

John M. Templeton, Jr., M.D.

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EHRHART: Today is August 25, 2006. My name is Mindy Ehrhart, E-H-R-H-A-R-T. Today I'm meeting with Dr. John M. Templeton, Jr. regarding the Louise Schnauffer Oral History Project conducted for the College of Physicians of Philadelphia and funded by the Foundation for the History of Women in Medicine. The first question is, I would just like you to please state your name and your current position as well as your previous positions.

JOHN M. TEMPLETON, JR.: My name is John M. Templeton, Jr., I am now the president of the John Templeton Foundation. I spent most of my career as a pediatric surgeon at Children's Hospital of Philadelphia both in regard to my training as well as my clinical practice from the years of 1977 until 1995.

EHRHART: How and when were you associated with Dr. Schnauffer?

JOHN M. TEMPLETON, JR.: I first got to know Louise when I started my first day of training on July 1, 1973, at the old Children's Hospital on Bainbridge Street. Louise was a full-time staffperson. The staff at that time consisted of only three persons -- Dr. Koop, Dr. Bishop, and Dr. Schnauffer -- and that's when I first met her.

EHRHART: Had you heard anything about Dr. Schnauffer before you had met her?

JOHN M. TEMPLETON, JR.: No, I had not known about her.

EHRHART: Ok, so that was the first time you had met her. Can you describe what your impressions were when you did meet her and as you began to work with her?

JOHN M. TEMPLETON, JR.: Well, she wasn't one to put herself forward such as in meetings and the context of rounds and meetings, conferences. So I just recognized that she was somebody whose opinion everybody valued. She made me, as well as everyone else, feel very welcome.

EHRHART: How did she do that?

JOHN M. TEMPLETON, JR.: Just starting with her smile, her friendliness, just the simple words of welcome that she shared.

EHRHART: So did you take formal classroom study with her, or was it more under the auspices of conferences or meetings before and after...

JOHN M. TEMPLETON, JR.: In surgery, the crux of training is hands-on experience with managing patients, whether you see them in the clinic, whether you see them in the emergency department, whether you see them at the time of admission to the hospital. It also involves if you're taking care of a private attending's patient, such as Louise's private patients, knowing

from the private attending any unusual problems that we needed to know about and then being responsible for the entire care of the child as controlled by the attending, or Louise, and including for Louise's cases scrubbing with her and participating in surgery and being taught how to do surgical procedures and then keeping her completely informed as the child recovered, and helping to make plans for the child's discharge. That was the bulk of the time of activities for surgical training.

JOHN M. TEMPLTON, JR.: But we did have regular conferences where we would evaluate deaths and complications. Those were organized, regular meetings to look through every one of the deaths or complications. Also regular meetings to talk about unusual cases or to talk about diseases that perhaps there was new research on about how to improve care.

EHRHART: You had mentioned the word "scrubbing" before. Can you explain the significance of that – you said "scrubbing" with her. What exactly do you mean by that, and how was that significant in your relationship working with her?

JOHN M. TEMPLETON, JR.: In the whole history of surgery, scrubbing is a relatively new concept, coming from perhaps the mid- to latter part of the 1800s, when people began to understand that there were germs, which we largely know as bacteria, and that if you could cleanse your hands as much as possible, including using soap and a brush for scrubbing, you can reduce the bacterial count. In prior times, people still didn't wear gloves, it's just their hands were cleaner. Now we maintain the tradition of scrubbing in case there's some violation or tear in the glove, but our primary protection is wearing usually latex gloves over our hands to also reduce bacterial contamination.

EHRHART: And you would scrub with several people at the same time? Was that like a social opportunity, or was it to prepare? How would you describe it fitting into the larger spectrum?

JOHN M. TEMPLETON, JR.: As the anesthesiologist brought the patient into the room and then began an intravenous infusion, and was starting to put the child to sleep, the surgeons would be out at a sink, where you could, using your leg, start or stop the water, you could pick up the soap, you can scrub with brushes and sometimes during that period we would discuss the case. Sometimes if it was very a routine case and there wasn't much to discuss so we'd talk about other patients or other things. Or if you were the only surgeon, you might be all by yourself scrubbing and preparing for surgery.

EHRHART: My next question is: In all of those different interactions you had with Dr. Schnauffer, how would you describe her teaching style?

JOHN M. TEMPLETON, JR.: Her teaching style was to assume, first of all, that you had shown the initiative to know about the child's problem difficulty; secondly, to know about the disease through reading, to know something about the nature of the surgery that was needed. But she was so open and very low-key in terms of being judgmental that you always felt safe and open to say "I don't know this," or "I don't understand this." If it was matter of knowledge, she would be helpful to participate right away. If it was a matter of not knowing the precise technique for some maneuver that you were going to do, she would show you how to do it, and then watch you

do it in turn until she felt that you were doing it right. So she was a gentle mentor, but always very attentive, of course, in order to make sure that nothing would ever be harmful to the patient.

EHRHART: Can you describe some of the procedures that you assisted her in performing in the operating room?

JOHN M. TEMPLETON, JR.: Over many years they would include the more common procedures, which were childhood hernias, operations for a male child for a testicle that was undescended, where there might be relatively simple obstructions to the intestinal tract, something called pyloric stenosis. But then the nature of the operations would go up substantially in terms of newborn blockages to the intestinal tract. Whether that was blockage of the esophagus, which often meant that there were connections to the trachea, which meant the child would have contamination of the lungs if you couldn't correct it; blockages or abnormalities all the way through the intestinal tract; and then also the biliary tract, where there might not be adequate size bile ducts; and then other organs were things that we dealt with also. Primarily the total capacity of abdominal surgery would be part of what we did in pediatric surgery, but would also include some procedures in the head and neck area for some tumors, for thyroid surgery, for operations on the legs for certain types or problems such as vascular problems. So it was quite a gamut of surgical procedures.

EHRHART: Within the operating room, can you please describe any particular situations or procedures that is vivid in your memory? What was it, what happened, and why do you think it's stuck with you?

JOHN M. TEMPLETON, JR.: The situations that would happen the most were those where the uncertainty of whether you would be successful was great, whether it was an emergency condition or because of the severity of the condition. One of the more frequent newborn surgery-type problems was esophageal atresia. Usually the child was stable, so it wouldn't be considered a true emergency operation. But on the other hand, a person like Louise would make sure that the tissues were handled with utmost delicacy so that you wouldn't have any problems with breakdowns with the repairs that you'd make, or later scarring. So being a master technician, and somebody who was a great mentor about how to handle tissues with gentleness, she was a good model for how to be a good surgeon of children.

EHRHART: Any others that you'd like to add? We can always hop back, too, if something comes up.

JOHN M. TEMPLETON, JR.: Yes, well, there were certain surgical conditions like Hirschsprung's disease, like biliary atresia, where she became one of the leading experts at the hospital. These were not always that common of a case, so she would do a combination of showing, doing herself, and then having you do yourself, so that you would be able to not only see what was the problem and how to correct it, and the technique for correcting it. Sometimes if something was so unusual she might have to put in a few sutures, but once you got the knack of it then you would go ahead and finish the job.

EHRHART: Is that how she approached a lot of in-the-operating room teaching?

JOHN M. TEMPLETON, JR.: Yes. There are older and still persisting models in different parts of the world where you're considered privileged just to see the great master operate. Yet that master would never condone to letting you do part of the procedure or taking the extra time to teach you some technique. Somehow by osmosis, and just observation you were supposed to learn how to do something. The kind of tradition Louise came from, as well as Dr. Koop and others, was that the best learning came from hands-on, shared care, both medically and surgically, of the child.

EHRHART: That gets to my next question, or in part, at least, answers the question, which was: How would you describe her teaching technique in the operating room? How did she utilize the fellows in the operating room? I believe you've answered that, if you'd like to add anything.

JOHN M. TEMPLETON, JR.: The fellows were in a very privileged position, which is that we were still in training, but we had all finished five or more years of general surgery. So by the law, you could have gone to any state and if some hospital had given you privileges, you could have been doing any one of those surgical procedures, even if you'd never even seen one, you could do it. That meant that as a fellow, we had a legal status as a private attending. If we were then left for some reason, either to do the whole case, or after half of the case was done and Louise had to leave, we were left to finish the case. The patient was left in the hands of somebody who was a fully trained surgeon, not a fully trained pediatric surgeon, but a fully trained surgeon. There were a number of situations where, after the most demanding or risky part of the surgery was completed, then Louise and other attendings would leave the room and let you finish the case.

EHRHART: So she put a lot of trust into...

JOHN M. TEMPLETON, JR.: Yes.

EHRHART: But rightfully so, like you said, because training as a surgeon had already been complete, it was now the specialization of pediatric surgery that you were undertaking at the time.

JOHN M. TEMPLETON, JR.: Right.

EHRHART: I had reviewed these questions with Dr. Peitzman, who's working with me to develop the questions, particularly the medical background because I do not come from a medical background. He noted that he was very interested that I ask about the atmosphere in the operating room, and the interaction among the surgeons with the nurses, as well as the anesthesiologists and so forth. Do you have any comments about that?

JOHN M. TEMPLETON, JR.: Do you mean generally, or in regard to Louise?

EHRHART: In regard to Louise and your work with her.

JOHN M. TEMPLETON, JR.: In regard to Louise it wouldn't just be my work with her, but everybody would, I think, verify what I will say, which is that she always thought of other people, she was not about ego. She was not about making herself seem to be the most important person even if she was actually the expert on the disease problem. She knew that other parts of a child's care, including good anesthetic preparation, was important. She knew that the nurses' role in providing the instruments and circulating to provide all the things to support the operation. She knew and respected every single person's role, and that included medical students. She was often very generous and inclusive when medical students would come, I think in part because she hoped that a light of enthusiasm might be kindled in some of them and they might then consider being surgeons or even pediatric surgeons as well. So she was, short-term, day-to-day, a very considerate person, but also a long-term thinker in terms of building the field of surgery. I never remember her being angry in the operating room. There are famous cases of some surgeons who throw instruments and use foul language and abuse other people, whether it's a nurse, or even a colleague like an anesthesiologist. That would have just been inconceivable in Louise's case. I think she maintained authority because one, people knew and respected her competence, and secondly because they knew that she respected their role and that then generated a kind of mutual sense of regard and mutual support.

EHRHART: Now my next question has to do with performing surgeries itself. An important aspect of performing surgeries is the ability to make appropriate decisions at crucial moments. Can you reflect on her decision-making ability and her procedure, how she would come about making a decision while doing the procedure?

JOHN M. TEMPLETON, JR.: One advantage I, and most of the people she trained with had, was that she'd already had I think six or eight years of practicing pediatric surgery. She was one of the first women, or maybe the second woman that Dr. Koop ever trained in pediatric surgery, and he greatly admired her. But a job opportunity came up for her at Johns Hopkins, so I think her first practicing job in pediatric surgery was in Johns Hopkins. Every day, every year, when you're involved 80 hours a week, as surgeons often tend to be, you begin to pick up a wealth of practical experience, unusual situations that you might have faced before or that are similar so you can apply it to a current dilemma that you're facing. Nevertheless, one of the great things about a field like surgery is that you can never reach perfection, you can never be as totally good as you would like to be because you're always faced with unexpected challenges.

JOHN M. TEMPLETON, JR.: A typical type of surgery that presents challenges would be tumor surgery, so that if you are operating with what the preoperative diagnostic technology told you was a kidney tumor, it seemed to be quite large, but it didn't seem to be beyond the kidney. Especially in earlier years of surgery as you were carefully dissecting the tissue you might find that a portion of the tumor was exiting the vein for the kidney and going up into the inferior vena cava, so you would have to then improvise on how to open one of the most risky parts of the body in abdominal surgery, which is the inferior vena cava, and get the tumor out without losing some of the tumor in the body and without causing fatal or catastrophic hemorrhage. Louise always maintained an aura of calmness. If something was bleeding profusely you could put pressure on it and stop it from bleeding, and then have the composure to be able to discuss "What are our options here?" and then come up with the solution that seemed best. Basically,

with her already considerable experience when she joined the faculty at Children's Hospital, almost everything she did worked out well.

EHRHART: What did you learn from her about her bedside manner, or how did she relate to her patients and their families outside of the operating room?

JOHN M. TEMPLETON, JR.: There were two contexts. One is especially in the times that I practiced at Children's Hospital, including in training. Each surgeon had their own private office hours; you would not necessary have somebody in training be with Louise when she was seeing her own patients, but if she knew that there was something unusual to see, or something to discuss and learn from, she might call you in. She did it in the way in which there was implied or actual consent from the parent that this was fine and that this was going to benefit the child, not detract from the child, and then use it with full consideration to the parent, to the child, and to the person that she was trying to teach. All the attendings provided coverage when we had so-called "fellows" or "residents" clinics where we would be seeing our own patients. But often being inexperienced, we saw things that brought up questions we couldn't answer. So she was a very ready source of wise and long experience to help us to understand the situation and to make recommendations about how to take care of it.

EHRHART: The next question is: As Dr. Schnauffer was seeing, treating, or dealing with her patients and their families outside of the operating room, is there a particular situation that is vivid in your memory?

JOHN M. TEMPLETON, JR.: I can't remember a specific one, but more of a composite in which, either in a tumor case or in a trauma case, in which in spite of our best efforts the surgery was not going to be either completely successful, resulting in a cure, or some complication had happened. She was always very forthright, direct, not defensive, but able to convey to the parents not only the information she thought they needed to know, but also that the child was still getting 100 percent total care and support. For example, in a tumor case sometimes you didn't know whether you could get all the cancer out. She might then have to go to the parents and say, "The tumor was so extensive and invaded so many other critical structures that we might have jeopardized your child's life to try and get every last bit of the cancer out, and we felt that it was in the best interest of the child to settle with getting 95 percent of the tumor out and then work with other techniques such as radiation therapy to see if we can get a cure or control."

EHRHART: Can you describe how many women you believe were in pediatric surgery at the time you worked with Dr. Schnauffer, and in addition to that, how do you feel she made a name for herself in a male-dominated field?

JOHN M. TEMPLETON, JR.: As I said, she was one of the first or second women that Dr. Koop ever trained in his career as surgeon-in-chief at Children's Hospital, which began somewhere around 1950 or 1948. Most of the people he trained were young men, but I think he was one of the first training chiefs who accepted women into pediatric surgery. Secondly, by the time I was in training, it was still very rare for women to even apply for the position of pediatric surgery. So that's something about the question of whether women wanted to first go through the rigors of five or six or seven years of general surgery, and then go on two more years in

pediatric surgery. I would say by the time that I finished my practice, which included practicing surgery as a fellow private attending with Louise in 1995, probably 25 percent of the applicants and the trainees were women, and I think the figure now is probably closer to one-third.

EHRHART: Would you attribute, by any chance, the lower numbers of women pediatric surgeons as Dr. Schnauffer was beginning of her career due to the newness of the specialty, or...

JOHN M. TEMPLETON, JR.: The specialty goes back at least into the early 1930s, where some leaders in surgery decided that although they were trained in adult surgery or surgery in general that children presented such unique and difficult challenges that they should spend their entire time with children. Now that happened in a few rare hospitals like Boston Children's Hospital and then eventually Philadelphia Children's Hospital. So the vast majority of pediatric surgery around the country was still done by general adult-oriented surgeons. But...now I've lost my train, what was the other part of your question?

EHRHART: The one I just had asked, about the newness of the specialization?

JOHN M. TEMPLETON, JR.: Yes, so it was not all that new. I think you have to see the context of women coming into a field like surgery, which is fairly similar to most of the branches of surgery. By 1980, women were still maybe, depending upon the nature of the surgery, at most maybe only 10 or 15 percent of surgeons in different surgical fields. Again I think the demands, especially if a woman was married and wants to have a family, that sort of thing, an 80-hour-a-week job is hard to integrate with plans to also be raising a family. So I think women surgeons had to make decisions about going into surgery that many males did not have to make.

EHRHART: Another part of that question is whether or not you ever observed any kind of gender issues arise in or out of the operating room. Was there a particular instance where that the fact that Dr. Schnauffer was a woman practicing pediatric surgery that it seemed to affect the situation?

JOHN M. TEMPLETON, JR.: No, I think Louise's integrity, the quality of her skill, her judgment-making, her technical abilities and so on made her somebody that, whether they were nurses, or anesthesiologists, or other surgeons and so on, she was imminently respected.

EHRHART: The next question is about hospitals and the competitiveness. And you did mention earlier that Dr. Schnauffer didn't, during her years of practice, didn't have an ego, so to speak.

JOHN M. TEMPLETON, JR.: She had a healthy ego.

EHRHART: A healthy ego, excellent, okay. But hospitals can be competitive and stressful places. How do you feel that Dr. Schnauffer dealt with the stress and conflicts that arose either in and out of the operating room, among colleagues, and/or among fellows?

JOHN M. TEMPLETON, JR.: I think a question like that suggests somebody's been watching too much television, or, an alternative perspective is that Children's Hospital really was a remarkable oasis of compatibility and cooperation. There was very little of what I would

consider competitiveness. Now there are certain diseases, like thyroid disease, for example, that general surgeons are fully trained to take care of, and so-called head and neck surgeons, or ear, nose and throat surgeons, are trained to take care of, and plastic surgeons are trained to take care of, so they would be the potential for competitiveness. But generally that didn't exist, because if the patient was referred for whatever reason to your office and you felt capable of handling it, none of the other specialists would object so long as they knew that you were competent. The only question they would have brought up is if they thought that this was out of your range of competence. And so I think the overwhelming atmosphere at Children's Hospital again that might occur between a bigger gap between the surgical fields and the medical fields was still one that the child was the focus of why we're here. We may have good faith disagreements, but the final decisions should really be based on as much quality science and as much objectivity on the decision of how to care for the child. It made almost everything to do with working at Children's Hospital, as hard as it was -- by hard that means particularly hard work, long hours - a joy, because it was a sense of people working together.

EHRHART: Can you describe the type of personal relationship you developed with Dr. Schnauffer?

JOHN M. TEMPLETON, JR.: Yes, I've made some notes which I'll leave with you if that's useful.

EHRHART: Thank you, yes.

JOHN M. TEMPLETON, JR.: Louise was famous for her openness to us, either as fellows or trainees. That could include junior residents, medical students, and so on, and nurses. Nurses often came to her as a female figure reflecting experience and wisdom, even for not just medically related issues, but often personal issues. She was somebody that many people at various levels sought out because they felt that she would keep in confidence what was said, and often had some very reasoned and thoughtful ideas that could be shared. A symbolic component that my wife reminded me of was what I call the "advice, counsel, encouragement, and spiritual sustenance" meetings in her office, which usually occurred between 5 and 6 in the afternoon, which were always accompanied by peanut butter and crackers. She had a drawer full of peanut butter and crackers, and not just because after a long day in the operating room we were kind of hungry, but it was a way of sitting down and relaxing and unwinding -- talking about how the day went, talking about what other issues have to be addressed. So that would be if it was dealing with medical issues, but if you came to her on some personal matter, and quite seriously if you came to her on a spiritual matter, she might also say, "Well, would you like some peanut butter and crackers?" That seemed to be kind of a nutritional gap to sort of set the tone that this was something we were sharing as equals. So that was the kind of framework in which she related to people.

EHRHART: Would you mind identifying your wife and how she was also affiliated with Dr. Schnauffer, since you mentioned her previously?

JOHN M. TEMPLETON, JR.: Yes. My wife and I had what I think is one of the rare privileges in life, which is to have such integrated and compatible fields, her field being pediatric

anesthesia, mine being pediatric surgery, that in effect we worked as colleagues, one on one side of the screen and one on the other side, but very much cooperating all the time in regard to the child's needs, especially during the surgery itself, or in preparing the child for surgery. My wife's training just fortunately tracked my own training in that by the time I finished training in pediatric surgery, she finished training in pediatric anesthesia. She then went into a year or so of private practice anesthesia, we had our first child, and then by the time the two-year experience when I was a surgeon in the Navy was over, we were both offered attending positions in the private practice group, me for Dr. Koop's surgical team, and her for the anesthesia-in-chief team. So we both came on to the staff at Children's Hospital at the same time. Although it was demanding, particularly in terms of the hours that we spent, we each could instinctively understand the problems or stresses or concerns that the other had. This is really a history about Louise, but part of that meant that Pina, my wife, worked very closely with Dr. Schnauffer because she probably gave as many anesthetics for Dr. Schnauffer as she did for me.

JOHN M. TEMPLETON, JR.: One of the things that my wife, as we've talked about this interview, pointed out, that after the end of his career as surgeon-in-chief, Dr. Koop was nominated by President Ronald Reagan to be Surgeon General. It was striking how uniform the media was in what I would call a media "feeding frenzy" in fabricating allegations against Dr. Koop. One of those allegations was that he was anti-woman. So both Louise and my wife, Pina, wrote separate letters to the committee in Congress, giving many specific examples of how much Dr. Koop had worked hard to advance their careers and also to empower their status at the hospital. But really the questions that were addressed about the status of women at the hospital probably was a reflection of the top leadership like Dr. Koop and the standards he set for objective qualifications.

EHRHART: And just so I have it on record, your wife's name is spelled P-I?

JOHN M. TEMPLETON, JR.: P-I-N-A.

EHRHART: N-A.

JOHN M. TEMPLETON, JR.: Her formal name is Josephine.

EHRHART: Josephine.

JOHN M. TEMPLETON, JR.: She's Italian. Josephine in Italian is Josepina, so "Pina" is a nickname for Josephine.

EHRHART: Is her last name also Templeton?

JOHN M. TEMPLETON, JR.: Yes.

EHRHART: Okay, thank you. I just wanted to make sure that was on record.

JOHN M. TEMPLETON, JR.: Okay.

EHRHART: Were there other reflections of your personal relationship with Dr. Schnauffer that you'd like to include right now?

JOHN M. TEMPLETON, JR.: Well, I could read them or I could just hand them to you, what would you like?

EHRHART: Well, why don't you read them?

JOHN M. TEMPLETON, JR.: Okay, all right.

EHRHART: Even as you read them maybe you want to elaborate on a few. About 10 more minutes and then I'll flip the tape.

JOHN M. TEMPLETON, JR.: I'll just go through some of the ones I haven't covered so far. I think Louise had a genius for nurturing anything that is growing, and that certainly included tiny premature babies as well as kids later in life, but also struggling plants. When Pina and I went on a vacation during my surgical fellowship, Louise agreed to care for our plants, which we brought in to her from our home. She thought that our plants were badly handled. She first identified a specific diagnosis for each plant's malady, and then instituted specific treatment. Next, she put the plants in intensive care. After the plants were resuscitated and thriving, we then came back to claim them. She provided us with detailed prescriptions for treatment and directions for responsible care. She pointed out that she had made several diagnoses, including dehydration, failure to thrive, malnutrition, and plant abuse. She said that she seriously considered bringing us up on charges for neglectful behavior, but instead, she gave us a detailed, customized treatment regimen and put us on probation. She then made sure that we gave her regular reports.

EHRHART: Did she come back to check on the plants as well?

JOHN M. TEMPLETON, JR.: Well, since she would have to come to our house she didn't. She just trusted that the plants were staying in proper shape.

JOHN M. TEMPLETON, JR.: Another aspect, not necessarily in chronological order: Louise used her limited number of vacation days many years, particularly later in her career, to go on medical mission trips to underdeveloped countries to provide surgical care for some of the most medically deprived children in the Third World. Louise was and is a lifetime very committed Christian. She and Dr. Koop were members of the same Presbyterian church in Philadelphia, and Dr. Koop in his own right also did a number of mission trips, but Louise herself would learn from missionary groups who were part of missionary hospitals what were some of the difficult surgical problems that they didn't feel capable of handling. Some of them Louise wasn't an expert in, so she would scrub in and participate on some ear, nose, and throat-type procedures that she wouldn't normally do, and become fairly qualified in them, and then she would travel to Africa or Latin America and do the surgery that these kids desperately needed. It didn't matter that she wasn't out on a beach somewhere or putting the emphasis on herself. Instead she felt more inclined to want to put an emphasis on trying to help somebody else.

EHRHART: Can I ask you -- do you know of anyone who would have gone on those trips with her that maybe would be a person that could be interviewed for this project?

JOHN M. TEMPLETON, JR.: I do know that Dr. Koop went with her on some follow-up trips. Dr. Koop participated, as Louise did, in the very famous separation of Siamese twins in the Dominican Republic. Louise was one of the two lead surgeons in those children's care, so she went with Dr. Koop on follow-up medical care visits.

EHRHART: I'm actually interviewing him in a few weeks; I have an appointment scheduled in the middle of September. If any particular name of a surgeon who would have worked with her on one of those trips comes to your mind, please by all means let me know, I'd be happy to get in contact with them, because that is a very important aspect as well of her career, of her continuing to give back to people and even sacrificing her vacation, so to speak, in order to do so.

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JOHN M. TEMPLETON, JR.: I'll give another example of how Louise would do things that she wanted to be kept confidential to help somebody else. It's obvious that she not only deeply admired Dr. Koop, but appreciated how he gave her a start in life, where as noted, as we discussed earlier, not many women were getting into pediatric surgery. When she was finally on the staff with him, in the early years there were just three on the staff -- Dr. Koop, Dr. Bishop, and Dr. Schnauffer -- and they would be on roughly every third night, or every third weekend. But unbeknownst to Dr. Koop, if Dr. Koop was on, she would quietly tell the surgical fellows or residents not to call Dr. Koop for patient care advice unless it was something that was clearly related to one of his very important patients, or if it was necessary to come back to the hospital, even for surgery. Instead, even though she had just been up all night the night before, she wanted the fellows or residents to call her and have her come in instead of Dr. Koop come in. This was something she felt that she could do to reduce the continuing heavy burdens that Dr. Koop had on him, doing many different things as he did. She never wanted Dr. Koop to know about that because he would have objected, but it was always standard practice in the years that Dr. Koop was surgeon-in-chief.

EHRHART: Did he find out?

JOHN M. TEMPLETON, JR.: I don't know, you could ask him.

EHRHART: I will ask him, in fact.

JOHN M. TEMPLETON, JR.: Okay. Another part that repeats something that we've said.

EHRHART: That's fine.

JOHN M. TEMPLETON, JR.: As a doctor, Louise Schnauffer was an astute diagnostician. I think this came from her not only being very well-read and informed, but from a remarkable capacity to remember years of prior experience, and also a remarkable instinct for knowing what

the essence of the problem was and what to do about it. So she was a superb patient care doctor, physician, as well as if surgery was what was needed, a surgeon as well.

JOHN M. TEMPLETON, JR.: Another aspect is that her small hands were those of a technical artist. She was able to delicately remodel and shape a child's fragile tissues to restore the child to health. She used her skill both as a patient care doctor and as a technical surgeon to train generations of young future pediatric surgeons in what excellence in medical care meant in giving a sick child 70 or more years of health and a productive life.

JOHN M. TEMPLETON, JR.: This goes back to something else we had discussed. With an ever-present kind smile and gentleness of heart and voice, she guided junior residents and senior fellows through difficult and complicated surgical procedures and patient care problems.

JOHN M. TEMPLETON, JR.: Another aspect of how much she was quite willing to sacrifice time for herself and do things for others, was that she was one of the most faithful caretakers and tenderers of Dr. and Mrs. Koop's vegetable and flower garden each year. In fact, even when I was in training, some Saturday in the spring would be "garden day" and so we would all go out for a wonderful lunch that Mrs. Koop prepared, and then in the morning and the afternoon we would be digging in the garden, planting the flowers and the plants and so on. Louise enjoyed that tremendously.

JOHN M. TEMPLETON, JR.: Another aspect is: both patients and doctors-in-training have benefited from her caring and wise care. In many ways, she was a remarkable example of what some call a "doctor's doctor," which is that doctors in medicine, knowing who the best caretakers are, will often then use the doctor for their own care or their family's care. Many of her medical colleagues who might have a child with a surgical problem would seek her out because they trusted her judgment, technical ability, and patient care commitment.

JOHN M. TEMPLETON, JR.: Just one or two others. Now let's see, we spoke about Hirschsprung's disease, which probably has existed since the dawn of human existence. But of course unfortunately everybody with Hirschsprung's disease died. She became one of the nation's experts in Hirschsprung's disease, both in expeditious ways of diagnosing it as well as mastering the then-current forms of surgical treatment and cures.

JOHN M. TEMPLETON, JR.: And just one other last perspective. Although Louise was small in physical stature -- that included always using one or two stools to stand on while doing surgery -- she has cast a long and enduring reflection of accomplishment, especially in regard to the inspiration and shaping of dozens of major contributors today in the field of pediatric surgery.

JOHN M. TEMPLETON, JR.: So that's just some summary of some notes that I put together.

EHRHART: Thank you. I appreciate that. That will go in the file that will also become what is deposited in the archive, as long as that's agreeable to you.

JOHN M. TEMPLETON, JR.: Yes, I just probably should put my name on it.

EHRHART: Okay, thank you. I'll make sure that that accompanies the materials. I have a few other questions. And actually, it's really a perfect segway, because my next question was about the counsel that she provided to her colleagues and fellows. My question -- if you feel you've already answered this we can skip it, but basically my question was: Do you believe you benefited from her advice, and if so, how?

JOHN M. TEMPLETON, JR.: Yes, her advice to me, and how much I respected her, because there's no substitute for experience, having seen things and gone through tough problems. My seeking her out for these crackers and peanut butter sessions weren't just while I was in training, but when I was a junior attending and even later in my clinical career. I would run over with her some of the details of some great surgical dilemmas that I was looking at. I did it because I felt that she might have a very valuable perspective on what to do.

EHRHART: In addition to that, what advice did Dr. Schnauffer offer you as you completed your fellowship and were developing your career after your training?

JOHN M. TEMPLETON, JR.: At the time it was a two-year fellowship in pediatric surgery. The next two years were clearly already laid out because I had military service obligations. I was going into the Navy with the privilege of being a pediatric surgeon, as well as having to fill in for care of the military personnel as well. But my primary focus was already spelled out -- that I would be mainly doing surgical care for children of Navy personnel and Marine personnel. It wasn't until after I had been doing that for 9 or 12 months that Dr. Koop then contacted me and offered me a position. So my main ties with Louise as I left CHOP and was in practice represented what could have been private practice in pediatric surgery. This was the first year of my being on my own. Louise was always open to me calling her back and asking her for advice. So she didn't give proactive advice, but she let me know that she was always there for any ideas.

EHRHART: Did you have...I'm just curious how that worked. Were you stationed overseas, or were you here in the U.S.?

JOHN M. TEMPLETON, JR.: No. In Portsmouth, Virginia.

EHRHART: Okay, I was thinking that perhaps if you were perhaps abroad it may have been hard to get in contact with her logistically. How about when you did receive the offer to return to Children's Hospital, did you consult with her about making your decision?

JOHN M. TEMPLETON, JR.: No, I was so grateful for the offer, I accepted immediately.

EHRHART: If you reflected on your career and how you conduct yourself, perform procedures, or did perform procedures, and relate with patients and their families, do you see any characteristics that are based on what you learned from Dr. Schnauffer, and if so, what are they?

JOHN M. TEMPLETON, JR.: I have to go back first to the whole culture of caring for children, whether you're a pediatrician or in one of the surgical fields, especially the surgical fields like general pediatric surgery, because many of the diseases we dealt with weren't just going to be

addressed by a simple procedure and a short post-operative recovery and then you maybe saw the child one or two more times. Many of the conditions we dealt with, kids continued to have problems: their growth was not normal, their development issues were there, or they were born with other birth defects and so on. The culture in pediatric surgery was that for many of the patients you cared for you became kind of married to the child and the family. That was a culture of long-term care and commitment. She understood that; she embodied that. She acted as a role model because of the times that she would have back in her office a patient with one of these multi-dimensional medical problems that still had ongoing components, and teach you that it was not just enough that five years ago she did a particular surgical procedure that I was learning at the time, but that I would have to be alert to some problems that may show up two, four, five years later. Again, I think everyone in pediatric surgery knows how much the concept of continuity of care really exists in this component of the surgical discipline, probably more than in many other fields.

JOHN M. TEMPLETON, JR.: A common thing, not just unique to Louise, but certainly she was the recipient of hundreds of pictures, hundreds of Christmas cards, hundreds of graduation cards. Even twenty years later, the parent or the child would send an updated picture, an updated letter or card about how they were doing.

EHRHART: So you found yourself also making sure that that continuity of care was within your practice with your patients.

JOHN M. TEMPLETON, JR.: Yes.

EHRHART: And you feel that that was modeled.

JOHN M. TEMPLETON, JR.: Well, what she and Dr. Koop and Dr. Bishop, which were my three principal teachers, conveyed is that you are buying into not a moment in time of commitment, but perhaps years or even a lifetime of commitment, and she embodied that.

EHRHART: In addition to that, how would you describe Dr. Schnauffer's impact on your career? Do you believe that perhaps it would have gone in a different direction had you not become acquainted with her?

JOHN M. TEMPLETON, JR.: Well, I do have to emphasize what a strong contributor, as you might imagine, Dr. Koop and Dr. Bishop were. So I would say that she was a huge factor in my surgical training. If, for some reason, God had ordained that she would not have been part of my training, I think I would have still have gone on to be a pediatric surgeon because of the culture of pediatric surgery in terms of lifetime of commitment to patients if they need it. All that would have continued. But it was wonderful to have somebody with such an approachable, non-judgmental, and immensely open and helpful person like herself.

EHRHART: Do you want to talk about your relationship with Dr. Schnauffer outside the operating room, like for example if you and your family would see her for social gatherings outside of the work environment?

JOHN M. TEMPLETON, JR.: The best example, and I hope I can find pictures, is her willingness to pitch in wherever she might be able to help. My wife and I, for about 20 years, had an annual children's Christmas party at our house, which eventually grew to Santa providing 140 presents for individual children. As Santa's pack became just too much for one person to carry, we prevailed upon her, which was not much prevailing because she was so excited to do it, which was for her to become, on one or two years, Frosty the Snowman. Pina, my wife, would make a Frosty the Snowman suit with little pieces of coal as buttons and maybe a Frosty cap and pillows for a paunch, and Louise would be Frosty the Snowman and would bring down one of Santa's packs. My wife then on other years would make an elf outfit so she would be Santa's helper and come as an elf carrying the pack. She never felt that was demeaning -- below her station -- it was just a part of how much she loved children. The joy of something like a Christmas party was one of health and well-being, and she loved to celebrate health and well-being as much as she did dealing with helping sick children. I hope very much I can find some of the pictures of her and her Frosty or elf outfits.

EHRHART: Well, even if you can't, your description was very, I would say, more than adequate to picture the scene in one's mind.

JOHN M. TEMPLETON, JR.: Okay, yes.

EHRHART: Now that does conclude... basically my final question was: Did you stay in contact after completion of your training, but certainly you worked with her then.

JOHN M. TEMPLETON, JR.: Yes.

EHRHART: So the answer to that is yes. Do you want to discuss any research you might have done or papers you might have published about particular procedures where you worked with her?

JOHN M. TEMPLETON, JR.: Because it is so much of what pediatric surgery is about, which is about dealing with newborn conditions, Louise was of immense help to me in some original research that I and others did on esophageal atresia, imperforate anus, Hirschsprung's disease, and so on. That was part of the privilege of working with somebody who could give you a wealth of advice about what you needed to pay attention to in setting up your research protocol.

EHRHART: Any other comments, anything you feel that I've missed that you want to address now? We can also schedule another appointment if something comes to mind.

JOHN M. TEMPLETON, JR.: No, but I think it is important, because it's not the kind of thing that our secular-oriented culture that people even think about as important to a person, is the core of religion of Louise's Christian belief. She saw herself as a child of God, somebody who was born again, and who saw that as everything she did as trying to honor the Lord. Maybe that's why she had a healthy ego, as we were talking about, because she certainly had appropriate self-respect and knew her qualities. She would never demean herself, but she was also a humble person who was never in a point of trying to promote herself, and I think that came from her

strong Christian faith. Although she was not one to talk about her faith, she was an outstanding model of the living of one's faith.

EHRHART: Can you describe, elaborate, on living one's faith and how you believe she did?

JOHN M. TEMPLETON, JR.: I've used quite a lot of examples of how she wouldn't want someone else to know even that she was going out of her way to help. So with Dr. Koop, for example, she knew the heavy burdens that he was carrying. Dr. Koop would have that surgeon's or doctor's ego "I can do everything"-type thing, but she knew he was tired many days, so she would work two nights in a row just so he wouldn't have to come into the hospital, and yet it was essential as a part of that that we not do anything to let Dr. Koop know that she was covering for him -- and that included her willingness to go out of her way to just pitch in. She was the kind of double-attitude that certainly used to be characteristic and still in many ways is characteristic of America, which is a "can-do" attitude, which is "if there's a challenge, we'll find a way to overcome the challenge." Also, to do it in a way that didn't have the attention focused on yourself, but at least made sure that if there was credit, others would be credited as well.

EHRHART: Thank you for elaborating on that. Any other comments you have, or is there a name that comes to mind that you feel that is an absolutely crucial person to interview for this project? I did mention that I will be interviewing Dr. Koop in a few weeks. Is there anyone besides that?

JOHN M. TEMPLETON, JR.: I'll try to answer that question. I thought you were going to ask a different question, which was a word or two that would summarize her.

EHRHART: Oh, that's excellent.

JOHN M. TEMPLETON, JR.: I think the two words that most summarize her is a "servant leader" -- which was no job was too small that it was still not worthy of her to be able to help. Yet that just only added in people's minds to what they saw already as her integrity, and why people would follow her lead and follow her advice. So she's a very good example of a servant leader.

JOHN M. TEMPLETON, JR.: But in terms of others to interview, the ideal thing would be to get from Renate Rodgers the list of every single fellow that she ever trained.

EHRHART: I do have that, actually, I mean I do have a list of people, but if there's...

JOHN M. TEMPLETON, JR.: Even if you could just do telephone interviews.

EHRHART: Right. I do have a list of about 20 people...it depends also on the travel and the schedule and so forth.

JOHN M. TEMPLETON, JR.: But I would say that, it's a personal comment, but I find it immensely helpful to get the kind of questions that you've put together, which seem to be ones that you're kind of asking multiple people that you interview, to give those questions to people

ahead of time, because that triggers the mind, which at the moment may not call back the memory, but the next day after you've read the questions, suddenly incidents begin to come back to the mind.

EHRHART: Okay, I appreciate that feedback.

JOHN M. TEMPLETON, JR.: So I would send that out to each person you're planning to interview, and explain that this is not the total interview, but it's a way to be reflecting and prepare for the meeting.

EHRHART: Okay, thank you for that feedback. I appreciate it. I just want to state again that my name is Mindy Ehrhart and I'm working for the College of Physicians of Philadelphia for the Dr. Louise Schnafer Oral History Project, which is funded by the Foundation for the History of Women in Medicine. Today is August 25, 2006, and I've been speaking today with Dr. John M. Templeton, Jr.

JOHN M. TEMPLETON, JR.: Thank you.

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