

# Seebert Goldowsky, MD, Memorial Lecture: April 12, 2011 – Remembrance of a Past Internship

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**My assignment this morning is to bring** you back in time—if only momentarily—so that you may experience the ambience of medicine some 65 years ago: To feel “the way it was” in 1946.

Why this exercise in nostalgia (1946 being, incidentally, my first year of internship)? It is to reinforce the notion that our profession, despite its nobility, requires relentless re-examination and earnest re-appraisal in order to grow, to re-affirm its purpose; and self-examination recognizes how little we, as a profession, had been capable of accomplishing until recent years. A clergyman or lawyer educated, say, in the first decade of the 19<sup>th</sup> Century, might succeed admirably at today’s pulpit or before today’s bars of justice. A physician-colleague of theirs also trained in, say, 1810, would be hopelessly lost in today’s medical arena.

Let me share with you three older commentaries to emphasize how poorly our profession had been viewed until recent years:

**Thomas Jefferson:** “Whenever I see an assemblage of three or more physicians, I look up to the skies to seek the gathering of vultures.”

**Oliver Wendell Holmes:** “I firmly believe that if the whole materia medica could be sunk to the bottom of the sea, it would be all the better for humanity and all the worse for the fishes.”

**Lawrence Henderson:** “Somewhere between 1910 and 1912 in this country, a random patient with a random disease consulting a licensed physician chosen at random, had, for the first time in the history of mankind a better than fifty-fifty chance of profiting from the encounter.”

A bit hyperbolic perhaps, but those pivotal years mentioned by Henderson were not randomly selected. 1910 witnessed the publication of the Flexner Report on Medical Education underwritten by the Carnegie Foundation. Using the model of the recently established Johns Hopkins Medical School the Report condemned virtually every American school then in existence; and, indeed, over two-thirds of American medical schools were then forced out of business by 1912. The Flexner report demanded the following, elements we now take for granted: A preliminary four-year baccalaureate education in the humanities, social and biological sciences and nationwide medical school admissions examination testing cognitive, verbal and mathematical skills. Each medical school to be embedded within a university with a serious 4-yr curriculum, two years devoted largely to the basic medical sciences, a fulltime premedical and medical faculty with their role primarily in teaching and research, university-managed hospitals closely integrated with the medical school, and a uniform, nationwide set of qualifying examinations for licensure.

So, now to 1946: the first year of global peace since 1939: Harry Truman is president, all telephones are connected to neighboring walls by black wires and one could bring one’s children to any movie theater without fear of moral corruption. My rotating internship takes place, in 1946, at Bellevue Hospital, New York City, a 2,400 bed and major teaching institution.

Bellevue was the quintessential municipal hospital begun in 1795 during the city’s yellow fever epidemic. It was the model for the many subsequent, historically famous city hospitals. By 1816, Bellevue had expanded into a 26 acre enclave comprising a penitentiary (with outdoor plaza for public executions), an alms house with a wing for arrested street-walkers, the city morgue, workhouses, a foundling home (over 1,000 infants were abandoned there each year)—and a general hospital largely for pestilential disease.

It was a huge structure of grey granite blocks, as enduringly solid as the moral faith of those who willed its construction. Its purpose was twofold: to isolate the many municipal depravities (communicative or moral) and to instill abject humility in those harbored within its walls. Bellevue, in the 19<sup>th</sup> Century, blurred the distinctions between criminality, vagrancy, moral dissoluteness, mental deficiency, abject poverty and organic illness.

The internship of 1946 was a fulltime 24 month experience, a rigorous—vaguely monastic—process and an annealing, moral exercise. We all lived in the hospital dormitory, wore whites, ate their contrived diet and were each paid \$18.75 per month, with a bonus of a large package of Philip Morris cigarettes at Christmas.

My first assignment was to Bellevue’s Emergency Room. Let me hasten to explain that seeking emergency medical assistance in 2011 bears no resemblance to the ER population of 1946. The ER then was truly a site of last resort and no middle class adult, except victims of auto accidents, ever frequented such medical establishments. The demography of ER usage in the 1940’s reflected the greater employment of the municipal hospitals, historically, as refuges for the dispossessed.

What was an ER like in 1946? First its entry illuminated by a green light—a door never locked, never idle—leading to a large waiting room filled with wood benches, more crowded in the winter when many itinerants sought shelter to warm themselves. It was the ultimate goal of the acutely distressed, the injured and so often, the lonely and homeless. No fees were charged and therefore no clerical personnel were present. The supervising nurse at an outer desk looked more like a stern classroom teacher than a nurturing soul. And her assistants? Two patrolmen in full uniform.

A word about hospital uniforms. The nurse of the 1940’s lived in the hospital, was typically unmarried, poorly salaried and always dressed in an immaculate white uniform. No nurse went without her identifiable nurse’s cap indicative of her nursing school of training—each with its characteristic millinery

contour. And each RN displayed her precious gold pin denoting her educational achievement. Interns and junior residents wore white blouses with short white jackets, pockets heavy with diagnostic instruments, notebook, Merck manual and jacket lapels adorned with 22 gauge syringe needles. Chief residents, the immediate icons of relentless authority, were allowed to wear long white coats similar to those employed by junior faculty. The senior faculty—those austere members of an illustrious medical pantheon—wore 3-piece business suits with vests adorned by a gold chain and a pocket watch.

The core of the ER—its sole reason for being—was the central treatment room, well-illuminated, with chairs along its margins and numerous, wheeled gurneys holding those too ill to sit. A triage system determined the speed with which each supplicant was seen—those acutely bleeding or visibly injured were brought in first. Mothers with ailing children were also given priority, partly to diminish the waiting room noise. Privacy was a low priority and reserved only for women with gynecological distress.

Suturing was an art quickly learned by the ER intern. On some nights, dreaded by the staff, there were countless stab wounds and lacerations occupying the gurneys. The interns speculated on such etiologic factors as the phase of the moon, the barometric pressure or, if they ever heard of it, the Dow Jones average.

Rubber gloves were not expendable items but were cleansed and reused. For the overly taxed intern, a single pair of gloves might last an entire 12 hour shift, not to be changed unless the glove was damaged. At the margins of the central treatment room was a large basin filled with a bluish solution, mercuric bichloride (corrosive sublimate); and after contact with each patient, we rinsed our gloved hands in this antibacterial solution.

Local anesthetics were rarely employed since so many patients were dulled by prior alcoholic intake. And there were uniformed police stationed in the treatment arena to help with unruly patients.

Restlessness was not uncommon amongst the ER patients and occasionally it verged upon manic behavior. We learned quickly—aided by those men in blue—how to don strait jackets upon the excessively inebriated or delirious. The jacket—a restraining camisole—was of heavy canvas with excessively long sleeves which are crossed ventrally and securely tied dorsally. Sedation was achieved through the oral administration of chloral hydrate, a rapidly acting sedative known by its street-name of Mickey Finn.

If, like Marcel Proust, I needed an olfactory reminder of my consignment to the ER, it would be the sickly sweet aroma of chloral hydrate. Indeed, in an era before air-conditioning, each area of Bellevue had its distinctive odors: the ER with its stench of chloral hydrate; the operating rooms with the persistent smell of ether, the obstetrical floors with that curiously appealing odor of the newborn infant, and the vast 36-bed general wards reeking of chlorine (and with a faint ammonia hint) reminiscent of a swimming pool. Those ward floors were swabbed with a chlorinated soapy solution, by student nurses, every eight hours. And then there was the distinctive aroma of Sneaky Pete. It consisted of a pint of unbonded brandy added to a quart of cheap claret wine to produce a cloudy, curiously sweet-odored mixture, the

principal intoxicant for most of NYC's vagrant population. Its fragrance on the breath of ER patients was as distinctive as a Chanel perfume.

What else to remember from one's servitude in the ER? (12 hr shifts, six days/week, 72 very active hours/week): Certainly the commonness of alcohol as an accompaniment of civil and domestic disputes; the expanding use of heroin and its inevitable withdrawal syndromes, the emergence of tropical disease in a temperate setting, afflicting newly discharged army veterans, the countless children with measles, mumps, pertussis and, most dreaded of all, diphtheria perhaps requiring tracheotomy.

**April, 1947:** A visitor from Mexico to NYC brought with him the virus of smallpox. He transmitted the infection to some neighbors in upper Manhattan; and the decision was then made to revaccinate the entire NYC population, this task assigned to the municipal hospital medical staff. And so, each intern was assigned to a street corner with an RN nurse to assist and a student nurse (or medical student) to help further and to act as a local recorder. We vaccinated a new candidate about every three minutes; and in the course of a 12 hour day, about 250 persons. Before the campaign was halted over two weeks hence, over five million humans were vaccinated—and the smallpox outbreak was halted—but at a cost.

What did those of us in the ER dread the most in our daily encounters with Manhattan's sickest? It was the middle-aged male alcoholic who was concurrently a diabetic. This was a person who was ill-equipped to manage his diabetic state, indifferent to his basic hygienic needs and often too obtunded to realize the gravity of his deteriorating clinical condition. His chief complaint, often, was painful feet and what we feared most was vascular insufficiency of his legs with signs of impending gangrene. Faciocerebral mucormycosis was yet another complication in a diabetic with acidosis.

A few reflections about the inpatient services at Bellevue. For those of us who find a contemporary semiprivate hospital room, with two beds and about 440 square feet of floor space, too crowded, it might be well to ponder upon a typical adult medical ward at Bellevue in 1946.

You enter a vast room, about 90 feet long, housing, seasonally, 36 to 48 beds, a chamber bereft of frivolity, ornamentation or excessive sound. Everything is grey or white including the nurse's starched uniforms. Amenities are few. Getting a non-lumpy mattress or a warm bedpan was deemed a sign of benevolent attention. Visiting hours were 1 to 3 PM and only 2 adult visitors allowed per patient.

Short-term clinical outcomes were generally good not because of any miraculous medications but because of meticulous nursing, good food with no alcohol, and most of all, a temporary parole from some wretched tenement or homeless shelter from whence they had come. Good inpatient care, in their thinking, was measured by a warm bed, abundant food and a respite from the loneliness that most had customarily experienced.

What else distinguished an internship in 1946 from one in 2011? Certainly more than the salaries or even the ambience of the hospitals. The newly graduated physicians of the current era are vastly better educated, more sensitive to the tenets of preventive medicine and strikingly more compassionate to those seeking their

healing help. The average intern today has seen more of the world and is more cognizant of the ethnic diversity of those asking for medical aid. The institutional hierarchy then was more personalized, more strictly observed, and a chief resident or a charge nurse (called matron to her face and less appealing names behind her back) were awesome figures of inflexible authority. To experience the ancient halls of Bellevue, please read Charles Dickens.

We gave little thought, in 1946, to causal relationships or the fundamental precepts of clinical epidemiology. Each patient was an idiosyncratic case-study of one unrelated to broader communal trends. We paid much attention to the daily temperature-curves, seeking patterns for example, suggestive of tuberculosis or typhoid. The odor of a patient's breath might hint at impending acidosis or a gram-negative pneumonitis. And the texture of his forehead might suggest impending uremia. Nor did we retreat at the sight of head-lice. Auscultation was a high art in an era dominated by rheumatic and syphilitic heart disease. Urinalysis and blood counts were done by the interns, and blood chemistries were a research intervention.

The nurses of 1946 were more compliant, more religiously motivated and, sadly, were taught always to stand when a physician entered the premises. The nurses of today, substantially better educated, are now partners in this complex enterprise called healing.

We 1946 physicians were given far greater latitude in patient-care; we had no therapeutic protocols to follow, nor were we that closely supervised in our attempts at clinical management; and, on average, in our missionary zeal, we made many more mistakes. Our cumulative clinical experiences indoctrinated us with a variable mixture of courage, intemperate arrogance, indecisiveness and perhaps, an emerging awareness of our relative ignorance.

We in 1946 were at the near margins of a new era of rational medicine with the discoveries antibiotics, steroids and other endocrinologic agents; in general, the sweeping discoveries that transformed medicine into a more exact science.

Of the multitude of experiences that I might recall, one stands out because it exemplifies how much we as a profession were then on the threshold of a modern, rational medicine where the great majority of patients might confidently expect to be healed.

Penicillin was discovered in the 1940's but until it was synthesized a decade later, its supply was severely limited. Accordingly, since much of parenterally administered penicillin spilled out in the urine, we routinely collected all of the urine from penicillin-treated patients, brought these numberless gallons to a basement room and slow boiled the volumes until reduced to mounds of yellowish powder, principally urates. These were then extracted with an ether mixture and the recovered penicillin happily re-injected into those ward patients.

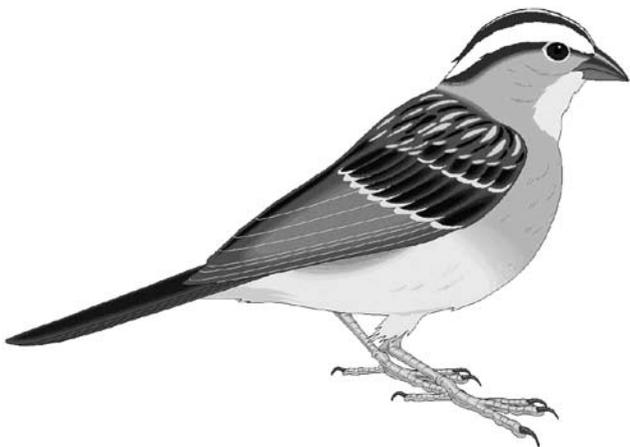
And if we overly worked interns, salvaging precious penicillin, had time to reflect upon the Biblical words of Ecclesiastes (11: 1) we might have remembered that when we cast bread upon the waters, that after many days it shall return to us, perhaps even as penicillin, a renewable blessing for humanity.

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