

Joy Kerr, R.N.

FILE: KERR1

EHRHART: Today is April 25, 2007, and this interview is being conducted for the Louise Schnauffer Oral History Project, which is a project that's being conducted for the College of Physicians of Philadelphia and funded by the Foundation for the History of Women in Medicine. My name is Mindy Ehrhart and today I'm interviewing Joy Kerr.

EHRHART: Could you start out by spelling your name and providing your job title?

KERR: Joy, J-O-Y, Kerr, K-E-R-R, and I am a registered nurse at the Children's Hospital of Philadelphia in the operating room.

EHRHART: Where and when did you train to become an operating room nurse?

KERR: I trained right here at the Children's Hospital of Philadelphia. Back in 1990 was the first time that I became an OR nurse, and I learned on the job.

EHRHART: So you've been here since 1990 then?

KERR: 17 years.

EHRHART: Can you please describe how you were acquainted with Dr. Schnauffer, and for how long?

KERR: I've known Dr. Schnauffer since 1990. She was one of the very first surgeons that I ever had the privilege of working with. She was one of the surgeons in general surgery...the way that the orientation process is for nursing is that you go through the general surgery service because you basically get a big exposure to a lot of different types of things, but it's very repetitive. Because of Dr. Schnauffer's kindness, she was always the surgeon who got all the new nurses. So she ended up with new people all the time. I was very privileged to be able to work with her, initially, as a new nurse here as CHOP. She always did things the same way. She was just very predictable, and that made your job easy -- learning how to do this new job that you felt all thumbs. She made you feel like you knew what you were doing because she always presented it the same way. It was wonderful.

EHRHART: Why do you think she, as you said, she wound up with the new nurses? Why do you think that was the case?

KERR: Because she was kind to people, and because she was such a good teacher. She really was. Like I said, there's just something about knowing that this is a doctor who always does things the same way. Even when she runs into something that's not typical in a patient, she still handles something the same way, and so she was very good at being calm and putting everyone at ease in the room.

EHRHART: Let me just ask a few other questions based on that. So you said that she was the one who got the new nurses. How many new nurses would she be working with, and how long would they stay with her?

KERR: When I started, there were eight of us that started all at the same time. We can't all start at the same place, so you would all start in a different service. I was with her for about four to six weeks. She had two OR days every week, that was her block time, and so I would work with her pretty much two days a week for six to eight weeks. At that time she was taking call at nighttime, and coming in for emergencies, and so when I actually got to take call I would occasionally get to work with her at nighttime for emergency cases. That was a really comforting thing, to come in and know, "Oh, it's Dr. Schnauffer, oh good. Even though it's an emergency and I'm tense because I don't know what to expect, I know she knows how to handle anything." So it was always comforting to know that she was there.

EHRHART: Did she really know how to handle everything?

KERR: She did. As far as from a general surgery standpoint, so many people would come into her room, not in one day, but over the course of the years. A new surgeon might be working in another room down the hall, and he'd say, "I really need someone with gray hair to come in and look at this kid because I don't know what's going on." And she would break scrub and go to another room and then come back and say, "Oh, we fixed it, it wasn't a big deal." Everybody looked to her for her wisdom because she had seen so many things from a general surgery perspective. She was such a humble person that people didn't even notice her. When you first saw her and you hadn't worked with her, you didn't even know who she was. Many people thought she was the cleaning lady, they really did, because she would be sitting in the lounge, having her coffee between cases and reading her newspaper. She always brought the paper for everybody to read. Then she'd be cleaning up here and there and people actually would mistake her for the cleaning lady.

EHRHART: How did she respond when people mistook her for the cleaning lady?

KERR: It wasn't a problem for her. She'd say, "No, I'm one of the surgeons." She was very good that way.

EHRHART: When you said everybody went to her, who would you classify as everybody?

KERR: I would say the younger guys. The younger guys who were really struggling with a particular case would come in, or they'd send their nurse from their room down and say, "Tell Dr. Schnauffer I really need her to look in on this case for me," so the guys who just got here maybe. Over the course of 17 years I've seen new surgeons come and surgeons go, and so there were just many different people who would send people in. Or I would be in a different room and they'd say, "Is Louise here today? Is she in her office?" I mean, we'd call her in her office if we needed to.

EHRHART: Were these residents primarily?

KERR: No, these were new attendings, newer attendings who didn't have as much experience as she had.

EHRHART: Okay, so the new attendings, but how about anybody on the staff, like the nurses or the anesthesiologists, would they ever call on her?

KERR: Well, the nurses: Louise used to have a mole clinic here.

EHRHART: A what clinic?

KERR: A mole clinic. Here in the operating room.

EHRHART: As in mole as in...

KERR: As in if you had a little bump or lump or lesion that you needed removed. It was back in the days when we didn't have the busyness as we do now, because we don't have rooms just closed at one in the afternoon like we did back then. But we would put sheets up on the doors, and she would remove.... Anybody who had something that needed to be removed, she'd have a whole afternoon of just here, as a service to the people who worked here, she would take things off for them, and we'd send them to pathology and whatever.

EHRHART: That was for anybody?

KERR: For whoever, yes. "Louise is having her mole clinic in room 8. Room 8's closed for the day."

EHRHART: Would this be advertised to people?

KERR: No, but it was just among the nurses -- mostly the nurses. Probably wouldn't be a kosher thing in this day and age to be doing, but that was one thing that she used to do.

EHRHART: So how about professionally, with clinical issues or what have you? Would nurses and anesthesiologists also request for Dr. Schnauffer's help or expertise?

KERR: Yes, at that time. A lot of those people are gone now, too. There's a set of Siamese twins or conjoined twins, I think they're in their 40s now. If they were coming, Louise would be here. She knew how to handle these two. The anesthesiologist would say, "We're not doing anything until Louise is in the room," because she knows everything about... So she was really a...definitely a wealth of information for many people on different things about general surgery-type patients. But I think the nurses, definitely, because she shared our locker room with us, she went out with us after work, those types of things. Everybody felt so comfortable with her, and felt like they could ask her any question. "My mother has...or my sister, or my...." You'd ask for your own family: "What do you think we should do?" Of course we all would go to her and say, "Here's what's going on..." and if she didn't know she would say, "You ought to go talk to this person, because they'll know what to tell you." She was very good at knowing what her own limitations were. If somebody had a cardiac problem, she'd say, "I don't know who the best

person is, but this person's going to know, so go talk to them about it." That's something that, in the medical family that we have here, you do for each other, you help each other out, and she was always really good at that.

EHRHART: What was your role and responsibilities in the operating room when you first began to work with Dr. Schnauffer?

KERR: Well, I was a brand-new nurse, learning. I came in 1990, and she retired in 2000 from the operating room, which is when I left here. I took a sabbatical from here, too, and left for three years and I came back. I was working for another division of surgery. Over the course of that time I was doing general surgery, I was in charge of the brand-new laparoscopy program back in 1991, and I worked on the transplant team, and I left and went for a very short time to the cardiac team, and then finally in 1995 I became the specialty nurse for general surgery as well as fetal surgery for five years, I did that from 1995 to 2000. So I got to work with her and be at all their functions with them. I was at many things before that, but definitely included over that five-year period of time.

EHRHART: When you're talking about functions, what are you referring to?

KERR: Christmas parties, and different things that the division, that specific division, had. You just got to see a different side that you don't always see here.

EHRHART: As a procedure was beginning, or before a procedure would begin, would you communicate with her ahead of time – when, how, that type of thing?

KERR: Often you'd come in in the morning, and she'd come in first thing and you'd say, "Okay Louise, we've got a couple of hernias, and then we've got this big case." She took care of a lot of kids with esophageal atresia. There were a couple of kids that she and I did repeat surgeries. I scrubbed with her for colon interposition cases. They're big-deal cases. You take a large part of the colon and you transfer it up to a new esophagus, basically. She and I had done a few of those, and that was one of the very first cases, big case, that I ever did with her. This kid had such a strictured esophagus. She had gone to dinner with this family the night before his surgery. He had, I'll never forget it, as we were opening this kid's esophagus up, we found, she said, "Oh yeah, he had spaghetti and meatballs," and there were pieces of spaghetti that she was pulling out of his esophagus, and pieces of lettuce. "Oh, yeah, and we had salad, there's pieces of lettuce." Nothing really ruffled her, she was very unflappable in that way. Or she found humor in things that maybe somebody else would say, "Oh, they should have been totally cleaned out." And it just didn't bother her. She was funny that way.

EHRHART: But what, as your role as an operating room nurse, I understand there are two different....

KERR: There's the circulating nurse, who basically runs the room, takes care of the patient, and then a scrub nurse, who basically makes sure that the surgeon has, and the team has everything they need to do the surgery.

EHRHART: And in which capacity would you most often function?

KERR: I loved to be a scrub nurse. That was my favorite role, especially with Dr. Schnauffer because she also allowed me to help out. I wasn't just handing instruments, I was holding retractors, I was handing in ties. She fostered that kind of team approach, where she wanted you to be included in the procedure. She wanted you to know what was going on, and to see how amazing what we were doing: "Isn't it amazing?" Just little things that maybe...I still get excited when I see an adrenal rest in somebody's hernia sac. It's not a big deal, but that was one of the very first things that she taught me. "Look at this. You need to see this. You're going to see this if you stay here. You'll see these." It's just a little piece of orangey tissue in the hernia sac, and she said, "That's an adrenal rest." I just saw one the other day and I thought of Louise. She was the first person to point little things out to you, she's very good that way, so I loved scrubbing with her. The fellows, the surgical fellows loved scrubbing with Louise because she really let them do the surgery. I mean, she would never allow them to do anything.... If they were competent, she allowed them to do the surgery, and she'd question them: "Why do you think you're going to do that?" or "What's your next step here?" I just think she was such a great teacher in that way.

EHRHART: When she was showing you these things during the course of the operation, was it like, "Okay, you need to look at this because you're going to see this again," or was it almost like "Oh, isn't this neat?"

KERR: It was. She was still excited by things. She was still at, when I met her, she would have been 65, and she was still excited about, "Look at this, isn't this great?" It was really neat to be with somebody who wanted you to see how awesome her job was and how neat it was, how privileged we were to get to see inside somebody's body.

EHRHART: I think that gets to a bigger question about how she perceived life and humans, and that type of thing. Do you have any insight regarding the way she looked at a human life?

KERR: I believe that she regarded life as a really precious thing. I know that Louise went out on a limb in her career and did procedures that no one else was doing or that were questionable to save a child's life that maybe other surgeons wouldn't have done. But if that's what the parents wanted, if they wanted to do everything they could to save that baby, she would do it, she'd step out on that limb and she'd do it. But yet, I think she also knew when enough was enough, "We've done all we can for this baby and we're not going to torture this baby anymore, we're done." She knew how to counsel families and say to them, "We have done everything we can, but there's nothing else we can do," as hard as that was. She really valued life, and she lived life to the fullest. From that perspective you can see that she truly valued life.

EHRHART: Did your responsibilities in the operating room change over time as you were working with her or other surgeons?

KERR: Yes, because I went from being just the staff nurse who was learning to becoming in charge of the general surgery service, so I got to work more closely with all the general surgeons in that role, and took more leadership responsibilities at that point in time.

EHRHART: So for example, when Dr. Schnauffer was showing you this, or having you help in this way or that way, would those types of skills that you would learn from her transfer over to when you would work with other surgeons?

KERR: Yes, definitely. I think that there were a few surgeons, I can remember her being one of them, that truly took the time to teach me how to be a good scrub nurse. They would say, "Every time you're going to hand me a suture, I'm going to need a forcep in my other hand, because I need something to pick up my needle with when I put it through the tissue." She would make you think. She'd think out loud for you as a new person, and she'd say, "And so the next thing you're going to need after you hand me the suture is I'm going to need a scissors so I can cut it." She just had such a great way of teaching you. Actually, I'm also an RN first assistant, and she allowed me to assist her on cases when she didn't always have a resident or a fellow with her. Our chief of urology, who I work with also as an assistant, he'll say, "How would Louise have done it?" That's how much he valued her and knew what a great surgeon she was. He knew that she and I had worked together so much and I had done so many hernias with her, and it's just one of those things where you have people who knew that you worked with Louise and would say, "Well tell me how Dr. Schnauffer would have done it."

EHRHART: So even though she's no longer at Children's Hospital, you still have people who are....

KERR: They know her, they still know the legend of Louise Schnauffer.

EHRHART: What is the legend? How would you describe it?

KERR: That she was a humble, excellent surgeon. I always would say to her, "Louise, you are simply elegant," and she truly was. She has these five and a half glove hands, the tiniest gloves that you can buy, and they'd say, "I need Louise's hands for this," or "I need a Louise finger to get down here," when they were doing a dissection that was deep in a tiny little area. Everybody knew what a phenomenal.... She wasn't just a good surgeon. There are good surgeons, there are good technicians, but she had the whole thing. She was all rolled up into one – a wonderful person, families loved her, those types of things.

EHRHART: I'm going to get back to some of that in a little bit. But you had mentioned the term earlier, and I just want to make sure that I understand what it is, you said about how she would "scrub out." What exactly does that mean, "scrub out"?

KERR: Well, she'd finish out the case, then scrub out. It just means that you'd break from your case and then you'd come back in while the kid was waking up. So she'd say, "I'll be over as soon as I'm done here." She'd finish out the case, we'd put the dressings on, she'd scrub out, she'd go to the other room, and then she'd come back before the child left the room to make sure everything was fine.

EHRHART: And then you had also mentioned that there were times in which she would scrub out during her case, and then go see someone else, go to another room, operating room, and then come back...

KERR: She'd run across the hall, and then come back, check on that patient and make sure they were doing okay if that surgeon needed her, and then come back and we would wait for her.

EHRHART: You mentioned that very early on and I didn't follow up right away. So who else is or has been part of the OR staff? Aside from the surgeon, and you had mentioned the scrub nurse, and then the circulating nurse, and then who else would be part of the OR staff?

KERR: I really believe that there's a lot of different people here. We have technicians: anesthesia technicians, and core technicians. I think they all knew Louise very well, they all knew who she was. They didn't have the same interactions with her because they didn't work closely with her, but they all knew her. They'd see her in the lounge, they knew she brought the paper every day that she was here. Everybody loved it because they knew Louise was here when she had the paper. We'd all sit in the lounge and eat popcorn together. She would mingle with other people. I think everybody knew Louise, but there were definitely people who were closer to Louise than others were. We tried so hard to consistently keep the same people working in the same types of procedures so that they're very good at it.

EHRHART: This question may seem irrelevant, but I don't think it is. Which newspaper?

KERR: The Philadelphia Inquirer, with 14D on the top of it, because that was her apartment number. It was delivered to her house, it was in red, 14D. The Philadelphia Inquirer, she brought it in.

EHRHART: I don't want to say separate yourself from Dr. Schnauffer and specifically her for a moment, but let's just talk about the operating room in general for a few minutes. So you had talked about who else might have worked with Dr. Schnauffer, and the fact that there was a scrub and a circulator and a surgeon there and...

KERR: And an anesthesiologist.

EHRHART: And an anesthesiologist. What were your interactions with those different people like during procedures, just you as either a scrub nurse or a circulator, maybe both?

KERR: As a scrub nurse I have a tendency to always have my ear out for the monitors. If you hear the monitors, the pitch coming down, that means the oxygen level's coming down, you just become very in tune with what's going on in the room at all times. You have to have a good relationship with your circulator or else your life is miserable.

EHRHART: Why and how?

KERR: Because your circulator is the one who gives you everything you need to do the case if you don't have it already on your field. So if I need a specific suture, if I need more sponges, I

need to do my counts to make sure everything's correct. She's my lifeline because I'm sterile and I can't break my sterility to get something, so she's my lifeline to whatever it is that I need for my patient. The circulator has a huge job. As a circulator, not all circulators feel the same way, but I usually just linger around the table, watch the procedure. Because to me, especially in the beginning, things were excellent learning experiences to watch other scrub nurses, how they did things, and watching the surgeons so that I could know the next time I do this type of procedure how they're going to do it and what the next step's going to be. So as a circulator, your job is to make sure your scrub team has everything they need. You have to get all the paperwork done, do all of the charges, making sure that's all completed, we get paid for our procedure. Making sure that all of our documentation is correct; what lines the patient has in, any procedures that we've done outside of the surgical procedure.

KERR: Also as a scrub nurse that your goal is to be five steps ahead of your surgeon, in your mind. You want to know that you know the sequence of how they're probably going to do this so you have everything ready to go. I took great pride in that. The anesthesia team is so important. If I have a patient who's starting to move because their muscle relaxant's wearing off, I've got to be the one to communicate that to them because they're not going to know until the patient is practically jumping off the table, not that they are, but that's important, so we all communicate with each other. If we make an incision and we hear the heart rate go up, we know that maybe their block didn't work as well as they expected it to, when they do an anesthetic block in a certain area. So those are all things that we communicate amongst each other, and it's really a team effort in every way. We all have to work together. We say they're our roles in the OR, yet we all overlap each other in many ways. If my anesthesiologist is busy, I put the IV in, if I'm busy, they might take my IV up for me, or whatever. So we all kind of have our roles, but we all kind of overlap and work as a team together, including the surgeon.

EHRHART: Regarding the scrub nurse and the circulator, is there one position that's viewed as more senior than another?

KERR: Not really. I will tell you that I view the scrub nurse role as the most important role. Yet now we have scrub technicians who don't have as much education as a nurse does, and some are wonderful, wonderful people and they really know what they're doing, they really have the interest and that understanding of what's going on. Others don't so much and that always breaks my heart because I have such a passion for the whole process of what we're doing and what a great thing it is that we're doing for these children. So if you had to say that there was a more senior role, it would be a circulating nurse because you have to be a nurse to do that role. You can be a technician to be in the scrub position.

EHRHART: You had mentioned that you are, what is it called -- an RN first assistant?

KERR: Yes.

EHRHART: What did you need to do to get the "first assistant" role?

KERR: I had to take a class, and I had to do a hands-on week of training, and I had to do a mentorship here at CHOP. Dr. Schnauffer was one of my many mentors who taught me how to

be a good assistant, and how to sew and suture things, and how to make incisions, and all those things. I actually have pictures of her and I doing some cases together. She was very valuable in that way, she's a patient teacher.

EHRHART: Is there always a first assistant?

KERR: We have residents and fellows here at CHOP for the most part, however, we don't have them out at our specialty care surgery centers, and so that's hopefully the role of the future for me. I do some assisting with some of our surgical groups here. She really encouraged me because she would say, "You're such a phenomenal scrub nurse." Or "You should be a surgeon," is what she told me, but I wasn't willing to go to med school.

EHRHART: How did you feel when she said that to you?

KERR: I felt that she was probably right. I really love it, and I love doing everything, but I just wasn't willing to take the plunge and go to med school. But she really influenced me positively and I love what I'm doing. I love being a nurse.

EHRHART: Again, more general questions for a few more minutes, and then I have some Dr. Schnauffer-specific questions. The next one is: You said you've been here since 1990, so have you seen a change in the equipment and procedures, and if so, how have they changed?

KERR: Tremendously. It's amazing. Like I said, I started the first laparoscopy program here in 1991, and that was a huge deal. To see just how that equipment in itself has streamlined itself and how much it's changed and how many more procedures we're doing laparoscopically and minimally invasively than we did. Everything that we did open: we did open appendectomies, open cholecystectomies, all those are being done laparoscopically. Pyloromyotomies, which was one of Dr. Schnauffer's most favorite procedures, and now we do them laparoscopically. We now have a robot that does laparoscopic robotic surgery. So yes, there has been a huge change. I don't work so much with lasers and things like that, but we had a laser in our plastic surgery room that was probably as big as that desk [approximately 5 feet wide, 3 feet deep]. That was just what it was. There was an arm that came off of it that the laser came out of it. But now we have these lasers that are like a suitcase, I mean they're so small. Just to see the change. We had these huge outlets that had to be installed for the KTP laser in every OR, or we had certain ORs that couldn't accommodate it, we couldn't get them in every OR. There were days where I was like "Schew! I'm in the OR that you can't do the KTP laser in," because they weren't my favorite cases. But these huge things, and now everything is so streamlined and you just see how much better the instrumentation has come across the years. I think because we do such delicate surgery that we get to see these beautiful German instruments, that are just, oh, they're beautiful to me I would say, versus something that you might see in a little suture removal kit, which looks so clunky when you take it out, and you're like, "I'm so spoiled, I'm so used to working with these delicate, beautiful instruments."

EHRHART: You had mentioned, I'm probably going to butcher the name, pyloromyotomy...

KERR: Pyloromyotomy. It's the hypertrophy of the pyloric muscle, so the pyloric muscle gets really big and thick, and the pylorus is what allows food to escape from the stomach into the small intestine. It usually occurs between four to eight weeks after birth, and they start having projectile vomiting and these kids get really, really sick. You go in and you basically cut the muscle. It's like a donut. Louise would always say, "It's like a donut. You need to cut the donut in half so that it freely moves, just cut the one side of it so it freely moves and then the food can get through." It was delicate because you can't cut too far because then you cut into the mucosa of the stomach and the small intestine. But the babies get well, immediately. I mean they might throw up a couple of more times after that, but they really just make this dramatic improvement and they get better. They look so sick when they come in. It was a very gratifying procedure to know that we were really fixing something that was going to make this sick child well.

EHRHART: You said earlier that she really enjoyed doing those procedures, that was one of her favorites?

KERR: Yes, and she'd always say, "And they always come in threes. There's going to be two more. We had one today, I bet there's going to be two more in the next week. They come in threes, pylorics always come in threes."

EHRHART: First of all, why would you call that her favorite, and then what do you think made it her favorite?

KERR: Well, I think those reasons were because it was a really sick baby. They're in electrolyte imbalance and they're sick kids, and they're vomiting, projectile vomiting. Then you do this little surgery, it's a teeny, tiny incision, you fix it, and the next day they're like a new baby. I think that was very gratifying for her. Not that that was her all-time favorite surgery, but I think she really enjoyed those. She'd say, "Ohhh, we have a pyloric," so they were just fun for her. I think it was more a fun case to do because she knew what a big difference she was going to see.

EHRHART: I just didn't know if she ever came up to you and said, "Well, you know Joy, this is really my favorite surgery," I mean, I was just curious as to, you called it her favorite...

KERR: One of her favorites, I'll say.

EHRHART: I was just curious why it would get that label.

EHRHART: You talked a bit about the equipment, and how the equipment's changed over time. Do you believe that those changes have all been for the better?

KERR: I think for the most part they have been. We hate to see change. Even though I helped start the laparoscopy program, I have to be honest: laparoscopy is not my favorite. I really love getting my hands in there and doing the surgery. I struggle; I am not a Gameboy or video game person, and so to look at a screen and try and decipher how you're going to repair or do something, it's a totally different skill. Some people might say, "Well, that's not for the better,"

but it is for the patient, definitely. We see that they get home faster, and they heal quickly. So it is good, but you miss seeing... I like seeing the guts out there, I like having everything right on the table. But definitely things have improved, and nothing comes to mind that I could say, "That was the worst thing that ever happened to surgery."

EHRHART: Why do you like seeing the more open procedures?

KERR: I just think it humbles you. It makes you realize that this is an amazing body that we have been given. We all get one and we're all a little different, yet many things are very similar. It's just so cool to watch somebody fix or to be the one to help fix something, even down to the appendectomies. To see this horribly inflamed or ruptured appendix and you take it out and you clean it all up and you irrigate everything out and it looks better and you know it's only going to get better. To think that people used to die of appendicitis and peritonitis and that so much doesn't happen anymore. I don't know, I enjoy seeing, touching the human body. That's just neat.

EHRHART: How have the cases changed over time?

KERR: I think we have much sicker children with more complex diagnoses. So we have many children that are challenges, from maybe not necessarily from a surgical standpoint, but from a physiology standpoint of managing that patient because they're so sick. While we are able to repair something that may not be such a challenge except for the fact that they're such a sick patient. I think that's probably our biggest challenge in this day and age. We save children as premies, much earlier on. They have a lot of issues, there's a lot to deal with, and so I think those are the challenges. The more good we're able to do, the more we have to pay for it at some point or the patient has to pay for it at some point along the way, because there are complications to being born earlier. There are complications to... we do a liver transplant, but then you have to be on certain medications to help you not reject the liver, and that causes other.... It's almost like we take a step forward, but sometimes we take a step back or two steps back because of the whole treatment and what we have to do to make things work. So I think the anatomy doesn't change a whole lot, but the physiology can be a challenge.

EHRHART: It makes a lot of sense to me. Can you tell me how operating room dynamics are created and/or fostered by surgeons?

KERR: Yes. I can tell you that you either have a surgeon who is open and thoughtful and teaching and people are confident in, or you have a surgeon who is an intimidator, who does not allow questions, or makes you feel small for asking questions. There is a range of what you find. So you have one end, the one who wants you to ask every question, to the one who doesn't want to communicate. I think communication is what fosters an excellent operating room. Anyone who is willing to share their knowledge, and not only to share it by teaching you but to allow you to ask the questions as well.... To me it all comes down to communication, and it can be on every member of the team, including myself. There are times when I feel not as willing to share or to be as good a communicator when I'm uncomfortable with certain people, or I'm intimidated by people. It works all the way around if you think about it.

EHRHART: So where on that spectrum that you just illustrated, where on that spectrum was Dr. Schnauffer?

KERR: She was a communicator, very open. I think there were times that she would feel frustrated about things, and she couldn't always communicate exactly how she felt. Maybe there was an anesthesiologist that she was butting heads with that day for whatever reason, but she communicated to somebody in the room, and we could find a way to.... That was our goal -- it was to keep our room moving, and keep things happy, and keep things upbeat, and keep things going. I often was somebody that she could take aside and say, "We are moving too slow. We've got to keep things going, we've got a lot of cases to do today." We'd do our best and we'd say, "Okay, let's have a meeting with our anesthesia team. We'd all say, "Okay, what can we do to help things move along? We're feeling like things are dragging." She was never confrontational. She's definitely open, but not a confrontational person.

FILE: KERR2

EHRHART: This is a continuation of an interview with Joy Kerr, who is an RN at Children's Hospital.

EHRHART: We were talking about the dynamic in the operating rooms and you were talking about how Dr. Schnauffer communicated well. So would you say that that really different from the dynamic in the operating room from a lot of other surgeons, or?

KERR: No. I have to say that I think that most of the surgeons here at CHOP are pretty good communicators. There were a few who weren't so good, that you learned how to read. But I think that was kind of the status quo here, that we had good communicators. There were a few who weren't, though, I will say.

EHRHART: Did they wind up staying here?

KERR: No.

EHRHART: You said that she was a good communicator, and that is certainly a good attribute to have, but what do you think her motives were in creating the dynamic that she did, aside from, well, I don't want to put any words in your mouth. What was motivating her to create that environment do you think?

KERR: I think good outcomes for her patients. I think it all came down to the children, that she really loved what she did, she loved these kids. She wanted to take good care of her patients. She knew that if things were going well in her room that.... She liked to enjoy life. I mean honestly, I really believe that she enjoyed life and she was a hard worker. She was not afraid to work hard at all. So those were the important things, that she really.... I just think that was valuable to her, that she have a pleasant atmosphere to work in and so she was part of that.

EHRHART: Are there any specific cases that you worked on with Dr. Schnauffer that you could use to illustrate the dynamic?

KERR: Well, the colon interposition cases were always a big deal, and so she would always make a list and say to you, "We're going to need this, this, this and this," just to let you know ahead of time. There were times when you'd move that colon and it wouldn't like it. She'd say, "Okay, now it's not doing well." We weren't perfusing, the blood was not getting to the whole thing, and that would be frustrating and we'd have to free up more of it to somehow get it in the right spot so that it would like where it was, otherwise it would die and it wouldn't be good. You'd be stuck with this in your chest. She was very good that way; she would just tell you what she needed, and we would always update her preference carts for her and make sure she had what she needed on every case. There were a few cases where we had some really tough situations, and she didn't like the outcome of maybe what something happened, or a child that wasn't going to do well. She'd say, "I'm really sorry that we couldn't do more." She'd say it to the team, and then she'd go talk to the family.

EHRHART: So that was her response, just "I'm sorry we couldn't do more"?

KERR: Yeah. I think she knew when we've done everything we can here. This is all we can do.

EHRHART: Did she ever outwardly display... Certainly there would have been some sort of disappointment or what have you. Did she ever display her emotions regarding this, or was it all sort of business-like?

KERR: You knew when she was really happy, but I don't think she ever displayed the emotion of being really sad. She was very good at being stoic that way. I think she learned that early on as being a female in a man's world.

EHRHART: So you think that gender really played a role in that?

KERR: Well, think about it: she was a physician when there were very few female physicians, and so in order to get to where she was in her life, she had to work really hard. She lost both of her parents at an early age, and she was just one of these people who was determined that she was going to succeed in life. Not in a boastful way, because she was so humble. You would not know that this woman was going to endow what she endowed to this institution by the way she dressed every day. She did not dress in flashy clothes, she did not drive a flashy car. She had nice things, but she was not that kind of person. She was very humble in every way. I would say she was a product definitely of her generation, and she knew how to save, she knew how to get the most out of things. But she also was very generous, extremely generous. She also had to make it in this man's world that she was in, and she did it well.

EHRHART: We're going to get to this a little bit later. I guess I'm just sort of trying to figure out how, because there's got to be some sort of emotional response whether or not it's outwardly expressed when something doesn't go right or what have you. I believe you were a friend of hers outside of Children's Hospital as well.

KERR: Yes.

EHRHART: Did you ever see any manifestations of that – a case failing or things not going as well? Is there any way that you can think of that she would deal with these losses or disappointments?

KERR: She wouldn't eat. Or she'd be sick at her stomach, I think, and that she just wouldn't eat. She'd say, "Oh, I can't eat anything." Those were pretty much her manifestations of how she was feeling about a case, or how she was feeling about the day after something bad had happened. I can't think of anything off the top of my head, if there was a particular case, but I knew that there were a few that she just felt sick and she couldn't eat.

EHRHART: So we talked about Dr. Schnauffer and the way in which she helped foster the operating room dynamic. But Dr. Schnauffer aside, how about the different tools and technologies and the new procedures that were coming into play here? Maybe not specifically Dr. Schnauffer, but how did those types of developments change the dynamics in the operating room?

KERR: I think that we definitely...we all struggle with change. I think that is the bottom line, and so I think it was difficult. Change was very difficult as new things came on and as we started to do new procedures that we hadn't done here before. I think that at times Louise felt a little bit left in the dust with this laparoscopic stuff, but she'd be awed by it. She would be cheering everybody else on. She'd say, "I could never do that. I want to touch the tissue. How do you know how hard to do something, or how soft to do something? How effective it's going to be?" It's something that's learned, and you learn it as a resident. It's not something you learn when you're in your 60s. It's hard to build your confidence at that point. I think that was a hard thing for her to see, that some cases were going to other surgeons who were doing those types of cases and she wasn't doing them. I think it changed all of us. We all have that tendency to want to do it the same way we've always done it. We've always done it this way since 1855, you know?

EHRHART: You said you started with the laparoscopy in 1991?

KERR: Yes.

EHRHART: And so when that came into play, there were some surgeons who said, "Okay, well I'm not going to do it. I'm not, I'm opting not to do it."

KERR: Right, and we still have surgeons who don't do much laparoscopy. There are certain surgeons that do almost everything laparoscopically, and that's why they were brought here, because they're phenomenal at it. Whereas there are other surgeons who aren't as great at it, and so they've got to let these other guys do it, and that's just the way it is. There are so many subspecialties within a specialty when you think about it. Dr. Adzick here does all the pancreatectomies pretty much, on babies, because he's built that practice. Everybody has their thing that they build. Louise took care of a lot of babies who had necrotizing enterocolitis as newborns, but she really did everything up until the whole laparoscopy thing came into play.

EHRHART: I feel like I should ask another question based on that, but I can't think of one right now so I'm going to go back to my script. How would you say that the working relationship with a surgeon changes over time as you work with that person?

KERR: You know what they do. You know their procedures, you know them well. They trust you, you trust them. You trust that they're not going to change something that they've done for five years and do it differently this time, although there are surgeons who do things like that. For the most part, most of these guys, what they learned in their fellowship is what they carry with them until they die. So there's that trust. You just learn to trust that person and you know what kind of mood they're going to be in just by looking at them that morning. You just get to know somebody.

EHRHART: So the benefits of working with someone over time would be what?

KERR: Would be that it is predictable, for the most part. If you like that person then you're going to enjoy your day and you're going to have a great day at work, and that you're going to take great care of the patients.

EHRHART: Well, what are the drawbacks, then?

KERR: That you know that person so well, and that there are going to be annoying things that do it to you sometimes. So you may just feel like...there are just little things sometimes. Or you know they don't like a particular procedure, and you think, "Why do you book these cases if you don't like them?" You know maybe you're going to have a great day up until this point, and then it's going to be painful. That's the drawbacks of any relationship: you take the good with the bad.

EHRHART: The stereotypes of surgeons cause people to believe that they're tense, under pressure, and likely to express that pressure with an undesirable emotional, verbal, or physical response. So how did Dr. Schnauffer respond when an unexpected event occurred?

KERR: She was always like, "Oh, look at this!" Or "Oh!" She was not a screamer and I've known my share of screaming surgeons and surgeons who throw things and get angry. Just work in the cardiac room for a short time and you'll find that out. She wasn't that kind of person. I think she was such an inquisitive person and had such an inquisitive nature. She would say, "Oh, well look at this! Oh! We weren't expecting this!" or whatever. When things were tense, there were times. I remember we did a case with her; this child had a tumor that weighed over 20 pounds. It was like she looked nine months pregnant and we thought, "How could this family not know that this child had a tumor?" She was holding onto it with both arms, holding it back so that they could dissect it off of the pedicle. When it came off she almost fell off of her two stepstools, and it was like, "Whooo!" She's unflappable, she just didn't get upset. She could have been really, "You could have warned me that I was going to go flying across the room with this thing," or whatever, but she was very unflappable in many situations. I rarely ever saw her overreact to anything.

EHRHART: How or did she help others on the surgical team deal with unexpected events?

KERR: Because of her calm nature, I really believe it. And that is the truth. Whoever is running that ship, if they're calm, then everybody remains calm. We get into plenty of situations where there's bleeding, but she teaches you: you suction it, you clear the field, you pack it with some laps, and then we're going to find it, and we're going to ligate it, and we're going to take care of it. Whereas other surgeons are, "Oh my word, we're bleeding!" and it's like, "Let's get the suction out!" They react differently because they're not used to.... She just really would be very calm, cool, and collected all of the time. Really, I rarely saw her overreact to anything.

EHRHART: At that point, how about her communication with people in the room, and with specifically the nurses and the anesthesiologist, and her assistant if she had one?

KERR: When it was an intense situation?

EHRHART: Yes.

KERR: I think she was very good at it. She'd say, "We have some bleeding, we're getting it under control, we've packed it off, just stick with us," just reminding her anesthesiologist, "Watch the pressure, watch this, give more fluids." Very calm and cool.

EHRHART: It sounds to me, and I could be wrong, that it's sort of matter-of-fact?

KERR: Yes.

EHRHART: Is that appropriate?

KERR: Yes, definitely.

EHRHART: You had already mentioned some cases, but are there other specific cases that you worked on with Dr. Schnauffer that you could describe in detail to illustrate how she dealt with the unexpected events?

KERR: I think those were pretty much the two that I can truly remember: the lettuce and the spaghetti in the esophagus and then the tumor that she almost fell over with. No, I think those are it for right now.

EHRHART: Do you think that her gender played any role in that?

KERR: Yes. In what in particular?

EHRHART: In dealing with the unexpected events.

KERR: Yes, I think it did.

EHRHART: But why?

KERR: I think because, I think maybe not so much her gender, but because of her gender she couldn't overreact to things being a woman in a man's world. I think she made herself think clearly in order to get through the situation. And she presented herself very well or else she would have never survived.

EHRHART: Did her ways of dealing with the unexpected events, how did they compare to those of other surgeons?

KERR: Like I said, she was very unflappable. There were other surgeons that I had worked with over the years who did not handle themselves as well, or who freaked out, or screamed at you when things were going bad, threw instruments, those types of things, looked to blame you for something happening on the field that you really had nothing to do with. That just was never her. That just wasn't her. She took responsibility for everything that happened. There were days when I wasn't working with her, and I was in charge of her service and she'd come to me and say, "Please don't put that scrub nurse with me again, because she didn't know what she was doing. Why didn't you work with me today?" So those were kind of more her reactions. She would never say it to that person, to their face, that just wasn't her style.

EHRHART: You have worked in different settings in Children's Hospital, general surgery and others. Do you find that among the general surgeons as a whole, when they deal with unexpected events and maybe just the operating room dynamics in general, do you see a difference in general surgeons versus [other] pediatric surgeons at Children's Hospital?

KERR: I see a difference, I think across the board. The pediatric surgeons that we have here in every specialty are a kinder, gentler group of people than you see in the adult world. I think that there is more intensity in certain jobs. Our transplant group, our vascular group, our heart team, there is a lot more intensity in those jobs every day, or our neurosurgery group. They are dealing with life and death on a daily basis often, and so I think their stress levels are much higher. Whereas in a general surgery world, you get to take care of the baby with the hernia, and then the pyloric stenosis, and then maybe the big bowel resection, and maybe a tumor that's cancerous, but you've got a full range, probably on a daily basis, of different things. For most of the time, their "bread and butter" cases are the hernia repairs. These are healthy kids coming in to have something fixed. We're going to fix it, they're going to go home, and they're going to do well. That's a beautiful thing. You can't say that in all those other services. They're really intense, and these are chronic patients -- not that general surgery doesn't have its share of chronic patients. They do, but I think they have a great wealth of kids who are healthy who come in for their surgery and they go home well. That, in itself, has to be very rewarding. So that's probably the difference that I see from service to service.

EHRHART: Some previous interviewees have said that Dr. Schnauffer respected every person's role in the operating room. Did you find that to be true, and if so, in what ways did she respect your role?

KERR: Well, I do believe that she respected everyone's role. She knew that if we were going to do well, we would have to do it as a team. I do believe that she, down to the cleaning people, she was kind to everyone. And expected everyone to do their job, and that was part of it too. She

wanted people to do their job and do it well. I feel that she always fostered in me, as a woman, woman to woman, she always pushed me to do more and pushed me to be better at what I was doing. That was really a great thing for me, to have somebody who would mentor me as an assistant, teach me how to be better at what I was doing in my own job so that I could be a good assistant to other surgeons as well. So to me that was a great thing.

EHRHART: Do you think that she ever did that to sort of say, "Oh, there are too many men in this field and us women, we need to show them"? Was there any kind of sort of competitive gender thing going on?

KERR: No. I think she really, truly respected the men in her life that were in her workforce with her. But there was always that glimmer in her eye when she would know that we were getting a female fellow. It would be somebody that she could pass on her knowledge to. I think that was important to her, but it wasn't her first and foremost thought, ever. I think that it made her happy when she saw other women coming into the field that she loved so much, and she wanted to share this knowledge with them and see them go on to impact other people's lives as well.

EHRHART: Aside from encouraging you personally to continue to pursue different responsibilities and so forth, are there other ways in which she respected your role as a nurse?

KERR: I do think that she did. She recently had surgery. I don't know if anybody had talked to you about that. She had had some surgery recently. She allowed me to help her and take care of her. She respected me enough to let me take care of her, just at her bedside. She was in the hospital, it wasn't like I was her nurse or anything, but she let me do things for her and she'd say, "Oh, no you don't have to," and I'd say, "But Louise I want to do this for you." Then it was okay, and she'd say, "Well, that's really nice." Just little things, caring things that nurses do. I felt to me that was more gratifying, to know that she trusted me to take care of her than anything.

EHRHART: That is a good segway into the next question, which is: Were you able to form a friendship with Dr. Schnauffer, and if so, please describe that friendship.

KERR: Yes. Louise, and our friend Marie, and our friend Roberta and I all had season tickets to the Walnut Street Theatre. We would meet after work and we'd go out to our favorite restaurants, either Ralph's, or there were a couple of different ones downtown that we would go and have our Italian meal. Then we'd go to the theatre and we'd enjoy our time together, and I'd always drop Louise off at her house, or at her apartment. I've had her to my home, and my sister has a farm. Louise loves cats, loves cats, yet she is allergic to them. She lived with a cat for years and she'd come in with a horrible nasal congestion and she'd be sniffing. She'd go, "I know it's the cat, I know it's the cat," but she really loved cats. My sister's always got kittens at the farm. It was about a year and a half ago I took her out to the farm, and I have pictures of her with the kittens, holding all the kittens. She just really loved life, she really did. I wish I saw more of her than I do right now. With two jobs and going to school, I am juggling a lot right now. But I think she's just a wonderful person, and my family just loves her.

KERR: We had dinner with her one night, and it's just the funniest story. We're sitting at the dinner table. It was in the fall at my sister's house, and my brother-in-law was just fascinated with her and asking her about all the...Dr. Koop, and "Tell me your most exciting surgeries." She loved doing the twin surgeries, the separation of the twins and how complicated they were, and all the workup before, and telling those stories. As we were sitting there, I look over in the kitchen, and I can see a mouse. It's an adjoining kitchen and dining room. I'm doing this, pointing at the mouse to my brother-in-law, and he's not getting it. Well, she sees this mouse. She thinks this is the cutest thing. My brother-in-law set this trap three times to try and get this mouse, and it was hysterical. We sat at the dinner table and watched this mouse get out of...he ate everything off this trap. She just thought it was the cutest thing: "Oh, isn't it cute? Oh, isn't this funny? This is better entertainment than going to a show tonight." She can find in life enjoyment out of just the littlest things – out of a mouse that my sister really didn't want in her house. Just a wonderful, beautiful person who loved life.

EHRHART: What enabled you to develop a friendship with her?

KERR: I think that we share...our faith is very similar, so that was one of the things that really allowed us to connect on that level. I think that she recognized me as a hard worker and that she appreciated that in me, knew I would do anything for her, and bend over backwards for her because I saw what a wonderful, compassionate person she was and how kind she was to me. That's what really fostered our relationship from the beginning. It's that first day when you work with somebody, often that first impression is a lasting impression, and that's what started it all off for me.

EHRHART: Would you mind briefly describing whatever you're comfortable with sharing regarding your faith, your shared faith values? Whatever you feel is appropriate.

KERR: I know that Louise attended the 10th Presbyterian Church in town for many, many years. She really appreciated the ministry of Dr. Barnhouse who was there, and then, I can't remember the name of our last pastor who was there. I attended that church for a short time as well. The basic belief is a Christian belief, that Christ was the ultimate sacrifice and that there's nothing that we can do, he did it all on the cross for us and rose again the third day and conquered death. I believe that Louise has great peace in knowing that there is an afterlife and that she will be in heaven, and that she can rest in that, and know that she has comfort in knowing that she has a relationship with Christ in her life. I really believe that that's what drove her over the years to be the physician that she was, because she saw the great physician healing in her own life, and her own need for knowing who her maker was.

EHRHART: Was that something that would ever be discussed here, in the work setting?

KERR: Not in the work setting so much. I think I came to know of Louise's values and her Christian beliefs just on a personal level when we would talk about different things. She'd talk about doing this at church or doing that. That's how I found out about her beliefs and mine being very similar. I think that's probably how we connected as well.

EHRHART: Along with that, another question is: Dr. Schnauffer was known to provide counsel to many of her colleagues and fellows.

KERR: Yes.

EHRHART: Did you benefit from her advice, and if so, how?

KERR: I had a very difficult decision in my own life to make here at CHOP. I took on the fetal surgery program here in 1995, and in the year 2000 a surgery was proposed to us that would be a termination of a twin. It was a twin pregnancy. One child was a normal twin, and the other twin had a cardiac defect that was sometimes lethal, but I knew, because I had worked in the cardiac ORs, we were repairing this type of defect on a daily basis here in this operating room. That was really where my faith came to a driving halt. I mean, I had to make a decision. Louise had counseled me numerous times in the past because I struggled with doing twin separations and knowing that one of them would have to be sacrificed. I really do believe in the sanctity of life. I do believe that life is valuable and that I'm not the person who has the right to make the decision as to whether or not somebody dies, and I really drew on that wisdom that she had counseled me. She said: "If both babies are going to die, it's like the wisdom of Solomon." You remember the story of the one woman who stole the other woman's baby, and Solomon said, "Well then I'll cut the baby in half and each of you can have half the baby," and the real mother said, "Let her have the baby." Solomon knew that she was the real mother because he knew that the real mother would never want that baby to be cut in half.

KERR: Louise used that story one day with me in saying: "You have to understand that this is almost like the reverse. When we separate these children, if we don't separate them, they're both going to die. But if we separate, one of them will die, but the other one will have a normal life. But that baby can't live on its own and it's going to bring this baby.... It's like having one parachute and two people on it. You're not going to both make it to the ground, you're both going to die because you're too heavy. The parachute can't take both of your weight. It can only take one person's weight." That's how she got me through some of these things that I really struggled with. I think those were the days that I realized what her faith was about and how she helped me. Those conversations were the conversations that came back to me when I had to make a decision about what I was going to do. I resigned from my job because I knew that I couldn't be the one to be involved in terminating the life of a baby that I knew could be repaired after birth. So it was a really tough thing for me, because I loved my job. I loved it. To come back here after leaving for three years was a tough thing, but my own mother was dying. And so Louise encouraged me, she said, "Those people love you. You go back there. They will take care of you." And they did. I came back here, and all the surgeons and the nurses, everybody, it is like a family here. People took care of me through some of my hardest times, and respected my decision. Didn't agree with my decision, but respected my decision. I really believe that Louise was one of the people who, through her counsel in the past, helped me make that decision.

EHRHART: Why did you feel that you could approach her for counsel about this issue or any others?

KERR: Well, maybe it was the gray hair? I don't know. But I guess I saw so many people approach Louise about medical issues. I'd heard her talk. When you're in the OR, you don't just talk about the surgery, you talk about a lot of different things: what movie you saw, what you watched on TV that night. Louise was always up at night, late, watching Ted Koppel on Nightline. To hear her talk about some of the issues that would be brought up on the show, I knew she was a really wise woman. She'd say, "Could you believe what was on Ted Koppel last night?" and she'd tell you. "Oh," I'd say, "How can you stay up until 12:30 and get here at seven in the morning?" She'd just amaze me. But she truly is one of these people, whose knowledge, just critical thinking, going through and hashing it out in the OR the next day during a case, I just knew she was a wise woman and I valued her wisdom and her opinion. I did value her opinion of me and how she would perceive me if I made poor choices. That was important to me.

EHRHART: So it sounds as though you have a really unique relationship with her that maybe is more than just like a supervisor and employee type of...

KERR: Yes.

EHRHART: So if you had to use other terms to describe your relationship with her, either familial terms, or maybe an aunt or sister, how would you describe your relationship with her?

KERR: In some ways I would say she was like a mother here to many of us in the OR. She's a little older than my grandmother was, yet so hip and willing to go out and go and do things with you, so I couldn't say that I'd see her as a grandmother. I did see her as a mother figure in many ways, even though she never was a mother. She was a wonderful friend, and she still is a wonderful friend. But here, when things were difficult, or when times were changing.... She was the interim chief for a while when Dr. O'Neil left and before Dr. Adzick came, she was the interim chief. Those were fun days here, and we really loved having her as the chief. We just thought she was great. We love having Dr. Adzick, but she was just a different...a breath of fresh air. But I think she also knew it was a limited time, and she didn't want the position but she was put in the position, but she made it a fun time. She definitely loves to have fun and loves life. So I guess the best thing I...a friend, and my mother was my best friend, so I could say Louise was probably like a second mother to me in some ways.

EHRHART: There were two questions that I also have. I was wondering whether or not she helped create a sense of community at Children's Hospital, and if so, in what ways? And how do you think she did that?

KERR: Well, as you could see from some of my pictures, she would attend every party. She was always here, so yes, she was definitely a part of the community. She contributed when we were collecting for gifts. She wanted to be part of this group, and she showed up at everything. If she said she was going to be there, she was there. She was definitely part of this community and did foster community amongst this group of OR people, the OR staff here.

EHRHART: And she did that by contributing, or did she initiate things?

KERR: She wasn't an initiator in that kind of a way. But maybe she'd say, "We should have a party. We should do this." We would do the work, but she would always show up, and she would always contribute, and she would always do her part. She just was really wonderful that way.

EHRHART: My last question...I added these two today. My last question is in history what we would call counterfactual, and that is: How do you think the environment at Children's Hospital would have been without her?

KERR: I think that our fellows would have been lost a lot of the times. I'm sure you talked to them and they told you, I think she had peanuts in her office for them all the time, and they would just go and sit there and totally vent, and de- whatever you want to call it – debrief themselves from whatever frustrations they were feeling from the day. Louise was like that kind of a figure to everybody. You could just let it all out. She wouldn't judge you and she would truly be your champion. "Okay, now get back in there and do it. Okay, let it go and get past it." I see her endowed chair and how important that is here, to pass her legacy of surgery and her skill on to our surgeons that are in training. Her community is so wide. I know she worked with so many different services: the oncologists, the pediatricians, the chronic care people. She knew so many people. The friends that she has.... I just think it wouldn't have been as happy a place without Louise here. I truly believe that Louise put some of her own attending colleagues to shame because of her willingness to show up at everything, and I think she shamed some of them into it. I think there would have been a wider gap between the surgeons and the rest of the staff here if it hadn't been for Louise because of her willingness to be right down in here with us and be one of us.

EHRHART: That gets to the end of my questions. Is there something that we haven't talked about that you would like to share or add at this point?

KERR: No. I feel that this is a huge privilege for me to be interviewed about Louise because I just love her so much and think the world of her, and I know what a wonderful person she is. We really miss her here. We miss her beautiful spirit being here, and wish she were here operating with us. I think she wishes she was here operating too sometimes. When I get to see her she'll talk about it and say, "How are things there?" She misses it. But she has [undecipherable] a lot of fun things in her life, and it's all good, it's all part of the process, and I think she really sees it that way. I think that's everything.

EHRHART: Just to recap, today is April 25, 2007, and this has been an interview with Joy Kerr, an RN at Children's Hospital of Philadelphia. The interview has been conducted for the Louise Schnauffer Oral History Project, which is for the College of Physicians of Philadelphia, and funded by the Foundation for the History of Women in Medicine.

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