FILE: MELHUISH1

EHRHART: Today is April 9, 2007. My name is Mindy Ehrhart and today I'm interviewing Ms. Marie Melhuish. This interview is being conducted for the College of Physicians of Philadelphia and the Louise Schnaufer, M.D. Oral History Project, which is funded by the Foundation for the History of Women in Medicine.

EHRHART: Can you start by please spelling your name and providing your job title?

MELHUISH: Yes. My name is Marie, M-A-R-I-E, Melhuish, M-E-L-H-U-I-S-H. I'm a nurse in the operating room here, and presently I am the project manager for the construction of the new ORs that we're building at the Children's Hospital of Philadelphia.

EHRHART: Can you please describe where and when you trained to become an operating room nurse?

MELHUISH: I went to nursing school in Philadelphia at Saint Joseph's Hospital, and we had some exposure to the operating room at that time, for about six weeks. After I graduated from school, I stayed at that hospital and worked there for a year and a half before I came here. So I would say that most of my learning to be an OR nurse was here at CHOP. My basics, my original basics, were at Saint Joseph's Hospital.

EHRHART: And where is Saint Joseph's Hospital located?

MELHUISH: At 16th Street and Girard Avenue, Philadelphia.

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

MELHUISH: I've known Dr. Schnaufer since November of 1976. I've worked here since then. When I first came to work here I heard everybody talk about Dr. Schnaufer, "Aunt Louise," "the little lady," someone who you could tell was very well-loved. And then I got to meet her and she truly was a very tiny little woman who just seemed to have the respect and the admiration of everybody that she came into contact with. I worked with her from November of 1976 until her retirement. I can't really remember when her retirement was, about five years ago, maybe? About five years ago. So the entire time I worked here I worked with Louise.

FILE: MELHUISH2

EHRHART: You were talking about that you had heard about Dr. Schnaufer before you had met her. What were the types of things you were hearing about her, and how was she described to you?

MELHUISH: She was actually the very first female surgeon that I ever met, to be quite honest, because I hadn't worked with any before I came here. There were a couple of residents around, but Louise was the very first staff physician that I ever worked with who was a woman. She is a maternal figure for a lot of people. She cared about what happened to nurses, she cared about what happened to the surgical fellows, she cared about the people in her department. She was kind of like everybody's watchdog. People would talk about her and speak nicely of her. She was kind of leery of new people, but once she knew you, you were fine. And it didn't take long for her to know you, either. She was pretty welcoming that way. She was very close to the people that she worked with all the time. If you were the new person, it probably took a couple of weeks, but not much longer than that. It was a very comfortable environment when you were working in her room.

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

MELHUISH: I worked in both the scrub and the circulating role. I was young, I wasn't as experienced as some other people, and there was a lot to learn. Louise actually taught us a lot. She taught me a lot about anatomy. She was very good at explaining what she was doing. She was an excellent teacher. From the beginning of every case she was teaching the residents that she was working with, she was teaching the nurses, and she never cared about any questions you asked. She never made you feel like any question was not the right question to ask. She liked to teach, so she'd like to teach anybody who was there.

EHRHART: How could you tell that it was something that she enjoyed?

MELHUISH: From the look on her face, from the way she spoke.

EHRHART: Which was how?

MELHUISH: She was wonderful with patients. Patients and their families absolutely loved her. If you just watched her with them, she was just kind and warm, and very inviting. She was the same way with the nurses and the physicians. She would joke, she just encouraged you to be you. She was never intimidating; you never had to be nervous when you worked with her. It was just a nice, peaceful environment that everyone enjoyed being in.

EHRHART: In her teaching role you said that you could tell that she really enjoyed teaching. Was that also by her voice and the way she spoke?

MELHUISH: Absolutely. She had a wonderful way about speaking to people. She never raised her voice. She could get short if she was nervous about something, but she never made you uncomfortable.

EHRHART: Can you describe what some of your responsibilities were prior to surgeries that would occur when you'd work with Dr. Schnaufer?

MELHUISH: When I first came to work here it was a lot easier to know what is was people wanted to do. Things were a lot more standardized, I guess we would say, that's the word we would use today, and there wasn't as much technology involved. We knew what everybody liked to use, that was pretty much what we had. It was easy to get ready. You always knew how you were to position your patient, so you knew what kind of tools you needed to get to get your patient in that position. You knew what instruments you needed. You knew what suture you needed. It was just a very easy place to work in the 1970s when I first came to work here.

EHRHART: And then that changed over time?

MELHUISH: Yes, and that has a lot to do with technology. The whole place has expanded. When I first came to work here, I think there were only maybe seven operating rooms functioning, I may even be exaggerating that. They had moved here from the old hospital, and everybody talked about the old hospital, and I was really sad that I never got to be a part of the old hospital, that I never even saw. And now I kind of long for the old hospital right here in this building, because we went from six or seven ORs to right now we have 16 rooms, and pretty soon we're going to have 22 rooms. The place has really grown and expanded, and that would be in every service. Every surgical service has just really blossomed with people and technology. It's much more difficult to work here now. You really need to be specialized, because you need to be able to know everything that you're going to use intimately – in and out. You need to know how to work all the machinery and how things are changing, and everything's computer-driven. It's a whole different atmosphere than it was when I first came to work here. But before, when it was a smaller place and there were fewer options, and you just knew what to do and everybody worked well together, and we knew how it was going to go. Pretty much we got ready for patients, and it was easy to turn over between cases and it just was a nice flow.

EHRHART: Do you believe that even though...maybe the number of procedures or the nuances within different procedures has increased? Would that be accurate?

MELHUISH: Absolutely.

EHRHART: Do you believe that patient care capabilities has also increased with that?

MELHUISH: Oh yes. We took great care of patients then, and we take great care of patients now. But it's just so technically driven now. It just makes it more difficult to do. But I believe we take great care of patients, which is probably one of the reasons that I've stayed here as long as I have, because I've never doubted the integrity of anything that we do here.

EHRHART: If you don't mind me just asking about some of the nurses or the RNs that are coming in to Children's Hospital now. Is their training accommodating these additional technologies?

MELHUISH: Absolutely, yes. Orientation to the operating room, which used to probably take maybe four to six months, now takes minimum of one year, it really takes a long time. The new nurses that come in spend maybe a month to six weeks per service as they move along. We have a very organized perioperative course now that we never had to have before. When I first came

to work here it was like on-the-job training. You came in and you just got matched up with your preceptor, and we didn't even call them preceptors then. You just got matched up with this person and you just moved with them from service to service, or you would move with the person who was in charge of the service. Now there's this official precepting program. We have the whole perioperative program that truly takes at least one year to go through each service so that you feel competent enough to do what you have to do. We used to take a lot of call. Call responsibilities are not as frequent as they were previously. Part of that has to do with the whole working schedule has changed. Before you never worked more than eight hours, unless it was an overtime day. If you worked overtime and you were on call, we could potentially work 24 hours. You can't do that anymore. Even the law won't let you do that anymore. It's very different. There are specific people that work every shift, so there's not so much call to be taken.

MELHUISH: Younger people are more protective of their own personal time. They work 12-hour shifts as a routine, which, when I was their age, nobody ever thought to work 12-hour shifts; an 8-hour shift was about as long as you worked. Now people like to work 12-hour shifts three days a week and then not work anymore during the week. They really don't like to take call. For a while it was really kind of hard to understand people. If you came to the OR to work, you knew you had to take call. Why would you come here if you didn't want to take call? It was just part of what we did. But they're more protective of their personal time, and lots of us have gotten to benefit from that. Younger people just...they want more concrete teaching, and I think because things are so technologically advanced they really need to have their hands on and touch things and feel things. It's a little more difficult I think for them to adapt. You can't just walk into a room and think, "Okay, I've done that, I can do the next thing." Sometimes you really need to have experienced that procedure before you can go in there and function independently, just because of everything that you need to come into contact with during the procedure.

EHRHART: When you say "call," are you referring to being on call?

MELHUISH: On call. When you have to come in. We used to come in from home if there were emergencies at night. There was never a night shift. The latest anyone worked here was 11 p.m., our 3-11 staff, and then you were on call from 11 to 7 in the morning. You'd get called in maybe 40 to 50 percent of the time. And then we became a trauma center. Somewhere around 1986 I believe we became a trauma center, and from that time on when you took call you needed to sleep in the hospital, you needed to be on the premises. Then as times got busier, we had a night shift with back-up call. So the place has just really grown and grown and grown.

EHRHART: When we were talking about training for specific procedures and specific technologies, it sounded as though the training for those particular technologies and procedures actually occur after the RNs begin working.

MELHUISH: Absolutely. You can have class time and you can learn about certain things, but when you come into contact with it and need to learn how to function this machinery.... You have to experience things to anticipate what you need to do next, and that's part of what you learn as an OR nurse. Probably in any profession, but I think as an OR nurse you really need to learn to anticipate the needs of others, whether it be the anesthesiologist or the surgeons, and it's

all for the patient. But it's best that you know it and experience it so that you can tell what it is you're going to need as you move from case to case, or through each portion of the procedure.

EHRHART: I guess what I should be asking more specifically is: Where is the training being done for these new technologies, is it being done as the new RNs are being trained as nurses before they get to the operating room, or is it being done in the operating room?

MELHUISH: It's being done in the operating room.

EHRHART: So the actual training of RNs, as far as these procedures are concerned, it's not so much done in school, it's done more on the job after they're hired?

MELHUISH: It's done on the job, absolutely.

EHRHART: Is there a particular course that one needs to take in order become an OR nurse?

MELHUISH: Like I told you before, we run our own perioperative program, but there's a couple of programs around the city. Delaware County Community College, Jane Rothrock, who is a big name in AORN, which is the professional organization for OR nurses, she runs a program there, and we have ours. Lots of different hospitals have their own setup systems. But you can go to these programs, and then you have to go out and do internships as you go on. We have two nurses actually working here now who just recently went through that Rothrock course and came here to do their internship, and then as a result of that, came here as employees. And in addition to them we have five or six other people right now in our perioperative course that are going through their orientation.

EHRHART: Thank you for explaining that. My next question was: Did your responsibilities change over time, and I think you've communicated that they have. Is there anything else you'd like to add to that?

MELHUISH: I've said this to a lot of people, you wouldn't be the first person I said this to, but if I walked into here as a 23-year-old, I don't know that I'd be here 30 years later because it's just so much harder than it was before. And I don't think 23-year-olds go anywhere and stay for 30 years anymore either, but it's just...

EHRHART: What do you think would make it easier or more, I don't know what the word is, doable, approachable? What would make a 23-year-old walking in here want to stay, not necessarily about the environment, but the job itself?

MELHUISH: The job itself? I don't think there's anything we can do to change it. We can't stop progress. We just can't do it and things are just going to continue to change. Actually, in some aspects I think for a younger person it will be easier, because technologically they think differently than I do as someone who was raised in the 1950s and 1960s. Younger people I think are hard-wired differently than I was, so maybe it won't be as difficult for them to do. It's actually a much more physical job, too, than it used to be.

EHRHART: Physical in what way?

MELHUISH: Physical in a lot of this technology you need to move things in, move things out. For a number of years I worked in orthopedics, and it's a pretty physical environment to be working in.

EHRHART: In addition to being physical, does it also require timing of that physical shifting things around?

MELHUISH: You just need to know how to plan for it and get it done. Even when you know in advance there's still a lot of work to be done. If we had better support services I think it would make things easier. We have them, it's just a matter of also educating them to get to where you need to be. Actually, we're also going to be working in a new facility. We're building these eight new ORs, and they are going to be very cutting-edge in technology, and the rest of the ORs will then have a renovation process that goes on. So that will tend to make things a little bit easier, I believe.

EHRHART: Can you please describe who else is part of the OR staff, and describe your interaction and/or responsibilities for working with them?

MELHUISH: We work with anesthesiologists, surgeons, we have our support staff. We have core techs, anesthesia core techs, we have people who work in processing who take care of cleaning and the resterilization and the processing of all our instruments, environmental services. It's a very big team and everybody's very dependent on one another within the OR. You have to be, nobody can practice in isolation of anybody else.

EHRHART: What would your interaction, let's say with the anesthesiologist, be?

MELHUISH: I think we have a pretty collaborative process that goes on here. We have meetings every morning – we're supposed to have meetings every morning -- to discuss the patients through the day and if they're going to want any special equipment or anything that they need to do. And then we together go and speak to patients, the nurses and the anesthesiologists, sometimes together, sometimes it's the nurses after the anesthesiologists have seen the patients. We bring the patients into the room. We stay with them while the patient goes to sleep and help them with anything they might need to get that started. And then they're there for the whole procedure. We help them with things that they need, and we're also right with them, right next to the patient while the patient is waking up also. And always planning for the next case to come.

EHRHART: So the staff again would consist of the physician or surgeon, the scrub nurse, the rotating...

MELHUISH: The circulating nurse.

EHRHART: Circulating nurse, I'm sorry.

MELHUISH: The surgeons.

EHRHART: Anesthesiologist.

MELHUISH: Residents. Anesthesia residents and surgical residents.

EHRHART: And then how about the other people that you mentioned, are they necessarily in the room with you?

MELHUISH: At various times during the procedure. Sometimes it's before the patient comes into the room or after the patient leaves. Our core techs are the ones that help us bring our instruments in, help us clean up the room after the case is over, help us turn the rooms over. The people from processing that work here, they'll bring us instruments as we need those through the procedure.

EHRHART: So it really varies then, I guess.

MELHUISH: Yes. It all depends on what kind of a patient you're taking care of.

EHRHART: Can you spell "core techs," please?

MELHUISH: C-O-R-E, one word, and T-E-C-H, technician.

EHRHART: My next question was about the equipment and the procedures and how they've changed over time. I think you've mentioned that, we've covered that. Do you have anything that you want to add to what you said before?

MELHUISH: I don't think so.

EHRHART: How about the cases, how have the cases changed over time?

MELHUISH: An appendectomy, for example, used to be a pretty basic, simple procedure. You brought the patient in, made an incision, used your forceps, scissors, knife, everything. Now we do things laparoscopically. Now you make a smaller incision. Everything is done through the small incision. The patient benefits from this because it's not as large, they can recover quicker. It's actually the best thing for the patient. For us, in the beginning it wasn't a whole lot of fun because we took an operation that could take 20 minutes to maybe an hour, and sometimes you'd drag it out for two, two and a half hours just because you're doing it with optics, you're doing it with remote instruments and watching this on a TV monitor to see what you're doing. That was a little frustrating for me – to know that you took a simple procedure and were dragging it out. However, having been a patient myself, and the benefit of laparoscopic surgery, I am here to tell you that I would support it for anybody. That's one of the things that's different. You had to watch something that was quick, that you could get it done, and now we're going to take all this time and do it this way, but in the long run it's what's best for the patient.

EHRHART: Does it still take as long to do?

MELHUISH: It takes longer. It's gotten better when you have surgeons that do that routinely. It moves quicker, but it still takes longer than when you do an open procedure.

EHRHART: Any other ways in which the cases have changed over time?

MELHUISH: Like I said also before, I used to do a lot of orthopedics, and in orthopedics there's lots of different hardware systems and different things that you do. When you work in general surgery or ENT, you kind of do the same procedure, just a variation of the same procedure through the day. In orthopedics you could be doing any different limb, it could be a simple soft tissue procedure, it could be major reconstruction of something, and as that has progressed, the systems change. You get used to using one thing, everybody's really used to it, we move along, everything's quick, everything's slick, everything's smooth, and then we have a new system, so then everybody kind of steps back a little bit. It's always for improvement. As things improve, things just become different.

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

MELHUISH: Depending on who your surgeon is, you could have a really nice, easy, calm room, you could have a nice, friendly room, or you could have somebody who is intimidating, in which case everyone in the room could kind of be intimidated by what's going on. Everybody kind of is on edge. In the cardiac rooms in this hospital, at least, it's as quiet as a church in there, you could hear a pin drop. It's quiet, it's very regimented, and it's just different. Then you get to a room where everybody's kind of laid back, and chatting and talking and laughing. It pretty much depends on the personality and the type of surgery that you're doing to see what goes on from room to room. I think personality probably plays the biggest part in any room.

EHRHART: Personality of who?

MELHUISH: Sometimes it's the surgeon, sometimes it's the nurse, sometimes it's the anesthesiologist, but mostly I think it's the surgeons.

EHRHART: Understanding that there is that range of dynamics, between intimidation versus laid back or silent and church-like – you said "as quiet as a church," you didn't really say church-like, so let me say that correctly. How do you think the surgeons foster that type of – are they the ones who set the tone or the dynamic?

MELHUISH: I think they do set the tone, they really do.

EHRHART: How do they do that, do you think?

MELHUISH: If you have someone that doesn't like chit-chat in the room, you know not to do it, because if the chit-chat goes on, they get unhappy. They just, I don't want to say, "make it miserable," but they let you know when they're not happy and they don't like the way things are functioning. You know how you have to be. And then you have some people who don't like

working with someone they don't like working with all the time, they prefer... Everyone, that's human nature, you would prefer to work with the people that you really like that would make it easier. So if there's a nurse in there they don't like, if there's an anesthesiologist in there they don't like, don't get along with, things just don't go as smoothly and as nicely as they do when you can pretty much hand-pick who's in your room.

EHRHART: So again, it's about personality do you think mostly?

MELHUISH: Personality, I think it's trust sometimes, because you know if you're with the people you work with all the time, you know you can trust that the right thing is going to be happening all the time. You don't have to worry about questioning everything that happens. And they pretty much know that they just have to put out their hand and they're going to get what it is they need. That's when things are the best, when there doesn't have to be a lot of communication, when it's like an innate thing where you just know you're going to flow from this, to this, to this.

EHRHART: Was the dynamic with Dr. Schnaufer different than with other surgeons?

MELHUISH: Yes, it was. I'll compare her to Dr. Koop. When Dr. Koop was in the room, everything had to be...you had to know, you couldn't think about how things were going to go, you just had to know what the next step was going to be. When he was this many minutes into this procedure, you knew the next patient across the hall had to get started because when he got finished here he was going to go right to that room. A lot of times he would be the first surgeon in the room and he would be followed by Louise -- when I first came here, anyway. He kind of had slowed down in his practice, so you knew the first couple of cases were going to be tense and get them moving and the nervous stomach was going on, and then you knew that okay, Louise was the next surgeon in here. You couldn't wait until it was time for her, because you could kind of take a breath and step back, and then just everything kind of flowed really nicely. She was fun to work with, she really was fun to work with.

EHRHART: What was the dynamic like when she was there?

MELHUISH: Anesthesia was happy, the nurses were happy, the residents were happy. There were some days if she was in a bad mood she would be kind of whiny, but that was a rarity. She wasn't like that all the time at all. She liked everybody to be themselves, and she liked everybody to learn, and she was more than willing to let you know how that would be.

EHRHART: If you could, in one word, describe what the dynamic was in Dr. Schnaufer's operating room, what would you...?

MELHUISH: Comfortable.

EHRHART: My subquestion was: Why do you think it was that way? I think you've responded to that already. Is there anything you'd like to add about why you think that?

MELHUISH: I think she liked to be comfortable. This was kind of like home to her. She wanted people to be happy in her home, so she wanted you to be comfortable.

EHRHART: In a way, you've again touched on this already, in advance. Did the use of different types of tools, technology or procedures change the dynamics in the operating room, and if so, how?

MELHUISH: Yes, it has. Like I said before, surgeons are much more comfortable when they're working with somebody that they know. They're going to be able to anticipate and they know how to use the equipment that they need to use. So when it's someone who's not as experienced, or someone that they haven't worked with before, they're kind of uneasy with that kind of person, so that allows for some unrest to go on until you set up that trust factor.

EHRHART: Do you think that's the only thing that's affected the dynamics in the operating room over the years?

MELHUISH: I think people's personalities are just different than they were before. For one thing, I don't want to say "subservient," because that's not what I mean. Nurses were nurses, physicians were physicians, and you kind of knew what your boundaries were. But now people don't have as many boundaries as they did before, people want to exercise their knowledge and they don't want to be thought of as "just the nurse," or "just the resident." I think all over there's just a different persona in people. I don't think it's just in the operating room, I just think it's the way things have progressed. People just want to be known for what they know, not for only what you think I should know.

EHRHART: Do you think that comes from respect, and a desire for respect and recognition?

MELHUISH: I believe so. I think everyone wants to be respected the same way that they're expected to respect other people. I think equality is something that really is out there, and it's not just male and female but it goes across our boundaries of what our functions are. But everybody deserves the same amount of respect and people now demand it, and I think that has changed the dynamics.

EHRHART: Specifically talking about surgeons and working relationships with surgeons. How does the working relationship with a surgeon change over time as you work with that person? What are the benefits, and then what are the drawbacks?

MELHUISH: Like I told you before, I think people really like working with the team that they're familiar with. The more you work with somebody, the more you learn about them. The more you learn what their capabilities are, the more I would learn how you would like things to function -- just to make things as easy as can be with the least ruffle that there is. To be able to work with the same team all the time would be wonderful, it just can't happen all the time here, that's just not the way we're set up, because you kind of have to be ready to do whatever comes in the door. You can be working with the people that you usually work with, and then we change services in the middle of the day. Like the next procedure, it will be from a different service that you're not used to working with. Say you're doing general surgery all morning and

then all of a sudden here comes an ENT case. Then you change the whole personality of what's going on in the room. If we've been the same four-five people working in the room all day, we have our rhythm, we're doing what we're doing. And then a new group of surgeons comes in. It kind of changes the dynamics of the day, sometimes for the good, sometimes not. Sometimes if you have to work with people that you're not used to working with, it's just not as smooth, it's just not as happy as it was. I think that now, as we've expanded and we keep expanding, the times that you work with people that you were familiar with and comfortable with are fewer than those that they're not. Before it was the exception to work with people that you weren't used to. Now it's the exception to work with people that you like to work with, and that you're used to working with, because there's so many new people, so many people that we're training that it's kind of hard to be able to work with the same people every day. Does that make sense?

EHRHART: It does. I'm thinking about two things. I'm thinking first of all, Ms. Petrillo had mentioned to me that there are also these subsets of, like ENT in one realm, and then there's another set.

MELHUISH: Different services?

EHRHART: Yes.

MELHUISH: We have clusters.

EHRHART: That's what it is. So they are, in a way, trying to accommodate for those types of issues.

MELHUISH: We really are trying to do that. There's one cluster that has neurosurgery, orthopedics, plastics, and ophthalmology, and the other cluster has general surgery, urology, ENT, and I forget who. Cardiac, they're their own team, they don't come across. What we try to do is match up the nurses that work within the clusters within their cluster. You try not to have people work out of their cluster. You just don't want to take people out of their comfort zone. When you take people out of their comfort zone, you just, I won't say "set things up to fail," but it just won't be as smooth, it's not as smooth. Even within your cluster, you're most comfortable in your own service, but you're expected to go out to these other services. We've actually done a good job of trying to match up what services are most alike so that you're pretty much trained in that area and you can be a little more adaptive.

EHRHART: So there are attempts being made within the profession and within the hospital in particular to accommodate keeping people within a certain realm of services.

MELHUISH: Oh, absolutely. Right. Sometimes you may have a whole lot of people from one cluster one day, and not enough people to cover their services, and sometimes people do have to be able to work out of their service. One of things actually that we're working on doing with the next group of people that come in as orientees, because we've had so many people who have come, and they've worked like six, seven months, maybe a year, and then they leave right away.... What happens is you move from one service to the next. You start feeling good about one service and you're doing really well. Then you move to the next one and you're like, "Oh,

I'm starting all over again." So we're thinking with the next group that comes in, I believe they come in June, maybe putting them only in one cluster for eight months – don't move them around to all the services – make them feel really good about themselves in a pretty wide area before you put them out to the whole place. And then maybe at the end of that, move over to the other cluster and work with them. At the end of your orientation you're allowed to choose, right now you're allowed to choose which cluster you prefer to work in.

EHRHART: You said there's a new set of people coming in June?

MELHUISH: In June.

EHRHART: Is that when typically people...?

MELHUISH: No, that's just when our next class is coming in, and I know there'll be another group in September. We try to hire people...an experienced person can start whenever. But inexperienced people that need to take the perioperative program, I think it's four times a year, four or five times a year.

EHRHART: Are there any drawbacks with working with a surgeon, the same person over the years?

MELHUISH: Yes.

[interruption, resume at 35:12]

EHRHART: Drawbacks with working with the same person over time, are there drawbacks?

MELHUISH: Yes, I think because sometimes you can start to take advantage of people, as well as sometimes you get in a rut and you like it the way it is. You don't want things to change and you're just not as open to learning different things. In some ways there's really good parts of working long-term with somebody, but then if you get somebody who's kind of tired of their job and needs to do something different and they don't want to admit that, it just gets difficult. And if you're working with a surgeon, too, who's not the nicest person in the world. They could have started out as a nice person, and as time goes on things just change. I say surgeon, but it could be anybody. Then it gets not to be fun anymore and it's kind of hard to back yourself away from it. Sometimes it's hard to walk away from it.

EHRHART: 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. Schnaufer respond when an unexpected event occurred?

MELHUISH: She pretty much took it in stride. I was in cases with her where sometimes things would go wrong, but she always stayed calm and took care of things. She was never one to act out. She did not fit those stereotypes. She didn't stamp or throw things or carry on. I would say for the most part that kind of stuff didn't really happen in this operating room at all. We might

have had one or two people over the years who did act that way, physically, but not Dr. Schnaufer, she pretty much got right down to it, took care of it.

EHRHART: How did she help others on the surgical team deal with, or the operation room staff deal with it?

MELHUISH: I think that fact that she was so calm and so in control of what she was doing. She would help fellows through very difficult cases that other people wouldn't be as calm with. I worked with some other surgeons who would get angry and huffy – when I say "throw things," I don't mean like throw things across the room – but just like drop something maybe a little strongly on the table or be a little nasty. But she pretty much kept her cool and made everybody else around her keep their cool based on the way that she acted. She diffused a lot. She was a big diffuser. She could diffuse a lot that was going on with Dr. Koop in particular. She could even sometimes diffuse some things with Dr. Bishop, although Dr. Bishop didn't need the diffuser as much as Dr. Koop some days.

EHRHART: When you mean "diffuse," could you elaborate on what you mean by "diffuse"?

MELHUISH: If she came into a room and she knew that somebody was giving you a hard time -- and actually Dr. [Pina] Templeton could do the same thing, I guess it was the maternal thing in both of them -- Pina Templeton, not Jack Templeton. They could start a conversation with the person, or just make a comment and kind of draw the attention away from whatever the unexpected event was or whatever the person that was being singled out as the reason for things not going as well, and they could kind of pull the attention off of that person and bring it to them and work everything out and calm everybody down.

EHRHART: What would be the setting of those types of situations?

MELHUISH: Just when things were going wrong or if somebody was in a bad mood. I can think of days when Dr. Koop would have just been really tense and you could tell something was wrong, and she would just come in and talk to him and just calm him down. She just was a pretty calming influence on a lot of people.

EHRHART: That's not necessarily in the operating room, though?

MELHUISH: I'm talking about in the operating room, yes.

EHRHART: So this would occur as procedures were...

MELHUISH: Yes. You know how sometimes you get up and you're in a bad mood and your bad mood carries you through the day? I think she could recognize when that was going to happen, and so she would put herself on the scene.

EHRHART: In the operating room?

MELHUISH: In the operating room. She pretty much was here the days when he was here. She wouldn't just come along when she knew somebody was in a bad mood, but if she was in the OR on those days she could do that.

EHRHART: She would just sort of pop in almost?

MELHUISH: Pop in and just calm things down.

EHRHART: What would....

MELHUISH: Well, because she would be waiting to do her cases, so she would be here.

EHRHART: So it would be more like a general mood or stress about a particular thing, not necessarily something that happened right then and there?

MELHUISH: No, just somebody's mood. But during a case...I actually remember one day very well. I came in on a Saturday morning and I walked through the doors in the OR and I could smell that something was wrong. I mean literally I could smell, I could smell blood, so I knew there was something ugly going on in this room. It was this kid that had a GI bleed and he was sick, sick, sick. It was a terrible, terrible day. She kind of kept everybody really calm and in gear. It was one of those days where I was really proud of what I did because it was a nasty, miserable case that went on for hours, but she just kept kind of everybody on an even keel. It really worked well just because she could handle herself and have the people around themselves feel sure of what was going on. Does that answer your question?

EHRHART: I think it does. I guess I was more after if it was more situational or if it was an overarching – if it was Dr. Koop having a problem with someone else, or if it was just like he had a difficult day, or....

MELHUISH: It could be both, because actually I was one of those people who he wasn't fond of because I looked like somebody else. It wasn't because of anything I did, it was because I looked like somebody else. It took me a while to prove myself, because I guess when he saw me, he saw someone else. So I was one of those people that Louise could help out by just standing there and talking to him and get the attention off of me and onto her. She could just kind of chill him out so that I could.... That was my own personal experience. Then after a while he finally realized I was who I was, and I was pretty capable, and it wasn't necessary for me anymore. But I knew that she would do that for other people, too.

FILE: MELHUISH3

EHRHART: This is a continuation of an interview with Marie Melhuish.

EHRHART: The next question is: 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 when they occurred?

MELHUISH: I told you before about the GI bleeder. Another thing that Louise was involved with frequently – I shouldn't say frequently, it wasn't like something that happened all the time -- but she was involved a lot when we separated conjoined twins. She would collaborate with Dr. Koop and Dr. Bishop, and Dr. O'Neill, when it was time for him. She was able to handle those situations because they certainly weren't your run-of-the-mill case, there was something different about each and every one of those children that we took care of. She really could handle any situation and keep things flowing, keep it going well. Take learning from that experience and move it on to the next one and be able to apply it to where she went next. Not only did she teach us, but I think she learned from different procedures also.

EHRHART: How did her ways of dealing with these unexpected events in the operating room compare to the ways other surgeons would deal with unexpected events?

MELHUISH: I wouldn't say that she didn't have times when she got angry, but they just were so minimal, they're just not the things that stand out in my mind. But other people, like I said, they would get angry and lose patience with what was going on, and not her. You just kind of knew that we were just going to do the best we could possibly do through every procedure. Whether it was something that was unexpected or routine, it was just a nice learning situation.

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

MELHUISH: I think she did. She respected everybody for what they did. When I first came to work here, it was a smaller, more family-like environment. Everybody did know one another. It was easy to know one another, because it was a smaller place. If you didn't work with them today, chances are you are going to work with them tomorrow or before this week was over. She was nice to everybody: she was really nice to our transport people who took our patients back and forth, she was nice to our housekeeping people. She knew everybody. She would know your name, she would acknowledge who you were. Right now there are certain people in this OR that just walk down the hall and they have no idea who you are, and they don't even necessarily make eye contact with you because they've never worked with you before, so why would they talk to you? But Louise knew who you were, knew what it was you did, and acknowledged that, and was thankful, I think, for all those people, and all those people were thankful that she was here.

EHRHART: In what ways was she "nice"? You said she was "nice." In what ways was she nice and how did she exhibit that?

MELHUISH: Because she knew your name and she would address you as who you are, and ask you questions about things that were going on in your life. She would just remember from day-to-day those kind of things. I think that makes people who don't have major jobs in the OR feel important about themselves, if somebody like Dr. Schnaufer knew who they were and cared enough to say hello and "Good morning, Helen," or "Good morning, Willy," in addition to all the nurses and the doctors. She knew everybody.

EHRHART: What kind of friendship did you form with Dr. Schnaufer?

MELHUISH: I was pretty good friends with Louise. I actually still see her occasionally. For many years we would go out to dinner, we had tickets for the Walnut Street Theatre for probably five or six years, and before that we had tickets for the Forrest. We would just go and do things. And even when she moved to Cathedral Village we would visit her and take her out to dinner, and just go and spend time with her. She would invite us to her house on the river down there in Maryland. A couple times a year three or four of us would go with her to her home on the river and just spend the weekend together and go antique shopping. She's a fun person to be with. And sailing, we used to sail, too. Other people's boats, usually.

EHRHART: Where would you sail?

MELHUISH: On the Chesapeake. Luis Schut, who was a neurosurgeon that used to work here, have you interviewed him also?

EHRHART: No.

MELHUISH: Because he was friends with Louise. We used to go usually every summer to his house and sail, and I know Louise used to sail with him. Many years ago they used to sail every winter, and there was another surgeon here, Dr. Stafford, that she used to go sailing with them. So it was a fun life.

EHRHART: Let me ask a question that's sort of not related to Dr. Schnaufer, but why do you think so many surgeons are into sailing? I have not been able to figure this out.

MELHUISH: I don't know. I guess number one they have the money to buy a boat. Number two I think it's because they're in control of this boat and they can take it out on the water and they really are the captain of the ship.

EHRHART: Being the captain of the ship in the operating room...

MELHUISH: They are literally being the captain of the ship.

EHRHART: When you all would go out as friends, would you bring work with you?

MELHUISH: We would talk about work, because that was really our common denominator. We would talk about old days, we would talk about old residents, we would talk about nurses that we used to work with. There were a couple of very strong people that used to work here, nurses, and Louise was really good friends with them. Unfortunately a few of them have passed away, but we used to talk about them and just remember good times. She is a friend.

EHRHART: Were there also ways in which you would get together at work?

MELHUISH: Sure. Sometimes we would just have lunch together or sit around after work for a while in the lounge and talk and have a cup of coffee. Actually, previously, probably 15 years

ago, the OR did a lot of things together. There was always this big Christmas party every year and Louise was the official photographer of the Christmas party. That was her job. Wherever she was, she was the official photographer. She would always take these pictures, and she would bring two copies of everything, one for the album, and one to give to the people who were in the picture. She was always passing around pictures. But we did – we used to do a lot of things together. We used to have a lot more parties where everyone was involved, and Louise was always part of all of that.

EHRHART: But you don't so much anymore?

MELHUISH: No. It's just because the place is so big. And like I said, people don't only work eight hours anymore, they work eight, 10, 12 hours, so people don't get off at the same time, and everybody's lives are so busy. It's just not as family-oriented as it used to be. Everybody has their own family, but it's too big of a group to be that cohesive anymore.

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

MELHUISH: I personally did. She used to give us insight into a lot of people more than anything. Some of the surgeons that were her peers, or people that were here in the past. She would just let you know things about them that made you understand better why they acted the way they acted, or performed the way they performed. But I know that the fellows used to love to go and just sit and talk in her office. I know that because I was told that by many of them. They would just spend time with her. She had a secretary, Renate Rodgers. Have you met Renate?

EHRHART: I haven't, but she's been very helpful with this project.

MELHUISH: She was kind of like Louise's protector for a long time, too. But you just knew that everybody was welcomed in her office and she used to give them all kinds of advice, whether it'd be about cases they were doing or what job to take or where to go. She was somebody that they could all turn to. Just a very comforting thing to know that not only was she was there for me, but she was there for other people.

EHRHART: Do you believe that the nurses felt comfortable with also going over to her office and talking to her?

MELHUISH: Not everybody, but there were certain people that you knew that you could go and do that. You were welcomed. No matter who you were, she would welcome you to see her. And she was always very welcoming to people's families. Louise was one of the first people people would turn to. "Oh, my friend's baby has a hernia that needs to be repaired." "Oh, Dr. Schnaufer will see them." Whenever. And actually, a couple of my nieces had problems when they were younger and didn't even think twice, she was the person that they would go to. She was very welcoming to all kinds of people.

EHRHART: You sort of answered this, but why did you feel as though you could approach Dr. Schnaufer for her counsel?

MELHUISH: Just because she acted more like your friend than the physician that you were working with. She was the physician I worked with second, she was my friend first. I guess she became my friend because she was the surgeon I worked with, but then after a time she was more of a friend than a surgeon.

EHRHART: Do you think that, as a woman, Dr. Schnaufer brought particular attributes into her work that enhanced how effective she was?

MELHUISH: I think so. I think the caring -- the maternal side of her that men didn't always have. Men didn't see it that way. I also believe that she thought of nurses as kind, loving people. She never saw a nurse as any kind of...what's the word I want to use? We were never in competition. As more women came into medicine, they didn't treat us as nicely as Louise. I think they were trying to assert the fact that "I'm a woman, and I'm not a nurse, I'm a doctor." They kind of had to let you know they were a doctor. It's not that way anymore. I think it was in the beginning. The earlier women were just trying to get there, and I think they were just trying to stake their claim, stake their ground, and they had to do it. They just had to let people know that they were physicians. But Louise was never like that. I don't think it's like that anymore, I think because there're just so many women in medicine. I don't want to say it's gotten easier for them, but they're not breaking the grounds that the earlier women that came into medicine did.

EHRHART: What do you think was Dr. Schnaufer's biggest contribution to the department?

MELHUISH: I think her personality. Just her sweet, kind personality just brought out the best in everybody I think. It really did. I think we talked before about how she could tend to let herself be abused sometime, but I don't think anything was ever malicious. I just think because she was so nice and so kind. She was the heart of that department. I would have to say she was the heart of general surgery, she really was. She was just who she was.

EHRHART: When we were talking about people depending on her, which you just referenced her being abused, so to speak, it [the recording device] wasn't on, so can you just mention what would cause you to use that term?

MELHUISH: I think that "abused" was not the right word, maybe "taken advantage of." I think probably because Louise didn't have a family that she had to go home to every night, I think that a lot of guys thought, "Oh, I can get Louise to do this," "Louise will do that for me, Louise will do that for me." I think that's what it was about. I don't think they ever did anything to hurt her or be malicious. I just think that she had some extra time to give that they didn't, and they would ask her a little more frequently than they would ask anyone else to do that.

EHRHART: Did Dr. Schnaufer influence your career at all, do you think -- in deciding to stay here or stay in the OR or stay at Children's Hospital?

MELHUISH: I don't know. I think she was probably one of those things that did that for me. I told you before about a group of older nurses that were here. I'm saying older now, they were younger than I am when I first came to work here and I thought they were the older people. But they were the stronghold of this place; they were very well-respected. Not everybody came in here and felt like this was the place they should be, but I did. And there's a large group of people here. I probably work with six or seven people that I've worked with about the entire time I've been here. You're just part of the family, and they made you be part of the family, and Louise was part of that group. She was their equal; she did things with them. And I think she just set up that family atmosphere that led people to stay here for as long as they did, just part of that feeling of belonging.

EHRHART: Is there anything else you wanted to add? I threw in a few extra questions at the end as you could tell.

MELHUISH: That's okay.

EHRHART: Is there anything else that you think we haven't touched on that you think is important -- that maybe I haven't asked about, that I missed in my questions -- that is crucial to understanding Dr. Schnaufer and her role here and her success here and her influence?

MELHUISH: I just think it's a shame that people don't get to meet Louise now and get to see the person that she was and get to share in these experiences. She's the legend now. Now she's a legend, now she's not the real person that she was. She's the real person to probably over 50 percent of our staff, but to the rest of it she's just a legend of someone that we all speak kindly of and respectfully. I just wish that more people could have experienced life with her to see how things were. And I do feel bad that people don't get that opportunity.

EHRHART: Today is Monday, April 9, 2007 and this interview has been with Marie Melhuish for the Louise Schnaufer 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.

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