

Josephine Templeton, M.D.

FILE: PTEMPLETON1

EHRHART: Today is Wednesday, May 23, 2007. This interview is with Dr. Pina Templeton, and it's for the Louise Schnauffer Oral History Project, which is being conducted for the College of Physicians of Philadelphia, and funded by the Foundation for the History of Women in Medicine.

EHRHART: Could you please start by stating your name and your current position?

PINA TEMPLETON: Yes. My name is Pina, actually it's Josephine Templeton, but everyone knows me as Pina, which is P-I-N-A. I'm a retired anesthesiologist from Children's Hospital, and currently I'm involved in volunteer-type work. I was hired at Children's Hospital in 1977 on the attending staff after a fellowship. I first met Dr. Schnauffer during my fellowship. I have to say that my first impressions of her...she was absolutely very kind to a new, kind of a nervous and shy anesthesia resident. But I was also very frightened of her because she seemed to be so important, although very humble in her own state. I was actually born in Italy, so I went to medical school in Italy, but I specialized in pediatric anesthesia at the Children's Hospital of Philadelphia. It's a fellowship under Dr. Jack Downs.

EHRHART: How many years was the fellowship?

PINA TEMPLETON: It's a year after two years of general anesthesia.

EHRHART: How long did you work with Dr. Schnauffer? How long did you work at Children's Hospital? You said you started in 1977 with your fellowship, and that was one year.

PINA TEMPLETON: Actually, my fellowship was in 1973 to 1974, and then we, my husband was in the Navy and we left for two years and we came back on the average of two years in 1977, the middle of 1977. I would say I would work with Dr. Schnauffer at least once or twice a week. We all vied to be in her room. You felt very lucky if you were in her operating room. She also did very complex cases, so as a young anesthesiologist you wanted to do those special and complex cases.

EHRHART: Why would you say that the anesthesiologists vied to be in her particular operating room?

PINA TEMPLETON: She was an excellent communicator. One could go to her and express problems that you would see with the patient, and come to a conclusion of what was the best anesthetic. The anesthesiologist chooses the anesthetic, but you discuss it with the surgeon if there are concerns about the patient, or there are aspects of the surgery that you don't fully understand, and she was very available to that. She was just pleasant to be with. She never lost her temper. She communicated well. There's a separation between the surgeon and the anesthesiologist, so you sort of talk over the screen all the time, and she was very informative.



She had a good sense of humor as well. She was also very kind to her residents. Consequently, she was kind to the anesthesia residents as well, so it was a very good teaching environment.

EHRHART: When did you leave Children's Hospital?

PINA TEMPLETON: 1999.

EHRHART: 1999. So you really worked with her almost...

PINA TEMPLETON: Almost to the end. I think at the time I left, and I'm not sure, she may have stopped operating, but she was in the clinic as a preceptor for the students.

EHRHART: Were there additional ways in which you would interact with her prior to the surgeries?

PINA TEMPLETON: Yes, because my husband [Dr. John M. Templeton, Jr.] was on the surgical service, so I was often in her office. Her office door was always open. She had peanut butter and crackers, and she had peanuts, so the surgeons at the end of the day, especially surgical fellows, would always go into her office just to meet with her, and I would go downstairs. The anesthesia floor was on the fourth, and her office was on the third floor, and my husband's office wasn't too far away from hers. So as I would go to see him sometimes, I would just stop in her office. And when we were fellows she actually took care of our plants, and this is why I say she had a great sense of humor, because we were on vacation, and we brought these straggly plants that were dying. We just said, "Louise, would you take care of them for the two weeks we're away?" She looked at them and says, "Well I will, but you should take better care of your plants." When we came back, each plant had a diagnosis. And then she said that she would take us to court for plant abuse. Each plant had dehydration, abusive parents...she had all these funny diagnoses for the plants. Her office was almost like a forest. She loved her plants, and she could do very well with them, so people went to look at her plants and how well they were doing.

EHRHART: Were there other people who had plants in their offices, or was she different?

PINA TEMPLETON: The men tended not to. For a long, long time she was the only woman in the surgical department, so the men may have had one plant that maybe their wives gave them.

EHRHART: How about in other ways that you would confer prior to operations, as far as discussing operative strategies and so forth? You said that you worked together with her to discuss what was going to happen. When would these meetings occur, and were they formal, informal?

PINA TEMPLETON: They would be very informal. You would just call her, and you could even call her at home if you really had a concern, or you'd just page her. It didn't happen all the time because if they were routine surgeries and you didn't have any questions, you didn't call her. The issue is that she was available if you needed her. The other thing is that you could call her for advice, even if it were another specialty but the child also had a general surgery disease

or a previous surgery and you didn't fully understand the surgical procedure that went on, she was available to be called. Now I was in a different position because my husband's a surgeon as well, so very often I would go to him. But the importance is that she made herself very, very available, and I think you would find that from almost anyone you would speak to, as well as the nurses. She was a great friend of the nurses as well.

EHRHART: How about during the actual procedures? In what ways would you interact with her during a procedure?

PINA TEMPLETON: Well, if she knew she would get into an area where there may be severe blood loss – we're talking about pediatric patients and sometimes they were as small as two pounds so you couldn't see as well as you would with an adult. More than even other surgeons she would be very likely to say, "I'm concerned there may be bleeding here," or "I'm pulling on the intestine," which causes changes in heart rate and that sort of thing. She would advise you of it. That's what I mean where the interaction was very good. And if you were having problems that the patient was not as stable, you could say, "Louise, just wait a minute, I need to fix things back here," and she would stop. It was never confrontational. I would say it was a teamwork aspect [to dealing with it].

EHRHART: Does that differ from the way that other surgeons would have handled it?

PINA TEMPLETON: Not in a large way. It's just a way of dealing with the situation. Most surgeons there's always a back-and-forth relationship. If you have a question, you just ask the surgeon. There's a lot of talking that goes on in the operating room, because there's a need to do that. A good anesthesiologist is always watching the surgery; you don't watch the ceiling, that's just the way anesthesia is given. With Louise it was just a bedside manner aspect to it. And I have to say that what helped also was that we were friends outside of the operating room in a sense that it isn't that we necessarily went out together, but you might sit in the coffee lounge or after an emergency in the middle of the night she would tend to stay around until the patient was out of the recovery room, have a cup of coffee, and so you would get to know her better and she was always interested in what was happening to other people.

PINA TEMPLETON: She also was Mrs. Santa Claus. We had a Christmas party that little by little became larger and larger. It was a combination of our neighbors, but primarily children from both departments of the operating room and some of the nurses. Dr. Bishop, who was a colleague of Louise, was Santa Claus, and as the party enlarged, she became Mrs. Claus. As my children grew up they knew her as Mrs. Claus.

EHRHART: What do you think that says about her?

PINA TEMPLETON: She was willing to laugh at herself. It's not easy to don on a costume and put a wig on. The younger children were very happy to see Mrs. Claus, the older children thought she was funny, so I think you have to be sort of secure. In some ways she was a shy person, but in other ways she was a very strong person, because if you really think about it, if you think of her age and when she went into medicine, but also she went into a very masculine field. There were very few women in surgery, which is very different than today, so she had to

forge a way. Surgery, especially in her time, was exceptionally time-consuming and needing total dedication because we didn't have the 80-hour work week of today. Very likely during her training she was on call every other night. So I think she barely went home, went to sleep, and then back in the hospital. And everybody around her...she never said that, but in some ways it must have been also lonely because everybody around her were men, and sometimes you just would like to talk to women.

EHRHART: You said that she was shy in some ways. In what ways would you describe that? In what setting?

PINA TEMPLETON: I think...maybe shy is not...she was reserved. She had a quiet presence about her. She was very tiny. She is tiny now, but she generally had to stand on two or three stools depending on how tall the residents were. And that's another good aspect of her: she never minded. There would be some surgeons that would make the residents stoop over, and instead she raised herself up so that the resident could be comfortable. But she always gave me the impression that she was shy, she was quiet, but there was a strength behind her.

[Following the interview, Dr. Templeton added that Dr. Schnauffer also stood on stools at the operating table if she was working with a tall scrub nurse so that the scrub nurse did not need to stoop over the table. ME]

EHRHART: Can we spend a few minutes talking about the actual operating room setting and surgeries? The next question is: In addition to the surgeon and the anesthesiologist, who else is part of the OR staff?

PINA TEMPLETON: The more complex the surgery, the more people are there. But typically there is a surgical attending, which would have been Louise, and a resident, depending on the level of the surgery. The type of resident would be there would be either more senior or less senior. They generally didn't have interns. But she was always willing to take any resident, and she had a really great way of training them or making them feel that they actually were doing the surgery, where she was really guiding their hands. So there was the attending, a surgical resident, a surgical scrub nurse or technician, depending again on the level of the surgery, and a circulating nurse. That nurse is responsible for the tenor of the operating room: what's happening on the field and so on. And because it's a teaching institution, there's an anesthesia attending or fellow, and an anesthesia resident.

EHRHART: Can you describe what your responsibilities as an anesthesiologist in and out of the OR, consist of?

PINA TEMPLETON: Typically the conduct of the patient under surgery or anesthesia is your responsibility, totally, which is always done in concert with the surgeon in the sense that the surgeon...anesthesia has become very complex.

[interruption]

PINA TEMPLETON: So the stability of the patient during surgery is the responsibility of the anesthesiologist. The reason I say that it's done in concert is because the surgeon understands the surgery that he's going to do, he or she, better than the anesthesiologist. You can't know every type of surgery, so there's always explanations going back and forth. Or if something is happening to the patient, such as a drop in blood pressure or a drop in heart rate, you can look into the surgical field, and if you can't explain it from an anesthetic point of view, then you talk it over with the surgeon. That seems like, "Oh gosh, this takes a long time." This is very quick. You just say, "Are you tugging on the intestine?" or something like that. "Oh, yeah," and then you might joke about it, "Why didn't you tell me?" So it's very, very controlled. And then in a teaching institution you're also responsible for your resident, for teaching that person. And then afterwards you're responsible for the patient in the recovery room, or the post-anesthesia room, or the intensive care unit, depending on the acuity of the situation. Typically the responsibility of anesthesia would be in the first 24 hours after surgery, because many of the issues could be related to anesthesia, not necessarily so. So if something's happening to the patient, the anesthesiologist needs to look at whether what happened anesthesiologically had an impact on the course of the patient in those early hours. But then the responsibility goes back to the surgeon. The patient belongs to the surgeon. The anesthesiologist really is a consultant, because their specialty is to administer or to understand the physiology of the patient under anesthesia. And since you don't go to the hospital only for anesthesia, but you go for the surgery, the anesthesiologist needs to understand the impact of that surgical procedure in concert with the anesthesia.

EHRHART: You talked a few minutes ago about who is part of the OR staff, and you also described your responsibilities in and out of the operating room. Can you tell me who do you believe in the operating room creates and/or fosters the operating room dynamic?

PINA TEMPLETON: It's interesting you say that because typically the surgeon, if you look especially at more senior surgeons, they've always been considered "the captain of the ship" if you think of a ship, and they can still think about it that way. There's a certain tenor to the operating room that's really under the prerogative of the anesthesiologist, and really the everyday workings of the operating room, as to which cases are done at a certain time, how it functions, it's really under the anesthesia department. This would be regular-scheduled surgery. It's always been my impression that once the anesthesiologist enters a particular operating room, there's a certain calmness or tenor that comes along with their presence, and then everything is prepared for the surgeon to arrive. So the patient typically will come in at a scheduled time, and the anesthetic is administered. Generally during that time the surgeon is right outside of the actual individual operating room scrubbing, because that takes time. By the time the anesthetic is actually induced, the surgeon is ready to come in. The patient is then prepped, which is almost a jargon -- the patient is washed and disinfectant-type agents are placed in whatever area that the surgery is going to occur. Drapes are put on, and the field is made sterile. The surgeon will typically turn to the anesthesiologist and say, "Are you ready?" because you know if there is that level of anesthesia for them to make the incisions. And if you want to be very dramatic, you could say, "Your patient is ready." It really doesn't happen like that, but there's some sort of understanding between the two to say, "Yes, the patient is ready, I'm fine."

EHRHART: So would you say, then, that the dynamic is created in stages almost?

PINA TEMPLETON: Yes, it's fluid, but there are stages.

EHRHART: So first it would almost be created by the anesthesiologist who's in the room administering the....

PINA TEMPLETON: Yes. For example, the operating room tends to be very quiet when the patient comes in because you don't want to disturb the patient. And we're talking about children here. Anesthesia for children is a little different. You may have the parent come in, and then begin the anesthetic in the parent's arms. I've even anesthetized children on a bicycle and then the nurses have helped me with the child because you don't want to scare them. It's very different than the adult. Typically the adult will come in on a stretcher as a teenager would, the older children, and then we'll move them to the operating table and then make sure that they're calmed and so on. By that time they will have had what's called a premedication, which is a sedative, outside, so they're relatively calm. Then with the adult you must start an intravenous as you would with a teenager. With a child, they don't like needles. So unless you absolutely have to you don't, but you start with a mask. Children are also afraid of masks, so you start very slowly. You flavor the anesthetic, for example, or you come from the side, you tell them stories. Very often Louise would be there for that part of the anesthetic, and then she would go outside and scrub. But she liked the idea. She didn't necessarily have to be there, but she was very responsible for her patients. Sometimes she would walk in with you and the patient. Also typically before the child came in the operating room she would make sure she would see the parents for the last time before surgery if they had any last-minute questions.

EHRHART: Would you say that a shift occurs in the person who is creating or fostering the dynamic in the operating room once the surgeon begins the surgery?

PINA TEMPLETON: Yes, in the sense the focal point now becomes the surgery. It's not so much taking a step back, but you have to think of yourself as the consultant so that you're helping the surgeon get through his surgery without having to worry as to what's happening with the patient. That's where I mean where it's a teamwork. Maybe what may put it clearly for you, when I was very young in anesthesia -- this has nothing really to do with Louise, this is just an explanation -- there was one of my attendings that had sent me to see a patient that was very ill. The patient, I don't think he had one organ in his body that was functioning correctly. So I came back and I said, "Well, I think he's too sick to go to surgery." The attending looked at me and said, "Well, tell me about the patient." And I did, and he says, "Well, he is very sick," and he said, "What are you going to do about it?" So I said, "Well, I'm going to tell the surgeon." He said, "And then what?" And I had no answer, and he said, "Now you must understand," and it worked very well for me, always, "That the surgeon decides whether a patient needs surgery or not. And anesthesia helps him decide when is the best time for the anesthetic to occur, because the patient really is ready for surgery. He may not be ready for anesthesia. Then you have to help the surgeon make the patient ready for anesthesia." So that's where I mean where it's a teamwork. So if one keeps that in mind, the surgery has now been scheduled by the surgeon. You may have questions, or you may not think he's ready. If it's an emergency, you know that's different, you just have to do it. But you may think that he's not ready, let's say for tomorrow, well then you go to the surgeon and say, "This is what I need before it makes it safe for this

patient to go to surgery,” and that’s where the discussion occurs. The surgeon is not specialized in anesthesia, so he or she may very well say, “Well, why do you really need that?” and there’s an explanation that goes on in there. It sounds like this takes a lot of time. It doesn’t; it’s very, very fluid.

EHRHART: The dynamics that are created and fostered by the anesthesiologist at first, and then the surgeon, and then in concert: How would you describe the variation of the operating room dynamics depending on who is in there working with you and that type of thing?

PINA TEMPLETON: It can be fractious. You don’t see that too much in pediatrics -- and it’s been a long time since I’ve been in the adult operating rooms. You have to understand, though, when there’s a child on the table everyone is concentrated on that patient. There’s something that happens when you’re treating a child that may not happen when you’re treating an adult. But there are very few situations where there’s altercations between surgeons and anesthesiologists, because the preeminent entity is the patient and so everything becomes concentrated on that. I don’t know if I’m answering it.

EHRHART: Absolutely, you’re answering my question. Let me extend that question, though, and ask you whether or not there were sometimes when rooms would be more tense, more relaxed, laid back...?

PINA TEMPLETON: Oh, sure. If the patient is unstable because of his disease... Maybe a better explanation is a trauma patient. Generally there isn’t that much time, depending on the seriousness of the trauma, to prepare the patient before surgery, so they come to the operating room very quickly, they may be bleeding. Sometimes you have extra help, extra equipment so that you can give blood faster, or there’s something unexpected that happened during the surgery so that the operating room will be very tense, but it would be controlled tension, it’s not what happens on television.

EHRHART: So would you say then that it’s based primarily on the case as opposed to the people in the room?

PINA TEMPLETON: Sometimes it’s personalities, too. We’re human beings, and you prefer to work with some surgeons than others. A surgeon may prefer a particular anesthesiologist because he may feel that he or she is more attentive. Physicians are human beings as well, so we have personality issues. But on the whole, those are a secondary. So I would prefer to be with Louise, but I can work with Joe Shmoe as well. But if you see yourself in the room where Louise was working, you say, “Oh, I’m going to have a great day,” regardless of the acuity of the problem with the patient.

EHRHART: Why would you know that you were going to have a great day when you worked with her?

PINA TEMPLETON: Because of her personality. She was just that type of person. She brought a certain calmness to it. You knew that she was an excellent surgeon, so there weren’t issues of that. You knew she was extremely ethical, so there were no issues of that. There was

no issues of substance abuse of anything that may be a problem. And again, I fortunately never had to deal with the inebriated surgeon, it just never happened. I can only give you my experience at Children's, or at Norfolk General, that was the other hospital that I worked in. But all I can say is she just had such a nice personality about her. As I say, she did some very, very difficult cases. And yet, you enjoyed them because they were interesting. It's nice to do healthy children and hernias, you need that too, but you also like to know how good your skills are if you can take a patient that's very ill through surgery. She was very involved in conjoined twins as well. For example, that would be a very tense situation.

EHRHART: Are there any specific cases that you worked on with Dr. Schnauffer, aside from the conjoined twins, which you just mentioned, you could describe in detail to illustrate an operating room dynamic with her, like say a hernia?

PINA TEMPLETON: She did a number of congenital anomalies, of which some were diaphragmatic hernia, where part of the abdominal contents are in the chest. Some of the views have changed on how to take care of those children today, but in her time those were truly emergency surgeries that came to the operating room just as soon as you could get the baby to the ER. They were difficult cases for the surgeon and for anesthesia just because of problems of ventilating the patient. Other congenital anomalies, such as trachea esophageal a fistula, which is the communication between the esophagus and the trachea. Those were surgeries that occurred in the chest of the baby, and these are small babies. One of the diseases or surgeries that she was known for is called the Kasai procedure, and that's spelled K-A-S-A-I, where children are born with abnormalities in their liver. Their conducting systems are not well-developed and you have to create a way for the biliary movement of the products that are formed in the liver to be excreted. She probably had done most of them. She was very well-known for that.

EHRHART: In addition to the people in the operating room creating the dynamic, and the actual cases that were occurring, can you reflect on whether or not the use of different types of tools or technology, or maybe variations of procedures that evolved over time, caused the dynamic to change at all?

PINA TEMPLETON: Surgery has changed, and it's probably not fair for me to discuss that too much. She was more hands-on. I don't think, for example, she has ever done a laparoscopic case, or maybe if she did it was at the very end of her career. I personally don't remember them, because she was from an era where the surgeon was almost the beginning of pediatric surgery. But she was also an innovative surgeon in the sense that she didn't shy away if there was a different way to perform a procedure. For example, there is a surgical procedure called a Pains procedure, after the surgeon. The best I understood about the particular surgery was an old surgery done in a new way. She looked at the benefit of that and she adopted that procedure. So there was a certain humility in saying, "I can look at this, and I can do better or change the way I used to do it because it is a better procedure," and that takes humility, appropriate humility.

EHRHART: Would you say the adoption of something like that different procedure would change the interactions that would occur or the tension in the room or anything like that?

PINA TEMPLETON: Not really.

EHRHART: Can you describe how the working relationship with a surgeon changes over time as you work with that person?

PINA TEMPLETON: You become much closer to them. At the time that Louise was there and I was there, Children's Hospital was much smaller. You almost could second-guess [sic] what she was going to do, because you knew her well, and you could know her well because you worked with her so often. When I talked about discussing cases with her, that would happen less and less because you just knew, and she would know that if you decided on something, you felt strongly about it and you felt that the patient needed it, so the discussion was even less. Not because you didn't want to talk to her, but it was established before. And you'd say, "Louise, I think I'm going to do so-and-so," and she'd say, "Okay." And that was it. That comes from just years of working together; her trusting you and vice versa. So that's how I would say that it would change.

EHRHART: Are there any drawbacks, do you think, to working with someone over such a long period of time?

PINA TEMPLETON: I guess there could be, I just didn't see them. I never felt that she abused friendship, for example. She would never think of abusing friendship in the motive of saying "I'd like to get my case done before." If she did want to do that, she would come with a reason why she did, or if she wanted to change one patient to another, it seemed reasonable and you just did it, but she would never abuse. That happens, but she never did it.

EHRHART: In what ways does that happen?

PINA TEMPLETON: There are surgeons, heads of departments, that their patients have to be done before everybody else. Louise was very understanding. For example, if there was an emergency, she may not have liked that she had to wait, but she would, there were no questions about it.

FILE: PTEMPLETON2

EHRHART: This is a continuation of an interview with Dr. Josephine Templeton. It's May 23, 2007, and this is for the Louise Schnauffer Oral History Project, which is being conducted for the College of Physicians of Philadelphia and funded by the Foundation for the History of Women in Medicine.

EHRHART: My next question, actually the next series of questions, has to do with unexpected events during a procedure. Stereotypes of surgeons cause people to believe that they are tense, under pressure, and likely to express that pressure with an undesirable emotional, verbal, or physical response. How did Dr. Schnauffer respond when an unexpected event occurred?

PINA TEMPLETON: She would become quiet. She would state what the problem is, and she would go right to it to fix it. There was never any awful language, there was never any cursing,

there was never any screaming. I would say she would frown. Obviously, if something happened it would upset her, but there wasn't verbal abuse because of that.

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

PINA TEMPLETON: She would emit a sort of a calmness, especially to younger people or to residents. For example, if something happened that was unexpected – a blood vessel in the way or something like that – she would say, “Okay, we’re going to fix that,” or something of that order, and then she would just go to it. So there was never any loss of time, either. She always seemed to know what the next step was going to be if there was a problem.

EHRHART: You referred to the residents, someone younger that she was working with. But how about with the nurses and the anesthesiologists in the room, how would she...?

PINA TEMPLETON: I would say it would be the same. I don't know how to really explain it to you, but there was a sense of calmness around Louise that was very often even different from other surgeons. Her operating room was quiet except that she liked classical music, so there was background music, but that's how it was. There are times in the surgery that things are, everyone is rather quiet and focused, then once the procedure is actually completed, but now the patient is being closed -- that's sort of a medical jargon -- things relax, because the patient is quite stable, the major procedure is done. You tend to talk over the screen, not necessarily totally about the patient. She may ask you how your children were, or that sort of thing, or something funny that she read. So there's that kind of...it doesn't take anything away from the patient, it actually is almost relaxing to the whole tenor of the operating room. That doesn't mean that the focus is away from the patient, but if you think of yourself as darning or sewing a hem, when you begin to close the tissues that's what you're really doing, so that there's not that attention that needs to be done.

EHRHART: You have mentioned a few times “a screen.” I just want to make sure that I have it documented what screen are you referring to.

PINA TEMPLETON: It's often called the ether screen because it goes back to when ether was used as an anesthetic. It's no longer used, but there needs to be a separation between the anesthesiologist and the patient's surgery. Since we're talking about general surgery, you're talking about surgery that occurs either in the chest or the belly, so the separation usually done by sheets, by sterile sheets, occurs about the level of the neck, and the anesthesiologist has the head of the patient. And the arms: sometimes the arms are at the side of the patient because we're talking about children or babies. It depends a lot on the position. There's always a separation done by sterile sheets between the anesthesiologist and the surgeon because the anesthesiologist is clean, the surgeon is sterile. So there has to be a sterile field, and it's separated by sterile drapes. Ether screen is just something that's in the verbage.

EHRHART: Previous interviewees have said that Dr. Schnauffer respected every person's role in the operating room. Do you agree with that statement, and if so, in what ways did she respect your role?

PINA TEMPLETON: Absolutely. She was a humble person and she also knew who she was, and I think those two aspects...and she was a Christian. Her religion, I think, allowed her to respect you as a human being. So for her you were first a human being, and if you were to question her she probably would describe you as a child of God, and then in that sense she owed you that respect. But she also would respect what you attained professionally. For her, everyone was equal. In a sense, yes, she was a surgeon, so if you were to put her on the scale she had a lot more education than a nurse did, but she respected her because the nurse had acquired that amount of skill and did her job well. The anesthesiologist, by training, probably had fewer years of residency and so on, but he or she had acquired her skill, and unless she had reasons to doubt that skill there was no reason in her mind to treat her any differently than she would have treated a colleague in surgery.

EHRHART: How was her respect for people's roles illustrated? How did you know there was that respect? Was it something she did, or what she said?

PINA TEMPLETON: She would take, for example, the advice of the nurses. If the nurses felt, for example, that the surgical tray would be better at the end of the table, she might think about it and say, "Well, I guess you're right," or "No, I don't want it." But she took their counsel, and she would think about it. Now that doesn't mean that she would sacrifice her principles, that never happened, but she would listen to what you had to say about almost anything that had to do outside the operating room or inside the operating room, and then evaluate it. I'll give you an example, maybe that may illustrate it. If she had a patient that had a hemoglobin that was just normal, it could have been higher, she would come to you and say, no surprises, in the sense that, "I've just found out that the hemoglobin is that low, do you think it's better for me to study it now, or do you think we could do the surgery and then send the blood work while we're doing the surgery?" The anesthesiologist had his or her views on it, based on science, and so they would evaluate together. She listened. In the end she may not have agreed with you, but she listened. If she didn't agree, she stayed at that and she would argue for her patients. But it was always done in a very civil way so there was never any in-fighting. And that translated to the nurses as well, because she felt that they did their job. If the nurse, for example, didn't feel she was ready, that all the instruments that were needed for that surgery were not ready or they were still in the sterilization, the nurse would say, "I don't think we can start," but Louise could say, "I think we can because I don't need those until the second phase," so that kind of back-and-forth relationship would go. But it's very different if a surgeon would have said, "No, I want it done now!" and somebody else say, "Well, I think we can start, because I don't need them until a half hour, an hour into the case."

PINA TEMPLETON: I think if you had been in an operating room with her, you would have seen all this. It would take you about a day or two, at the most, and you would get a real sense of who she was.

EHRHART: So would that differ from how other surgeons would have responded?

PINA TEMPLETON: In some cases, I would have to be honest, in some cases. Again, I go back to...I think there's different personalities that go into pediatrics. They tend to be just easier to work with. In my time there we were fewer surgeons, fewer anesthesiologists; we tended to

know each other on the outside as well as inside the operating room, and that made it different. Some of what I say is also personal experience, because my husband was a colleague of Louise, so I had a different relationship with her than maybe some other anesthesiologists, but on a whole I don't think that my experience is very different than theirs.

EHRHART: Is there a particular situation or procedure that is vivid in your memory, from any situation, that you want to mention? Because sometimes things stick in our memories for one reason or another, and I just want to give you the opportunity to describe what it was or what happened.

PINA TEMPLETON: There was a very difficult child that happened in the middle of the night. It was a cancer patient, and the patient was not going to survive from the surgery itself. But we made it so that the child could come off the table, could go back to the ICU, and the child could die in the parents' arms rather than on the operating table. It may not make sense to a lot of people, but it made a whole lot of sense for the parents to be able to say goodbye to the child. However, we are not aware...it's always unclear when patients slip into comas. But we do know, or we feel pretty strongly that probably hearing is one of the last senses to go, so it's important for the parent to feel that the child is hearing them, and maybe for the child. It went without saying that Louise would think of the parents as much as thinking about the children.

PINA TEMPLETON: Now having said that, she also liked to tease me in the sense that she would be working in the belly and everything was fine, everything was perfect, the patient was stable. And she would say, "Pina, is something wrong? The intestine looks so pale." And you worry about it, and she was just kidding, she'd just like to wrangle your chain.

EHRHART: Oh, really, as like a joke?

PINA TEMPLETON: Yes.

EHRHART: That's another example of her sense of humor then?

PINA TEMPLETON: Yes.

EHRHART: I've heard that she's a little bit mischievous.

PINA TEMPLETON: Oh, yes. Or she would hide things on you, for example. Not important things. She would see your keys on the table or something, she would put them behind something else and then enjoy the fact that you were looking around. She goes, "What's the matter, what are you looking for?" and I said, "Nothing, nothing." Then she would smile. And then finally I would say, "I can't find my keys," and she would just laugh and eventually tell you, that sort of thing. I don't mean childish in the sense of childish, but mischievous I think is a very good way of doing it.

PINA TEMPLETON: What I think she really loved, other than her patients -- there were parents that would not take their child to surgery unless Louise was there -- is her impact on our residents and fellows, especially the fellows, because they were there for two years, they worked

very closely with her. I would think, at least it's my impression, that not only they remember her for the actual surgical skills that she taught them, but who she was as a physician. She was a total physician, she wasn't only a surgeon. She worried about everything about the patient.

EHRHART: You had mentioned a few minutes ago that Dr. Schnauffer thought of the parents, especially in situations that were difficult. For example, the child that you mentioned who wasn't going to survive and how she wanted to make sure that patient was with his or her parents when the child passed away. Were there other instances that you can talk about that would describe how she related with her patients and their families outside of the operating room, or how she thought of them?

PINA TEMPLETON: She remembered names, and she remembered patients. Now I wasn't necessarily with her when she would see the patients before surgery, in the sense when the initial diagnosis was made. I would see her relating to them outside the operating room, physically outside the operating room. But she could remember patients by name...their parents. She would talk about a particular patient with you if you had been involved with the anesthetic, because there is a sense of patient confidentiality, so you don't talk about patients. But there were patients that were known to all of us because of their either congenital anomalies, so they came to the operating room often, or you might say, "Louise, what's so-and-so doing?" She knew everything about them because she had been following them. But she knew other things: when they were graduated, whether they had a boyfriend, that sort of thing that you don't expect them to know -- because her patients were also her children in a way. She wasn't married, and she was really dedicated to... If I say she was dedicated to her career it sounds almost so barren; it sounds like the woman that's totally career-oriented. It went beyond that. She was dedicated to her patients. Her career was sort of a tool to take care of her patients. That was my impression of it.

EHRHART: And that was throughout the entire time you worked with her?

PINA TEMPLETON: Yes. And even when she was older -- your stamina goes. She would be more tired, probably. She took night call for the longest time, when other surgeons might not have. It was just in her very later years that because of her age she started cutting back on the number of surgeries, but that's typical.... But I think she did it a lot later than the men. I mean she had a lot more stamina than the men did. I wouldn't say that in front of everybody, but I think she did.

EHRHART: Can you describe that stamina that she had?

PINA TEMPLETON: I think she did more complicated surgeries, and longer surgeries for a longer period of time than maybe men would have done. But that's an impression.

EHRHART: That's fine. The thing about these interviews is it really is about your perception and your experience, so it's totally fine. Do you believe that that's something that she took on? Or things were deferred to her that she was, I don't want to say "stuck with," the more complicated things, but how did it come about that she had to deal with these cases?

PINA TEMPLETON: I don't know exactly, but I think probably patients talk. If you came to me at a time when Louise was still active and you had a child with a problem, and a friend, I would say, "Well you know what," -- I would be unlikely to refer you to my husband just because he was my husband -- but I would say, "I really think that Louise..." The good thing about Children's is that every surgeon we had in that group was excellent. So it wasn't a question of, "I'm going to send you to the more competent or less competent," but very often you would choose Louise because she was very competent and excellent at what she did, but she also had a great bedside manner. So if you were to tell me, "The mom is so nervous," I would say, "You know, Louise might be just the right person for you, because she could calm them." Now having said that, Dr. Koop was excellent at that, and many of the surgeons that I could mention. I don't know if you've talked to Michael Nantz, a surgeon now. He has that sort of temperament. He's very calming and that sort of thing, and he was one of our fellows, although later on.

EHRHART: Regarding the families and the patients, you mentioned how good she was at maintaining all their details and where they were and what they were doing and following them. Is there any particular situation that is vivid in your memory in that?

PINA TEMPLETON: I think something that might interest you is the first pair of conjoined twins we did. She was very, very involved with those, even though Dr. Koop was the senior surgeon, Louise would have been the second, and at the time my husband was still a fellow and there were two fellows. If you think of conjoined twins, they're basically two surgeries, two anesthetics until they're divided, and then one operating room becomes like two operating rooms. But there's two surgical teams, two anesthesia teams. The first pair was done when the hospital had moved close to Penn. Then a year later Dr. Koop decided he wanted to see what the children were doing, so we all went as a team to the Dominican Republic. The parents were very happy to see Dr. Koop, but they were delighted to see Louise. And she was like a little girl; she just loved the whole idea. It was a tiny town, everybody knew everyone else; it was a very poor town, but the parents of these children were relatively better off because they had a tiny vegetable stand, so in comparison to the poverty of the others.... There was a Catholic mission that took care of the town, and the priest had a beautiful voice and he would serenade us at night. And I can't remember -- I think I slept with Louise because we basically slept in the convents; they put the women with the nuns and the men with the...except for Dr. Koop, I think he slept with his wife, they had a special room for him. But the priest would serenade us at night. She was like a little girl; it was great thing. It fascinated me because she ate all the food that they prepared for us. Some of it, I wanted to know what it was made out of, but she was a much better sport than I was.

EHRHART: Well, everybody has their own comfort levels.

PINA TEMPLETON: But she had traveled in different areas much more than I had done, that sort of thing. She always enjoyed people. There was a urology summer picnic, because one of her good friends was a surgeon by the name of John Duckett and Peggy Duckett. He has since died so I don't think he'd be on your list of interviewees. But he had a picnic for the incoming urology residents. She was always one of the favorite people there and she would stay until late at night because there'd be singing around the campfire and that kind of stuff. She just enjoyed

people. When I say she was “shy,” I think “reserved” may be the better word, because she was also a strong person. She didn’t, for example, love to give conferences or talks, she’d rather be a one-to-one person, although she would do it.

EHRHART: Hospitals can be competitive and stressful places. How would you say that Dr. Schnauffer dealt with that stress and maybe conflicts that arose, either in and out of the operating room, among colleagues, and/or among fellows?

PINA TEMPLETON: She did pretty well. My husband would be better to answer that. But I think sometimes she was hurt. Again, I’m looking at it as a woman to a woman, because she was in a field that was all men. There’s an old dictum that women have to do twice the work of men to be considered half as good, and then the answer to that is luckily that’s not hard, and that might describe her. She probably had to be twice as good as the men, and probably worked twice as much as the men. It was a totally different era, this is before the women’s movement. You felt a certain responsibility that you were forging the way, and you were not going to make any mistakes because you wanted to give an easier road to the woman that came behind you, and I think she was very cognizant of that. So I think she always crossed the “Ts” and dotted the “Is.” and made sure that everything she did was above-board. I’m not only talking about ethically, but just how she related to the men and so on. But I think sometimes it was difficult for her. A man may be chosen over her for one reason or another. By the same token, Dr. Haller at Johns Hopkins really wanted her back, and Dr. Koop wanted her, so we’re talking about maybe the 1950s [sic] or something like that. So even though I say it was difficult for her, they also recognized that she was really worthy of who she was.

EHRHART: How many women were in pediatric medicine at the time that you worked with Dr. Schnauffer?

PINA TEMPLETON: On the attending staff? She was the only one.

EHRHART: But aside from that?

PINA TEMPLETON: You’ll have to check this, but over the years they’ve probably had, until recently, because I’ve been away, about three or four fellows, female fellows.

EHRHART: And how about in anesthesiology?

PINA TEMPLETON: We had more. We generally had about...in a group of five fellows, because the residents, it’s hard...it varied, but maybe half of them would be women. But we didn’t have a woman on the attending staff until 1977.

EHRHART: With you?

PINA TEMPLETON: Yes. But then after that Dr. Nicholson came behind me, and other women, and it’s a very different department now.

EHRHART: How long were you the only woman?

PINA TEMPLETON: Maybe for about three years. Not long.

EHRHART: I'm asking this about your studies: Did being a woman in a male-dominated field create any obstacles that needed to be faced or overcome as you pursued your studies or your career?

PINA TEMPLETON: I guess I would have to answer that in that I never vied to be the head of the department, so that made it easier for me. I didn't feel, having said that I was first woman, that they treated me differently. I think we imposed on ourselves to be the perfect woman. We wanted to make sure that there were no questions about our abilities, but it's self-imposed. I don't remember criticism about that. For example, I became pregnant three months after I was hired, and I had this fear of telling them, and it wasn't an issue, but there were no provisions for women that were pregnant. I'm not faulting the department at all, it was just the era, whereas now....

EHRHART: But I guess it worked out since you....

PINA TEMPLETON: Oh, it worked out. I wasn't fired or anything of that sort. It worked out, and I had an easy pregnancy, which also helped. If I can go back to the first conjoined twins, I was one of the anesthesiologists as a fellow. Now what happened is that I was aware that these twins were coming before the department even knew about them because my husband was a fellow in surgery. So what I did, this is before the era of computers, so I went to the library and looked up everything I could find in the index medicus, as far as anesthesia for conjoined twins, even surgery, and I made four copies of everything. I gave one to my husband so that surgery had it, but their problems were different than ours, and then I gave one to my chief, and one to the head of the OR, I kept one, obviously, and one was an extra. So when they came to choose who were the fellows that were going to be involved, they had to choose me because I had done all this work. Now had I not done the work, I don't know if I would have been chosen, because probably the men.... Maybe I would have, maybe I wouldn't have. But I put it on myself to have done all this so I could be sure that I would be one of them. Having said that, though, because I had done the first, and then I did another group, even after Dr. Koop left CHOP, Dr. O'Neill that followed Dr. Koop would generally say, "Well, Pina's experienced, but I leave it up to you who you choose," but logically I would be one of them. So in that sense they didn't make differences between men and women. But the initial I think...and you may find that in your own field, I don't know.

EHRHART: I don't know that I'm in it enough yet to make that determination, but it'll be interesting. Were there any situations that arose as you worked at Children's Hospital that were due, at least in part, to the fact that you were a woman?

PINA TEMPLETON: Not personally. I think if you were to question others.... I always had a problem with women that would complain that things were done differently because they were women without they themselves looking at whether they had been...what their part was in the whole issue. And you know very well that we turn to tears when we want things to get done, or women will do that. You can't have it both ways if you want to be in a man's world and want to

be considered equal. I truly believe that women are women and we bring something different to the table, and that's fine. We see things differently, we act differently, and that's totally fine. What I don't approve of is to have different recognition because we're women – either lower, whether it's monetary or whether it's career-wise. But I didn't see that for myself, although I'm not sure about others. I always felt that, for example, Dr. Nicholson is the head of cardiac anesthesia. She is extremely bright, very good at what she does, and it was clear that that's where she was going to be because she was so good, but she worked very, very hard. I don't know, and I have no way of really knowing, whether had she been a male, whether she'd have to work as hard. But how can you say that?

EHRHART: Yes, it's hard to know, isn't it? How do you believe that Dr. Schnauffer made a name for herself in a male-dominated field?

PINA TEMPLETON: I think Dr. Koop helped her quite a bit, initially. Then it was just her abilities. And she did publish some. I can't tell you the studies, but she did some lab work. I think it was mostly her surgical skills and teaching skills. If you went to surgical conferences, she was extremely well thought of by colleagues that had not necessarily trained under her, but just knew of her. The surgical societies are small societies, so they knew each other, and she was very well thought of.

EHRHART: How do you think that Dr. Koop helped her?

PINA TEMPLETON: First of all, he hired her. He thought of her as a colleague, and deferred to her very often, appreciated her counsel. Dr. Koop knew exactly who he was, and yet he could be humble enough that if Louise was right, he just took her counsel. She was the third person, I think, you would have to check on that, hired by Dr. Koop. I think when Dr. Koop hired a partner, it was Dr. Harry Bishop, and then Louise was the next one, or maybe the fourth one. But I don't think he made differences. I didn't have the feeling that he thought that Dr. Bishop had better judgment than she. Louise also became somewhat of a family member, so wherever he was, very often there was Louise. Whether it be at his house...I always remember cleaning this big fan that Dr. Koop had at his house. We would clean it for him. It was sort of what we did when I was a resident, and Louise could do it better because she was tinier than I am. But if we say that, it sounds as if Koop was abusing us – we had fun. My husband was a fellow at the time, we didn't have children. We spent the day at Dr. Koop's house, and it was a fun day. He would tell us stories.

PINA TEMPLETON: One interesting case about Louise, which I was not involved because we were away, but was a little orangutan. Probably people have told you about the child – it's not the child, it's an orangutan. But the baby orangutan was born at the zoo, and he had a congenital anomaly which is common in children, not in orangutans. They didn't know what to do. They called, what I can't remember is whether they called Dr. Koop or Dr. Schnauffer, but they admitted the baby to Children's Hospital and they put it in a separate room away from all of the other babies. Then the pediatric residents decided to have fun with the surgical residents, and called them and said, "We have a new baby that has some strange anomalies. We don't know what they are, but I do think that he has an acute abdomen, or a surgical abdomen. Will you come and see him? But let me explain to you, the baby's very [indecipherable], and he has

reddish hair, and he has long, long fingers, and his toes look almost like fingers.” So you can imagine the poor, tired, surgical residents that went to see this – first looks at him and goes, “He almost doesn’t look human.” And he wasn’t human. But then they thought better of it and they actually admitted him to the vet school, which is close to Penn. Then the next day Dr. Koop and Louise went to operate on the little orangutan, and did that. I think he’s still alive. They live pretty long. I’m not sure where he is now, but Michael Goderer was the surgical fellow at the time, and I think he was part of the operating team.

EHRHART: When you were at Dr. Koop’s home with this fan and so forth, was that like a work day or something that they had, or just a gathering?

PINA TEMPLETON: No. He would say, “Oh, I think it’s time to bring things out to the yard,” and we would say, “Dr. Koop, do you need any help?” And he would say something like, “Oh, I don’t think so, but it’d be nice if I had some help.” It would be on a Saturday or something like that.

EHRHART: Actually, Mr. Dr. Templeton actually mentioned something of a garden day, or something like that, and I was just wondering if perhaps it was the same.

PINA TEMPLETON: We were two fellows who lived in Center City, and Dr. Koop lived on the Main Line. I can even remember it was down Blackwell Road. It was just a fun day. He was a great raconteur. He would tell you stories of surgeons of his time, or how he came to Children’s Hospital, because it was right after World War II and he was told to go to Children’s Hospital. He had no idea he wanted to be a children’s pediatric surgeon and stuff.

EHRHART: Sounds like it was a very memorable time.

PINA TEMPLETON: It was a fun day.

EHRHART: How about with Dr. Schnauffer? Did you ever notice, as far as gender is concerned...did you ever notice any situation that came up? For example, one fellow told me about a comment that a male, it wasn’t someone in general surgery, but someone who was passing by happened to make a very gender-oriented, unnecessary, inappropriate comment to them as they were working with a patient. I was wondering if you ever observed anything like that, or any other situation that you were aware of, where, I don’t want to say that Dr. Schnauffer had to struggle because of her gender, but her gender was...?

PINA TEMPLETON: I wouldn’t have noticed that in the operating room. Outside of that, I think the residents or colleagues may have noticed it, because they just spend more time in that sense. I never had the impression in the social situations where there were other surgeons. I think if you think about it, just a social situation, for example, when we had parties here, for one reason or another, if anything they were amazed that she was a surgeon. They were enthralled by the idea because she came off as very understated. You know how some women just come in and take over. She would come in quietly and softly. But at the same time in the operating room she had a very commanding presence, but it was not prima donna-ish. There’s a difference.

EHRHART: On the same lines of the whole gender issue: Did the women who worked in pediatric medicine at Children's Hospital at the time you were there ever develop a unique bond, alliance, or relationship?

PINA TEMPLETON: There is such a thing as women in medicine and that sort of thing. She was more active with that than I. We did in the sense that sometime you just wanted to talk to women in medicine rather than men in medicine. But once again, it was very ad hoc. We didn't go out together necessarily, or sometimes we did, but it wasn't a coffee klatch-type thing, because we were busy -- when you're finished. You know who she tended to go out much more with was the nurses. Because I had children, and once I was finished I felt I owed them the time. She did travel with other women that were involved with Children's Hospital, not necessarily physicians.

EHRHART: Were there instances in which women doctors needed to unite to deal with gender-related issues at Children's Hospital?

PINA TEMPLETON: Not in my time. I think more recently. They didn't in a protest form, I don't mean that at all. But because there were more women, many things changed such as maternity leave. The whole idea of maternity leave appeared, whereas we didn't even think about it. Of course it wasn't an issue for Louise. But I wouldn't say...it wasn't done on the protest. But I think she was, for example, very helpful. I don't know if you talked to Holly, I'm trying to think of her last name.

EHRHART: Hedrick? No, I didn't.

PINA TEMPLETON: But she basically replaced Louise when Louise retired. And she was very helpful to Holly. There were no competition, and that's where I say that Louise was unique in that, and that she felt that Holly should be taken care of, and helped her in every way, rather than hampering her, because she was the young person that was going to take Louise's place. Even though Louise knew that at some point she was going to retire, there's always that little bit, "who am I?" But she wasn't like that at all. I think if anything, she was extremely supportive of Holly.

EHRHART: Can you tell me about what kind of personal relationship you developed with Dr. Schnauffer?

PINA TEMPLETON: I would say it was more of a friend. There was an age difference, but it wasn't visible. I felt I could go to her for advice. She would come to me if she was concerned about something. There was one time that she didn't feel well and I didn't want her to go home, so I just brought her here. I remember our children being worried about her because they knew her as Mrs. Claus.

EHRHART: You said you would speak with her about different things. Why did you approach her in specific?

PINA TEMPLETON: Because she was a physician, she had been there before I was. I didn't necessarily talk about very personal things, but if I was frustrated about dealing with a particular surgeon or something, I would feel she would understand as opposed to going to talking it over with my sister, who is not in medicine. She also had had a very interesting life because of her travels. Sometimes we would just talk about, "Louise, what have you done?" or, "Louise, come over, I know you don't just want to go home. Just come over," that sort of thing. A good friend of hers was Shirley Bonnem. Have you talked with her?

EHRHART: I haven't interviewed her for the project because she was in administration as opposed to....

PINA TEMPLETON: But they're very good friends.

EHRHART: There are only 12 people that I interviewed, or am interviewing, I should say, since this is the last one. The project is pretty much over, in the next few minutes, as we wrap up, the project, the interviews will have concluded. There is only so much time and allotment available for interviewing, unfortunately, because I could probably make a list of another 24 or 50 people I could interview. But the project scope doesn't allow it.

EHRHART: Is there anything else you might like to say about the way in which she provided counsel to her colleagues, fellows, and how you personally may have benefited from her advice?

PINA TEMPLETON: I think they would speak better to that than I can. One of the things I relied on her: when I had to give my talks in anesthesia she was a great source of slides because she would save everything. Often you take, well, now they would be digitals, but at the time you took slides of surgical procedures, and especially if they were interesting. She had the greatest library of that, so we all would benefit from it. I'd say, "Louise, I need slides on fallowseals," or something like that. She says, "Well, I want them back." I said, "Louise, all I want to do is copy them." That saved you an enormous amount of time, and I always had the best slides in the anesthesia-type conferences, because you could show all of these wonderful surgical specimens. So in that sense, and then you could also go to her and say, "Louise, it's an anesthetic talk, but tell me a little bit about the surgery so that I can apply it." She would just sit down and go step-by-step and just tell you. And that took time on her part.

EHRHART: So you would say that in addition to what you were mentioning earlier, about how you could talk with her about if there was a certain situation and frustration, or what have you, but also on a professional level, you always felt as though you could approach her for, in addition to the slides, just information about...?

PINA TEMPLETON: Let's say that the patient had had a general surgery procedure, but was coming in for an orthopedic procedure, and even if it wasn't her patient, you could go to her and say, "Louise, what am I dealing with here?" Very often she would remember the patient because someone had talked to her about it. She had a great mind like that. Or you could say, "Louise, if I pull out the chart, can you explain to me what they actually did?" because very often you felt more comfortable to go to her than the actual surgeon. Other times you just needed to know what the surgery would have been like, you didn't have to know the particulars. She was such a

fount of knowledge, and a great, great memory. She would remember patients, procedure, name, and the parents, and very often, siblings. Not always, but very often siblings.

EHRHART: You had mentioned something earlier about her, and this really, totally takes us to a different place than what you had just mentioned. I've reached the end of my questions. One thing that I wanted to ask you about was the role of her religion and spirituality. You had mentioned before that she viewed people first of all as a human, and then as a child of God, and then on a professional level. So my question is: Were there other ways in which you felt that her religion or spirituality impacted her work or any other aspect or way in which she dealt with people or what have you?

PINA TEMPLETON: If you think about someone that didn't really take a whole lot of vacations for herself, but was always on mission-type, medical missions.... But I think her ethical behavior was founded on the fact that she viewed everything...that didn't make her a bad scientist, she wasn't one of those people that, "God's going to see it through," and stayed back and let God do it. She felt very strongly that you worked to the best of your capacity, but that there was a higher power up there that she called God and Jesus that helped her in everything that she did. She also, I think what I could surmise by the way she spoke, that she did what she did, yes, because she believed in her career, because she believed in her patients, but she also believed that this was in God's master plan, that she was part of his master plan for her, and that's what she was called to do. She wasn't the type that she quoted the Bible every five minutes. I never saw that, it wasn't a person that didn't look at a scientific paper for what it was, it wasn't one of those. Religion had an integral place in her life, but it didn't occlude the fact that she was also a science person and believed in science. She wanted to see what particular studies and what value the studies were. It's hard to explain, because there are religious people that talk about religion, and there are others that feel the presence of a power and a higher presence that permeates all their life, but they're very sort of normal individuals, and you're very comfortable with them.

PINA TEMPLETON: I'm sure in her lifetime as patients, she had Christians, well, for sure she had Christian, Jews, and other religions. But she also had atheists, and I think you have to respect them as much as you respect the Christian, the Muslim. I have a little bit harder time with Jehovah's Witnesses, but I still respect them, and I think she was capable of that. The atheist is a very interesting person, because I think for the most part, there is very few. I don't know...I think many of them are agnostics that just don't know what's out there and what to believe. Then there are some that are truly...the angry atheist I have no time for, because I think there can be no discussion, but there are individuals that don't feel that there is a higher power, that everything can be explained by science, and even if it can't be explained, they're just not going to accept that there is somebody up there. I don't want to get into the problem of intelligent design or creationism, or that kind of stuff, but they still have to be respected because there is a spirituality to those people which we may call differently. I think you're beginning to see that back in medicine, where the patient is not a case, is not a disease, but there's a whole part of the patient that is non-tangible, somebody may call it a soul, somebody just spirituality, but it's whatever makes them work the way they work. In my mind, the atheist is part of that. It's a different language that you have with them, but you still can communicate.

EHRHART: I just want to make sure that I'm understanding correctly, in that you said that there are two types of, there are of course more than two types of people, but the two that you named in regard to religion, and a Christian religion, is: one person who talks about it a lot, and quotes Bible verses or what have you, and another person who...

PINA TEMPLETON: Lives it.

EHRHART: Lives it. Okay. And so where does she fit in?

PINA TEMPLETON: She lived it. She was certainly a person that read the Bible and believed in the Bible. Her church was the 10th Presbyterian in the center of Philadelphia, and she was a faithful attender of it, and she truly believed. But her religion permeated everything that she did. She didn't necessarily quote the Bible, or I don't remember in the operating room, saying "Oh, Second Corinthians," or whatever. There are people that can quote very well, and you don't see it in their actions. With Louise, on the other hand, and maybe I'm being too strict in that, but with Louise, you saw what the Bible said without her quoting it because she acted. So I think, if I can go back, even if there was a non-religious person, or a person that didn't want to have anything to do with religion, they felt and saw that there was something different about Louise. They could explain it in many ways, or they could just try to understand what made her the way she is, and if you did, then you'll realize there are many factors to a person's being, but in large part was her religion.

EHRHART: Would people seek her counsel in spiritual matters as well?

PINA TEMPLETON: That I can't tell you. I would presume so, but I don't know. I never did.

EHRHART: Is there anything else that we haven't talked about that you would like to add at this point?

PINA TEMPLETON: No, I think you've been more than thorough. I felt like I went through my boards again. I'm just very glad that this is being done for her, because I think wherever history will appear, it will be very good for, especially women, but not only women, to read what impact a tiny little woman that probably weighed maybe 105 pounds in her heyday, what impact she had on the field of pediatric surgery and just people that came across her.

EHRHART: This has been an interview with Dr. Josephine Templeton. It is May 23, 2007. The interview was conducted for the Louise Schnauffer Oral History Project, which is funded by the Foundation for the History of Women in Medicine, and is being conducted for the College of Physicians of Philadelphia.

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