	10	31
Nervous disease	-	-	1	6	6	3	-	-	7	9	16
Bone and joint disease or injury	-	-	15	23	8	19	2	1	25	43	68
Anaemia	-	-	4	5	-	1	3	1	7	7	14
Diabetes	-	-	-	5	2	2	-	3	2	10	12
Nutritional disorders	-	-	19	17	2	4	2	2	23	23	46
Neoplasms	-	-	1	-	7	7	1	-	9	7	16
Other diseases	-	-	5	8	1	-	1	6	7	14	21
No abnormal medical condition	63	94	11	6	-	-	-	-	74	100	174
TOTAL	64	94	99	103	50	77	37	26	250	300	550

(a) Cardio-vascular/

(a) Cardio-vascular diseases.

The predominating diseases are those affecting the cardio-vascular system and include cerebral haemorrhage, thrombosis, arterio-sclerosis, auricular fibrillation and myocarditis. Many crippling disabilities were the end results of cardio-vascular lesions causing disabilities ranging from slight to total incapacity. In this group there are 77 women and 75 men. The following case histories are typical illustrations of the fate of old persons suffering from cardio-vascular disease:-

(1) A man, aged 67 years, worked as a labourer until the age of 63 when he had to give up his work on account of his suffering from breathlessness on exertion. He has lived for 10 years in a common lodging house from which he was admitted to hospital with swelling of the legs. He was found to be suffering from congestive cardiac failure. He has been in hospital for five weeks and already there has been much improvement in his cardiac condition. He looks upon his stay in hospital as a temporary expedient and it is his intention to return to the common lodging house on his discharge from hospital. He fully realises that he will not be able again to undertake strenuous employment, and that he can only resume his former unsatisfactory existence in the lodging house. One can with some degree of certainty predict that shortly after discharge from hospital he will inevitably have to be readmitted.

(2) A woman, aged 63, was admitted to hospital on account of auricular fibrillation. She has previously been in hospital three times, and, on the last occasion, was discharged from hospital on a maintenance dose of digitalis, with instructions to attend the Out-patient Clinic. She defaulted from attendance because she did not feel well enough to travel unaccompanied to the Clinic, and her husband who is in full-time employment could not leave his work to act as her escort. She resides with her husband in a two-apartment house on the third floor of a tenement. Unfortunately, this patient on discharge from hospital returns to an environment highly detrimental to her condition. Without/

Without adequate measures for after-care, it is clear that the medical skill and nursing care expended upon this case in hospital will be thrown away. The marshalling of the Local Authority services to provide adequate domestic assistance, a ground floor house and after-care by means of home visitation by the health visitor are all necessary if the improvement in her condition achieved by hospitalisation is to be maintained in her home.

(3) A man, aged 74 years, worked as a sheet metal worker until eight years ago when he suddenly lost the power of his right leg. He received treatment in hospital and recovered to such an extent that on discharge he was able to get about with the aid of a stick. Subsequently, he secured employment as a night-watchman and retained this job for six years. During this time there has been a gradual deterioration in his condition, and six months ago he was admitted to hospital as he was unable to walk. This man has lived in lodgings for many years, but his landlady has made it clear to him that she will not readmit him to her house. He has no near relatives who can help him. The outlook in this case is grave. He has only recovered the partial use of the limb and will require to be accommodated in a Home for old people. At present, he refuses to accept the verdict and a very difficult time will lie ahead of him until he resigns himself to his incapacity.

(4) A woman, aged 70, was admitted to hospital suffering from congestive cardiac failure. All her life she has worked hard as a hawker in order to support herself and her "ne'er-do-well" husband; she resides in a single apartment on the third floor of a high tenement. There is no doubt that her mode of livelihood, viz., hawking large heavy bundles of old clothing and rags up and down tenement stairs, has put an undue strain on her heart. This is the fourth occasion during the past three years on which she has received hospital treatment for this condition. She was discharged from hospital only three months ago and since then she has been in bed "off and on". While she makes good progress in hospital there is little hope of the recovery being maintained on her discharge, in view of the arduous nature/

nature of her work, the handicap of an indolent husband, the situation of her house and her addiction to alcohol.

(b) Bone and joint diseases.

Next in order of frequency comes the group of cases who suffered from bone or joint disease or from the results of injuries to bones and joints. These numbered 68 in all, with a definite preponderance in the case of women. Such complaints as recurrent slight "fibrositis" have not been regarded as coming within the ambit of definite illness. It must, therefore, be understood that in this category are recorded only those who have a definite degree of incapacity. The following cases are illustrative examples:-

(1) A woman, aged 84, has been in Crookston Home for 17 months. She enjoyed good health until five years ago when she fell and fractured her femur. She was a year in hospital, and, on discharge, she returned to live alone in her one-apartment house. Her daughter, who lived nearby, came to assist her with the shopping and housework. But her daughter was not prepared to undertake these duties indefinitely, nor was she willing to have her mother to stay with her although there was adequate accommodation, living as she did in a four-apartment house with her husband and two children. Arrangements were accordingly made for the admission of the mother to a Home. The old lady is heartbroken at finding herself in an institution. She does not sleep well and can find no companionship in the Home. Unsettled and unhappy, she can find solace neither in reading nor in knitting which interests previously took up much of her time. Had it not been for the unfortunate accident she sustained, this old person might have lived happily in her own home for many years.

(2) A woman, aged 78 years, has been in hospital for almost a year. All her life she worked hard as a hawker, buying cast-off clothing which, after cleaning and pressing, she resold or pawned. The average/

average profit for her labour on a suit was 3/-. Two years ago her metatarso-phalangeal joints became painful and swollen and the condition spread insidiously to all the joints, passing from the small to the large joints. She is now bedfast and is unable to hold a cup. She was admitted to hospital from her five-apartment home, where she resided with her son and his wife. For financial reasons this patient had sublet two rooms in her house to married couples with children, with the result that there were 17 persons occupying the house. She fully realised that it was hopeless for her to return to such overcrowded conditions which were bereft of any degree of comfort. She was acutely miserable and resentful of her fate. This case illustrates the impossibility of a chronic sick person being cared for adequately in an unsuitable environment.

(3) A woman, aged 64 years, has had rheumatoid arthritis for six years. She first experienced pain in the hands and elbow joints which gradually began to stiffen. Then the knees and feet became affected. Employed as a weaver, she had to stop work at the age of 58 because of her joint condition. Previously she had never been unemployed for any length of time. Weaving shawls and turbans for export to India, she worked from 8 a.m. to 6 p.m. The workshop was bitterly cold and damp, and she had to carry a midday "piece" as there was no canteen. She resided with her sister in a single apartment house, situated on the third floor. On the death of her sister, five years ago, she was admitted to Crookston Home as she was unable to look after herself. She is now bedfast. She can still manage to feed herself and hold a book, but, although she would like to knit, she cannot hold the needles.

(4) A woman, aged 60, was admitted to hospital four months previously on account of painful swelling of the elbow, wrist and finger joints. She has had intermittent pain in the knees and shoulders during the past two years, and has been unable to walk for five months previous to admission. Her husband, who died two years ago, was a steel worker. He had been unemployed for ten years prior to his death. She believes, and probably rightly, that the enforced unemployment of her husband and consequent prolonged period/

period of under-feeding has undermined her health. She has now been bedridden for ten weeks and is only able to feed and wash herself with difficulty. There is not much prospect of recovery, and the married daughter, from whose home she came, refuses, with some justification, to undertake her care.

(c) Nutritional disorders.

These were found to be present in 46 cases, the incidence in the males and females being the same. The importance of malnutrition as a reason for admission either to old people's Homes or to hospitals cannot be over-estimated. A synopsis of typical cases is given hereunder:-

(1) A labourer, aged 66 years, was admitted to hospital suffering from debility; he had worked as a loader of railway wagons, but six years ago he sustained an injury to his arm and had to give up his work and thereafter was able to secure only casual employment. On the death of his wife two years ago he found it impossible to maintain his home, and went to live in a common lodging house where his meals were irregular and badly cooked. The little money he had did not enable him to purchase adequate food. This man has no incurable disability which would prevent him from working, but, after six years of unemployment, he will be unlikely at his age to secure employment through his own efforts. Following on recovery from his original injury six years ago, efforts should have been made to secure employment for him. This case emphasises the need for the establishment of rehabilitation units for elderly people who are recovering from curable disorders.

(2) Another case is that of a marine engineer, aged 71 years. He had been separated from his wife for fifteen years, and, during that period, had been living in lodgings. At the age of 58 he developed cerebral haemorrhage and was unable to resume work. When his savings were exhausted he was impelled to give up his lodgings and take up his abode in a common lodging house, where, being/

being a man of some refinement, he abhorred the rough mode of life. He became ill and was admitted to hospital suffering from malnutrition. He made a good recovery and would have preferred to return to ordinary lodgings, but, as he had no means, he ultimately elected to be transferred to Crookston Home for old people.

(3) A woman of 67 years was admitted to hospital twelve days after the death of her husband. She was found to be suffering from malnutrition and from a grave degree of anaemia. She and her husband had lived in a sublet room in a two-apartment house, after having been evicted from their own home on account of non-payment of rent. In this two-roomed house there lived in the kitchen the landlady with her seven children. The elderly couple had no facilities for cooking, and the landlady took serious objection to their using the gas cooker in her kitchen. In consequence, they lived chiefly on bread and jam. The woman had two married sons, but neither of them was willing to give accommodation to their mother. She was persuaded to enter a Home for old people, because, had she returned to lodgings, the former state of neglect with consequent malnutrition and anaemia would have recurred.

(4) The next case is that of a single woman, aged 80 years, who had been employed as a post office sorting clerk until she attained the age of 62, and thereafter as a clerk with a firm of dyers. After retirement she lived in a small sublet room in a four-apartment house in which there were three other inmates. She remained quite well until four months prior to her admission to hospital when she scalded her arm. After the accident she was afraid to handle kitchen utensils and undertook very little cooking. Latterly she lost her appetite and stated that she could not be bothered cooking meals. She was so frail that when out shopping she had difficulty in maintaining her balance against the slightest breeze. She was in bed for one month prior to admission, and during that period the landlady looked after/

after her. She was admitted to hospital a fortnight ago and it is really remarkable how proper attention to diet and hygiene have restored her to health. In view of her age and previous history, it would not be proper for her to return to lodgings, but she is a person who will maintain her good general condition in an old people's Home.

(5) A woman of 82 years stated she had never had an illness until five weeks ago when she fell and injured her back. She was living alone until she sustained this injury, whereupon she went to reside with her family who subsequently arranged for her admission to hospital. She was found to be suffering from malnutrition and secondary anaemia. She exhibits some degree of mental confusion, but this is probably due to her weak condition and the fact that she has been moved twice within a short period into new surroundings. She has undoubtedly been unable to look after herself for a long period and has become thoroughly undernourished. With good care and attention it is hoped that she will soon be restored to health. In this case a well-disposed family could have provided for their mother.

(6) A man, aged 74, has resided for the past ten years in a common lodging house. He has had only casual work as a labourer since the age of 65. As he collapsed in the lodging house medical attention was sought on his behalf, and he was admitted to hospital, where he was found to be suffering from malnutrition and scurvy. He cannot with safety return to his former unsatisfactory environment.

(7) A woman, aged 70, had cerebral haemorrhage at the age of 63, and this left her with a right-sided hemiplegia. Since this illness she has not been out-of-doors. She shared a room with another lodger, aged 78, in a four-apartment house. The house was tenanted by a man, his wife and six children, and there was in addition one other male lodger/

lodger. She paid 14/- a week for this room and her fellow lodger undertook the shopping, but, as they had few facilities for cooking, their diet was both monotonous and inadequate. She was admitted to hospital four months ago on account of general weakness, and was found to be suffering from malnutrition and vitamin C deficiency. Her general condition has improved immensely. She is now able to be out of bed and can walk about the ward, this excellent result having been attained by proper diet and by the application of massage and electricity applied to the affected limbs. Return to her former mode of life will undoubtedly be followed by a relapse.

(8) A man, aged 83 years, collapsed when waiting in a queue for his pension and was admitted to hospital. He was employed as an ironmonger's salesman until the age of 65 years. He lived alone in a one-apartment house and was fully occupied with his shopping and domestic chores. He states that he has never had a serious illness but lately has been suffering from vertigo. He admitted he had had very little to eat during the previous week as most of that week's pension had gone in payment of rent. He has been much neglected, but his general condition will improve with balanced diet and adequate rest. How is this good result to be maintained?

(d) Respiratory diseases.

In the series, there are 31 cases of respiratory diseases. The incidence of respiratory diseases is found to be greater amongst males, 21 males being affected as compared with 10 females. Respiratory diseases include pneumonia, pleurisy, acute bronchitis, chronic bronchitis aggravated by myocarditis, bronchiectasis, tuberculosis and asthma. An outstanding feature of the respiratory infections is the large number of patients who resided in bad environmental conditions. Most of these sufferers came from common lodging houses, and those who came from their own homes and lodgings have/

have been living under unsatisfactory conditions for some time past. In all these cases there is ample evidence of a long history of neglect and malnutrition which culminated in a respiratory infection eventually leading to admission to hospital. These findings are illustrated in the following examples:-

(1) A man of 69 years was admitted to hospital on account of dizziness, general weakness and pain in the right side of his chest. He had been previously employed as a labourer but had not worked for the past five years, during which time he had resided in a common lodging house. One morning he was unable to rise on account of the giddiness. The Superintendent of the common lodging house summoned the doctor who found him to be suffering from acute bronchitis. The man has now been in hospital for four weeks. He states that he only wishes to remain in hospital until he is well again. He does not wish to stay in a Home for old people and says that he is quite sure he could work. In view of his history of unemployment since the age of 64, it is not very likely that he will be able to secure work, and it is almost certain that his general health will deteriorate on his return to life in the common lodging house.

(2) A widower, aged 75, has not worked since the age of 67. Three years ago he was admitted to hospital with bronchitis, and since then he has not felt really well. Since the death of his wife thirty years ago he has lived in lodgings. He shared a room with another man. At the time of this survey, his total income was 26/- a week, and out of this he paid 22/- to his landlady. He did not drink but he spent 2/6d. per week on tobacco. His meals were as follows:- breakfast - porridge, cup of tea and bread; dinner - soup and a cup of tea; supper - cup of tea, bread and cheese. He attributes his present illness to lack of food. He felt himself gradually becoming weaker and weaker. He was admitted to hospital suffering from debility and acute bronchitis. There is no doubt that this man has not been receiving a sufficiency of food, and it would not be advisable for him to return to his lodgings. He is, however, most reluctant to enter/

enter a Home for old people, chiefly because he feels that he will thereby sacrifice his independence.

(3) A man, aged 77, was in regular employment as a labourer until the age of 70; since attaining the latter age he has only had occasional work. He says that he would like to work, but that no one will employ him on account of his age. He was admitted to hospital from a common lodging house on account of weakness of the legs and severe dyspnoea. He suffers from malnutrition and chronic bronchitis and he regards the future with misgiving. He does not wish to leave hospital, but he realises that he will be discharged shortly and he knows that he cannot return to the common lodging house and remain well, but he absolutely refuses to enter any institution to which the stigma of poor law can be attached. When he leaves hospital he will be without a penny until he receives the statutory financial assistance.

(4) A man, aged 70, was admitted to hospital suffering from pneumonia, and, until he fell ill, he was working as a loader of railway wagons. He lives in lodgings in a three-apartment house in which there also reside one other lodger and the landlady. It is not likely that this man will be able to resume work for some considerable time, and, when unemployed, he will be unable to pay for his lodgings, so that, when his slender savings are exhausted, he will have to seek accommodation in a common lodging house or in an old people's Home. He states that he does not feel himself to be old and that he will not seek accommodation in a Home for old people. He wishes to return to work, but it is doubtful whether he will ever be fit again to undertake hard manual work. For his complete rehabilitation, he would require prolonged residence in a Convalescent Home.

(5) A man, aged 74, is suffering from acute bronchitis. He was well until three weeks ago but he gives a history that he had on two previous occasions suffered from pneumonia and pleurisy. The X-ray examination shows a consolidation of the right side of the chest with a pleural effusion. He lived in lodgings in a three-room and kitchen house. His room is small, cold and miserable, but he is allowed to sit in the kitchen. His landlady and her husband have four young girls, but these parents go out to the pictures several times a week and he is left/

left to look after the little girls. He was a plater in the shipyards and worked there till the age of 65. It is doubtful what is to become of this man on his recovery. Although he has lived in these lodgings for four years, the landlady is not anxious to have him back, and, with his history of chest ailment, he could not live in a common lodging house. He is most reluctant to give up his home attachments, such as they are, for institutional life. What of his future?

(6) A woman, aged 62, was, up to the time of admission, working as a housekeeper to a family of seven in a large house of fifteen rooms. She became ill seven weeks ago and was admitted to hospital suffering from pneumonia. She states that she would like to return to her work when she has recovered, but she has misgivings as she feels that she will not be fit for the arduous duties of a working housekeeper. If she cannot resume household duties, she will be rendered homeless and will have to seek accommodation in an old people's Home.

(7) A man of 68 years was employed as a joiner, but was dismissed at the age of 65 on account of his age. He took a job as a labourer and was working as such until the time of his admission to hospital. At his work, he was much exposed to the elements, and, following a soaking, he developed a shivering attack and was found to be suffering from pneumonia. He had been living in a common lodging house since he ceased working at his own trade. The future of this man is uncertain. It is obvious that he will not be able to continue work as a labourer and live in the common lodging house. The change of occupation from skilled to unskilled work has undoubtedly been detrimental to his health. He will never entertain the idea of entering a Home for old people, as he is certain that once he is well again he will be able to work, and work for him means independence.

(e) Nervous diseases.

The cases of disorder of the nervous system numbered 16. They were, for the most part, diseases of long standing and included paralysis agitans/

agitans, epilepsy, chorea, cerebral syphilis, disseminated sclerosis and paralysis following poliomyelitis. These diseases, with two exceptions, were all encountered in Crookston Home. There follow several cases illustrative of the types of nervous diseases encountered in Crookston Home and in hospital:-

(1) A man, aged 66, had worked as a plumber until the age of 61, when he developed encephalitis. For this condition he received treatment in the General Hospital on two occasions. He lived alone in an upstairs house of two apartments. Unable to look after himself, he was admitted to Crookston Home. He exhibits a pronounced tremor which is intensified by questioning. He showed great anxiety lest he be removed from the Home. He spends much of his time reading, but he exhibits towards the other residents irritable tendencies which at times become somewhat alarming.

(2) A woman, aged 77, developed infantile paralysis in early childhood. She spent six years in Eastpark Cripple Home, Glasgow, where she learned to read and knit. From the age of 13 she lived at home, and, as her widowed mother went out to work, she did all the housework, including the scrubbing of the floors. On the death of her mother she went to reside with a sister who tired of her and subsequently arranged for her admission to Crookston Home where she has been for five years. She uses a wheelchair to get about, but is not happy because the use of the chair is shared by other patients and it is not always available when she would like to use it. This patient is intelligent and has no disability of the upper limbs. Her horizon would be widened if a chair were put entirely at her disposal.

(3) The third case is that of an old lady of 80 years who, despite the fact that she suffers from chorea, is bright and active. Formerly she lived alone in a one-apartment house, but she was persuaded to go to reside with her married son at Tighnabruaich. After a year, her relatives tired of her and arrangements were made for her admission to Crookston/

Crookston Home where she has been for six months. The manifestations of her disease, which is long-standing, are not pronounced. In the good weather she goes out walking every day. This case is pathetic in that she is not happy in the institution. She speaks constantly of her son, and is still hopeful that he will again take her to live with him. Had it not been for the son's intervention, the woman might still be living happily in her own home.

(4) A woman, aged 64, suffering from infantile paralysis has now been resident in the Home for six years. She previously stayed with her mother, on whose death she went to reside with a married sister who, finding her to be a burden, arranged for her admission to the Home. She was until ten years ago able to get about with the aid of a stick. She now uses a wheelchair which she takes out to the verandah. She has not access to the grounds as she has been placed in a ward on the first floor and has the use of the lift only for attendance at Sunday services. Only a small adjustment was necessary to place her in a ground floor ward and thus give her a complete reorientation of life.

(5) This is the case of a woman, aged 60, who was admitted to a General Hospital at the age of 53. In her early thirties, she developed disseminated sclerosis. The condition progressively deteriorated, and, for thirteen years prior to her admission to hospital, she had not been able to leave her house. She was transferred eventually to Crookston Home. She is now bedridden, unable to feed or wash herself, and is practically inarticulate.

(6) Another case of disseminated sclerosis is that of a man, aged 65 years, who had been in Crookston Home for five years. The disease was of long duration, and he was brought to the Home from a common lodging house. He is completely bedridden, incontinent, inarticulate and is barely able to hold a feeding cup.

(7) A man, aged 65, has been eleven months in Crookston Home to which he was admitted on the death of his mother. He has suffered from epilepsy since childhood. An exceptionally/

exceptionally strong man with a violent temper, he is easily roused to acts of violence. He is kept in bed as he is most easily managed under these conditions. He reads a little, but, as he has practically nothing to occupy his time, he sullenly broods upon his malady. He has a fine tenor voice and prior to his admission he sang in the Church choir. He should certainly not be resident in this Home. The old people fear his outbursts of temper, so easily provoked, and he himself would be more content if he had some physical and mental outlet for his energy.

(8) An advanced phase of Parkinson's Disease is illustrated in the case of a woman, aged 72, who has been in hospital for more than a year. She was bedfast for two years prior to her admission and was admitted to hospital as the burden of her nursing had become too much for her daughter who was at work all day. She lies rigid in bed, any attempts at movement being associated with a coarse Parkinsonian tremor. She has to be both washed and fed. She is much more alert than her inert appearance and mask-like expression would suggest, and her response to questions, although slow and monosyllabic, indicates great interest and full appreciation of her surroundings.

(f) Neoplasms.

Sixteen cases of neoplasm were found in the 550 cases under review. In eight cases, four males and four females, the bowel was affected, and in two instances colostomy had been performed. There was a relatively large number of cases of lung tumour, viz., four, and again the sexes were equally affected. The sites of the remaining cases of neoplasm were the uterus, breast, liver and bladder.

In the cases of neoplasm affecting old people, it was noted that the condition was not diagnosed until it had reached an advanced and inoperable stage, the early symptoms of the disease being attributed by the old/

old persons, and, regrettably in some instances, by the medical attendants, to advancing old age. All the cases of neoplasm were in hospital, with the exception of two patients.

Four examples of neoplasm occurring in old age are appended:-

(1) A man, aged 69, was admitted to hospital on account of pain in the back. On investigation of his complaint the presence of secondary carcinomatous deposits were found in the spine. He had been receiving medical treatment for gastritis for several years.

(2) The second case is that of a woman, aged 78, who is suffering from Paget's Disease of the breast. Following on cerebral haemorrhage at the age of 73, this patient suffered from hemiplegia and was unable to look after herself. As she had a small income of her own, she went to live in a private nursing home where she resided for four years. Nine months ago she was transferred from the nursing home to hospital on account of the breast condition which, on investigation, was found to have reached an inoperable stage.

(3) A woman, aged 78, suffering from gastric neoplasm, has been for six years in Crookston Home. She had rheumatic fever in childhood and had never been robust, and indeed she seems to have lived all her life in the rôle of a semi-invalid. Prior to her admission to Crookston Homeshe had been several years in hospital on account of endocarditis. She showed a disinclination for food and lost weight, but these symptoms were attributed to her cardiac condition and the gastric neoplasm was not diagnosed until the development of secondary deposits in the liver.

(4) A man, aged 65, was admitted to hospital six weeks ago suffering from anaemia. He was employed as a machinist and had always enjoyed good health until fourteen months ago when he complained that he was very easily tired. He attributed the symptoms to the fact that he had worked for twelve years on the night shift and that he was "getting on in years". On investigation of his condition he was found to be suffering/

suffering from a gastric neoplasm.

(g) Anaemia.

There were fourteen persons who suffered from anaemia. The majority of these were diagnosed as cases of pernicious anaemia. Secondary anaemia was also encountered, but, as this was commonly associated with malnutrition, it has been dealt with as a nutritional disorder.

It may be recorded in passing that, in respect of the cases of pernicious anaemia in the series, the disease had developed late in life. While many of the old persons had had the disease for several years, the first symptoms could, in all instances, be traced to their appearance at the age of at least 60 years.

Pernicious anaemia, in so far as it affected the old persons in the series, gives a brighter prospect than the other diseases more commonly encountered amongst the aged. Recovery and continued maintenance of good health can be achieved through recent advances in therapeutics. Once the disease has been diagnosed and response to treatment effected there is nothing to prevent the old persons from returning to their homes, or to the care of relatives. This is borne out by the case histories recorded below:-

(1) A man, aged 65, who complained of increasing weakness and lethargy of three weeks' duration, was admitted to hospital and found to be suffering from pernicious anaemia. He was employed as an engine-turner and had been forty-six years with one firm. His daughter kept house for him in their two-apartment home. He has been eight weeks in hospital and is progressing satisfactorily. It is his intention to return to work as soon as he is able.

(2) A man, aged 72, retired from his trade as a joiner/

joiner at the age of 65. He had been employed with the Railway Company for thirty-eight years. He had never been ill until the age of 60 when he complained of dizziness and weakness of the legs. He was found to be suffering from pernicious anaemia for which condition he received treatment in hospital. He returned to work and remained fit until two weeks ago when he again complained of weakness in the legs. He was admitted to hospital for treatment and has made good progress during his ten weeks' stay. He is anxious to return to his home - a three-apartment house - where he lives with his wife, who is 64, and his three children who are all employed. He is looking forward to resuming his pastimes. He is fond of gardening and is a member of the local Bowling Club.

(3) A man, aged 75, stated that he had always enjoyed good health until four weeks ago, when he suffered from shortness of breath and general weakness. He has worked hard all his life, beginning as a "half-timer" at the age of ten in the Rope Works where he earned 2/6d. per week. He followed several different occupations, but, in recent years, has only had casual work. He is a widower and lives in a three-room and kitchen house. He has two lodgers who have stayed with him for very many years. He has been in hospital for five weeks and appears to be making good progress. On recovery he wishes to return to his home.

(4) A man, aged 65, was admitted to hospital on account of his suffering from general malaise of four months' duration. He stated that he had never been ill before. He is a single man and lived in a one-apartment house, one stair up. There is a water supply in the room, but the lavatory is on the stair landing, and is shared by nine other tenants. His room is bright and sunny. He did his cooking on the fire but he had also a gas ring. He worked as a dealer and travelled the countryside with a horse and cart. During the war, owing to difficulties in securing supplies, he lost this means of earning a livelihood. He had lately been able to obtain only casual labouring work/

work. He is a decent-living old man who finds it difficult to live within his income. He stated that, after he had paid his rent, and met the cost of coals, gas and the cleaning of the outside stairs, there were only a few shillings left to purchase food. He did not drink nor bet. He smoked only one ounce of tobacco a week. He rarely went to the pictures. He stated that life was very lonely and that he would have very much liked a wireless set, but he could not buy one except by the hire purchase system, and he did not believe in getting into debt. On admission to hospital his general condition was found to be very poor. He was suffering from pernicious anaemia but is responding well to treatment and to the general care which he is receiving in hospital.

(h) Diabetes mellitus.

In the series of 550 cases, there were twelve cases of this disease, representing 2.2 per cent of the total. Although the numbers were small the individual investigation of these cases was most interesting and instructive. On the one hand, there were some cases in whom the body balance was maintained by strict adherence to diet and this was possibly due to the tranquillity of life imposed by nature on the aged and the absence of temptation in regard to excess in diet. There were other cases in whom the disease was kept under control by the administration of insulin with, of course, some dietetic restrictions. These cases also did well, but it is rather remarkable that the old persons showed little interest in the technique of insulin administration which was carried out by twice daily visits of the district nurse. It appears to the author that the faculty of administering insulin hypodermically decreases with advancing age.

In striking contrast, however, were three old diabetic persons suffering from the dread complications of this disease, namely, blindness and gangrene. It is lamentable to have to record that the diagnosis in these/

these cases was made only after admission to hospital and, in two of the cases suffering from gangrene, the ultimate treatment was amputation of the limbs.

A few examples of the cases of diabetes in old people are given hereunder:-

(1) A widow, aged 76, has been in the Cottage Homes for four years, and states that she has had diabetes for ten years. She is on a restricted carbohydrate diet to which she adheres conscientiously; she does not require insulin. She is an active person, undertakes all household duties and is kept fit by her strict adherence to diet, regular habits and absence of worry.

(2) A woman, aged 78, has been resident in the Cottages for almost seven years. Her diabetic condition was discovered at the age of 60. She requires five units of insulin twice daily. She, like the previous case, efficiently performs household tasks and her general health is sustained by the feeling of security which the Homes give her.

(3) A woman, aged 78, suffers from diabetes, the condition being diagnosed only four years previously when her leg was amputated on account of gangrene. Formerly she was a teacher. She is gradually growing blind. Lying all day on her back with little to occupy her time, she finds life dull and uninteresting. At home she had a low bed and could get up without assistance into a self-propelling chair. She used to sit up every afternoon and enjoyed looking out of the window. She has now been in the institution for a year. She shows great determination to overcome her disabilities, and would like to try her crutches. Unfortunately, the nurses have to perform multifarious duties which prevent them giving the individual attention which this deserving case really merits.

(4) A man, aged 78, has been resident in Crookston Home/

Home for two years. He was admitted to hospital suffering from gangrene of the foot and was then found to be suffering from diabetes mellitus. During the last year his sight rapidly deteriorated and now he is totally blind. He has been bedfast for the past month and there is little prospect of his ultimate recovery. The author was impressed by the pathetic aspects of this case. Sympathetic handling of the man could ameliorate his condition but the nurses have neither the time to deal with nor the knack of handling such a case. Regular visits by a sympathetic voluntary worker would do much to help this sufferer.

(5) A married woman, aged 62, developed diabetes nine years ago. She was admitted to a General Hospital and there was prescribed a diet which she followed for two years. Seven years ago she consulted her own doctor who advised the administration of five units of insulin before breakfast and ten units before supper. This was subsequently increased to ten and fifteen units respectively. She continued with the insulin treatment for three years, but discontinued it on the advice of a neighbour. She developed misty vision, became giddy and once again consulted her doctor who advised the injection of twenty-five units of insulin daily. Two years ago she was admitted to hospital on account of weakness and numbness of the legs. On discharge from hospital she returned to her home. but was re-admitted eight weeks ago, again on account of weakness and dizziness. The lesson to be learned from this case is that, when diabetes has been diagnosed and when it has been established that it can be controlled only by the administration of insulin, the spasmodic use of insulin brings only disaster in its trail.

(6) A woman, aged 70, has had diabetes mellitus for the past nine years, receiving twenty units of insulin daily. She lived alone, but her two married daughters lived nearby and looked after their mother, undertaking all the shopping and house cleaning. Ten months ago she was admitted to hospital as she had lost the power of her limbs. She is still bedfast and her condition has improved but it is doubtful whether this improvement/

improvement will be maintained as she does not adhere strictly to the prescribed diet. She says that, on her discharge from hospital, she will go to live with a married daughter, but will this be a good arrangement in view of the fact that the daughter and her husband, with their five children, live in a two-apartment house? The tranquillity so necessary for the continued well-being of the diabetic will assuredly be absent.

(i) Other illnesses.

The other types of illness found amongst the cases reviewed were chiefly those affecting the gastro-intestinal and genito-urinary systems. There were four cases of cholecystitis in women; three of them were in their early sixties and the fourth was seventy-two years of age. Cystitis, nephritis and pyelitis accounted for fourteen cases. Cystitis, associated with frequency of micturition and incontinence, was found to be commonly the reason which prompted the relatives to secure the admission of the old persons to hospital. A typical history is illustrated in the following case:-

A widow, aged 82, has been bedfast in hospital for five months. This is said to be her first illness. She gave up her house some time ago and went to reside with her daughter and son-in-law in a three-apartment house. As she was suffering from cystitis with incontinence, she was admitted to hospital. The cystitis has been cured and she no longer suffers from incontinence. The daughter, however, does not wish to have her mother home. The old lady is very unhappy. She says that she has been active all her life and likes to be doing things and there is nothing to do but grow gradually weaker lying in bed. Her desire to go home is so intense that her stay in hospital is producing a state of acute misery.

The remaining diseases met with amongst the old people are chronic

skin/

skin ailments, gastro-enteritis and gout. The case of gout has interesting features, the nature of employment being a contributory factor to the disease:-

> A man, aged 66, was admitted to hospital on account of pain and swelling of the feet. He left school at the age of ten and was ultimately apprenticed in the monumental marble trade. He later became an interior decorator in marble, but, with the decline in demand for such work, he returned to the monumental trade. He was employed cutting and polishing the marble. This work is carried out in yards or in sheds which provide little protection from the elements. In winter, the frozen marble sticks to the fingers. While most of the cutting is carried out by machinery, certain processes are performed by hand. The work is dusty, and, although masks are available, they are very seldom used. Dry oxalic acid is used for polishing, but protective gloves are not provided. He carried with him his mid-day meal which he ate at his bench. He washed his hands by dipping them in a pail of water. He had had no serious illnesses, other than treatment for gunshot wounds in 1918 and an operation for inguinal hernia in 1942. For the past eighteen months he has complained of pain and swelling of the feet. The pain was first experienced in the heel and later spread to both ankles. He received treatment for rheumatism and secured a larger size of boot. The pain became excruciating and he could not stand on his feet. He remained at home resting for two months, and, as the condition showed no improvement, he was admitted to hospital where the condition was diagnosed as gout. He lives with his wife and daughter in a three-apartment house. He is a moderate drinker and is partial to spiced and curried foods which attracted his palate during his war service. His condition is responding to treatment, and, if he follows strictly medical advice, the condition may not recur.

3. Mental Health. Advances in medicine in recent years have shown the all-important part which mental health plays in the life of the individual. It is therefore natural that, having completed the study of the physical state of/

of the persons under review, one should turn to the examination of their mental state.

The case histories of the 550 old people have shown clearly that the pattern of their lives was such as might have resulted in some degree of mental sickness. Poverty, unemployment, drudgery, insecurity, marital disharmony, filial ingratitude - all these might be expected to precipitate mental illness. Despite the heavy burden of miseries which many had to bear, investigation revealed that in 485, or 88.2 per cent of the cases, the mental state was normal.

The mental state in the various categories is recorded in the following Table:-

TABLE 25.

Mental State	Able-bodied	Frail	Bedfast or Chronic Sick	Acute Sick	TOTAL
Normal	156	183	83	63	485
Facile	1	1	1	-	3
Confused	-	7	34	-	41
Defective Memory	1	9	6	-	16
Pathological	-	2	3	-	5
TOTAL	158	202	127	63	550

Reference to the above Table shows that the mental state of all the able-bodied is normal, with the exception of one facile person and one person who suffered from defective memory. Amongst the frail, defective memory is found/

found in nine cases, and in seven persons there exists some degree of mental confusion. The deterioration of physical health to a state of frailty may be accompanied by a similar deterioration in the mental state, evidenced by a slowing of the intellectual processes which may gradually result in defective memory. Impairment of memory of the old person may be shown only in his difficulty in memorising names or in recalling recent events, but, in a severe manifestation, the impairment of memory may prevent the execution of tasks and so forgetful may the old person become that his very safety may be endangered. Serious impairment of memory is associated with mental confusion. Mental confusion is exhibited in various degrees and in extreme cases ends in complete disorientation. The largest number of confused persons appears in the chronic sick category. All the old patients admitted to hospital suffering from an acute illness were of normal mentality.

So far as conclusions can be drawn from the numbers surveyed by the author - and it is admitted that, for statistical purposes, the numbers are small - it is evident that impairment of the mental state is not definitely related to age.

In Table 26 is given the mental state of the old persons in the various age groups:-

TABLE 26.

Mental State	60-64 years	65-69 years	70-74 years	75-79 years	80-84 years	85 years and over	TOTAL
Normal	33	110	121	124	70	27	485
Facile	-	1	1	-	1	-	3
Confused	2	8	12	12	4	3	41
Defective Memory	1	-	3	5	5	2	16
Pathological	2	-	1	2	-	-	5
TOTAL	38	119	138	143	80	32	550

Reference/

Reference to this Table shows that, in the youngest age group, viz., 60 to 64 years, there are 38 persons, of whom 33 are of normal mentality; this represents 86.8 per cent of the cases of that group. In the four successive age-groups the cases number 119, 138, 143 and 80, equivalent to percentages of 92.4, 87.7, 86.7 and 87.5 respectively. Thirty-two persons were aged 85 years and over and twenty-seven of them, or 84.4 per cent, were of normal mentality.

The mental state was considered in relation to the medical illnesses from which the old persons suffered and these findings are set forth in the following Table:-

TABLE 27.

Mental State by Medical Diagnosis

Medical Diagnosis	Normal	Facile	Confused	Defective Memory	Patho-logical	TOTAL
Cardio-vascular disease	107	-	33	12	-	152
Respiratory disease	31	-	-	-	-	31
Nervous disease	12	-	1	-	3	16
Bone and joint disease or injury	64	-	2	2	-	68
Anaemia	14	-	-	-	-	14
Diabetes	11	-	1	-	-	12
Nutritional disorders	40	1	3	1	1	46
Neoplasms	15	-	1	-	-	16
Other diseases	19	1	-	-	1	21
No abnormal medical condition	172	1	-	1	-	174
TOTAL	485	3	41	16	5	550

Reference/

Reference to Table 27 shows that, of the 174 old persons who did not suffer from physical illness, there are only two cases in whom the mental state is impaired; one is a simple-minded person and the other has impairment of memory to a slight degree.

An abnormal mental state is found most commonly amongst those suffering from cardio-vascular disease. Cerebral haemorrhage and thrombosis result in the impairment of function and in a large number of cases involves both the mental and physical states.

The mental state of the persons resident in the various institutions is given in Table 28:-

TABLE 28.

Institution	Normal	Facile	Confused	Defective Memory	Patho-logical	TOTAL
Stobhill	174	1	15	2	-	192
Western District	36	-	4	-	1	41
Crookston Home	175	2	22	14	4	217
Cottage Homes	100	-	-	-	-	100
TOTAL	485	3	41	16	5	550

It will be seen from inspection of Table 28 that the residents in the Cottage Homes are all of normal mentality.

In Crookston Homes there are 22 confused cases and 14 with defective memory. Mental confusion is often aggravated by the admission of the old person to an institution. So long as the old person remains in a familiar environment/

environment he may be able to cope with his surroundings, but when he is taken into new and strange places he may become acutely distressed. Some degree of perplexity or confusion is to be expected in the early days following admission and it may be some time before he knows the position of the different rooms, his place in the dining room and his bed in the dormitory. The inability to grasp surroungings is the more readily understood when it is remembered that many old persons forced to enter the institution against their wish arrive in an emotionally distressed condition. It is not easy for the old person who has hitherto lived alone suddenly to assume communal life. Nor are his difficulties lessened when he enters a Home staffed by sisters and nurses. The very presence of uniformed personnel emphasises to him that he has entered upon a restricted and regimented mode of living and his anxieties are intensified by his fear of incurring the displeasure of those in command. His worries are further increased by the presence of other residents who are in the process of adjustment to institutional life and who may exhibit intense irritability at his mistakes. The new arrival has only to take the wrong place at the dining-table, lift someone's paper in the recreation room or ensconce himself in the oldest resident's acclaimed chair to bring down a storm of protest and to precipitate an emotional scene. On the other hand, it is often a kindly old resident who comes to the rescue and guides the new arrival through the intricacies of the administration of his new home. If a helping hand is not available then confusion becomes intensified and, as the anxieties increase, complete disorientation may ensue.

Old persons who do not exhibit confusion in other respects often show complete inability to grasp the location of the Home in relation to their/

their previous residence. As they are never competent to grasp the relationship and master new and strange bus and tram routes, they fear to leave the safety of the Home and are confined henceforth to its precincts. Thus is denied to the old person the solace of visiting old friends and the realisation that he is unable to bridge the gap of isolation fosters unhappiness and anxieties. The fear of losing himself may be so acute that he cannot be persuaded to take even short walks in the neighbourhood. Frequently, those in charge of the Home fail to appreciate these very real fears or limitations of the old person and peremptorily hustle him out-of-doors. When the old person meets with this unsympathetic attitude he can only resort to the subterfuge of physical inability to excuse him from non-compliance with their requests. This is a possible explanation of why so many able-bodied persons simply sit around indoors. Their inactivity is the more to be deplored since it denies to them the benefits of physical recreation.

The following are three typical examples of confused old persons in Crookston Home. Perusal of the cases will prove conclusively that they should not be kept in a Home for old people but should be resident in a special type of Home.

> (1) A woman, admitted a year ago, suffers from no physical disability but exhibits complete mental confusion. She was formerly employed as a clothing alteration hand. Her state of confusion is evidenced by her remark that "the ward is a light, airy workroom".
>
> (2) A woman, aged 72, has been in Crookston Home for three years. She has no physical disability but she does not know where she is nor can she give any information about herself. She does not recognise her visitors. She just sits in the ward smiling. The nursing sister states that she gives no trouble and that she appears to enjoy the ward parties/

parties.

(3) A woman, aged 70, has been in the Home for eighteen months. She suffers from cerebral thrombosis and is somewhat confused. She is docile but is kept in bed, although she is able to get up and go to the bathroom. Her restlessness - as shown by her moving furniture about, by putting her shoes in the bed and by her ceaseless activity - disturbs the other patients and the nursing staff consequently employ the device of keeping her in bed. She formerly resided with her two daughters who stated that they were afraid to leave their mother alone as she was so forgetful.

4. The State of Activity. Information has now been gained regarding the physical and mental illnesses from which the old persons suffer and it has been shown that in 174 cases no abnormal conditions are found to exist. These persons constitute the healthy old people and the majority of them are able-bodied. There are included in this number sixteen persons who could not be considered as fit to look after themselves in all respects and who, in consequence, are classified as "frail". In respect of the remaining 376 cases in whom evidence of definite illness is present, the incapacity produced by the diseases shows great variation. It is now proposed to study the old people in order to ascertain how far their disabilities restrict their mode of living.

(a) Degree of Mobility.

Practically one-half of the old people, viz., 278, are able to walk about unaided. There are 62 persons who use a stick and seven who require a wheelchair. The bedfast patients, numbering 190, comprise approximately one-third of the cases. This figure includes not only the 127 permanently bedfast or chronic sick persons, but also 63 patients suffering/

suffering from acute illness who were bedfast at the time of the survey. The state of activity of the cases in the various institutions is recorded in Table 29:-

TABLE 29.

State of Activity

Institution	Mobile	Mobile with stick	Mobile with Wheel-chair	Immobile	Bedfast	TOTAL
Stobhill	48	21	2	10	111	192
Western District	7	5	-	-	29	41
Crookston Home	123	36	5	3	50	217
Cottage Homes	100	-	-	-	-	100
TOTAL	278	62	7	13	190	550

The chief diseases restricting activity are found to be the cardio-vascular diseases and rheumatic conditions affecting the joints.

The following case histories illustrate the state of activity of the old people, some of whom, although in advanced years, have no disabilities. Some require assistance and use a stick or a wheel-chair.

(1) An engineer, aged 84, who asserted that he never had had a day's illness, had lived alone in his own home for five years, but on account of asthma was admitted to hospital. Whilst he was in hospital, his family decided that he should not in future live alone, and, on his discharge, they arranged for him to be admitted to Crookston Home. At the time of the author's survey, he had/

had been resident there for two years. He does not like the Home. He grieves that all his old ties have been severed; he complains that there is nothing for him to read and he does not find the company congenial. He does, however, take long walks of two or three miles every day if the weather is fine, and, during the summer months, he is never in except at mealtimes and at bedtime. This case is typical of the robust state of many old people in advanced years.

(2) The oldest person in the survey is a woman, aged 96 years. She lived alone in a three-roomed house since the death of her husband sixteen years ago. She has no family and no near relatives. Her admission to hospital four months ago was arranged by the neighbours who thought that at her age she should not be allowed to live at home. Up to the time of her admission to hospital, she undertook her own shopping, despite the fact that she lived on the top flat of a three-storey tenement. She has a good appetite and enjoys her food. She is somewhat lonely as she cannot read because of her failing vision. This case is given to illustrate the fact that even in very advanced years old persons retain their zest for living.

(3) A widow, aged 75 years, suffered from cerebral haemorrhage and gave up her house. The members of her family all offered her a home and she stayed first with one and then another, but the family in turn tired of her and she eventually went to reside in furnished rooms. As she could not afford the cost of upkeep of the rooms, she made application for admission to Crookston Home. She has slight impairment of function of the left side and walks with the aid of a stick. Outdoors, she can move briskly, but indoors she is afraid of falling on the polished floors.

(4) A man, aged 85 years, had worked as a rivetter until the age of 75. He had lived alone in his two-apartment house, two stairs up, since the death of his wife seventeen years previously. He found it difficult to manage the stairs as he suffers from an osteo-arthritic condition of the knees, particularly the right knee, and, on this account, he sought admission to Crookston Home. He walks with a stick and enjoys being out in the grounds. His dormitory is on the first/

first floor but he says he can climb the stairs provided he takes them very slowly. He admits that he would go out more often if it were not for his difficulty in manoeuvring the stairs.

(5) Two brothers, aged 87 and 78 years respectively, have been in Crookston Home for two years. Both brothers worked in the shipyards; the elder was a boiler-maker and suffers from defective hearing; the younger brother had been employed as a plater. In their youth they had played for Rangers football team, the elder as outside right and the younger as outside left. They lived together in a one-apartment house. The elder brother could no longer look after the house and the younger brother would not do so, so that there was no alternative but to seek admission to a Home for old people. The elder brother is a kindly old man who would have preferred to have lived at home. He deplores his brother's inability to keep house, but the latter, although not domesticated, has an infinite capacity for enjoying himself and he is rarely in the Home except for meals.

(6) A woman, aged 60, has been for six years in Crookston Home. She was admitted on account of her inability to live alone as she is afflicted with rheumatoid arthritis affecting chiefly the hip joints. The upper limbs are not involved and she uses a wheel-chair with dexterity. She states that, prior to her admission to Crookston Home, she was able to undertake most of her housework. She made the beds, washed the dishes, peeled potatoes and performed other domestic tasks. She enjoyed reading, mending and sewing. Her son is at present serving in His Majesty's Forces, but she states that on his discharge he intends to make a home for her. She lives only for her son's return and the possibility of a home of her own. This prospect sustains her spirit and keeps her in a consistently cheerful state of mind.

(b) Bedfast Patients.

Reference has been made to the fact that the bedfast patients constitute a third of the cases in the survey. It is felt that they should be specially studied in order to ascertain the degree of nursing care required/

required. The bedfast patients are investigated in order to ascertain to what extent they can care for themselves by way of washing and feeding and whether or not they are continent.

(i) The Ability of Bedfast Patients to Feed Themselves.

There are seven persons who are completely unable to feed themselves and eleven who experience difficulty in feeding, being only able to grasp a feeding cup. Feeding embarrassment was found in all age groups but in an increasing degree in the cases aged 85 years and over. The ability to partake of food in relation to age is detailed in Table 30:-

TABLE 30.

Patients' Ability to Feed Themselves

Age in years	Able	Unable	Able with difficulty	TOTAL
60 - 64	34	-	4	38
65 - 69	117	-	2	119
70 - 74	132	2	4	138
75 - 79	141	1	1	143
80 - 84	79	1	-	80
85 and over	29	3	-	32
TOTAL	532	7	11	550

The cases with feeding difficulties were encountered both in the hospitals and in Crookston Home. It will be seen by reference to Table 31 that three of the seven cases of patients requiring

to/

to be fed occurred in Crookston Home while, of the eleven persons who experienced great difficulty in feeding themselves, there were also two in this Home for old people.

TABLE 31.

Patients' Ability to Feed Themselves

Institution	Able	Unable	Able with difficulty	TOTAL
Stobhill	184	2	6	192
Western District	36	2	3	41
Crookston Home	212	3	2	217
Cottage Homes	100	-	-	100
TOTAL	532	7	11	550

The medical conditions in which feeding difficulties were met are given in Table 32. The predominating disease is cardio-vascular which accounts for five of the seven patients unable to feed themselves. A sixth case was that of advanced disseminated sclerosis and the seventh patient was suffering from an inoperable neoplasm. In other cases the difficulties in the patients' ability arose from cerebral vascular lesions, disseminated sclerosis and rheumatoid arthritis. The last named disease was predominating in respect of this disability.

Table 32//

TABLE 32.

Patients' Ability to Feed Themselves

Medical Conditions	Able		Unable		Able with difficulty		GRAND TOTAL	
	M.	F.	M.	F.	M.	F.	M.	F.
No disease	74	100	-	-	-	-	74	100
Cardio-vascular diseases	71	73	3	2	1	2	75	77
Respiratory diseases	21	10	-	-	-	-	21	10
Nervous diseases	7	7	-	1	-	1	7	9
Bone and joint diseases or injury	22	39	-	-	3	4	25	43
Anaemia	7	7	-	-	-	-	7	7
Diabetes	2	10	-	-	-	-	2	10
Nutritional disorders	23	23	-	-	-	-	23	23
Neoplasms	9	6	-	1	-	-	9	7
Other diseases	7	14	-	-	-	-	7	14
TOTAL	243	289	3	4	4	7	250	300

(ii) The Ability of Bedfast Patients to Wash Themselves.

The ability of the bedfast patients to feed themselves is retained long after they become unable to wash the face and comb the hair. In the survey there are 34 persons who are unable to wash themselves and of this number 20 are in hospital and 14 are residing in Crookston Home. The findings are/

are shown in Table 33:-

TABLE 33.

Patients' Ability to Wash Themselves

Institution	Able	Unable	TOTAL
Stobhill	180	12	192
Western District	33	8	41
Crookston Home	203	14	217
Cottage Homes	100	-	100
TOTAL	516	34	550

The ability of the patients to wash themselves is related to the medical diagnosis, and it is found that cardio-vascular lesions, disseminated sclerosis, paralysis agitans, rheumatoid arthritis are the diseases associated with the incapacity.

In the following Table is recorded the patients' ability to wash themselves in relation to the various diseases from which they suffer:-

Table 34/

TABLE 34.

Patients' Ability to Wash Themselves

Medical Conditions	Able		Unable		TOTAL	
	M.	F.	M.	F.	M.	F.
No disease	74	100	-	-	74	100
Cardio-vascular diseases	68	69	7	8	75	77
Respiratory diseases	21	10	-	-	21	10
Nervous diseases	6	7	1	2	7	9
Bone and joint diseases or injury	22	34	3	9	25	43
Anaemia	7	7	-	-	7	7
Diabetes	2	10	-	-	2	10
Nutritional disorders	23	23	-	-	23	23
Neoplasms	8	4	1	3	9	7
Other diseases	7	14	-	-	7	14
TOTAL	238	278	12	22	250	300

The ages at which these difficulties are encountered are recorded in Table 35. If the old persons are viewed in the following age-groups, viz., 85 years and over and 60 to 64 years, we find that the former group shows the greater proportion of cases having difficulty in self-ablution but that in the younger age-group the proportion is also high.

Table 35/

TABLE 35.

Patients' Ability to Wash Themselves

Age in years	Able	Unable	TOTAL
60 - 64	34	4	38
65 - 69	114	5	119
70 - 74	130	8	138
75 - 79	135	8	143
80 - 84	75	5	80
85 and over	28	4	32
TOTAL	516	34	550

(iii) State of Continence of Bedfast Patients.

Incontinence is not a common occurrence, its incidence in the total cases reviewed being less than four per cent. Its low incidence gives no indication of the importance of this state as it affects the individual. The incontinent person is amongst the most miserable of human beings, and especially to be pitied is the person in whom the mental acuity is high. Its occurrence increases the demand for nursing services and is often the decisive factor in determining the admission of the old person to hospital. Even with all goodwill it is impossible for the incontinent patient who is heavy to be nursed at home, for he requires trained nurses to lift him

for/

for the frequent changing which his condition demands. Amongst the bedfast patients there are 21 incontinent persons. The incidence and degree of incontinence is recorded for the various institutions in Table 36:-

TABLE 36.

Condition regarding Continence

Institution	Continent	Incontinent - Urine	Incontinent - Urine & Faeces	TOTAL
Stobhill	185	6	1	192
Western District	36	3	2	41
Crookston Home	209	6	2	217
Cottage Homes	99	1	-	100
TOTAL	529	16	5	550

Incontinence of urine occurred in 16 cases and of both urine and faeces in five cases. As is seen from the findings set out in Table 37, no relationship is established between age and continence.

Table 37/

TABLE 37.

Condition regarding Continence

Age in years	Continent	Incontinent - Urine	Incontinent - Faeces	Incontinent - Urine & Faeces	TOTAL
60 - 64	35	3	-	-	38
65 - 69	116	2	-	1	119
70 - 74	135	3	-	-	138
75 - 79	138	3	-	2	143
80 - 84	77	3	-	-	80
85 and over	28	2	-	2	32
TOTAL	529	16	-	5	550

The cases of incontinence were investigated and the condition of continence was determined in the various diseases occurring amongst the 550 cases. These findings are shown in Table 38:-

TABLE 38.

Condition regarding Continence

Medical/

TABLE 38.

Condition regarding Continence

Medical Conditions	Continent		Incontinent - Urine		Incontinent - Urine & Faeces		TOTAL	
	M.	F.	M.	F.	M.	F.	M.	F.
No disease	74	99	-	1	-	-	74	100
Cardio-vascular diseases	68	71	6	4	1	2	75	77
Respiratory diseases	21	10	-	-	-	-	21	10
Nervous diseases	7	8	-	1	-	-	7	9
Bone and joint diseases or injury	24	42	1	1	-	-	25	43
Anaemia	7	7	-	-	-	-	7	7
Diabetes	2	10	-	-	-	-	2	10
Nutritional disorders	23	22	-	-	-	1	23	23
Neoplasms	8	5	1	1	-	1	9	7
Other diseases	7	14	-	-	-	-	7	14
TOTAL	241	288	8	8	1	4	250	300

Cardio-vascular conditions are the chief diseases associated with incontinence and account for thirteen cases. Disseminated sclerosis is associated with urinary incontinence. Two advanced cases of rheumatoid arthritis suffer from urinary incontinence. Three patients in the terminal phases of malignant disease are incontinent/

incontinent. One man, admitted on account of neglect, was found to be suffering from general debility and urinary incontinence.

5. The State of Vision. In discussing the limitations of the old people in getting about, it should be kept in mind that impairment of other special senses, such as vision and hearing, may restrict their activities in many fields. To the elderly who suffer from blindness in advancing years is denied the pleasure of reading. Where the handicap develops late in life it often prevents the old person from enjoying physical recreation, except under guidance. Social activities are also restricted and the old person is dependent upon the goodwill and efforts of others for friendly contacts. Vision is classified into five categories, as follows:- (1) good; (2) defective; (3) seriously defective; (4) partially blind and (5) blind. In the category "good" are placed cases in whom there is no impairment of vision. In the "defective" group are classified those with defects which can be remedied by the provision of suitable spectacles. Those whose vision is stated to be "seriously defective" suffer from visual defects which cannot be remedied by spectacles. The "partially blind" suffer from visual impairment of such a degree that it constitutes a serious handicap and prevents them from finding their way about. The "blind" are those who have little or no vision. In Table 39 the vision of the old persons in the various institutions is stated in accordance with the above classification.

Table 39/

TABLE 39.

Vision

Institution	Good	Defective	Seriously Defective	Partially Blind	Blind	TOTAL
Stobhill	121	46	11	10	4	192
Western District	26	11	1	2	1	41
Crookston Home	92	101	11	10	3	217
Cottage Homes	59	37	3	1	-	100
TOTAL	298	195	26	23	8	550

There are 298 persons, representing 54.2 per cent of all cases, in whom vision is good. A further 195 have defective vision but the disability is of a minor degree in that the visual defect can be corrected with the provision of proper spectacles.

The state of vision at the different age periods was considered, and the factors are recorded in Table 40:-

TABLE 40.

Vision

Age in years	Good	Defective	Seriously Defective	Partially Blind	Blind	TOTAL
60 - 64	24	9	3	1	1	38
65 - 69	73	35	4	5	2	119
70 - 74	85	44	1	6	2	138
75 - 79	69	57	8	7	2	143
80 - 84	36	33	7	3	1	80
85 and over	11	17	3	1	-	32
TOTAL	298	195	26	23	8	550

It/

It is found that the proportion of persons with defective vision is highest in the oldest age-group but serious visual defects show no such trend. The visual state of practically 90 per cent of the old people enabled them to lead a perfectly normal life and did not prevent them from engaging in activities open to younger people.

The state of vision in the various medical diseases from which old people suffer is given in Table 41:-

TABLE 41.

Vision

Medical Conditions	Good		Defective		Seriously Defective		Partially Blind		Blind		TOTAL	
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
No disease	29	65	38	31	2	3	5	1	-	-	74	100
Cardio-vascular diseases	39	33	30	34	5	4	1	4	-	2	75	77
Respiratory diseases	13	6	6	3	-	-	2	1	-	-	21	10
Nervous diseases	3	3	2	5	-	-	1	1	1	-	7	9
Bone and joint diseases or injury	13	31	8	5	1	6	1	-	2	1	25	43
Anaemia	7	4	-	1	-	-	-	2	-	-	7	7
Diabetes	-	2	1	6	-	1	-	1	1	-	2	10
Nutritional disorders	12	14	9	4	1	3	1	1	-	1	23	23
Neoplasms	7	4	2	2	-	-	-	1	-	-	9	7
Other diseases	1	12	6	2	-	-	-	-	-	-	7	14
TOTAL	124	174	102	93	9	17	11	12	4	4	250	300

Visual/

Visual defects are shown to be highest in those cases suffering from cardio-vascular diseases.

6. The State of Hearing. Deafness is a great handicap to the aged. The deaf are forced to live in comparative solitude. The fear of traffic which he cannot hear may keep the old person a prisoner within the precincts of the institution. Communication with his fellows can only be accomplished by the employment of laborious devices.

For the purpose of this thesis, hearing is classified as (1) good; (2) defective; (3) seriously defective and (4) total deafness. Persons with no impairment of hearing are classified as having "good" hearing. Hearing is designated as being "defective" when the old person experiences slight difficulty in hearing but can readily comprehend when spoken to in a clear, slow and distinct manner. "Seriously impaired" hearing requires slow and deliberate speech; repetitions are frequent and commonly the voice has to be raised before words can be understood. The "deaf" are the persons who cannot hear and all communications have to be made in writing. None of those whose hearing is impaired uses hearing aids, and none is able to lip-read. The findings in respect of the hearing ability of the cases in the various institutions are shown in Table 42:-

TABLE 42.

Hearing

Institution	Good	Defective	Seriously Defective	Deaf	TOTAL
Stobhill	179	11	2	-	192
Western District	36	1	2	2	41
Crookston Home	188	17	6	6	217
Cottage Homes	95	2	2	1	100
TOTAL	498	31	12	9	550

Impairment/

Impairment of hearing is less frequently encountered than visual defects. Reference to this Table shows that hearing is good in 90.5 per cent of cases. Slight impairment of hearing is present in 31 persons. The defect is serious in 12 cases and nine persons are completely deaf. As in the case of vision, impairment of hearing was found to increase with age.

The condition of hearing in the different age-groups is recorded in the subjoined Table.

TABLE 43.

Hearing

Age in years	Good	Defective	Seriously Defective	Deaf	TOTAL
60 - 64	35	3	-	-	38
65 - 69	111	5	2	1	119
70 - 74	128	4	2	4	138
75 - 79	128	11	2	2	143
80 - 84	71	4	4	1	80
85 and over	25	4	2	1	32
TOTAL	498	31	12	9	550

7. Recreational Activities. Finally, the manner in which the old persons occupy their leisure hours was reviewed. Enquiries were made with a view to ascertaining to what extent interests and pursuits had been engaged in by the old persons prior to their admission to the institution. Recreational activities/

activities are grouped into (1) physical; (2) cultural and aesthetic; (3) social and (4) handicrafts. The term "recreational activities" is interpreted widely, and if the old persons do no more than read a newspaper or listen to the news broadcast they are regarded as having cultural interests. If they do no more than take short walks in the grounds of the institution they are regarded as enjoying physical recreation.

(a) Physical Recreation.

While the ability of old persons to indulge in physical recreation is dependent upon their degree of mobility, there are many able-bodied persons who do not undertake physical recreation. In Table 44 appear the physical recreational activities in relation to the state of activity of the old persons

TABLE 44.

Physical Recreation undertaken by the Old Persons

State of Activity	Formerly only	During Residence only	Formerly and during Residence	Never	TOTAL
Mobile	57	18	172	31	278
Mobile with stick	27	-	2	33	62
Mobile with wheel-chair	1	-	-	6	7
Immobile	8	-	-	5	13
Bedfast	101	-	-	89	190
TOTAL	194	18	174	164	550

192

The number of persons who can get about without assistance amounts

to/

to 278, but only 192, including two old persons who use a stick, enjoy going out for walks; 18 persons have taken up walking since admission and 172 persons who had been in the habit of going for walks prior to admission continue to do so after entering the institution. There are 57 active persons who have discontinued exercise since their entry to the institution and 31 old persons who did not previously participate in physical recreation and have no inclination to take it up since their admission. An explanation of why these 88 persons, representing 31.7 p er cent of the active old people under review, should not undertake physical recreation is therefore sought. It is found that some of these active old people are in the wards of a general hospital where no facilities for physical recreation are available. Others, in Crookston Home, placed in a dormitory on the first or second floors have discontinued their daily walk as they do not feel able to climb the stairs. It is noted also that many old people have lost the incentive to go walking; such persons have come to regard themselves as "finished" from the time of their admission to a Home for old people and therefore incapable of making the slightest effort. The attitude of "giving up" is particularly significant amongst the old people who have been placed in the Home by their relatives against their wishes. Broken in spirit, they sit around impassively. Little encouragement is given to old people to take walks if their outdoor garments are not readily available. Often a much-desired walk is abandoned because of the formalities to be gone through before the old person can secure his coat from the cloakroom to which the nurse alone has entry.

The impairment of vision does not operate alone to exclude the old person/

person from the enjoyment of physical recreation, but, where seriously defective vision is accompanied by a physical handicap, however slight, the old person is denied physical recreation.

TABLE 45.

Physical Recreational Activities having regard to Vision

Vision	Formerly only	During Residence only	Formerly and during Residence	Never	TOTAL
Good	105	9	94	90	298
Defective	68	9	68	50	195
Seriously defective	9	-	5	12	26
Partially blind	9	-	5	9	23
Blind	3	-	2	3	8
TOTAL	194	18	174	164	550

Physical recreation as it is affected by hearing is described in Table 46.

TABLE 46

Physical Recreational Activities having regard to Hearing

Hearing	Formerly only	During Residence only	Formerly and during Residence	Never	TOTAL
Good	169	15	161	153	498
Defective	15	-	9	7	31
Seriously defective	7	2	-	3	12
Deaf	3	1	4	1	9
TOTAL	194	18	174	164	550

It/

It is seen from the above Table that, of the 12 cases in whom hearing is seriously impaired, only two persons undertook any form of physical recreation. The totally deaf number nine, and of these, five persons went out walking but rarely ventured out of the grounds. It is not commonly appreciated that the deaf because of their handicap are deprived of the simple pleasures of physical recreation.

The amount of physical recreation undertaken by old people was found to be extremely varied. There are many whose faltering steps lead them no further than the nearest seat in the grounds. Others, again, have made walking their pastime and think nothing of braving the wintry elements for their five mile daily walk. Bowls are a favourite pastime for both men and women and give a vicarious enjoyment to those who play the part of spectators.

(b) Cultural and Aesthetic.

Reading provides a desirable and necessary diversion for many. The interest of some is merely cursory and they do no more than glance at the headlines of the newspaper. Others have an avid appetite for literature which the meagre contents of the institutional library cannot satisfy. Possibly one of the most pathetic features of the survey is the fact that many old persons wish to read but are unable to do so because of failing vision which cannot be corrected by the provision of spectacles. Many experience a desire for someone to read to them. Others painstakingly pick out the words with a magnifying glass.

Radio broadcasts do not make a universal appeal. Bedridden patients, in wards where earphones are not provided, complain that the radio is played continually/

continually, and that the noise makes their heads ache. It is found that few old people care for the radio programmes. They find the patter of the artistes too quick and many of the features seem to them to be meaningless jargon. Generally speaking, only the old-time melodies are acceptable. Even in respect of the news broadcasts, interest is usually limited to home affairs, and persons resident in the Home for a number of years lose touch with the world so that the international situation is quite beyond their grasp and outwith their interest. The statement, corroborated by many old people, that the radio is played all day long because the nurses like it is illuminating and shows clearly that the old people certainly find little pleasure in it. It appears that there is a need for specially selected programmes for the aged. An "Old People's Hour" with old-time melodies and songs, readings from old books and from familiar plays would undoubtedly bring much pleasure to many. It is found that the blind take an intense interest in broadcasts. This is readily understood when one considers how much in other fields is denied them.

(c) Social.

Social recreational activities are of a diverse nature. They include the visiting of friends and relatives outside the institutions, participation in games of billiards and dominoes, whist drives and the simplest forms of social intercourse, such as conversing with fellow residents in a pleasurable fashion. It is found that 191 persons enjoy social intercourse and six persons have participated in social activities since admission; a total of 197 persons, representing 35.8 per cent, enjoy social recreational activities/

activities. Such a low percentage might suggest that an asocial sample has been chosen for the survey, but reference to the following Table shows that 310 persons, representing 56 per cent, have previously been engaged in social activities. These figures prove, as does the author's experience, that the desire for social recreational activities is impaired and in many cases disappears when old persons enter institutions.

Deafness also excludes the old people from contact with their fellow beings. Reference to Table 47 shows that seven deaf persons who enjoyed social intercourse prior to institutional residence are no longer able to participate in any form of social activity.

TABLE 47.

Social Recreational Activities in relation to Hearing

Hearing	Formerly only	During Residence only	Formerly and during Residence	Never	TOTAL
Good	279	6	176	37	498
Defective	18	-	11	2	31
Seriously defective	6	-	4	2	12
Deaf	7	-	-	2	9
TOTAL	310	6	191	43	550

Blindness operates as a bar to social contact to a more limited extent. The blind person makes many friends, and it is only the blind person who is mentally confused or in other ways disabled who does not enjoy social activities/

activities.

(d) Handicrafts.

Handicrafts are enjoyed only by one-fifth of the old persons. Knitting is the chief occupation of the women. Some like to sew and a few showed with pride the dresses and coats they had made. Dressmaking is not easy in an institution. The task of cutting cloth to a pattern is an involved and lengthy process, but, despite the difficulties, one lady was found to be busily occupied cutting out a dress on the ward table. In the Cottage Homes dressmaking presents no such difficulties.

There are no handicrafts amongst the men, although many had been skilled craftsmen in their youth. It is surprising to find that 344 persons, equivalent to 62.2 per cent of cases, had never been interested in handicrafts. It is during youth that hobbies should be cultivated for the enjoyment of leisure in later years. If hobbies are not cultivated in youth there is little likelihood of them being enjoyed in later years. Table 48 shows that visual defects restrict recreational activity.

Fine sewing previously enjoyed could no longer be performed, but failing eyesight can be compensated for by the introduction of those handicrafts which make no strain upon the eyes.

TABLE 48.

Handicraft Recreational Activities of the Old Persons

Vision	Formerly only	Formerly and during Residence	Never	TOTAL
Good	50	79	169	298
Defective	31	31	133	195
Seriously defective	7	2	17	26
Partially blind	4	-	19	23
Blind	2	-	6	8
TOTAL	94	112	344	550

PART III.

THE FUTURE OF THE OLD PERSONS

1. The prospect of improvement in general health.

2. The need for segregation.

3. Requirements on leaving the institution.

4. The ability to live outside the institution.

5. The old persons' choice of residence.

    (a) Own home
    (b) Lodgings
    (c) Common lodging house
    (d) Attitude of relatives
    (e) Place of the Cottage Homes

6. The old persons' capabilities for work and leisure.

7. The state of contentment.

PART III.

THE FUTURE OF THE OLD PERSONS

In the previous two sections of the thesis, the author has dealt in some detail with the various factors which led to the admission of the old persons to the Hospitals or the Homes. The physical and mental conditions of the old persons were discussed, as also was the part they could play in relation to recreational activities. So far their past and their present have been dealt with fully, and it now remains to consider the future of the old persons. Their outlook was reviewed in the light of their health prognosis, their requirements and their wishes. This part of the study is concerned primarily with the investigation into the factors which secured the contentment of the old persons in their placing. It was hoped that there might emerge certain guiding principles which, if followed, would help to solve the problems of the aged.

1. The Prospect of Improvement in General Health. The cases have been examined in order to predict, as far as possible, what future lies before the old persons. For the expectation of life a three-fold classification has been adopted. In the first category are placed cases for whom there is no likelihood of improvement in the state of health. The second category consists of cases for whom early relapse will almost certainly follow such improvement as may take place. The third category is reserved for persons for whom there is a prospect of a few years of reasonably good health. In the last category are found many able-bodied and frail persons, but, in addition, there are also those suffering from acute illness for whom there is every likelihood of recovery. In this assessment the health prospect has been/

been taken as a few years, but the years to be enjoyed will, in certain cases, be very many indeed. In Table 49 is recorded the prospect of improvement in health in the various age groups:-

TABLE 49.

Prospect of Improvement in General Health

Age in years	No prospect	Prospect, with likelihood of early relapse	Prospect of a few years' reasonable health	TOTAL
60 - 64	9	7	22	38
65 - 69	27	15	77	119
70 - 74	26	12	100	138
75 - 79	31	8	104	143
80 - 84	16	8	56	80
85 and over	7	1	24	32
TOTAL	116	51	383	550

The Table shows that 383 persons, representing 69.6 per cent, had a prospect of a few years of reasonably good health. This number includes 184 persons who are 75 years of age and over, and, in fact, 80 of them have passed their eightieth birthday. Amongst those of 85 years and over there is a positive outlook of good health for 24 cases, representing 75 per cent of that age group. Thus, it is clear that, in making provision for old people, planners must bear in mind that old persons who have reached the advanced age of 85 have a prospect of future life which merits careful consideration/

consideration. The future health prospect has been further reviewed in relation to the period of time which the old persons have already spent in institutions. These facts are recorded in Table 50:-

TABLE 50.

Duration of Stay in Institutions

Prospects of Improvement in General Health	Under 1 month	1 - 6 months	7 - 12 months	1 - 2 years	3 - 5 years	6 - 10 years	Over 10 years	TOTAL
No prospect	10	25	10	33	25	10	3	116
Prospect, with likelihood of early relapse	7	22	7	9	6	-	-	51
Prospect of a few years' reasonable health	69	95	28	67	53	64	7	383
TOTAL	86	142	45	109	84	74	10	550

From this Table it will be seen that of the ten persons who have been more than ten years resident in institutions, seven have a prospect of a few years of good health, and of the 74 persons who have been resident for periods ranging from six to ten years, there are only ten persons for whom there is no prospect of physical betterment.

The prospect of improvement in relation to the diseases from which the old persons suffer have also been investigated. In this connection reference should be made to Table 51 which follows:-

Table 51/

TABLE 51.

Prospect of Improvement in General Health

Medical Condition	No prospect	Prospect, with likelihood of early relapse	Prospect of a few years' reasonable health	TOTAL
No disease	-	-	174	174
Cardio-vascular diseases	63	27	62	152
Respiratory diseases	-	2	29	31
Nervous diseases	9	1	6	16
Bone and joint diseases or injury	26	8	34	68
Anaemia	-	1	13	14
Diabetes	3	2	7	12
Nutritional disorders	1	6	39	46
Neoplasms	13	3	-	16
Other diseases	1	1	19	21
TOTAL	116	51	383	550

In the case of cardio-vascular diseases the ultimate prognosis in many instances is grave, but, in 62 cases, or 40.9 per cent, of those with cardio-vascular lesions, the prognosis is good. Respiratory diseases are associated with a good prognosis. It has been emphasised that many such conditions have frequently had their origin in the bad environment in which the old persons lived, and, although for these cases the prospect of clinical recovery/

recovery is good, it should be kept in mind that early relapse may be precipitated by return to unsatisfactory home conditions. The outlook amongst those suffering from diseases of the bones and joints is varied. In many cases of established rheumatoid arthritis permanent improvement is unlikely; in others only temporary improvement seems possible, whilst in another group the crippling manifestations of the disease are slight and the prospect of reasonably good health exceptionally good. The prospect is also good in such diseases as nutritional disorders, diabetes and anaemia for which appropriate treatment may effect a cure.

2. The Need for Segregation. During the classification of the old persons in relation to their health prospect, it was found that there was no segregation of old persons according to their state, either physical or mental. The acutely sick, the bedfast, the mentally confused, the emotionally unstable, the epileptic, the blind, the frail and the able-bodied were all housed in one institution. This system in which the sick and the healthy are closely associated must be unreservedly condemned. Within the past twenty years it has gradually been realised by all hospital administrators that effective treatment and care can be provided only in "one-purpose" institutions, each type of case being cared for in a separate institution or in a separate block of an institution. The recovery of those suffering from acute illness is perceptibly impeded by the presence of the mentally unstable whose ceaseless activity or emotional crises upset the necessary calm of the institution. The confused patient who wanders around the ward through the night not only disturbs the sleep of the sick patients but the very presence of the mentally abnormal individual/

individual upsets the waking hours of the others and retards their recovery. Nor can one find a single laudatory explanation why normal healthy old persons should sleep in the same ward as chronic sick persons for whom there is no prospect of recovery.

The author made an endeavour to determine whether segregation was necessary and the grounds upon which the need for segregation was founded. In Table 52 are set forth these findings:-

TABLE 52.

Necessity for Segregation from normal Old Persons

Classification	None required	Necessary on account of physical condition (temporarily)	Necessary on account of physical condition (permanently)	Necessary on account of mental condition	Necessary on account of mental & physical condition	TOTAL
Able-bodied	158	-	-	-	-	158
Frail	188	3	1	9	1	202
Bedfast or chronic sick	-	2	94	6	25	127
Acute sick	-	61	2	-	-	63
TOTAL	346	66	97	15	26	550

Segregation is advocated on account of the mental or the physical state, but, in respect of physical conditions necessitating segregation, the cases are classified according to whether this condition is of temporary or of permanent/

permanent duration. It is seen from Table 52 that the able-bodied are all normal old people. Most of the frail are not debarred from living with normal old people. A certain number suffer from acute illness, from which it is hoped that recovery will take place and that they will revert to their usual state of health. The chief condition which calls for segregation amongst the frail is the presence of mental confusion. A great strain is imposed upon old people of normal mentality when they have in their midst a confused person. Quite commonly the admission of an old person to an institution is sought by his relatives on account of their being unable to contend with his abnormal behaviour which is created by his confused state of mind. When such a person is placed in an institution he is forced into the company of strangers and his confusion is thereby intensified.

With regard to the necessity for segregation on account of physical defect, it is found that there are many bedfast patients who are able to enjoy a measure of happiness although confined to bed. Such patients are mentally normal and are confined to bed because of some physical disability; they may enjoy wireless programmes, books, occupational therapy, calls by visitors and the conversation of the old persons in adjacent beds. If there is placed in an adjoining bed a patient in whom mental abnormality exists then great distress and unhappiness may be occasioned. Many bedfast patients are caused much misery in the closing phases of their lives by propinquity with patients suffering from mental conditions.

The mental state in relation to the necessity for segregation is shown in Table 53:-

Table 53/

TABLE 53.

Necessity for Segregation from normal Old Persons

Mental State	None required	Necessary on account of physical condition (temporarily)	Necessary on account of physical condition (permanently)	Necessary on account of mental condition	Necessary on account of mental & physical condition	TOTAL
Normal	334	66	84	-	-	484
Facile	1	-	-	2	1	4
Confused	-	-	7	9	25	41
Defective memory	10	-	6	-	-	16
Pathological	1	-	-	4	-	5
TOTAL	346	66	97	15	26	550

It is apparent that a confused mental state is the chief condition calling for segregation and there are nine cases where mental confusion would be the sole reason for this action. In addition, however, there are 25 cases who suffer from physical disabilities which render them unsuitable for mixing with normal old persons. In seven cases the mental confusion present is of such a mild variety as not to debar them from free association with the ordinary old. Defective memory, of which there are six cases, does not call for segregation. There are four cases of mentally subnormal persons, two being of such low mental ability that provision should have been made for them in an institution for mentally handicapped persons. In Table 54 is detailed the/

the need for segregation in relation to the diseases from which the old persons suffer:-

TABLE 54.

Necessity for Segregation from normal Old Persons

Medical Condition	None required	Necessary on account of physical condition (temporarily)	Necessary on account of physical condition (permanently)	Necessary on account of mental condition	Necessary on account of mental and physical condition	TOTAL
No disease	174	-	-	-	-	174
Cardio-vascular diseases	54	25	43	10	20	152
Respiratory diseases	11	19	1	-	-	31
Nervous diseases	7	-	5	3	1	16
Bone and joint diseases or injury	38	3	25	-	2	68
Anaemia	9	5	-	-	-	14
Diabetes	5	3	4	-	-	12
Nutritional disorders	35	4	4	1	2	46
Neoplasms	1	-	14	-	1	16
Other diseases	12	7	1	1	-	21
TOTAL	346	66	97	15	26	550

In/

In the groups of diseases specified in Table 54, it is seen that, with the exception of nervous diseases and neoplasms, there are 66 cases in whom the illness is such as to necessitate only temporary segregation. Permanent segregation, on account of the physical condition or mental condition, or both, is necessary in 138 cases and this constitutes 25.1 per cent of all cases. The figures for permanent segregation in cardio-vascular lesions are 73, in nervous diseases 9, in bone and joint conditions 27, and in nutritional disorders 7, giving the respective percentages of 48.0, 56.3, 39.7 and 15.2. Anaemias do not call for permanent segregation, but in all cases of neoplasms, save one, permanent segregation is recommended.

Reference to this Table also shows that 346 old people do not require segregation. Of these 174 do not suffer from any apparent disease. There are 54 affected by cardio-vascular lesions; 38 suffer from bone and joint ailments and 35 from nutritional disorders. Other ailments, such as chronic bronchitis, anaemia, diabetes and infantile paralysis, do not incapacitate to such an extent as to call for segregation. There is also included in this category one case of neoplasm in which the performance of colostomy enabled the old person to resume life with normal old people, if only for a temporary period.

The need for segregation as affected by age is set forth in Table 55:-

Table 55/

TABLE 55.

Necessity for Segregation from normal Old Persons

Age in years	None required	Necessary on account of physical condition (temporarily)	Necessary on account of physical condition (permanently)	Necessary on account of mental condition	Necessary on account of mental & physical condition	TOTAL
60-64	16	9	8	4	1	38
65-69	57	31	25	3	3	119
70-74	91	17	19	6	5	138
75-79	103	5	24	2	9	143
80-84	55	3	17	-	5	80
85 and over	24	1	4	-	3	32
TOTAL	346	66	97	15	26	550

It is interesting to note that the need for segregation does not increase with advancing age as is illustrated by 16, or 42.1 per cent, in the 60-64 age-group not requiring segregation, as compared with 55, or 68.7 per cent, in the 80-84 age-group. Amongst those of 85 years and over 24, or 75 per cent, of the cases do not require segregation from normal old people.

The need for segregation in relation to the duration of stay in the institution is recorded in Table 56:-

Table 56/

TABLE 56.

Necessity for Segregation from normal Old Persons

Duration of stay in institutions	None required	Necessary on account of physical condition (temporarily)	Necessary on account of physical condition (permanently)	Necessary on account of mental condition	Necessary on account of mental and physical condition	TOTAL
Under 1 month	47	27	10	1	1	86
1 - 6 months	76	28	28	3	7	142
7 - 12 months	25	9	5	2	4	45
1 - 2 years	74	1	22	6	6	109
3 - 5 years	53	1	22	3	5	84
6 - 10 years	64	-	7	-	3	74
Over 10 years	7	-	3	-	-	10
TOTAL	346	66	97	15	26	550

Amongst those who have been resident for less than a year little more than half of them are regarded as suitable for life with normal old persons, whereas, amongst those who have been resident for long periods, for example, for six to ten years, 64 or 86.5 per cent are regarded as able to live with ordinary old people. There are ten persons who have been in the institutions for more than ten years and seven of these are classified as being able to join in the community life of the Home. These facts are of interest/

interest in that they show the necessity of classifying persons prior to their admission to Homes for the aged so that the residents may not be distressed by the admission of persons who, in addition to the handicap of years, suffer from such mental enfeeblement as will interfere with the necessary quietude of the Homes.

3. Requirements on Leaving the Institution. It has been shown that in the 550 cases reviewed 383 have a prospect of improvement in general health and that 346 persons do not require to be segregated. There are also 66 persons who should be segregated on account of an acute illness, but it is hoped that this segregation will be only of a temporary nature as they are likely to regain their health. The author then considered that it would be of benefit to carry out a further investigation with a view to ascertaining what degree of medical or nursing care, if any, would be required for those old persons who were considered able to leave the institution.

The needs of the old persons in respect of special care and after-care are grouped as follows:-

Nature of Care Required	Number of Cases
Permanent medical care . . .	35
Permanent medical and nursing care .	158
Occasional medical care . . .	169
Occasional medical and nursing care .	53
None required	135
TOTAL .	550

This/

This after-care is related to the old persons' ability to live outside the institution and the findings are recorded in the following Table:-

TABLE 57.

Ability to live outside Institutions

Requirements on leaving institutions	Able	Unable	Able - under sheltered conditions	TOTAL
Permanent medical care	2	10	23	35
Permanent medical and nursing care	-	158	-	158
Occasional medical care	19	15	135	169
Occasional medical and nursing care	-	9	44	53
None required	111	-	24	135
TOTAL	132	192	226	550

With regard to the 132 cases who are classified as fit to live outside the institution, there are no fewer than 111 persons, representing 84.1 per cent of these cases, who are not in need of any supervision. They are all persons who enjoy relatively good health. They have suffered from no serious illness, and many even allege that they have never had a day's illness in their lives. The statement by an old person that he has never had a day's illness in his life must be regarded with some degree of reservation because not infrequently there are unintentional inaccuracies in the memories of/

of the aged. Many have memories for long past events, while others enjoy clarity only as regards recent happenings. Those who have had considerable experience with the aged will have undoubtedly encountered several very old people who have boasted of their advanced years and tended to exaggerate them. In the same way there is a tendency amongst the aged unconsciously to magnify their continued absence of ill-health. There are two persons in the "able" category who will require permanent care on account of cardiac disease and 19 persons for whom occasional medical care may be necessary in view of previous illnesses during recent years or on account of extreme old age. In the group of 226 cases who would require to live under sheltered conditions, the number for whom medical or nursing care is not required is small and amounts only to 23 and includes able-bodied men who do not suffer from any physical frailty but are incapable of looking after a home. In the group "able to live under sheltered conditions", the majority, numbering 135, will require occasional medical care; they are composed chiefly of frail persons, but include certain able-bodied persons who are aged 75 years and over. It was decided that persons over 75 years leaving the institution should be regarded as requiring occasional care in view of their advanced years. Occasional medical and nursing care are required by 44 persons suffering from such diseases as anaemia, diabetes and cardio-vascular lesions. One hundred and ninety-two cases, classified as unfit to live outside institutions, are all in need of care which, for 158, representing 82.3 per cent of these cases, constitutes permanent medical and nursing care.

The after-care of the cases was analysed in respect of the various institutions in which the old persons were accommodated and details in this connection appear in the subjoined Table:-

Table 58/

TABLE 58

Requirements on leaving Institutions

Institution	Permanent Medical Care	Permanent Medical and Nursing Care	Occasional Medical Care	Occasional Medical and Nursing Care	No care required	TOTAL
Stobhill	20	75	68	27	2	192
Western District	5	16	16	4	-	41
Crookston Home	10	67	69	16	55	217
Cottage Homes	-	-	16	6	78	100
TOTAL	35	158	169	53	135	550

In the Stobhill series of 192 cases, in only two instances is complete recovery anticipated. The majority of these cases require permanent medical and nursing care and number 75. There are 20 persons who would require permanent medical care and 68 persons whose recovery is such as to necessitate probably only occasional medical care.

Among the 41 cases in the Western District Hospital, after-care of one kind or another is considered essential.

In Crookston Home practically one-fourth of the cases require no after-care, but 67 persons, representing 30.9 per cent of the persons in the Home, require permanent medical and nursing care.

In the Cottage Homes the majority require no special care; here, there are 16 persons for whom occasional medical care is advocated on account of their advanced age, and six persons, suffering from diabetes or pernicious anaemia, receive occasional medical and nursing care.

The degree of medical care associated with the various diseases

from/

from which the old persons suffer is detailed in Table 59:-

TABLE 59.

Requirements on leaving Institutions

Medical Condition	Permanent Medical Care	Permanent Medical and Nursing Care	Occasional Medical Care	Occasional Medical and Nursing Care	No Care required	TOTAL
No disease	-	-	39	2	133	174
Cardio-vascular diseases	20	77	44	10	1	152
Respiratory diseases	3	2	24	2	-	31
Nervous diseases	1	11	1	3	-	16
Bone and joint diseases or injury	6	37	11	13	1	68
Anaemia	4	1	3	6	-	14
Diabetes	-	4	-	8	-	12
Nutritional disorders	-	9	30	7	-	46
Neoplasms	1	15	-	-	-	16
Other diseases	-	2	17	2	-	21
TOTAL	35	158	169	53	135	550

It will be noted that of the 174 cases in whom no disease was found, occasional medical care is advocated in 41 instances. This is deemed advisable in view of the age of the persons, and in two cases nursing care might/

might in addition be necessary as the persons in question were both over 94 years of age.

In cardio-vascular lesions the type of after-care varies in accordance with the severity of these lesions. The diseases of the nervous system amongst the old people in the Homes are grave in character and require permanent medical and nursing care. Rheumatic conditions vary in severity and most of the sufferers require permanent medical and nursing care. Similarly, as regards anaemia, the type of the disease and the ages of the patients are all-important in assessing the after-care needs. In nutritional disorders after-care is very important in order to prevent a recurrence of the condition. There are 37 cases in which occasional medical care is required, and for seven of these nursing care may in addition be necessary. There are nine patients, however, where recovery from the effects of grave malnutrition is not hopeful, and for these permanent care is essential. There are 12 cases of diabetes, eight of whom would require occasional medical and nursing care. Four diabetic patients suffer from severe complications, for example, blindness and gangrene of the leg, and these conditions necessitate permanent medical and nursing care. All cases suffering from neoplasms are regarded as in need of permanent medical and nursing care, with the exception of one man who suffers from bowel carcinoma and in whom a colostomy had been successfully performed. The general condition of the colostomy case is such that, in the event of his discharge from the institution, medical care would be necessary, but he would not require nursing assistance.

In the light of the information available in respect of the assessment of after-care, it was deemed advisable to review the cases in relation to/

to the factors which had led to their admission to the institutions and the findings are shown in the following Table:-

TABLE 60.

Predominating Factors determining admission to Hospital or Institution

Requirements on leaving Institution	No one to look after old persons	Ill	No home	Financial difficulties	Unwanted by relatives	Own volition	TOTAL
Permanent medical care	-	31	-	1	3	-	35
Permanent medical and nursing care	33	83	4	4	33	1	158
Occasional medical care	17	83	9	21	31	8	169
Occasional medical and nursing care	7	22	4	3	14	3	53
No care required	2	2	14	31	41	45	135
TOTAL	59	221	31	60	122	57	550

As regards the 135 persons who do not require after-care, 45 had entered the institution of their own volition, for the most part to take up residence in the Cottage Homes. An almost equally large number had sought refuge in the institution as they were unwanted by their relatives. There are 14 persons who had no home and 31 who had no means. Thus it is obvious that the disposal of the aged cannot be viewed simply in terms of after-care.

Consideration/

Consideration requires to be given to the factors leading to the admission of cases to the institution as many of these same factors will operate to prevent the old persons leaving the institution although they are not in need either of medical or of nursing care.

The duration of stay in the institution gives no indication of the amount of after-care required. In Table 61 the degree of after-care is related to the period of residence in the institution:-

TABLE 61.

Duration of Stay in Institutions

Requirements on leaving institution	Under 1 month	1 - 6 months	7 - 12 months	1 - 2 years	3 - 5 years	6 - 10 years	Over 10 years	TOTAL
Permanent medical care	5	16	7	4	1	2	-	35
Permanent medical and nursing care	13	40	13	41	34	13	4	158
Occasional medical care	45	49	12	23	18	16	6	169
Occasional medical and nursing care	14	15	3	7	8	6	-	53
No care required	9	22	10	34	23	37	-	135
TOTAL	86	142	45	109	84	74	10	550

In respect of the ten persons who have been more than ten years in the institutions, permanent medical and nursing care is required for four bedfast patients; occasional medical supervision is recommended for the remaining/

remaining six persons, although healthy, as it is felt that after ten years of the routine medical supervision in Crookston Home it would not be proper to discontinue medical care. There are 74 persons who have been resident for periods varying from six to ten years, and, of these, 37 are healthy and not in need of after-care. It is, of course, probable that the routine care received during this long period of institutional stay contributed decisively to the physical wellbeing of the residents.

4. The Ability to live outside the Institution. It has been ascertained that a large proportion of the 550 old persons, viz., 383, representing 69 per cent, had a prospect of enjoying good health for several years, and it has further been shown that the accommodation provided was often unsatisfactory in so far as many healthy old people were forced to live in the closest proximity to sick persons. In order to pursue the question of the adequacy of the provision for old people it was necessary to determine the number of old people for whom residential institutional accommodation was essential and the number of persons who were fit to look after themselves and who could, in fact, have been living in their own homes had favourable domiciliary conditions prevailed. There were very many persons who, although they did not require institutional care, were nevertheless unable to look after themselves in every respect. Most of these cases come within the category of frail. Some of the able-bodied could not, in view of their great age, be regarded as fit to live completely independent lives. Other able-bodied persons had been resident in the institutions for many years and it was felt that these persons could not, without special aid, resume life in the community from which they had so long been separated. Such disabilities as deafness, impairment of vision and defective/

defective memory precluded many old persons from regaining their independence; if such persons were not to remain in the institution - and for them institutional accommodation was not essential - then some measure of protection would require to be forthcoming to enable them to live outside the institution Protection of this nature can be provided in the home of a relative, in the shelter of the Cottage Homes, in houses specially designed to meet the needs of old people and by local health authorities who have organised welfare services for the aged in respect of health visiting, home nursing and domestic help.

The classification of cases according to their ability to live outside institutions is as follows:-

TABLE 62.

Ability of the Old Persons to live outside Institutions

	Number
1. Those unable to live outside .	192
2. Those able to live outside .	132
3. Those able to live outside under sheltered conditions . .	226
TOTAL .	550

The ability to live outside institutions according to the health prognosis is recorded in Table 63:-

Table 63/

TABLE 63.

Ability of the Old Persons to live outside Institutions

Prospect of Improvement in general health	Able	Unable	Able - under sheltered conditions	TOTAL
No prospect	-	116	-	116
Prospect, with certainty of early relapse	-	37	14	51
Prospect of a few years' reasonable health	132	39	212	383
TOTAL	132	192	226	550

It will be observed that there are 14 persons whose clinical state is indicative of an early relapse but they do not require institutional care; these cases include cardio-vascular diseases where it is felt that sheltered conditions outside the hospital, such as the homes of kindly relatives, could maintain the well-being of the old persons so far as this is possible. The certainty of relapse in some cases is attributable to the nature of the lesion and in others to the advanced age of the patients. It is also to be noted in Table 63 that of the 383 persons whose health prospect is good there are 39 who are not regarded as fit to live outside the institution; these cases include persons who suffer from serious impairment of the special senses, amounting to absolute deafness or complete blindness, and also persons who suffer from impairment of the locomotory system.

The ability to live outwith institutions is recorded in Table 64:-

Table 64/

TABLE 64.

Ability of the Old Persons to live outside Institutions

Institution	Able	Unable	Able - under sheltered conditions	TOTAL
Stobhill	18	79	95	192
Western District	2	20	19	41
Crookston Home	37	93	87	217
Cottage Homes	75	-	25	100
TOTAL	132	192	226	550

The figures in the hospital series are revealing. There are 79 cases in Stobhill Hospital and 20 cases in the Western District Hospital for whom institutional treatment is necessary. In these two hospitals there are 192 and 41 cases respectively, so that in the hospital series the cases for whom hospital care is essential amounts to only 42.5 per cent. In Crookston Home there are 93 persons, or 42.9 per cent of the cases there, requiring institutional care; the cases not requiring institutional care number 124, of whom 37 are not in need of any supervision and 87 who, on leaving the institution, would require to have special provision made for their welfare. In the Cottage Homes 75 of the residents are able to live in their own homes but 25 would be unable to undertake the full responsibilities of a house. In the Cottage Homes, relieved of many tasks, they are able to enjoy the privileges of living in their own domain.

Many of the old people have been resident for many years in the institutions where, relieved of all responsibilities, they have become dependent/

dependent upon others to such an extent that they can no longer make decisions regarding even the smallest details of their own lives. Accordingly the ability of the old persons to live outside the institutions was reviewed in relation to the period during which they had been in institutional residence The findings are recorded in Table 65:-

TABLE 65.

Duration of Stay in Institutions

Ability to live outside institution	Under 1 month	1 - 6 months	7 - 12 months	1 - 2 years	3 - 5 years	6 - 10 years	Over 10 years	TOTAL
Able	17	28	8	31	17	31	-	132
Unable	17	49	16	49	36	17	8	192
Able under sheltered conditions	52	65	21	29	31	26	2	226
TOTAL	86	142	45	109	84	74	10	550

It is an interesting fact that in respect of the 86 persons who have been resident for a period of less than one month there are only 17 persons for whom institutional care is essential. There are also 17 persons who are able to live outside, and the remaining persons, who number 52, are suitable for life under sheltered conditions. If we turn now to consider those who have been resident in the institution for more than ten years we find ten persons, only two of whom are designated as fit to live outside; the relatively large proportion in need of permanent institutional care is attributed to the fact that these persons are advanced in years, and indeed

it/

it is remarkable that any in this group could be considered as able to leave the institution after the long period of more than ten years' residence. Consideration is further given to the preceding residential period of six to ten years in which there are 74 cases, 57 of whom are able to live outwith the institution, including 31 for whom no special supervision is required. It is reassuring to have evidence that so many old people are physically and mentally fit, despite prolonged residence in an institution. Their ability to live independent lives is an important factor in the event of it being proved that supervision can best be made for the care and welfare of the old people in their own homes.

These findings call for investigation as to the reasons which led to the old people entering the institutions. The reasons determining the admission of the cases to the institutions under review and the previous places of residence of the old persons have been already discussed, but it is of interest to survey the ability of the old persons to live outside the institution in regard to the factors determining their admission. The findings are recorded in Table 66:-

TABLE 66.

Predominating Factor determining Admission to Hospital or Institution

Ability to live outside	No one to look after O.P.*	Ill	No Home	Financial difficulties	Unwanted by Relatives	Own Volition	TOTAL
Able	1	21	10	22	35	43	132
Unable	37	95	6	14	39	1	192
Able - under sheltered conditions	21	105	15	24	48	13	226
TOTAL	59	221	31	60	122	57	550

Illness/

*O.P. = Old persons

Illness was the chief factor which led to the admission of the old persons. There were 221 persons admitted on account of illness, and of these 95, or 42.9 per cent, did not make sufficient recovery to enable them to leave the institution. The next common factor determining the admission of the old persons to institutions was the refusal of the relatives to have the old persons to reside with them, and this accounted for 122 cases, or 22.2 per cent, of the total admissions.

Of the 132 persons able to live outwith institutions, 43 had entered of their own volition and most were admitted to the Cottage Homes. There were 35 persons who had sought institutional refuge because they were unwanted by their relatives. Economic necessity accounted for the admission of 22 cases. There were 21 persons who had been admitted to hospital as ill patients and who had sufficiently recovered to be able to leave. Similarly, one old man, admitted because he was unable to look after himself, improved so much in general health that he was classified as fit to return to his own home. Ten persons sought admission to a Home for the aged because they had lost their homes as a result of eviction or through circumstances which they could not reasonably have foreseen, such as fire or war damage.

There are 226 persons who are classified as fit to live outwith institutions provided they could reside under sheltered conditions. The majority of these persons, viz., 105, had been admitted to hospital primarily on account of illness. As these people on recovery were unable to make suitable arrangements for life outside they were admitted to a Home for old persons. Forty-eight persons were admitted to the Home not primarily because they were ill but because they were unwanted by their relatives.

In/

In this group there are 21 persons who were admitted because there was no one to look after them. These persons still remain unfit to look after themselves, but would be able to live outside the institution provided some measure of protection were available. There were 13 persons who came into the institution of their own volition. Amongst them are men who resided in the common lodging house and had previously been in hospital; they realised that, on their discharge from hospital, there was little hope of their retaining the improvement in health secured by treatment in hospital if they had to return to the common lodging house, and in consequence made application for their admission to the Home. As in the previous category the lack of a home and financial difficulties influenced the old persons to seek admission to the Home.

5. The Old Persons' Choice of Residence. In the survey it was found that 192 persons could not be regarded as fit to be discharged from the institutions The remaining 358 cases were interviewed to ascertain if they were content to reside in the institutions. Those who were dissatisfied with institutional life were further questioned to ascertain where they would choose to reside. The findings are recorded hereunder:-

Table 67/

TABLE 67.

Wish to live outwith the Institutions

Ability to live outside institutions	Wish	No wish	Not applicable	TOTAL
Able	45	87	-	132
Unable	-	-	192	192
Able - under sheltered conditions	168	58	-	226
TOTAL	213	145	192	550

This Table shows that 213 old people wish to leave the institution. This number represents 59.5 per cent of the cases who were regarded as able to live outside. It will be observed that 145 persons choose to remain in the institution; this number - representing 40.5 per cent of those considered to be suitable for residence outside - is high and at first sight might lead one to believe that a large proportion of the old persons are content with institutional life. But it has to be borne in mind that included in the number fit to leave the institution are 100 old people who dwell in the Cottage Homes. Living conditions in the Cottage Homes bear little resemblance to true institutional life, and so adapted is the Cottage environment to the needs of the old persons that in only one instance did a Cottage dweller express the desire to live elsewhere. If we disregard the 99 contented Cottage dwellers, then the total number of persons satisfied with institutional life is 46. The final view must, therefore, be that only 12.8 per cent of those who are fit to leave the institution prefer to remain where they/

they are and that the overwhelming majority of 87 per cent express a preference for more home-like conditions than any institutional environment can afford.

Enquiries were now pursued to discover the kind of home which made an appeal to the old persons who were dissatisfied with institutional life. The wishes of the old people are given in Table 68:-

TABLE 68.

Ability to live outside Institutions

Ability to live outside Institution	Choice of Residence										TOTAL
	Not applicable	Own home alone	To live with husband/wife in own home	To live with relative in own home	To live in relative's home	To live in lodgings	To live in common lodging house	No proposition	Cottage Homes	Other Home or Institution	
Able	87	5	14	2	3	2	-	11	8	-	132
Unable	192	-	-	-	-	-	-	-	-	-	192
Able under sheltered conditions	58	22	17	12	36	16	21	29	11	4	226
TOTAL	337	27	31	14	39	18	21	40	19	4	550

Reference to this Table shows that, excluding those who do not wish to leave the shelter of the institution, the majority of the old people wish to live in their own homes, either alone or sharing the home with their spouse/

spouse or with near relatives. Many persons choose to reside in the homes of relatives. It will be noted from the Table that this choice is more popular amongst the less active old people who have been classified as only fit to live under sheltered conditions. This choice is undoubtedly founded on the old persons' realisation that they are not as fit as formerly and will have to depend upon others for assistance. Unfortunately, the old persons' preference to reside in the relatives' homes is often made without reference to the fact that they may not be acceptable to the relatives. Lodgings are also a popular choice, particularly by those who require some measure of assistance. This choice is made irrespective of the old persons' ability to pay for this accommodation, but it is surprising to find that 21 persons who require a protected environment choose as their abode the common lodging house. This choice is made by them with the full knowledge that life in the common lodging house is deleterious to their health. The Cottage Homes are chosen by 19 persons. There are four persons who do not wish to abandon institutional life but who would like to be transferred to a smaller and more home-like institution. A very large number, 40 persons in all, have no proposition to make; anxious as they are to leave the institution, they can offer no suggestions as to where it would be feasible for them to reside. This inability of the old persons themselves to find a solution for their problems may account for the trend of the choice of the old persons to rest upon the place in which they resided prior to their admission to the institution.

(a) Own Home.

The choice of the old people for their own homes although natural

is/

is for them an unrealisable choice. Their own home usually no longer existed because officious relatives had commonly disposed both of the home and its furnishings when the old persons went to hospital, so that on recovery they no longer had homes to which they could return. Some homes were totally unsuited for old people to live in. It was not infrequently found that the old people lived in a single apartment three stairs up, without a lavatory, the latter being on a half-landing and shared by several other tenants. Old people suffering from crippling diseases, whether of heart or of limbs, have no freedom of action when residing in such dwellings.

In some instances the old person still had his home and could have returned to it but for the fact that there was resident in the home a husband or wife, often more enfeebled than the patient and unable to look after him. For the old person the most satisfactory solution is undoubtedly life in his own home, but in order for this to be effected he must live in a house designed to meet the needs of his failing strength and be provided with organised domestic assistance.

(b) Lodgings.

The old persons' choice to reside in lodgings as an alternative to residence in the institution cannot be regarded as a feasible proposition in view of the facts which have been elicited in the survey in respect of the aged who resided in lodgings. It was found that the men who lived in lodgings were chiefly single men who had stayed with their parents until the latter died. There were also many widowed men who were still young and active and who had, on the death of their wives, chosen lodgings as the best means of being looked after. So long as these men remained in regular employment their stay in lodgings was quite satisfactory, but, after retirement, the old persons/

persons could rarely afford to pay for their lodgings, and when their savings were exhausted they had to seek alternative accommodation. In a vain attempt to remain in lodgings, the old persons seek cheaper accommodation and, where previously they had a room to themselves, a coal fire, hot cooked meals, with washing and mending undertaken for them, they find that now they can only pay for a small unheated room which they may have to share with strangers; under these conditions they may be provided only with tea, porridge and bread, whilst they must themselves tend to their washing and mending. Thus, those in lodgings are less well-cared for in old age than those in their prime who are much more able to look after themselves. The standard of the accommodation was sometimes little better than that of the common lodging house. In some instances four men shared a room, and in others an old person had his bed in the kitchen in which several other lodgers prepared and ate their meals. It is obvious that landladies who have to earn their livelihood by taking in lodgers cannot be expected to accommodate unprofitable boarders. Many of the old persons had resided in the same lodgings for many years, and had it not been for the death of their landladies, often of more advanced years than the old persons themselves, they would have been able to remain in these lodgings. After twenty or thirty years in the same lodgings an old person has become one of the family.

A certain number of old persons had gone to reside in lodgings after retirement. They were commonly old men who had given up their homes on the death of their wives to live with relatives, and so difficult had their position become in the relatives' homes that they had had to move into lodgings/

lodgings. The old person who takes up life in lodgings for the first time in advanced years can rarely adapt himself to the new position.

Few of the women lived in lodgings. They were for the most part women who, during their working years, had been in residential posts such as hotel maids, housekeepers and the like. They appear to suffer more acutely than the men. They were all decent old people accustomed to a good standard of living, who, shunning the common lodging house, had perforce to take meagrely furnished lodgings. So much did the payment of these lodgings reduce their income that many were left with insufficient money for their sustenance. The incredible pathos of these cases is revealed in the history of how they come to be admitted to the institution. One old lady, whose case is illustrative of many, said:-"I went out a lot, for the landlady did not like me in except for meals. One day I was sitting in the park when a young woman, a stranger to me, sitting on the park seat spoke to me and told me about Crookston Cottages. My prayers were surely answered that day. I never thought I would ever find peace again".

As already stated, old people are not a good proposition to the landlady. They sit about all day, demand a fire and use gas or electricity all the winter evenings as they rarely go out. The landlady prefers working men whom, after breakfast, she will not see again until the evening meal and who have also many interests to take them out in the evenings. While doubtless there are many old persons happy in the lodgings in which they reside, one cannot regard as feasible the translation of old people resident in institutions to lodgings which landladies naturally conduct with an eye to profit.

(c) Common/

(c) Common lodging house. In the course of this survey, it has been only too evident that conditions obtaining in the common lodging house are most unsuitable for old persons. The common lodging house is primarily a hostel for working men, and as such it cannot offer the more generous facilities required by men whose working days are over. In the common lodging house the inmates are accepted on a casual basis of a night or a week; they have no place of their own. Their beds they possess for the night only and they may not rest upon them during the day. They are discouraged from sitting in the day room and this for active young men may act as an incentive to them to look for work, but for the aged means being driven out irrespective of the weather and regardless of their need for rest and relaxation.

In the common lodging house the old persons rarely receive adequate rest. Where the inmates cook for themselves the old persons cannot compete with the more vigorous for the possession of the frying pans and the most favourable place on the cooking stove. Soups and stews are unheard of as they require constant watching during the cooking process. Unlike the working man, the old person cannot pay for a hot meal outside and he consequently lives on bread supplemented on occasions with fried food. It is little wonder that many cases of malnutrition and bronchitis are encountered in the common lodging house, or that readmissions to hospital on account of these diseases are frequent. The rules of the common lodging house are harsh and are designed to control a community of flotsam and jetsam. While many of those who reside in the common lodging house are decent people, the majority are of doubtful reputation and the solid core of the common lodging house/

house is made up of social misfits. To this unsavoury atmosphere many old men are driven through necessity when they can no longer pay for accommodation in ordinary lodgings.

The worker has few opportunities for saving in his working life, especially when he rears a large family and he tries to better their conditions Such money as he has acquired quickly dwindles in spells of unemployment. Illness of some member of the family is rarely absent and makes great inroads upon savings, so that the average working man, whether skilled or unskilled, can lay aside little unless he is self-employed. If the old person retains his home he may have sufficient security to enable him to live on his retirement allowance, but, if he has no home of his own, he will not manage to pay for lodgings and he will not be able to maintain his health in the common lodging house. It is sad to think that a man whose whole working life has been spent for the good of the community has, in his old age, to rub shoulders with the cadger and the jail-bird with whom he has nothing in common. It is most surprising to find that there are so many decent old people in the common lodging house. This is because they fear to give up their independence which they believe will inevitably follow their entrance to an institution for the aged. They thus lower their standards of living to secure independence. Why so many old people have given their choice as the common lodging house on leaving the institution calls for comment. It can only be because life in the Home seems to them less tolerable than the one they know but loathe in the common lodging house.

(d) Attitude of relatives.

We/

(d) Attitude of relatives.

We have seen that many old people, unhappy in the institutions to which they have been admitted, wish to leave the institutions and live in the homes of relatives. Reference has previously been made to the part played by the relatives in determining the admission of the old persons to institutions. It has been shown that in 22 per cent of cases the old people were admitted because they were unwanted by their relatives. We must accept the fact that the old people simply do not fit into the relatives' homes. So intense was the desire of the old persons to return to the homes of their relatives that it was deemed necessary to explore further the attitude of the relatives to the old persons and to determine, if possible, the causes which led to their rejection. The number of cases in which the old persons had relatives was ascertained and enquiry was made as to whether their relatives were prepared to have the old persons in their homes. These findings are recorded in Table 69:-

TABLE 69.

Willingness of Relatives to have Old Persons

Ability to live outside institution	Relatives willing	Relatives unwilling	No Relatives	TOTAL
Able	18	93	21	132
Unable	7	144	41	192
Able, under sheltered conditions	40	152	34	226
TOTAL	65	389	96	550

It/

It will be seen from the above Table that 96 old persons are without relatives, and that 454 persons have near relatives; it is also revealed that in 389 cases, representing 85.7 per cent of those with relatives, the latter do not wish to accommodate their aged relatives. An explanation of this attitude was sought in the demands which the old persons make upon their relatives for care and attention. The willingness of the relatives to provide accommodation for the old people was therefore related to their after-care requirements. The facts are recorded in Table 70:-

TABLE 70.

Willingness of Relatives to have Old Persons

Requirements on leaving Institution	Relatives Willing	Relatives Unwilling	No Relatives	TOTAL
Permanent medical care	15	13	7	35
Permanent medical and nursing care	6	118	34	158
Occasional medical care	32	110	27	169
Occasional medical and nursing care	9	38	6	53
No care required	3	110	22	135
TOTAL	65	389	96	550

It can be readily appreciated that for permanently bedfast patients the relatives may be reluctant to shoulder responsibility. Reference to the above Table/

Table shows that this is indeed the case. Where the greatest possible demands are made upon the relatives, viz., in the 158 cases requiring permanent medical and nursing care, there are only 6 instances where the relatives denote their willingness to look after the aged persons. On the other hand, it is most surprising to find that where the old persons require neither medical nor nursing care they are equally unacceptable to their relatives. Only three active old persons are wanted by their relatives, while 110 are refused a home.

Fuller evidence of the fact that the attitude of the relatives is not wholly influenced by the state of health of the old persons is available in Table 71 in which the attitude of the relatives is related to the prospect of improvement in health of the old persons.

TABLE 71.

Willingness of Relatives to have Old Persons

Prospect of improvement in general health	Relatives Willing	Relatives Unwilling	No Relatives	TOTAL
Improvement with certainty of early relapse	3	88	25	116
Improvement with prospect of a few years' reasonable health	11	31	9	51
No improvement	51	270	62	383
TOTAL	65	389	96	550

It/

It will be seen from the Table that there are 116 cases in which there is no prospect of improvement in health. In three instances the relatives expressed the wish to have the old persons to reside with them but in each of these cases the old person bore the close relationship of husband or wife. Where there was only a prospect of temporary improvement in health it was found that, in the eleven cases where the old persons were returning to the care of their relatives, this close relationship also existed.

The attitude of the relatives is influenced not only by the physical condition of the old persons but also by their mental state. In Table 72 are recorded the mental state of the old persons and the willingness of relatives to have them:-

TABLE 72.

Willingness of Relatives to have Old Persons

Mental State	Relatives Willing	Relatives Unwilling	No Relatives	TOTAL
Normal	63	338	84	485
Facile	-	3	-	3
Confused	2	31	8	41
Defective	-	13	3	16
Pathological	-	4	1	5
TOTAL	65	389	96	550

This Table shows very clearly that the relatives do not wish to give accommodation to the old persons where there is any abnormal mental state.

The/

The only exceptions are found in two cases where there is exhibited a degree of mental confusion which is very slight, and in each case the relative is the wife of the confused person.

A difficult situation arises where the old persons desire to live with their relatives and the relatives reject them. In only a few cases can the old people find sanctuary with their relatives. Residence in relatives' homes cannot be regarded as a solution for the domiciliary provision of the old persons who are fit and wish to reside outwith the institution.

(e) Place of the Cottage Homes.

The Cottage Homes are the choice of 19 old persons. This choice calls for special comment in that those old people already in the institution, from their personal knowledge of the Cottage Homes, elected to reside there rather than seek the complete freedom offered by life outside the institution.

One of the outstanding features of the survey was the contentment of those who dwelt in the Cottage Homes. Since the old people are so happily placed in these Homes, the question arises as to whether this provision should not be extended in welfare schemes for the aged, especially as it is already evident that the old persons' own choice is, in few instances, capable of realisation. Accordingly, the cases were reviewed to ascertain the number of old people suitable for residence in Cottage Homes.

It was found that 173 cases, equivalent to 31.5 per cent, are suitable in every respect for residence in the Cottage Homes. More than two-thirds of the cases under review cannot be regarded as suitable on account of physical or mental disabilities. Debarred from living in the

Cottages/

Cottages on account of physical disabilities are the permanently bedfast, those who walk with difficulty and others who use wheel-chairs and eleven who are unable to walk without assistance. But, irrespective of physical disabilities, old persons cannot be regarded as suitable for the Cottage Homes if their mental faculties are so impaired that they are confused or even forgetful to such a degree that they might endanger their lives and imperil the safety of their neighbours. Apart from the requirements in relation to physical and mental health other conditions must be fulfilled before the old persons can be regarded as suitable for residence in the Cottage Homes. A certain standard of domesticity must have been attained. Many of the widowed men are not domesticated. On the death of their wives they struggled in vain with domestic chores until they eventually had to seek admission to an institution. Others, particularly single men, had always lived in lodgings and had never had to do anything for themselves. They had no knowledge of how to set about simple tasks, such as making tea or boiling an egg. Those who had lived for many years in common lodging houses had long ceased to achieve the standards of the normal home and could not be considered capable of maintaining a reasonable standard in the Cottage Homes.

Lastly, not all who were deemed to be suitable for residence in the Cottage Homes would, given their choice, have selected this type of residence. Of the 173 persons regarded as suitable, 25 persons state that they do not wish to reside in the Cottages as they feel that life there will be too lonely or that they will have too much to do.

The very active old men have little inclination to live in the

Cottages/

Cottages because the daily round of domestic work will entail a restriction of their liberties. There are many men in the institution who lead a most active life. These people take long daily walks or are busy organising whist drives, bowling matches and concerts for the other residents. These able-bodied and active persons have little inclination to forego these pursuits for the more placid but less interesting life which would be theirs in the Cottages.

Some of the women do not wish to reside in the Cottages as they think the tasks in the Cottages are beyond their strength, and, furthermore, they fear the loneliness, particularly at night, when there is no one at hand to call upon in the event of sudden illness. All the women who, for these reasons, decided against living in the Cottage Homes come into the "frail" category.

6. The Old Persons' Capabilities for Work and Leisure. It has been shown that good health was enjoyed by a large proportion of the old people many of whom, although in advanced years, had a good health prospect. There were many able-bodied and frail persons able to live outside the institution. At this stage it appears to be appropriate to make a closer scrutiny of the lives of those old persons in order to determine whether they were living as full a life as possible. The capabilities of the old people to undertake work or to enjoy leisure were now investigated.

The ability for work and the different occupations which the old persons used to follow are shown in Table 73:-

Table 73/

TABLE 73.

Ability for Work

Normal Occupation	Able for previous work	Able for light work	Unable for work	TOTAL
Professional	-	4	3	7
Skilled (manual)	2	46	67	115
Unskilled (manual)	2	91	112	205
Sedentary with responsibility	-	6	7	13
Distributive	-	16	14	30
Housework at home	2	54	84	140
Personal service	-	19	13	32
H. M. Forces	-	2	3	5
None	-	-	3	3
TOTAL	6	238	306	550

It will be seen that only six persons can be considered as fit to work at their former employment. There are 238 persons, or 43.3 per cent of cases, who are fit for light work. Such persons are quite able to undertake remunerative employment which does not involve strenuous exertion. The remainder, numbering 306, representing 55.6 per cent of cases, cannot be regarded as able to undertake even light routine work; many of them are nevertheless active and well able to look after themselves. Although the above table shows that only six persons were fitted for work at the time of the survey it must be remembered that this is not the estimate of their working/

working capacity at their time of entrance to the institution. Some of the old persons had been resident in the institution ten years or more during whic time their physical abilities for their previous occupation would undoubtedly deteriorate..

The old people were then interrogated regarding their wishes to undertake employment. Their views are detailed in Table 74:-

TABLE 74.

Desire for Work

Normal Occupation	Desire	No Desire	Not Applicable	TOTAL
Professional	4	-	3	7
Skilled (manual)	48	-	67	115
Unskilled (manual)	92	1	112	205
Sedentary with responsibility	6	-	7	13
Distributive	16	-	14	30
Housework at home	55	1	84	140
Personal service	18	1	13	32
H. M. Forces	2	-	3	5
None	-	-	3	3
TOTAL	241	3	306	550

This Table shows that all persons who were able to work wished to do so with three exceptions, all of whom were social misfits.

A/

A certain number of the old persons was not considered fit to undertake work, even of a light nature, and yet they were active persons who could have participated in occupational therapy and would have benefited thereby. Throughout the investigation the author was impressed by the number of persons who stated that time hung heavily upon their hands and who sat aimlessly around. The ability of the old persons to undertake occupational therapy was investigated and the findings are detailed in Table 75:-

TABLE 75.

Participation in Occupational Therapy

Ultimate ability for work	Able	Unable	TOTAL
Able for previous work	6	-	6
Able for light work	238	-	238
Unable for work	101	205	306
TOTAL	345	205	550

There are thus 306 persons classified as unfit for work, but of this number 101 persons could engage in occupational therapy.

Investigations were further continued to determine to what extent inability to engage in occupational therapy is affected by the state of activity, vision and hearing. These findings are given in the subjoined Table:-

Table /

TABLE 76.

Participation in Occupational Therapy

State of Activity	Able	Unable	TOTAL
Mobile	255	23	278
Mobile with stick	25	37	62
Mobile with wheel-chair	5	2	7
Immobile	6	7	13
Bedfast	54	136	190
TOTAL	345	205	550

It is therefore proved that occupational therapy could benefit many whose physical activity is severely restricted. In respect of the bedfast patients there are 54 who could enjoy some form of occupational diversion.

The ability to participate in occupational therapy as affected by vision is set forth in Table 77:-

TABLE 77.

Participation in Occupational Therapy

State of Vision	Able	Unable	TOTAL
Good	214	84	298
Defective	114	81	195
Seriously defective	7	19	26
Partially blind	7	16	23
Blind	3	5	8
TOTAL	345	205	550

While/

While impairment of vision may restrict the activities available to the old persons, it does not exclude them from engaging in various occupations. Table 77 indicates that in the case of those with seriously defective vision or blindness, there were many who could profitably have undertaken some form of therapy.

In respect of defects of hearing, the ability of the old persons to engage in some form of activity is given in Table 78:-

TABLE 78.

Participation in Occupational Therapy

State of Hearing	Able	Unable	TOTAL
Good	316	182	498
Defective	19	12	31
Seriously defective	5	7	12
Deaf	5	4	9
TOTAL	345	205	550

Again, as in the case of visual defects, impairment of hearing does not alone operate to prevent participation in occupational therapy.

It can be readily appreciated that the ability of the old persons to occupy themselves is dependent to a certain extent upon sight, manipulative powers and physical and mental alertness. But what is commonly overlooked is that the occupation available must appeal to the individual temperaments and tastes of the old persons. Special difficulties are encountered in the application/

application of occupational therapy to the aged. In advancing years adaptability diminishes and the sphere of interests is narrowed. If occupational therapy is to meet with success in this field then without doubt it must be organised to meet the needs of the individual, and so many projects, such as the making of artificial flowers by all the old people in a Home, without regard to their inclinations and temperaments, will be a dismal failure. The range of crafts which may be introduced to the old has often to be restricted because of diminishing vision and loss of manipulative ability. On the other hand, the old person has often latent powers which are capable of development. In a Home which houses persons of varied occupations there is amongst the residents a great wealth of hidden experience which could be pooled and utilised to the advantage of all.

For the old people the term "occupational therapy" should be interpreted very widely. It should be organised to include the blind, the deaf, the disabled and bedfast. In a Home for old people, projects of sufficiently wide scope should be launched to include all the residents and to sustain every interest. The growing of tomatoes, poultry keeping and gardening are some of the pursuits enjoyed by the active old. These are not restricted to the country-bred man and woman and some of the keenest gardeners have been found amongst those who have lived all their lives in the City. The investigation made it clear that the initiation of schemes, even in their simplest forms, are often beset with difficulties. For example, in an institution there lived a retired gardener, aged 85 years. It gave him great pleasure to rake the flower beds and the garden paths. Unfortunately, the gardener who was employed in the Home objected to the old man working and complained

that/

that he would not tolerate the old man's interference, particularly as the latter sometimes broke off a flower with the rake. It was quite beyond the comprehension of the gardener to appreciate that a broken blossom or two were of little account compared with an old man's happiness.

On retirement some persons state that they have abandoned work in all its forms, but this is only a temporary phase and soon they are eager to seek some form of activity. A retired carpenter, on being shown a workshop in an Old People's Home, said emphatically that he would never set foot in it. Within a month he was imploring the matron for "something to repair in order to keep his hand in". Similarly, old ladies on entering a Home are known to state that they can neither knit, sew nor crochet, but, after a very short period of idleness, they are eager to join the other members in their handwork and prove that they were expert needlewomen. It appeared that they had been afraid to admit their skill lest they were forced to undertake routine sewing or mending.

Despite the difficulties in introducing diversional occupations for the aged, there is no need for a defeatist attitude to the problem. If the correct approach is made to the old person when he first enters the institution then his interest will be stimulated and sustained. Passivity and inactivity are qualities alien to human nature. The old and the young alike want to be busily occupied. The old woman is content as she watches over the fish she is cooking for the expectant cat, and the old man is happy as his gnarled fingers still skilfully whittle a boat for his little grandson. Again and again when carrying out this investigation, it was impressed on the author that old people like to be "up and doing".

As regards the old people who live in the Cottage Homes, the employment of leisure presents no difficulties. There is no need to introduce occupational therapy as the old person is fully occupied. There are so many things to do, even under the protected conditions of life in the Cottage Homes, and old people take longer to perform ordinary tasks such as preparing tea and washing up. Household work, mending, entertaining friends and neighbours are all pleasurable occupations in one's own home. But in the institution there is little to do. For the more active there are, it is true, tables to set, dishes to wash, floors to polish, but these are tasks rather than pleasurable occupations. One woman, aged 71, who sat idle said she had been nine years resident in the Home. She had previously been a sewing maid and for the first eight years in the institution all day long she had sewn identification marks on the linen of the Home. She was tired of this sewing and at last refused to do it. Yet she confessed to the author that it would give her the greatest pleasure to dress a doll. It is lamentable that no steps were taken to fulfil such a simple wish, especially when we remember the great number of deprived children crying out for dolls in Children's Homes. There is room for the co-ordinating of the welfare services for the young and the old. The old men could find much pleasure in making and repairing children's toys, and the old ladies could find much interest in knitting vests, matinée jackets and bootees for the babies in the residential nurseries.

Christmas Day in a Home for old people is often a most melancholy occasion because the old have their celebrations in isolation, but the real spirit of Christmas could be captured if on this occasion children were introduced/

introduced to the old people. Many pleasurable days of preparation could be devoted by the old people in plans for the Christmas party, in the making of toys, the wrapping of gifts and the decoration of the Christmas tree.

7. The State of Contentment. Throughout the investigation it was only too apparent how far from satisfied were many of the old persons with the environment in which they found themselves. A contented mind is scarcely to be expected amongst the sick but one would hope that all the other old people would have found some measure of contentment in their surroundings. An assessment was made of the reactions of the old persons to their placing whether in hospital, in Crookston Home or in the Cottage Homes. The feelings of the old persons were ascertained and in respect of these findings the following four categories were determined:- (1) contented, (2) discontented, (3) resigned and (4) indifferent. The findings in the various institutions are shown below:-

TABLE 79.

Old Persons' reaction to their Placing

Institution	Contented	Discontented	Resigned	Indifferent	TOTAL
Stobhill	11	120	53	8	192
Western District	3	16	19	3	41
Crookston Home	48	112	37	20	217
Cottage Homes	99	1	-	-	100
TOTAL	161	249	109	31	550

The total number of persons who can be regarded as contented is 161, or 29.3 per cent of the total cases. The largest group is composed of

unhappy/

unhappy persons; these number 249, which is equal to 45.3 per cent of the total cases reviewed. There are 109 old persons, or 19.8 per cent of cases, who, although formerly discontented, have resigned themselves to their surroundings and are designated "resigned". These persons on interrogation commonly stated, "I just have to make the best of it" or "I just have to stay here as there is nowhere else for me to go". A small number of persons, namely 31, are quite indifferent as to their surroundings; these are the bedfast patients who suffer from cerebro-vascular lesions and who appear to be quite unaware of what is going on around them.

In the hospital series one expects that there will be a large proportion of unhappy patients but thirteen hospital patients are contented and indeed would be happy to spend the remainder of their lives in the hospital. This abnormal attitude calls for comment. They are all homeless old people who have suffered much hardship before their admission to hospital. The hospital is for them a haven which they do not wish to leave so much do they fear conditions outside.

The unhappiness of the old people was only too evident, but it would be unreasonable to conclude that this unhappy state was the direct consequence of unsatisfactory environmental conditions. It occurred to the author that the physical state of the old persons themselves might play a large part in producing unhappiness. The state of contentment was, therefore, related to the physical condition and the findings are detailed in Table 80:-

Table 80/

TABLE 80.

Classification according to Physical State

Contentment with present placing	Able-bodied	Frail	Bedfast	Acute Sick	TOTAL
Contented	106	49	4	2	161
Discontented	40	114	79	16	249
Resigned	12	32	20	45	109
Indifferent	-	7	24	-	31
TOTAL	158	202	127	63	550

Contentment, as one would anticipate, is higher among the able-bodied, namely 106, or 65.8 per cent of this category. In contrast, discontent prevails amongst the frail; 114 out of 202 were actually discontented; only 49, or 24.3 per cent of the group, were happily placed. Amongst the bedfast - in whom contentment is not expected - 79 were discontented, only 4 were contented with their environment, 24 were indifferent and 20 expressed themselves as having lost all interest in life.

The state of contentment was now considered in relation to the health prospect of the old persons and the findings are recorded in the following Table:-

TABLE 81.

Prospect/

TABLE 81.

Prospect of Improvement in General Health

Contentment with present placing	No prospect of improvement	Prospect, with likelihood of early relapse	Prospect of a few years' reasonable health	TOTAL
Contented	4	1	156	161
Discontented	68	30	151	249
Resigned	18	16	75	109
Indifferent	26	4	1	31
TOTAL	116	51	383	550

It has already been shown that 383 cases had a prospect of good health for at least a few years. It was found that of this number 156 persons are contented; 151 are discontented, 75 resigned and one is indifferent. One would expect the mental outlook of patients whose health prospects are good to be also optimistic and it cannot be readily comprehended why only 156, or 40.7 per cent of the old persons with a good health prospect, are happy.

It would be natural to find some degree of bewilderment amongst the old persons on their entry to the institution, but it is distressing to find that after many years of residence in the institution the disquietude and the fears of the old persons are as strong as when they first crossed the threshold.

The attitude of the old persons in relation to the duration of their stay in the institution is given in the following Table:-

Table 82/

TABLE 82.

Duration of Stay in Institution

Contentment with present placing	Under 1 month	1 - 6 months	7 - 12 months	1 - 2 years	3 - 5 years	6-10 years	Over 10 years	TOTAL
Contented	14	22	10	33	33	46	3	161
Discontented	45	76	24	53	27	20	4	249
Resigned	26	37	9	14	16	5	2	109
Indifferent	1	7	2	9	8	3	1	31
TOTAL	86	142	45	109	84	74	10	550

Comment will be made only on the old persons who have been longest in the institution. There are ten persons who were resident in the institution for more than ten years and amongst them there were four unhappy individuals. Is it not to be deplored that after spending ten long years in a Home for the aged so many old persons have failed to find tranquillity of mind? In some instances, it was only too apparent how far from satisfied were the old persons with the environment in which they found themselves, their every word and gesture portraying bitterness and resentment. Others in the telling of their story re-lived the mental anguish which they had suffered on first entering the institution and which the passage of time had in no way alleviated. Many cloaked their unhappiness with resignation. They seemingly found contentment in the routine of the institution but they had no happiness of spirit; for them, living had lost its significance. This state of bleak and dreary existence has come to be regarded as the normal state of old people in institutions.

The/

The happy old person stands out in striking contrast; his expression his conversation, his whole demeanour all denote his joy in living and this joie de vivre was especially in evidence in the Cottage Homes. In the home-like atmosphere of the Cottage Homes the old persons retain their independence which for the aged carries a special connotation. For youth independence denotes activity and accomplishment in every field of human endeavour, whereas for the aged it may mean no more than freedom to make decisions about the little things of life - when to put on the kettle, whether to have bovril or cocoa for supper, the time to go to bed - all these are of great moment to him and because he has freedom of choice in these matters his life is full and he is content. How different is the life of the old person in the large strictly disciplined institution? The daily routine has been established by others and he must conform to it. Each day and each hour of each day has been organised for him. There is a time for getting up and a time for going to bed, a time for recreation and a time for relaxation. Under such a régime the old person becomes a mere automaton.

By what means, we ask ourselves, can we arrive at a happier solution for these old people? We have first to consider how many of these unhappy old people could live outwith the institution and these findings appear in Table 83:-

Table 83/

TABLE 83.

Ability of the Old Persons to live outside Institutions

Content with present placing	Able	Unable	Able, under sheltered conditions	TOTAL
Contented	88	18	55	161
Discontented	22	114	113	249
Resigned	22	30	57	109
Indifferent	-	30	1	31
TOTAL	132	192	226	550

There are 249 discontented old persons. Of these 114 are permanent institutional cases, 113 are designated as able to live under sheltered conditions and 22 are capable of looking after themselves. Thus in respect of the 249 discontented persons alternative provision could have been made for 135. It cannot be claimed that the resigned in outlook had found any measure of real happiness. There are 109 "resigned" persons, of whom 22 are fit to live independent lives, and 57 under sheltered conditions, in all there are 214 persons who are not finding any measure of positive happiness in their present placing and for them provision outwith the institution could have been made. This large number of unhappy persons - practically 60 per cent of those for whom institutional care was not essential - points all too plainly to the inadequacy of the provision which had been made for the aged. These figures have an arresting significance from a statistical view-point, but from the humanitarian aspect they signify human lives terminating in tragedy.

SUMMARY of FINDINGS

This thesis was undertaken by the author with the object of studying the many problems connected with aged, infirm and chronic sick persons who were resident in institutions. One of the chief points to be investigated was whether or not the old people had been properly allocated to the various institutions. The number of cases involved is relatively large, viz., 550; 233 of these were resident in Stobhill and in the Western District General Hospitals, while 317 were resident in Crookston Home and Crookston Cottage Homes. In this investigation, an arbitrary age limit was adopted - 60 years for women and 65 years for men. The cases were divided into four groups according to their physical condition, viz., able-bodied, frail, acute sick and chronic sick.

It may now be appropriate to reflect upon certain aspects which arrested attention during the survey. At the outset it was apparent that a totally wrong approach had been made to the problems of the aged by the industrialists, by the economists, by the medical profession and by the old people themselves. The industrialists had in the main no use for elderly workers; men were dismissed, not because they were unfit for work, but solely on account of age. The industrialists were aided and abetted by the economists who laid down the arbitrary ages of retirement when contributory pensions were payable, irrespective of the physical and mental capacity of the individuals for work. There may be some excuse for the attitude of the industrialists and the economists, but none for the medical profession who adhered to the unenlightened belief that old age was actually a medical ailment. A misconception of this nature fostered by the medical profession was followed by

nurses/

nurses, medical students and by laymen alike. The old people themselves, unable to challenge the opinion expressed by professional men and by materialists, bowed to the inevitability of old age. The life histories of the old persons are illustrative of the far-reaching and dire consequences of such beliefs. Men and women as they advance in years have to face the horror of dismissal from work which they are still capable of performing with efficiency. In this survey, it is estimated that the loss to production by the retiral of skilled workers on account of age was 20 per cent - a loss which the nation can ill afford to bear at this juncture of its history.

In respect of those admitted to hospitals, it was ascertained that the reason for admission of the old persons was commonly stated to be "senility". How fantastic it is to make the passage beyond certain years synonymous with disease! The too ready acceptance of senility as the cause of illness has impeded the full medical investigation of cases, and the failure to provide the appropriate treatment has led to the immobilisation of hospital beds. Few medical men are anxious to spend time on the examination of those classified as senile. It was all too evident in certain of the cases of neoplasms how regrettably had the early symptoms of the disease been assigned to those of old age. The old persons themselves lost heart, gave up all effort and prepared for their demise. It used to be generally held that man's allotted span was "three score years and ten" but in this survey it was found that one-third of those aged 75 years and over were hale and hearty, and indeed two-thirds of all the residents in the several institutions were fit to look after themselves in all respects. Forty per cent of the old persons, many of whom had been resident in the institutions for years, were fit for some work.

An almost universal urge to work was encountered, even amongst the

frail/

frail, and it was with sadness that the author reviewed the working lives of 170 men and women who told the same story of repeated or continued unemployment throughout the years. It was for the most part the inability to find work which produced this tragedy, rather than the inability to work. The elderly worker who loses his job finds it almost impossible again to obtain employment.

Amongst the old, illness had quite commonly its origin in the environmental conditions in which the old persons lived and this was clearly illustrated in the cases of malnutrition, secondary anaemia, bronchitis and heart disease. Treatment in hospital could restore the patients to health but it was most wasteful of human endeavour to permit the patient to return to those conditions which had precipitated the illness. Some old people were with great regularity admitted to hospital every winter, and some were admitted two or three times in the same year and for the same condition. The remedy for the preventable diseases mentioned above lies outwith the hospital and calls for a closer examination of the circumstances in which the old people live.

The housing conditions under which many of the old persons lived were definitely detrimental to health. In this discourse, it has been shown how the old people dwelt on the top flight of a three-storey tenement without adequate sanitary facilities and with no modern labour-saving devices; they were virtually imprisoned in their homes and were denied the enjoyment of fresh air and sunshine, physical exercise and human companionship. Shopping proved to be laborious, especially to the old persons whose slender purse made it necessary for them to shop where the prices were keenest, nor could their limited strength allow them to carry heavy shopping bags up three flights of stairs/

stairs. The old persons have usually to carry their own messages, for, living alone, their purchases are meagre and do not interest the shopkeeper who is more concerned to please the housewife who places with him a large order for her large family. The difficulties of shopping by old persons are so great that they go out less often, purchase less, cook less and eat less, with the result that their strength deteriorates.

Lodgings for the old people cannot be regarded as a feasible proposition. The landlady earns her livelihood by her labours. Old people make additional demands upon her. Old people require her to provide lodgings at a reduced rate, and, at the same time, to provide care beyond the normal. It is not an economic proposition for landladies to provide for old people, although it redounds to the credit of many of them that they care for their old lodgers long after the latter are unable to look after themselves. In many instances, the lodgings were found to be totally unsatisfactory, and for the money which the old persons could afford to pay they received poor accommodation and inadequate feeding. The very many cases of old people living in ordinary lodgings and suffering from malnutrition indicate the inadequacy of this type of accommodation for the aged.

It was found that many old people resided in common lodging houses, drifting there from the lodgings they could no longer afford. The common lodging house, the one-time refuge of vagrants and the hostel for homeless working men, is unfortunately fast becoming a Home for the aged. It was evident how reluctant are old persons to give up their independence which they feel that they will lose even on entry to an Old Persons' Home. This/

This is the explanation why they cling to the common lodging house which is practically the only abode outwith the institutions available to those receiving assistance allowances. The old men resident in the lodging house are always hopeful that they may obtain employment, even although they may not have worked for very many years. But the lodging house is not a suitable hostel for old people. The discipline of the lodging house is necessarily harsh. Its standards are designed for younger men. The old persons are made to rise when they would like to sleep; they are forced to go out when they would like to sit. In the common lodging house deterioration of health is progressive. Not only are the living conditions unsuited to maintain physical well-being but great mental stress is occasioned to decent old men who, for financial reasons, are forced to associate with men whose standard of living is much below their own. There is no wish to condemn the lodging house as such for it serves a useful and necessary function. In view of the decrease of vagrancy and the promotion of schemes for the rehabilitation of the workless, it is a moot point whether the common lodging house should be replaced by a better standard of hostel for working men; this subject does not come within the ambit of this thesis but the author has no hesitation in condemning outright the use of the common lodging house as a place of residence for the aged.

It was found that many old people gave up their homes to live with relatives and that subsequently the relatives tired of them and they had of necessity to seek institutional accommodation. Much publicity has recently been given to the neglect of parents by their sons and daughters, but no emotional/

emotional public outbursts on the lack of filial affection and neglect of duty are likely to have the slightest effect upon the situation, nor is the criticism in many cases warranted. While there were many cases encountered in the survey of shockingly callous and brutal behaviour by sons and daughters, it would be wrong to condemn the attitude of the relatives in general. The cases in the survey were weighted in this respect but there are many old people, probably very many more than in institutions, who are reverenced and cherished by their families.

Where the old person has grown old in the home of relatives, then it is hoped that in his declining years there will be forthcoming that additional care which he requires. On the other hand, when the old person enters the relative's home in his old age he is less likely to be acceptable. After being accustomed to his own domestic routine for a life-time, the old person cannot adapt himself to the ways of the new household and the relative, who has already made major adjustments in his home to accommodate the old person, is not prepared to alter further his mode of living. The life led by the old person in his old home is usually very different from that in his new abode, organised as it usually is for active working people. Much "give and take" is required on both sides if adjustment is to be achieved. Sometimes the old person is unable to grasp the material differences of his new home. He may be used to gas and unable to master the intricacies of the electric cooker. His demand for a candle to use as a night-light may be regarded by his relatives as foolish in a house supplied with electricity, but the fumbling fingers of the old person who rises in the night may not be able to contact the electric switch. The old person may be of the spartan type who has practised strict economies; these he may attempt to introduce into the household/

household and may thereby produce intense irritation. The old person who has hitherto led a simple life may criticise with vehemence the late hours of his grandchildren. He may constantly attempt to mould them to the standards of his own early youth. If the old person would realise that he no longer holds the reins and were content to sit back and withhold criticism, and if the relatives would make allowances for the old person, then it might be possible for him to dwell happily with his relatives. The findings of this study go to show that, even with goodwill on both sides, the old person just does not fit in.

The predominating factor determining admission to hospital was illness. On recovery, patients were commonly kept in hospital for long periods as there was no suitable accommodation to which they could be discharged. In the hospital series, 40 per cent of the aged did not require to occupy hospital beds. This is a grave position in view of the large numbers who urgently await admission to hospital. This lack of domiciliary or allied accommodation immobilised hospital beds; it was found in the survey that many of those for whom institutional provision had been made need not have been admitted to an institution, and were acutely discontented with their placing. More than half of the old people could have lived outwith the institutions altogether provided some measure of assistance had been given, and, in addition, as many as 14 per cent were able-bodied persons fit to live completely independent lives.

It has been shown that residential accommodation had to be provided for certain old people - able-bodied men who had never been accustomed to household/

household duties, the frail whose mental or physical condition showed progressive deterioration, the handicapped who, because of impairment of vision or hearing, were unfit to live alone. Furthermore, those persons who have been resident in an institution for periods exceeding five years cannot be regarded as capable of adjusting themselves to other modes of life.

It was only too obvious that diverse categories of old persons had been living in the institutions. Too long has age alone been the criterion for admission to residential accommodation. This has led to the practice of classifying all people in advanced years as "aged" and housing them together irrespective of their physical, mental or social states. The system which groups the bedfast, the mentally confused, the emotionally unstable, the epileptic, the frail and the able-bodied under one roof must be condemned. Such provision could not possibly achieve contentment amongst the residents, nor is there any justification for the "composite" or "mixed" Home in respect of those who do not require institutional accommodation. It was found that practically two-thirds of the old persons under survey did not require institutional care, nor did the setting up of this provision prove satisfactory to the old persons themselves.

The overwhelming majority of the old persons in the institutions had found no measure of contentment. If we exclude from consideration at this point those who dwelt in Crookston Cottage Homes, then the very small number of 46 persons were happy in the residential accommodation provided. Those who found contentment were those who continued, whilst in the institution, to lead active and purposeful lives. They found satisfaction in all manner of pursuits - walking in the countryside, shopping expeditions, visiting distant friends/

friends, organising recreational activities, such as whist drives, bowling matches and concerts for the other residents. In contrast was the marked unhappiness which prevailed amongst the old persons who looked on life with a weary eye. The enforced idleness of institutional life following upon one of never-ending activity can but produce acute misery. The allocation of ward duties was a poor substitute for the natural and varied tasks which their own homes had provided. Great happiness was met amongst those who dwelt in Crookston Cottage Homes. There institutional life approximated closely to a real home. They are, in fact, ideal homes, providing as they do the measure of help which is necessary to maintain the health of the old people. Occupational therapy has no place in the Cottage Homes for, as in real life situations, the old people have sufficient diversional activities.

RECOMMENDATIONS

As will be gathered from the preceding pages, this study involves 550 persons - aged, infirm and chronic sick - resident either in Hospitals or in Homes for the aged. The author has, however, in view of her present position as Depute Medical Officer of Health for the City of Aberdeen, had every opportunity of studying the conditions under which the aged live in their own homes and she therefore ventures to submit certain recommendations as to how this vast problem - which has both social and economic facets - may be tackled.

In approaching this subject, it is but natural to feel pity for the aged unless they be numbered amongst the fortunate in being comfortably situated and happy with their lot but an endeavour has been made to set aside all sentiment and to obtain in proper perspective the picture of the problem of the aged. It must be acknowledged that, until the National Assistance Act came into operation on 5th July, 1948, the main place for the aged and the infirm and usually for the chronic sick who, for one reason or another could not be cared for at home, was the poorhouse with its adjacent sick wards, but the provisions of this Act made it incumbent on Local Authorities to break down this old tradition and to provide accommodation in houses for, say, 30 persons in substitution for the soul-destroying life in the poorhouse type of institution and all Local Authorities in Scotland have realised the wisdom of this change and are endeavouring to fulfil their responsibilities by purchasing large houses and moderately-sized mansion houses for the accommodation of the aged.

The/

The old poorhouse had notorious defects which persisted for many decades. Its reputation was such that decent working people, however great their need, shunned it like the plague. It was a "mixed" institution, the unemployed or unemployable able-bodied, the fatuous lunatic, the mental defective and the aged person sitting side by side in bare, repellent wards. The National Assistance Act aims at abolishing these conditions and substituting the "one-purpose" institution where each category can be cared for properly.

Coincident with the National Assistance Act was introduced the Children Act. Inter alia the former deals with persons in the higher age-group and the latter with those in the lower age-group, and the author has formulated her recommendations with the full realisation that weight must be given to those embodied in what may be termed the industrial age-group - those aged 15 to 65 years - on whom the survival of family life and indeed of the nation depends. There is at present a tendency to place undue emphasis on the provision of institutional accommodation for the aged.

It has been estimated that only one in every 20 old persons requires accommodation outside their own homes. Old people are happiest in their own homes and must be encouraged to remain there, if at all possible, and this leads one to the first recommendation.

1. How to retain old persons in their own homes.

To enable the old people to carry out the ordinary activities of life, their houses should be situated on the ground floor, should be of simple design, furnished with labour-saving devices, equipped for safe use and available/

available at a rent which the old persons can afford. Many of the houses in which the old persons dwell were found to be unsatisfactory from the hygienic point of view. Little can be done to these old houses, but, in the planning of new housing areas close attention should be given to the housing requirements of the aged in order to ensure that the best possible provision is made. At present there is a tendency to erect blocks of some 20 houses for old persons on a single site. No doubt this plan is followed because it is more economical to build in this manner and it gives architects scope to create a pleasing lay-out of attractive dwellings. But such schemes have many great de-merits: they segregate the old from the rest of the community and this is in the interests neither of the old people nor of the community as a whole; they impress upon the old people that they are something apart from other citizens and this leads to age consciousness; demands for domestic help are thereby increased. The old persons in need of assistance cannot look to their neighbours for help as the latter may be even more aged and infirm whereas if they are living in the midst of an ordinary community they may obtain welcome assistance from their less aged neighbours. On the other hand, it is much too costly for Local Authorities to provide whole-time domestic helps over long periods for old persons. Where the old persons receive organised part-time domestic help, their neighbours could be called upon to give the further assistance necessary to ensure the old persons' comfort. Accordingly, it is recommended that in all new housing areas and in the re-development of existing areas there should be set aside a certain number of houses for old persons. Into these houses, built on the ground floor and of smaller size than the other houses in the area, the old persons would move as their family grow up

and/

and leave them. This would make available the larger house for families who have need of greater accommodation. Thus, the old persons would be provided with accommodation more suited to their needs, and, at the same time, they could remain in the neighbourhood with which they were familiar and where they had established friendly relationships.

The old people should be encouraged to live in their own homes and the Local Authority should give the necessary help to enable them to do so by the provision not only of houses suited to their needs but also regular assistance. At the present time such domestic assistance is rarely instituted until the old persons have reached a stage when they can no longer look after themselves and when the standards in the home have deteriorated to such an appalling state that the domestic helps are reluctant and in some cases unable to take up duty. Domestic help should be given to the old persons at an early stage of their declining strength to conserve their well-being.

Laundry services and the provision of meals are other schemes which require to be developed and extended for old persons with a view to avoiding the necessity of admitting them to institutions. The meals-on-wheels scheme has been organised in many areas in Scotland by voluntary effort. Although the Local Authority is empowered to give grants to meet the round costs of such a scheme, their efforts in this direction must be restricted according to the degree of voluntary help forthcoming. The difficulties in the distribution of meals are considerable, and their delivery to individual homes and the collection of the used containers is a time-consuming process. Meals-on-wheels services should be restricted to old people confined to their houses.

For those/

those who are able to get about dining centres should be established. Proposals to extend the school meals service to old persons is commendable, but the use of the school's canteen can rarely be regarded as a practical proposition. Where there are two or three sittings of school children it is impossible to introduce another sitting which will enable the old people to dine at an hour to which they have been accustomed. The service in operation at the Crookston Cottage Homes for the provision of the cooked mid-day meals for the residents suggests a scheme which might be introduced into new housing areas where houses are being provided for the old people. On a convenient corner site there might be established a small centre where the old people could meet and dine. This meal would be cooked and delivered from a central depôt. After the tables had been cleared, the old people could linger and enjoy the company of their fellows, exchanging their news and gossiping awhile. Such a centre would provide excellent recreational facilities for the old people of the area, and, under the charge of a suitable warden, would enable the old people to be kept under unobtrusive supervision. The centres, which should be small and within easy walking distance for the old people, would be under the supervision of health visitors. It would be the duty of the wardens to report to the health visitors the absence of any regular diners. This would enable the health visitors to visit the absentees in order to ascertain their state of health and whether they had all the necessary help which they required. Too often are the cases of old persons in distress brought to the notice of the Local Authority only when the old persons are gravely ill. Physical and mental deterioration of the old persons may continue over a long period before neighbours interfere and bring the cases to the notice of the Local Authority or to the family doctors. Under the proposed scheme, however, the health visitors/

visitors would be able to keep the old people, especially the frail, under routine supervision and would be able to secure for them, at an early stage, such domestic help or home nursing or medical care as was considered necessary in order to maintain them in their homes and permit them to lead independent lives.

2. How to release beds in general hospitals.

In the course of investigation of the elderly cases in the two general hospitals which came within the scope of this survey the author was repeatedly faced with the fact that the specialised facilities of these hospitals were being slowed up by the presence of patients who did not medically require actual hospital treatment. Surely, in view of the long waiting lists of patients who urgently require hospital treatment, alternative accommodation can be provided for cases who do not actually require residence in hospital.

There are three possible solutions:-

(1) The author encountered a number of cases who - if they had homes of their own or had willing relatives - would have been sent home, provided that the Local Authority supplied domestic help, adequate nursing and efficient medical care. There are everywhere in Scotland many practitioners who would willingly give comprehensive medical service to these patients and Local Authorities are empowered to supply both domestic help and adequate nursing services.

(2) Where it is impossible to return the elderly sufferers to the homes which they occupied prior to admission, it has been suggested that to general hospitals there should be attached/

attached annexes for the accommodation of those cases who require medical and nursing attention short of that available in the general hospitals. The staffing of such annexes - which may be termed geriatric units - could be effected by the employment of a skeleton staff of trained nurses supplemented with assistant nurses and ward orderlies. A scheme of this nature would certainly release an appreciable number of hospital beds. But, in the present financial stringency, it is very doubtful whether the government could finance the building programmes involved.

(3) The third, and the most attractive solution is the establishment of the "Half-way House" which has been recently the subject of controversy in the Press and is often the subject of discussion at meetings of Regional Hospital Boards. What are the functions of a "Half-way House"? It entails an ad hoc building, part of which would be set aside for the aged and infirm who fall short of requiring hospital accommodation and who cannot be sent home, the other part being reserved for the mentally enfeebled who are too confused to be housed either in homes outside or in Old People's Homes. It is shocking that elderly old persons who are mentally enfeebled should be certified insane and transferred to Mental Hospitals/

Hospitals. These aged persons are not insane; they all lack the mental acuity which would enable them to enter Mental Hospitals as voluntary boarders and in their declining years they have involuntarily to submit to the unjustified stigma of lunacy.

The author strongly favours the institution of "Half-way Houses" which could be established in large existing houses. But on whom will the financial responsibility rest? Is it on the Local Authority or on the Regional Hospital Board? The author considers that the provision for such cases does not legally fall on either of these bodies; there appears to be a real gap in the legislature. In the interests of humanity, however, the author holds firmly that these bodies should shoulder the burden equally and that this might be brought about if Medical Officers of Health and Senior Administrative Medical Officers of Regional Hospital Boards endeavoured to educate their respective committees as to the urgent necessity of catering for this class of elderly persons - whether medically infirm or mentally enfeebled. In this connection, voluntary organisations can but conduct pilot experiments, and the author is convinced that "Half-way Houses" should be established now in the four cities in Scotland and that the closest liaison should be established between the/

the Local Authorities and voluntary organisations on the one hand and the Regional Hospital Boards on the other so that proper medical and nursing facilities may be afforded to the medically infirm and the mentally enfeebled, as natural degenerative changes are inevitable as age increases.

3. How to deal with the aged resident in common lodging houses.

Many of those aged persons whose normal habitat has, for a number of years, been common lodging houses, prefer to return to lodging houses after they have recovered from their ailments, the most usual being malnutrition, bronchitis and cardiac conditions. But return to these surroundings leads to early relapse; in this survey there have been many cases who have returned to lodging houses - with their relative independence - and have absolutely refused to enter Old People's Homes.

Legislation should, however, be introduced whereby common lodging houses should be debarred from admitting frail or elderly persons who are not in employment. It is further suggested that an extension of Section 47 of the National Assistance Act should be introduced whereby common lodging houses should not be allowed to admit as residents old persons who have recently been discharged from hospital. It may be thought that such action would constitute an undue interference with the liberty of the individual, but when one considers the restrictions universally imposed on dwellers in common lodging houses it will be apparent that, in the interests of old persons, the common lodging house is the last place where physical and mental stability can be maintained.

4. The social status of old persons in Old People's Homes.

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4. The social status of old persons in Old People's Homes.

A common shibboleth is that in sickness all men are equal and that no distinction should be made as regards either institution or treatment but, in the case of the aged, one cannot accept that all old persons whose circumstances demand residence in Old People's Homes be admitted to these Homes irrespective of previous mode of life and education. However undemocratic the author may seem, she considers the educated or professional old persons should not have to associate for the remaining years of their lives with old "lags", with post-alcoholics and with those whose mental calibre is of the lowest. There must be a differentiation; there must be a grading of old people's homes so that like dwells with like.

5. The value of Clubs for old people.

It is held that Clubs for old people are essential in all centres of population. The Club serves a dual purpose. It helps to dispel the tedium of life which is such an evident characteristic in many old people; it brings the old person into periodic contact with his contemporaries. Further, the Club can play a special part in relieving tension in the home. The old person sitting over the fire all day may interfere with the performance of routine domestic duties whereas attendance at the Club takes his presence from the home to which he later returns in a happy state of mind and makes an interesting conversational contribution to the family group.

6. Occupational Therapy - Its application to the aged.

Much has been written on the subject of occupational therapy for the aged and the value of training in youth for the utilisation of leisure in old age/

age. The author considers that occupational therapy for old people need only be organised in a very simple manner. Formal instruction in handicrafts to those advanced in years constitutes for the most part misdirected effort. While the old people who are trained in handicrafts should be encouraged to continue with them it is futile to teach handicrafts to old people whose vision and finer muscular movements are impaired. The latter should be encouraged to do exactly those things which they used to do and which they like doing. The author recommends the appointment in a large institution of a trained occupational therapist. Such a person would study the individual interests and capabilities of the old people and would devise occupations along the lines of those interests.

7. The arbitrary age of retirement.

With the changing times, there must be a re-adjustment of the arbitrary age of retirement. Bernard Shaw wrote on more than one occasion about "the horror of the perpetual holiday!". Many men at the age of 65 years are at their best. They have a clear conspectus of the position, present, past and future, and to put them on the shelf arbitrarily is entirely wrong - always provided that they are physically and mentally fit. If they are fit at the so-called retirement age they should be encouraged to continue at work as their ripe experience may be more valuable than the efforts of successors much junior in years and in experience. It is, however, essential that each case must be dealt with on its merits and it is not always easy to depart from arbitrary standards.

The statistician has shown that, since the beginning of this century, the expectation of life has been appreciably increased. It would be only reasonable/

reasonable to assume that the conditions which have led to the prolongation of life have also resulted in an improved state of health and an extended capability for work. In the light of these advances, it is necessary to review the statutory ages of retirement. It was clearly evident in the cases reviewed that there was a great loss to production by the compulsory retirement of fit persons. This loss of potential power in an ageing population is to be deprecated, as is also the disastrous effects of compulsory retirement upon the able workers. Not only must the age of retirement be extended but the employment of elderly workers on a part-time basis must be encouraged, even although it necessitates considerable re-organisation of industry to achieve this end. The employment of the healthy aged workers could replace in industry young married women who could fulfil a much more useful function by looking after their young children in their own homes.

8. The importance of co-ordinated effort.

If one surveys the problems of preventive medicine, one finds that progress has in almost all instances been attained by voluntary effort. Voluntary organisations, sponsored often by the Church, have performed outstanding work in the matter of education and in the care of the poor and of the aged. It is not an exaggeration to state that progress in social welfare has been originated and stimulated by voluntary endeavour. The efforts of voluntary organisations in their establishment of "Eventide Homes" for the aged are welcomed and appreciated. The problems associated with the aged, in their several categories, have become so varied and complex that voluntary organisations can touch only the fringes and the solution, which is vast in its implications and is social, economic and medical in character, must ultimately/

ultimately rest with Local Authorities. In the care of the aged, Local Authorities cannot operate alone. There must be complete co-ordinated effort exercised by the Local Authorities, by the Executive Councils - representing the family doctors - and by the Regional Hospital Boards who will require to deal with those aged persons who need hospital treatment on account either of acute or chronic sickness. It also falls on the Regional Hospital Boards to see that the chronic sick receive every attention by up-to-date methods of therapy so that bedfastness will, if at all possible, be averted. Regional Hospital Boards are responsible for all specialist services and should deal with such conditions as can be ameliorated by what is now termed the "comfort surgery" of old age, that is, the excision of piles, prostatectomy and the like. In none of the institutions which the author surveyed did there appear to be organised comfort surgery.

Finally, the author felt that, in these institutions, too little attention seemed to be paid to such ancillary services as dental treatment, chiropody, the supply of spectacles and hearing aids. Such services would have been welcomed by the old persons and it is gratifying to be able to state that all the services mentioned above have been provided in many of the recently established Old People's Homes.

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The author expresses the hope that, when further research has been conducted into the problems of the old and when comprehensive and co-ordinated domiciliary, hospital and hostel services have been devised, the difficulties which/

which now present themselves to workers in the field will gradually vanish. Some of the problems have their origin during adolescence and early manhood and therefore measures to prevent the physical and mental suffering that one so often encounters amongst the old must be instituted in early life and not in old age. Fifty years ago, the infant mortality rate in Scotland was 130; stated otherwise, there were 130 deaths of infants under one year per 1000 live registered births. Such a wastage of infant life aroused the public and the legislators alike and in consequence specific preventive duties in this direction were imposed on Local Authorities. The result has been most satisfactory, the infant mortality rate in Scotland in 1950 having been reduced to 39. If concentrated effort at the beginning of life has borne such rich reward, is it illogical to suggest that, if the problems of the aged were tackled with similar enthusiasm by economists, industrialists, medical men and legislators, the lot of the aged would be enriched in the matter of housing, personal comfort, recreation and rehabilitation? Old age must hold neither terrors nor anxieties. Let these be replaced by peace and tranquillity.

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Acknowledgements.

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V O L U M E I I

This Volume consists of photographs illustrative of places and of statements appearing in Volume I of the Thesis. The photographs are tabulated as under:-

Nos.	1 - 8	Crookston Home.
	9 - 19	Crookston Cottage Homes.
	20 - 28	Woodend Home, Aberdeen.
	29 - 34	Common Lodging House, Aberdeen.
	35 - 42	Old people in their own homes (Aberdeen).
	43 - 44	Houses in Aberdeen specially designed for old people.
	45 - 50	Aberdeen Corporation Hostels for old people.

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Crookston Home.

Central Administrative Block of Crookston Home which accommodates approximately 300 persons.

Crookston Home.

The Home has two wings. Above is shown the large three-storey wing for male residents. To the left of the photograph is the Central Administrative Block (Photo 1) to which it is attached by means of a long corridor.

Crookston Home

A dormitory in the Home. Old persons, on their first admission to the Home, find the large dormitory strange. In the large dormitory the old person with bronchitis disturbs the sleep of the other residents, as also does the old person who snores.

Crookston Home

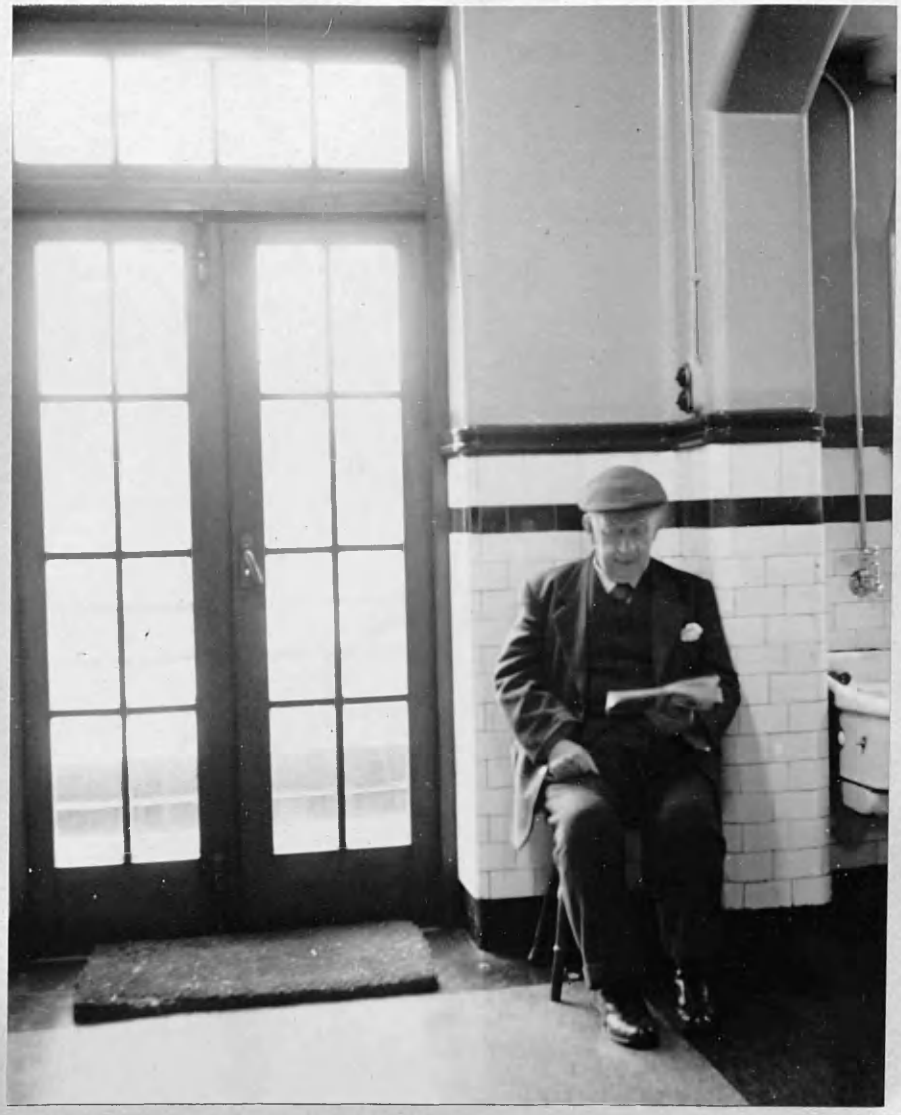
In the Home there is only one recreation room in each flat. This recreation room is provided with a good billiard table, but, unfortunately, it is in this room that others, having no interest in the game, must congregate.

Crookston Home

The old ladies in the foreground enjoy a game of dominoes. In the background is seen the large room in which the old persons are grouped, mostly along the walls.

Crookston Home

Unfortunately the Home is built in three storeys and the residents are required to use the stairs. This places an unnecessary strain on those elderly people who have disabilities of heart or limbs.



Crookston Home

This is not a posed photograph. The old man was encountered by chance in the course of taking photographs of the Home. He is stone deaf and this photograph exemplifies the voluntary isolation of the deaf.

Crookston Home.

The maids' section of Crookston Home was converted into a hostel for 15 old persons. The above photograph shows the sitting room in which the old people are enjoying a pleasant Sunday afternoon.

Crookston Cottage Homes

The Cottage Homes are built in two-storey blocks. The above photograph shows eight cottages, with verandahs looking on to attractive gardens.

Crookston Cottage Homes

The blocks of cottages differ in design. Here are seen both single and two-storey cottages.

Crookston Cottage Homes

The low building in front is one of the combined dining and recreation rooms of the Cottage Homes.

Crookston Cottage Homes

The interior of the combined dining and recreation room, the exterior of which is depicted in Photograph 11. In this room is being served the hot mid-day meal.

Crookston Cottage Homes

The interior of the combined dining and recreation room. The residents are enjoying a quiet game of cards.

Crookston Cottage Homes

Interior of one of the Cottage Homes. The man seen above is as house-proud as any woman. He keeps his cottage in excellent order.

Crookston Cottage Homes

Interior of one of the Cottage Homes. The housewife in her well-appointed kitchenette devotes herself with real pleasure to the baking of scones.

Crookston Cottage Homes

Interior of one of the Cottage Homes. Contentment reigns in the pleasant living room of the cottage. The wife is knitting socks for her husband who, reclining at his ease, reads to her interesting items of news.

Crookston Cottage Homes

Interior of one of the Cottage Homes. The bed annexe opens off the living room. It has an independent window and is thus well lit and ventilated.

Crookston Cottage Homes

Interior of one of the Cottage Homes. This is a picture of the oldest resident in the cottages. She is aged 95 years of age and she is shown tuning in to her favourite programme to which she will listen while she undertakes her mending.

Crookston Cottage Homes

Interior of one of the Cottage Homes. In this sheltered environment, this remarkable old lady of 95 - who also appears in Photograph 18 - is able to undertake her household tasks.

Woodend Home, Aberdeen - an Old Poor Law Institution

The bare, dingy recreation room is typical of many poor law institutions. A few chairs are provided with arms, but all have wooden seats.

Woodend Home, Aberdeen.

The attitude portrayed by the inmates is typical of life in any poor law institution. They find nothing with which to occupy themselves and simply sit around on the hard comfortless chairs or benches.

Woodend Home, Aberdeen.

This picture again illustrates the relics of the poor law institution. The old people either doze in their comfortless chairs or brood on the miseries of their existence. The light, bentwood chairs slip on the highly polished floors and many a fall is sustained by the less agile old people.

Woodend Home, Aberdeen.

There is no cheer in this large, cold "mausoleum" in which the old people dine. Food is partaken with all possible haste. Even in the dining room the male and female residents are segregated.

Woodend Home, Aberdeen.

The day-room for the women is almost as cheerless as that for the men. In order to accommodate all the old people in the room, the chairs are arranged in rows and those at the back enjoy little of the warmth of the fire.

Woodend Home, Aberdeen.

Another corner of the day-room. Again is apparent the utter dejection of the residents and their state of complete inactivity. Even to the most casual observer it is evident that some of the residents are of very low mentality.

Woodend Home, Aberdeen.

These three old women are in striking contrast to the old lady portrayed in the Cottage Homes (Photographs 18 and 19). Their bare, comfortless environment brings little happiness to them in the closing years of their lives.

Woodend Home, Aberdeen.

The only recreation available to the old people is walking in a paved courtyard enclosed by a high wall. Overshadowed by other buildings, for only a short period during the day is sunshine available.

Woodend Home, Aberdeen.

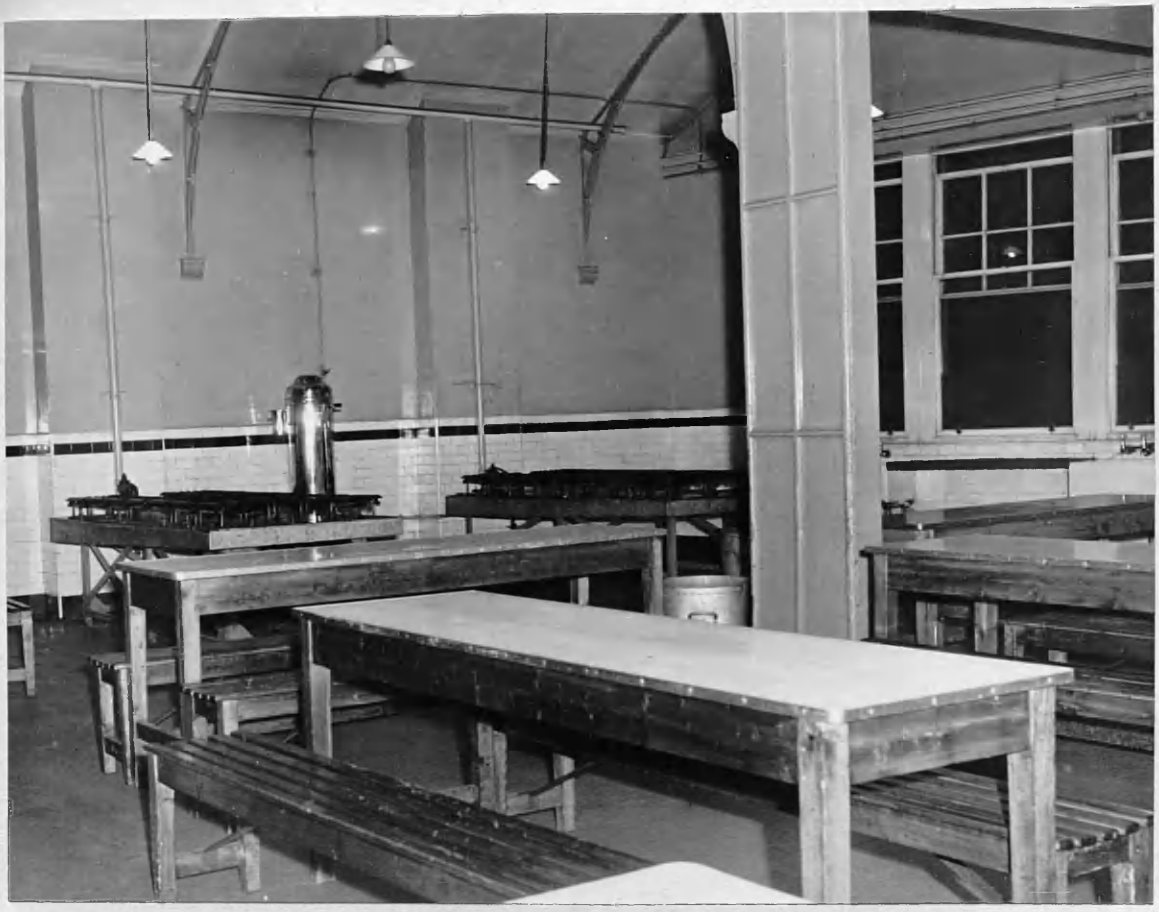
Recreation amongst the old people for the most part consists of pacing the long corridors. The old people gaze out with longing on the world outside. This photograph was taken without the knowledge of the old people.

Common Lodging House, Aberdeen.

The new arrival awaiting admission is the typical lodging house habitué. His belongings are few, his prospects uncertain and his residence indefinite.

Common Lodging House, Aberdeen.

The day-room. The inmates are of all age groups. Although the photograph was taken at 11.30 a.m., when one might have expected the young men to be out looking for work, they seemed to be content to indulge in a game of cards. The forms give even less comfort than the hard chairs in the poor law institution.



Common Lodging House, Aberdeen.

The kitchen cum dining-room. This photograph shows the dining tables and forms in the common lodging house. In the background are seen the gas cookers upon which the men cook their food and the Jackson boiler which delivers a constant supply of hot water.

Common Lodging House, Aberdeen.

The "kitchen". The unattended pots on the cooking stove belong to residents who made a quick departure on the arrival of the photographer. They were convinced that the photographer was a police agent.

Common Lodging House, Aberdeen.

Their meal, when cooked, is carried by the residents to the adjoining dining tables. Many of the old men cannot be bothered to stand and watch pots, and, in consequence, live chiefly on tea, bread and jam.

Common Lodging House. Aberdeen.

The narrow cubicle is a poor resting place for the aged and infirm person. His rest is disturbed by the noisy presence of the more boisterous residents in the lodging house.

Old people in their own homes.

The appalling conditions under which some old people dwell are shown in this picture. This type of case is usually only brought to the notice of the local authority when the old person falls ill. The institution of organised domestic help for such cases is impossible. Radical changes would require to be effected in this building before it could be made reasonably fit for human habitation.

Old people in their own homes.

Despite the squalor in which he lives, this old man of 80 is supremely happy in his garret. It is inconceivable how rest on such a palliasse could induce sleep.

Old people in their own homes.

Since the death of his wife many years ago, this old man has lived alone. Although his home is poorly furnished, he tries to keep it clean and through his independent nature he has refused all offers of domestic assistance.

Old people in their own homes.

This old man who lives alone is finding it increasingly difficult to look after himself. He does, however, keep his room spick and span despite the lack of modern facilities and his own failing strength. He would appreciate living in one of the houses specially designed for old people.

Old people in their own homes.

This old lady has become much neglected through living alone. She suffers from an osteo-arthritic condition of the joints which has confined her to the house. She has neither friends nor relatives and is somewhat lonely. The institution of regular domestic assistance will be of immeasurable benefit to her.

Old people in their own homes.

This depicts the sad case of a bedridden man whose wife has recently been taken to hospital. He is dependent upon the part-time services of a domestic help and of his neighbours. Unless careful watch is kept over him his physical state will rapidly deteriorate.

Old people in their own homes.

One of the difficulties encountered in the homes of old people was the washing and drying of clothes. Here in the kitchen is a make-shift arrangement for drying clothes; it causes considerable inconvenience to the old person both day and night.

Old people in their own homes.

The difficulties which the old person experiences in looking after himself in his own home are increased when there is no water available within the house. Many of the old people obtain their water from a common tap on the stair landing and consequently have to negotiate stairs whenever they require drinking water or wish to empty slops.

Houses specially designed for old people.

These houses situated at Kaimhill, Aberdeen, are attractively designed for old people; they are built in groups of twenty in the form of an open square. Unfortunately, they have been situated far distant from the shops and the old people have quite a distance to travel in order to do their shopping and to draw their old age pensions.

Houses specially designed for old people.

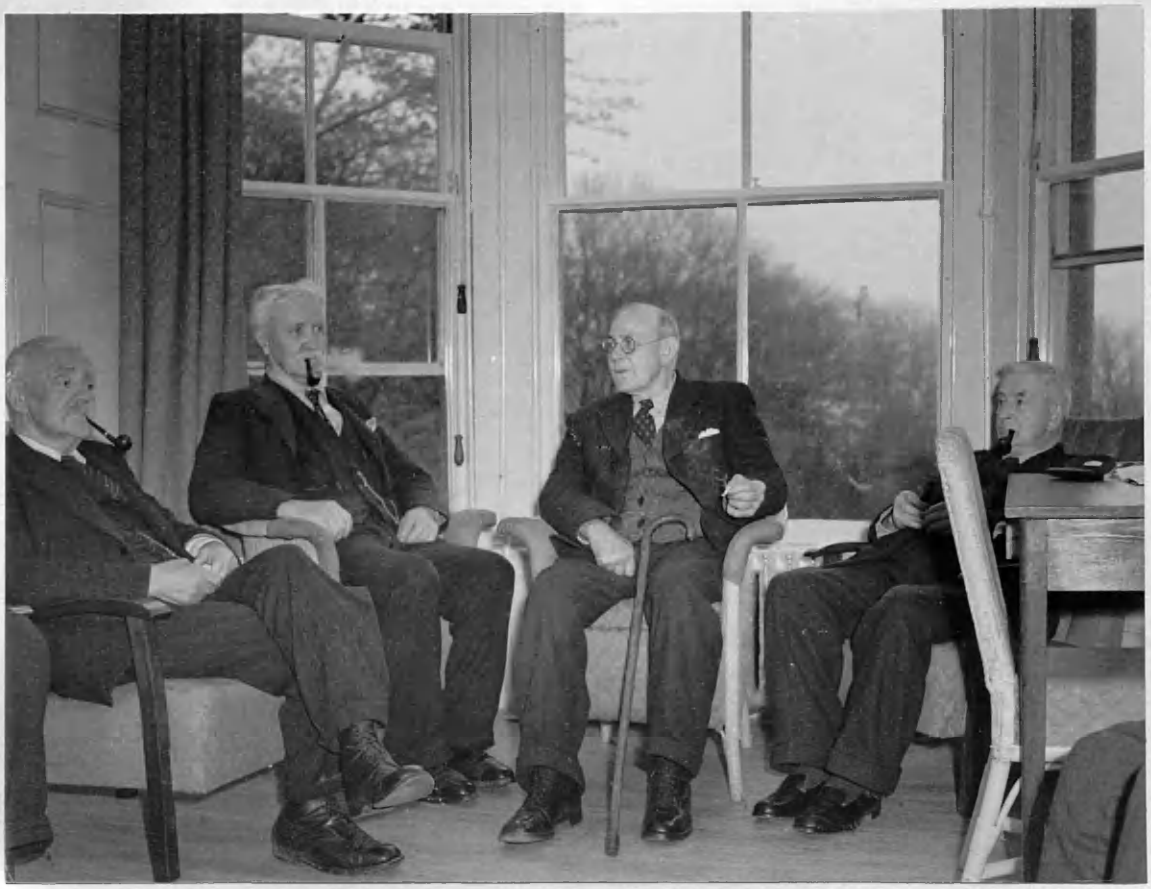
Kaimhill cottages are built for married couples and the old people live here, enjoying to the full their lives in these homes equipped with the latest labour-saving devices.

Balnagask Home, Aberdeen.

This attractive mansion house, purchased by Aberdeen Town Council, accommodates 24 old people. In the spacious grounds the old people enjoy all forms of physical recreation. The house is situated convenient for buses so that the residents are not isolated from the community.

Balnagask Home, Aberdeen.

This corner of the lounge in Balnagask Home shows a group of old ladies who were transferred from the poor law home, previously pictured (Photograph 24). There has been a tremendous transformation since their entry to the hostel. The picture of inactivity in the Home contrasts vividly with the happy occupations of the women here.



Balnagask Home, Aberdeen.

These old men sitting in the sunshine of the window recess in the smoking room were also removed from the institution previously mentioned. They are happy and contented in their new surroundings and take a keen interest in the activities of the Home.

Balnagask Home, Aberdeen.

A corner of the bedroom contrasts vividly with the bare dormitories found in the large Homes for old people. Each resident is provided with a locker of his own, in addition to having his own wardrobe.

Balnagask Home, Aberdeen.

The conservatory. The old men enjoy the morning papers in the warmth and sunshine of the conservatory.

No. 3 Ferryhill Place, Aberdeen.

The end house of a Terrace has been purchased by Aberdeen Corporation and converted into a Home to accommodate twelve old men. It is situated in a good working class residential area, convenient for 'buses and within walking distance of a very fine park.