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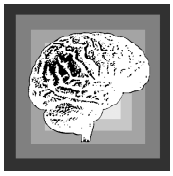

V. A. Kral, the Montreal Hebrew Old People's Home, and benign senescent forgetfulness

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The term Benign Senescent Forgetfulness, introduced in 1958 by V. A. Kral, constitutes the origin of the concept of Mild Cognitive Impairment (MCI), a widely studied but controversial entity. The ambiguities surrounding MCI warrant a re-assessment of its historical origin. Any attempt at an in-depth investigation of Kral's works on that subject should begin with a description of the patient population and professional arena in the Montreal Hebrew Old People's and Sheltering Home, where Kral was a consultant. Based on archival and published sources, I describe the Home's facilities, population, staff and programmes/services, followed by an overview of the dynamic factors inducing a re-examination of its mode of operation in the mid-1950s when Kral joined the Home's professional staff as a consultant.

***Keywords**: Benign Senescent Forgetfulness; Canada; Mild Cognitive Impairment; Montreal Hebrew Old People's and Sheltering Home; V. A. Kral*

Introduction

Currently, Mild Cognitive Impairment (MCI) designates an intermediate state between normalcy and dementia, characterized by a certain clinical representation (not normal, not demented),[1] scores on neuropsychological measures, and presumably by imaging studies, cerebro-spinal fluid findings and other biological markers (Winblad, Palmer, Kivipelto, Jelic, *et al.*, 2004). There is controversy regarding whether MCI is a clinical entity and treatment target (Petersen and Morris, 2005), or not (Gauthier and Touchon, 2005), and

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a recent editorial said: 'MCI's story . . . is characterized by heterogeneity, uncertainty, ambiguity, and poor conceptualization' (Schneider, 2005). MCI is actively investigated; memory complaints are common, and many persons in the population at large have been found to have MCI. In addition it is of interest to scientists seeking understanding and prevention, or very early stage remedies, for dementia.

Benign Senescent Forgetfulness (BSF) was a term introduced in 1958 (Kral, 1958*b*) by Voijtech Adalbert Kral (1903–88), a Czech-Canadian psychiatrist and neurologist (Lauter, 1991; Merskey, 1989; Reichensfeld and Agbayewa, 2001; Vojtechovsky, 1995).[2] BSF is undisputedly believed to be the first among more than a dozen terms referring to mild changes in elderly cognition (Burns and Zaudig, 2002; Ritchie and Touchon, 2000), and is thus the most cited origin of MCI. BSF is characterized by the inability of the subject to recall relatively unimportant data and facts of an experience, whereas the experience itself can be recalled. However, those facts may be recalled at another time. The forgotten facts seem to belong to the remote rather than to the recent past. Also, the subjects are aware of their shortcomings and try to compensate by circumvention, and may be apologetic. It occurs with approximately equal frequency in both sexes, and seems to progress relatively slowly, if at all (Kral, 1962).[3] BSF enjoyed periods of popularity, followed by criticism, and in recent years, parallel to the introduction of MCI, 'scholarly indifference' (Heinik, 2005*a*). In contrast to MCI, BSF was not considered a pathological entity, or a pre-dementia stage or even a risk-factor for the development of dementia, but rather a variant of normal aging memory changes explainable as 'senium naturale' (Kral, 1962).

Kral's BSF patient population consisted mainly of the residents of the Montreal Hebrew Old People's and Sheltering Home. This affiliation (among others) appears in six articles published between 1958 and 1961, in which Kral alone and with psychologist Blossom Temkin Wigdor (b. 1924) report on various aspects of BSF (Kral, 1958*a*, 1958*b*, 1959; Kral and Wigdor, 1961*a*, 1961*b*; Wigdor and Kral, 1961).[4] Given the immense popularity of MCI today and the controversies and poor conceptualization that surround its use, a re-assessment of its historical origin might be warranted. Therefore, Kral's original work on BSF needs reconsideration. However, any attempt at an in-depth investigation of Kral's works on BSF should begin with a description of the human and professional arena in which he operated: the Montreal Hebrew Old People's and Sheltering Home.

This is a descriptive study of the Home in the mid-1950s (mainly 1956) when Kral's investigations on BSF had started. Some background information is presented below, and then the paper is divided into three main sections: a summary of the Home's physical facilities, population, staff and programmes/services; an overview of the dynamic factors and forces inducing a thorough re-examination of its mode of operation at that time; Kral's appointment as the Home's neuropsychiatric consultant in 1955.[5]

Some background historical and demographic notes

During the period 1901–11, the Jewish population in Montreal, Canada, increased from 6,975 to 28,838.[6] In 1912[7] a small Old People's Home and Orphanage, initially housing orphans as well, was established by the Federation of Jewish Philanthropies.[8] Gradually the focus turned to the care of the aged, and the number of old persons in this establishment grew to 20. As the Jewish population continued to grow (to 45,846 in 1921, and 58,032 in 1931), another home – the B. and S. Steinhouse Nachlas Zkeinim – was set up in 1924 on City Hall Avenue, housing about 20 residents. In 1928, as a result of ever-expanding needs to serve Montreal's Jewish elderly, a new four-storey structure was built on land purchased at 4373 Esplanade Avenue, and the two earlier homes were merged into the 'Montreal Hebrew Old People's and Sheltering Home', which had 40 residents when it opened. By 1935–36 the number of applicants continued to grow, so another floor with an additional 40 beds had to be added. (The Jewish population of Montreal was 63,937 in 1941; the percentage of those aged 65+ years increased from 2.6% in 1931 to 4.8% in 1941.) In around 1950, in response to the further demand for more beds, an adjacent property was purchased which was joined to the main building, thus providing 30 additional beds.

1. A description of the Home in 1956[9]

The Home consisted of a main building, six stories high (a fire-proof building with two automatic lifts), plus a basement and an adjacent building (the annex), which had two storeys and a basement. At the rear of this annex there was a small building containing two apartments, one for the resident physician and one for the engineer. Fig 1. summarizes the Home's facilities. The fifth floor was the infirmary floor for chronically ill residents in need of long-term care, as well as for those who required protective care. Also situated on the fifth floor were two wards for acutely ill residents with short-term illnesses (8 beds). In total there were 60 rooms for residents. More than half of them contained 3 or 4 beds. Several of the rooms in the annex contained from two to four individual cubby holes with 6-foot high partitions.

Population

During 1956 the total number of residents in the Home for any one month ranged from 140 to 146, and these figures were the same during 1954–57. Generally, females constituted 60% of the residents. In September 1956 the average age was 78.5 years, with 24% aged up to 74 years, 53% aged 75–84, and 23% aged 85 years and over. The typical resident was described as an aged person who had lived with relatives or friends prior to his/her admission to the institution; orthodox;[10] of Eastern European origin, having arrived in Canada between 1900 and 1930; and a Canadian citizen.

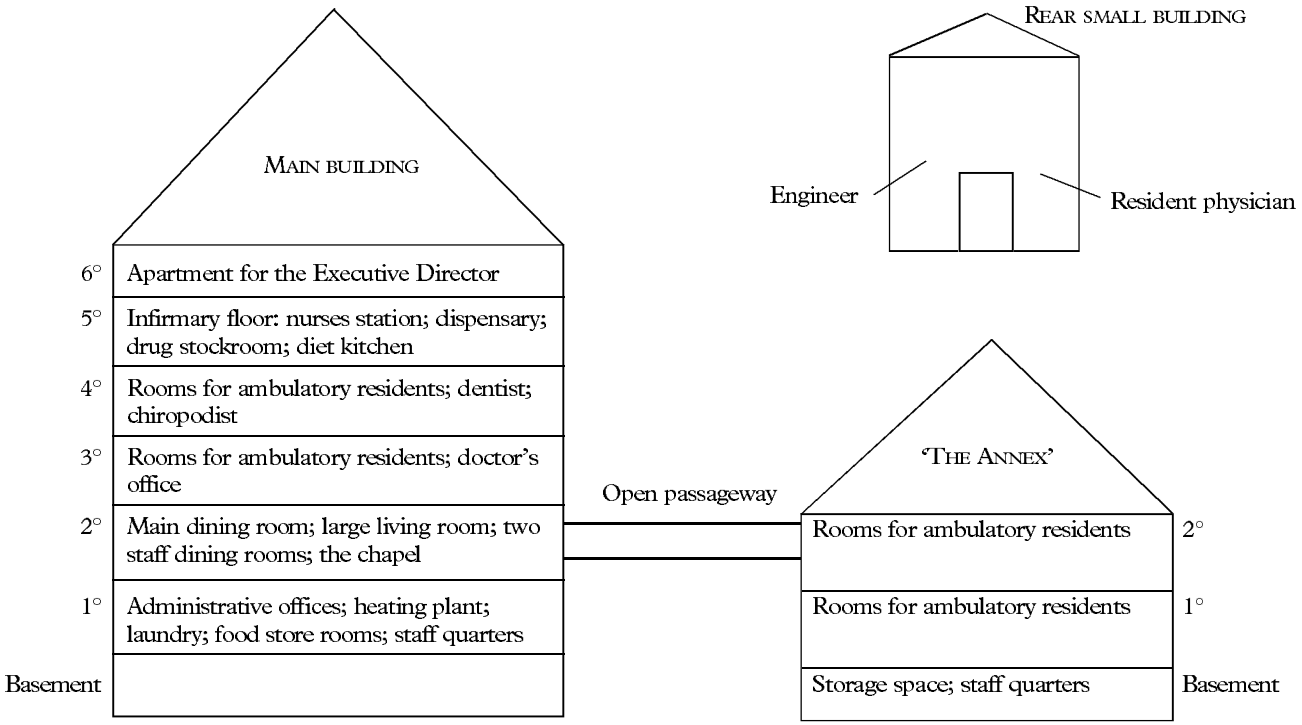

FIG. 1. Schematic representation of Homes' facilities: buildings, floors and room descriptions

The medical histories of 150 residents of the Old People's Home were analysed by the co-medical directors of the Home in July-September 1956. However, the summary below is based on the medical histories of 138 residents (12 had died, and not all medical histories were available on March 1957, the date of the Report). The vast majority of the residents (93%) suffered from circulatory-cardiac disease, and about half of them (49%) from what was called a mental illness (including loss of memory, mild senility, etc.). About a third (35%) suffered from partial or total deafness, and 22% from total or partial blindness. The analysis is followed by a long list of diagnoses (obesity, incontinence, strokes, paralysis, recent fractures, crippled, diabetes, anaemia, arthritis, parkinsonism, etc.), but no totals were given since often one resident suffered from more than one disease. Table 1 describes the functional activity of the residents, and Table 2 presents the types of medical care needed.

In 1956, 27 residents died, 2 were discharged, 4 left, and 2 were discharged from day care. During the same period, 32 persons were admitted as residents and 2 to day care. The average stay of residents was 5 years.

Intake policy and procedure

An applicant to the Montreal Old People's Home had to be of Hebrew birth and had to be willing to observe Kosher dietary laws at the Home, and also had to be unemployed. The minimum admission age was 60 years for women and 65 for men. Individuals and couples were admitted. The two categories of persons admitted were: the 'well-aged' and the chronically ill who did not require help in dressing, bathing or eating and who were not permanently bed-ridden. The applicants had to be able to look after their

TABLE 1. *Functional activity of residents*⋆

	Number	Percentage
Can be trusted alone anywhere in the city	51	37
Can be trusted in the vicinity of the Home but require escort on long or tiring trips	26	19
Practically housebound, requiring some supervision	27	20
Bedridden or remain close to their beds	31	22
Partially or totally blind, requiring close supervision	3	2
Total	138	100

⋆ *Source*: Report, March 1957 (see Note 9)

TABLE 2. *Type of medical care needed*⋆

	Number	Percentage
Both medical and nursing care	19	14
Primarily medical only	53	38
Primarily nursing only	9	7
Psychiatric care	10	7
Protective care (custodial)	11	8
Complete hospital care (acute and chronic illnesses)	18	13
No medical care needed	18	13
Total	138	100

⋆ *Source*: Report, March 1957 (see Note 9)

immediate needs. Psychotic persons were not accepted, nor were advanced senile or mentally confused persons who probably would not have been able to adjust to the normal routine of the residents in the Home. Not admissible were applicants who: (a) suffered from acute infectious disease; (b) had inoperable terminal cancers or other terminal stages of disease; (c) had personality problems which would interfere with group living; (d) had advanced mental disease.

Preliminary enquiries were made by telephone, letter or in person at the office. At this time an appointment was made with the social worker for personal interview with the applicant and a member of his/her family, if possible. Each applicant had to be seen by the worker for the purpose of developing a social and medical history in relation to the request for admission of the aged person. In order to determine the applicant's eligibility, he/she was required to complete questionnaires as well as the actual application form. Each applicant was required to have a medical examination on the premises by the resident physician and a member of the medical board. He/she was also required to have a psychiatric examination. As part of the pre-admission study, where deemed necessary by the social worker, the applicant's home was visited. Upon presentation of a summary of all the findings, the admission committee of the Home considered and determined whether or not an aged person was eligible for admission.

In 1954, for example, a total of 60 persons applied for admission: 23 of these applicants were chronically ill (7 were ambulatory requiring supervisory care, 8 were ambulatory requiring extensive medical care, 8 were semi-ambulatory, requiring extensive medical care); 7 of the group had an acute or terminal illness, 10 applicants had some kind of mental condition (7 were

mild incipient cases and 3 were advanced cases requiring hospital services). Twenty of the 60 applicants were so-called 'well-aged'.

The typical applicant (of the 'well-aged' group) was female, widowed, 70–79 years old, living in Montreal, a citizen of Canada though born in Eastern Europe and had lived in Canada more than 10 years. She was a housewife and, if she had worked, was unskilled or semi-skilled. She had a private source of income which included an old-age pension plus help from either her children or savings. She had been referred to the Old People's Home by her children and her application to the Home was pending for about four months. She was able to care for herself but occasionally needed some physical care. She presented some form of minor mental aberration usually associated with advancing age. She needed continued light routine medical care and was not known to a social agency.

Staff, programme and services

In 1956 the staff of the Home included 49 persons, with the following full-time personnel: Executive Director, Associate Executive Director, social worker, office clerk, administrative assistant, resident physician, 4 nurses (1 registered nurse, the others practical nurses), 3 nurses aides, 3 orderlies, 1 night watchman, an engineer, an assistant engineer, 7 cleaners, two spare cleaners, one cook, 3 assistant cooks, 1 dishwasher, 1 potwasher, 1 matron, 4 assistants to the matron, 1 laundryman, 1 assistant laundryman, 2 waiters. Part-time staff included the supervisor of religious activities, 1 part-time practical nurse, a neuropsychiatrist (Dr Kral), 2 physicians-in-chief and a dentist.

The resident Home physician carried out the medical programme under the supervision of the medical directors. Two physicians affiliated with the Jewish General Hospital Geriatrics Programme acted as co-medical directors. Each assumed responsibility for two 3-month periods a year. The medical director visited the Home twice weekly for a 3-hour period. His responsibility was supervising the medical programme and the establishment of medical records, as well as for referral to the Jewish General Hospital (and other hospitals).

The resident physician took care of the infirmary ward located on the fifth floor together with three nurses, three nurses aides and one orderly. He was also available daily to the other residents at fixed hours. A general physical examination was given to every resident twice yearly. The neuropsychiatrist visited the Home for one hour three times a week. The dentist came to the Home twice a week and other consultants (gynaecologists, dermatologists, etc.) were eventually on call, as needed. The residents had eye examinations as needed.

The recreation programme, organized by the Recreation Committee, was carried out by groups of volunteers. It lacked a group-worker and included passive participation activities, such as parties, concerts, single games, films, etc. However, the Home was an open institution: visiting hours were 9:00 a.m. to 9:00 p.m. daily, and visits were encouraged; most residents had at least one

visit per week. Volunteers were asked to visit residents with no relatives. Residents were able to spend weekends and holidays with relatives. Even though 10:00 p.m. was the routine bedtime, there was no provision for night lights, though arrangements could be made by a resident to be admitted at a later hour.

An informal day care programme was initiated in 1953, and in January 1955 this became an official programme of the Home.[11] By 1956 the Home could serve a maximum of 7 day care persons, providing them with meals, medical care and other institutional facilities, except sleeping spaces.

2. Dynamic factors and forces inducing changes during the mid-1950s

In 1956 the Montreal Hebrew Old People's and Sheltering Home was an active institution, unique to Montreal and proud of its extensive medical programme. No less important, the Home had not operated on a deficit for the previous five years (in 1956 the annual total income and expenditure were $153,093 and $147,063, respectively). Of course, there were minor problems which also affected similar institutions, for example, the Home was short-staffed since it was difficult to obtain workers due to the low salaries paid, and some friction seems to have existed between medical staff (e.g., 'The co-medical Directors of the Home's relationship with the resident physician has not been clearly defined'; Report, March 1957). Other limitations (e.g., lack of active recreational and rehabilitation programmes) were acknowledged. At the beginning of 1957 Dr Giangrais, an outstanding local authority in the field of rehabilitation, surveyed the Home at the request of the co-medical directors and presented his report to the Board of Directors. Dr H. Caplan (Director of the Jewish Mental Health Service) on one of his first visits to the Home, was 'aghast at all the old people sitting around and literally doing nothing with their leisure time' (Report, March 1957). Consequently, the Home's social service was upgraded to a 'Department' level (October, 1956), and a part-time group worker was added (temporarily) to the one social worker. In addition, services of a physiotherapist and an occupational therapist became available to the residents (Social Service Report, 1958). These, however, constituted only short-term remedies.

Evidently, four major dynamic factors and forces shaped the Home's destiny for the years to come.

(*a*) *Demographic* The increase in absolute numbers of Montreal's Jewish elderly population during the first decades of the twentieth century has already been mentioned. In the Canada 1951 census, Jews constituted the third largest ethnic group in Montreal (80,829 out of 1,395,400, i.e., 6.0%) after the French and the Anglo-Celtics, and their natural annual rate of increase exceeded that of the French population (18.7 per 1,000 vs. 16.6 per 1,000, respectively). Jewish persons over 65 years were 6.4% of the Jewish

population in 1951, and these figures were estimated to be almost double by 1981 (to 10.1%). In 1956 the estimated Jewish population in Montreal was 95,000, and the number of aged persons served by the Home represented about 2% of all those aged 65+ years. The annual number of new applications to the Home nearly doubled (from 60 to 108) during 1954–58. Evidently the Home with its constant capacity of 140–145 beds was facing a problem.

(*b*) *Professional/medical* Advances in medicine achieved after World War II increased life expectancy, and the illnesses which beset elderly people had by then been more extensively studied. The field of geriatrics was introduced and was progressing (Evans, 1997; Morley, 2004), followed by geriatric psychiatry (Hilton, 2005*a*, 2005*b*; Rabins, 1999). In Montreal, a Gerontology Unit was opened at the Allan Memorial Institute of Psychiatry in 1944, the first of its kind in North America (Shorter, 2005), and the Jewish General Hospital operated a Geriatric Programme and Clinic beginning in 1955. The new field of gerontology designated and studied new, specialized services for the elderly, in the community and in institutions (Stones,1999). In addition, the methods of meeting the needs of the elderly in other Jewish communities were considered by the Home's administration, as Nathan Deskin mentioned in his report (Brief study, 1954):

> Larger communities, as in New York City,[12] solved some of their problems by providing specialized services to the aged. This community had, in different localities, apartment projects for those aged who were well, homes for the chronically ill, and homes for those who required custodial care. In other communities of approximately our own size, the existing Homes for the aged were adding wings to their present structures, to house the chronically ill. Where this was impossible or impractical, as in Toronto, a new Home [the Baycrest] including a fully-equipped modern hospital and an ambulatory section, was built to accommodate 250 residents. This Home contained single and double rooms and other facilities to maintain the individual's privacy, self-respect and dignity.

Clearly, the Home's heterogeneous fields and patient population (including mild chronic physical problems, bedridden, seniles, mentally sick, the 'well-aged', etc.) needed more specialized consideration

(*c*) *Conceptual/economic* From its inception, the basic services of the Home had always been to provide, for those aged 65+, food, shelter, general medical care, and an environment which closely followed the Jewish tradition. It had also unanimously agreed that the Home should care for indigent persons only. However, if over the years the Home developed a programme of care and facilities to cater for the needs of different persons, what objections, asked Executive Director Nathan Deskin in 1954,

> could there have been to the Home making these services available to persons who had funds to pay for them or to pay even in excess of the

> cost of their care? Why should the large segment of the population which was the middle income bracket or even the wealthy, be precluded from the qualitative services, knowledge and techniques which had been built up over the years for the benefit of the aged?

Not that the Home administration waited for such a confirmation. Slowly, apparently due to changes of their own admission policy as well as to improved old-age pension legislation, the economic situation of the Home residents was changing. While in 1951 the majority of residents (119 of 167) were unable to meet the cost of their maintenance, by 1953 only one-half were classified as being dependent on the community for support, and in 1957 most residents met the cost of their maintenance. Thus, the applicants in the mid-1950s came mainly for health and social reasons,[13] not for economic reasons as in the previous decades. If an aged person had only an economic problem, The Baron de Hirsch Institute Family Welfare Department would supplement him/her in the community by supplying the old-age pension. These, however, seem to be unilateral steps, as a letter written on 12 January 1954 by David Weiss, Executive Director of the Family Welfare Department, to Nathan Deskin demonstrates:

> I am acknowledging your letter of 1 December 1953, in which the previous policy regarding our Agency participation in admission procedures to your House has been changed as of 1 January 1954. This means that the agreements that we made in 1949 . . . are no longer operative. All requests from the community for admission to the Old People's Home will have to be made directly to your office. Incidently, it would have been helpful if prior to your letter . . . we could have met with the Federation to discuss this change just as we met in 1949 for the agreements which are now nullified.

(*d*) *Physical facilities and living conditions* In the mid-1950s it was clear that older people in homes for the aged and nursing homes have certain characteristics which arise in the aging process. At the same time, they have the same essential rights and needs as the general population: the right to maximum self-determination, privacy of person and thought, and personal dignity. The older person also has the universal need to be regarded as an individual. Older people have widely differing experiences and outlooks, and also differ in degrees of intelligence, vigour, expectations, and capacity to adapt to changing life situations.

Regimentation and disregard of personal differences can be harmful to physical and mental health. In the light of the above, Deskin's description of the Home in 1954 is deeply instructive: 'a casual examination of the Home's quarters will disclose that the precious commodity-privacy, the last inalienable right which a person should be asked to give up – is just non-existent'. And he continues:

> We still have 4-bed, 3-bed, and 2-bed overcrowded and poorly furnished

> bedrooms. In such quarters we house people with divergent social, economic and cultural backgrounds, ranging from the first generation immigrant, with the 'huddled masses' instinct, who forgot his Yiddish and has not as yet learned English, people with – to say it charitably – peculiar concepts of personal decency, cleanliness, food habits and sleeping habits, together with highly intelligent older citizens, whose daily living routine is just like yours and mine. Thrown together these people are a source of minor but constant irritation to each other, which is repeated day in and day out. Little things, like open windows or closed windows – what time does one go to bed, and how do people go to bed at different times with shuffling gait and assorted sounds without disturbing each other? The use of ointments and the resultant odours, snoring, going to and from the bathroom in various stages of undress, personal belongings to which an aged person clings desperately, and so forth. The lack of privacy strikes a person adversely at the most critical junctures of the 24 hour day, namely when he gets up in the morning to face a new day and when he retires at the end of the day. The damage to his prestige at these junctures is so severe that it cannot be completely offset by an interesting day including good food, weather, conversation, arts and crafts, playing cards, and visitors. Constant irritation has a snowballing quality. It spreads from resident to resident, to staff (and let's remember that the staff will take so much and no more). To be sure, to the outsider, everything looks peaceful. This is as it should be, but to those of us who have been living right here amidst and with the aged, it is otherwise. . . . Furthermore, we have only one large living room, which is used for many purposes indeed. It is at once a sitting room for the residents, a Synagogue on Saturdays and Holidays because the Chapel is much too small for the total population, a recreation hall when movies are shown, a television room must be darkened much to the annoyance of those who wish to read or play a game of cards, and a place where the residents must entertain visitors. Since this living room is situated on the second floor, it is used mostly by those who are in good health and able to come down to spend some time there. The others who have no sitting room or sun parlours on their floors must either remain in their rooms or sit out in the corridors staring at blank walls. These people have every right to a small, bright, well-ventilated and comfortable furnished sitting room on their floor, where they can spend some leisure time chatting with a friend or just relaxing in a comfortable easy chair with a good book.

Time for changes

It was evident that changes were needed, based on applied research and as part of long-term planning. As early as 1952 an FJCS Old Age Research Project was established (in the same year, the Montreal Council of Social Agencies conducted a survey on the needs of the chronically ill in Montreal). In 1953 the Council of Jewish Health Agencies[14] was established after recognition of the fact that it was necessary to develop a common platform on which the various health programmes and institutions could work

together for the common good. In 1955 a Joint Study Committee of the Home and the FJCS was established. These agencies and projects nominated committees which sent questions to the Home's administration. This is reflected in Deskin's answers to a questionnaire delivered by Frank Shore, Old Age Research Project, and Louis Rosenberg, Chairman of the Research Committee in November 1952.

The questions were as follows: (1) When was your organization incorporated and when did it begin its programme – if there was a difference in time what were the reasons for it? (2) What were the needs that motivated the development of your programme? (3) How many people did your organization serve in its first year of operation? How many people did you serve in 1951? Has the growth (or decline) of the numbers served each year been gradual or have there been sharp rises or declines? (4) Give a brief outline of your present programme and the needs you feel that it meets. (5) What age group are you serving? What is the average age? What economic group do you serve? (6) What needs do you feel are still unmet from the point of view of the service you are rendering? (7) What plans does your organization have with respect to enlarging your programme and entering new fields of service? (8) What suggestions can you make that you feel should be considered in old age programming in Montreal?

Essentially similar were the questions raised at the Executive Committee meeting in January, 1954; they concerned the following: (1) the present population of the Old People's Home (number of men and women, ages, medical problems); (2) reasons for changes in the policy (of admission); (3) progress of new building improvements; (4) special programmes developed; (5) plans contemplated for the future; (6) a joint study of the Old People's Home.

Nathan Deskin's answers were brief and succinct. In a letter replying to Frank Shore and Louis Rosenberg he wrote somewhat apologetically: 'the answers given are based upon 30 years of experience gained in the Home, by extensive visits in Old Peoples Homes abroad and in the attending of numerous conferences on the subject of care for the aged'.

The time was now ripe for a thorough survey of the Home's residents (demographics, medical, etc.). This was conducted between July and September 1956, and its findings appeared in the Report of March 1957 (see Note 9). It seems that the demographic data were taken by the social worker, while the medical co-directors were responsible for the accumulation of medical data, as the above Report indicates. The Report's chapters followed the subjects of the questions raised above.

Concurrently, programmes and services of other similar Jewish agencies in North America were reviewed, and some professional visits held (e.g., Alex Schneiderman, the President, and other Board members visited the Jewish Homes for the Aged in Springfield, Massachusetts, Hartford, Connecticut, USA, and Toronto, Ontario), and Morris Zelditch of the Council of Jewish

Federation & Welfare Funds (NY) had been invited to participate in a meeting held on 25 October 1955 as a consultant to the Joint Committee. Several points in Zelditch's speech (which was accepted with 'a spontaneus burst of applause') should to be mentioned. (a) The Home was one of only a few out of the 82 Jewish homes for the aged in the USA and Canada that barred applicants for reasons of ill-health. (b) Old people's homes were no longer boarding homes for the aged, but more essentially nursing homes with more than 50% of the beds being occupied by the chronically ill and the senile (he gave the example of the Toronto experience where the new home for the Jewish aged was constructed in two sectors, one to serve as a 'home' and the other, 'The Baycrest Hospital', as an infirmary; he added that by doing so a subsidy from the Government Hospital programme was obtainable). (c) For the senile patient, Jewish institutions might be preferable to public institutions. In fact this need was accentuated not only by the requirements for a programme of Kashrut, since most aged Jews were Orthodox, but also by the tradition of Jewish cultural patterns. He added that commitment to public institutes generally reduced the lifespan of the patient, not to mention that the families themselves were reluctant about such admissions. (d) The better 'homes' were open to all Jews, rich and poor alike, with everyone paying according to their ability. These homes also included, besides the 'well aged', the sick, the senile and disabled; they had a full complement of professional staff and, aside from the various services, they conducted a comprehensive programme of rehabilitation.

However, the most important action seemed to be the retainment by the Joint Committee of the Home, of Ben Grossman, Executive Director of the Drexel Home for Jewish Aged in Chicago, to visit the Home and give a comprehensive report (one of Zelditch's suggestions had been to secure the services of an expert consultant to help in the developments of plans for the new institution). Although Grossman's 1957 report was accepted only in part, some recommendations were accepted almost unanimously: that 300 beds should be provided; that the admission policies of the new Home should specifically provide for care of the sick aged as well as the apparently 'well'; and that a hospital unit should be provided as part of the Old People's Home.

However, Grossman's suggestion that the present facilities of the Hebrew Old People's Home be remodelled to serve as a residential unit and that a separate medical unit be built on Jewish General Hospital grounds was questioned. Representatives of the Old People's Home, particularly, felt that it was inadvisable for a variety of reasons: (a) the present facilities did not easily lend themselves to renovation, and it was estimated that the cost of suitable alteration would be prohibitive; (b) after renovation the facilities would still be inadequate and allow no room for expansion; (c) the site of the present Home was a poor one in terms of Jewish population movement as well as the level of the neighbourhood itself (in fact until 1951, 75% of the

Jewish population was contained in an area of half a square mile in the north-eastern part of the city, while in 1956 this population was rapidly moving to northern and western areas of the island); (d) the medical and residential units should be in close proximity to each other, possibly in separate wings, for more effective administration and lower operating costs.

In 1961 the name of the Home was changed to 'Maimonides Hospital and Home for the Aged' (in honour of Rabbi Moshe Ben Maimon, the great medieval Jewish philosopher and physician), and shortly afterwards the building in Esplanade was sold and a 7.5-acre site in the Cote St-Luc was purchased. Here, in 1964, a new facility was built containing five floors, later expanded to seven floors with 387 beds, now called the Maimonides Geriatric Center.

3. V. A. Kral joins the professional staff of the Home as a consultant

That the Home needed a physician consultant with expertise in mental disorders was evident for the following reasons. (1) Almost half of the Home's population were known to have some kind of mental disturbance (including, as already indicated, those with memory impairment). (2) Some of them were 'real' psychiatric patients. All residents with 'other mental conditions' lived in the infirmary floor constituting 'a miniature mental hospital'. The problem, as seen by residents and staff, was that 'shortly after the resident physicians transferred an acutely ill patient to the Infirmary, the patient begs to return to his own room on the other floors long before he has recovered, so as to escape from the *meshugaim* [mad, Hebrew] house' (Brief study, Deskin, 1954). (3) Psychiatric hospitalizations and interventions were performed by non-sectarian institutions (e.g., the Verdun Protestant Hospital, the Allan Memorial Psychiatric Institute). However, concerning their suitability for Orthodox Jews, the same arguments as those on the commitment of Jewish senile patients to public institutes might apply here. (4) Before Kral, the psychiatric problems of the Home residents were dealt with by Dr H. Caplan, Chief of Jewish Mental Health Services,[15] who probably preferred to deal with child psychiatry. In a meeting of the sub-committee on Existing Services (Montreal Council of Social Agencies, Committee on Emotionally Disturbed Children) held on 20 January 1956, he said that 'a good deal of time was spent on becoming familiar with the problems of residents and management'. Nevertheless, in the short period in which he was consultant for the Home, out of 210 consultations made to all the agencies, 31 were done for 'Home' residents.

Kral was hired as a neuropsychiatric consultant to the Home in 1955. He was 52 years old with an impressive professional CV, and a painful personal record (Lauter, 1991; Merskey, 1989; Vojtechovsky, 1995). Born on 5 February 1903 to a Jewish reform family in what was then part of the Austro-Hungarian Empire and is now the Czech Republic, he studied at the German

Gymnasium in Prague, and later received his medical education in the German-speaking Charles University in Prague where he graduated MD in 1927. For the next 7 years he trained there in psychiatry and neurology, and also spent some time in the most famous psychiatric clinics and research institutes of central Europe (the Psychiatric Clinic in Zurich, the German Research Institute in Munich, the Pharmacological Institute and Psychiatric Neurologic Clinic in Vienna). From 1934 to 1939 he was a *Privat-dozent* in the Department of Neurology and Psychiatry in Prague. From December 1942 to May 1945, he and his family were detained in Thereisenstadt (Terezin) concentration camp; Kral, his wife and his mother-in-law were among the 13% who survived from that camp. In 1946 he and his wife fled secretly from Czechoslovakia, and started 'from scratch' in Canada. After 5 years at Verdun Protestant Hospital in Montreal, he was invited to move to the Allan Memorial Institute to become the Director of the Gerontologic Unit (this was the first to be inaugurated in North America, in 1944; Shorter, 2005). In 1955 he was also a consultant in the Geriatric Clinic of the Jewish General Hospital, one of the first to use a multidisciplinary team approach (together with psychologist Blossom Temkin Wigdor, personal communication, 2002; also Kral and Wigdor, 1957), and from 1952 served first as a lecturer and ultimately as an Associate Professor at McGill University, having achieved a Canadian Specialist Certificate both in Psychiatry and in Neurology. At retirement, in 1972, he moved to London, Ontario, where he pursued clinical work as well as academic and research activities, and became a Clinical Professor Emeritus at the University of Western Ontario. He died on 7 June 1988 during a visit to relatives in Israel, and is buried there. Today, Kral is considered one of the founders of geriatric psychiatry in Canada (Reichensfeld and Agbayewa, 2001), and of psychogeriatric research (second to Arnold Pick) in the Czech Republic (Vojtechovsky, 1995).

It seems that Kral's appointment as a consultant to the Home might be considered an excellent 'acquisition'. In fact, being of a similar personal background to his patients there, he also filled an important position in Montreal's newly established geriatric psychiatry, not to mention his impressive knowledge and interest in amnestic syndromes and dementias of various aetiologies. Kral's interest in memory disturbances can be traced to the early 1930s (Merskey, 1989), even though his major initial research on amnestic syndromes and dementia was carried out in the late 1940s and early 1950s while at the Verdun Protestant Hospital (Dorken and Kral, 1951; Kral, 1951, 1955, 1956; Kral and Dorken, 1953; Kral and Durost, 1953).

Given three hours a week, and apparently for $10 per hour (FJSC's rate of pay per hour for psychiatrist), Kral's primary duties included: (a) neuro-psychiatric examinations of applications, and (b) development of a research programme.

As mentioned earlier, the Home's residents constituted the patient sample

of Kral's original works on BSF, the most widely cited predecessor of MCI. It is obvious that Kral arrived at the Home in a period of turbulence and major plans for changes. Years later some critics of Kral's work on BSF (Bamford and Caine, 1988; Barker and Jones, 1993; Blackford and LaRue, 1989; Crook, Bartus, Ferris, *et al.*, 1986; Reisberg, Ferris, Franssen, *et al.*, 1986) would say that the population studied by him was un-representative (for demographic and clinical reasons), and the methods he used were inappropriate. However, as the present study demonstrates and as Kral himself indicated several times, the primary purpose of these studies was not memory research. Rather, it was to assess the state of mental health among the residents of the Home and to recommend whatever measure might seem advisable to improve present conditions (Kral, 1958*b*). Only in third place 'it offered the rare[16] opportunity to study more closely certain aspects of mental functioning in a relatively large number of aged people, most of them well preserved' (Kral, 1958*b*). Kral's methods of examination and his practical gero-psychiatric classifications leading eventually to the concept of BSF and Incipient Amnestic Syndrome (IAS), the true predecessor of MCI (Heinik, 2005*b*), need to be examined in light of this descriptive study. We might inquire whether the Home's arena permitted a comprehensive neuro-psychiatric evaluation, whether neuropsychological tests used (e.g., the Wechsler Memory Scale, Wechsler, 1945) could be administered to the Home's residents, and in what way the Home's structural and content changes, needs and programmes might have influenced Kral's practical gero-psychiatric classifications. These subjects will be dealt with separately in a future article.

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Notes

1. This representation is operationally defined to include: subjective memory complaint, preferably corroborated by an informant; memory impairment relative to age and education-matched healthy subjects (the amnestic variant); relatively normal general cognitive function; largely intact activities of daily living; no clinical dementia (Gauthier and Touchon, 2005; Petersen, Smith, Waring, *et al.*, 1999).
2. A very brief biography of V. A. Kral is provided in Part 3 of this paper.
3. BSF was differentiated from Malignant Senescent Forgetfulness (MSF), a typical progressive amnestic syndrome, corresponding practically to today's Alzheimer's disease with or without a vascular component.

4. It is remarkable that the Montreal Hebrew Old People's and Sheltering Home is not mentioned in Kral's paper, 'Senescent forgetfulness: benign and malignant' (Kral, 1962), which is the most widely cited BSF reference. This might be attributed to its publication in the transition period between the Home closure and the opening of its successor, the Maimonides Geriatric Center.
5. The method used for this study was a historical review of the Canadian Jewish Congress (CJC) archives in Montreal (containing annual reports, minutes of board meetings, memorandums, correspondence, publicity material, etc., with particular emphasis on the mid-1950s), and published academic papers and books. For the sources used for information on the Home, see Note 9.
6. These demographic data were taken from 'Canadian Jewish population studies. Number 4' and '"Draft": Age and sex distribution of the Jewish population of Montreal 1936–1956' as they appear in the Source Material section of 'The Montreal Hebrew Old People's Sheltering Home, March 1957, final draft'. Both were by Louis Rosenberg (1893–1987), a social statistician of Canada Jewry (Weinfeld, 1993), and author of the monumental monograph *Canada's Jews. A Social and Economic Study of Jews in Canada in the 1930s* (Rosenberg, 1939). This may suggest a working relationship between the Home's administration and Rosenberg himself. The latter moved from Regina to Montreal in 1945 to become the national research director of the Bureau of Social and Economic Research of the CJC, and continued until his retirement in 1972 – as Weinfeld (1993) comments, Rosenberg himself was the 'Bureau'. Rosenberg seems to have played a role in the mid-1950s dynamic processeses to be discussed in Part 2 of this paper.
7. According to Report, March 1957 (see Note 9); however, according to another source the Home was founded in 1910 (*Canadian Jewish Chronicle*, Montreal, 12 Oct. 1928, p. 13). The history of the Montreal Hebrew Old People's and Sheltering Home has yet to be studied.
8. Jewish benevolent societies and organizations in Canada can be traced back as early as 1863. In order to improve efficiency, several organizations joined together in the second decade of the 20th century to form the Federation of Jewish Philanthropies, renamed in 1951 the Federation of Jewish Community Services (FJCS). On 18 January 1955 in a professional staff seminar, Donald Hurwitz, then Executive Director of the FJCS, lectured on the topic: 'Jewish community structure in Montreal'. He pointed out that 'Montreal is quite different than any other city in the American continent, not having a public social service department, having no community chest. This unique structure is a reflection of the cultural pattern of life in Montreal'. The FJCS was part of several main bodies (Federations) including: the Combined Jewish Appeal, the Canadian Jewish Congress (CJC), the Jewish Community Council and other independent organizations. FJCS was the representative, centralizing and programming parent body to eight agency affiliations of which the Old People's Home was just one. Among these eight agencies, two provided health services (the Herzl Health Service Center and the Mount Sinai Sanatorium), while the others served welfare, vocational and recreational purposes. Note, too, that the Jewish organizations in Montreal gave birth to other health services, e.g., the Jewish Hospital of Hope (in 1942) and, even earlier, the Jewish General Hospital (1934), which was an outgrowth of the Herzl Dispensary, an outpatient clinic established in 1912 to supply free medical care for the Jewish poor by Jewish doctors in their own language.
9. This section is based predominantly on the following sources: (1) 'The Montreal Hebrew Old People's Sheltering Home, March 1957, final draft' by L. Rosenberg [henceforward, Report, March 1957]; (2) 'A brief study of some of the problems of the Montreal Hebrew

Old People's and Sheltering Home, 1954' by Nathan Deskin, Executive Director of the Home for several decades [henceforward, Brief study, Deskin, 1954]; (3) 'Annual report – 1958. Social Service Department. Montreal Hebrew Old People's Home' by Sylvia Angell, Superior, Social Service Department [henceforward, Social Service Report, 1958]. Other archival sources consulted are descriptive, and helped in the elucidation of the influences during the mid-1950s.

10. This refers to the religious programme that was based on Jewish orthodox principles and laws. However, residents were under no obligation to attend religious services (in fact the small synagogue for only 40 was sufficient for most daily religious practices; for Saturdays and holidays the recreational hall was used). Religious views and practices were considered a private concern.
11. Probably the first of its kind in North America, Maimonides Geriatric Center operated the first Geriatric Day Hospital in 1964.
12. This refers to the Home for Aged and Infirm Hebrews of New York.
13. The following were the main reasons given by those applying to the Home: 'I cannot get along with my children', 'I am too much alone and desire companionship', 'I require the comfort, peace and security which the Home can offer me', 'I need medical care' (Brief study, Deskin, 1954).
14. Which included the following agencies besides the Home: Baron de Hirsch Institute (Family and Child Welfare Departments), Herzl Health Services Center (ambulatory services to persons who could not afford private medical care; however, the general medical clinic did not treat old people), Jewish General Hospital, Jewish Hospital of Hope (for the chronically ill), Mount Sinai Sanatorium (for TB patients), and the FJCS (ex officio).
15. The Jewish Mental Health services in Montreal, an FJCS agency, had a short-lived history as a independent service. Inaugurated on September 1954, it closed on January 1957 and was assimiliated into the psychiatric service at the Jewish General Hospital. Its team included a psychiatrist (Dr Caplan, also the chief of the service), a psychologist and a psychiatric social worker. Its main activity was to provide consultation to the various welfare and recreational agencies, and to the Home. The service was funded by a grant donated by the Mona Bronfman Shechman Foundation. An effort was made to obtain a Federal grant as well. The correspondence on that topic shows that Professor Owen Cameron – Chairman of Psychiatry at McGill, a dominant figure of North American psychiatry at that time and Kral's superior at the Allan Memorial Institute (Shorter, 2005) – was serving as the government professional co-ordinator. In several letters to FJCS administration, he was in favour of such a project even though more statistical data and service information were required. The correspondence also mentioned that Kral served as a consultant to the Home. The grant processing procedure was slow. The grant refusal letter was received shortly after the transfer of the Jewish Mental Health Services to the Jewish General Hospital was accomplished.
16. It was evidently rare for a clinician working mainly with hospitalized psychiatric patients with major pathologies.

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(Details of some unpublished reports are given in Notes 5, 6 and 9 above.)

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