From the 1870s through the early 20th century, physicians frequently relied upon nutritive enemata to succor patients suffering from bowel obstructions and other disorders of the gastrointestinal system. Far from extraordinary or outlandish, this therapy was used on paupers and presidents alike, including on Garfield and McKinley after their assassination attempts. The medical milieu of the late 19th century provided particularly promising circumstances for its practice, with the rise of allopathic medicine generally—and surgery especially—coinciding with flourishing research on the physiology of nutrition. Although ongoing discussions debated the merits of different methods and various ingredients, few in the United States or Europe doubted the efficacy of rectal alimentation. However, in the early 20th century, new studies utilizing biochemistry demonstrated the inability of such instillations to provide significant calories or protein, and the intervention fell from favor. Proctoclysis—or rectal hydration—remained standard of care for the next 20 years, strongly supported by John B. Murphy and other surgeons. Ultimately, intravenous hydration and, much later, total parenteral nutrition replaced the rectal route.

**Keywords:** rectal nutrition, rectal alimentation, nutritive enema, proctoclysis, Austin Flint, John Murphy

**INTRODUCTION**

By August of 1881, President James A. Garfield lay dying. Charles J. Guiteau had shot him twice in the back on July 2, 1881, and one 0.44 caliber bullet traversed his torso, coming to rest posterior to the pancreas. In an era before routine laparotomies, the President’s medical team explored the wound locally while providing supportive care. Although he initially tolerated an oral diet, by August, Garfield had become septic, peritonitic, and unable to take any nutrition by mouth. His weight dropped from 210 to 130 pounds. Attempting to sustain the President, his physicians provided nutrition rectally, instilling defibrinated blood and beef extract up his bottom. These nutritive enemata, far from an outlandish or last-gasp effort, were standard medical interventions in the late 19th and early 20th centuries, applied to presidents and paupers alike. Despite the best efforts of the surgeons caring for him, President Garfield died on September 19, 1881.

This article explores the adoption and abandonment of rectal alimentation. Relying on a careful review of the contemporary surgical literature, analysis of the minutes of major surgical organizations like the American Surgical Association, and scrutiny of contemporary lay media, the research examines both the circumstantial and physiological arguments behind the meteoric rise in popularity of this therapy. It demonstrates the widespread usage of the method in both the United States and Europe, with robust debate over the type and amount of ingredients instilled. The article also highlights the internal intellectual debates over the merits of nutritive enemata, which occurred coevidly with its pervasive utilization. As food per rectum began to decline in the early 20th century, resuscitative fluids per rectum emerged as a generally accepted therapy across the medical and surgical professions. Finally, it examines the slow decline of proctoclysis by the mid-20th century, when intravenous fluids and, eventually, total parenteral nutrition replaced it. By investigating a medical intervention deemed standard of care in its time but passé—if not risible—today, our article provides an opportunity to understand medical decision-making and how a combination of scientific, cultural, and social contexts ultimately determine care delivered to patients.

**BACKSTORY**

Normal, evacuative enemata date to the earliest civilizations in Egypt, where providers were allegedly inspired by the ibis bird injecting water into its own bowels. The therapy gained increased prominence in ancient Greece, as clinicians struggled to rebalance the body’s 4 humors through the use of emetics, purgatives, and clysters. These therapies remained central to medieval medical practice, with frequent debates over who should be administering the financially lucrative intervention. In the early modern era, enemata expanded to include more therapeutic indications, such as the use of tobacco smoke to treat drowning victims, although relief of constipation and bowel irritation remained the most common indications.

Rectal alimentation gained popularity in the specific medical milieu of the late 19th century. Although periodic references to nutritive enemata pepper the medical literature from Galen (200 CE) onward, these remained relatively rare yet seemingly routine affairs that attracted little scholarly attention. Interest exploded in the 1870s, indicated by a marked increase in publications on the topic and reports of patients treated. Three major shifts explain the timing of this development. First, society was
changing in ways that brought more people in contact with allopathic physicians, who, in the United States at least, had emerged as the dominant medical sect.7 Cities grew, hospitals proliferated, and patients who may have sought medical treatment from a village healer in a previous century now increasingly approached “regular” physicians. At the same time, the medical profession increasingly professionalized and globalized.8 The number of clinical journals ballooned—479 new titles appeared in Great Britain over the 19th century—facilitating the proliferation and transfer of knowledge across international boundaries.9 Individuals suffering from complaints that prohibited their eating thus came to the attention of a developing community of physicians and surgeons eager to apply the latest research in caring for the sick.

Second, surgery modernized with the development of catalysts anesthesia and anti/asepsis. Operations grew in number and diversity: over 100 new procedures were described between 1880 and 1890 alone.10 Abdominal surgery in particular expanded rapidly, with Theodor Bilroth and colleagues pioneering gastrectomies, enterectomies, colectomies, and similar interventions. This change affected nutritive enemata in 2 ways. Before the 1880s, patients with mechanical bowel obstructions were untreatable—they either improved or died. Implementing a nutrition support program was thus pointless, just as doctors today do not provide total parenteral nutrition to patients with metastatic cancer. After surgeons began safely resecting and reanastomosing the bowel in the late 19th century, many obstructive pathologies became fixable. Supporting patients’ nutrition in the perioperative period transformed from futile to utterly necessary. Moreover, as surgeons increasingly invaded the abdominal cavity, they created iatrogenic complications, such as adynamic ileus and adhesive bowel obstruction, that benefited from supplemental nourishment. For these reasons, the surgical profession often dominated the discourse on rectal alimentation.

Third, the science of nutrition and the physiological understanding of the gastrointestinal (GI) tract developed considerably over the same period. This corresponded with a general appreciation for basic sciences and especially for physiology in the American medical profession over the second half of the 19th century. These disciplines increasingly featured prominently in the curricula of universities and medical schools.11 In the 18th century, scientists and physicians moved away from a humoral understanding of disease, instead recognizing the importance of the mechanical and chemical components of macerating foodstuffs for absorption in the intestines.12 René Réaumur and Lazzaro Spallanzani demonstrated the role of saliva and gastric juices in dissolving starches in the late 1700s.13 William Beaumont famously elucidated the function of gastric secretions in a series of experiments, exploiting the gastroduodenal fistula of Alexis St. Martin, whom he purportedly kept alive for the 17 days following his gunshot wound via nutritional enemata.14 In the decades that followed, Justus von Liebig and Claude Bernard characterized the content of pancreatic and hepatic secretions and their importance in digestion.15 In the 1800s, scientists had clearly established the ability of rectal mucosa to absorb drugs such as alcohol and opiates that would then affect the entire body. That food would act similarly seemed like a logical conclusion. Moreover, its robust vascular and lymph supply promised easy access to systemic circulation.16–18 Most practitioners recommended cleansing enemata before any food bolus to increase the mucosal surface available for absorption. Finally, patients were dying, and trying something was preferable to doing nothing. In these cases, physicians followed the recommendation of Flint and his contemporaries, like William Porter who “advised that the stomach be entirely abandoned for the purposes of nutrition, and that rectal alimentation be substituted.”19

Proposed ingredients varied widely. Flint believed that “what is true of digestion in the stomach and small intestine is true also of digestion in the large intestine, namely, a varied diet is better than the persistent use of the same kind of food prepared in precisely the same way.”20 Eggs, various meat broths, alcohol (usually brandy), and milk were commonly employed by physicians who advocated substituting foodstuffs for absorption. For purely hydration, doctors experimented with hypodermoclysis or injecting fluid under the skin for resorption. Although still used in veterinary medicine, this method proved less successful in humans due to the relative inelasticity of our skin and the inability to infiltrate adequate quantities of liquid, although it remained in limited practice for much of the 20th century. Attempts at injecting foodstuffs below the dermis caused significant pain without any evidence of absorption and were quickly abandoned. The now-standard intravenous supplementation came at the end of this era and is discussed at the conclusion of the article.

MAKING ENTRY

Mr. P, a 41-year-old male, had a nervous-sanguine temperament and sedentary occupation. On February 18, 1877, he suffered from unremitting severe hematemesis, with a combination of exhaustion, exsanguination, and dehydration threatening his life. Dr. Austin Flint tended to him. Flint, today remembered for the eponymous heart murmur associated with aortic regurgitation, had graduated from Harvard Medical School before spending his career primarily in Buffalo, NY. By the 1870s, he was a towering figure in American medicine, having helped start the American Medical Association, founded Buffalo Medical College, and establish the scientific and pathologic basis of auscultation.21 Determined to cure Mr. P, Flint insisted on a strict regimen of nil per os (NPO)—denying him even oral medications. Instead, for 3 weeks, he nourished his patient exclusively through enemata, delivering 6–8 ounces of either beef or chicken broth every 4 hours (Fig. 1). Some 21 days later, Flint was pleased to report the full recovery of his patient.22

Flint discussed this case in a famous 1877 lecture to the New York Academy of Medicine that heralded increased attention to, and practice of, rectal alimentation. The method made intuitive sense to contemporaries. The ability of the rectum to dilate and expand analogously to those of the stomach. By the 1800s, scientists were less frequently featured. S.G. Armor of Brooklyn, New York, preferred milk mingled with beef blood, although noted “when using stimulants by the rectum, I usually add cream to the milk.”23 Amounts typically ranged from 3 to 12 ounces, with recognition that larger doses were more likely to be promptly
returned. Many physicians included laudanum or another opiate for the purposes of slowing peristalsis and keeping the concoction in the rectum as long as possible.29 “Fortunately,” remarked Richard Harte in his presentation to the American Surgical Association, “there is no palate in the lower bowel, and such mixtures are well tolerated.”30

Indications for rectal alimentation proved as diverse as their composition. Mechanical obstructions of the bowel, particularly cancers, were an obvious and immediate application. William Mayo, among others, advocated for its use after gastric surgery to provide nourishment while the organ healed.31 Famous French neurologist Charles-Édouard Brown-Séquard wrote in The Lancet to “call the attention of alienists and of superintendents of lunatic asylums to the advantage they would find in employing such a means of feeding, instead of the usual plan of forcing food into the stomach.”32 Multiple obstetricians raised the hope that rectal alimentation would enable nourishment of gravid women suffering from severe morning sickness and eliminate the necessity of aborting the fetus in those cases.27, 33 General practitioners looked to rectal feedings to counter the pharyngeal edema present in diphtheria and the facial paralysis seen in tetanus.13, 34 “The largest and most important class of cases in which the physician has to make use of rectal alimentation,” according to Prof. Seymour Sharkey in his 1906 Bradshaw Lecture, “is that of the simple ulcer of the stomach.”35 The incidence of gastric and duodenal ulcers rose significantly in the late 19th century, likely due to improved awareness and diagnosis more than any real epidemiologic change.13 Medical and surgical attention followed suit, and the profession generally agreed on the importance of bowel rest to allow the ulcers to heal. In the majority of articles on gastric ulcers published in the 1880s and 1890s, authors also recommended rectal alimentation while NPO, although this later proved controversial as some doctors believed nutritive enemata stimulated gastric acid secretions, either through a direct physiologic link or a Pavlovian-like response.22, 24, 31, 36

UNCOMFORTABLE CHALLENGES

Advocates of rectal alimentation encountered 2 significant physiological hurdles: the inability of the colon and rectum either to digest food or to absorb nutrients. By the late 1800s, physicians clearly recognized the importance of pancreatic and hepatic secretions to digestion—and realized these did not normally exist in the colon. Although some early proponents of nutritive enemata believed the extensive rectal lymphatics and blood vessels provided a network amenable to absorbing nutrients,15, 26, 37 by the 1880s most admitted to its impossibility, at least for solid food. Still strongly supporting the nutritional intervention, its champions proffered 3 potential workarounds. They were described semiconsecutively, but support for the 3 explanations overlapped chronologically.

One of the earliest suggestions was “retroperistalsis” or the idea that the enema solution would find its way back to the small bowel where it could be digested and absorbed. Advocates of this idea cited various cases dating to the Civil War, where patients with enterocutaneous and colocutaneous fistulae received enemata only to have a portion of the injection egress from the fistulous opening.2, 26, 27, 38 Henry Campbell, 1 of the strongest proponents of what he termed “intestinal inhausation” laid out additional supporting evidence, using bile reflux and vomiting to prove the alimentary tract was not exclusively unidirectional.31 He also cited patient testimonials of tasting beef broth after its injection into their rectum. Campbell verified his theory by administering enemata of fluid dyed in various colors to baby goats, sacrificing the animals, and visualizing the presence of these hues in the proximal intestines. An intuitive solution, retroperistalsis addressed the apparent deficiencies of rectal feeding without resorting to exotic regimens. Later research in the early 20th century followed Walter Cannon’s pioneering studies and utilized barium enemata and X-rays to prove “intestinal inhausation” was at best infrequent and could not be relied upon to sustain patients.39

Other physicians reasoned that if the food was not going to reach the pancreas, they should bring the pancreas to the food. These conclusions relied on the 1840s work of Leibig and Bernard in demonstrating the critical importance of pancreatic secretions in digesting foodstuffs, highlighting the growing connection between the clinic and the laboratory.10 German W. O. Leube published the seminal article on injected pancreatic secretions, proposing a mixture of ground pancreas with beef in 1872.41 Subsequently, in 1877, Ewald stressed the importance of also including pepsin, a stomach ferment discovered in 1830 by German physiologist Theodor Schwann and thought to transform protein into peptones.42, 43 These 2 articles became the standard references for the next 30 years, with multiple variations proposed. Some common recipes included 10 ounces of ox meat mixed with one-third of its weight of finely chopped ox pancreas, adding 5 ounces of water to lubricate the admixture.22 Brown-Séquard opined, “it is essential that the pancreatic gland which is to be used, be from an animal quite recently killed, as the tissues and juice of that gland lose their property very quickly,” and suggested removing all fatty tissue to ensure that just glandular cells remained. Alternatively, 1 could add commercially produced pancreatic extract, like Liquor Pancreaticus from Motterhead & Co. Chemists, to meat broth just before
injection and rely on the warm temperature and peristalsis of the rectum to digest the concoction. By the 1880s, commercial preparations of pancreatized meat, such as Darby’s Peptonized Fluid Meat and Valentines Meat Juice, were available for purchase and, over the next 3 decades, became a standard component of nutritional enemata (see Fig. 2).

Finally, some doctors reasoned that if the goal was to nourish the blood, why bother going through the digestive process at all, and instead recommended injecting animal blood per rectum. Presenting a lengthy article championing this variant to the New York Academy of Medicine in 1879, Andrew Smith describes multiple patients he sustained on enemata of defibrinated blood alone. Smith did mention several side effects, including constipation in one-third of cases, rectal irritation causing “immediate return” of the enema, and “in two cases the discharges were so very offensive as to cause serious annoyance in the house.” Building on this research, F. E. Stewart of New York stressed the importance of obtaining fresh, high quality blood: “inflammatory blood from diseased cattle will not do, or blood from animals fatigued from long journeys. None but powerful, vigorous bullocks, fed and rested” are suitable as donors. Most sources recommended 60–180 grams of blood to be administered rectally 2 or 3 times a day. That President Garfield’s team of doctors turned to this regimen highlights its widespread practice and broad appeal. For 4 days, they tried defibrinated blood enemata, but “the volume of offensive gases developed together with the character of the ejecta rendered necessary a return to the beef extract.” Popular in the late 1870s and early 1880s, rectal alimentation via blood represented a creative solution to the problems of digestion and absorption in the colon.

**POPULAR OPINION**

It is difficult to overstate just how common and well-accepted the practice of rectal alimentation was in late 19th century. Popular medical and surgical textbooks of the day recommended rectal feeding, highlighting the trans-Atlantic interest in its practice. Artificial nutrition products such as Darby’s and Valentine’s meat juices lined storeroom shelves as consumers turned to them in droves. The therapy was well enough established for President Garfield’s doctors to apply it to their patient, as cited in the opening of this article.

Yet another American President was shot on September 6, 1901: President William McKinley was struck by two .32 caliber pistol rounds fired by anarchist Leon Czolgosz at the Pan-American Exposition in Buffalo, NY. One bullet penetrated McKinley’s abdomen, requiring emergency celiotomy at the clinic on the fairgrounds. Lead surgeon Matthew Mann primarily closed the anterior and posterior gastric perforations but was unable to identify or repair the presumed retroperitoneal injury. Facing a difficulty recovery, McKinley started enema on postoperative day 0, first with saline to hydrate and resuscitate the patient, followed by salt and sugar solutions on postoperative day 1. By postoperative day 3, the President was receiving 3 nutritive enemata per day that included eggs, beef juice, and whiskey, although by the September 11, his doctors noted that “the rectum was becoming irritable, and did not retain the nutritive enemata well.” As the course and prognosis worsened, the physicians also resorted to hypodermic infusions of fluid and drugs such as adrenalin. Despite the best efforts of the medical team, McKinley unfortunately died on September 14, 1901. Remarkably, the doctors had accessed his rectum more than 20 times since the wounding, not only relying on this route for hydration, sustenance, and medication administration but also detailing their efforts in the public report published in the *Journal of the American Medical Association*. Once again, this episode highlights the prevalence, popularity, and attention to rectal feeding.

**SOLIDS OUT, LIQUIDS IN**

By the early 20th century, opposition to nutritive enemata surged. The rise of physiology and biochemistry led to new studies that questioned the purported success of rectal alimentation. In 1891, Munk and Rosenstein proved the inability of fat absorption in an elegant if fortuitous experiment: identifying a patient with a thoracic duct fistula, the Germans provided her lipids via enema, measured the fat content of the extravasated lymph, and found negligible change. This conclusion launched a series of experiments in the early 20th century attempting to quantify the absorption of nutrients provided rectally. Some tracked patients’ weights over weeks of rectal feeding; others evaluated their nitrogen balances; a few surveys utilized the new metric of respiratory quotient. By 1910, all arrived at the same conclusion: “rectal feeding is a poor substitute for...
oral feeding...the individual is being subjected to partial starvation" and "rectal alimentation, as ordinarily practiced, is of little or no value." W. W. Keen’s 1907 American Textbook of Surgery called the method "scientific starvation," as fat and protein were clearly not absorbed despite the administration of pancreas extract or utilization of blood. By 1915, most physicians and surgeons had forsaken the practice. Dextrose and glucose-containing enemata continued for the next decade but were largely abandoned by 1930 as evidence accumulated to vitiate their efficacy.

These studies not only relegated nutritive enemata to history, they also highlight a shift in surgical epistemology. Articles advocating rectal alimentation, predominately published between 1875 and 1900, relied on case reports and case series to justify the intervention. Many of the same episodes were re- and re-re-reported in the literature, often citing an earlier publication. To these physicians, the narrative proof of a patient surviving exclusively via rectal nutrition was sufficient evidence to support and adapt the practice. In contrast, the articles rejecting the value of rectal alimentation, predominately published between 1905 and 1915, relied upon careful, repeatable measurements of biochemically analyzed molecules. In creating this more objective, numerical evidence and relying on it to determine their clinical decision-making, physicians questioning rectal feeding were part of an exciting new trend in surgery that increasingly privileged quantitative data. Interestingly, neither proponents nor opponents attempted head-to-head (butt-to-butt?), controlled comparisons, a methodology increasingly utilized in medicine but not widely adopted in surgery until the 1920s.

Although nutritional enemata faded in the early 20th century, hydration per rectum—a process called proctoclysis—grew in popularity, largely due to the presentations and articles of John B. Murphy (1857–1916). Murphy grew up on a farm in Wisconsin and received his early medical education apprenticing to a local doctor. Later interning at Cook County Hospital, he eventually traveled to Germany to learn from Billroth and others. Returning to Chicago, Murphy established his reputation as a leading surgeon over the jealous protestations of the local medical establishment, which found the man vainglorious and accused him of falsifying his data. Nonetheless, by 1900, he had risen to the heights of American medicine, presiding over the American Medical Association after proving the importance of early appendectomy, the ability to sew blood vessels together, and the value of the Murphy-button in anastomosing bowel. In 1908, he published a seminal 34-page article in Surgery, Gynecology, and Obstetrics outlining the proper management of peritonitis. He recommended the immediate assumption of the Fowler position, discouraged opioid use, insisted on early operative repair, and proposed implementing proctoclysis as soon as the patient returned to their ward bed. "We believe," wrote Murphy, "that next to the conservative technique of the operative procedure, proctoclysis is second in importance as a life-saver. It rapidly restores blood pressure, it improves the capillary circulation, it quiets the thirst, it eliminates the septic products."

Murphy articulated a specific method of rectal hydration and criticized those who deviated from it. "The retention of fluid in the colon depends entirely upon the method of its administration," he wrote.

The fluid should be given through a tank to which is attached a 3/8th of an inch bore rubber hose fitted with a hard glass vaginal douche tip with multiple openings. The tube should be flexed almost to a right angle three inches from the tip...A straight tube must not be used, as the tip produces pressure on the posterior wall of the rectum when the patient is in the Fowler position. The tube is inserted into the rectum to the flexion angle and secured in place by adhesive strips of plaster to the thigh, so that it cannot come out. (see Figs. 3 and 4)

With this setup, Murphy relied on gravity to infuse roughly 18 pints of warm fluid continuously every 24 hours until the patient could tolerate an oral diet.

If imitation is the highest form of flattery, the medical and surgical professions spent the next decade flattering Murphy by publishing variations on his methodology. Famous orthopedic surgeon Paul Magnuson noted that the Murphy method relied on electricity to heat the fluid, a technology not universally available in 1908, and proposed an insulated mug instead. Other inventors suggested alternative materials, gauges to determine volume administered, and similar such modifications. "Personally...I have used the ordinary soft rubber rectal tube," remarked Peregrine Wroth in proposing a new nozzle, "and the discomfort caused by that drove me to change over to the smallest catheter I could find." Surgeons also experimented with different solutions to infuse. In 1 of the largest trials, Hugh Trout relied on 2000 patients to compare the value of normal saline with water and found that saline delivered an unnecessarily large salt content to patients. "We can see no more reason for the giving of salt solution by rectum to prevent and relieve thirst," concluded Trout, "than we can for its employment by mouth under like conditions."

These various formulations and modifications underscore the widespread acceptance and popularity of the Murphy method. It too featured prominently in surgical textbooks of the day and was presented at prestigious conferences such as the American Surgical Association. In commentary, John Deaver opined...
that “there is no question that Dr. Murphy’s line of treatment has been responsible for saving more human lives than has any other line of treatment in peritonitis.”

The therapy remained standard of care through the First World War.

IN THE END

By the mid-20th century, intravenous (IV) fluids had almost entirely replaced rectal administration. Again, history reports various one-off attempts dating back centuries, but technological constraints (no hypodermic needles until the 1850s) and limited physiological understanding severely curtailed the early utilization of maintenance IV fluids. Thomas Latta and other physicians treating dehydrated cholera victims found success with the method in the mid-19th century, but it remained cumbersome and unproven in surgery until Rudolph Matas’ seminal 1924 article. This publication built on previous work recommending bolus of fluid or blood for the resuscitation of patients in shock; Matas went further to demonstrate the utility of IV fluids as a long-term solution for patients unable to tolerate a diet, such as those recovering from abdominal operations. Matas’ stature in the field of surgery hastened its adoption. Nutritional options remained limited until the 1960s, when Stanley Dudrick began publishing his success keeping dogs alive through total parenteral nutrition (TPN). A remarkable biochemical and physiological achievement, TPN realized everything that Flint and others hoped to accomplish 100 years earlier. Sporadic reports of rectal infusions remain in resource-poor environments, mentally handicapped populations and, interestingly, counteracting the hunger strikes of terrorist prisoners at Guantanamo Bay, but for all intents and purposes, rectal alimentation has been exclusively of antiquarian interest for the past century.

That interest, however, has important academic value when exploring fin de siècle medical practice. Too often, historical investigations focus on past successes, the enduring triumphs that the profession can herald with pride. Yet, in reality, the majority of medical and surgical interventions fade into irrelevance over time as newer and seemingly more effective therapies emerge. Exploring the daily utilization of since passé modalities informs us about the beliefs, priorities, and practices of contemporary medicine. Although outdated—if not seemingly risible—today, nutritive enemata commanded significant attention for decades. The therapy arrived in the late 19th century and exploded in usage, rapidly spreading over 2 continents and across disciplinary boundaries. It leveraged renewed interest in the alimentary system coupled with novel biochemical understandings of digestion. However, solutions need problems before being utilized. The rapid adoption of rectal feeding highlighted attention to diseases of the gastrointestinal tract and especially its ontological separation from broader diagnoses of “ill-health.” Specific GI maladies now had particular treatments. The simultaneous rise of abdominal surgery, with both its therapeutic potential and array of complications, brought further focus to the method and its potential. The propagation of rectal feeding relied on case reports espoused by thought-leaders such as Austin Flint, Charles Brown-Séquard, and John Murphy, an authority-based system of evidence that was ultimately exposed as inadequate. As science and epistemology developed, so too did novel methods of examining and ultimately disproving, rectal alimentation, but that does not negate the years that smart, dedicated, caring clinicians applied the technique to thousands of patients in need, fully expecting it to nourish their charges back to health. Exploring this history is a reminder that much of what we are earnestly doing today, future generations may find similarly bewildering.

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