Harry C. Bishop, M.D.

FILE: BISHOP1

EHRHART: Would you please state your name and how you were and are affiliated with Dr. Schnaufer?

BISHOP: My name is Harry C. Bishop, I am a physician, a pediatric surgeon. I retired from Children's Hospital, is this adequate? I've been there for a long period of time. I knew Dr. Schnaufer before she ever came to Children's many years ago. Let me go back and express my point view about where she came from when we first met her. She was orphaned at a very young age. Her parents both died and she was cared for by an aunt, who was, I think, the mother of Dr. Otto, who is her cousin. It was an aunt who raised her and got her through high school in either Maryland or Delaware.

[interruption]

FILE: BISHOP2

EHRHART: We're resuming, we're talking with Dr. Harry C. Bishop.

BISHOP: So Louise was raised in either Baltimore, Maryland, or Delaware, and then when she finished high school in one of those states she moved on to Wellesley College. Did you know all this? Actually she was a classmate of my first wife at Wellesley College, as is there another lady down here who knows her well because of the college days. So I've known of Louise before she came to the Children's Hospital. At that time, even having gone to a very good university, or college, whatever Wellesley is, I think she then had trouble finding a medical school which would admit her, because there weren't too many women going into medicine at that time, so she actually ended up going to Women's Medical College here in Philadelphia, which is now extinct, it no longer exists. But it's interesting that that had to be a full-fledged medical school just for women at that time. She finished there, and that was a good exposure for her. She then had her residency in general surgery, which all pediatric surgeons have to do. You don't start off being a pediatric surgeon, you start off being a general surgeon.

BISHOP: So she trained in Baltimore at Union Memorial Hospital, and there she had her adult training, and eventually, I don't know why she decided to go into pediatric surgery, I think it's because she got involved with a man named Dr. Alex Haller, who was a new professor at Hopkins who was a pediatric surgeon very early on. I think it probably was he who influenced her on this, but I'm not sure about that. But in any event, she decided she wanted to be a pediatric surgeon, and applied for the job with us at Children's Hospital. I was relatively new there since I'm four years older than she, so I wasn't there very long when she was hired to be the chief surgical resident. And she had that role I think about a year, and finished it up with great pleasure to her and to us, and then went back to Baltimore, and actually practiced pediatric surgery with the help of Dr. Alex Haller at Hopkins.

BISHOP: At that particular time we had trained another man named Dale Johnson, who had finished his adult training and wanted to be a pediatric surgeon, so we trained him here at Children's Hospital of Philadelphia, and then he stayed on with us as a staff member. He was with us a few years and because he came from Salt Lake City, Utah, he was then asked to go back to Salt Lake City and start the department of pediatric surgery there. And since that was his home and his birthplace and all the rest of it, he decided to do that, which was a good idea for him because he's still there and doing very well. So we had a spot here in our staff position for someone that would have to be replaced what with him leaving. Chick and I chatted, Chick Koop, that is, C. Everett Koop, who was the surgeon-in-chief at the Children's Hospital and started the whole program here at Philadelphia Children's. We'll have to go into that a bit more. He and I chatted about this, and I finally suggested that maybe it'd be good to have Dr. Schnaufer come back from Baltimore. And he thought that was a good idea and he arranged for all this, so she came then as a staff person in the late 1950s I would guess it was [sic]. She's been there a long time as a staff of general pediatric surgeon, as was I. Dr. Koop again was the chief until he retired when he became 65.

BISHOP: Incidentally, Dr. Koop, the original part of pediatric surgery started in Boston Children's, where I had gone to medical school and hence had my exposure to pediatric surgery and was trained up there in pediatric surgery before I came down here to work with Dr. Koop. So that was the mecca, the beginning of it all in pediatric surgery. It all started with a fellow named William E. Ladd, who was the professor then at Harvard and Children's Hospital pediatric surgical department. So he started the whole thing. Then there's a man named Robert E. Gross, who came to work with him, having trained at the Brigham Boston Hospital, and he got interested in pediatric surgery, so he sort of took over when Dr. Ladd was getting old and getting ready to retire. So Dr. Koop had arranged for himself because Dr. I. S. Ravdin, who was the chief of surgery here at the University hospital, decided that Philadelphia should get on the bandwagon and start a department of pediatric surgery. Dr. Koop was given this appointment as surgeon-in-chief of the Children's Hospital, which was then on 18th and Bainbridge, not where it is now near the University. So Dr. Koop was sent up to work with Dr. Gross, and he went up and hung around the ORs and went on rounds and all these things and became a full-fledged pediatric surgeon, one of the very first in the country. Probably Philadelphia was the number two spot in the country to do all this work.

BISHOP: Prior to that time it had been done by general surgeons, and not by pediatric surgeons, so that they sort of dabbled in it, they didn't spend enough of their time to do it to become too familiar with the subject -- what the birth abnormalities were -- and so the field of pediatric surgery did not advance too far until Dr. Ladd started all this program at Boston Children's. So that's the beginning of pediatric surgery, probably late 40s, early 50s, this was in its infancy. Dr. Koop was trained by Dr. Gross and returned here to Philadelphia and became the surgeon-in-chief at a very young age of the up-and-coming Children's Hospital of Philadelphia. That's the beginning of how this happened to ever come to Philadelphia. Whether she applied to Boston Children's I really do not know, and it doesn't make any difference -- she was wise to come here to Philadelphia Children's Hospital.

BISHOP: So we're back now, she's had her training with us at Children's Hospital of Philadelphia and then went back to Baltimore, and then we asked her to come back here to be a

staff person here, which she did, and quite happily so. Although I think she hated to leave the state of Maryland, which was the original part of her existence. She arrived here and we welcomed her with open arms, and she fit in extraordinarily well. We had learned this from when she had been a resident -- she had a real knack for taking care of children and her surgical skills were "upper drawer" and so that she fit in very well to the group that was here. So that's the beginning of why Dr. Schnaufer came here to Philadelphia.

EHRHART: Okay, excellent, thank you. All right, shall I run through the list of questions that I've prepared? Do you have any more that you would like to add?

BISHOP: Well, now one of your questions is going to be "Why was she a good pediatric surgeon?" Well, you have to understand that Dr. Schnaufer spent her lifetime being a pediatric surgeon; she didn't spend her life being a mother or a wife. She spent her whole life being a pediatric surgeon. She really delved into this with great enthusiasm and this seemed to be enough to satisfy her as her main existence, so she never married, to my knowledge she never even thought of getting married, and to this day she's not married.

EHRHART: Okay, well, the first question I had prepared is: Why do you think that having women pediatric surgeons was uncommon at the time Dr. Schnaufer was in her residency?

BISHOP: Well, for the same reason that there weren't many schools that would take women. I went to Harvard Medical School and we did not have any women when I graduated in '45, it was only several years later that we started having women being trained at Harvard Medical School. Women were not really very prominent in medicine. Although interestingly enough there were two women who came here to be one of the first people who came to Philadelphia Children's to work with Dr. Koop who were female. They have sort of dropped out of it. One of them went down to New Orleans and I think is still alive, and she spent a lifetime practicing and doing a good job in pediatric surgery. So she [Dr. Schnaufer] was not the very first woman to do all this.

EHRHART: Yes, I did come across that name, I think it's like Dolores or something. I can't recall it at this moment, but I did find it in his [Dr. Koop's] autobiography, the name of the first woman resident that he had.

BISHOP: It's interesting that the first resident he [Dr. Koop] had was a woman.

EHRHART: I think you touched on this already, but in case you have anything else you want to add: What talents and skills did you recognize in Dr. Schnaufer at the time of her residency? Were these talents and skills unusual or uncommon for a resident, and if so, how?

BISHOP: You have to understand that Dr. Schnaufer is a highly intelligent woman, as her educational exposure predicted. And because she was intelligent and because she certainly had certain maternalistic interests -- she adored children and they seemed to like her very much -- and I think it was very good for us to have a female surgeon there at the hospital because some people would have preferred, some mother and father, or perhaps a father too, would like this, to have a female surgeon. I think the mothers communicated very well with her and what she told them, and what the diagnosis was, and what she was going to do about it. But I think it basically

comes back to the fact that she was a terribly nice person personality-wise and she was an educated and very intelligent person. This all started it all.

EHRHART: In CHOP's *Children's View*, which is a publication I guess that was sent out every once in a while from CHOP, in fall and winter of 1992...

BISHOP: By the way, I'll have to tell you, I don't like the word "CHOP."

EHRHART: Oh, I'm sorry, Children's Hospital.

BISHOP: I rarely use the word "CHOP." The connotation is not good for me.

EHRHART: Okay, that's fine, I understand.

BISHOP: It *is* called "CHOP."

EHRHART: In the 1992 issue of *Children's View* published by Children's Hospital, you were quoted as stating that Dr. Schnaufer was "far from an assistant" during the conjoined twin separation in 1957. How was she "far from an assistant"?

BISHOP: She came here as a staff person. When you came here as a staff person you had your own patients, you were responsible for them night and day. Even when you were off-call, you still were ultimately responsible for them. And she was treated like every other person there who was doing the work that we were doing, and Dr. Koop and I were included in this. She came as an independent practitioner of surgery, and she worked on her own. She was a full-fledged surgeon who had to make up her own diagnosis and mind as to what she needed to do about it.

[ed. note: refer to Schnaufer's C.V. for dates; it is possible he is referring to the 1970s instead of her training at CHOP during the 1950s.]

EHRHART: Do you want to say anything about that particular operation in addition to that?

BISHOP: The Siamese twins?

EHRHART: Yes.

BISHOP: I might tell you what I think about the Siamese twins. I think Siamese twins is a very rare anomaly. That was not the reason we were there, to take care of Siamese twins. This was a rare thing that came upon each of us. I operated on a number of Siamese twins. But this has been developed seeming as if this is the main reason for pediatric surgery and it isn't at all. Pediatric surgeons take care of the entire body – there are birth abnormalities of your head and face and neck and chest, diaphragm, intestinal problems, rectal problems, extremity problems – and they all fall into birth abnormalities, and that was what we were trying to find and find operations that would be successful for getting some of these babies through. For example, one of the most common things that are talked about is esophageal atresia, with an abnormal connection between the esophagus and the trachea. There was a man named Thomas Lanman

who in Boston wrote a very unusual article describing 23 patients that died as a result of this difficultly, this birth abnormality, and why they died, and what he thought might be done about it. So he published this review, and all patients died in the review. This was the interest of us all, with the advancement of anesthesia and intensive care areas and how to take care of a baby. You couldn't do this unless you were full-time at all this, or worked in a major children's hospital that gave us access to this. During my lifetime, from zero number of people who ever survived esophageal atresia, we're now saving 98%. In my lifetime it's been a gigantic improvement in the care; although it is rare, it's a birth abnormality that is salvageable. Most of us, including Dr. Schnaufer, was interested in birth abnormalities that were compatible -- that you were destined to die of if you didn't develop a concept of what sort of operations and how you managed these things and have them survive. If you got a baby to survive, whether a very difficult birth abnormality, you have a full lifetime ahead of you, it's not like operating on an older person who is going to live maybe 10 years. So it was a great pleasure for us to do all this stuff and the rewards were gigantic for that individual.

[Interruption to adjust recording equipment.]

BISHOP: Now getting back to Dr. Schnaufer. Her role, as I've implied before, she was given a full responsibility of taking care of an individual who came to her as a patient. She made up her own mind about it, she decided what operation might be best. She was not an assistant, she was an associate who had full responsibility for the maintenance of her patients. Now having said that, obviously we referred to one another and asked her advice and conclusions about a certain thing that was vexing to us, but by and large it was the individual who was the surgeon who was responsible for what was done and how it was done, and she falls into that category. [Ed. Note: He seems to be referring to her role after her appointment as a staffmember.]

EHRHART: My next question is when Dr. Schnaufer received the 1997 distinguished alumni award at Children's Hospital, in his speech Dr. Templeton said that you and Dr. Koop recognized that Dr. Schnaufer would be someone who would contribute greatly to patients' care and pediatric surgeons' training. Describe some of the characteristics or talents you and Dr. Koop saw in her. Had she changed or grown from the time of her fellowship, and if so, how?

[Interruption to adjust recording equipment.]

BISHOP: Well, about the residents. She was very, very kind to the residents who were there in training with us. They almost looked to her because she was perhaps less busy than either Dr. Koop or I was. The residents liked scrubbing with her. She taught a great deal while operating or helping them operate, and they felt this is why she got the award, because she was so dedicated to training them fully at the times that she was at the operating table. And perhaps the rest of us did not do it as well as she did, and that's why she got the award.

EHRHART: Now that's interesting, because Dr. Templeton also said something about scrubbing. And what is it exactly? I understand scrubbing is in order wash the germs away...

BISHOP: Scrubbing means that you get ready to operate. You have to define what an operation consists of. It's the patient, usually a baby or a somewhat older child, and they have the

anesthesia man who puts the child to sleep, and then you got the main surgeon who is ultimately responsible for the progress of the case, and then usually one or more residents. Very often the resident is there for a period of time. If you came now you'd have to be there two years -- I think originally it was maybe one year -- and then you might have a Penn medical student who would scrub with you. So there were three people other than the anesthesia person at the head of the table, three people usually at all operations. If Dr. Schnaufer was going to do it, the resident would assist her in doing all this, as is true of all of us. And maybe the medical student was there mainly to observe with the whole retractors so that you could see what you were doing. She was very good at this and that's why she got the award, because she was thought to be better at this than most of us could have been.

EHRHART: Either during her residency or after she returned to work at Children's Hospital, can you describe the operating room dynamic when you worked as part of a team with Dr. Schnaufer?

BISHOP: Well, we weren't part of a team. The team that is taking care of the operation is the team. We're all not involved as a team effort. Each individual surgeon, each staff surgeon, has patients that are cared for by him, dealt with by him, and operated on by him, and taken care of post-operatively by him, so that it's really not a team effort. Now when you talk the Siamese twins, and again, I sort of hate to bring up Siamese twins because it's such a tiny little part of what we did – a very minimal amount of role. Now there you have to have a team effort because once the two children are separated and you have two children rather than one, then you need two surgeons in different parts of the operating room and each have to be responsible for what they're doing to that particular patient. So that's when you're an assistant, but most of the time you're acting independently.

EHRHART: So there weren't very many situations in which you, and Dr. Schnaufer and/or Dr. Koop would have been in the same operating room.

BISHOP: We might be next door, and we'd communicate back and forth if there was a particular problem. Then all of us, whether Dr. Schnaufer or Dr. Koop or I needed some advice while the patient was -- incision open on the operating table, you might say "Chick, what do you think of this, what would be best to do about all this?" but it was up to you to make up your mind, as it was up to her to make up her mind.

EHRHART: And how would you communicate with each other?

BISHOP: We're in major operating rooms, they're all connected.

EHRHART: They're all connected with doors, or with just openings between the rooms?

BISHOP: Yes.

EHRHART: Just openings?

BISHOP: Generally there's a big hallway, and then the operating rooms go off it. And the scrub sinks are there. Scrubbing means getting ready to operate, it doesn't mean part of the operation itself, you're all scrubbed up by the time.

EHRHART: During the actual procedures would you call into the other room? Would you send someone in?

BISHOP: Very rarely. We were all competent people, and by and large we didn't need to communicate. This happened very rarely. In fact, I cannot think of a single time when Dr. Koop and I scrubbed in together on the same case. I don't think it ever happened.

EHRHART: Did you ever observe Dr. Schnaufer...

BISHOP: Yes.

EHRHART: as she was operating, and/or...

BISHOP: Well, I knew her as a resident and then I knew her when she came back as a staff person.

EHRHART: Can you describe what kind of dynamic was in the operating room when she was the leader?

BISHOP: She had the ability, in my opinion, to get along with the scrub nurses very well. And that's an integral part of being a good surgeon -- you have to keep the team in that room happy and she was very good at all this. She became a close personal friend of many of those scrub nurses and still retains that friendship.

EHRHART: Can you define what scrub nurses' responsibilities would have been?

BISHOP: They're there to get the patient ready to be operated upon, and place the patient on the table, and usually they pass the instruments, the sterile instruments that have been done by some other nurses in the operating suite. And she is scrubbed and passes the instruments to the surgeon who says what he or she needs.

EHRHART: Can you give an example of a way that she would help foster a positive working dynamic with the scrub nurses?

BISHOP: She was such a delightful lady that everyone enjoyed knowing her and meeting her. This came naturally to her. And this was, again, her whole life. Everything, this is what she did that pleased her most, rather than raising children or marrying a husband.

EHRHART: In the operating room or with a particular case, is there a particular situation or procedure when you were working with Dr. Schnaufer that is vivid in your memory, and if so, what was it, what happened, and why do you feel it sticks in your memory?

BISHOP: Well, again it would be rare for any of us to have called in someone else to advise about this. Only in a very, very difficult situation. But by and large, you, the surgeon in the operating room, are in charge of the thing, and you see it through from beginning to end.

EHRHART: It's been written that Dr. Schnaufer, along with you and Dr. Koop, performed new, or progressive, surgical procedures, such as repairing infant hernias. How did you work, or did you work as a team to develop and support each other in the development of these new procedures?

BISHOP: Again, this was a surgical field that was in its infancy, so that there was a lot of reason for developing new ideas about how to deal with things. So it's not surprising that all of us developed our operations that would be effective in taking care of the difficult problem ahead of us.

EHRHART: So would you discuss these cases as they came up with each other before you...

BISHOP: Well, I can tell you about an operation that I devised, and I developed this concept when I was at Boston Children's. Without going into great detail...I thought this is for a very rare thing called a meconium ileus, where you have a blockage of the intestines of the newborn so that the material cannot go through the intestinal tract from beginning to end and you had to operate on it. I considered a new method of handling this, where you exteriorize a portion of the intestinal tract out, so-called a Roux-en-Y procedure, so that you had access to open the stuff that was blocking the movement in the intestinal tract after the surgery, not while doing the surgery. And that's called a Roux-en-Y, it has been picked up around the world, and it's called the Bishop-Koop procedure. And the reason it's called the Bishop-Koop rather than the Bishop procedure is that Dr. Koop had a meconium ileus patient arrive and we were chatting about this and I said "Let me present, Chick, a new concept that I have about how best to handle this thing." And he agreed with it, and he was the first one to have done it. So that he was the first one to operate on it, but it was my suggestion that he do it. The interesting part of all this is that the Annals of Surgery -- Chick and I chatted about this and said it worked extraordinarily well, it ought to be publicized. And although we'd done only one, Annals of Surgery accepted my article showing a single case with good results for managing of this complicated thing. It's very unusual for Annals of Surgery, which is probably the best surgical journal in the United States, to have accepted a single case report, which is really what it was.

FILE: BISHOP3

BISHOP: This particular operation, the Roux-en-Y method of emptying out the meconium of the intestinal tract post-operatively, is now, was originally used all over the world. It's written up in many of the foreign textbooks of pediatric surgery.

EHRHART: How would one spell that, please?

BISHOP: Roux-en-Y [corrected]

BISHOP: But Dr. Schnaufer was not involved with that one, but she did the operation many times after that was described and published.

EHRHART: So you and Dr. Koop, with that particular procedure, worked with each other. Is there a particular procedure, that you, or not even a particular procedure, but is there a particular way, you know people think about things, conceptualize things differently. With the procedures that were developed or being conceptualized by Dr. Schnaufer, is there a particular way you would be able to see her thought process about how she would approach different procedures that would need to be done?

BISHOP: She had the same surgical attitude about these things as we did, and she fit into the scheme of our service very well because of this.

EHRHART: 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?

BISHOP: Most of the time we knew what we were going to do ahead of time. Because our diagnostic acumen was good enough so that we knew what we were going to find when we opened the abdomen or opened the chest, what we would find.

EHRHART: So it's not so split-second as we make it.

BISHOP: You generally ought to know what you're going to do before you get there. Now granted, all of us are fortunately capable of changing one's opinion about something depending on what we find, but usually once you know what the situation is, you generally have a fairly good concept of what to do about it.

EHRHART: Hospitals can be stressful places. So how did Dr. Schnaufer deal with that stress and situations that arose, either in or out of the operating room, among colleagues...?

BISHOP: She had a marvelous personality, and if she didn't have that and wasn't able to get along with people, including patients, and their families, and their relatives, and fellow surgical people, or the medical people who might have referred the case to you, she wouldn't have done as well, but she was very good at all this. Perhaps even some lady pediatricians would rather have had her as the pediatric surgeon because of her gender.

EHRHART: Do you feel that was the case often?

BISHOP: Oh, not too often, no. By and large, hospitals run night and day, seven nights a week, and a full month schedule so that somebody's on call all the time of a senior level. And she took her turn as senior and when she was in charge and was the only one there, she took over admirably.

EHRHART: You've reflected on this already, but is there anything you'd like to add regarding how Dr. Schnaufer related to her patients and their families outside of the operating room?

BISHOP: Most of that occurred privately, you'd talk to patients in the privacy of your office, you don't blab it all over the hospital, you sit down quietly and discuss it with them. I've not really reviewed, didn't have a chance to review what she said to people, but obviously what she said was appropriate and wise, because that's why they liked her so much.

EHRHART: As one of Dr. Schnaufer's colleagues, can you describe her commitment to and her work with her fellows? Would you consider her guidance or relationship with them unique when compared to the relationships that most surgeons have with their fellows, and if so, in what ways?

BISHOP: I think she was almost the "mother hen" to the surgical people who were already trained in adult surgery who were there studying pediatric surgery with us. She was very good at communicating with those people. And interestingly enough, I don't think we ever had a female resident once Dr. Schnaufer was on our staff. Now they have, very often will have female residents, but I don't think there was ever one during Dr. Schnaufer's tenure that was a female.

EHRHART: Do you want to elaborate a little bit on the "mother hen" title? What would that entail? I mean, I think I understand what you mean, but just how would you define that?

BISHOP: In what regard?

EHRHART: When I think of a "mother hen," I think of someone who would go and make sure that "Joe" is doing the right thing and counseling them and....

BISHOP: Well, that's the role of the surgeon with the group of people who is working with him. Again, you don't work with your staff people, you work with junior people in there. So she was a mother hen to them who were there helping her get the patient well.

EHRHART: So her assistants and her residents?

BISHOP: Yes.

EHRHART: Did you have the opportunity to observe what one may call her "teaching technique," and if so...

BISHOP: Well, she's a very modest lady, and would deny a lot of what I'm saying about her because of her modesty. But she was competent enough and qualified enough, and so forth and so on, that she did it well.

EHRHART: How many women do you recall worked in pediatric surgery at the time you worked with Dr. Schnaufer?

BISHOP: Oh, two or three.

EHRHART: And what year would that have been?

BISHOP: Late 50s, early 60s, early 70s.

EHRHART: And how do you believe she made a name for herself in a male-dominated field?

BISHOP: Well, by being competent and by the fact that all the people that trained and then went elsewhere to continue a practice of pediatric surgery. So she was well-known around the country and abroad. She belonged to the pediatric one in England, I can't think of the name at the moment. But she went to international meetings as all of us did. And although she didn't give too many presentations...Dr. Koop was the best presenter we had, I was maybe far down the line at number two. But this was such a young field that this was spread all over the world, and we were all invited, for example I've been all over the world giving lectures on pediatric surgery. I've been to China twice, I've been to Japan twice, I've been to Australia, I've been to India. You're invited to do all these things because it was a brand new field and we were taking the lead in being pediatric surgical people who knew what they were talking about, and hence we were invited to go all over the world and talk about these things. Particularly Dr. Koop, he is a remarkable speaker, and is able to relate things extraordinarily well so that he was asked much more than I was.

EHRHART: You know, you reminded me of something that I read, and that was that Dr. Schnaufer had been invited to China to participate on a surgical team. Do you have any details about that?

BISHOP: I was leader of that team.

EHRHART: Were you? Okay, excellent. Well, could you maybe comment a little bit about why your team was invited there and what exactly you did and how Dr. Schnaufer functioned?

BISHOP: We and Boston Children's were preeminent in the field, and since then there are a lot of preeminent people in the field all over our country. And there's now the president of the American College of Surgeons is a pediatric surgeon in Los Angeles. She trained in Washington. But all these people that we trained went off to other places around the country and started programs of their own, and it's a way of dissipating the information by the people you've trained, by them going elsewhere.

EHRHART: Do you recall what year that was that you took the team to China?

BISHOP: No.

EHRHART: I believe it was the early 1990s, does that sound correct?

BISHOP: I took a group of people there. And I think she was on one of those trips, but I'm not sure of that.

EHRHART: Do you believe that Dr. Schnaufer – you touched on this already, but perhaps there's something else you might like to add – do you believe that Dr. Schnaufer, as a woman,

brought particular attributes to her work that enhanced her effectiveness, and if so, please describe how.

BISHOP: Maternalistic.

EHRHART: Can you elaborate on what you mean by "maternalistic"?

BISHOP: I think that women have a different approach to certain problems and she had that, but nevertheless had the male concept of "you've got to find out what's wrong and take care of it and do it." This is called surgical personalities, and she developed a surgical personality of necessity, otherwise she wouldn't have been as good as she was.

EHRHART: So it was a combination of different attributes.

BISHOP: Yes. Now the question is whether you develop your surgical personality or if you are born with it or you develop it. My guess is you're born with it [sic], but Dr. Koop had it when he was born.

EHRHART: Oh, he did, okay.

BISHOP: His ability to speak and make the right judgment, he was born with that innate ability.

EHRHART: Pediatric surgery was considered a fledgling specialty for a while, do you believe that Dr. Schnaufer contributed to its development and legitimization?

BISHOP: Only because of all the people she trained. She didn't write excessively, she wrote on certain subjects, but not as much as perhaps I did or Dr. Koop did.

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

BISHOP: I'm sure it was private advice.

EHRHART: It was private advice? How about you personally? You certainly developed a friendship with her. And that's my next question, what type of relationship, personal relationship....

BISHOP: It's been a very close personal relationship and I've enjoyed knowing her and I hope the reverse is true. We, as a group of people, got along extraordinarily well. Usually there's a lot of competitiveness, arguing back and forth amongst people who worked in the same institution, but we never had that. We were lucky enough to avoid that. Dr. Koop recently got up and was talking about me at an open meeting, and he said he can't remember a single episode where he and I totally disagreed on anything. We generally looked at the material and came to the same conclusion about it, and so did she.

EHRHART: How about personally, can you define what your relationship is like? You see each other. You mentioned to me earlier that you get together with her upon occasion. So it's a personal, a social relationship?

BISHOP: We did a certain number of vacations together. I had a boat in the Caribbean and she used to come down and sail with me on the boat. So it was not only a professional relationship, but it was a relationship of big friends.

EHRHART: Why do you think it was that you got along so well? You and Dr. Schnaufer and Dr. Koop?

BISHOP: We were lucky.

EHRHART: No, I think there's probably more than luck.

BISHOP: Perhaps it's Dr. Koop's ability to select the right people to work with him. With the group, not with him, but with the group.

EHRHART: Knowing what personalities and what expertise?

BISHOP: Yes. Dr. Koop and I went to the same college together, for example, we went both to Dartmouth College, so that maybe that had a little bearing on all this, and that's why now he lives in Hanover, New Hampshire, where Dartmouth is.

EHRHART: Well, that comes to the end of my questions, is there anything you'd like to add that we haven't discussed already?

BISHOP: The most amazing thing to me is that here was a woman who was small in stature, not particularly impressive, as a big hulk of a person, really quite diminutive, sort of a not physically impressive person, but yet she got along very well in a man's world. I often have thought that women's lib should take a lesson from Dr. Schnaufer as to how she did it so well. A lot of this is hard to define, but I am annoyed by the women's lib behavior pattern on occasion. I don't mean to denounce women.

FILE: BISHOP4

BISHOP: I'll express it in another way. I've often wondered how she was able to do this, as a not physically impressive person, was able intellectually to do all this with great ease. I've often wondered. I wish a lot of overly bearing women would take the same lesson from her that she's able to give. But I don't know she gave all it. Do I say that right?

EHRHART: Yes -- no I understand, well I guess it could have been in her approach, attitude, tactics, so to speak.

BISHOP: And intelligence, knowing how to behave. And doing it well.

EHRHART: And what do you mean by that exactly, "knowing how to behave"?

BISHOP: Well, to get along with other people, rather than being a bull in a China shop.

EHRHART: You were commenting before the bell rang, you were commenting about the women's lib efforts and how, I think what I understand is that basically you're saying she made a great impact without, without going at it in a particular way that may put people off.

BISHOP: It came very naturally to her.

EHRHART: Okay, it came naturally to her.

BISHOP: And it's very interesting that here was an orphaned child who, although was raised by an aunt who really cared for her. But yet she developed the ability to get along well with people. A lot of overbearing women, I wish they could develop that attitude about how to get along well with people.

EHRHART: Were there any other comments that you had? Any stories that come to mind that you'd like to share?

[INTERJECTION]: By the way, what he said is true for that day and age, not for this day and age, that sounds so strange in this day and age. But in that day and age, it really was true, it was a whole other ballgame. And Louise was one of the people that broke it. It really was, it was male-dominated and not nice.

BISHOP: I think there are unknown factors that even I don't know about or can't express that must have existed in her that caused her to be as good as she was. I think having talked to a number of people I think you'd come away with...by the way, did Jack Templeton have the same concept about her?

EHRHART: I really honestly don't recall. He of course worked with her in a different capacity than you did, at least initially, since he was one of her residents.

BISHOP: That's right.

EHRHART: So I really don't recall regarding the women's lib, for example. He did comment, however, about her religious faith. Is there anything you'd want to mention about that and how that maybe influenced her? If you do have that opinion, if it's not how you feel, you don't need to...

BISHOP: I think religious faith is a very personal matter. I don't think you can comment on other people's religious faith and why they do what they do.

EHRHART: No, it wasn't that so much, but he mentioned that he felt that her...yeah, okay, well we can leave it at that.

BISHOP: Dr. Koop might say the same thing about her, but the religious part of this played no bearing as far as my relationship with her. I think it did in reference to Jack Templeton and Dr. Koop. I think they have an unbelievably strong religious belief. And although think I will get to heaven as soon as they will, I don't believe it the way they believe it.

EHRHART: That's fine. That's totally fine. I don't want to put words into your mouth or anything.

BISHOP: Right, right.

EHRHART: Anything else you might want to add about working with her, or getting together outside of the hospital?

BISHOP: No, I don't think so.

EHRHART: Okay, all right then, we'll wrap it up. Today is September 5, 2006, and my name is Mindy Ehrhart. My last name is spelled E-H-R-H-A-R-T. And this is an oral history interview with Dr. Harry C. Bishop, B-I-S-H-O-P, regarding the Louise Schnaufer Oral History Project conducted for the College of Physicians of Philadelphia and funded by the Foundation for the History of Women in Medicine.

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FILE: HALLER1

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

HALLER: Alexander.

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

HALLER: Correct.

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

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

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

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

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

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

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