Marks-Hirschfeld Museum of Medical History

Newsletter — April 2022

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Curator's introduction

Dear Readers,

So far this hasn't quite been the 2022 we had all hoped for. Restrictions to combat COVID's Omicron variant meant a slow start at the Museum, and recent rains and humidity have wreaked havoc in the collection stores. On the bright side, we've all had an extra long and refreshing break and everything is now sparkling clean!

I am so thankful to Robert for sharing his experiences as an assistant mental health nurse in the 1960s, the feature article of this edition. Large residential psychiatric hospitals such as St Audry's were an innovation in mental health care when they were established and operated almost as a small village. While most certainly not without their problems, Robert's recollection of his experiences working in an asylum highlights some aspects of chronic mental illness we may be overlooking today. It's a fantastic read.

Again I'd encourage any of our readers with their own experiences in medicine to share to please get in touch. We can help you put together an article and find the right images, alternatively you might prefer for us to interview you and tell your story that way. Long or short, amusing or deadly serious, we welcome any stories. Details on how to contribute can be found on our website or by contacting the Museum.

Thanks to everyone who voted in our newsletter renaming survey. We had a great response and some clever and creative suggestions from our readers. The results were neck and neck but we have a winner. The new name will grace the top of our next newsletter in June.

Despite the start, 2022 promises to be an exciting year for the Museum, with new acquisitions, exhibition and events in the pipeline. I hope your year is looking equally bright.

All the best,

Charla Strelan

Curator
Marks-Hirschfeld Museum of Medical History

Volunteers deal with an outbreak of mould in the collection stores.

Memories of another era

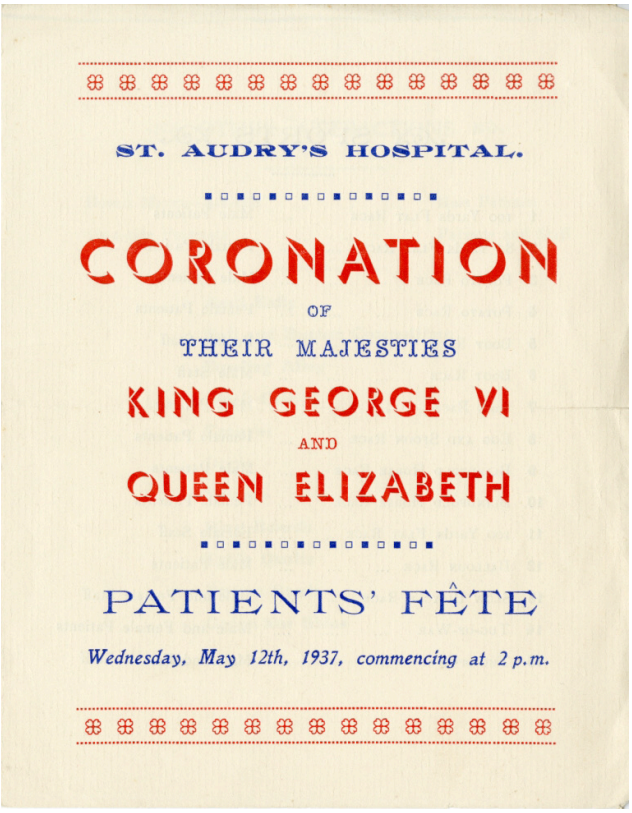
by Robert Craig, MHMH Voluntee

The front entrance to St Audry's—now converted to residential apartments.
Image courtesy of Suffolk Archives.

In 1964, having left school at 18 with a university place to study medicine, I was given the opportunity to work as an assistant nurse for three months in a large residential mental hospital in Suffolk, England. The job was meagrely paid but board and lodging were included in a nursing home for single students and a few other older nurses. Suffolk was a poor rural county and renowned for its parsimonious treatment of the services which legislation required the county council to provide. Mental health services were not an exception but after 1948 the hospital came under the National Health Service Regional Health Authority, though it still seemed as though that there was never enough money for improvements. This experience was available to me by virtue of my medical student status and was hugely beneficial after a privileged upbringing and, for the most part, a private boarding education to get such close contact with everyday life before entering the somewhat privileged precincts of Cambridge University. In the long term, the time I spent giving personal nursing care to a wide range of people, all of whom were deprived of liberty and in a less than comfortable situation, became even more influential. The hospital buildings were very old, built in 1765 as a workhouse dating from the Poor Laws to deal with vagrants and the impoverished from the time of Elizabeth 1st. With several extensions, it had become the County Asylum for Lunatics from 1827 and in 1916 was renamed as a Hospital for Mental Diseases.

An enduring memory was the New Year's Eve ball attended by many staff, patients, Board members and their families. The hospital housed approximately 2,000 patients and probably employed as many as 1000 nurses and other health staff (such as a dentist, social workers, anaesthetist, pathologist, physiotherapist, occupational therapist, hairdresser and barber) in addition to the many others needed to run such a substantial estate as an almost self-sufficient enclave. It meant apprenticeships for staff, including gardeners, engineers (steam, refrigeration and mechanical), builders and other many other tradesmen, which in turn meant training for many patients.

Most of the wards were locked routinely, though only the male and female admission and acute wards maintained strict security. Male and female patients lived in separate wards and staffing for each retained this gender separation. There were no junior doctors, and the few psychiatrists and medical officers had a low profile. I had the impression that the senior nurses were the permanent fixture and ran the hospital. There was a hospital secretary with minimal secretarial support but little other in the way of administrative staff. The hospital was close to a small town and there was transgenerational employment for many in an almost closed society. This was the era when the Chief Nursing Officer and Matron ruled. The two World Wars had terminated the previous period when doctors (often labelled alienists) had been supreme when so many were called away on military duty, but before the administrators gained control in an increasingly bureaucratised health service.


ST. AUDRY'S HOSPITAL.

CORONATION

OF

THEIR MAJESTIES

KING GEORGE VI

AND

QUEEN ELIZABETH

PATIENTS' FÊTE

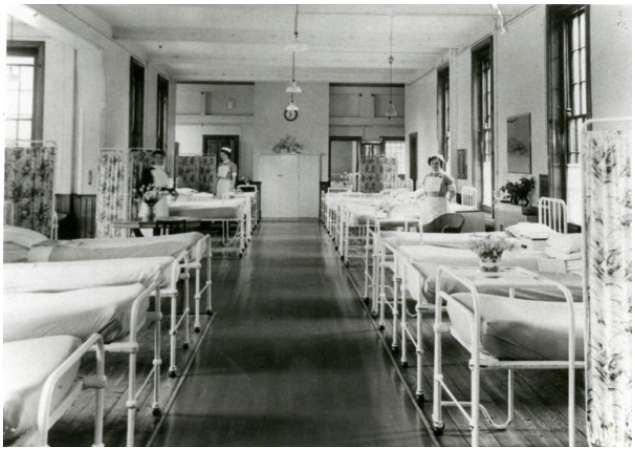
Wednesday, May 12th, 1937, commencing at 2 p.m.

Patient fetes, concerts and special events were a part of life at St Audry's. Images courtesy of Felixstowe Museum.

A feature of mental hospital design of the period was the long corridors, intended as a security measure. These connected the wards and other buildings, giving rise to a claustrophobic and closed in atmosphere. The wards were all the same design: a large day room separated from an even larger dormitory of up to 100 beds, close packed with two central double rows and single rows at the sides each with a small personal bedside cupboard. At the far end was the charge nurse's (or sister's) office flanked by about four single rooms with furniture secured to the floor, which served as seclusion and observation rooms. Off the dormitory was a large bathroom with three or four unscreened baths and numerous washbasins. Alongside the dayroom was a kitchen with steam heated containers for the food which was delivered from a central kitchen and served in the dayroom. The meals served were palatable and in fact often enough for the staff meals after the patients had been fed. Cutlery was boxed and counted on return to the kitchen. As another suicide prevention measure all windows were securely barred. Hospitalisation has never prevented suicide attempts and I have found it surprising and distressing that the immediate weeks after discharge remain a high-risk period.

One of my jobs was bed-making after breakfast. Usually with another student nurse this meant 50 beds apiece, with attention to neatness and regularity. After this I was usually told to accompany patients to work (such as occupational therapy or work groups attached to the hospital) for which they received small sums of money. At that time pensions, sick and unemployment benefit were not paid to hospitalised psychiatric patients, so unless they had other savings this was the money needed for tobacco, toiletries, personal items and clothes. The latter were provided if the patient couldn't afford them, but a constant complaint was the damage done by laundering and lost items, so all patients ended up with dishevelled and ill-fitting clothing. 'No work: no pay' was the order of the day, except for a few exemptions due to ill health.

Another of my work allocations was to play cribbage with a pleasant elderly man who had independent means. My recollection was that we played for threepence a hand and so I quickly learnt how to play and have enjoyed the game ever since.



On the wards at St Audry's. Year unknown.
Image courtesy of Felixstowe Museum.

Bathing and shaving were afternoon activities for those deemed unsafe to be left to do this themselves, which included several of the patients I cared for, either because of incompetence or suicide risk. I was not informed about diagnoses but did not always require explicit explanation: Florid psychosis (e.g. demanding to be called Napoleon by a bed ridden imposing old man suffering GPI (general paralysis of the insane from tertiary syphilis—a common diagnosis in the hospital); severe depression (with melancholic withdrawal) and marked intellectual disability which was frequent though complicated by developmental trauma and poor education. Bathing grown men and even more so shaving them with the added risk of scraping the skin—electric razors were not provided—made for quite a learning curve but also taught me the empathy and sympathy derived from such close human contact.

Electro Convulsive Therapy was carried out in the dormitory area about twice a week for probably a dozen patients using inhalational anaesthesia by a visiting anaesthetist and certainly a visible seizure was obtained. I don't remember any accidents or problems occurring, but I am sure like elsewhere at this time, ECT treatment was used too often, ineffectually and often leaving unnecessary memory loss. However, I have a lasting memory of witnessing a middle-aged farmer being admitted with severe melancholic depression, almost without speech, expression or movements and after three treatments he had recovered to his usual self.

On one occasion deep sleep therapy had been recommended which was carried out in an observation room with a nurse in constant attendance, Sleep was induced for, I think, 72 hours or so with amylobarbital repeated when signs of waking occurred. However, this procedure was uncommon, and I understood it to be a somewhat of a last resort for unremitting psychotic depression. Up until a few years earlier insulin coma was used but proved even more dangerous. Paraldehyde mixed with fruit juice, with its distinctive smell, was the usual sedative and given in shot glasses before dinner.

Example of a portable ECT machine like those used at St Audrey's Hospital, c.1965.
From the collection of the Marks-Hirschfeld Museum of Medical History.

This ritual earned the name 'cocktail time' and was seemingly relished by the recipients. I've never forgotten the smell and was given a taste which I can still recall after nearly 60 years! I've also not forgotten seeing how painful it was as an intra-muscular injection which was the usual sedation for out-of-control psychosis on admission to hospital. Chlorpromazine had only recently been introduced and maybe was deemed unreliable—circumstances would have made IV injections difficult; but use of the aversive effect of paraldehyde was probably in play as well.

Violence on the ward was uncommon but always close at hand (not only against staff but also between patients and I was reliable informed just as problematic in the female wards). I was told on arrival NEVER to turn my back to a patient. Notably, the only time I've been assaulted by a psychiatric patient was as a psychiatric registrar, in an outpatient clinic in Stanthorpe many years later, when I thought the consultation had finished, I dropped my gaze to write notes and the patient leapt over the desk with fists flying. Luckily, he had no weapon. In 1964, junior nurses were on the chronic wards for night duty. I was not asked to do this but as far as I know there was only one nurse, and the wards were locked with no key provided to the on-duty nurse. Using the safety provided by other patients for his or her protection and time to get help proved more effective and safer than measures which could encourage more conflict through weaponizing a confrontation or having keys in the ward.

Occupational therapy was taken seriously and in various forms. The art and crafts sections were extensive and therapeutic. The industrial section took on outside orders for woodwork and particularly fabric work and such things as sock making, even if occasionally a lack of supervision led to mistakes—such as when somebody in charge of the sock maker decided not to include the heel in its program. The workshops and studio were run by qualified craftsmen with nursing staff always available. For the most part it seemed as though it was appreciated by the patients and gave pattern to their lives, with the possibility of rehabilitative qualities and the token payment introduced a reward for effort. Most patients stayed for long periods in hospital and sometimes for life. Stories of a few being born in the hospital were told to me but I never encountered such a resident, and it is probably more likely that they would have been made a ward of the state. Many long stay residents were abandoned by their relatives. A story was related to me that on one occasion when a resident had a significant win on the football pools plenty of visitors arrived! Whilst working at Baillie Henderson Hospital in Toowoomba I participated in a project to contact 'lost' relatives and it was clear that they had often in the past been discouraged or even refused permission to visit, but reinstituting contact was not always successful.

Woodworking for occupational therapy, 1960.
Image courtesy of Felixstowe Museum.

This experience has been unforgettable. At the time I decided that the job tended to make for highly eccentric psychiatrists and chose to take up general practice. After coming to Australia when nearly 50, I decided to join the psychiatry training scheme and worked at both what was Wolston Park Hospital and Baillie Henderson Hospital as well as other acute mental health units in Brisbane and Toowoomba. The two older hospitals were opened in the same era as Saint Audrey's in Suffolk. Unlike the acute units in general hospitals, I was constantly reminded of my earlier experience by staff and patients alike. Nostalgia can be negative, but I greatly value the experience and often wonder if we have been too quick to dismiss asylum as a valid therapy for chronic mental illness, especially if we consider how cheaply it was provided in the past and what a difference extra financial support could make to a modern equivalent. The number of people with poorly or untreated serious mental disorders ending up in prison or homeless is clear evidence of an ongoing gap in our service provision.

Further reading: For more detailed accounts of the themes to which I've alluded, I'd recommend John Cawte's The Last of the Lunatics from his experiences from the 1950s in Adelaide. Melbourne University Press, 1998.

Advances in medical science has repeatedley led to misguided or useless medical practice

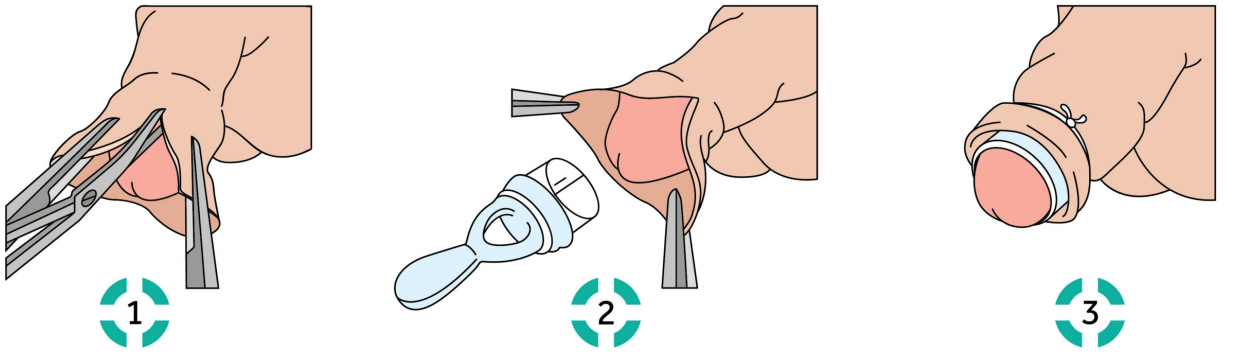
by Robert Craig, MHMH VolunteeR

As pointed out in Newsletter No 80, misguided and useless operations and treatments are ubiquitous. The persistence of these practices long after they have been shown to ineffective is difficult to explain, except by the conservatism and unwillingness inherent in human behaviour and justified by the limitations of personal experience. I thought this warranted a return to the subject.

Popular and professional understandings of disease and its relationship to religion, philosophy, politics, economics and social structures underpin our attitudes to ill-health and the acceptance of these treatments. Since the overturning of tradition and religious belief, the basis for managing illnesses by experimental proof has been the standard for the acceptance of an effective treatment when it has been validated by peers who include the elite of medical establishment and the approval of their institutions and disinterested centres of excellence in universities, but it is the interpretation of the results which determines our conclusions. Often the target audience has insufficient knowledge or expertise to critically assess the claims especially when it answers the search for cure by what seems a rational or easy solution, or one that fits their world view. There has been a continued paradoxical reluctance to relinquish the magic, folk lore and eccentric beliefs in the quest for an elixir of life to overcome all diseases, and so the mixed and often contradictory messages regarding health information continue.

Much of medical practice has in hindsight been shown to be both more dangerous and less effective than its practitioners would have us believe when it is introduced. Both doctors and patients are desperate to find cures and have been guilty sometimes of overenthusiastically taking up the theme that “anything is worth a try” when nothing seems to be effective. Several items in the Marks-Hirschfeld Museum collection reflect this.

The uvula scissors and information about the operations designed to treat stuttering (outlined in the last newsletter), reminded me of hearing about attempts to cure delay in speech and speech impediments by incising the lingual frenulum because it was thought to restrict the development of these skills and diagnosed as



Plastibel instruction sheet

Dental forceps
Collection of the Marks-Hirschfeld Museum of Medical History.

tongue-tie. Winston Churchill was subjected to this procedure. Often male circumcision was carried out for cultural/religious reasons as there is only the occasional case of severe phimosis when it could be reasonably claimed to be necessary, but the hygienists of the early 20th century popularised it without admitting the significant rate of serious mishaps for what appears to be a simple cosmetic procedure. These complications, such as damage to the urethra, are reduced using methods such as the Plastibel but the procedure is almost always unnecessary and maintaining good hygiene is all that is needed to prevent chronic balanitis which rarely has led to malignant change. Examination of the basis for these treatments shows the difficulties of separating malpractice from acceptable evaluation of a contemporary treatment.

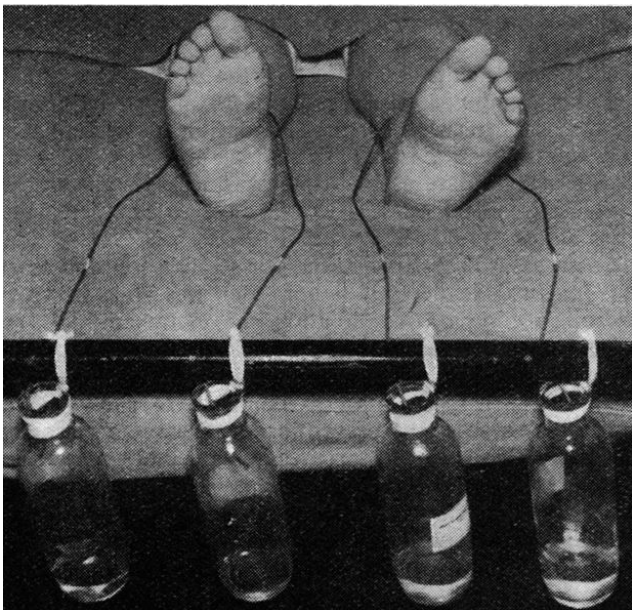
Gum cutting lancets and blood letting instruments were discussed in another recent newsletter. Similarly, dental clearances for the purpose of treating systemic disease, especially arthritis, gained popularity when the treatment of gum disease without antibiotics was unsuccessful. Unfortunately, it was recommended for untreatable systemic disorders without benefit to the patient. In his discussion of autointoxication, a contributor to William Osler's Modern Medicine 1937 (of which there is a facsimile copy in the Marks-Hirschfeld Museum collection) there is reference to cryptogenic sepsis causing various ailments including ulcerative endocarditis and pernicious anaemia and halitosis. These conditions were correlated with Pyorrhoea Alveolaris in a way that could easily be interpreted as cause or chance rather than effect and dental treatment including extraction was recommended (vol V; pp41 and 54-56).

Prior to the development of effective diuretics (firstly mersalyl as an injection and then oral chlorothiazide) Southey's Tubes were fine tubes inserted subcutaneously into the calf tissues to reduce oedema in the commonly occurring dropsy associated with chronic renal, hepatic and cardiac failure.

The effect would be satisfying to observe the watery fluid running out and the oedema subsiding with elevation and bandaging but utterly ineffective for treating the underlying condition.

Southey's Tubes

Collection of the Marks-Hirschfeld Museum of Medical History.



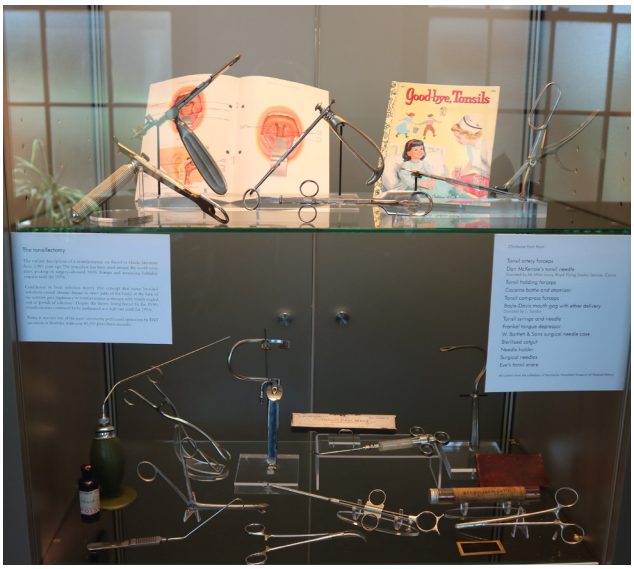
Southey's Tubes

Collection of the Marks-Hirschfeld Museum of Medical History.

It was also harmful due the significant protein depletion' let alone the risk of life-threatening cellulitis with the introduction of bacteria into the fragile skin.

Tonsillectomy snares and guillotines are plentiful in the Museum collection and indicate the high frequency of tonsillectomy.

Until the advances of recent years in our understanding of immunology the importance of tonsils, appendices and other collections of lymphatic tissue in the gut, spleen and lymph nodes were therefore deemed to be unneeded for health and so excised as expertise in surgical practice developed. This occurred with the increasing use of tracheostomy for diphtheria and the apparent success of the removal of scarred and swollen tonsils leading to ENT surgeons gaining confidence in their skills of in this operative field. It was a short step to the increase rates of tonsillectomy because it could be done, and it almost became a rite of passage for well cared for children! There are indications for chronically damaged tonsils to be removed but not without considering the risks of such surgery and the requirement for anaesthesia which inevitably might threaten the airway. This is an example of another situation where, because it was possible, the procedure was done to excess.



Tonsillectomy display

Collection of the Marks-Hirschfeld Museum of Medical History.

The story of tonsils applies to appendix, until recently considered an unnecessary anatomical throw-back to a 'more primitive' stage of development. Until the late 19th surgery most doctors tried hard to avoid abdominal surgery. Hippocrates disallowed ethical physicians to 'cut for the stone', and a wish to avoid surgery often distinguishes physicians from surgeons to today.

Just prior to his coronation King Edward VII was seriously ill with appendicitis. Frederick Treves, the Sergeant -Surgeon, successfully operated to drain an appendix abscess, which was well publicised and so ensured confidence in such surgery. It probably did not become a readily accepted procedure until after 1945 with the advent of safer anaesthesia and antibiotics, when the operation became a common treatment for chronic and acute abdominal pain. Often it was performed for mesenteric adenitis (swollen lymph nodes in the gut associated with any intestinal inflammation). Like tonsillectomy the operation is safe enough and lifesaving, when necessary, but now is performed much less frequently when imaging pre-operatively reduces the risk of misdiagnosis and unnecessary surgery.

In addition, as is evident in the collection's Evans, Lescher and Webb Materia Medica Box, until about 1950, much of commonly prescribed medication was misguided, useless or dangerous. This applied especially to heavy metal products (though arsenicals had proved partially effective in treating syphilis by 1900 and antimony had a place in treating some bacterial zoonoses). The multitude of tonics prescribed for what we would now label mild depression and anxiety were of doubtful use other than as a placebo.

After the discovery of the pathophysiology of the absorption of vitamin B12 in pernicious anaemia and subacute combined degeneration of the spinal cord, the use of injections of cobalamin as a 'nerve tonic' for neurasthenic patients became common. It is an example of the generalisation of a scientific finding to a "might as well try treatment" with the added advantage of the mystique of an injection. There is a similar story regarding thyroxin which until recently continued to be occasionally recommended as an adjuvant to antidepressants in euthyroid patients.

Controversial areas persist in the use of hypnosis, aversion therapy and some other forms of psychological as well as physical therapies however it is incumbent on the practitioners to be scrupulous in the testing of these therapies and this has not always been so. Regulators must be aware of a practitioner's potential to unduly influence their customers and patients and to continue to be sure the treatment is working, and they have not fallen into the trap of misunderstanding that the distress of stopping an ingrained habitual practice is not misattributed to the return of the illness for which it has been given. They are also obliged to assess any harmful effects resulting from the therapy which in the case of homeopathy, reflexology and other non-invasive treatments are unlikely. Acupuncture receives many claims and particularly combined with moxibustion could be considered riskier if the traditional form of deep insertion is performed, but by far the most serious unwanted iatrogenic damage is caused by conventional medical interventions.

There must always be an awareness for the possibility of dismissing an effective therapy due to its misuse or overuse. Acupuncture can be effective for pain and the minimisation of withdrawal symptoms on stopping addictive drugs though its use in a wide variety of other conditions is contentious. Relief from withdrawal symptoms following cessation of cocaine and opiates was well documented in studies carried out at the University of Hong Kong in the 1970s and has been confirmed in many studies since either alone or in combination with opiate agonists. Magnetic therapy would seem to be an extension of electrical therapy and has been sold to relieve muscle and joint pain but for the most part has been dismissed by established medical opinion. Recently, using considerably stronger magnetic fields its effect on polarising and depolarising ions in individual cells has been used in the medical imaging (Magnetic Resonance Imaging) and to induce seizures as in ECT to attempt to avoid some of the side effects of this procedure, especially the amnesia which is often of short duration if the number of seizures is kept to a minimum. With these two I examples I emphasise the importance of keeping an open mind.

Ergot Aseptic c. 1920

All objects have a story to tell. In medical history in particular, these stories are often a thrilling blend of terror, hope, skill and beauty.

Here, we shine a light on an object from the Marks-Hirschfeld Museum of Medical History collection to reveal fascinating detail of past lives and to celebrate its important place within the collection.

Ergot has been used for centuries to hasten childbirth by causing violent contractions of the uterus. One hundred years ago, ampoules of ergo aseptic like these were a common intravenous treatment for postpartum haemorrhage.

Ergot is a fungus that attacks rye and can be extremely toxic. It contains lysergic acid, from which LSD is derived. Long-term ergot poisoning, or ergotism, causes psychosis, mania, blood constriction, hallucinations and seizures.

Epidemics of the disease have been identified throughout history. Being impervious to heat and water, the toxic properties of ergo could survive being baked into rye bread, and tainted crops could affect entire communities. There was no known cure for ergotism, nor was there knowledge of the source of the poison. As rye bread was a staple food in many parts of Europe and America, sufferers of ergotism would often continue to imbibe ergot-laden food. The resulting vasoconstriction would cause dry gangrene, oedema and ultimately the loss of limbs.

Ergo-induced hysteria has been put forward as a theory behind the 'bewitchment' that spurred the Salem witch in 1692. In France it has been linked to the Dancing plague of 1518 and the Great Fear of 1789 at the start of the French Revolution.

Ergot aseptic c. 1920
Collection of the Marks-Hirschfeld Museum of Medical History.

Get involved

Support us

Our generous philanthropic supporters are vital to our work and play an important role in preserving Queensland's medical history.

- Your gift to the Marks-Hirschfeld Museum could support:
- Conservation of our rare book collection
- Protective storage for our laboratory and pharmacological glassware
- Archival sleeves for our collection of Trephine magazines
- Digitisation of our photographic and vinyl record collections
- Refurbishment of historic exhibition cases
- Publication of an exhibition catalogue
- Purchase of an audio-visual display to play significant films from the collection
- And that's just for starters!

You can support the Museum by:

donating online

contacting us on 07 3365 5423

or emailing med.advancement@uq.edu.au

Become a volunteer

If you'd like to join the volunteer team, please contact us at medmuseum@uq.edu.au.

Join the conversation

Contribute to the Museum newsletter

The Marks-Hirschfeld Museum of Medical History newsletter is issued four times per year. We are always on the lookout for interesting materials that explore the rich tapestry of medical history. If you would like to contribute a story or have a topic that you would like to see included in future editions, please send an email to medmuseum@uq.edu.au.

Our next newsletter will be distributed in June 2022. If you are interested in submitting an article, please send your story and photographs by no later than Monday 16 May 2022.

Share your feedback

Your experiences and suggestions will help shape future editions of the newsletter and ensure we continue to create content that you can enjoy. Completing the survey will also help us get to know you personally.

The University of Queensland
Level 6, Oral Health Centre
Herston Rd, Herston Qld 4006
www.medicine.uq.edu.au

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