

Introduction: A Strange Eventful History

*Last scene of all,
That ends this **strange eventful history**
Is second childishness and mere oblivion;
Sans teeth, sans eyes, sans taste, **sans everything**.*

William Shakespeare, *As You Like It* (Act II, scene vii)

On 21 January 1965 Barbara Robb visited an elderly acquaintance, Amy Gibbs, an in-patient on a long-stay back ward at Friern psychiatric hospital, North London. There, she stepped into the murky, longstanding and hardly shifting territory of older people's institutional care. Shocked by what she saw, such as harshness from nurses and the patients' uniform haircuts, institutional clothing and lack of personal possessions and occupation, Barbara began a diary of her visits because 'I felt that I would never have another really easy moment unless I did everything I could to try to right this situation' (Allen 1967). Within months she established AEGIS, Aid for the Elderly in Government Institutions, which became one of the country's most determined pressure groups (Robinson 1970). Barbara Robb resembled earlier well-known women campaigners, such as Elizabeth Fry (1780–1845) the prison reformer, and Florence Nightingale (1820–1910) who professionalised nursing. All three women were appalled by the inhumanity they witnessed in institutions and set their minds to eliminating it. They were upper-class women

of independent means with strong religious inspiration for their work. They all dedicated years to achieving improvements.

This study primarily concerns the back wards of National Health Service (NHS) psychiatric hospitals in England. These wards mainly housed people over sixty-five years of age alongside some younger people with chronic mental illness. Psychiatric hospitals were only one part of the health and welfare services used by older people, but care provided in them was particularly problematic. Patients, their families and hospital staff, all had low expectations of improvement or discharge. Staff showed little interest in older people who often received no clear psychiatric diagnosis, treatment or rehabilitation, unlike younger people in the same hospital (Martin 1962). Many staff could not ‘formulate a “psychogeriatric” problem in any other terms but as the need to get it instantly off their hands’ (Arie 1973, p. 541). The patients did not benefit from the expertise of geriatricians, the doctors who specialised in older people’s physical health-care. Geriatricians aimed to diagnose illness accurately and provide treatment to improve health, well-being and function, but they worked mainly in general hospitals and hardly entered psychiatric hospitals (Denham 2004, p. 357). In hospitals without geriatricians, older people were particularly at risk of poor-quality care associated with negative, ageist stereotypes, which assumed they were all afflicted with irreversible chronic illness that would result in inevitable and hopeless decline.

AEGIS’s book, *Sans Everything: A Case to Answer* (Robb 1967), described scandalous inhumane and inadequate care in long-stay wards. The wards were overcrowded and understaffed. Undignified and unkind practices included teasing, hitting and swearing at patients. In many hospitals, there was no privacy for personal care, and bedtime could be as early as 5 P.M. *Sans Everything* revealed deficits and proposed remedies, including specialist psychiatric services to treat and rehabilitate mentally unwell older people to prevent admission and enable discharge, and housing schemes on surplus land around psychiatric hospitals to generate income to help pay for the services. It also recommended a hospital ombudsman, an inspectorate to monitor and ensure high standards, and better NHS complaints procedures.

Throughout AEGIS’s campaign, NHS staff, patients and their relatives, the media and the wider public responded in a diversity of ways. These ranged from acknowledgement of the allegations of bad practice, such as by the press, to rejection, particularly in higher tiers of NHS administration. AEGIS struggled to convince the Ministry of Health and the Regional Hospital Boards (RHBs) about the happenings in the hospitals that they oversaw.

This study argues that Barbara Robb, AEGIS and *Sans Everything* had a far greater role than previously recognised in influencing improvements in services. *Sans Everything* was controversial, and the Ministry of Health discredited it, which obscured its centrality. However, Richard Crossman, Secretary of State for Social Services (1968–1970), and Brian Abel-Smith, Professor of Social Administration at the London School of Economics (LSE) who had a long-term interest in the NHS, regarded AEGIS as a powerful influence on NHS policy and development (Crossman 1977, p. 727; Abel-Smith 1990, p. 259). Alternative views include those in Robin Means and Randall Smith's (1985) study about welfare services for older people, which emphasised the government's role in making improvements, rather than pressure from AEGIS to ensure that it acted. Charles Webster (1998, p. 119), official historian of the NHS, regarded the Ely Hospital Inquiry as pivotal for stimulating change, rather than the events that preceded and followed it, which Barbara steered, often behind the scenes.

The primary aim of this book is to tell the story of AEGIS, *Sans Everything* and the campaign to improve older people's care. Barbara intended to do this herself, but time did not permit it.¹ Little is known of the people and events behind the allegations described in *Sans Everything*, who made them and what inspired them to do so. Published sources reveal merely summaries of the official inquiries into the allegations, the shortest being one and a half pages (Ministry of Health (MoH) 1968, pp. 82–83). These reports only glimpse at the inquiry processes, their findings and recommendations stemming from them. Barbara's tenacity to the cause was remarkable: every defeat or success increased her resolve to achieve her aims, yet little is known of her background and personality, and the support mechanisms that enabled her to do so. She organised AEGIS from her cottage home and was constantly at the helm. AEGIS's story is thus inextricably interwoven with her life. When Barbara died in 1976 at age sixty-four, AEGIS died with her. However, by then the government had initiated many of the *Sans Everything* proposals, and other campaigners, such as the Group for the Psychiatry of Old Age at the Royal College of Psychiatrists, adopted some of AEGIS's longer-term objectives (Hilton 2016b).

This book also has a secondary aim: to explore whether issues raised by AEGIS have lessons for today, because many of its themes ring true fifty years on. It aims to give insights into the reasons for repeated deficits in provision and inform current debate concerning older people's health and social care. Recent scandals have included *Care and Compassion?* (Health

Service Ombudsman (2011), the Mid Staffordshire Inquiry (2013), *Orchid View Serious Case Review* (West Sussex 2014), and the BBC Panorama documentary *Behind Closed Doors* (2014). Analysis of: how, why and by whom abuse and neglect took place in the 1960s; the recommendations made to remedy the situations; and what was (and was not) achieved, may contribute to understanding the mechanisms behind abuse in institutions and hence the steps that can be taken to prevent recurrences. Historical studies of the care of older people are particularly important as inhumanities towards them escape from public memory more rapidly than cruelties towards children. Margaret Panting, a seventy-eight-year-old woman who suffered repeated physical injury and died at the hands of relatives in 2001 is virtually unknown (Ash 2011, p. 100). In contrast, children, such as Victoria Climbié, killed by her guardians in 2000, and ‘Baby Peter’ who died at the hands of relatives in 2007, are embedded in public consciousness.

A study of AEGIS lies at the interface of the history of NHS policy and practice, mental health, mental hospitals, old age and gender. It reveals much about the workings of higher levels of NHS administration, such as how it managed complaints and deficits in services and its relationship with the public. It fills a gap in twentieth-century women’s history, including from the slant of their position as older patients. Adequate health and welfare support in old age is particularly relevant to women because on average they live longer than men. They often live alone while suffering from frailty and age-related chronic degenerative illnesses. They may struggle to cope and require institutional care towards the end of their lives. In the 1960s, older working-class women often had particularly meagre financial resources so depended on state welfare provision and occupied a disproportionate number of psychiatric hospital beds. Other women discussed in the study besides Barbara include her supporters and author-witnesses; journalists who publicised her concerns; hospital staff; and middle-class women undertaking voluntary roles on RHBs, on Hospital Management Committees (HMCs) and with charities.

To understand the context and background of AEGIS’s campaign, and to highlight this study’s contemporary relevance, several further issues are discussed in this introduction: early- and mid-twentieth-century psychiatric hospital scandals; the handful of studies concerned directly with AEGIS; pressure groups; and ageism. The larger background subject of how psychiatric hospital provision developed for older people until the mid-1960s is explained in the next chapter.

SCANDALS OF PSYCHIATRIC HOSPITAL CARE

Sans Everything was not the first or the last time poor care in psychiatric hospitals was reported and investigated. A review of existing historical studies about these episodes gives some indication of the hurdles which AEGIS might face in its endeavours. Montagu Lomax, a doctor who worked at Prestwich Asylum for a short time, wrote *The Experiences of an Asylum Doctor* (1921) about inadequate clinical practice there. It became a cause célèbre. Colleagues were hostile and accused him of sensationalism and exaggeration. The asylum regulatory authority, the Board of Control, criticised ‘the methods which Dr Lomax has seen fit to adopt in preparation and publishing his book . . . the charges made were sheer nonsense and a gross calumny’ (Harding 1990, p. 180). A committee of inquiry was unreceptive, and an anonymous contributor to an academic psychiatric journal (Anon. 1923, p. 91) praised it for a ‘masterly and logical’ rejection of Lomax’s complaints. Despite the rejection, the committee made recommendations for improvements based on Lomax’s report, as did the Royal Commission on Lunacy (1924–1926), whose conclusions underpinned the Mental Treatment Act 1930 (Harding 1990, p. 181). Harding provided insights into the way a whistle-blower can be victimised and officialdom can viciously reject constructive criticism but then use it as a basis for proposing improvements.

Relatively little historiography is available about AEGIS. Four researchers from the academic discipline of social administration and policy explored its work. Kathleen Jones and AJ Fowles (1984) included AEGIS as part of their study on the literature of long-term care and custody in the 1960s. John Martin (1984) analysed hospital inquiries from 1968 until 1984, and David Cochrane (1990) based his doctoral thesis on a case study of AEGIS and the process of health policy change in England. Some other writers have touched on *Sans Everything* but have tended to follow the Ministry of Health’s interpretation, that *Sans Everything* was irresponsible scare mongering and an inappropriate smear on all psychiatric hospital nurses.² Although even a cursory glance at *Sans Everything* (p. xiv) shows this is incorrect, the perception has crept into secondary sources. Michael Arton (1998, p. 288), for example, stated that AEGIS gave ‘the impression to the general public that mental nurses were a group of uncaring sadists’, but he did not cite confirmatory evidence for his statement.

Jones and Fowles’ analysis was based on a handful of published works, leading them to place little credibility on the accounts of neglect and abuse

in *Sans Everything*. They accepted the official inquiry reports that most of the allegations were false. They concluded, in an uncomplimentary way, that: ‘The whole affair was a very skilful exercise in public relations; and despite the flamboyance, the distortions and the inaccuracies, it worked’ (p. 108). Archival sources used in the present study challenge their criticisms; the ‘affair’ label would be more apt for the Ministry’s handling of the situation than for AEGIS’s allegations.

Martin (1984) analysed the first cluster of inquiries into psychiatric hospitals, including *Sans Everything* (MoH 1968), Ely (Department of Health and Social Security (DHSS) 1969), Farleigh (DHSS 1971), Whittingham (DHSS 1972), and South Ockendon (DHSS 1974). He described them as being of the ‘old order’, because ‘their circumstances derived from past inadequacies of provision, and from lack of new thinking’.³ Martin concurred with the published inquiry reports into *Sans Everything* and with the Ministry’s view, that almost all allegations were disproved, thus discrediting AEGIS. However, he did not discuss the incongruity of that in the context of the rapid succession of investigations into similar allegations in other hospitals that were shown to be justified.

Martin discussed patterns of malpractice. Usually there was a chain of events and a broad context of failures of care rather than a single ‘bad apple’. Staff often knew what was going on but did nothing about it, partly because of the power of the work group and of staff loyalty to it (Martin 1984, p. 243). Good clinical practice was undermined when secondary aims (making things easier for the staff) were substituted for primary ones of person-centred care. This resulted in gradual deterioration of standards, and ‘the ultimate exposure made by a newcomer who is not conditioned to standards which have become familiar to the long-term staff’ (p. 244). Martin also noted that hospital hierarchies, especially in the nursing profession, did not encourage questioning by the all-important ward staff undertaking face-to-face work with patients, and that creativity, individuality and clinical responsibility produced better care. Failure of staff to take on as much personal responsibility as possible was ‘likely to result in the quality of care sinking to that level which is most convenient for the staff to provide and which satisfies minimum standards’ (p. 243). This conclusion was unnervingly close to a comment made by Andy Burnham, Secretary of State for Health, 2009–2010, to the Mid Staffordshire Inquiry (2013, p. 1378): ‘the NHS is not good at giving its front-line staff a sense of empowerment. People with good ideas do not feel that they can easily

put them into action.’ Martin’s comment about the importance of the newcomer in detecting poor standards was apparent in the role of Julie Bailey, who visited her mother in hospital and whose concerns culminated in the Mid Staffordshire Inquiry (Cure the NHS 2016).

Martin also argued that professionally isolated staff, such as in the rural psychiatric hospitals, could perceive outside influences as threatening and likely to show up their deficiencies, rather than being revitalising. On wards with inadequate staff levels and resources, complaints could be resented strongly. In such circumstances, staff stuck together, showing up ‘the darker side of group loyalty’, suppressing criticism and victimising the critic. Martin also noted that ‘To say one is doing one’s best under the circumstances is to recognise that one is *not* doing the best work. It is a defence with built-in vulnerability. It almost invites attack and it generates a guilty sensitivity to criticism’ (p. 245). ‘Doing one’s best under the circumstances’ is also heard in the NHS today, to justify inadequate clinical services associated with underresourcing.⁴

Cochrane’s (1990) analysis of the important role of AEGIS in NHS policy development challenged the earlier interpretations, which were largely based on published texts. He demonstrated how it initiated the succession of scandals in psychiatric hospitals (c.1968–1974) and contributed to health service policy, including raising the priority of mental illness and mental handicap services and influencing the establishment of a hospitals’ inspectorate, ombudsman and NHS complaints procedures. Cochrane documented Barbara’s political career as a social reformer, but some of his conclusions, such as extrapolating her influence into the late 1980s, are hard to justify historically in view of the complex processes of social and health policy change.

Cochrane was fortunate to have Abel-Smith to supervise his thesis. He also had the advantage of being able to undertake oral history interviews with people who knew Barbara, collaborated with her or opposed her. They included Geoffrey Howe, WJA ‘Bill’ Kirkpatrick, Kenneth Robinson, CH Rolph (Bill Hewitt), David Roxan and Lord Strabolgi, all of whom have since died. Cochrane did not give reasons why Sir Arnold France, Permanent Secretary and Robinson’s ‘right hand man’ at the Ministry of Health (1964–1968) (Green 2004) declined to be interviewed, and other DHSS officials and ‘senior health authority officers’ asked not to be named (Cochrane 1990, p. 389).

The present study differs from Cochrane’s in several ways. First, it is outside the constraints of a social science discipline and aims to explore

what happened historically rather than relate events to a theoretical model. Second, it is more people focussed. Who was Amy Gibbs, ‘Miss Wills’ in *Sans Everything*? Who were the pseudonymous contributors to the book? How did Barbara cope with the hostility and discrediting of her work? Third, now that the closure period for official archives has expired, more sources are available so it is possible to explore the *Sans Everything* allegations and inquiries in greater depth. This supports the timeliness of a further study of AEGIS’s work.

SOCIAL JUSTICE, PRESSURE GROUPS AND THE EMERGENCE OF AEGIS

Societal changes in the 1960s included a focus on personal autonomy and individuality with less submissiveness to authority. This affected lifestyles, expectations about standards of living and demands for humane and safe public services and environments. Despite greater affluence for many people, disturbing large-scale poverty, especially affecting children, large families and older people, was ‘rediscovered’ by researchers at LSE (Thane 2011). LSE academics particularly conspicuous in this work included Abel-Smith and Peter Townsend. Abel-Smith supported and gave credence to several campaigns, such as the Child Poverty Action Group (CPAG) (Townsend 2004; Sheard 2014, pp. 224, 256). Townsend (1962, 1963) published in-depth sociological studies, including about the needs of older people. He wrote about their poverty and the disadvantageous health inequalities that accompanied it. He cited a 1950s estimate that up to 75 percent of retired people had incomes low enough to qualify for means-tested National Assistance (Townsend 1963, p. 186). Poverty became an important social justice issue and a matter for ‘pressure groups’.

Pressure groups, and lobbying and petitioning governments and leaders, were well-established mechanisms for conveying public unease and encouraging social change. For example, 150 years before Barbara formed AEGIS, Elizabeth Fry established a small campaign organisation, Association for the Improvement of the Females at Newgate, after her first visit to the London prison (Howard League 2016). In the 1960s many new organisations emerged, expressing concerns and aiming to generate action. They campaigned on issues such as the environment, nuclear disarmament, abortion, homosexual and women’s rights and other ‘conscience’ issues. The broadly focussed Consumers’ Association,

founded in 1957, became a powerful representative of this general trend (O'Hara 2013). Crossman was wary of well-run pressure groups, like AEGIS and CPAG: 'these small splinter groups, can be extremely powerful if they provide the press with hot poisonous news. They can really damage our image.'⁵

Investigative journalism and a less deferential media emerged in the 1960s, with some newspapers 'geared to shaking and rattling', seeking justice and making 'people sit up straight'.⁶ One journalist, Andrew Roth, contrasted the changes in his profession from the 1950s to the 1960s:

Pressmen, political correspondents like myself, for example, would know a great deal more than they would report because they didn't think it was 'nice' to report about certain things. . . . Now that's changed very considerably, thanks to a number of institutions like *Private Eye* and the breakout of the BBC in *That was the week that was* (Davies 1985, pp. 17–18).

This gave opportunities for professionalised, media-aware campaigning organisations to publicise their concerns to help achieve solutions. The BBC, for example, showed *Cathy Come Home*, Ken Loach's film that told the bleak tale of Cathy, who lost her home, husband and eventually her child through the inflexibility of the British welfare system. The film was central to founding the housing charity Shelter (Shelter 2016).

Before the creation of the NHS in 1948, financing of hospitals and long-stay care was largely addressed through philanthropic and Poor Law mechanisms. The donor–beneficiary relationship inhibited protest about substandard practice or facilities, a deeply engrained pattern that, to some extent, recurs or has continued. In the 1960s, patients generally expressed their appreciation and uncritical acceptance of the care they received (Cartwright 1964, pp. 8, 203). Older people rarely complained then or now (Parliamentary and Health Service Ombudsman (PHSO) 2015). The authorities interpreted lack of complaints to mean that provision was satisfactory.⁷ They did not take into account that many patients and their relatives feared the consequences of complaining or did not know how to complain (also PHSO 2015), and there were no guidelines informing them how to do so.

Although patients had individual contact with doctors, the paternalistic doctor–patient relationship in the 1960s discouraged patients from asking questions about their own health or commenting on aspects of the service they received. Societal changes away from conformity towards greater

personal autonomy were associated with less acceptance of medical paternalism and a shift away from the assumption that the doctor and the NHS always knew best. Disquiet about experiences of NHS patients received public airing, such as in Gerda Cohen's *What's Wrong with Hospitals?* (1964), based on her own frustrating and depersonalising experience of hospital care. She wrote that patients of all ages had 'no rights, no dignity, no status', were treated 'like chipped flower-pots in for repair' and were kept in ignorance 'merely because it's no one's job in a hospital to tell the patient what is happening' (pp. 7, 9).

In contrast to pre-NHS days, after 1948, general taxation funded the NHS. Public funding meant public ownership. In the early 1960s this linked to the idea of patients as 'consumers' of health services with some control of the 'product' they used (Anon. 1961). This connected to the creation of NHS-focussed pressure groups, which concentrated on efficacy of official policy, or post-policy failure, rather than on individual needs (O'Hara 2013). Helen Hodgson, a teacher, set up the Patients Association (PA) in 1963 following reports about the drug thalidomide that caused severe physical deformities in children born to mothers who took it during pregnancy, and Maurice Pappworth's (1962) revelations in 'Human guinea pigs: a warning', about doctors' experiments on unknowing patients (Mold 2012, p. 2032). The PA aimed to be a nationwide patient-participatory organisation, focussing on a growing tide of discontent with NHS services, particularly hospitals, doctors and bureaucracy, including the paucity of information on how to make a complaint. It aimed to educate the public on their rights and responsibilities as patients and to improve care across the NHS (Macfarlane 2009). Pressure groups developed various styles, ranging from the antagonistic (such as the PA) to the National Association for the Welfare of Children in Hospital (founded 1961) (Action for Sick Children 2016), whose members were afraid of being seen as difficult, partly out of a fear that hospital staff would exact reprisals on their children (Mold 2013, p. 238).

Alex Mold's study (2013, p. 240) of the changing role of the patient and NHS consumer groups concentrated on acute hospitals, only once mentioning long-stay patients. The care of older, mentally ill and mentally handicapped people on long-stay wards was peripheral to health service pressure groups such as the PA. Concerning older people, the National Old Peoples' Welfare Committee (founded 1944; later Age Concern) mainly provided practical philanthropic support and lobbied the government about community provision for older people, and Help the Aged

(founded 1961) emphasised social support and relief of poverty (Age UK 2016).⁸ Neither had specific expertise or interest in mental health. The National Association for Mental Health (NAMH; founded 1946; later MIND) focussed mainly on younger people. Nevertheless, in 1963, NAMH devoted one issue of its journal to older people. An editorial, ‘The elderly: “Living and partly living”’ (Anon. 1963) referred to many older people ‘with little sense of usefulness, little interest in anything, and little affection from anyone’. It was hardly optimistic, but did suggest that interested psychiatrists could work together with ‘the many other workers in this field—within the health service and outside’.

AEGIS emerged into this climate of more pressure groups eager to make improvements in NHS and social care. AEGIS was the only one doing that specifically for around 60,000 older people in NHS long-stay psychiatric wards (Townsend 1962, p. 282).

AGEISM

New social constructs in the 1960s included *ageism*, a term coined by Robert Butler (1969) in the United States, and *gerontophobia*, which was coined by Alex Comfort (1967) in England. These terms reflected excessively negative attitudes and practices, or age discrimination, that could affect provision of services for older people. Ageism is unlike many other sorts of discrimination, such as gender, sexual orientation, race and religion because most of us will live into old age. Ageism means that paradoxically we treat ourselves as ‘other’. It is self-perpetuating: ageist stereotypes may be internalised in childhood and reinforced across the life span, often unconsciously, so that when someone becomes old they may adopt the stereotypes themselves (Levy 2009, p. 333).

Pat Thane (1993, 2000) took up some of the issues around ageism and stereotypes in her historical studies of old age. She noted that the ‘cultural conservatism’ of the ‘continuing belief that it is “common sense” to expect inequality past a certain age’ was used to justify ageist attitudes (Thane 2010, p. 22). She also explored the complex issue of mass retirement in the mid-twentieth century, which had an impact on ageist ideas. In her view, it was one of several changes that ‘increasingly defined old people as a distinct social group defined by marginalisation and dependency’ (Thane 2000, p. 406). Socially accepted marginalisation can affect expectations of people providing services and older people receiving them. It can legitimise governments overlooking older people’s needs, thus affecting the

resources allocated to them. Paul Bridgen (2001, pp. 507–508), in his analysis of geriatric medicine and long-term care, concluded that the early NHS was disappointing from the old age perspective: despite relative improvements in provision in acute hospitals, ideas about rehabilitating older people were slow to be integrated, and no firm strategy for long-term care provision was established, either by the NHS or by local authorities. Marginalisation of older people could also affect historians' interest in them, as Webster commented (1991, p. 165): 'Considering the importance of the elderly as users of the NHS, remarkably little retrospective analysis has been written about the health services from their perspective.' Since 1991, more historical research has been undertaken, including about psychiatric services for older people (Hilton 2015, 2016a, 2016b), considered in the next chapter.

METHODOLOGY

If Barbara had persisted with her initial idea to destroy her archive, far fewer sources about the AEGIS campaign would be available today. In a letter in 1970 to her executor, her brother 'Darling FJ', Frederick John Charlton, she said she had changed her mind because someone at the DHSS 'surprisingly enough' suggested that many files 'had a certain sociological interest'. She bequeathed her files to Abel-Smith.⁹ He arranged for them to be deposited at LSE. The AEGIS archive, as far as we know, is as Barbara left it. It did not encounter pruning after retirement or weeding, common to organisational archives when a new leader takes over or the organisation changes its archives policy. It takes up eight metres of shelf space and includes thousands of letters and hundreds of cuttings from newspapers, magazines, medical journals and nursing journals about positive and negative aspects of the NHS and related subjects. It records Barbara's campaign in minute detail but contains little autobiographical material. A separate personal archive appears not to have survived. Most biographical information was drawn from private archives, *The Jung-White Letters* (Lammers and Cunningham 2007), and other people's memories and memoirs. Much was recorded by the author in semistructured oral history interviews (2015–2016). Interviews quoted in Cochrane's thesis provided valuable insights where other sources were unavailable. Unfortunately, Cochrane's original interview transcripts have not survived.¹⁰

Other public and private archive collections were used, to ensure inclusion of different perspectives. The National Archives (TNA) and

county record offices hold extensive relevant official documentation. The London Metropolitan Archives (LMA) holds records of Friern Hospital, central to the AEGIS story. The Royal College of Nursing (RCN) unfortunately lacks archives relating to nurses' roles in, or perspectives on, *Sans Everything* and AEGIS.¹¹ The University of Warwick Modern Records Centre holds the unedited typescripts of Richard Crossman's diaries, which provide his personal perspectives on Barbara and her campaign.

Some terms used in this book require clarification. A challenge of writing about stigmatised people and places is that terminology changes frequently in the hope that new language will be associated with less stigma and kinder attitudes and practices. The Mental Treatment Act (1930), for example, replaced *asylum* with *mental hospital*, which became *psychiatric hospital* after the Mental Health Act (MHA) 1959. Uptake of new terms was inconsistent, and, for example, well after the MHA 1959, the terms mental hospital and psychiatric hospital were used interchangeably in official sources for no apparent reason. Around 1970, *mental subnormality* changed to *mental handicap*, and the terms *a dement* and *senile* became offensive. Colloquially, out-dated language risks being used pejoratively, but I have used terms when they convey meanings, attitudes and expectations in the historical context better than modern alternatives.

The term *the elderly* is avoided. Geriatrician Bernard Isaacs (1982) and Pat Thane (2010, p. 19) criticised its use because it reinforces a stereotype of older people, conveying an unhelpful and inaccurate impression that they are a homogeneous group, rather than being as diverse as the rest of the population. *Psychogeriatric* is used only to refer to modern proactive psychiatric services for older people, which began in a few hospitals by the end of the 1960s (Hilton 2016b). It is not used to refer to the earlier passive custodial system of care for older people in the psychiatric hospitals. Another inconsistency in official documents was the spelling of *inquiry* and *enquiry*. I have used the former throughout except where *enquiry* appears in quotations.

Writing about Barbara Robb, I have referred to her as 'Barbara' throughout. Letters in Barbara's archives reveal her often informal approach, and Ann Lammers (2007, p. 258) noted her ability to 'melt' formality; she would have been comfortable with a respectful but casual approach. More difficult to deal with historically is the blurring of identities between Barbara and AEGIS. Taking into account that AEGIS would not have existed or functioned without Barbara, it is sometimes unclear whether to refer to 'AEGIS' or 'Barbara'. The Ministry, for example, was uncertain whether to blame her or AEGIS

for fanning criticism¹² and accused her of ‘making as damaging a case as she can’.¹³ Crossman and Rolph, in diaries and memoirs, tended to refer to her by name rather than the organisation she represented, both because of her influence and because she was unforgettable as a person (Rolph 1987, p. 183). This account uses both ‘AEGIS’ and ‘Barbara’, whichever seems most appropriate and accurate in each context.

Barbara was conscious of the huge trust people put in her by revealing sensitive information. She did not want a witch-hunt or for individual staff who revealed their concerns to be scapegoated by the authorities. Nor did she want a backlash of reprisals by angry staff against their colleagues, patients or their visitors who made criticisms, a fear that prevented many from doing so.¹⁴ Similarly, it is not my intention to embarrass the descendants of the staff discussed whose behaviours were allegedly unsatisfactory. Most were not deliberately cruel but thought they were practising according to professional standards (Whitehead 1970, p. 13). I have therefore identified them by their pseudonym, if Barbara allocated one, or by a single initial. In contrast, for the author-witnesses in *Sans Everything*, except in quotations, I have used their real names. Fifty years on, the pseudonyms are no longer required: the course of events showed the legitimacy of the allegations, and the witnesses’ courage and humanity in revealing them.

NOTES

1. Robb, in ‘Record of a Campaign’, which describes the AEGIS campaign in ‘chapters’; Letter, ‘Bill’ Rolph to Robb, 1 April 1968, AEGIS/B/3. (AEGIS archive, London School of Economics).
2. Kenneth Robinson, in *Man Alive*, BBC2, 16 July 1968, transcript, 18, AEGIS/2/7/A.
3. Martin included Napsbury (DHSS 1973) but the type of issues raised were different from those of the other inquiries. Napsbury is not further discussed in this study.
4. Comment made to the author in the course of her clinical work.
5. Crossman Diaries, May 1970, 168/JH/70-27 (University of Warwick Modern Records Centre).
6. Anne Robinson, investigative journalist with the *Sunday Times* (1968–1978). Reported on the AEGIS campaign and conditions in psychiatric hospitals, including South Ockendon. Interview by author, 2015.
7. Meeting, Robb and Geoffrey Tooth, 25 May 1965, AEGIS/1/1.
8. Help the Aged merged with Age Concern to become Age UK in 2009 (Age UK 2016).

9. Letter, Robb to FJ Charlton, 19 August 1970, AEGIS/1/10/B.
10. David Cochrane, discussion with author, 2015.
11. Neasa Roughan, archives assistant, RCN, email to author, 2015.
12. Memo, C Benwell, 'Condition of the elderly in mental hospitals', 10 March 1967, MH150/349 (TNA).
13. Memo, C Benwell to Miss Hedley, 20 June 1967, MH150/350 (TNA).
14. Memo, H Yellowlees to Mrs Croft, 27 July 1967, MH159/213 (TNA).

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