FILE: PETRILLO1

EHRHART: Today is March 21, 2007, and this interview is being conducted with Debra Petrillo, and it's part of the Louise Schnaufer Oral History Project, which is conducted for the College of Physicians of Philadelphia and funded by the Foundation for the History of Women in Medicine.

EHRHART: To start out, can you please spell your name and provide your job title?

PETRILLO: Yes, it's Debra, D-E-B-R-A, Petrillo, P-E-T-R-I-L-L-O. I'm an R.N. and I'm the schedule coordinator in the operating room at Children's Hospital [of Philadelphia].

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

PETRILLO: I went to Chester County Hospital Nursing School in West Chester, and also West Chester University, and I graduated in 1974.

EHRHART: Have you spent your entire career at Children's Hospital?

PETRILLO: Yes, I've been here since September of 1974.

EHRHART: Can you please describe how you've been acquainted with Dr. Schnaufer and for how long?

PETRILLO: I met Dr. Schnaufer my first week of work in September of 1974. I started here on September 7 and I met her on my first week when I was on orientation as graduate nurse in operating room. I still keep in contact with her, so I've known her for almost 33 and a half years, I guess, and I still keep in contact with her now.

EHRHART: I know you worked extensively with her, and I know you also worked for other surgeons as well. Can you give me a percentage of about how much time you would spend with her as opposed to other surgeons?

PETRILLO: In my early years here at Children's we really worked with everybody. So I would say, when I was doing general surgery I was with Dr. Schnaufer 25 to 50 percent of the time that I was in general surgery. Then in my later years I took on administrative positions, so I worked with her, I didn't scrub with her, but I worked with her on more of an administrative level – coordinating her patients and things like that.

EHRHART: So you said at the beginning of that time period you worked in the operating room with her. Can you please describe your role and responsibilities in the operating room when you first began working with her?

PETRILLO: Nurses in the operating room, there are two roles that you can have, you can scrub or you can circulate. The scrub nurse hands all the instruments and works side-by-side with the surgeon handing instruments, and getting their sutures ready and things like that. The circulating nurse is in charge of the whole room, so they do all the anticipation for the team, as well as taking care of the anesthesiologist and getting them anything that they need. As a scrub nurse you work extremely closely because the doctors rely on you to know what the equipment is and to hand them what they need. They're really not looking when they're asking you for something, you just pass it into their hand, then they look, but they don't want to have to look away from the table, so that's a very important role there. Then as I've said, the circulating nurse is really in charge of the whole room, basically getting whatever the team needs, taking care of the patient, checking lab values, assisting anesthesia, things like that.

EHRHART: Can you tell me how many nurses would be in those two different roles?

PETRILLO: A typical day is usually one scrub and one circulator, but if we're in a teaching process.... When I first started here and would work with Dr. Schnaufer initially, since I was a graduate nurse and I was learning there was always a third nurse in the room. So if I was scrubbing, someone was scrubbing with me to help teach me along with Dr. Schnaufer, and then once I was more proficient, then I was on my own, and the same thing with circulating. If you were circulating and you were brand new there was someone circulating with you, but on a normal basis there was one scrub and one circulator in the room, depending on the type of the procedure.

EHRHART: Now prior to the surgery, what type of communication or conferencing would you have ahead of time?

PETRILLO: Usually the surgeon will, depending if it's their room for the day, if they're going to be in there all day, it starts with the first case in the morning they'll come in and they'll explain what they're going to be doing. If I have any questions or if the team has any questions we have a communication back and forth – what type of suture they want to use, if there's any special equipment, if the doctor's not here right away in the OR then we can page them and talk to them over the phone. We like to have a conversation before we bring the child in the room. That way, we have whatever they need. When they come into the room again, they'll go over everything, they'll look at our setup and just make sure that everything's there that they need. If they need other things that's when the circulator can usually go and get what they need.

EHRHART: Now those conversations that occur before they come in the room, are those formal, scheduled?

PETRILLO: Not really, they're just more informal, and it depends on your knowledge of the procedures and how closely you've worked with somebody. In my later years, when I knew Dr. Schnaufer, what she would be doing, I wouldn't even have to really have a conversation with her, I would just call her and tell her we're bringing the patient in the room. She would just come right over, talk to the family, and then we'd go right into the room. It just depends on what the procedure was and the comfort level of the team and the history of the patient.

EHRHART: Have your responsibilities in the operating room changed over time, and if so, how?

PETRILLO: I started out as a graduate nurse, and then took my boards and became an R.N. About two and a half years into working here, I became assistant head nurse in the operating room, so I really moved from a scrub and circulating position to basically running the OR -- coordinating patients and physicians and families and anesthesia. Then I did that for a few years, and then I was head nurse of our day surgery unit and PACU. I coordinated the patients that were coming to the OR. The patients in the PACU – that's the post anesthesia care unit, that's where all the kids go post-op, after their surgery, they go to either the PACU, the recovery room is another term for it, or they'll go to the ICU. Most of our kids really go to the PACU.

EHRHART: And that would just be abbreviated P-A-C-U?

PETRILLO: Yes, post-anesthesia care unit. The old term is "recovery room."

EHRHART: What about the responsibilities of a nurse, either a scrub nurse or a circulator nurse – have those responsibilities changed over time?

PETRILLO: For us they have, because when I first started here and started working with Dr. Schnaufer, we didn't really have what you call a scrub tech -- they're technicians that can also scrub. We didn't have any scrub techs here, we were one of the only all-RN ORs in the city. Then with budgets and nursing and trying to get nurses, we were unable to get all the nurses that we needed, and state law says you have to have a nurse circulating, that's a state law, but a scrub tech can scrub or a nurse, so it can be a tech or nurse scrubbing, but you have to have an RN circulating. We started just growing and building more rooms and opening surgery centers, so we started hiring scrub technicians. I would say we're probably 60 percent RNs and 40 percent technicians now, and now with the nursing shortage, there's a big nursing shortage throughout the United States.

EHRHART: What about the responsibilities as far as dealing with different equipment? Did the technological developments change your responsibilities in the operating room?

PETRILLO: Technology's really evolved over the years. When I first started with Dr. Schnaufer, we had some technology, but now things – hernias that Dr. Schnaufer would do as we'd call an "open" procedure, where you would make an incision and repair the hernia with your hands, now we do them laparoscopically. We do them through very small incisions and do them with cameras, and the hands really aren't even entering the body cavity, so things have changed a lot technologically. But what we do here is, as our technology grows we have in-services and sales reps that come in and explain everything before we start using it, and we go to courses and classes and things like that for the technology.

EHRHART: Let's go back to the hernias that you were talking about, the hernias. You said that the procedure has changed, along with the technology, so does that mean that your responsibility in the OR with that particular operation has also changed?

PETRILLO: Not really. It's still really the same basic principles, so whether you're scrubs or circulators it's still the same basic principles. A lot of it has gotten easier over the years with technology. When we were first doing hernias with Dr. Schnaufer when I first started here, we would use cotton thread, sewing thread. We had these cotton boards that are...processing people who sterilized all of our equipment, they would have to cut sewing thread and put it on a board, different sizes, and we would have to take that thread and thread it through a needle, and that's what the physicians would sew with, because the sutures back then were just not as refined as they are now. Now it's already compact, it's on a needle, it's very easy. But back then it was a little more difficult, so the technology in some instances has made things easier. In other instances, it's become very advanced, and a lot to remember, and a lot, like you were saying about your microphone and everything – plug this here and this here and if you miss one thing you have to start all over again. Technology has been, believe me, for the better, but some days... Dr. Schnaufer was here one day and we were doing a procedure, and we were doing it laparoscopically, and she used to do it open, and I said, "C'mon, I want to show you something," so I took her into the room. She said, "Oh my goodness, look at this," because she was used to doing it a totally different way. Now with the technology we can do it with – "minimally invasive" is what it's called. You just make a little incision, so it's much safer, it's a better recovery for the patients, it's not as much pain.

EHRHART: That's true, however, like you said there are more "If you don't connect this type of equipment correctly," so would you say that the stress level is greater?

PETRILLO: I think at times it can be, and the way that we try to minimize that is by having in-services for new products. The physicians, as I said, they take classes so that they know how to use new products, and we have sales reps that come in and go over everything with us. So it's stressful in the beginning, but once you know, once you're familiar with what you're doing... We do have people that are experts in everything up here, so there's always somebody around that if someone is confused or is a little nervous or unsure, we would do that, we would take care of things like that before the procedure would start. People would say, " You know, I'm not really comfortable with this," so we would try to get an extra person in there to help them or go over everything, or physician, same thing. Physician to nurse: "I'm not really comfortable." "Oh, here, let me show you what we're going to be doing." They would do that when the patient was going to sleep, "We'll go over all this equipment together," and that's really very beneficial.

EHRHART: You had already mentioned the two nurses who would be in the OR with you, and then you also mentioned an anesthesiologist, so were there any other people?

PETRILLO: We're a big teaching facility here, so over the years, again, for anesthesia, it used to be residents, you have a staff anesthesiologist, just like you have a surgeon in the room. So you have the staff anesthesiologist, you have a staff surgeon, and then, depending on what the procedure is, the complexity of the procedure, we have anesthesia residents, who are learning how to become anesthesiologists, we have surgical residents who are learning how to become surgeons, and then we also have fellows for both areas. In general surgery, Dr. Schnaufer was a general surgeon, we have a fellowship. It's a two-year fellowship, and we have the fellows here for two years, they're a junior fellow their first year, and then they become the chief fellow their second year, and then a new junior fellow comes in. It's the same in anesthesia. The

fellowships, they're usually a minimum of a year, and if they decide to go on to specialize, even more than just pediatrics, then they might do more of a fellowship. But in a room at any given time, at times could be three anesthesia providers, two to three nursing staff, and three surgeons because of our teaching.

EHRHART: If it wasn't a teaching facility?

PETRILLO: If it wasn't a teaching facility – at our surg centers, they don't really teach at the surgery centers, they're not licensed as a teaching facility. They just have the surgeon, an anesthesiologist, a scrub nurse, and at the surg centers we only have nurses -- a scrub nurse and a circulating nurse, there's only four people, but the procedures are very minor procedures that they do at the surg centers. Some of the physicians do bring a first assistant, some of them don't, it depends on the complexity of the procedure. You can go anywhere from the minimum, which is four, to 12, 15 people on a procedure.

EHRHART: You mentioned something called "surg" centers?

PETRILLO: Yes, there are free-standing surgery centers where children can go and have their surgeries done. They have to meet specific criteria to go to a surgery center. They can only be certain procedures for general surgery -- they can do hernias or little skin tags, but they have to be healthy children, be able to go home that day -- they have to meet specific criteria to be done at a surgery center.

EHRHART: How would you spell that, please?

PETRILLO: It's surgery center, so S-U-R-G-E-R-Y. We have three of them that are ours, that we own – we have one in Bucks County, one in Exton, and one in Voorhees. We really built them because we're so big here. A lot of the procedures we do here are the sicker kids. It was easier for families to be closer to home, nicer facilities, they're just in and out, they don't have to drive, as you well know the construction and all of that stuff.

EHRHART: Can you describe the interaction that either you as a scrub nurse or a circulator nurse would have with, you had already described about the surgeon, really, but what about the anesthesiologist?

PETRILLO: It's the same that you would have with a surgeon. Since we are a teaching institution, they do have a resident or a CRNA, certified registered nurse anesthetist, with them, but if they need anything we can get that for them. We also reposition the patients with anesthesia, we help them start IVs, things like that, so if the children need more extensive lines, then that's done by the physicians, but we as nurses, if they don't have anyone helping them, or if they're busy we can help, we're all IV-certified, so we can start IVs for them. If they need any type of lab work done or blood or things like that, we can get the appropriate people to come and bring us the blood and things like that.

EHRHART: My next question is: How have the cases changed over time?

PETRILLO: We're still doing the same types of cases that we did with Dr. Schnaufer, but now we've become a fetal center, so we do fetal surgery here, so that's very different. And the minimally invasive procedures, we now do robotic surgery as well as laparoscopic surgery, I mean the technology has really advanced us. Some of the procedures, as I've said before, some of the procedures that we would do years ago as what we would call an "open" procedure, where you would actually cut the skin and really make a big incision, now we can do them through just little incisions, what we would call "port" incisions, and we just put ports through and cameras and operate that way. I think the biggest technological advance is what we call "minimally invasive" surgery, and that would be all the laparoscopy that we do and the robotics.

EHRHART: So it's not so much the cases as far as the illnesses that you treat?

PETRILLO: Correct.

EHRHART: It's more the way in which the cases are handled?

PETRILLO: Correct.

EHRHART: Can you describe how operating room dynamics are created and/or fostered by surgeons?

PETRILLO: The surgeon is always really called the "captain of the ship," he or she. It can depend if they're in a good mood, the whole room's fine, if they're not in that great of a mood, you know it can be a little difficult. But here in pediatrics, our surgeons have a little different temperament than in the adult world, which we thank God every day for. I mean we're very lucky. And we do have a camaraderie. If something isn't quite the way they want it to be or whatever, we can fix it, or if there's an issue we can talk to them and things like that. So it's changed over the years because I think that we've grown so big. When I first started here we had six ORs. We now have 16 ORs, with eight more opening in June, and three surgery centers. So I mean it's really grown over the years. We have a lot of different personalities, so it can be very challenging at times. The nursing staff, the surgeon's the "captain of the ship," but the nurses are in there, it's their room all day, they might only be here for an hour or two hours. We consider them visitors in our house, basically, but it's anesthesia and nursing's "house," and the surgeons are visitors because we're here 24/7, they only are here the day that they're operating, or the couple of days that they're operating. We've got a lot of good support from the anesthesia department also with handling situations. We really do try to promote and foster a team effort. We consider ourselves a team; everybody involved in the room, we're one big team. I think that for the most part everybody works very well together.

EHRHART: How do the dynamics vary among surgeons?

PETRILLO: I think it depends on the specialty that you're working in, and I think it depends on the severity of the case. Some cases that are very tense and very complex, the surgeons, of course are at times more tense and they can be nervous if they have new people in their room. Plus, we don't want to set any new people up, as far as we don't want to set them up for failure, so to speak. We have a really good preceptor program here where we buddy nursing staff up and

they work together for each specialty, so the whole time that they're in a specialty, they're working usually with one specific person nurse-wise, maybe not surgeon-wise, but nurse-wise. I think that helps too, because when the surgeon looks around, since we are a big teaching establishment, a lot of times they don't know who's in the room. A lot of times they'll look up and they won't recognize the anesthesia resident or whatever, so the nursing staff, they look and they see and it's like, "Oh, ok. Mary's here, Debbie's here," or whatever, and it makes them feel better.

EHRHART: Can you describe what the operating room dynamic was like with Dr. Schnaufer?

PETRILLO: Since you haven't really physically met Dr. Schnaufer, I don't know if anybody told you, she was very tiny, I think she's like 4'11" or something like that. Now we wear scrub pants, but when we started here we all wore dresses. All the females wore dresses. They didn't provide pants and tops for us, we all wore dresses and stockings and things like that. Dr. Schnaufer was so tiny that we would have to hem her dresses. Every day we would tape them up for her because she would trip over them, they were too long for her. Nobody owned their own stuff because it all had to go through the hospital laundry to be cleaned appropriately. So that would start off our day, her coming in, and some days she would come in and we would just start laughing because if nobody was in the locker room to help her tie it, she would just hike it up and tie it and walk into the room and we would just all start laughing because she would look so funny, because she's just this tiny little lady.

PETRILLO: She was just so personable, and really, really loved to teach, I mean just loved to teach, and even back then when we had new people – I was new. When I started here, we had just moved from the old building on Bainbridge over to here in 1974, so they went from only four rooms over there to all of a sudden having eight rooms, six rooms, eight rooms, so it was a big adjustment for everybody. There were a lot of new faces back then, too, for them, just as what we're going through now. But Dr. Schnaufer was always very personable, would come into the room, introduce herself to people and just make sure that everybody knew who everybody was. She just really wanted things to go smoothly. And she was always very supportive of, especially the residents, she was very, very supportive of them. She was very supportive of the nursing staff, too, but her real job wasn't really to worry about the nurses, her real job was to teach the residents and the fellows. She was very, very supportive of them, and was very patient with the residents and would really take the time to teach and to really let them learn and do with her so that they really would know when they left here, they would know what they were doing, or at least have an idea. We're a little different than maybe some other institutions also, because residents can never operate by themselves here. We don't even take a patient in the room until the surgeon's physically in the building. We won't, even if they: "I'm on my way," "Well, call me when you're in the building." But she was really very, very supportive of the residents in teaching and answering questions and things like that.

EHRHART: But what about her interactions with you?

PETRILLO: With the nursing staff she was fabulous. She was even teaching the nurses, and I can remember she was the first doctor that I scrubbed with when I graduated, when I became an R.N. So I got my license the day before and I came into work, "I'm a real nurse!" When we

started she said, "Okay, we have to take a moment and congratulate Deb, she's now an official nurse." She just was so happy for anything, any accomplishments, anything that we did. If there was something socially going on, she wanted to be part of it, she always was up for doing things with us. In-services, we would ask if she'd come and teach, and she'd be happy to. We have a very special bond, because I mean I've known her for 33 years, and I still see her and get together with her. She only lives about five minutes from me. I can honestly say that she's just extremely supportive. Even now, those nurses that you'll meet, Marie and Joy, they still go to the theatre together – they'll go to plays and musicals -- so there's still that whole bond with her. A lot of times, too, at the time Dr. Koop and Dr. O'Neill, who were our chiefs – Dr. Koop was our first chief, Dr. O'Neill our second chief -- if they were out of town, she would be acting chief. Someone has to act as chief, so she would be acting chief. There were many times that I would have to call her with questions and issues and about emergencies and cases, and maybe a surgeon issue where I needed her input on how to handle something, or tell her that this is how I was handling something just so she was aware of it, or if we had a family issue, because of being acting chief of surgery, she had to be aware of different things that were going on in the hospital, too, and she was always very, very supportive of the staff.

EHRHART: Would you say that the dynamic with Dr. Schnaufer was different from other surgeons?

PETRILLO: I think so. I think, too, because she was a female, and because she understood where we were coming from. She understood everybody's moods and things like that because she had gone through that over the years at her age. I think she sometimes could be more compassionate to patients and residents and nurses, but I really do, I think because she was female and also because she never married, so she was very, very close to her family and her cousins and everything, but we were her family. She was very close, and she was close with everybody, but became closer with a few of us over the years. As more people started and we got bigger and bigger, she was just like, "Oh my goodness, look at all these people." She would come up and say, "I don't even recognize anybody," some days, because people would be off or here and there or whatever. But I think that there was a difference because of her, and I really think because she was a female. She just understood us; she understood how women worked.

EHRHART: So you're speaking about specifically the nurses. Do you feel you're also speaking for the anesthesiologists?

PETRILLO: I think so, too. At the time we had one female anesthesiologist when Dr. Schnaufer was here, Pina Templeton. And Jack Templeton, her husband, was a surgeon with us, and Pina was an anesthesiologist. Now we have just such a mix of male and female, but back then we just had the two of them, so it was much different. It was a little different.

EHRHART: Are there any specific cases that you worked on with Dr. Schnaufer that you could describe in detail to illustrate the operating room dynamic? You said when you got your license, for example.

PETRILLO: That was just a minor procedure, but I scrubbed with Dr. Schnaufer on some of our conjoined twins' separations, and when you talk about different people, the dynamics for a

situation like that... We had meetings, we had meeting, upon meeting, upon meeting with the whole team weeks before, going over with all the different services that were involved. General surgery was always involved, and it was usually Dr. Koop and Dr. Schnaufer and Dr. Templeton. But they always invited the nurses to these meetings, it wasn't just, "We'll just tell the nurses what we're going to be doing." We were invited to be part of this and to make decisions with them, and how can we make things better, how can we transition different things, and how are we going to switch off our staff, because some of these cases could last – we didn't know – they could last 24 hours – how are you going to switch off staff and make sure people are rested and things like that. As much care as was taken with those types of procedures, she also took great care with even her minor procedures -- always talked to her families, always talked to the patients before she did the surgery. There were procedures here that were firsts; we did a number of first-time procedures here. Dr. Schnaufer would be involved in them. Off the top of my head I can't even think of some of them, but she would be involved and always make sure she would say, "You guys helped us, this is a first at Children's Hospital and you were involved," which really made everybody feel really good, because it was a team effort, it wasn't just, "Oh, the surgeon, this great god." A lot of surgeons are put up on pedestals, you hear a lot about surgeons, but you never hear about the team effort that went into it. She was always very aware of the team effort that went into things.

EHRHART: You said that she would talk to the patients before the surgery. Is that as they were falling asleep, or...?

PETRILLO: What happens is when a patient's coming to surgery, either through our day surgery center where they come in in the morning for their surgery that day, or as an in-patient, where they come in the day before and have surgery, she would meet them in what we call our "holding area." It's an area that we bring all the kids to and that's where the nursing staff meets the patients, and the anesthesiologists meet the patients. That's where the surgeons can also talk to the families and answer any last-minute questions, just go over things if the families have any issues or if the child has any questions. She was always very involved with that. Kids would bring their dolls or their stuffed animals, so when the child was going to sleep, if they needed something she would sew them up and put a little Band-Aid on them. Or if it was an arm, she would wrap web roll or a little cast on them, and would always say, "While I'm operating on your belly, does your doggy need his belly operated on?" "Oh, no, they're just coming to keep me company." Or if they needed something, if they were splitting at the seams she would take care of that and sew it up for us, while we were waiting, which was really nice. Back then, too, it was the beginning of what we call our parent-service coordinators, and she was extremely friendly with the woman, she was a very good friend of ours, the woman that started our parent service here. And what that is -- they periodically make rounds and get information for the families while their children are having surgery. I know that Dr. Schnaufer was very instrumental, she was very proactive in having this as a position so that the families could receive information and stay informed, especially during the big procedures, because the nurses can't leave the room to go and run and tell the family how things are going, so she was very instrumental in helping with the establishment of our parent-service coordinators.

EHRHART: Was it unusual for a surgeon to go in and talk to a child in the holding room?

PETRILLO: Not really. A lot of our surgeons do it, but she always did it. Some of the surgeons, they would say, "Oh, I saw them in the office, they don't need to see me." Now it's a law that they go and talk to them because we have to check the consents and things like that. So all of our surgeons and all of our anesthesiologists talk to the families, but even before this all happened she routinely did that. She always wanted to have that last-minute time with the family, and make sure that all their questions were answered. If there was something unusual during the surgery, then she would say, "Have our parent-service coordinator go get the family," and she would go out and talk to them and explain things and then come back into the surgery. If it was something that she felt that they needed to know before she continued, she would say, "Can you get this family for me and bring them over?" and she would go out and talk to them, and then come right back in and resume the surgery. So she was very, very family-centered.

EHRHART: Are there any other examples of her being family-centered that you can think of at this moment?

PETRILLO: She always made rounds with the residents, and when they made rounds, the families could always stay here in the hospital. It's become more family-centered, but families were always welcomed to stay in the hospital. She would always make rounds on her patients and talk to the families, post-op and things like that, which I know a lot of the docs do anyway. She would always come back and give us updates on specific kids, depending on if it was an extensive surgery, or cancer, how the child's doing, things like that, and treatments and everything. She always even kept the team informed. She'd say, "I'm bringing a patient back for surgery. You operated on her with me. C'mon, why don't you do the case with me, you can see how she's doing," which was different than some surgeons. She would keep us informed, too, about what was happening with the kids.

EHRHART: Did you find that to be helpful?

PETRILLO: Yes. It's always nice because we're in our own little vacuum here, so we really don't get to see the kids afterwards. We see them before, because we take them into the room, we operate on them, but we really don't get a chance to see them afterwards. So sometimes she would let us know if a particular patient was coming back for a visit, if we could get over to see them, or if something was happening on the floor with a patient -- "Oh, if you can get out today, so and so, she's back, she's having chemo, come see her." -- which was really nice, because it's nice to see the kids post-op and to see how they're doing, and how well they're doing. In fact, I think we have a couple nurses here that work in the hospital that Dr. Schnaufer operated on as children, as babies. And now they're here working as nurses, which is really fantastic.

EHRHART: We talked about this a little bit earlier, but this adds a little bit of a different dimension to it. Do you believe that the use of different types of tools and technologies and procedures changed the dynamics in the operating room, and if so, how?

PETRILLO: I think some of the technology, until you learn the technology and are comfortable with the technology, sometimes can make it seem more impersonal, because you're so focused on the equipment issues. By impersonal I'm not talking about patient-nurses, or patient-doctor, but team. You're so focused on the technology and you're not as comfortable with the

technology, but then when you become more comfortable with the technology I think the whole atmosphere in the room changes, it's not quite as tense. I don't know if "tense" is quite the right word, but once everybody's comfortable with the technology and we've done procedures, a couple of them, and they see results and post-op and things like that, then I think things, not that you become more lax, you're just more comfortable with what you're doing. I think technology, too, can be scary because, especially this minimally invasive surgery that we do now, when it's laparoscopic or robotics, the doctors have their hands on the tools, but they don't have their hands on the patient. Whereas before, where you would open, when you would actually cut in and open, you would feel them with your fingers, you're not feeling with a piece of equipment, and I think that makes it a little difficult and sometimes a little more tense, because the surgeons can't actually feel. What they're doing is they're watching it on monitors in the room, TV monitors, so they're watching as they're cutting and sewing and snipping and tucking, and all that kind of stuff, whereas before they were actually hands-on doing it. So I think that has changed because of the technology, but the positive of that is that the patients have less pain, they have a quicker recovery because it's called "minimally invasive." They just make little incisions and put the tool through the incision, so they're not manipulating as much as they are when they were doing it with their hands. So it has its pros and its cons.

EHRHART: And that minimally invasive – having a connection with the child -- how about the communication or dynamic with the team then, if the surgeons are watching these screens all the time, how does that change his or her interaction with [inaudible]?

PETRILLO: They still have to rely on their scrub nurse, or scrub tech -- I'll just say "scrub." They still have to rely on their scrub because they have to pass them everything that they need. It's not one tool that they use for the whole procedure, it's still several different tools. They're still teaching the residents, so there's still that interaction back and forth with the team, but it's just a little different dynamics because there's so much more equipment involved, so to speak, as opposed to just tools, forceps and a knife. Now you have big graspers and things like that, so it's a little different. But I think once the surgeon's comfortable.... Now Dr. Schnaufer really never did any of that, because that's all fairly new procedures. I would say more robotics, we just started doing robotics here, I want to say about a year and a half ago. Laparoscopy, we started I think about five years ago, but have really increased the different procedures that we're doing laparoscopically. It started out with small things like hernias and laparotomies but have since increased. Dr. Schnaufer really never utilized that type of technology, what she did utilize were different kinds of bowel staplers. Again, it was hands-on, but it was a piece of equipment that you put together on the field, put staples in it, you had staple cartridges, and put it together and then you would put the bowel in between and you would pull the trigger, and it would cut and staple and so there's a lot of trust there, too, with equipment when you're doing things like that. You have to really trust the equipment that you're working with.

FILE: PETRILLO TAPE SIDE 2

EHRHART: My next question has to do with working relationships with a surgeon. My question is: How does a working relationship with a surgeon change over time as you work with that person?

PETRILLO: I think that they become more trusting, because there were procedures that Dr. Schnaufer wouldn't ask for one instrument, because if you worked with her enough, you knew her routine. Unless she was deviating from her routine for certain procedures, she would just hold her hand out, and as I would hand her an instrument, I would tell her what it was, but I always knew what her routine was, so she wouldn't ask for anything, we would just do a whole procedure. She would be talking to the resident, so that trust is there that she knew that I knew what I was doing, so she could teach the resident. She didn't have to worry about teaching the resident and teaching me at the same time. As you work with a physician for a period of time, you develop this bond and this trust.

EHRHART: Are there any drawbacks, though?

PETRILLO: I don't think so, they just get upset if you can't work with them. Sometimes they get spoiled and think you're their private person.

EHRHART: So it's more scheduling?

PETRILLO: Yes. They'll miss you if you have a day off.

EHRHART: 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. How did Dr. Schnaufer respond when an unexpected event would occur?

PETRILLO: She was so composed, she was so cool, calm, and collected. I mean she never yelled, she never raised her voice. She would just step back from it, take a deep breath, say, "Okay, now let's regroup, let's start over, we're okay here." If the patient started bleeding, when they got the bleeding under control she would just say, "Okay, is everybody all right?" because she would know that if she was tense, so was the whole room because of what was happening to the patient. She would always do a little regroup, or once the procedure was over, she would just make sure everybody was okay, or once the child went to the ICU, she would come back down and us a little report on the patient. I can honestly she never raised her voice or yelled or threw any instruments, you know these horror stories that you hear sometimes about physicians. We've always been very lucky, especially in the early years when I was working here. Dr. Koop, who was our chief surgeon, and Dr. O'Neill who then replaced him, they wouldn't allow that kind of behavior in the OR. They would say there's no reason for people to act like that, we're all here for the same purpose, we're all here to take care of the patient, so there's no reason to....

PETRILLO: But if there was a situation, an emergency situation, you're always prepared, but if it happens, just as it's going on she was always cool, calm, and collected, and just asked for whatever she needed, you'd have it ready. Sometimes if you needed it you would ask for somebody else to scrub with you to help if the patient was really bleeding, or you'd get another resident in as another pair of hands to help out. But she was always very fair and she always treated everybody with respect.

EHRHART: I'm going to hop back to that in a few minutes. Regarding the unexpected events in particular, you sort of described this already, but maybe there's something you want to add. How did she help others on the surgical team deal with the unexpected events?

PETRILLO: Before the case would start, she would be able sometimes to predict if it was going to be what we call a "hairy procedure." So she would always say, "Make sure you have" sutures, special sutures that you would need, or what we call ties to tie off any bleeders, and extra this or extra that on the table. She would always communicate that beforehand, so that when it was happening, it wasn't what we call a "flail" -- everyone flailing around looking for things. Those things did happen, those instances would happen, where all of a sudden if you were removing a tumor it would start bleeding, and the child would really just start bleeding and you'd need extra help.

FILE: PETRILLO2

PETRILLO: Once she had things under control she would say to anesthesia, "Can I proceed? Are you guys caught up? Do you need more fluids? Can I keep going?" give them a chance to catch their breath and make sure that everything was okay with the patient, and then she would proceed with what she was doing. So she was always very mindful of the anesthesia team being as important in that surgery as she was.

EHRHART: What is a "flail"?

PETRILLO: If something starts going wrong, if you look in a room everybody is running around. It's always controlled, but it's unexpected. Sometimes you can anticipate that you might have some problems after op, so you're ready for it. But then other times you can't predict it, so when something happens we just call it everybody's flailing, everybody's just running around. It's always a controlled situation, but you may need more hands, you may need extra help, anesthesia might need extra help.

EHRHART: Would you describe it as an unexpected event that even though you've prepared for things in advance, that maybe for that particular instance it wasn't prepared ahead of time, or it's like a last-minute scurry?

PETRILLO: Well, you can never predict, you never know sometimes when you start a procedure what you're going to find. Some of these kids come in for masses, it's a mass. Again, our technology, the MRIs and things like that have gotten so advanced, but back then we didn't have a lot of that technology, so we would have maybe x-rays, CAT scan was really just starting, so we didn't even really have a lot of in-depth CAT scan. You would open a patient and there'd be this big tumor, or mass, and you weren't sure where it was connected, what vessels, what it was behind, what it was attached to. Sometimes that was the unexpected, when you would open and say, "Wow, this is worse than we thought, this is bigger than we anticipated," or "This is more involved than we thought." At that point we would even stop and say, "Okay, we're going to need this, this, this and this." She would say, "We're going to need this, this, this, this and this." Anesthesia, this, this, this. Sometimes you couldn't even predict that and say you would move the tumor and all of a sudden a vessel would burst because it was so fragile because the

tumor was connected to it. So when that happens it's like, "Oh my God." So everybody just kind of jumps in and just starts doing what we know how to do.

EHRHART: Are there any specific cases that you worked on with Dr. Schnaufer that you could describe in detail to illustrate how she dealt with unexpected events?

PETRILLO: Conjoined twins. We had studies, but not all the studies that we have now back then. I scrubbed with her on three sets of conjoined twins that we separated. So you never really knew exactly what you were going to find. I mean we did have studies done, but you weren't exactly sure what you were going to find. She was always very patient and would involve the whole team. If she was doing a procedure and she wasn't sure, then she would call her peers and say, "Call Dr. Koop, ask him to come down and look at this with me," because she trained with Dr. Koop at one point, so they were very close as far as teacher/student type of thing, and then peers, as surgeons, they did a lot of procedures together. But it was never beneath her to ask for help or to ask another surgeon for some help, or to refer to a different surgeon if she felt that she wasn't able to do the procedure.

EHRHART: So were there any situations that you recall where the tumor, like you were saying before, was too big, is there a particular case that comes to mind? I'm sure you've worked on so many cases over the years. If anything comes to mind later on we can always add it or come back, or if you want to write an addendum you can do that. But if anything pops in your mind, just feel free.

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

PETRILLO: I think there were some other surgeons at the time that didn't involve the team as much, didn't get the team input as much as she did, where they would just dictate to the team, "We're doing this, this, this and this," which, in certain instances you have to do that. But they wouldn't involve anesthesia as much, it would be after the fact that they would say something to anesthesia. I mean anesthesia would be right there seeing what was going on, but she was always in constant communication with them. Other surgeons would just keep doing what they were doing and rely on their anesthesiologist to just see what they're doing, not the verbal communication, so she was always a very good communicator.

EHRHART: Do you think that gender played a role in that as well?

PETRILLO: It was just her personality. Whether it was gender or not I'm not sure. It was just her personality. She just was a very team-oriented person. She was not a loner in that she always involved people in anything that she did, socially or business, work-wise and things like that.

EHRHART: You had mentioned this earlier, but previous interviewees have said that Dr. Schnaufer respected every person's role in the OR. Did you find that to be true, and if so, in what ways do you feel that she respected your role?

PETRILLO: I totally agree with that statement. She was very respectful. I think the biggest compliment was just her involvement of the nursing staff, whereas some surgeons would just come in and they would have a two-second conversation with you. I don't want it to sound like, because our surgeons here are great, they're much different than adult surgeons, they're much more communicative, and not as high-strung, so to speak, at times. But she just would come in to the room, "Hey, what's happening, how is everybody, what's new today?" just always put everybody at ease before your day started with her. So as the patients were going to sleep you always kind of knew where you stood with her. If you felt that you didn't do a good job, you could always say to her, "What could I do to be better?" "What could I do to make this better?" "Next time what could I do," like handing instruments or loading suture or whatever. "What could I have done that would have made it easier for you so you wouldn't have to take it out of my hand and reload it?" so to speak. She couldn't teach during, she would always teach afterwards. You didn't find that all the time. Some surgeons would just go, "Just give it to me," and do it themselves. So she always wanted to make you better. And she always wanted to make you feel comfortable. And she wanted people to stay and work here and love Children's the way she did. I think she succeeded in that with her years here, because everybody loved working with her.

EHRHART: Would you say that that environment or atmosphere in which you felt as though you could say, "What could I have done to make this better? What should I do next time to do something differently or to improve it?" Was it something that the nurses or part of the surgical team felt that they couldn't approach other surgeons?

PETRILLO: I think at times, yes. I think at times there were surgeons where you'd just say [inaudible]. Or, you would ask the resident instead of asking the surgeon, "Why did he keep taking that off and reloading it, what did I do wrong?" because you weren't as comfortable, depending on how long you worked here. I was kind of comfortable with everybody, and then in my role, as my roles changed, I was at times more peer or more boss to them because I was the one that was setting their schedule and moving their cases and things like that. So I had a little different rapport with some of the surgeons as the time went on. But there were surgeons that some people just don't click with, and you just, "Get through this case, let's just get it over with," kind of thing. Never to the detriment of the patient, but always where you just feel, "Oh God, I'm working with them today, it's not going to be as nice a day," as if you were working with, say, Dr. Schnaufer or maybe somebody else. You always knew when you were working with Louise that it was going to be a nice day, you really did. We do a staffing board in the OR, and we have all the cases and rooms and then we put up the nursing assignments – "I'm working with Louise today," "Louise, I'm working with you." People would just be happy, she just brought that out in people. And a lot of our doctors were like that back then, but she just, I don't know if it was like a motherly attitude sometimes because we were all so young. When we started here we were like 20 or 21, so she was a little older. She's what, 81-82 now?

EHRHART: Something around there.

PETRILLO: And I'm 53. When I started here, she's like 30 years older than me. So when I started here at 20, she was 50. So it was always that kind of maybe "mother henny" kind of

thing at times, too. There were certain people she just took under her wing and enjoyed being with and spending time with.

EHRHART: There are two things I want to ask you about that. First of all, I've heard something about she'd keep food in her desk drawer or something?

PETRILLO: Oh, over in her office she would keep peanuts and stuff for the residents.

EHRHART: Is that something that the nurses would participate in?

PETRILLO: Not really, because we were never over in the office area that much. The office area...they started out here in this building, and then in 1985 they added on the Wood Building, so we had a bridge that connected us, so she wasn't even in this building after that. She would come over, but her office wasn't physically here. She would always make sure we had...our nutrition services department would always deliver crackers and peanut butter, and the docs would call up and say, "We need crackers and peanut butter up here in the OR," because sometimes, depending on the case, you couldn't get lunch or you couldn't get dinner so you would just run in and they'd always try to make sure there was some protein here. We would always say to her, "Call nutrition services for us," because they wouldn't give it to us. "Just call them." The surgeons, they would do anything for the docs, that kind of thing. But we really weren't over in their office area that much.

EHRHART: That's one thing that I had heard about, but also you had mentioned something about she wanted people to stay here, and I was wondering if the pressures to, like you said the nursing shortage and so forth, was she unusual in that she took an interest to try to make sure there was more job retention here?

PETRILLO: Anything that we did socially here, little parties or showers, she always wanted to be involved in. So I think that in that respect people saw her as a person and not just as a surgeon. I think that that always made people feel good. They would just make them support the Children's Hospital kind of thing, and I think that being female, that had a lot to do with it. She would come to our baby showers and our bridal showers and things like that. The male docs aren't going to come to that kind of stuff. They would participate sometimes if they were walking through or if we had something in the lounge, but not on the outside. She would physically do things on the outside with us, which was very nice.

EHRHART: Such as what?

PETRILLO: We always have going-away parties for residents when they're leaving, or fellows. Especially when it was the general surgery team, she would always want to be involved. We would go to Tacconelli's Pizza, are you familiar with that in Port Richmond?

EHRHART: Yes, the famous one where you have to order the dough in advance.

PETRILLO: We used to go there a lot. We used to take residents there when they were leaving, because you had to go to Tacconnelli's. A lot of our residents when they left were moving out of

the city. They weren't staying sometimes even in the state. She would always say, "When are we going to Tacconelli's? We need to get a Tacconelli's night together." And then it would be funny, because I don't know if you've heard the stories, but the garlic there, it's fabulous pizza, but you really reek the next day. So we would all make our assignments so we'd all work together in groups because you stunk of garlic. Dr. Schnaufer, we'd say, "Okay, so you were out with her last night, you're going to be in the room with her because you're all going to smell of garlic. Nobody's going to be able to stand you." She always wanted to be involved socially. She has a vacation home in Maryland. She would have weekends where she invited some of us down there. We would go down once in the summertime and spend a weekend at her cottage, which was really very, very nice.

EHRHART: What did you do there?

PETRILLO: We would go into town, we would go shopping, we would go boating. She had a sailboat for a while so we would go out on her sailboat. We had other physicians that had homes down there, so we would go visit them. They'd know we were coming down. So one of our physicians, Dr. Schut, was a neurosurgeon, he had a house on the Chesapeake, and he would know we were coming, so we would start out at her house, stay overnight, go to his house and go out sailing for the day with him, things like that. She always would want to share what she had with us. She always wanted to share, "Let's go out to dinner. Anybody want to go out to dinner?" and things like that. "Oh, is everybody leaving? Okay, c'mon, let's go out to dinner. Are you getting off?" So she really enjoyed the company outside of here as much as she enjoyed us in here, and it was a chance for her to relax and unwind a little bit and not be Dr. Schnaufer all the time.

EHRHART: So outside of her role as Dr. Schnaufer, how would you describe her?

PETRILLO: She's very into the arts, she has always had season tickets to the Academy of Music and to the Walnut Street Theatre and would always invite.... She would call me and say, "I have an extra ticket to a play, do you want to come to the play?" She was very into the arts, and so that was something that she always promoted. She would always say, "Hey, anybody want to get season tickets? I'm going to get tickets. Anybody want to get season tickets?" I think that, as well as sailing and boating. She loved to sail. She had a boat for a long time, so she loved to do that, too.

EHRHART: I'm trying to figure out how I can phrase this. I was going to ask about being "one of the girls." [interruption] You know when you think of just "hanging out" with the girls, and like you said, going shopping and that type of thing.

PETRILLO: I have a mountain house, and she came up my mountain house on several occasions for a girls' weekend. It was always a county-wide fall folk festival, so she would come up and we would get up in the morning and we would just shop all day, we would go to flea markets and craft shows and things like that, and she was just one of the girls. She would go and we would go out to dinner, and just enjoy each other and just have a good time -- a group of the nurses and Louise.

EHRHART: Did it still seem as though she was in a maternal role at that point?

PETRILLO: Oh, no, she was one of us. She was just, "Let's go out and have a good time. Where are we going? What are we going to do? Do you need any beer? Are we going to do anything?" She was just one of the girls when we would be out here. She was never afraid to relax outside and with us, she was never afraid to just be herself. As I said, she would have us down at her place, and she would come up to my place. We just would have a good time. We would just have a really good time, and we didn't talk work, it was always just other interests. Her family members, her cousins, are woodworkers. They would make things and their money went to Habitat for Humanity. So we said to her one time, "Bring in a book of pictures or bring in samples or something, I'm sure people here would.... It's a good cause, plus nice things that they need." So again, she was always into selling things just for helping people out for a good cause. She would bring stuff in, and we would buy it and the money would go to Habitat for Humanity through her cousins, who I think one of them is her power of attorney now, he's one of the ones.

EHRHART: We already covered my next question, which was: Were you able to form a friendship with her, and if so, please describe that friendship. Anything you want to add on to that?

PETRILLO: She's just a wonderful person, and I'm just thrilled that in my young years here that I got to know her, that she was one of my mentors here, because she just made it such a pleasure, such a nice place to work in, just such a wonderful, wonderful place. Even when the chips were down, even when we opened up all our surgery centers and we were losing nurses, she still tried to keep us positive. "C'mon, we'll get more people, we'll recruit, we'll recruit," and things like that. I'm just thrilled that I was able to know her as a person as well as a surgeon. I learned a lot from her. I have two children, so she treated my kids at times, not here in the OR, but on the outside. My son had warts on his hand. I took him to her office and she took care of that, she just would do anything for the nursing staff. If people needed something, she'd say, "Well c'mon into the locker room, I'll check you out, I'll see if you need to go to anybody else." She was just always sweet in that respect, just couldn't do enough for us.

EHRHART: Dr. Schnaufer was known to provide counsel to many of her colleagues and fellows. Did you benefit from her advice as well, and if so, how?

PETRILLO: I had breast cancer back in 1985. I was diagnosed when I was 30 years old.

EHRHART: I'm sorry.

PETRILLO: Oh, I'm fine. Look at me now. That was a very difficult time for me back then. She would call me all the time at home. As a matter of fact, I called her when I was diagnosed. I had just had my daughter. My son was 26 months old. My daughter was six months old, and I went back for a routine post-partum six-month check-up and found a lump, and they said, "Oh, it's probably just a blocked duct, we'll get a mammogram, we'll aspirate." So the mammogram's done and I go to this physician from my local hospital, and he aspirated, sent it off, it turns out I had a malignancy. He called me in the afternoon. I called Dr. Schnaufer right away and told her

what was going on. She had an appointment for me next door, to see a physician next door, and had me all lined up. I went and met with the surgeon who had diagnosed me the next day and said, "No offense, but I'm going to go to Penn," and more for I knew everybody. I didn't know anybody next door at Penn, but I knew everybody here and I knew everybody here would take care of me, and they would make sure that I was taken care of at Penn. Dr. Schnaufer was very instrumental in that. She just called the surgeon's office and got him on the phone, and said, "You need to see her, she's my assistant head nurse, you need to see her," and I had an appointment two days later with the surgeon next door. Everything started moving right after that.

PETRILLO: But she was the first person that I called, physician-wise, medically, after I got my diagnosis over the phone. It was like 4 o'clock in the afternoon and I thought, "Holy crap, who am I going to call?" I was home on maternity leave. I hadn't gone back yet. I had just had my daughter and I hadn't gone back to work yet, and had been in touch with people at work the whole time I was out. But, "Who am I going to call, and who's around?" So I called the OR, they said she'd just finished, I called her office, she said, "I'll call you right back." "You have an appointment on Wednesday at 8 o'clock in the morning with Jack Mackie next door," who was then like "the god." When you talk about gods, he was the god next door. She just took over for me and just started that whole ball rolling for me, and just was very helpful. Back then you stayed in the hospital for a long time. She came to visit me like every day to see how I was doing. A lot of physicians, I have to say, a lot of physicians were like that, but just as soon as I heard "I have to call Louise...Louise will help me." And I called her, because I didn't know what I was going to do at the time. In that respect we have plus another connection there.

EHRHART: Why did you feel that you could go to her with things like that?

PETRILLO: Just because of the way our friendship was, and just because of the type of person that she was, and how caring and concerned. I just knew that her reputation and the respect for her...if she made a phone call for you, people jumped. "Louise Schnaufer is on the phone for you," people would say, "Louise Schnaufer, CHOP, must be something important." She was just that type of person, just had that type of effect.

EHRHART: How about in non-medically related personal matters, would you also go to her?

PETRILLO: Oh yes, as I said, socially we would go out together, we would just go out to dinner, go to a show, go to the Flower Show, things like that. It was always, "See what Louise is doing," or Louise would say, "Let's see what Debbie and Marie are doing," and call us, too. We would visit her at her apartment, she would visit us at our homes. It was that friendship, it was a true friendship.

EHRHART: There were two additional questions I wanted to ask you that weren't on the list, but based on what you said. I'm going to hop backwards pretty far to when you were talking about how you felt that maybe in some ways she wanted to create a supportive environment to encourage nurses to stay here, and I was just wondering in regard to Dr. Schnaufer, as well as just your work here at Children's Hospital, how that pressure to keep nurses or to recruit nurses has weighed in on your job.

PETRILLO: Right now it's paramount, and back then, too. As I said, they moved from the old place, it was a four-room OR, to coming here, almost doubling in size, and continuing to just add on ORs. They had a lot of shelled ORs when we first started here, closed store rooms that have been turned into ORs. They can't do the procedures if they don't have the nursing staff. They can't operate if you don't have the staff to help you, so that's a big, big consideration. Some of that would weigh on some people -- different surgical personalities, different people that they would work with. Then what we did, because we were growing, we started teams so that you would work with a specific team or group of services. Now we're called "clusters," we're on two different clusters. We have certain services in one cluster and certain services in the other cluster. You orient to everything, but you can't orient to every single case, it's just impossible. You orient when you're in orientation, because everybody takes call, you orient to all the specific services, so you learn the basics in all the services, but then you pick a cluster and you become more proficient in those services. That started towards the end of Dr. Schnaufer's time with us because we were growing and growing, and procedures were growing, and technology was growing, and things like that. So we started doing more service-oriented work.

EHRHART: Do you feel there are substantial benefits to that setup?

PETRILLO: I think there are because you become more proficient, the surgeons are more comfortable, you know the technology, so I think there are a lot of benefits. Depending on the service, and depending on the complexity of the service.... For every service we have specialty nurses, we have a specialty nurse in charge of each service, and then we have, as I said we're divided into two clusters so we have a coordinator in charge of each cluster, so we have two coordinators for that, and then within each cluster are specialty nurses that are in charge of the services and act as preceptors to teach new people. Then you also have people that routinely do general surgery, or ENT, and the surgeons love it, too, because the people know what they're doing. Teaching is time, and time is money. You can have a lot of down time between cases if you're teaching, because you don't want to be wasting time while the child's under anesthesia, because that's not safe. You may do some of your teaching before the child's brought into the room, so that can be an issue. Whereas if you're both proficient, room turnovers are quicker, kids are in the room, surgery goes, kids are out of the room, surgeons can do more cases, things like that.

EHRHART: How many nurses are in a cluster?

PETRILLO: It depends, we have 60 full-time staff here. I would say it's almost 30 and 30. One cluster is Neuro, Ortho, Plastics, Ophthalmology, and then the other cluster is general surgery, Urology, Fetal, Transplant, ENT. The complexity of the cases, Neuro Ortho Plastics cluster, you're doing all the craniotomies, and all the spinal fusions, and all the cranial facials and that kind of stuff. In the other cluster you have some smaller cases that you're doing as well as some big cases, but we're not doing liver transplants all the time, we're not doing fetal surgery all the time, so the general surgery people are doing hernias and exploratory laparotomies and some of the laparoscopic stuff. I think we've gone to that because we want people to be more comfortable, because if you walk in, you don't want to feel like you don't know what you're doing in the rooms. We've gone to the cluster concept because of our size, the number of

surgeons that we have, the new technology, so that we do have people proficient. Once you're through orientation you pick the cluster that you want to be in.

EHRHART: Do you think that any financial pressures have also caused that structure?

PETRILLO: Not really. I think financially that's a reason why we're not getting nurses right now. A lot of hospitals are offering these tremendous sign-on bonuses – strings attached, but $25,000 sign-on bonuses, stay for a year, an extra $25,000. Children's being a non-profit institution, we don't do that, they'll do some kind of little bonuses, but not things like that. Nowadays there are a lot of people, a lot of nurses that are coming out, they have phenomenal loans, student loans. Some hospitals are offering loan forgiveness – 100% tuition reimbursement, benefits, things like that. They want people to come to Children's Hospital because we're Children's Hospital, and that doesn't always cut it anymore. I thought I'd come here for a year and move on.

EHRHART: And here you are.

PETRILLO: Thirty-three years later, right?

EHRHART: Regarding those financial pressures. Have you seen a change in the, I don't want to say "speed," but within the turnover of patients, or what's expected as far as how many cases per day or has the workload increased?

PETRILLO: Our workload has changed because of our surgery center situation, because a lot of our more minor procedures will go to the surgery centers, so we're doing bigger procedures here. Some of the surgeons that operate at the surgery centers will take some of their smaller cases there so that here they're doing their bigger cases, so in that respect, things have changed. I think that there is pressure for turnovers. Surgeons book from 7:30 in the morning to 5:30 at night basically, and they'll come out and they'll say, "Well, you know my room is not going fast because we're teaching in between cases and we're doing this and am I going to be penalized for that?" Or, "Anesthesia's putting a block in, so just make sure it's anesthesia time, not my time." So there is pressure in that respect, because of all the teaching that we do. Some days the surgeons can't get as many cases done as they want to, but then on the other hand, they're teaching, too. "When you're doing the procedure, you're teaching your guys, so we're teaching our nurses, our anesthesiologists are teaching the anesthesiologists, we're all in this together, we're a teaching institution." You go to a for-profit, and some rooms are doing 15-20 cases a day because they're by themselves, they're not teaching anybody, and it's just business [snaps fingers]. It's like, "Whew! You did how many cases?"

EHRHART: On average, how many cases would you say that you typically deal with on a daily or weekly basis?

PETRILLO: We do 15,000 a year, so we do probably anywhere between 60 and 80 cases a day in 14 ORs, because two ORs are cardiac.

EHRHART: What would be a common number for a nurse?

PETRILLO: It depends on the procedures. If you're doing ENT, and it's just ears and tonsils, you can do like 12-15 a day. If you're doing some surgeries, you're only doing one case a day if it's a craniotomy, if it's a spine. General surgery, what we say "bread and butter cases," the hernias and things like that, a lot of the docs will do maybe two or three hernias, and then two big cases, two laparoscopic cases.

EHRHART: It almost sounds as though it's not something that can be averaged, because it just depends.

PETRILLO: Not really. It just depends on who they're seeing in their office and how they group their kids. And then we do emergencies, so we always have emergencies.

EHRHART: I guess my final question is you said that you have taken on a more administrative role now, and I'm wondering if that changed the interaction that you had with Dr. Schnaufer, or if it changed the dynamic between you two?

PETRILLO: Not really, because it was different in that since I controlled things, so to speak, she would come to me and say, she would discuss her whole day with me, and say, "You know, I have these two hernias, and then I have this case, and I have this add-on, but I really would like this add-on to go before this case," so that changed because I was the one that could make that happen for her. In the room, as a nurse in the room, I couldn't make that happen for her. It changed on that level a little bit, in that respect. I was more – I don't want to say "upper-tier," but you know what I mean? I was more of a consultant with her, as opposed to just working with her in the room. Or if I had rooms that were opening up and I thought I could, while one room was turning over I could do another case in another room. That changed, which is much different than just working with her in her room. When you're working in a room you're just going along doing the cases and treating the child and things like that. I always handled the parent issues for her. If there was a parent issue -- get the facts, and then go to her and give her the facts so she could go talk to the families, so the dynamics changed in that respect, but it didn't change the way we treated each other or anything like that. I'm sure some days she would come out and say, "Isn't there anything, can't you help me with another room?" and it's like, "No I can't, I'm sorry," that kind of stuff. It wasn't like, "Well, she knows Deb, they're good friends, so she'll do something for her that she wouldn't do for me." None of that ever took place, but I mean our friendship stayed true.

EHRHART: That comes to the end of my questions. Is there anything else that you feel that I haven't covered that you'd like to....

PETRILLO: I don't think so. I know that she still keeps in touch with a lot of her fellows. In fact, Dr. Koop's wife just passed away, and she went to the funeral, and some of her former fellows that are now physicians throughout the United States, they were there at the funeral so she got to see them and stuff, so people still keep in touch with her. She's just a wonderful person. I wish she didn't have to retire when she did, because it was just so enjoyable. Even when she wasn't operating as much, she wasn't over here as much, she would still come over and visit us. "What are you guys doing, what's happening? I'm done with my office hours,

what's going on?" that kind of thing. She would always be over helping in clinic, which they didn't have to help in clinic, they had their own private patients, they didn't have to take care of clinic patients. The residents and the fellows and she was always in the clinic helping and teaching and continued that until she left here, which I know the residents and the fellows just felt was extremely valuable. I feel bad because people who started after she left, not as much nurses, but the residents and the docs, because they would hear of her reputation because of the medical field, and "Oh, I'm going to Children's and Dr. Schnaufer's there." They'd get here and she was retired. It was like, "She retired, I'm so sorry I didn't get to work with her." I know that people really felt that way, when she initially retired, the fellows that were coming, because they knew just what a wonderful teacher she was. She was really in charge of the fellows I think back then, too, so they always knew that they could always go to her and talk to her. I know that the fellows that were coming, even though she might have interviewed them and then she retired, they were very disappointed that they weren't going to benefit from her expertise.

EHRHART: That's quite a reputation in a good sense.

PETRILLO: Yes.

EHRHART: A shame, but at the same time, she had such an extensive career.

PETRILLO: She had a wonderful career, she really did. She had a wonderful career.

EHRHART: Well, let me just restate again, unless there's something else you wanted to add.

PETRILLO: No.

EHRHART: It's March 21, 2007, and I've been speaking with Debra Petrillo, who's an R.N. at Children's Hospital of Philadelphia, and this is an interview conducted for the Louise Schnaufer Oral History Project, which is conducted for the College of Physicians of Philadelphia, and funded by the Foundation for the History of Women in Medicine. ###