EHRHART: Today is November 9, 2006 and this meeting is with Dr. Moritz Ziegler, and this interview is being conducted on behalf of the College of Physicians of Philadelphia. It's for the Louise Schnaufer Oral History Project, which is funded by the Foundation for the History of Women in Medicine.

EHRHART: Would you please state your name and your current position, and if you wouldn't mind spelling your name?

ZIEGLER: I'm Moritz Ziegler, M-O-R-I-T-Z, Ziegler, Z-I-E-G-L-E-R, but better called Mory Ziegler. I'm here at the Children's Hospital of Denver where I am the Surgeon-in-Chief, and I'm also a Professor of Surgery at the University of Colorado School of Medicine.

EHRHART: Would you mind providing a brief background of your career: where and when did you earn your MD, and how did you choose a specialization in pediatric surgery? And maybe also you mentioned you were in Cincinnati before you came here, maybe you could give us a brief chronology?

ZIEGLER: I am actually a Midwesterner, I was born in Ann Arbor, Michigan. I went to college in Ohio and then went to the University of Michigan Medical School and I graduated in 1968. And from Michigan – and I might add that during my medical school days I read a Reader's Digest article entitled “What I Tell the Parents of Dying Children” by a guy by the name of C. Everett Koop, who was then at the Children's Hospital of Philadelphia, and I had made a decision during medical school that I thought I wanted to pursue children's surgery. So the long and short of that story is that I ended up matching at the University of Pennsylvania, or the Hospital of the University of Pennsylvania to train in surgery, so I went there as a surgical intern in 1968. I then did my entire residency in surgery at Penn from 1968 through 1974. I spent 1974 to 1975 at the Institute for Cancer Research in Fox Chase. Then I started my children's surgical training with Drs. Koop, Bishop and Schnaufer at CHOP from 1975 to 1977. Then I became a CHOP faculty and Penn faculty member, eventually became a professor of surgery at Penn, from 1977 to 1989. In 1989 I went to Cincinnati Children's and the University of Cincinnati College of Medicine to be Surgeon-in-Chief at that institution. In 1998 I went to the Children's Hospital of Boston and Harvard Medical School to be Surgeon-in-Chief at Boston Children's and the Robert E. Gross Professor at Harvard, and then in 2004 I came to Denver Children's where I've been since that time. So my first experience with Dr. Schnaufer was when she was one of my faculty people when I was a general surgery resident rotating through CHOP, probably in 1972 or 1973, and that was at the old CHOP, and then I came back and was a pediatric surgical trainee there and was one of her partners in practice as one of the faculty members.

EHRHART: Let's hop back a minute to your first association with Dr. Schnaufer in the, as you called it, the "old building." In what capacity did you work with her?
ZIEGLER: My recollection for that time is sort of vague, but I would have operated with her as a junior resident being trained, and of course there were two pediatric surgical residents who were my seniors, so I had probably somewhat of a limited exposure to her. But I do recall a baby with really a horrible problem that I think the senior residents thought was a hopeless case, so they let me participate with Dr. Schnaufer. I think my first recollection was with her absolute commitment and persistence to seeing this really complex problem through to the end. It was really my first major children's operation that I ever did and I did it with her where I was the senior surgeon at the table.

EHRHART: Would you mind describing that particular case?

ZIEGLER: It was just a baby with what is called intestinal atresia, where part of the intestine wasn't developed. I think the child had 12 or 14 different areas of discontinuity of the intestine and it was a preemie baby. We were sewing together these multiple pieces of intestine that were about the size of a very small straw. If you repeat that about 14 or 15 times, it's seemingly fairly hopeless. I have to add the baby did not survive, but it was a testimony to her patience and her willingness to let me be the surgeon and help me do that case.

EHRHART: And did you interact with her throughout the entire procedure?

ZIEGLER: Yes.

EHRHART: In what way?

ZIEGLER: She was the senior surgeon and I was the resident, and so she was my first assistant, if you will. I think Louise's remarkable trait or ability was, is to first of all make you feel like you were very good. She was a very good surgical assistant, so it probably magnified any one surgeon's abilities more than they really were. And then, as you have heard from a bazillion people I'm sure, one of her favorite statements was "It'll be all right," and I think she said that probably two or three hundred times during the operation because she had the power of positive thinking.

EHRHART: Is it through that phrase "It'll be all right," that you believe her patience and her encouragement was displayed the most, or were there other ways she displayed that?

ZIEGLER: First of all, she was almost universally available. I think there's this classic "three As" in surgery, what marks a successful surgeon: ability, affability, and availability. And I would say that Louise would have had those three characteristics way back then during my time when I was the CHOP pediatric surgical resident and certainly when I was her partner. She was a very encouraging kind of person, but she didn't limit that to me, the surgical resident, she would have shared that with the nurses, she would have shared that with the child or the parents. I mean that was just her approach to problems. The truth is that as I got older and more experienced in the field, I realized that that perhaps wasn't always appropriate, to say, "It'll be all right," because it isn't always "It'll be all right." But it was her mantra, and it was how she dealt with stress and strain, and I think those around her looked to her, especially when you're
seemingly overwhelmed with a difficult situation, you like to hear an encouraging word. I think that was why she was such a popular person amongst the faculty as well as the residents.

EHRHART: When you say “popular,” how would you describe that popularity?

ZIEGLER: Don’t forget, there was, at that point in time, and for a lot of Louise’s career, there was Dr. Koop, Dr. Bishop, Dr. Schnaufer. So Dr. Koop is this very egocentric, very skilled, very recognizable human being for all of the reasons that we know. Dr. Bishop was a technically expert surgeon, just really good with a lot of judgment, Harvard training, sort of the pedigree. And Louise was this 5-foot something-or-other, diminutive woman, sort of gianited over by those two other huge leaders. Yet I would say that the “go-to” person was not Dr. Koop and was not Dr. Bishop, but it was Dr. Schnaufer.

EHRHART: “Go-to” regarding?

ZIEGLER: The person you went to with a problem, a difficult case, a need for consult, a need for advice, a need for an approach to a problem. To the point, that I think over time there was some, never resentment, but some sort of almost put-offness by Dr. Koop and Dr. Bishop of “so why don’t you ask me, why do you ask her all of the time?” But it was after a point in time I think it was almost on their part revered because it offloaded them of a lot of extra work and responsibility.

EHRHART: What do you think is the quality that Dr. Schnaufer had or has that enabled people to approach her in that way? You said Dr. Koop of course was the leader, the chief, and Dr. Bishop was skilled, as you said, expertly skilled in surgery, so then why would people turn to Dr. Schnaufer?

ZIEGLER: I think, again as I’m talking to you I’m wondering about how many of these things you’ve heard, but let me just give you an example. Here we are. I have a tough problem. I’m either a resident or I’m a faculty person, it doesn’t matter. And I need to feel that I could discuss that with an associate, so I walk into Louise’s office, she’s sitting at her chair, she pulls open her drawer and she says “Have some peanuts,” and there was always the right-hand middle drawer filled with peanuts. There were probably about ten zillion desk-side consultations that occurred over peanuts in her office over more than a decade of time. She was open, warm, present. Okay, Dr. Koop would have been, unfortunately like myself today, at meetings, or traveling, or other places, or you might think “My problem is too insignificant to confront him with, why don’t I talk with someone who’s going to welcome me, be available, be there, be a warm, friendly person?” and, because of this immense sort of approachability, and an enormous degree of experience. Louise was a phenomenal person. When I finished the residency at CHOP in 1977, we had in those days always a dinner at the Union League, for the faculty and the residents and the wives. I remember my little speech was crafted in some form of a poem and I actually did this, I know this is a little trite, but I looked up about how many cases I did with her, and then just did an extrapolation of how many sutures I would have put into a patient under her watchful eye, and it was in the multiple, multiple, multiple thousands of sutures. If I would have tabulated up that same thing with Dr. Koop or Dr. Bishop, both of whom I have immense respect for, it’s not a question, it wasn’t of the magnitude, so the person who really had the impact on my
personal development as a pediatric surgeon was Louise. Now does that mean that I remember only the things that she taught me? No, I remember Koopisms and Bishopisms very much as well, but in terms of sheer time spent with a person, I mean I was just with her an immense period of time.

EHRHART: How was it that you worked under her tutelage? Was that something she chose, or you chose?

ZIEGLER: I think it was more that I choose that. We saw eye-to-eye, so to speak, same height.

EHRHART: So it seemed like a good match?

ZIEGLER: Yes, I think it was a good match. I honestly think if you went through residents at CHOP from say 1972 or 1973 to probably the early 1990s or mid-1990s, they would all say that the person they went to, or who had the most impact on their personal development was Louise. I don’t think there’s any doubt about that.

ZIEGLER: Now when Jim O’Neill came as Surgeon-in-Chief, and Jim was actually here this week as our visiting professor, he’s also a very dominant kind of personality, a little different than Dr. Koop, but sort of a dominant kind of person. I think in that era since he was new and represented the outside, Louise was old and represented the tradition, and I think that her omnipresence or omnipotence persisted no matter who the leader was.

EHRHART: I think we’ve touched on this a little bit, but what were your impressions of Dr. Schnaufer when you first saw or met her?

ZIEGLER: A diminutive woman, probably more appearing like someone from environmental services or housecleaning, or a washerwoman. Most often my recollection is her in a scrub dress, not in street clothes. I just see her that way. I don’t envision her with clothes on, so to speak, I mean I see her in a scrub dress. And in those days, not in pants and top, but in an actual scrub dress, which are very uncommonly worn today by women in surgery.

EHRHART: Can you describe...

ZIEGLER: What a scrub dress is? It’s just literally a clean hospital gown kind of thing, shaped like a dress, what you call an A-line kind of dress, and it would just be buttoned together as opposed to zipper or anything like that.

EHRHART: In the back or the front?

ZIEGLER: I’m not 100% sure offhand.

EHRHART: And do you know what would be worn underneath?

ZIEGLER: I think she wore just her standard underclothes underneath it and then she would wear the dress. When you’d scrub on the case you’d put the gown over the dress, so if I went
into the operating room as a guy, I'd put on a top and pants, scrub pants and top, and then when I actually scrubbed on a case they would put a gown over me. Louise would have her hair in a hat, a regular cloth hat, or a paper hat, and then a mask as well. She did then, and I've never seen her operate without wearing glasses. Then over time she noticeably shortened. In other words, as she grew older with her osteoporosis, or whatever, she was already very small, but then she just got progressively smaller.

ZIEGLER: Some of these sincere admirations or warm feelings for her have been expressed on more than one occasion. She’s had more than one retirement event. I actually hosted a retirement event for her at one of the American Pediatric Surgical Association meetings in Florida and most of the fellows came for that -- everyone just pouring out their hearts and talking about all the warm feelings that they had towards Louise. Then I remember when the Schnauffer chair was dedicated at CHOP, or the program leader position or whatever. I did go to that, and that was at the new Wood Building at CHOP. That was really another very warm reception in recognition of her accomplishment.

ZIEGLER: My recollection was this totally understated diminutive little woman who, when push came to shove, was just always there. There was actually a time when she would say to us as residents, “When you’re on tonight with Dr. Koop, and if you have a problem, don’t call him, just call me, and I’ll come and deal with it.” I remember Dr. Koop eventually wondering why he wasn’t involved with a case, and he expressed that he didn’t know that she was backing him up to that degree. I never figured out whether that was true or not, that he really knew it and just wanted her to take care of it because he didn’t want to be bothered. I really don’t know, but she was, simply said, if you needed someone, you didn’t call Dr. Koop, you didn’t call Dr. Bishop, you’d call Louise.

EHRHART: You mentioned something about scrubbing. A lot of the interviewees that I’ve already spoken with mentioned scrubbing, and I’ve been very surprised at this because I don’t think of scrubbing as anything other than just washing your hands before you go and perform a surgery. However, it seems that scrubbing, at least with Dr. Schnaufer, had a different kind of significance in that being able to scrub with her was an honor almost? Am I understanding that correctly? It just deepened the link between her residents and... I’m not quite sure.

ZIEGLER: To scrub on a case really means that you’re going to participate in the case, that’s all that word means, but it’s commonly used as a “I’m going to scrub on a case,” as a verb. But it really means you’re just going to participate. Scrubbing, as a noun, I guess, is a process that you do in preparation for any operation. It is true today that there’s now a dry agent that you don’t actually wash your hands or scrub with a brush, you just rub it on your hands and it cleans them and more or less sterilizes them. I would have to say that I don’t have a particular recollection that scrubbing or washing my hands with Louise side-by-side at a scrub sink was a particular event, but in those days, and even today, I personally use a brush with every case, so I actually do mechanically wash my hands with every operation. It’s sometimes very nice to be standing next to the person who’s going to assist you, because you typically either talk about the ball game or you talk about the case and you talk about what your plan is and what the issues are and concerns and so forth. I think that there was a lot more formalization to preparation for operating years ago than there is today. We didn’t have the electronic medical record and all those things.
before, we didn't have the 80-hour work week, that was not part of the picture. But I think it was always a desired thing to be able to scrub with Louise or be on a case with her, because one, that meant for certain that the resident did the operation, she was always the assistant, so you loved that. Whereas if I would have scrubbed with Dr. Koop, even though I really enjoyed scrubbing with him, he probably would do the operation and I would do the assisting, versus the other way around with Louise. The teaching experience, or the experiential opportunity with Louise was terrific, just because she was, first of all, a very active and good assistant, she liked doing that, she liked teaching you her techniques, and you got a lot to do.

EHRHART: You talked a lot about how she was saying “It'll be all right,” as you were working through this one case that you had that was very early on, that was before you were doing your residency at CHOP, is that correct?

ZIEGLER: Yes.

EHRHART: Can you describe what her teaching style was through conferences and lectures and so forth as one of her residents?

ZIEGLER: These are going to be factual opinions, not necessarily good or bad. You might say, “Well that wasn’t a great trait,” but I think Louise was, as you are learning, a woman pioneer, and so her forthrightness, and her dominance was not her trade. Her trade was that she was a, and I don’t want this to be misinterpreted, but she was really a grunt worker, she was the person in the trench doing the work, gaining the experience, gaining the respect and admiration of everyone who was in the trench with her. Put her in a conference setting or a teaching setting, that was not her thing, it was not her comfort zone. She would or could comment, and did, on her opinion and what she would recommend or do in a particular case, but put Dr. Koop in that same room, or put Dr. O'Neill in that same room two decades later and probably Dr. Adzick after that, Louise isn’t the person who is going to stand, “Well, I disagree with you, Chick,” or “Jim, you’re wrong and this is my experience.” She wasn’t that person. What would happen in that circumstance is she may or may not comment, the case would be discussed or presented in a teaching venue, and then after the case, over those peanuts in her drawer, is when the real discussion would occur. And then, if it were my patient, then we'd make the plan. So I think both the good and bad. The good was you knew who had a lot of information that you trusted and revered. The bad was that sometimes in a public forum was not where you saw her strength because she was not a dominant kind of personality. Dominant in strength and integrity and toughness, no doubt about that, but not dominant in wanting to have the limelight, that just wasn’t her thing.

EHRHART: Do you believe that that had anything to do with gender?

ZIEGLER: I think it probably did. I think it may have had something to do with stature -- diminutive little lady, gender -- not a time when there were women. For example there rarely were women trainees in those days, some occasional surgical residents, but not many. Louise’s friends, her gender-like friends, were nurses and colleagues. Ema Goulding, Winifred Boetsch will be one of those kind of friends. Then occasionally, some other women in medicine -- Audrey Evans would be a fascinating person to interview if you haven’t already. But Audrey
Evans was a peer of Louise’s and she was a surgical oncologist, and it was probably one of the reasons that Louise was the tumor doc, because they did have a strong interactive relationship. In pediatric surgery at that time, nationally, you could count women on one hand, the number that there were. Up until the year of 2000, I think of American pediatric surgeons, I actually wrote this up, but it’s really a very small percentage that are women. Now that has in truth changed, or is in the process of changing, because right now the training class is almost 50% women.

EHRHART: Would you describe some of the procedures that you assisted her in performing in the operating room, or that you performed under her watch?

ZIEGLER: I would have done literally everything with her, every case known to man in pediatric surgery from the very routine to the highly complex. The very routine, in those days, were often times done by residents independently, which today we don’t do. The highly complex were all the newborn problems, esophageal atresia, diaphragmatic hernias, imperforate anus, Hirschsprung’s disease, and cancer surgery. I did a lot of tumors with Louise. I don’t think there would be a case that I didn’t do with her. The one thing I didn’t personally do during my training is I didn’t do the conjoined twins, although I participated and watched, but I never did personally do a conjoined twin with Louise. Jack Templeton would have done that, but I didn’t.

EHRHART: In the operating room, besides the situation you already mentioned, or if you have anything to add to that, please feel free. Is there a particular situation or procedure that is vivid in your memory, or maybe a case is a better way to describe it — what was it, what happened, and why does it stick in your memory?

ZIEGLER: I was thinking about this, knowing you were coming -- what are some of the recollections? First of all, if you just paint the picture, so if Louise is operating with me, she might be able to actually stand on the floor, or at the most stand on one standing stool. Now make her operate with a 6-foot, 4-inch trainee. Louise is standing on three standing stools, just trying to get up high enough so that the other doc can do the operation with comfort -- because of her very small height. The second picture to get is now the operation is 30 minutes, or now it’s 12 hours, but she’s still standing there, still working because she was tireless, you couldn’t beat her down with a stick, she was really a tough woman. I’m not going to go through the real detail of this, but I recall a case that I personally was not involved with, but was done by the leadership surgery people in the team. It was a very big operation and a very complex event occurred during the operation to the point that it just devastated the surgical team working -- an error, a technical error during the course of an operation. So what was the response? The response was, “Someone call Louise,” and so Louise had to come to the operating room, and literally not only bail out the team that was there, but totally take over the very tough case and try to reassemble things correctly and get the patient not only through the operation, but off the operating table and so forth. It was that kind of position that she was put in -- the tough, the really difficult, the impossible, even the now-complicated patient, who are you going to call? “Let’s call Louise.” That’s the recollection. I remember the case as if it were yesterday, and I remember her coming and giving one of those, “It’ll be all right,” and just diving in and working on it.
EHRHART: Did she have any resentment for being called in like that?

ZIEGLER: It’s a great question and it would be fascinating to know if she resented in her heart or in her soul being the “defer to” person, but not the person in the limelight, because she wasn’t the chief. I don’t remember her academic rank then. I bet she was at the associate professor level for a really long time because she didn’t write a lot of papers, she just was the grunt worker. If she ever had that resentment I would have to say it was totally buried. I never saw it, never ever.

EHRHART: Or no animosity, “you should have known what you were doing,” nothing like that?

ZIEGLER: I don’t think so, no. For example, Louise came to Philadelphia from Baltimore, and she might have said that Dr. Haller was a quirky guy, but never ever said negative things about him, only positive things, and I know that he revered her, absolutely revered her.

EHRHART: I know you can’t speak for other people, but would you say that the same feeling was present at Children’s Hospital of Philadelphia as well?

ZIEGLER: This woman did not get her due outside of her inner circle. The respect and admiration came from the inner-circle group; we, the resident team in particular, who worked there regularly and where Louise’s whole life was dedicated. Did Louise do any self-promoting at the University of Pennsylvania to get her academic rank improved? I mean not only did she not self-promote, but I would suspect that those of us, all of us: Dr. Koop, Bishop, myself included, did we do anything on her behalf to get her the recognition that she was due? I think the answer is that probably not nearly as much as we might have done. Here we’re talking about this oral history project, and when she’s how old?

EHRHART: She’s in her mid-80s, I believe.

ZIEGLER: I was going to say mid-80s, 88. This is long overdue. I mean in terms of recognition, not in terms of this project. In terms of what she gave to an institution and its people. Make her male, this would’ve been recognized earlier probably, I’m sorry to say. Well, I guess maybe I should say make her a male with a more self-centered personality, because I don’t think she was very self-centered at all.

EHRHART: But then would she have had some of the traits that...

ZIEGLER: She’s a surgeon...

EHRHART: I mean that would have enabled her to be endeared in the ways that she is? If she had been self-centered and so self-promoting?

ZIEGLER: Maybe the endearment wouldn’t have been there. Maybe the recognition would have been a bigger part of her future. Dr. Koop is a classic comparative example. Certainly very self-centered, and very egocentric, but those of us who trained with him, myself included, have
this enormous respect for him – but would I call it endearment? Probably not. Tremendous respect. I just was at his Washington, D.C. celebration, it was just phenomenal. I just think of him as a spectacular human being, but it’s a different feeling that I have for Louise, it’s just different, neither right nor wrong, just different.

EHRHART: My next question regards her teaching technique in the operating room, if one could say there was a teaching technique present. How would you describe it, and in addition to that, how did she utilize her residents in the operating room. In part you have answered that already. In addition, how did she interact with various people involved with the surgery, such as nurses, anesthesiologists, and so forth?

ZIEGLER: I think her technique was largely best described as patience beyond belief – or the patience of Job, because she would let the resident in fact be almost universally independent with her being an assistant, and you would have to do something really onerously bad, or get yourself into onerously bad trouble before she would intervene. If you asked do I ever recall her saying, “I wouldn’t do that,” or “don’t do that,” or “do this, do that,” yes, but really only after a remarkable degree of tolerance and patience, and so I think residents felt very empowered and very much the role of surgeon during the case.

ZIEGLER: In terms of her reaction or interaction with other people, I actually was telling this bad story on myself not long ago. I remember at CHOP, once working, scrubbing with Louise on a case, and I don’t remember the operation, I just remember it was a major deal. The anesthesiologist was doing something quirky in my mind. I knew the anesthesiologist well and really respected him, it was Russel “Russ” Raifly, who is another old CHOP guy. I just got bonker nuts about what he was doing, and I started to take him on in sort of an argument and he played the role of arguer back, and we literally had this sort of shouting match with one another in the operating room, patient asleep, waiting for the operation. Finally Louise said, “Will you two guys stop that, and let’s get on with the operation?” That was all she said. The argument just immediately ceased, and we did the operation. I learned a really bad thing about myself at that time, and that is that I was trembling so much following that discussion, that I have never, ever since argued with someone in the operating room because it affects my performance and I just can’t let it happen. So people actually accuse me of having totally unrecognizable emotion because they say, “You don’t express yourself enough.” I do that absolutely related back to that singular incident with Louise, because I find that if I lose self-control, it affects my performance, so it’s sort of interesting. I remember that, again as of yesterday, and I can tell you exactly what OR it was in at CHOP and everything, it’s not something you ever forget.

EHRHART: But it sounds like it was a valuable lesson to learn at that point.

ZIEGLER: I think that Louise was truly “one of the girls” in those days. When I mean “one of the girls,” one of the nursing colleagues. And so they would not uncommonly do things together. There’s one woman in particular, Winnie Boetsch, who was the head nurse of the operating room and Winnie I think is dead now. Louise and her and Erna Goulding used to do a lot of things together.

FILE: ZIEGLER2
EHRHART: Today is November 9, 2006, and this interview is with Dr. Mory Ziegler for the College of Physicians of Philadelphia. The Louise Schnaufer, MD Oral History Project is funded by the Foundation for the History of Women in Medicine.

ZIEGLER: This is a classic Louise story just because of her diminutive little size. I don’t remember all of the patient detail, but there was a very, very complex patient, I think from another hospital in Philadelphia, who had had a bad result from an operation and was sent to Louise, which, by the way, was a not uncommon thing, where she was the remedial surgeon, in other words, the “fix someone else’s problems” kind of surgeon. This child came in and we did an operation and I think things were going okay, not great, but far better than they had been. What then became apparent was that the parents were biker mom and biker dad, and when they came in to see the patient, they rode their Harleys or their other cycles to the hospital and came up and saw the patient in their “biker garb,” so to speak. One day I think the issue was that we were planning to discharge the patient finally to home and had arranged all of the follow-up stuff, and there was either a cancellation or a postponement of the discharge. Biker dad called Louise directly in her office and said that he was on his way to the hospital and he was going to create a ruckus and he was going to kill her. Louise took that threat very seriously and she called hospital security and the entire hospital was then surrounded by various security people, placed at the various entrances and exits of the hospital. Biker dad actually never did show up, so we continued to actually care for the patient. We had to have a lot of care conferences after that so that there was no ambiguity about our responsibility versus the parents’ responsibility. The police contacted the father and I think “calmed him down,” and Louise in her own fashion just went on with the care of the child and the management of the patient. She did not suggest that the kid had to be transferred elsewhere and cared for by someone else. Eventually she and parent mom and dad ended not only on a good relationship, but a remarkably positive relationship. I always remember that event because it was really quite the deal, and it was fairly scary and everyone was put on notice, and the hospital was actually secured, anticipating that this guy was going to try and do her harm. As our “mom,” we weren’t going to let that happen.

EHRHART: So now Dr. Schnaufer is the maternal figure?

ZIEGLER: Oh, I think she unquestionably was the maternal figure to many, many residents.

EHRHART: For the reasons that you mentioned earlier, or are there others in addition to those?

ZIEGLER: I think for the ones we’ve already talked about: the security of knowing who you could go to, the security of her being there, being there for you, the security of her making you feel comfortable, not telling you that you were a jerk or that you really screwed up, coupling that with “It’ll be all right,” and just her warm persona. I think those are all very maternalistic characteristics, and I think she lived her life characterizing those behaviors, and interestingly, herself was never a mom, but she certainly behaved like a mom.

EHRHART: My next question is: An important aspect of performing surgeries is the ability to make appropriate decisions at crucial moments. Can you reflect on her decision-making ability
and/or procedure? Was there a process that she actually went through that you could almost see her considering what the possibilities are, debating about what to do in a particular situation?

ZIEGLER: I would probably honestly answer that “no,” but what I would say is this: that again, picture the individual being extremely understated and not a dominant kind of personality. I mean if you use the word “team” in surgery, Louise would personify the word “team.” You were truly in it together, and that meant that you not only got to do the operation, but you got to do a lot of the decision-making. Again, remember the era, the era was different, so there was a lot more empowerment of residents to make decisions to do things independently than it is today. Residents would do a lot of decision-making and a lot of independent activity. But of the three people, of Drs. Koop, Bishop, Schnaufer, Louise was the only person that you would really be able to talk about care decisions with. The others you would talk about operative decisions and planning around what operation is best, when to do it and so forth, but if now you’re going to talk about what drug to give, what medication to alter, how to change the critical care of a certain patient, Louise was really the only person that had that fount of knowledge because of her daily experience and because of her presence at the bedside. I think her process of judgment was really an incorporation of the Koop-Bishop-Schnaufer consolidation of how we approached patient care, we did a lot of complete corrections of things rather than staged corrections. She was technically a very fine surgeon, and I would say that it’s a round-about answer to your question, but it was much more team judgment and that’s what she emphasized and personified.

EHRHART: There were two things that I wanted to ask you based on your answer. First of all, you said that there was much more of an empowerment of residents then as opposed to now. How would you describe that change and why do you think that’s occurred?

ZIEGLER: Well, I think that it probably has a societal component and it has a legalese component, and that is that in our litigious society there’s much greater responsibility on the attending surgeon in terms of, for example, daily care of patients, you have to be able to demonstrate or document or show some attending presence and activity around a patient’s daily care. Back in the 1970s when I was resident at CHOP, that just wasn’t the case, so not to say that Dr. Koop or Bishop or Schnaufer didn’t see their patients, they did see them. But in terms of managing nutrition, antibiotics, medication, that just wasn’t a part of it, that was the responsibility of the resident care team. That was one huge difference, and I think that generationally we were a different generation of individuals than today. You can easily see Generation X and other traits in medical trainees, just like you can in other fields. The personas are different, so it’s sort of an observational change over time of what people’s priorities and interests are and why. The current society is just a little different.

EHRHART: So would you say that that changed from, the shift from having the residents manage the care, versus now having the attendings more or less manage the care... Do you believe that has had a detrimental impact on the training of residents?

ZIEGLER: I think it’s a hard question to answer. I think in the end it should, should have a salutary benefit on the patient management overall. I think that the resident emphasis of care has shifted from the bedside to the operating room, so what we find is our residents love to be in the operating room, they’re not as enthusiastic about being at the bedside, and there’s a lot more
abandonment of the day-to-day care of the bedside patient to hospitalists or other specialty docs
back to primary care pediatrics. Whereas again in the 1970s the surgical patient was a surgical
patient was a surgical patient. There weren't multi-specialties involved in each given patient,
whereas today there's a lot more “team care.” Which again, that plus the attending involvement,
one would think would be better for the patient outcome than it might have been back in the
1970s, but that was just the way it was done.

EHRHART: So you mentioned about bedside manner and that actually segways very nicely into
my next question, which is: What did you learn from her about bedside manner, or how did she
relate to her patients and their families outside of the operating room?

ZIEGLER: Well, again I think Louise was very comforting, very maternalistic, very warm to
patients and families. I mean it would not be uncommon for her to go to the bedside, pick a
patient up, hold a baby. She would use the holding experience as an exam or an assessment, feel
the baby’s tummy or whatever while she was holding him, but it was also her way of relating to
the family, I think, that she genuinely cared about the child. I think she was particularly good
with younger parents, parents that had a baby with a major problem, a really challenging
problem. Again, that same office where we used to sit and eat peanuts, it would not be
uncommon for her to have the family in her office, sitting on her couch and her sitting in her
little swivel chair talking to them about what her plan was, what the things were, how things
were going. I think there was a lot more “have the parents come to the office” then than today, I
mean that has never happened since I’ve been here. I go to the bedside and that’s it, there’s no
parent coming down and really having an informal discussion with the doctor. I think Louise
thrived on those kind of circumstances. Plus, our evaluation area was imbedded in her office, so
if you walked out this door of Louise’s office, you walked into the exam room. I actually had
the adjacent office and we shared the exam room together.

EHRHART: So part of it, at least, is logistical?

ZIEGLER: Yes, it’s geographic.

EHRHART: Is there a particular situation that you recall with Dr. Schnaufer consulting with the
patients and/or their families outside of the operating room? A particular situation that sticks out
in your memory or was unique?

ZIEGLER: I can honestly say I can’t remember that, except to say that it would not be the same
for Dr. Koop and Dr. Bishop. It would be not uncommon, in fact, it would be commonplace to
see Louise in the intensive care unit or at the bedside or talking to families, talking to nurses,
talking to the residents, and team, about the care of the patient, and what the plan was, and so
forth. I mean she was a very omnipresent kind of person. She was there at the hospital a lot. Of
course I think, I don’t know if I’d say this is gender or this is situational, but I think both Dr.
Koop was married and had a family, and Dr. Bishop was married and had a family, and Louise
was well, “Louise doesn’t have anything else to do, so let’s let Louise do that.” She took it on
graciously, and gratefully, and we can all say that that wasn’t fair and she was taken advantage
of, and that might be true, but I think that that was her life, that was the way she designed her
persona or her style.

221
EHRHART: There is also a difference of being expected to do it, and doing it out of just one’s personal interest, so which do you think was operating there, or perhaps it was a combination of the two?

ZIEGLER: What I would honestly say is that I don’t exactly know if I have the horse and the cart in the right order, but I would bet that she did it out of love of doing it at first, and once it was an observed behavior it was easy for the senior guys to sort of defer to her, and say, “Well Louise, are you going to be around? Okay, I’m going to go if you don’t mind,” and she would just become the default player in that sort of scenario. I think she took it on probably in that sequence. In other words, she behaved that way, it became a behavioral trait, everyone just said okay. Now Jack Templeton and I came on the faculty the same day, July 1, 1977, and for the first time now there was someone else to defer to. I think that that, hopefully, and I don’t know what she would say about that, but hopefully we relieved Louise somewhat of her thing, because then I became, and as did Jack, I was younger than Jack by a couple years, but we became the “new guys on the block” to whom you could defer other cases. I think that her life probably improved a little bit after that.

EHRHART: We had talked a little bit about women in the field at the time that you worked with Dr. Schnaufer. You said that, if I recall correctly, you said that there were probably just maybe five people, women, if not less, in that time, that’s correct?

ZIEGLER: Yes.

EHRHART: Given that it was a very male-dominated field, how you believe that she made a name for herself? In a way you’ve answered that question, because you’ve said that she didn’t make a name for herself, but how do you think she was able to be so successful in her own realm?

ZIEGLER: I think I would have to credit Dr. Koop for that in some respects, because Dr. Koop had a great, young associate by the name of Dale Johnson at CHOP, who in, I think it was 1971, left CHOP to go to Salt Lake, where he finished his career. So Dr. Koop needed a replacement, I think someone I guess I would say he could defer to and know that things would be in good hands. He then called Louise back, if you will, from Baltimore, and to be that person, and the fact that Louise was Dr. Koop’s right-hand person, I would say is probably the thing that made her career. She was always his right-hand person, the right-hand person in the decade that I was there. I mean, she protected him, she was the person that he deferred difficult cases to, he respected her immensely, he just glowingly respected her. He would overtly never ever be negative about Louise in private or public. His respect was genuine. I think he really made her career, and then putting her in that position, again, we could talk about a lot of things, but just those “three As” we talked about before, and the fact that this was a resident training program, and continued to be a resident training program, to which residents she absolutely endeared herself, I think that that was her career, became her career.

EHRHART: My next question has to do with the setting of the hospital – that hospitals can be competitive and stressful places, so how would you say that Dr. Schnaufer dealt with that kind of
stress and conflicts that arose, in and out of the operating room, among colleagues, and/or among fellows?

ZIEGLER: The fact that I witnessed her personal chastising of me and my colleague for bad behavior I would say was really a quite unusual trait, assertive acting out of Louise – not a common thing. I’m thinking back right now to CHOP, at that era, in the 1970s and early 1980s. I can’t recall off-hand that we had any other women in the division of surgery. Amongst the other specialties, maybe someone in dentistry, but I don’t think in the other specialties. From a political, socio-political standpoint, I can tell you that Louise never was an active player in the national scene of pediatric surgery, so she wasn’t elected to a major office in pediatric surgery. I think she was active in the Association of American Women in Medicine, or something like that. She was active, I think, in the alumni association of the Medical College of Pennsylvania, where she trained, or went to school, I guess. So sort of placing her, socio-politically, would not have been her thing. Then even at CHOP, for example, within our surgical corporation, though probably if you would’ve looked at Louise’s charges and collections was probably at the top of the heap just because of her volume of activity. She never was an officer or a decision-maker. I mean, I think it just wasn’t her thing. She wanted to be clinician, she wanted to have operating activity with residents, and she wanted to have as busy a practice as possible. Said very simply, that was her thing. She wasn’t academically oriented in terms of writing papers or doing research. She had one very unique interest, it’s not a real big thing, but it was something that she contributed to initially, this stuff called anorectal manometry, which was one of her things. When I was a resident we did that, she did that herself, that was something that only she could do. I think there was an original paper about that in her CV. But I think her whole career was just what we’ve already talked about – busy clinical practice, a lot of surgical education, a lot of collegiality with the team, and all of the socio-political stuff, “I’ll leave that to Dr. Koop or O’Neill or Adzick, I don’t want that.”

ZIEGLER: I don’t think she had, for a long time, much of a life out of the hospital. But then, later on I think when Dr. Koop was, well after Jack and I joined the faculty, she had a little more free time. Then she did do some sailing with Dr. Koop, Bishop, Louis Schut, and John Duckett. So though the framework of her activity or “family” grew a little bit, it was always a hospital-based family.

EHRHART: And with that, my next question is: What kind of personal relationship did you develop with her?

ZIEGLER: I think a very warm personal relationship, but I must say, because I’ve moved a few times as I’ve told you, and because now she’s become more ill, I haven’t seen her for quite a while. But I felt immensely close to Louise when I finished, and on occasion would talk with her around a case, maybe call her about a case, but more often than that would be just trying to make sure, I don’t mean to overplay it, but trying to make sure she’d receive her due recognition. It’s one of the reasons we did that small thing for her at one of our national meetings -- when she said she was going to step down. I used to ask her, “When are you going to stop?” She told me and so I said, “We are going to have this thing,” and then she didn’t stop, she went on again, so that’s why she’s had more than one retirement thing. Louise has been at our home many times, but for example, Dr. Koop, as you know, Louise went on vacation with Dr. Koop, she went
sailing with Koop and Bishop: Koop, Bishop, Schut. I didn’t go on vacation with Louise because I had young kids, but I would say that I felt very close to her as mentor, mostly.

EHRHART: You did touch on this already, but if there’s anything you’d like to add, I’m more than happy for you to do so now. Dr. Schnaufer was known to provide counsel to many of her colleagues and fellows, and by counsel I don’t just mean necessarily office consultations or the conferences where she would have that drawer of peanuts that she would offer to people. I guess what I’m trying to say is not only about medical cases but also about life issues, what have you. My question is: Did you benefit from her advice, and if so, how?

ZIEGLER: I don’t honestly think I ever asked her about personal life issues, but I certainly talked to her about professional development or job issues. When I left CHOP that was a big deal to leave because I had grown up there, but I left to go to a great job. What happened is a few years after I left, Dr. O’Neill left, so I was asked to come back and look at the job. Louise was very warm, and said, which I believed her, that she wanted me to come back, and I made the decision not to go back. But around those kind of things, I could really very much count on her good judgment. I think that would be a great question to ask Jim O’Neill, because Jim O’Neill came as an outside guy, fairly egocentric also, in a positive way, from Vanderbilt University. Jim was really noticeably from the outside, and when I say that I’m not sure that we didn’t contribute to that. In other words, we were so internalized by the Koop system that it was hard for someone else to be accepted into our “group,” so to speak, because we all had trained with Koop, Bishop, Schnaufer, Templeton, Ziegler, we were all from CHOP. I think Jim must have felt a lot of that and it’s something I’ve always personally felt, and I’ve told him that, I’ve said, “Jim, if I knew then what I know now, I would have been a nicer man to you.” I wondered sometimes if he thought that I personally, or anyone else in the group were not receiving him the way we might have. I think he used Louise as a sounding board, but you’d have to ask him, I don’t know that personally for sure. But I know that he became very fond of her, and I think she would have been a great counselor in something like that, because I think she would be very forthright, but gentle forthright. She might not tell him exactly the way he was coming across, but she may be able to hint him towards, “Come on, cool it down a little bit, behave a little better,” because I think he was trying so hard to be his own self in that environment that it might have shown, and it did show. I would bet that he would identify some very significant help that she provided. I know that other people, especially young residents, used her a lot as a sounding board, and maybe some of them did use her as a sounding board for personal family problems or whatever, but especially I think career development stuff.

EHRHART: What advice did Dr. Schnaufer offer you as you completed your fellowship and were developing your career?

ZIEGLER: It was an interesting time because I stayed on the faculty when I finished my training. I think that was a decision that I can only assume happened because Dr. Schnaufer and Dr. Bishop approved, because Dr. Koop made the offer, of course, but I’m not sure that he was that tuned, because there was Louise and to a slightly lesser degree, or somewhat lesser degree, Dr. Bishop was involved. I think that they would have had to be strong advocates for myself to stay on. I’ll tell you this story, a personal fact. When I was a Penn resident, I knew I wanted to be a pediatric surgeon, and I went, as I told you, from medical school to Philadelphia because I
had read about Dr. Koop. When I applied for pediatric surgery in my residency, it was before there was ever an organized match, and so what you would do is you would just go and interview and if they liked you they might offer you the job right there or they might not. One might offer you a job for next July, the other for July a year from then, so it was all very sporadic. Of course now it’s done with a matching plan and it’s very regimented. The long and short of it is, I applied and I wasn’t selected. I was absolutely devastated, I mean really devastated. Interestingly, the Penn program at the time was a bit alienated from Koop and CHOP, and CHOP was then down at Bainbridge Street, and so they were separated. The Penn surgeons said to me, “Well, if you’re going to do pediatric surgery, you don’t need to rotate down there,” so at the time when I went down there for my interview for this residency position, Koop, Bishop and Schnaufer all said, “So who are you if you’re so interested in pediatric surgery, why have you never been here on a rotation?” and I said, “But they told me not to do that.” That was my own naivete at that time.

ZIEGLER: Anyway, I had to then go to CHOP on a rotation so they could see what I could do, and it was a really odd thing, because I felt like I was absolutely under the microscope. That’s when I did that big case with Louise when I was there as a resident, doing all those connections of all that intestine. The only thing I can say, and of course, no one ever really said that to me, but when I reapplied -- and I did research in between -- when I reapplied the following year I was accepted. So not only did they train me, but then they kept me on the faculty, so it couldn’t have gone too badly in the long run, but it was an interesting dynamic because there were only three people sort of pulling the strings; Koop, Bishop, Schnaufer. Louise was the only one who had what you would call real insight into what the residents were doing or were able to do. Harry Bishop is a fascinating guy but he was then very controlling of his own life, and he would come to work at a certain time and leave at a certain time always. He was a technically excellent surgeon, great teacher, but just controlling. Whereas Louise, her whole life was the hospital. So that was her life, whereas Harry, the hospital was only where he worked during the day, and Dr. Koop, the hospital was only where he made his name and reputation. And I’m saying that objectively. He had a bigger agenda, and so it was a fascinating trio to work for. The good news is that we all got along very, very well. This was not a department of in-fighting or backbiting, it was a department that was really very supportive of one another.

EHRHART: Is that a rarity?

ZIEGLER: I think it’s uncommon. We happen to have it here right now, but it’s something you strive for if you can do it. Sometimes it’s luck, sometimes it’s programmed.

EHRHART: Sounds like there certainly was a balance of personalities.

ZIEGLER: And then Jack Templeton, another just unique gem of a human being.

EHRHART: If you reflected on your career and how you conduct yourself, perform procedures, and relate with patients and their families, do you see any characteristics that are based on what you learned from Dr. Schnaufer?
ZIEGLER: I sometimes think it’s a flaw, but I think I have the patience of Job, especially working with residents. I would say that my method of working in the operating room is an absolute boiler plate, rubber stamp of Louise, and that is that I almost always let residents go very far down the road. I’m extremely patient, I let them feel, and I try to make them look, like they’re really good by being a very active and very good assistant for them. I don’t talk a lot at the operating room table. Louise didn’t either. I relate well to the other part of the team; I’m very respectful of the team component of the operating room. I think a lot of the interoperative mentoring resident training style I would say is very much something I picked up from her. Not exclusively Louise, because what you do is you evolve your own style by an amalgamation of literally hundreds of styles, but since I spent so much of my residency with her. You know, if I compare my Penn residency and ask the question “How much time did I spend with any one surgeon?” and then compare my CHOP residency and “How much time did I spend with any one surgeon?” they wouldn’t be comparable. The time spent with Louise in a two-year interval was huge.

EHRHART: How would you describe Dr. Schnaufer’s impact on your career?

ZIEGLER: I think I would describe it as immense, because I think she trained me to be a very good pediatric surgeon. I don’t think I’m the world’s greatest pediatric surgeon, but I think I’m a very good one. I think that stylistically she is the type of person I would be much more like Louise than I would be like Dr. Koop, but quite frankly I had a lot of the same aspirations that Dr. Koop had in terms of national leadership, in terms of leading a program as opposed to being an Indian in a program, and Louise didn’t have that, she wanted to be an Indian and just focus on practice. [Ed. Note: In his edit of the interview, the interviewee explained that the word “Indian” in this case refers to being a follower. One who leads would be called a “chief.”] So I had different interests than she did. But in terms of stylistically, the quiet, “get the job done” kind of person, I very much emulate that trait she had and trained me with.

ZIEGLER: I haven’t even said this today, but honesty, integrity, that’s Louise Schnaufer.

EHRHART: Did you want to elaborate on either of those?

ZIEGLER: Since this is an oral history project, you need to put the whole scoop in. I have an episode that I can still remember to this day that I felt like Louise, I guess I would say it this way - let me down, so to speak. We were in a conference presenting a case and it was one of those cases that came in in the night and Louise said, “Call me and don’t call Dr. Koop.” So I called her and we made a plan of treatment, fully discussed, we even saw the patient together, and confirmed the plan, and that’s what we were going to do. The next day I presented this patient at one of our grand rounds talks, that this is what the patient had, and this is what we were going to do. Dr. Koop, in his own inimitable, emphatic way, never shades of gray, always black, white, said, “You know, I don’t think you should be sitting here presenting this patient, you should really be in the operating room with this patient. This is a patient you should have operated on.” And he said, “In fact, I think you ought to get up right now and leave and go to the operating room,” you know, like get out of here, go to the operating room. All I did was say, “Yes, sir,” and got up, and walked out to the operating room. Louise never acknowledged that she had discussed this case with me, and it was her plan, or our collective plan. I think, you know,
sometimes those are situations, and sometimes the situation was that maybe, for whatever reason, that day she wasn't going to stand up to Dr. Koop and say, "You know, you're wrong, and this is why we did it. You may be right, we may be right, but this is why we did what we did." I would have to say, to be fair, never before that time, never after that time, did that experience repeat itself, but it's amazing that I'm telling you this story, because I never forgot it. I think that alone is an indirect way of training me in my traits, and that is that I didn't like that, that was not a good feeling, because in that case, my attending didn't acknowledge their responsibility. I don't think that I've ever put a resident in that position, but I wouldn't want to, because it was a negative feedback, whatever you want to call it, it made me feel bad. I don't recall if we went back and at the end of the deal said to Dr. Koop, "You know, look, this was discussed, and this was the plan." I suspect that out of the conference room Louise did go to him and tell him, but she didn't do it in front of my peers and her peers. So it was an interesting experience. But I think that probably speaks a little bit to these domineering personalities, and Dr. Koop was a domineering personality.

ZIEGLER: I'll give you another example. When I was the chief resident at CHOP, we used to have our regular conferences, and in the old conference room at CHOP the entire wall was a blackboard. I would, in the interest of "education," let's say that the problem was diagnosis "x," I would put up on the board what Dr. Haller wrote about diagnosis x, what Dr. this at that institution wrote about it, and usually quote some of the papers that had been published and just put up the statistics. I remember doing this. I don't remember what the issue was, but it was a problem, and having the whole conference. I presented this part, and then Dr. Koop offered his opinion and so forth. And the next day Dr. Bishop said, "Mory, I want to talk to you," he said. "Dr. Koop isn't really interested in what other places do with a certain diagnosis. What he would really like you to do is just present the problem and he'll tell you how it should be managed." That's a different era. That probably was not that shocking, I mean I was shocked by it, because that was not the way I was trained during my residency at Penn, but that is not surprising. Ask me my opinion, it doesn't matter what Haller thinks.

EHRHART: The final question, and you did already touch on this. Did you stay in touch with Dr. Schnaufer after you completed your training, professionally, discussing particular cases or to gain other advice, or to collaborate in research or trials, or personally?

ZIEGLER: I think I've answered that question, all of the above. My most recent conversation with her was probably little more than a year ago, but I'm aware of what's going on in her life, I think, in terms of her health and so forth, right now, but I haven't spoken to her since she's been in more of the, whatever it's called, like an infirmary kind of place, group part of the place that she lives.

EHRHART: Anything else you would like to add before I turn off the devices here?

ZIEGLER: I don't think so.

EHRHART: If there's anything you would like to add, you certainly can add an addendum. Again, this is November 9, 2006. My name is Mindy Ehrhart and this interview has been with
Dr. Mory Ziegler, and this is part of the Louise Schnaufer Oral History Project conducted for the College of Physicians of Philadelphia and funded by the Foundation for the History of Women in Medicine.

###