FILE: HALLER1

EHRHART: Today is October 19, 2006, and I'm speaking with Dr. Jacob Alex or Alexander?

HALLER: Alexander.

EHRHART: Alexander Haller [Jr.]. And your last name is spelled H-A-L-L-E-R – is that correct?

HALLER: Correct.

EHRHART: So this recording is on behalf of the College of Physicians of Philadelphia – the Louise Schnaufer Oral History Project, funded by the Foundation for the History of Women in Medicine.

EHRHART: My first question is: How did you first become acquainted with Dr. Schnaufer?

HALLER: I first met Dr. Schnaufer in the late 1950s when I was still in my residency training program at Johns Hopkins. She was not in that program but she was in an affiliated program at Union Memorial Hospital. We often would say hello to each other at the various weekly conferences. I did not know her well and I never worked with her professionally at that time.

EHRHART: How did she initially become affiliated or associated with Johns Hopkins?

HALLER: One of her mentors at Union Memorial, I think maybe several of them, were also on the staff at Johns Hopkins and she came over with them on a number of occasions to see patients and to participate in conferences, but she was not on the staff at that time.

EHRHART: And would you mind describing the positions that you've held at Johns Hopkins if not elsewhere and your role in the different institutions?

HALLER: Sure. I had my general surgery residency training at Johns Hopkins. I'm also a graduate of the Johns Hopkins Medical School in 1951. And then I had two years in the public health service for my military time and one of those years was at the National Institutes of Health, which was a part of a program in training in cardiac surgery. When I came back from Bethesda, which is where I was stationed, back into the general surgery training program, I then completed it in 1959 under the chief surgeon Dr. Alfred Blalock, and that's B-L-A-L-O-C-K. So I had essentially all of my training there except the time I was at the National Institutes of Health. Then from there I had my first paying job as the chief of cardiac surgery at the University of Louisville in Kentucky and was there four years, and then was asked to come back to Johns Hopkins in 1963 to begin a formal program in pediatric surgery. There had not been an identifiable pediatric surgery program at Hopkins, but of course children had been taken care of

over the years, there was just not a designated section within general surgery and I came back to begin that.

EHRHART: You're still also...

HALLER: From that then until I retired in 1992, I was the chairman of the section on pediatric surgery at Johns Hopkins, so I was the first chief, and then I continued to operate until 1998, and then retired from operating and have continued as an emeritus professor to teach the medical students.

HALLER: To fill in that little gap, where I knew Dr. Schnaufer as a resident -- when I came back in 1963, we had nobody else trained in pediatric surgery, and I knew that she had completed her training by that time, and asked if she would be interested in coming over as a part-time faculty member, which means they don't get paid, and work with me in developing pediatric surgery and she was generous enough to say "yes" and came and then our friendship began in earnest.

EHRHART: So why were you particularly interested in her?

HALLER: I was particularly interested in her because I had liked her very much as a person as a resident, I knew of her commitment to pediatric surgery, I knew also that she had excellent training at the children's hospital in Philadelphia, at CHOP. So I knew her credentials. I knew that she would be a good teacher and relate well with the residents, and she seemed like an ideal person for me to have as a partner.

EHRHART: What were her contributions as she worked with you to develop this program?

HALLER: Her main contribution was to be with the residents seeing patients in our clinic. She did not have private patients at Johns Hopkins, because she usually took those to Union Memorial, where she was primarily based. But she could bring patients if she wished to, because she had admitting privileges, but because of her training background and her relationship with a lot of the pediatricians in the community, she did most of her operations at an affiliated hospital, at Union Memorial, rather than at Johns Hopkins. So I did not need her so much to help operate on patients as I did to see them in the clinics, make diagnoses, and participate in the teaching of residents in surgery who were rotating through our service.

EHRHART: So you were her direct supervisor in that role?

HALLER: I was. I was her associate, but in the hierarchy of the department I was her supervisor.

EHRHART: Were there any other people who also had the same role as Dr. Schnaufer?

HALLER: There were no other pediatric surgeons at that time in Baltimore. Obviously there was a lot of pediatric surgery being done by general surgeons who had an interest in children and

who had had some experience during their training, but there was no one else in Baltimore who had board-certified training as she had in pediatric surgery.

EHRHART: Wow, I didn't realize that. So it was really the two of you forging it on your own then, eh?

HALLER: That's right. We began pediatric surgery in Baltimore.

EHRHART: How did you do that?

HALLER: Well, a number of ways. One, I had been in the training program at Hopkins as I indicated earlier, so most of the faculty in surgery and in pediatrics knew of my interest, knew of my commitment, and so as soon as I came back from Louisville, all of their patients who needed surgical evaluation came to me. And then all the pediatricians who had trained at Hopkins who were then in practice in the Maryland area largely sent their patients to me, selectively, because they knew me and knew what my background was. I had a lot of help from several senior pediatricians who wanted to support this new entity of pediatric surgery, and I also had important support from several general surgeons who had been doing pediatric surgery as a part of their general surgery training. Several of them, mainly two, called me when I came back and said, "If you're going to do just pediatric surgery, just operate on children, we'll send all of our newborn surgical candidates to you because we think it should be done at a university hospital and you're going to be committed to it, we're not, we've got large practices in adults as well as older children." And so that was a big help – to have their support. One of them, Dr. Mark Ravitch, R-A-V-I-T-C-H, had been one of my mentors at Hopkins, because he was on the general surgery faculty, operated on adults and children, but then he began sending all the children to me, and one of his trainees, Dr. Jack Handelsman, H-A-N-D-E-L-S-M-A-N, was in private practice and he also called and said that he would be sending all of the children to me, which was wonderful, because that immediately gave me a practice in the community, as well as a referral to Hopkins.

EHRHART: It seems like – and maybe I'm wrong – that it was also a commitment on behalf of the surgeons with whom you associated to actually refer the patients to pediatrics as opposed to treating them themselves.

HALLER: You understood exactly right. Many of the general surgeons who had been doing children's surgery in the past at Hopkins elected, and I don't think under duress, all elected to send their children to me because of my commitment and because we were developing this new division within general surgery. So I was not the chief of an independent department of pediatric surgery, instead it was called a section of general surgery, but essentially it was the same as being the chief of pediatric surgery in a children's hospital, because in my absence from Hopkins in Louisville, we began, or Hopkins began building its first self-standing children's hospital and it opened in 1965, just two years after I came back, and I had an opportunity to help in its planning and we then were an established children's center within a university hospital.

EHRHART: Going back to you and Dr. Schnaufer working together to develop the program, you really had a clean slate to work with when you were developing the residents' program, so

what were some components that you and Dr. Schnaufer decided to include or emphasize or tailor in a specific way?

HALLER: Well, with many suggestions from Dr. Schnaufer because she had been in an established training program in pediatric surgery at CHOP, and I was very anxious to have her ideas and her input. We began by seeing all of the general surgery in children in one clinic, and she was in charge of that clinic, and she taught the medical students and residents there. I saw some of the patients, but she was largely in charge of the pediatric surgery outpatient clinic. At that time we were not doing much outpatient surgery, so it was mainly seeing patients, post-operative patients, patients who had been injured and were coming back for follow up, or patients who needed to have a diagnosis for whatever their condition was. So she was really the lead person in our outpatient pediatric surgery activities. I was also doing children's cardiac surgery and children's thoracic surgery, chest surgery. She was not trained in those two areas and so we did not collaborate in that area, but I was also working in the general surgery area with her. So it's a little complicated because of the interaction of the different departments. And that was a problem, because as a pediatric surgeon in a university hospital, you had to have the same training and the same credentials as our general surgery counterparts in the academic department of surgery in order to be accepted. Since I had had my training all at Hopkins, there was no question about my credentials, which I think made it much easier for me to develop the program there than it would have been at some other university hospital. It was one of the first children's hospital departments within a university hospital, and that was one of the reasons that I had hoped we could begin the program, because it gave us an opportunity to do research in the university laboratories, which is not always possible by any means in a self-standing children's hospital. And that's what I added to pediatric surgery, and Dr. Schnaufer was interested in that. She did not work in the research animal laboratory, but she did a lot of clinical research, and I'll have a chance to tell you about some of those as we go along.

EHRHART: About the residents' program -- now would you say that it had a particular aspect that other programs didn't? Would you say it was unique in a particular way, and if so, how?

HALLER: It was unique in, first of all, that it was in a university hospital, since I've indicated there were maybe one or two in the country, and none of those programs had a training program in pediatric surgery, so ours was the first training program, that is, with fellows who were committing themselves to pediatric surgery in the United States, to be in a university hospital, so that's number one. The second thing that was unusual, if not unique, was that we had full access to all of the research laboratories and funds within a university department of surgery, which was certainly unusual and might not have been present in more than one or two other children's hospitals in the United States. And then the third thing that we had was that we had outstanding general surgery residents who were in five- and six-year training programs and who likely would become academic surgeons in other universities, rotating through with us in pediatric surgery to learn techniques which would be appropriate for the management of very sick surgical children and that was not available in other children's hospitals, so three things that I would emphasize.

EHRHART: And how did...?

HALLER: She participated, particularly, in the training of the general surgery residents rotating through, and also in some areas of research, largely clinical research, rather than animal research in the basic science area.

EHRHART: What do you think was Dr. Schnaufer's greatest contribution to Johns Hopkins in this pediatric program?

HALLER: Without question, her main contribution was her skill in evaluating surgical patients, or potentially surgical patients, her diagnostic abilities, her empathy, which came through so loudly in her relationship with parents and family, and her ability to work closely with general surgery residents, all of whom admired her, and she was an excellent role model for them as a committed surgeon. She was at that time not so much a role model for women because there were so few women in training in surgery, we had maybe at that time one or two out of a group of 40 residents who were women, and they were usually interested in going into gynecology or possibly into plastic surgery. There were no other pediatric surgeons, at all, card-carrying, and so of course there were no other women pediatric surgeons. They were very few and far between. In the 1960s there were possibly a half-dozen women in pediatric surgery in the whole United States.

EHRHART: To what do you attribute that small number?

HALLER: First there were so few women in surgery, period. And since pediatric surgery required additional training, I think it was a formidable undertaking for many women to be in a residency for eight or nine years. The hours were strenuous, the pay was poor, and I think most of them, most women, were interested in shorter residencies so that they could begin their practice and or their families.

EHRHART: You had mentioned that she had particular skill in diagnosing and evaluating patients. I guess not everybody has that skill, so why do you think she had it, was it in the way she examined someone, the way she listened, a combination, do you have any insight into how she...?

HALLER: That's a very good question, because it's true that certain people seem to have a natural ability. I think so much of it has to do with being able, first of all, to have a very sound knowledge of various diseases of childhood, what their symptoms are likely to be. In a sense, pediatrics is like veterinary medicine, because in the young child, you can't get very much verbal response from them, so you have to consider them as sick little animals, and having a certain empathy to relate to them is, sometimes I think god-given. It is probably not learned, although there are certain kinds of relationships that can be taught. That was one of the things, that she related so well to children and they were relaxed immediately in her presence. The second is that she had a very sound understanding of the diseases of children, and therefore would acutely pick up evidences of what was wrong with them when others might not have that background upon which to build in terms of what to expect. And the third thing is that she was able to many times get a nonverbal patient, a young child, to respond to certain kinds of hands-on evaluation where the child was not frightened by her presence. Some of that may have been because she was a woman, children would relate to that perhaps as they would to their moms, but also because of

her manner, which was so calm, so kind, that she immediately won the confidence of the child and therefore she could do examinations and feel things that a lot of other people couldn't. That was one of her great contributions. She showed the younger residents how to do those examinations, how to relate to the child and also to the parents, which is a very important part of pediatric surgery since all children have them. And I think that those skills were ones that she had both been born with, perhaps, some of her understanding of children, but also she had been in an excellent training program, and she had a huge experience and that's very important in terms of being able to make a diagnosis.

EHRHART: In regard to the empathy that you said that she had with her patients and their parents, would you say that was mostly related to her demeanor and her calmness that you were speaking about, or do you feel there was another element to that?

HALLER: A lot of it was intrinsic to Louise, she's just that kind of person, and you know everybody has their own style of reacting. She is a calm person who relates quietly and is not extravagant in her motions at all. But in addition I think she learned over her training period that that was a very important kind of quality to have in order to get the confidence of the child, and so she built on that and as she observed the responses she was able to pass that along to another generation of surgeons. And I think that was one of her important contributions to our pediatric surgery training program.

EHRHART: So I think we've covered maybe the first five questions already. But about the residents' program. So as her colleague you most likely observed her working with the residents. Was there anything about her work with the residents that differed from the ways in which other mentors would work with their residents?

HALLER: Yes. She treated the residents as equals. There was no hierarchical kind of "I'm boss and you're my servant"-type of approach. And therefore the residents responded by being very comfortable about saying they didn't know, or admitting that they had made a mistake. They were able to confide in her, and she, in turn, was very understanding and could use many of those experiences to strengthen the confidence of the residents in training. She communicated extremely well and they all appreciated that and looked forward to working with her.

EHRHART: By "communicated well," could you elaborate on that?

HALLER: She communicated well in the sense of being able to criticize them in an objective way, and also to point out to them better ways of doing things without being "top dog" and boss, and saying "You do it this way," it was "If you'll try this, I think you'll find you won't have that kind of a problem," rather than saying "Don't do that, do this."

EHRHART: You said for a certain period of time it was only you and she who were pediatric surgeons.

HALLER: Right.

EHRHART: So how long was it only the two of you were working in this department?

HALLER: We worked together without having any other faculty person for three years. Then we had the opportunity of training one of our chief residents in general surgery who had an interest in pediatric surgery, some of it had come about because of his relationship to Dr. Schnaufer, and he asked if he could come and spend a year with us after he finished his general surgery training. Well, this is when I began thinking we should have a formal pediatric surgery training program. So this was Dr. James Talbert, T-A-L-B-E-R-T, who spent a year with us in pediatric surgery as a sort of a senior fellow, being given more and more responsibility, then stayed on for a year as a junior faculty person, an instructor, that made it possible for him to relieve Dr. Schnaufer and me some for night call. And after one year he was actively recruited around the country from several university programs that knew about him and his training, and he chose to go to Gainesville, the University of Florida, at the age of 32 as the chief of pediatric surgery. He was first in a long line of such fellows trained at Hopkins, and as a result we decided, that is, the Department of Surgery decided (I discussed it with the chief,) and we decided we needed to have a formal program in pediatric surgery to train people like Dr. Talbert who had a special interest in academic pediatric surgery and with a research background as well. And so we began our training program as a formal one, designated as a pediatric training program in 1967. He finished in '66, and then he stayed on, and then we started the training program, and after that we had a chief resident coming from somewhere every year, one that we trained in pediatric surgery and subsequently in this country it was required that we have two years additional training after general surgery, which is the way it is now. So we altered our program to the extent of having two years rather than one.

EHRHART: Is Dr. Talbert still in Florida?

HALLER: Yes, he is. He's just retired. Hard for me to believe that one of my residents is retired, but he's just retired. He had a very outstanding career there, and had a number of superb pediatric surgeons working with him over the years.

EHRHART: So let me ask, I think before we take a break, why don't I ask you maybe one or two more questions. The first one is, many of Dr. Schnaufer's residents and colleagues from CHOP, or Children's Hospital of Philadelphia, cite her mentoring outside of the operating room, in her office, for example, as having a great impact, at times a therapeutic, spiritual, or emotional one. Did she have the same reputation among her residents and colleagues at Johns Hopkins, and if so, can you provide an example?

HALLER: She certainly did have that same reputation, and I alluded to it in saying that she was looked upon as a colleague that they could speak with freely, and not as a *Geheimrat*, not as "the boss" looking to one of his employees. I cannot myself give you good examples, because I was never in the receiving role, but I know that the residents have told me that about her, and that may be one reason that Dr. Talbert could be helpful with that question.

EHRHART: Well, how about among her colleagues, such as yourself?

HALLER: Certainly among her colleagues there was a feeling that you could always depend upon Louise, whatever she said. She also was a very dedicated surgeon, always available if you

gave her a call, would arrive at 2 a.m. if you'd ask her. And she exemplified I think very well a committed academic surgeon who was available to help any of her colleagues no matter what. I'll give you a little bit of an extension of that. It moves us along a way, but I'll mention it now and you may want to come back to it.

HALLER: She was so available in the community for all the pediatricians in practice that they would call her frequently if it was something like appendicitis or a hernia or something of that sort that didn't require coming to the big Johns Hopkins Hospital, I mean they could be seen and treated at a community hospital. Or if the baby had diarrhea and they weren't sure whether this represented a surgical kind of diarrhea or was this medical. They would often call her and ask her to meet them in the emergency room so that they together could make a decision. They had great confidence in her ability to differentiate medical from surgical things. She was so available, and as you know she never married, so she was really married to her profession, that over the years she was so available that they imposed upon her, to the extent that they would, in the final couple of years before she returned to CHOP, they would call her and say, "Mrs. So-and-So called me and says that her 4-year-old has a belly ache. I'm busy now, and besides it's 4 a.m., I'm sending them into such-and-such a hospital, will you meet them there and evaluate them and see whatever is wrong with them?" So they converted her almost into a primary care physician and it almost broke her health as a result. She was just working night and day as a general pediatrician with a possible surgical problem. And that imposition, I could see, was not healthy and was not good, but she said that these were pediatricians that she had a strong relationship with, and she would allow them to continue to do that until the summer that she decided to come back to CHOP, and I'll give you some details of that later. She just finally said, "I can't live like this any longer and I can't get out of it here in Baltimore because I've established a pattern."

EHRHART: That's very interesting. When you're talking about health problems was there a particular...just being run-down?

HALLER: Fatigue.

EHRHART: Fatigue? Okay.

HALLER: No special disease or anything that I know of, because her health was always good. The only time she had a big problem was that she developed a ruptured lumbar vertebral disk and had severe back pain so that she could not bend over at the operating room. She tried to use non-operative treatment for months, and tried bedrest and everything, which is not typical of Louise Schnaufer – bedrest! She was usually up and doing. Finally she had to have lumbar disk surgery, and after that she was okay. But that really bothered her for over a year, and then she finally had surgery on it.

EHRHART: Well, let me ask one more question and then maybe I'll advance the tape and flip it and we can take a few minutes' break. Could you please explain what you mean by differentiating between a medical versus surgical diagnosis?

HALLER: Children, especially, but adults also, can have various symptoms that could be caused by bacteria, could be caused by viruses, but are not going to require any kind of operative treatment. They can be just as sick, and they can die of those conditions. On the other hand, they can present with those same symptoms, vomiting, diarrhea, and this be evidence of a beginning surgical problem, such as appendicitis, or a ruptured ulcer, or even a gallstone, young teenagers get gallstones and require an operative procedure to get them well. So we refer to those as "medical" conditions and as "surgical" conditions to differentiate between how the treatment is going to go. Okay?

EHRHART: Thank you. I just wanted to make sure that was on the record there. I guess now would be a good time for a break.

HALLER: Suits me.

FILE: HALLER2

EHRHART: This is the continuation of the interview with Dr. J. Alex Haller [Jr.] for the Louise Schnaufer Oral History Project conducted for the College of Physicians of Philadelphia and funded by the Foundation for the History of Women in Medicine.

HALLER: Now just before you go further, let me just add: Did you know that Johns Hopkins was the first medical school to admit women on the same basis as men? And that's something that you might be interested in following up on, particularly related to women in medicine. That's why so many of the outstanding women in the field of medicine in the first half of the century, people like Dr. Helen Taussig, Florence Sabin, all of them, all came from Hopkins, because none of the other medical schools would accept women on an equal basis. Dr. Taussig's from Boston, for example. She applied to Harvard where her two brothers had gone to school, they wouldn't accept her, so she came to Hopkins. It occurs to me that really relates to the underpinning of this particular series of interviews that you're talking about.

EHRHART: I just wanted to hop backwards just a moment to the last question that I had that was about the relationships between Dr. Schnaufer and her residents, and/or colleagues. Several people have mentioned to me that a great part of Dr. Schnaufer's life is her spiritual beliefs or commitments, or what have you. And I wanted to give you an opportunity to state what you think about that in her life, if you have an opinion or observations you would like to mention. If not, we can move on to the next question.

HALLER: I can give you much insight into that, because I know her as a close friend, and I know that she is a very strongly committed Christian, in that she brings all of those values to bear on her relationship with her patients, but I'm not personally aware of her using those spiritual gifts in terms of her relationship with residents and medical students because I've never seen her in that kind of relationship. But I do know, as you were pointing out, that a number of her residents have said that she personifies a spirit of concern and warm feeling for the suffering that certainly demonstrates her own religious commitment and her own spiritual values. But in terms of impacting on others, I don't have that experience, so I can't speak to that.

EHRHART: My next question is turning in a different direction now, and this is in regards to any kind of new procedure she was developing at Johns Hopkins. The question is: Was she innovating new procedures during her time at Johns Hopkins, and if so, what were they?

HALLER: The answer to that is yes, and a very strong yes, because one of the big problems in the management of infants and young children is the group who are born with abnormalities of their bottoms – they don't either have an opening for the rectum, or there's a combined opening with the rectum and the vagina, or there may be other associated kinds of abnormalities, such that if they're not corrected appropriately and the muscles which act as sphincters to make sure that there's control of those, particularly the rectum, then you're left with a child growing up who is incontinent, who has no control. She was very interested in that group of patients because they are miserable. And, many times, we had patients referred to us from around the world who had just had poor treatment, and nobody had focused on just what the actual abnormality was. She studied embryos -- we have a large embryo collection of human embryos at Hopkins -- and looked at the development of that part of the human body, and how the relationship was to the rectum and the vagina and the urinary tract, and on that basis made the observation that we should be able to measure whether those muscles necessary for continence, either in the urinary side or on the bowel side, are there or not -- they could be not even there, and nothing you're going to do is going to be able to allow them to function normally, and therefore they need to have some kind of a bypass, they need to have either a colostomy, or ileostomy, or a cystostomy.

HALLER: So she worked with a couple of the GI pediatricians, pediatricians who specialized in gastrointestinal diseases, and came up with the original thought that if they could put a little catheter up one of those orifices with a balloon on it, it would be possible to blow up the balloon to a steady state, and then, by electronic connections to the balloon, be able to ask the child, (this requires a somewhat older child), to contract the muscle, and if they can, you would pick it up on the electronic recording device, pretty much like you would if you were doing a heart catheterization, you could see the pressure in the different chambers. This was her original idea. She worked with several of the medical device companies, and they were able to come up with such a balloon – it's called now balloon manometrics – which is used to study rectal function, and it can be used in adults as well as children. With this test she made several scientific studies. We had patients referred to us from all up and down the East Coast with rectal functional problems as a result. Now that technique has been modified some with newer technology, but the basic idea was hers. The original, somewhat crude balloon manometrics worked well, and convinced everybody that this was the way to go. And as a result, it became possible to measure some of those pressures and sphincter functions even before operating on a newborn if there was one little opening, if there was one hole (in the girls there should be three holes, in the boys there should be two) that catheter could go in, be inflated and then measure the normal kinds of sphincter reflexes, because many of them are automatic, they don't require a child trying to defecate or trying to empty his bladder, they're automatically stimulated just by the pressure. And she could show them, before operation, that these could be corrected if the muscle was there. And then she also knew where the muscle was in relationship to the balloon catheter, and where to look for it when you operated, because they're very tiny little muscle fibers, and very delicate, and need to be placed around the structure if it's going to act as a sphincter. This was a very important contribution.

EHRHART: What year was that?

HALLER: That was in the 1970s, I would say '75, '76. [sic]

EHRHART: And that was when she was first developing the procedure, in the 1970s?

HALLER: Yes, and by that time she was on our faculty. She was never on the paid faculty, because Johns Hopkins only paid a certain number of full-time people, and depended upon a lot of other practicing physicians to come in and give of their time as part of the heritage of medicine. And that Louise very generously did.

EHRHART: But then she did go on faculty then?

HALLER: Yes, well, she was on our faculty, but she was not on the paid faculty, so we call that the clinical or part-time faculty, rather than the full-time. I was called full-time, which meant that I was paid by the hospital and university.

EHRHART: All right, that's really important, and I actually hadn't come across that material before, so I really appreciate it.

HALLER: Good. I thought maybe you hadn't because a lot of people outside of the Baltimore area didn't know where that came from. They're using it at CHOP, and I'm sure she's never said that it was her idea.

EHRHART: I've come across infant hernias, also Hirschsprung's disease...

HALLER: In Hirschsprung's disease she was looking at the sphincter. In Hirschsprung's disease there's an absence of those contraction fibers in the lower end of the rectum. Using the balloon catheter is where she noticed the differences and was using that in that way.

EHRHART: Are there any other procedures that come to mind?

HALLER: I don't know if there were any others that she originated. She certainly brought her own experience to bear on certain other operations, infant hernias, for example, and I don't recall any other specific area. She was the type of surgeon who was always saying, "Can I do this better?" "What can we modify that would make this simpler?" and that is a very important approach in surgery.

EHRHART: Was there a particular – I don't know if infant hernias is a good example or not – was she able to modify it?

HALLER: Yes, she was, but I don't know whether she gets full credit. I think she may have learned some of this at CHOP, and then built on it, but she was certainly noted for her technical ability, and part of it had to do with infant hernias.

EHRHART: Well, if any other procedure, innovative procedure comes to mind, just let me know and we'll talk about it.

HALLER: I will. I should have done a little more homework and looked at her publications. I didn't do that.

EHRHART: It's okay.

HALLER: Most of her scientific publications until she went to CHOP were in the area of GI disease. After she went to CHOP she worked almost exclusively in the newborn intensive care unit as you've heard from the doctors up there. I don't think she invented or modified any special newborn problem, but she was much sought after by all of the residents in the management of those very sick babies. I think her biggest contribution from my standpoint, knowing what I know about CHOP, was her direction with surgical skills in the pediatric intensive care unit, and particularly in the NICU, the newborn intensive care unit, which is where she spent most of her time.

EHRHART: You said you wanted to mention clinical research later on.

HALLER: That was what I was talking about.

EHRHART: My next question is: Were there ways in which she conferred with her colleagues as she developed new procedures?

HALLER: Yes, she was very generous in showing all of us how this worked, and she presented it to all of us, then subsequently to all of her colleagues around the country because she published several papers and presented them at national meetings. She was not the kind of person who attempted to have a monopoly on something – that's the furthest thing from Louise's personality. She shared everything, and also asked for feedback from her colleagues, a very generous clinical experience. And she was honored for that as a confidant in the management of many of these difficult problems that would be sent to her, sometimes by a person who had operated in error, had problems, they felt very confident in sending their complications to Louise because they knew she'd handle them in an honorable way.

EHRHART: So as she developed the procedures, or as she worked to modify them or what have you, was there a setting in which maybe you and she would confer about what might work, what might not?

HALLER: Yes, these were working conferences, when she would present them. That's sort of the way clinical research is done. You have some idea, you discuss it with your colleagues, you make certain that the human research ethics board at your hospital agrees that this is something that can be done without harming the patient. As you know one of our ancient mottos is "First do no harm." And then she would carry out some of these studies in dogs. But it's not something as sensitive as rectal incontinence, you couldn't get very much feedback except automatic responses from the dog, you needed to be able to communicate and see what could or could not be done by the older child. And then she would bring back and show those tracings,

and then when we had better x-ray development – we got the CAT scan later, then we began to be able to see some of those nerves and muscles that she had been able to measure with her balloons, but we didn't know where they were. So clinical research is a work in progress, I guess is the way to put it, you modify it as you go along and get the feedback from your patients.

EHRHART: In our phone conversation, before we met, you mentioned that you had been interested in recruiting Dr. Schnaufer to work with you at Johns Hopkins at the same time she was recruited at Children's Hospital of Philadelphia. What qualities did you see in her that caused you to want her to become a permanent part of the staff and a permanent colleague as well?

HALLER: It's a great question, and I can tell you exactly the answer. What I saw in Louise was a compassionate teacher, and an excellent technical pediatric surgeon. I felt that our division needed to have someone like that who didn't spend all of their time in the dog or cat laboratory, but who did clinical research, and who would work well with residents and medical students in the clinic. Our training program, by that time we were involved in all kinds of intrauterine surgery, fetal surgery, things of great interest to me, and academically of interest, but we didn't have anyone who was willing to spend a lot of time with the interns, residents, and medical students. So I thought she would greatly enhance our faculty by bringing her experience and her qualities of compassionate patient care.

HALLER: I tried to get in touch with her. Nobody knows this story except you, but I'm going to give it to you, and then you can see how you think you can use it appropriately. I wanted to get in touch with her, it was early summer, and I'll have to get the exact time, but it must have been about 1988-89. She had indicated, as I told you, that she was really getting worn out being the general practitioner for all the pediatricians in Baltimore, and had to get out of that rat race. She had planned on a summer adventure with two of the lady physicians who were close friends of hers in Baltimore, to go to Africa, and go into the Congo. I tried to get in touch with her before she left, because I wanted to say, "I'd like to talk with you about the possibility of coming back to Hopkins." I was told by her secretary, "Oh too bad, she left yesterday to go on this adventure trip to Africa," something that she had always wanted to do, to go up one of the rivers, I've forgotten, up in the Congo basin. Louise told me this, so it has to be a fact, and I've had it verified by one of the other lady internists who went with her. She was about two days into the Congo, and they had a safari, and they were spending the night on the banks of a river, when one of the guides came in and said, "Dr. Schnaufer, there is a message coming through for you on our drums." [Makes drumming sound.] Louise said, "What does that mean?" "I don't know," he said. "But the message that we can pick up, is 'do nothing 'till you hear from me.'"

EHRHART: You? Dr. Haller?

HALLER: Yes. I'd sent the message through a telegram to the Congo company that I got from her office was responsible for the safari, and the only way they could get the message through was by drums. Louise said, "Well, I didn't know exactly what you meant, but I knew that you knew I was trying to make a decision and so I was thinking about that all on the trip whether I was going to go back to Philadelphia or not." She said, "On my way back, I decided that I needed to go back to get out of Baltimore, and I also wanted to go back to work with my hero,"

who is Dr. Koop and her surgical father figure. As soon as she got back, she called me and said, "I got your drum message, but I've already made up my mind, I'm going back to Philadelphia." That's a true story. It indicates how strongly I felt about trying to get her.

EHRHART: About the date, though, was that maybe the late 60s?

HALLER: Later than that.

EHRHART: Was it?

HALLER: When did she come back to CHOP?

EHRHART: I think she went back between '71 and '73.

HALLER: Well, it would have been just before she went back, the summer before she went back is when it was, so we can date it from that standpoint.

EHRHART: It's okay, I have her CV, I can verify the date. I just wanted to check.

HALLER: But that's how she got back. So I've given you the etiology of why she wanted to go back, and now why she decided that she shouldn't stay in Baltimore.

EHRHART: It certainly also yields information to work-life balance and that type of thing, and how women, demands are placed upon them, and I'm sure men as well, but in this particular case....

HALLER: Woman or not, she was the kind of person who would do everything she could to help the families. I think being a woman also gave her extra empathy and feeling for the sick child. You don't know this, but I'm married to a physician, and my daughter is a physician, so I'm very supportive of women in medicine, because I think they bring a very special quality that men don't have, or most men don't have.

EHRHART: And that is that empathy you were speaking of?

HALLER: Yes, and particularly in the area of pediatrics.

EHRHART: Why do you think...?

HALLER: I think because it has something to do with how a female relates to a child. Men are often more macho. And if it's a boy, then you know, we'll play baseball with them, but they're not as supportive of their emotional needs. That's perhaps too much of a generalization.

EHRHART: So it's almost like a biological...?

HALLER: Yes.

EHRHART: More research is showing now how men's and women's brains are different. Some people believe that argument that women are able to be more empathetic and some people don't, and that's fine.

HALLER: I think you can't generalize on something like that, because there are some women who are very cold and calculating, and really don't relate too well to others; they have a different agenda. And there are some men who are wonderfully kind and supportive of, not only their families, but also young people.

EHRHART: So it's perhaps more complicated than just biologic...?

HALLER: I think it's a lot more than just the y and x chromosome. It's how they were brought up, too.

EHRHART: You said that Dr. Schnaufer was able to develop an emotional connection with the children who were her patients. This is a perfect question to ask now. Can you describe that emotional connection and how she was able to develop it? We did touch on this earlier, but maybe you want to elaborate.

HALLER: To some extent she had an advantage over us men, because women are a little less threatening to children than men are, particularly I think in a clinical setting. For example, a child will often relate to a nurse better than they will to the male doctor. But aside from that, her calm demeanor, her ability to get the child's confidence by small talk -- about the doll that a little girl has, or the truck that a little boy has -- immediately erased a lot of the anxiety that child might have in that situation. Louise was also wonderful at talking with parents because she knew the stress they were under, and she could simply say to them, "I understand why you're so worried, let's see if we can't solve this together." She took time, which is one of the great concerns of many of us in medicine now, is that it's being so regimented, and so time-constricted by HMOs and quotas, that taking time like that to relate to a child is almost impossible, if you've got to turn out a certain number of patients every hour. So in any event, she would never have fit into an HMO-type of relationship, she would take just as much time as necessary to get the child's confidence, so by the time she got to "laying on of hands," as I call it, doing the physical examination, the child wasn't a bit worried about it – this is my friend. Then she had a particular way of examining patients, she never went to the area of question, or area of sensitivity, she would start out by saying, "Let's see how your ears are doing," when they had abdominal pain. By the time she got down to the abdomen she'd say, "Now is there something in here that's not right?" and then the child would say, "Here." And then she put the child's hand on hers, and together they put it on the abdomen. So the child knew he could push the hand away if he wanted to, but he didn't need to because he had the confidence. And I first learned that from her.

EHRHART: So that's a technique that you use?

HALLER: Yes. I use it now, all the time

EHRHART: And it works?

HALLER: It's great! Because if children realize they have some control -- the problem of being a child or any young person is that you don't want to give up your independence, you don't want to feel like you're totally at risk in this environment because this is a threatening environment. Why do you think a kid wants to hold onto his mom's hand while the examination is going on? He doesn't want to lose contact with his protector. This way, push my hand away if this hurts, or does this hurt here, does this hurt here, does it hurt here? And when she started in the abdomen, if it was in the right lower quadrant where the appendix is, she'd start in the left upper quadrant with the hand and just gradually work her way down, and then the child would say, "That's it, right there, doctor," she'd just turn and say, "He needs to have his appendix out." And she's a master at it because she's done it so many times.

EHRHART: So the "normal way" of actually approaching a problem like that or a pain complaint would be for the doctor to just go ahead and place their hand right there immediately?

HALLER: Yes, often. I think experienced adult physicians would know also not to go right away to the pain area, but it's critically important in children. They have to have confidence otherwise they can't do what you ask them to do, they simply can't, they're frightened. That's why pediatric surgery is so much fun.

EHRHART: Well, you did say that she spent a lot of her time with infants, infant patients. Can you elaborate on that?

HALLER: Yes. Of course, the real reason for having pediatric surgery separate from adult surgery, certainly one of the major reasons was to develop skills and techniques that were appropriate for very small children, particularly newborns. This is an area in which a lot of surgeons are not comfortable, because the structures are so small, the conditions are rather complicated, so often related to abnormal development in utero, and as you know, now we're making diagnoses in utero, which makes it a lot easier, knowing what the baby will have at birth. This fascinated Louise, and with her interest also in embryology, I think she just gravitated to this as a challenging area, requiring a great deal of skill, delicate surgery, as well as understanding of the various congenital abnormalities. And with her interest in being able to measure things, like using the balloon, etc., she naturally was also interested in all the techniques, of being able to measure the heartrate, even in prematures. She became so experienced in that area, that the pediatricians who commit themselves to that area, the neonatologists, felt very comfortable with her because they could discuss on a one-to-one basis. When a general surgeon, maybe equally competent, but without that experience would come down from the operating room where he'd been doing a heart operation and seeing an adult, and say, "Where is that little baby that you want me to see that's got something...," the pediatric intensivists and the neonatologists were put off by that. They are always critical of that sort of a macho surgery image, and Louise is just the antithesis of that, and so she was a natural in that area, and so I think because of her interest and her comfort level, and the cooperation of all of her colleagues in neonatology.... I didn't see the whole list of people you're talking to, but you really ought to talk with somebody who's not a surgeon....

EHRHART: Such as...?

HALLER: Such as one of the neonatologists there at CHOP. I really think that would give you a better answer than I gave you about her role, particularly since this is her final role in her professional career has been largely in that intensive care unit as I understand it. I think that's true, and so you ought to really check on that and see.

EHRHART: Well, I have two more questions. Actually, I wanted to hop back to the infant care. You had said in your phone conversation with me before we met today, well the phone conversation was actually a few weeks ago, but before we met you had mentioned that you thought it was unfortunate that these infants couldn't benefit from her care because she was able to develop such a great relationship....

HALLER: Oh, you mean in terms of emotional attachment.

EHRHART: Emotional attachment, empathy, that type of thing. How would you say that the infants were able to benefit?

HALLER: Because of her technical skills and her experience. And to some extent, the fact that she could be so compassionate in talking with the mother or the parents. That has an impact on the child, because they pick up, particularly a little older infant, will pick up right away from their parents whether this is a good situation or not. And as a result, almost by transference of her empathy, the parents also benefited.

EHRHART: Okay, I have two more questions, and the first one is: What do you see as Dr. Schnaufer's contribution or contributions to pediatric surgery?

HALLER: That was a question that I had trouble with because she has not been a joiner, she has not been a faculty person who enjoys being at international meetings and going to a lot of different scientific organizations. She's a shy person, and I think while everyone admired her and always welcomed her, she did not feel comfortable in that kind of environment, and as a result, many of her contributions were known more locally than they were internationally, except the things that she published, and that's why her work on the rectal incontinence, and to some extent some of her publications on intensive care in newborns is well-known, and I think that's where the impact is. She has been a participant in a lot of clinical studies at CHOP, but she's not been the lead author, and I think that fits her role nicely. She is very comfortable being a member of a team; she doesn't have to be "top dog."

EHRHART: And my final question is about, if you'd like to comment on your personal relationship with Dr. Schnaufer, how would you describe it, how would you say it began, evolved -- if you would like to, it's not necessary.

HALLER: I think I've probably indicated that in the course of our discussion, but I certainly started out as a colleague at the same level in training, then as she worked more and more with me, and I with her at Hopkins, I developed an increasing awareness of her excellence in patient care and admired it. We were good friends, but we were not social friends. She had a different social relationship to people that she had grown up with in Baltimore. She and my wife are very close friends, but they're in different medical specialties so they didn't meet at any of the

medical activities. And I would say up until she went back to CHOP, she was just a very dependable colleague that I thought a great deal of. Since then, I've been only able to see her rarely, and that friendship has continued and I still admire her greatly!

EHRHART: Is there anything else that we didn't touch on that you want to mention? We can talk again, or you can add something, we can add an addendum to the transcript if you would like to add a particular...

HALLER: No, I think your questions were very good, and your medical consultant did a good job. I think we've covered all the things that I know about.

EHRHART: Let me just close up here and just restate that this has been an interview with Dr. J. Alex Haller [Jr.] and this is for the project for the Louise Schnaufer Oral History Project conducted for the College of Physicians of Philadelphia and funded by the Foundation for the History of Women in Medicine.

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