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# Huey P. Long's Last Operation: When Medicine and Politics Don't Mix

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## ABSTRACT

Ochsner has a rich historical heritage in the Gulf South, Louisiana, and New Orleans. It is therefore not surprising that connections exist between Ochsner and one of the most important events in Louisiana history in the 20th century. This article examines the medical care Huey P. Long received after a gunshot wound in 1935 and the circumstances that may have ultimately led to his demise, as well as the important questions of whether the care he received was consistent with standards of the time and whether the best available surgical team participated in his care. Politics and medicine were intertwined in this incident, and the Ochsner connections are worth examination in this context.

## INTRODUCTION

One of the most important events to occur in Louisiana history in the 20th century was the shooting of US Senator Huey P. Long on September 8, 1935, and his death 2 days later.[1] The cause and effect of this event have been, and continue to be, debated.[2]

Long was a prominent and controversial political figure in Louisiana and the United States in the 1920s and 1930s. He has been accurately described as a polarizing figure. His fatal injury and the medical care he received are a noteworthy example of politics and medicine being intertwined and inseparable, with untoward consequences. Not until 1979-1980 when the medical care of the Shah of Iran and its political ramifications played out on an international stage did we see a similar medical controversy as detailed in Morgenstern's excellent article.[3] Situations such as these shape history and provide a thought-provoking basis for discussions of alternate history.

Ochsner institutions have a rich historical heritage in the City of New Orleans, the State of Louisiana, and the entire Gulf South,[4,5] so it is not surprising that ties exist between the stories of Huey P. Long and Ochsner. It is worthwhile and interesting to examine these historical connections in the context of the events of September 8-10, 1935.

Did Long receive the usual and customary standard of care, or was the quality of his care suboptimal? Did the quality of his care contribute to his demise? Might he have received better care if not for the victim's political alienation of his detractors? Were talented surgeons and expert medical care available but relegated to the sidelines?

## THE INJURY

Senator Huey P. Long (D-LA), age 42, sustained a gunshot wound to the right upper abdomen at close range just before 9:30 pm on September 8, 1935.[6] Whether the shooting was an assassination attempt by Baton Rouge physician Carl A. Weiss or an accident by one of Long's bodyguards remains definitively unanswered to this day despite a range of opinions. The injury itself is best described in New Orleans surgeon Frank L. Loria's case report:[6-9]

> The bullet which struck Senator Long entered just below the border of the right ribs anteriorly, somewhat lateral to the midclavicular line. The missile perforated the victim's body, making its exit just below the ribs on the right side posteriorly and to the inner side of the midscapular line, not far from the midline of the back.

The penetrating injury has been described as being caused by a .22 cal., a .32 cal., a .38 cal., or a .45 cal. weapon, or by a combination of 2 of them.[6-8] Immediately after receiving the injury, Long managed to move 40 feet down the hall and then down 4 flights (28 steps) of stairs. He met an associate and was brought by private car to Our Lady of the Lake Sanitarium, approximately one-quarter mile away.[6,9,10]

## PREOPERATIVE CARE

On arrival at approximately 9:30 pm, Long was awake and alert but pale and sweaty.[9] His jacket and

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shirt were cut off.[9,10] Arthur Vidrine, MD, superintendent of Charity Hospital–New Orleans (CHNO) and a Long political appointee, happened to be in Baton Rouge on business related to appropriations for his hospital.[1,11] He was present at the hospital and took charge as the admitting physician.[1,6,9-11] On examination Long was fully conscious and very nervous.[6,9,10] His pulse volume was weak, faint, and rapid.[6,10] Blood pressure (BP) was low.[10] The entrance wound was located just below the border of the right rib cage anteriorly, lateral to the midclavicular line, and vertical with the nipple.[7-10] The exit wound was posterior below the ribs on the right side in the midscapular line near the midline.[7-10] Long was given caffeine and 2 cc sodium benzoate by hypodermic needle.[6] William H. Cook, MD, Baton Rouge general surgeon and former CHNO house surgeon, was called and arrived at the hospital.[1,6,9,10]

Vidrine examined Long's wound, typed and crossmatched him for a blood transfusion,[9] cleaned the wound, and at 9:45 pm Long was taken to Room 314, a private room reserved for Catholic bishops. Long's BP and pulse were taken every 15 minutes, and the foot of the bed was elevated.[6,10] He was given morphine sulfate, gr 1/6, by hypodermic needle for pain.[6] Long reportedly demonstrated ''profound shock'' and ''clinical evidence of internal hemorrhage.''[7,8] Long received a transfusion of blood donated by Lieutenant Governor Jimmy Noe.[6,9,10] He was diaphoretic and nauseated and asked for and received ice.[6,9,10] Cecil Lorio, MD, a Baton Rouge pediatrician, was present.[1,6,10] Long's systolic BP was reported to be approximately 90 mmHg, and his pulse was above 110 bpm.[9] Long was in a cold sweat and received external heat.[6,9,10] At this point, Vidrine advised Long that surgery was needed; the patient agreed.[6,9]

The decision to operate was made by committee, including Long's aides and assistants, a variety of medical consultants, and interested parties. Vidrine called for assistance from experienced surgeons locally and regionally.[6] Long himself requested renowned New Orleans surgeon and chairman of surgery at the Louisiana State University (LSU) School of Medicine Urban Maes, MD.[9,11] Long also requested Russell Stone, MD, another prominent New Orleans surgeon.[9-11] Maes was delayed when his car, driven by resident James D. Rives, MD, was involved in a minor accident just outside of New Orleans.[6,9] Others from New Orleans and Shreveport set out for Baton Rouge, including CHNO residents and Long's personal physician and political appointee as superintendent of Charity Hospital–Shreveport, E. L. Sanderson, MD.[9,10]

The decision was made to proceed with the available manpower because of Long's deteriorating condition. Vidrine became chief surgeon by default. Cook served as first assistant, and Lorio served as scrub technician.[6,9] Cook was Long neutral,[1,9] while Lorio was pro-Long.[2,6,9] Anesthesia was problematic. The anti-Long Henry McKowen, MD, was reached. He had made an off-hand comment a few days earlier—''If I ever give Huey an anesthetic, I will put him to sleep for good''—and agreed to participate only if Lorio would watch his every move as a witness.[6,9] Lorio agreed.[6,9] No x-rays were taken,[1] and urinary catheterization was not performed, nor was a digital rectal examination. At 11:00 pm, Long's systolic BP was 104 mmHg, and his pulse was 114 bpm.[10] Long was taken to the operating room with a weak and rapid pulse.[6]

## THE OPERATION

As author Ed Reed notes, Long's surgery was ''one of the most bizarre and unreal operating room settings that one could possibly imagine. Spectators, bodyguards, and medical professionals elbowed each other for space in the operating room.''[10] Long biographer T. Harry Williams called it ''one of the most public operations in medical history,''[11] and Cecil Lorio described it as ''a vaudeville show.''[9,10]

Although Vidrine was the surgeon of record, assisted by Cook and Lorio, Pavy reported that Cook actually did most of the surgery.[1] Many nonmedical individuals involved in the consensus decision for surgery were present in the operating room as spectators.[1,6,9,11] Some wore surgical gowns; others remained in street clothes.[9] The scene has been described as chaotic and frenzied[9] as well as strange.[6] Ether and $N_2O$ anesthesia were first administered at 10:51 pm, and antitetanus serum was given. Surgery started at 11:22 pm.[6,10] Vidrine stood on the left (traditionally the first assistant's position) and Cook on the right (traditionally the surgeon's position).[6] An upper right rectus splitting (paramedian) incision was made, incorporating the anterior bullet wound. Abdominal exploration revealed very little free intraperitoneal blood. The liver, gallbladder, and stomach were not injured. The small bowel mesentery had a silver-dollar-sized hematoma, and there was a small in-and-out colon perforation at the hepatic flexure with minimal spillage.[6-9,11]

Clarence Lorio, MD, brother of Cecil and Long's personal physician in Baton Rouge as well as a close friend, arrived after the surgery had started and offered his assistance, taking Cook's place.[1,9,10] The colon wounds were primarily sutured, and the abdomen was closed in layers. Records showed that anesthesia ended at 12:14 am and surgery at 12:25 am.[6] Pulse readings during anesthesia were recorded as between 104 bpm and 114 bpm.[6,10] After surgery

Vidrine is reported to have said, ''It was nothing. It was just a perforation of the intestines.''[10]

## POSTOPERATIVE CARE

Postoperatively, the patient did not do well. He was taken to Room 325 (or 314; reports differ), and the foot of the bed was elevated.[6,10] He may have been catheterized at this point with no hematuria detected.[10] Many people went freely in and out of his room, and most were nonmedical personnel.[6] Long's vital signs continued to deteriorate, and he never regained full consciousness.[6,9,10]

Maes and Rives arrived at approximately 1:00 am, and Rives described the situation as ''nothing short of chaotic.''[6] Stone arrived somewhat later.[6] Stone and Vidrine discussed the operation, and Vidrine stated that the right kidney was injured and bleeding.[6,10] Stone asked if Vidrine had seen the kidney, and Vidrine replied that he had only felt it.[6] Apparently an argument ensued regarding the cursory nature of the operation; Stone eventually returned to New Orleans without examining Long,[1,6,10] and he estimated Long's chances of survival at 50:50.[10]

At 2:00 am, an optimistic update on Long's condition was issued from the hospital. At 2:40 am, systolic BP was 96 mmHg and pulse was 140 bpm.[10] In a 5:15 am bulletin, Vidrine noted that ''considerable hemorrhage from the mesentery and omentum'' had been observed intraoperatively.[1,10] At 6:00 am, BP was 82/63 mmHg, and pulse was 154 bpm. A blood count indicated the presence of infection and that Long was losing blood.[10] At 6:40 am, (9 hours postinjury and 6 hours postoperative), Stone[7-9] or Rives[6] suggested urinary catheterization.[10] The catheterization detected significant hematuria.[6-10] Stone felt this confirmed the major renal injury, and he and Maes felt—and all senior physicians agreed—that Long was too unstable to withstand reoperation.[6,9] Years later, some junior physicians present that night questioned this decision given the patient's steadily declining course.[1,10] Throughout the morning, Long received intravenous (IV) injections of glucose, sucrose, and saline solutions, as well as adrenalin and morphine for pain.[10]

At 1:00 pm, Long received a second transfusion from one of his bodyguards. His BP rose from 105/78 mmHg to 115/80 mmHg, his pulse rose to 140 bpm, and his temperature increased.[10] An hour later, Long received a rectal instillation of laudanum, aspirin, brandy, and saline. Vital signs were recorded as a pulse of 148 bpm, less labored respirations, less cyanosis, and temperature of 103°F 4/5 axillary. The patient was noted as being quieter.[6,10] However, his BP fell to nearly undetectable levels several times and was recorded in the early afternoon as 92/82 mmHg, at which time Long's pulse was 170 bpm. Nevertheless, reports about his condition were optimistic.[10] At 3:00 pm, an oxygen tent was started, and Long received more adrenalin. At 6:30 pm, BP was 92/65 mmHg and pulse rate was 160-170 bpm.[10] At 7:00 pm, his condition was reported as declining.[9,10] E. L. Sanderson, who had arrived from Shreveport, noted that Long's condition was ''extremely critical'' and not responding to treatment.[9]

At 8:15 pm, Long's pulse was thready, and he received a third transfusion from CHNO resident Willard Ellender, MD, brother of Long crony and Speaker of the Louisiana House of Representatives Allen J. Ellender, (D-Houma).[9,10] Long's pulse initially slowed and then climbed from 91 bpm to 118 bpm.[9] His vital signs were recorded as BP of 114/84 mmHg and a pulse rate of 170 bpm. He was still febrile.[10] At 8:30 pm, Vidrine stated that Long was ''holding his own,'' but by 10:30 pm there was ''little hope.''[9] Long's pulse rate continued to be monitored. At 11:30 pm, he was partly conscious and not expected to survive the night. An IV of glucose in normal saline was started.[9] At midnight, he received a fourth transfusion; a fifth was unsuccessfully attempted 2 hours later. Shortly after midnight, Long became delirious and restless, with shallow respirations; the oxygen tent was removed. Vital signs were BP 100/79 mmHg, pulse 170 bpm, and temperature of 104°F 4/5 axillary.[10]

At 1:00 am, Long's BP was 92/64 mmHg.[10] The attendance of Jorda Kahle, MD, chief of urology at the LSU School of Medicine in New Orleans, had been requested after the suspicion of a renal injury had heightened, and at 1:30 am Kahle retrieved gross blood from the right perirenal area via direct aspiration.[6,9,10] He felt this indicated massive retroperitoneal hemorrhage.[6-9] At 2:00 am ephedrine was obtained at an outside pharmacy,[10] indicating the dire circumstances and the need for hemodynamic support. By 3:00 am, Long's family had been summoned.[9] The patient was described as ''practically morbid with marked bronchorrhea.''[7,8] His IV was stopped. Respiratory dysfunction progressed, and his respirations became increasingly labored. Long died at approximately 4:10 am on Tuesday, September 10, 1935, just over 30 hours and 30 minutes postinjury. Although preparations had been made for an autopsy, it was not performed per Mrs. Long's wishes.[10]

## AFTERMATH

The multiple attempts to clarify the situation have been hampered because no autopsy was performed. Medical records are missing or unavailable, and eyewitnesses and direct participants were unwilling to speak. The stories that were recorded were often inconsistent.

Although Rives described the scene as ''nothing short of chaotic,''[6,10] chaos is inherent in medical emergencies involving prominent political figures. A well-known example is the trauma care that President John F. Kennedy received in 1963 at Parkland Hospital in Dallas. Those physicians were some of the best trauma surgeons available. The difference is chaos with a purpose as opposed to chaos without direction: The medical care President Ronald Reagan received in 1981 after his assassination attempt is an example of chaos with a purpose, well described in Wilber's excellent book *Rawhide Down*.[12]

Nevertheless, in Long's case, no x-rays were taken preoperatively,[1] and the patient did not undergo urinary catheterization until the postoperative period.[10] Presumably Long died as a result of ongoing retroperitoneal hemorrhage from a renal injury not diagnosed preoperatively and not addressed intraoperatively.

Edgar Hull, MD, another of the CHNO residents brought in to provide postoperative care for Long, maintained until his death in 1984 that Kahle aspirated no blood from the perirenal area, that the conduct of the operation was without fault, and that Long died from peritonitis.[1,10] Although many have dismissed Hull's theory of peritonitis, fecal spillage was documented, and abdominal irrigation was not reported as having been carried out. Furthermore, in this preantibiotic era, many individuals were present in the operating room in violation of standard aseptic procedure.[13] Interestingly Hull and alleged shooter Carl Weiss were medical school classmates, roommates, and friends.[1]

Long had often achieved his goals through intimidation and alienation. He has been described as dictator, demagogue, fascist, socialist, and power addict. Long had particularly alienated the medical community in Louisiana, especially in New Orleans.[1,10] As a result, it appears that many of the medical consultants that night were passive, indecisive, and noncommittal and did not want to be involved. They were more than willing to let Vidrine take all of the responsibility. Vidrine seemed to realize the situation he was in and likely would have welcomed the emotional, clinical, and technical support of a strong and experienced surgeon. When that help did not materialize, Vidrine found himself essentially alone and isolated in a sea of chaos. No one else was willing to take the lead.[1]

Questions about the operation persisted. Many of the onlookers in the operating room asked if a bullet was found. At one point, a small dark object was retrieved; it was determined to be fecal material.[10] The official investigation concluded that the injury was a ''through and through'' gunshot wound. A nurse on the case did not recall a bullet being found.[1,10] However, Cook was said to have reported that a bullet was removed from the body the following day, and Clarence Lorio reportedly stated that a small caliber bullet had been removed during surgery.[1,10] Clarence Lorio is also said to have removed a bullet from Long's abdomen at the funeral parlor the next day, while Reed wrote that Vidrine reportedly removed a flattened lead slug from the right adrenal gland.[1,10] Vidrine later stated that Long had two bullets in him, one of which was a .38. Vidrine is supposed to have kept that bullet, passing it on to relatives for safekeeping.[1,10] Whether or not a bullet was found and recovered remains unanswered.[10] By today's standards of care, bullet retrieval is more of a forensic issue than a clinical one. In this case, the forensic value would be monumental.

Why didn't the surgical team explore the retroperitoneum? Even if Vidrine was inexperienced in this scenario, Cook was not. Cook's apparent lack of surgical leadership at the operating table is strange. Were the others intimidated by Vidrine's leadership? Was Vidrine intimidated by the politicians and Long allies and cronies who were present? Perhaps the surgeons felt the retroperitoneal hematoma was stable, nonexpanding, and having a tamponade effect. Additionally, it has been postulated that Long's transient hemodynamic improvement in the early postoperative period caused further bleeding and ongoing hemorrhage,[10] analogous to an awake hypotensive patient with a contained ruptured abdominal aortic aneurysm who quickly exsanguinates once BP increases to a normotensive state.

In 1935, abdominal gunshot wounds were considered very serious, if not fatal, injuries. Surgical intervention was used, sometimes successfully. Hematuria as a sign of genitourinary injury was also known. The contribution of x-ray information in aiding the surgeon had been described. The relationship of shock and hemorrhage had been demonstrated and described by Blalock in 1927.[14] Thus, it is reasonable to assume that the knowledge and technology to successfully treat Long's injury were available.

Nevertheless, it has been said that Vidrine ''botched the operation.''[2] Surgical lore relates how a senior surgeon obtains excellent results from good clinical judgment gained from experience obtained from bad clinical judgment. Vidrine lacked appropriate training in gunshot wounds to the abdomen and likely had never had the bad clinical judgment that begets experience leading to good clinical judgment. Yet others present did posses this skill set. A perfect storm of circumstances involving a particular patient, politics, and strong emotions led to a constellation of events in which medical care was impacted, ultimately influencing the patient's outcome.

**Figure 1. Alton Ochsner, circa 1935.** (Image reproduced with permission from the Rudolph Matas Library of the Health Sciences, Tulane University.)

## THE CONNECTIONS

**Alton Ochsner, MD (1896-1981)** (Figure 1). In 1935 Alton Ochsner was a leading academician in surgery and chairman of surgery at Tulane.[15] He had experience in and published about abdominal surgery and caring for surgical patients.[16] He also had a history of conflict with Long and Vidrine.[1,11,13,15]

As noted, Vidrine played a key role in the effort to save Long's life in that he was the physician in charge. His background[6,9,10] is important to an understanding of the events during those days. He graduated from Tulane University School of Medicine in 1921 and had been a Rhodes scholar.[10,15] Following an internship at CHNO,[10] Vidrine worked as a general practitioner in the small south Louisiana town of Ville Platte, where he championed the Long cause.[6,13,15] He held the position of chief surgeon and administrator at the Eunice Sanitarium until 1926. Long appointed him superintendent of CHNO in 1929. Vidrine was largely considered a political physician and Long political ally.[10]

When the chair of Tulane University's Department of Otolaryngology became vacant, Vidrine asked the dean of the Tulane Medical School, C. C. Bass, for the position. Bass pointed out that Vidrine had not specialized in otolaryngology, and Vidrine replied that he could ''read up on it.''[13,15] He was denied the position. Vidrine also requested an appointment as professor of surgery from Tulane Chairman of Surgery Alton Ochsner. Ochsner felt the appointment would be inappropriate because as superintendent of CHNO, Vidrine was a political appointee. Ochsner denied Vidrine's request with a suggestion that Vidrine revisit the issue once his tenure as superintendent was completed. Just as Vidrine was not qualified for the otolaryngology position, he was also not qualified for a professorship of surgery because he had little training in surgery.[13,15]

Another episode is important in considering the events of September 8-10, 1935. In spring 1930, Alton Ochsner seriously considered moving from New Orleans and Tulane. In a letter to colleague Allen Whipple, MD, at Columbia University, Ochsner expressed his frustration at being unable to train surgeons and build the Department of Surgery at Tulane because of the university's dependence on CHNO, which was politically controlled and uncooperative with the medical school.[11,15] A copy of the letter was taken from his coat pocket, and in September 1930, it surfaced at the Roosevelt Hotel in New Orleans, where the CHNO Board was meeting.[1,15] Long used the letter to show Ochsner's lack of ''absolute loyalty.''[11,13,15,17] Long canceled Ochsner's position as chief visiting surgeon and barred him from CHNO. The letter was either given to Long by Vidrine, or Vidrine facilitated its receipt by Long.[10,15]

Long then announced a new medical school, LSU, and named Vidrine as dean when it opened in fall 1931. Vidrine recruited Urban Maes, MD, noted surgeon on the Tulane faculty, as chairman of the Department of Surgery at the new medical school.[13] One of the conditions of Maes's acceptance of the position was to rectify the situation with Ochsner (who was reinstated in September 1932).[1,11,15,17]

Ochsner stated ''it was a fortuitous thing, although it seemed a horrible blow at the time.''[15] These events have been nicely summarized by Frank A. Riddick, MD, who describes how these activities may well have ultimately led to the formation of the Ochsner Clinic.[18]

Ochsner maintained that Long's fatal injury was from his bodyguards.[6] Years later Long's son, US Senator Russell B. Long, told him, ''You know, if my father had had you to take care of him, he would be alive today.'' Ochsner's thought was ''I didn't know Russell realized this.''[15] Given the character of Ochsner and the humanism and empathy for patients he demonstrated,[15,16] it is hard to even consider that he would have denied his expertise despite his differences with Long and his politics.

**Thomas Edward Weiss, MD (1916-2004)** (Figure 2). Tom Ed Weiss had a long and distinguished career in internal medicine and rheumatology at Ochsner from 1947 until his retirement in 1984. He served as head of the Section of Rheumatology until 1977. He published nearly 60 articles and exhibits between 1941 and 1981. In 1974, he served on the Executive Committee of the Ochsner Board of Trustees along with physicians William Arrowsmith, Paul T. DeCamp, Merrill O. Hines, John C. Weed, C. Thorpe Ray, and William D. Davis, Jr.[4] Following his retirement, Weiss was instrumental in the organization and development of the Fellows Alumni Association (now the Ochsner Alumni Association). I knew him in this capacity during my tenure as president of the Ochsner Alumni Board, 1999-2002. We developed the annual Outstanding Alumnus Award, he was the first recipient, and the award was named in his honor. He treated generations of New Orleanians and was held in the highest esteem by his patients (Charles J. LeDoux, MD, personal communication, August 29, 2010). He was kind, compassionate, and a true gentleman.

The Weiss family has a long history in the medical profession. Tom Ed was the brother of Carl A. Weiss, MD, the individual accused of shooting Long, who was immediately gunned down by Long's bodyguards. Their father was a noted Baton Rouge physician. Tom Ed, an LSU college student at the time of Long's fatal injury, was at the scene minutes after the shooting and developed his version of the events over the years while burdened by history and the task of building a medical career for himself. He maintained his brother's innocence and spoke openly about it (Ranel Spence, MD, personal communication, June 27, 2010).[1,7,9] His beliefs were given voice in 1963, 1986, and 1999 in books by Zinman, Reed, and Pavy, respectively.[1,9,10] The family has continued this effort.[19]

**Rudolph Matas, MD (1860-1957)** (Figure 3). Rudolph Matas, renowned and revered New Orleans surgeon, was succeeded by Alton Ochsner as chairman of surgery at Tulane in 1927.[15,17] Subsequently, the two men had a close relationship for 30 years until Matas's death.[20]

After his retirement from Tulane, Matas maintained a vibrant and undiminished private practice. In 1935, he was an active 75 and had developed a ''consuming hatred'' for Long; his feelings were not subtle.[17] Matas detested political interference in medical matters, such as Long's establishment of the new LSU School of Medicine that many considered to be done out of spite toward Tulane.[17] Alton Ochsner's ban from CHNO further cemented Matas's distaste for Long. Nevertheless, as with Ochsner, Matas's humanism and empathy almost certainly would not have denied Long the medical expertise Matas would have provided if asked.[20,21]

Matas was also connected with other individuals involved in the saga. Urban Maes was a Matas ''favorite disciple'' and maintained a close relationship with his mentor, as did many of Matas's other trainees.[4] When Maes accepted the position as chief of surgery at LSU, his relationship with Matas was permanently damaged because of the school's connection to Long even though one of the conditions of Maes' acceptance was that Ochsner be reinstated.[17]

Carl Weiss was a protégé of Matas from 1926-1928 when he was in postgraduate training at Touro Infirmary in New Orleans. Matas supported Weiss's effort to obtain further postgraduate training at American Hospital in Paris from 1929-1930.[1,9,10,17] Matas was also a member of the committee that selected Louisiana winners of French government scholarships to study in Paris. In this capacity, he voted to select Yvonne Pavy of Opelousas in 1931. In Paris she and Carl met, fell in love, and later married.[17]

Frank L. Loria, MD, was another Matas-trained New Orleans surgeon. Loria, perhaps more than anyone else, examined the medical aspects of the case and published them for the medical literature.[6-9] He was a well-known and experienced surgeon who was educated in penetrating injuries of the abdomen. He had published several times on the subject prior to 1935.[22-24] He did significant research on the Long case and personally interviewed the 3 physicians (Vidrine, Cook, and Cecil Lorio) who performed Long's final surgery. Loria maintained that Long's operation was improperly performed and that his death was the result of ongoing retroperitoneal hemorrhage from a missed renal injury.[1,10]

## CONCLUSION

Although the death of Huey P. Long will continue to be the subject of research, debate, speculation, and controversy, Long was clearly a victim of timid medical care when he needed aggressive and purposeful treatment. Alternate history is interesting to contemplate in this case. The most obvious speculation is what would have happened if Maes and Rives had arrived in time to operate? What if Rudolph Matas had been called for advice? What if Alton Ochsner had been called and successfully operated and took charge of Long's care? Was Ochsner not considered for consultation because of politics, or was it just an oversight because of the chaos of the situation? Clearly Long would have benefitted from the talents of a surgeon such as

**Figure 2. Thomas Edward Weiss, circa 1950s [L] and 1990s [R].** (Photos courtesy of the Ochsner Medical Library and Archives.)

Ochsner. The attributes of a great surgeon—maturity of judgment, dexterity of hand, and serenity in crisis[25]—appear to have been absent that night. What if Tom Ed Weiss's assertions that Carl Weiss was not the assailant and that the fatal gunshot was from someone other than his brother are correct? What if the official findings confirmed this assertion in the 1930s? Politics in Louisiana may well have undergone permanent changes, and the impact may have had national ramifications.

**Figure 3. Rudolph Matas, circa 1932.** (Image reproduced with permission from the Rudolph Matas Library of the Health Sciences, Tulane University.)

Interestingly, these questions may never be definitively answered. However, this consideration of alternate history raises the question of whether the care Long received may have led to his demise. It is reasonable to conclude that Long likely died from hypovolemic and/or septic shock due to penetrating abdominal trauma resulting in renal injury superimposed with peritonitis secondary to bowel perforation and aseptic surgical conditions. Expert surgical care unhindered by political constraints may have provided the best opportunity for a successful outcome. Although medical standards of care were evolving in 1935, sufficient existing expertise appears to have been reasonably available. However, this expertise was not available to Huey Long on that fateful night.

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