

# Residency Days of Sidney R Garfield, MD

By Vincent J Felitti, MD  
Emilio Morfin, MD, FACS

## A Suitcase Traveling Through Time

In the mid 1990s, Sidney Garfield's grandnephew, Ed Blackman, contacted one of us (VF, an internist) to ask if he would like to have a suitcase of Dr Garfield's medical records that Ed had just retrieved from his grandmother's, Sally Garfield Blackman's, basement. (Ed and I already knew each other because, years ago, Ed had worked in my department for a few months after Dr Garfield called to ask whether the department might have a temporary summer opening for his sister's grandson.) I was certainly interested in the papers, I told Ed.

A few days later, Ed brought over a battered, black suitcase that clearly was from another era. Inside, in addition to a number of desiccated spider corpses, lay a trove of medical documents dated from 1930 to 1941. These were the carbon copies of all Dr Garfield's operative and autopsy records from his residency days at Los Angeles County-USC Medical Center plus some correspondence from the early war years, when he was in private practice. (Unfortunately, these reports of autopsies performed by Dr Garfield as part of his surgical training had been lost in transit during the process of getting them reviewed.) Preliminary review of the reports revealed what we today would consider unusual causes of death, not only because of disease type,

but also because so many medical conditions were at an advanced stage at presentation. The autopsy findings gave witness to a historical fact: Tuberculosis, endocarditis, syphilis, and visceral perforation were vastly more common than they are today.

The suitcase also contained some personal memorabilia: the results of Dr Garfield's California Medical Board examination for licensure (Figure 1); a handwritten poem; and a notice from the US Treasury Department that a new series of booklets about venereal disease had become available at an annual subscription price of 50 cents. The US Public Health Service was then part of the Treasury Department because of the relation between public health and international commerce. Of course, some things never change: The library was owed 20 cents for an overdue issue of *Surgical Clinics of North America*, and the typing pool had issued several reminders about overdue dictation. But some things do change, and quite a bit: Postage on a first-class envelope was two cents and was one cent on an unsealed second-class envelope that contained an advertisement from a pharmaceutical company.

We all recognize that medicine has changed greatly since the Depression, but Dr Garfield's records bring new depth and reality to that awareness. *Los Angeles County General*

*Hospital Bulletin #1356*—received from Dr Berman, that institution's Medical Director—listed the 50 compounded prescriptions available to the Outpatient Department, including several different formulations of bromine, a compound prescribed long ago for nervousness. (Today, long after the drug has been forgotten, the term "an old bromide" is used idiomatically to mean a phrase or notion that is so common that it has become a cliché or platitude.) A notice from the laboratory told of a new analytic test for bromism, a then-common problem resulting from chronic use of bromides for sedation or seizure control. Pseudohyperchloremia was a helpful indicator for this condition because bromine would interfere with measurement of chlorine.

The bulletin found in the suitcase also reminded us of other past practices:

- Luminal (phenobarbital) was available for sedation and to treat seizures;
- Stramonium with KNO<sub>3</sub> was compounded to burn so that its fumes could be used to treat asthma;
- Ephedrine and epinephrine were other compounds available to treat asthma;
- Several formulations of cascara were available to treat constipation, as were mineral oil and the proprietary product, Petrolagar;
- "I, Q, and S" was available as

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**Vincent J Felitti, MD**, (left) has been with the Southern California Permanente Medical Group since its opening in San Diego in the late 1960s. E-mail: vjfmidsdca@msn.com.  
**Emilio Morfin, MD, FACS**, (right) is a retired founding partner of SCPMG, San Diego. He is a member of multiple national and international surgical organizations. E-mail: morfin2cox.net.



a general tonic because of the various benefits of its components—iron, quinine, and strychnine;

- Cod liver oil was carried in the outpatient formulary to treat or prevent rickets;
- Aspirin and amidopyrine were listed for fever;
- Blaud's Pills were available for anemia.

For some reason, digitalis was not on the list; perhaps it required specialist consultation. And sulfa drugs did not yet exist. All told, one might have preferred being a surgeon in those days.

**Surgery in the 1930s**

One of us (EM, a surgeon) reviewed 347 of Dr Garfield's operative notes—a major sample—dated from 1930 through 1932. Of these, 182 were for blood transfusion (a procedure then done in the operating suite) using the then-new Luer technique involving multiple sy-

ringes. (Luer-lock syringes are still with us.) The typical amount of whole blood transfused in adults was 500 mL. Local anesthesia was always used. For 70% of patients receiving transfusion, the indication for transfusion was primary anemia, including pernicious anemia; in the other cases, transfusion was used as treatment for acute leukemia, appendicitis, auricular fibrillation, pellagra, empyema, endocarditis, pneumonia, diabetic coma, peritonitis, "general debility," sepsis, and various types of carcinoma. Blood transfusion was viewed as a tonic to improve the general status of a patient. Banked blood did not exist, nor did the concept of packed red cells. Typically, skin was prepared for surgery by using Tincture of Merthiolate, the new proprietary product introduced by Eli Lilly & Co. in 1929.

We were interested also to observe that American nursing in the 1930s was not a job either for men or for married women: All surgical nurses named in the reports were listed as "Miss." Another professional reality of the times is reflected by a glaring omission: None of the physicians' or surgeons' named in the reports were women.

Of Dr Garfield's operative procedures, the most common was appendectomy. Of the 95 appendectomy cases for which the suitcase held records, nine had questionable diagnoses, and four were diagnosed as pelvic inflammatory disease. In the remaining 86% of appendectomy cases, the appendix was described as acutely inflamed, gangrenous, or perforated. For cases in the latter two categories, Penrose drains were used. The predominant incision was right paramedian; a McBurney incision was used in only 5% of the patients. A clear sign of the times was the large number of

including one that had propagated to form a scrotal abscess. In the years since Dr Garfield's residency, the comprehensive health insurance that he pioneered has made a huge difference in the stage at which a diagnosis of appendicitis leads to surgery in the United States.

The reports showed that 25 hernia repairs were performed: 18 inguinal, 5 femoral, and 1 epigastric. Two hernias were incarcerated, and 3 were strangulated. The Bassini technique was used in 14 of the 18 inguinal repairs. This procedure has now mainly been replaced by the use of mesh.

Considering the pre-antibiotic era in which Dr Garfield practiced as a resident, we were not surprised that his notes described 32 drained abscesses. One of these was a tuberculous abscess of the neck with associated tuberculous lymphadenitis. And unlike Dr Garfield, most of us will never see a case of scrofula in the United States. Of the several cases of intestinal obstruction mentioned, one resulted from tuberculous peritonitis with four liters of fluid removed during the surgical procedure. Dr Garfield's postoperative status note consists of one word: hopeless. He used that word more than once in his reports. Leafing through the notes, we repeatedly found patients coming to surgery very late (Figure 2). In a substantial percentage of patients who received cholecystectomy, the procedure was done as treatment for empyema of the gallbladder with early rupture. As was typical of any large charity hospital, the events leading to surgery also included gunshot wounds, stabbings, and eviscerations.

Spinal anesthesia with Novocain (procaine hydrochloride) was used in most cases, sometimes combined with local anesthesia. A few cases received ether; still fewer received

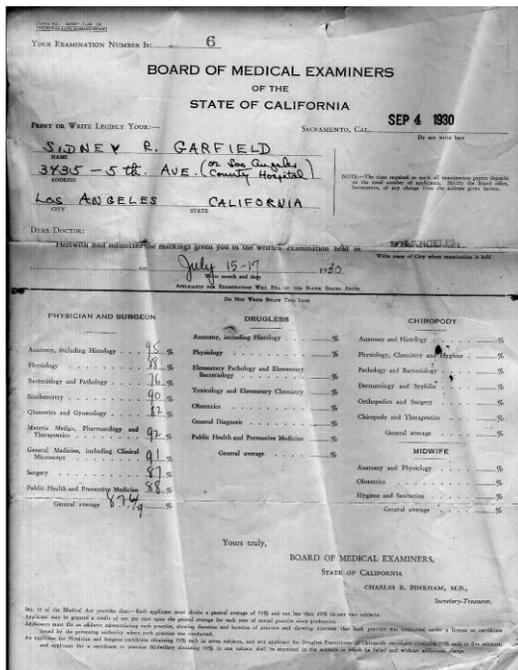


Figure 1. Sidney Garfield passes the State Boards. Reproduced with permission.

nitrous oxide, but we could not determine the basis for this choice except in cases where the operative site was obviously too high to be reached with the anesthetic-filled needle. In one case, a two-liter retroperitoneal abscess was drained with the patient under local anesthesia. In the 1930s, local anesthesia was often considered the safest choice for patients in poor physical condition; now, because of endotracheal anesthesia and muscle relaxants, we believe the exact opposite. In no instance was endotracheal intubation used.

Two newborns received surgery without anesthesia. At that time, the general belief was that newborns did not feel pain—and that if they did, they would retain no memory of it. Reinforced by new concepts of somatic and emotional memory and by recent advances in neurobiology, our thoughts have changed dramatically on this point.

Reading the operative reports left us wondering what life must have been like on a personal level for a surgical resident practicing 75 years ago, during the Depression. Some hint is provided by a handwritten poem penciled on the back of a reprint describing the current state of knowledge about spasm of the gastroesophageal sphincter:<sup>1</sup>

All by myself I've traveled  
weary miles, unraveled  
along the hiway of love.

Where is Simple hiding?  
I'm so in need of guiding  
along the hiway of love.

My poor heart is torn  
with anguish and woe.  
I just find a thorn instead of the roses.

And when my searching is over,  
I'll know love and live in clover  
along the hiway of love.<sup>a</sup>

Dr Garfield's operative notes at LA County-USC Medical Center stop in

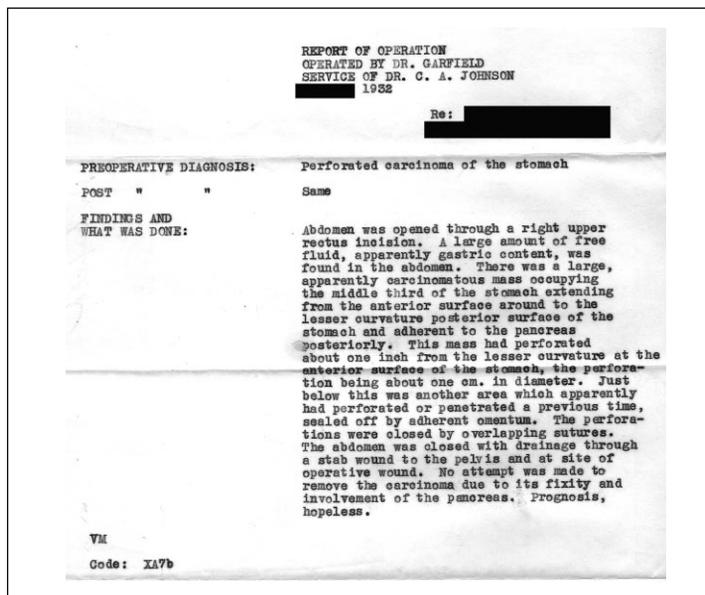


Figure 2. An operative note. *Reproduced with permission.*

June 1933. Later that year, he traveled to Desert Center, California, and took out loans that, along with \$2500 of his personal savings, he used to build his now-famous 12-bed Contractor's General Hospital for the workers constructing the Los Angeles Aqueduct. Here came Dr Garfield's first contact with industrialist Henry J Kaiser—a separate story which begins Paul de Kruif's once-famous book, *Kaiser Wakes the Doctors*.<sup>2</sup>

Dr Garfield remained in the desert for several years, developing his ideas, and then returned to private practice in Los Angeles. His operative notes, again from LA County-USC Medical Center, resume in 1940, when his office address was 350 North Alta Vista, Los Angeles. He was operating on the same kinds of cases, often late in the disease course. In June 1940, a letter from the President of the University of Southern California shows that Dr Garfield was made an unpaid Instructor in Surgery while he worked as a fee-for-service surgeon until 1941. Soon after, he was drafted into the US Army. But shortly thereafter,

at the request of Henry J Kaiser and by direct order of President Roosevelt, Dr Garfield was released from military service so that he could create a health care system for workers at the shipyard that Mr Kaiser was building in Richmond, California.

Those of us at Kaiser Permanente realize that our system is not perfect; indeed, Dr Garfield remained a critic of his own creation until his death. However, the records contained in his suitcase readily remind us of the enormous progress that has been made in the knowledge base available to us in medical practice. The records remind us also of an equally important set of accomplishments: those of Sidney Garfield and Henry J Kaiser in making current medical knowledge available to more people, far earlier, than ever before. ♦

<sup>a</sup> *Reproduced with permission.*

#### References

1. Hara HJ. Cardiospasm. *California and Western Medicine* 1929 Jun;30(6):390-4; discussion 394-5.
2. de Kruif P. *Kaiser wakes the doctors*. New York: Harcourt Brace; 1943.