FILE: TAYLOR1

EHRHART: Today is March 28, 2007 and this is an oral history interview with Dr. Lesli Ann Taylor. This is for the Louise Schnaufer, M.D. Oral History Project, which is conducted for the College of Physicians of Philadelphia and funded by the Foundation for the History of Women in Medicine.

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

TAYLOR: I'm Dr. Lesli Ann Taylor, my position is the Chief of Pediatric Surgery at East Tennessee State University, Johnson City, Tennessee.

EHRHART: Could you please provide a brief background of your career?

TAYLOR: I began my college career as a theater major at Boston University. I became aware that I did not want to pursue that. I took two years of pre-med courses at the University of Massachusetts and I was accepted into medical school at Johns Hopkins in 1977. I completed that in 1981 and did a general surgery residency at Beth Israel Hospital in Boston between 1981 and 1988. During that time I confirmed my interest in pediatric surgery and was accepted at Children's Hospital of Philadelphia for a fellowship between 1988 and 1990. When I finished my fellowship I accepted a job at the University of North Carolina Chapel Hill, where I was first an assistant professor and then an associate professor with tenure between 1990 and 2005. In August of 2005 I began my position as the chief of pediatric surgery at East Tennessee State University in Johnson City, Tennessee.

EHRHART: You had mentioned before we started recording the interview that you were influenced during your time at Johns Hopkins to choose the specialization of pediatric surgery. Would you like to comment some on that?

TAYLOR: When I was a senior medical student at Johns Hopkins, I had gotten some inkling of my interest in surgery during my obstetric rotation as a third year, but it was really in my fourth year I was first exposed to Dr. Alex Haller, who was the chief of pediatric surgery at that time. Because Dr. Haller is very tall it's hard to miss him, and he's also extremely friendly to everyone, but especially to medical students. I did a rotation on pediatric surgery for a time as a medical student and really got my first exposure to the specialty at that time.

EHRHART: Why did you find it appealing?

TAYLOR: The appeal of surgery in general is that you can take somebody who is very, very sick, and with sometimes a very short procedure, make them immensely better. Particularly in pediatric surgery, the two conditions of pyloric stenosis and patent ductus arteriosus, are examples where a baby can be very sick beforehand, and a procedure that can take less than an hour can literally turn everything around and they can have very rapid recovery after that. The

appeal of pediatric surgery is to take an infant and sometimes perform a procedure that will carry them through their lifetime. An example of that is esophageal atresia, where the baby is born with a blind esophagus, cannot eat until their esophagus is put together. And you do the surgery and within a week they can eat, and most of them do very well the rest of their life. They carry your stitches in their body for the rest of their life, so that's very gratifying.

FILE: TAYLOR2

EHRHART: How and when were you associated with Dr. Schnaufer?

TAYLOR: I began my fellowship in pediatric surgery at the Children's Hospital of Philadelphia in July of 1988. She was an attending at that time, and I completed my fellowship in May of 1990, and so I was associated with her for those two years. I've kept some contact over the years after I left my fellowship.

EHRHART: Would you say she was your primary trainer or mentor?

TAYLOR: She was one of six attendings at that time. I would not say she was my primary one.

EHRHART: Who was?

TAYLOR: I'd have to say the Chief, Dr. James O'Neill, but I had contact with Dr. Jack Templeton, Dr. Mory Ziegler, Dr. Harry Bishop, Dr. Art Ross.

EHRHART: What had you heard about Dr. Schnaufer before you met her? Had you heard anything about her?

TAYLOR: Just a little bit, I think during the time that I was interviewing in pediatric surgery and trying to get an idea of who were all the pediatric surgeons at all the different programs. What I had heard is that she was the only woman who had been at CHOP for many, many years. That was pretty much what I knew about her.

EHRHART: What were your first impressions when you first met her?

TAYLOR: She is and was a very compact, energetic, down-to-earth woman. Very capable, very friendly, outgoing, really very caring about the children that she took care of.

EHRHART: When did you first meet her, in what capacity was it?

TAYLOR: I can't remember our actual first meeting, but it would have been sometime after July of 1988 when I started there as a fellow.

EHRHART: How would you describe her teaching style through conferences?

TAYLOR: I'd say very informal. Most of the teaching was either in the operating room, or during rounds on the floor or in the clinic. When you're in your second year as a fellow there

you run your own clinic and have pretty much your own patients. But of course there's always a patient or two that comes along where there's something you haven't ever seen before and I would call her in during clinic to just give me a second opinion when I was evolving into my own clinic.

EHRHART: You said that her teaching style was informal. How would you explain the informality?

TAYLOR: I'd say it was mostly patient-based, meaning whatever condition the patient had, that's what we'd talk about rather than lectures. It was just very practical, meaning the patient-care issues on rounds or in the clinic.

EHRHART: Was it more through observation, would you almost say, rather than active teaching?

TAYLOR: Almost all surgical training is a sort of apprenticeship where you scrub with a senior surgeon, or you make rounds with a senior surgeon. It's always case after case after case of just doing cases, and seeing patients alongside, following alongside. Her style was pretty much in line with all the other attendings, and that is sort of the basis of surgical training.

EHRHART: What are some of the procedures that you assisted her in performing, or perhaps she taught you in the operating room?

TAYLOR: Really, it was whatever came in on her day on call, and that's sort of the luck of the draw, meaning you never know what's going to come in. It could be a baby with gastroschisis, diaphragmatic hernia, appendicitis, just whatever happened to come in that day.

EHRHART: Is there a particular situation or procedure that is vivid in your memory?

TAYLOR: The situation I recall, it was actually not so much about a surgery, but one day we were in the operating room together, and the x-ray machine was there, taking an x-ray of our patient. A plastic surgeon walked by the door and made a remark, which I remember to this day because it was prejudicial and probably could be considered gender-harassing. He said, "Oh, Louise, you don't need to worry about your ovaries," meaning you don't need to cover up with lead to protect your ovaries from the radiation. Whenever you're in a room with an x-ray being taken, the people in the room have to be concerned about radiation exposure themselves. Their choice is to step farther away or to wear a lead apron. I was a bit shocked that this plastic surgeon would walk by and make that comment, because really it was none of his business, and it seemed really out of the realm of appropriateness. First of all, we were trying to take care of the patient in the operating room. Second of all, I considered it a harassing comment that he would make out of the blue like that, because if we were to say the same thing to a male, "Oh, you don't need to protect your genitals from radiation," I think it's an inappropriate comment. That is one of the memories that I have of Dr. Schnaufer, watching how she reacted to that. She didn't try to say anything back to him, but on the other hand she didn't get rattled. So it was an example to me of how a woman can just be trying to go about her business of her profession, and

yet you can be attacked at any point, and you may not be able to respond, and yet you still have to go on and do your job and not be rattled by that sort of event.

EHRHART: Is that exactly what happened? You two just continued?

TAYLOR: My recollection is that she didn't honor his remark with any response, and we just continued on to take care of the patient. But I suspect that that is something that she had to deal with on a very frequent basis, being the only woman there for many years, where another surgeon can just walk by and just make a comment, a personal comment that's totally out of the realm of necessity, so to speak. There's no reason he should make that comment except to distract her, belittle her, remind her that she's a woman, or whatever his intention was with that comment.

EHRHART: Now that was a plastic surgeon, so was that sort of behavior or interaction common at Children's Hospital, and particularly in the pediatric surgery division?

TAYLOR: I don't think so. My remembrance of the department is that she was very well-respected by Dr. O'Neill, certainly the fellows, Dr. Templeton, Dr. Ziegler, and Dr. Ross. They were the three junior attendings at that time. They had also been fellows under her. I don't ever recall any inappropriate comments from them. That one episode about the plastic surgeon stands out as a glaring example, and hopefully an infrequent example of what she may have had to tolerate.

EHRHART: Do you think...I don't want to say do you think she was right or wrong in the way that she handled it, but from that situation moving forward then, how did you decide that you would handle future situations that might be similar that might come up?

TAYLOR: Well, I think she did the right thing, because instead of getting distracted, going out and talking to the plastic surgeon, or even giving any acknowledgement to his remark, she focused on staying in focus with the patient. That is how I've found that for me the easiest way to get through – sometimes when you're the only woman in the room or the only woman in the group – is to focus on the work, rather than get into little side fights, or one-upmanship.

EHRHART: We talked about her teaching style through conferences and so forth. How about in the operating room? How did she utilize the fellows in the operating room, and how did she interact with the various other people involved with the surgery, such as the nurses and anesthesiologists?

TAYLOR: Of course by the time that I had arrived she had been there for many years, I think at least 18 years or so.

EHRHART: Yes, she had started sometime in the early 1970s.

TAYLOR: She seemed to have just a very congenial interaction with the nurses. I don't recall any problems in the operating room. She was usually a very calm surgeon, very confident. I don't recall any times when she didn't know what to do, or problems that way.

EHRHART: Let's look at it through a gender lens for a moment, because if you were in the operating room with Dr. Schnaufer, the operating room nurses, were they all female at the time?

TAYLOR: That's my recollection, yes.

EHRHART: And how about anesthesiologists?

TAYLOR: I think Pina Templeton was the only female anesthesiologist, there might have been one other. Almost all of the others were male.

EHRHART: So the presence of a male anesthesiologist at times. Would that change the dynamic at all in the operating room?

TAYLOR: Not that I recall.

FILE: TAYLOR3

EHRHART: We were talking about the dynamic in the operating room, and dynamic when there were men in the room as opposed to an all-woman surgical team, and you were saying that you felt as though the dynamics were the same regardless of gender?

TAYLOR: Correct. As I said, probably Pina Templeton was the only female anesthesiogist, so the number of times that it would be an issue of an all-male versus all-female team... I think that was one of Dr. Schnaufer's great strengths, is that she seemed comfortable in just about any situation I saw her in. I don't ever recall her seeming rattled, or at a loss, or flustered. She seemed very comfortable in the operating room and working with whatever team was there. That is one of the big challenges in the operating room: you never know which anesthesiologist or which nurse you're going to get for any particular case. You have to work with what you have, and I think she did that very successfully.

EHRHART: An important aspect of performing surgery is the ability to make appropriate decisions at crucial moments. Can you reflect on her decision-making ability and/or procedure?

TAYLOR: It was subtle in a way, in that she never seemed to belabor a decision. Again, I think it just speaks to her great wealth of knowledge at the time that I was working with her. She had pretty much seen everything, so I think the decisions were pretty much easily made just because she had so much experience.

EHRHART: How did she guide you to create your own decision-making procedure?

TAYLOR: I can't answer that one. I don't recall her ever specifically becoming that involved to personally guide me that way.

FILE: TAYLOR4

EHRHART: I think I didn't formulate that question well enough. I think what I meant was not did she ever take you under her wing and sit down and say, "Well, Dr. Taylor, you really need to do it this way," but was there a way in which, let's say you were assuming more responsibility for a patient. Would there be a way where you would talk about the options and the diagnoses?

TAYLOR: I'll give the example which goes along with her more informal approach to things. She kept a bag of peanuts in the bottom drawer of her desk in her office. The attendings, Dr. Ross, Dr. Ziegler, Dr. Templeton, would gravitate there. Sometimes I'd stop by her office, or Dr. Lau more frequently, the other fellow, would stop by her office and find them eating peanuts together. I think it was her way of saying, "My office is open, my mind is open to you," meaning stop by anytime to feed on the peanuts, but also that's where you just hashed out the patient that wasn't quite doing so well, or the new patient that you couldn't figure out. So I think her style was not didactic, her style was more interactional or conversational, of "Let's just talk about this patient together in an informal way," was more her style of teaching than giving a lecture.

EHRHART: Did you find that to be effective?

TAYLOR: I did. I must say I didn't go to her office to eat peanuts very often, but just the number of times I'd be looking for one of the other attendings and find them in there eating peanuts, it was clear that this was sort of a welcoming environment where people felt comfortable just dropping in to her office, sitting down to talk over things. So I did find it effective in that way, because she was available. You may not have always known exactly what question you had, but you didn't have to have formulated the question, it was okay to just go in and talk, and eventually you'd come to get your problem worked out.

EHRHART: So you felt welcomed there as well?

TAYLOR: Yes.

EHRHART: What did you learn from her about bedside manner or how she related to her patients and their families outside of the operating room?

TAYLOR: I think she had excellent bedside manner, and actually in that case I think her short stature was to her advantage. I've noticed that among pediatric surgeons, I think overall we may have shorter stature than other groups. I don't know, but I think that maybe shorter people gravitate towards pediatrics because they're dealing with children and their stature isn't as important. I think she had an easy rapport with children. By the time I was with her she was in her late 60s or 70s and she had sort of a grandmotherly appearance and manner. I think that she had an easy bedside manner. Again, she had just been doing it for so long that she'd pretty much seen everything and there was very little that she didn't know what to do, and so she was able to project confidence. I think that benefited the parents and the children very much, particularly the parents to know that she'd been doing this for 30, 40 years, and that she was very experienced and could handle anything that came up.

EHRHART: Is there a specific situation that you recall?

TAYLOR: Not off the top of my head right now.

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

TAYLOR: The easy answer is, the women that trained at the Children's Hospital of Philadelphia were very few. There was Dr. Rowena Spencer in 1949, Gretchen Wagner in 1952, and then Dr. Schnaufer in 1957, and then no women until myself in 1988 through 1990. There also were not very many women at other institutions. Was your question in all of pediatric surgery?

EHRHART: In all of pediatric surgery, yes.

TAYLOR: Another woman that was very helpful to me in my career was Dr. Patricia Donahoe, who was at the Children's Hospital in Boston at Massachusetts General. I was in her lab for two years. I didn't mention that as part of my training, but between 1984 and 1986 I was in her lab. There really were not very many other women in pediatric surgery, there was Dr. Ann Kosloske...I'm blanking on the names.

EHRHART: That's okay. I don't need the names, just the ballpark. So it's almost like a half-dozen or so? That's what it sounds like to me.

TAYLOR: Yes.

EHRHART: How do you believe that, given the small number of women in the field at the time, how do you believe she made a name for herself in a male-dominated field?

TAYLOR: I think just by her daily work, meaning she just stuck it out in a sense that she worked hard for many, many years just doing the clinic and the call and the rounds, just the doggedness of coming in every day and dealing with the problems that always come up. I think she made her name by her longevity, and by just being really the only one around, the only woman around at that time. What I remember is they had some turnover in staff after I left, meaning they had taken Dr. Lau on as an attending, and then another attending, Dr. Hoffman, and they didn't hit it off and I think both ended up leaving. So Dr. Schnaufer at different times tried to retire, but because of other staff coming and going, and then Dr. Templeton left to go into private business, and Dr. Ziegler left to go on to be chief at Cincinnati Children's. Dr. Schnaufer was just sort of the backbone that was always there, and she probably wanted to retire sooner, but with all these other people coming and going she stuck it out as the person that was just reliable, going to be there to hold things together as other people were coming and going.

EHRHART: I know she never married, she never had children. Do you think if she had it would have changed the way she was regarded?

TAYLOR: I've wondered about that. To get where she got, meaning to be asked to be on the staff at Children's Hospital by Dr. Koop, and just do the grind of the daily work. I don't know, I never asked her if she wanted children or relationships. I wonder if she felt that the only way she

could get through was to be singled-minded, focused on her job, on her career, and not try to have much else in her life, like children. Basically her patients were her children, or at least she devoted so much time to them. Most women going into the profession would not want to pursue it if it meant that they had to totally isolate their life and not have family and children and other parts to their life. I don't know if she made that choice because she felt that that was the only way that she could really make a career goal of it or not.

EHRHART: Or whether it's just the way her life worked out.

TAYLOR: Right.

EHRHART: It's hard to know. It's sort of counterfactual. I just want to hop back a minute to the time you were a fellow at Children's Hospital. This is not specifically related to Dr. Schnaufer, but did you feel that as the only woman, pretty much in the pediatric staff, as well as probably in pretty much in the hospital among the doctors, how do you feel you were regarded? Were you regarded differently than others?

TAYLOR: There was a female pediatric neurosurgeon there at the time, and there were certainly plenty of female pediatricians, emergency room doctors, that I can recall. That's a very hard question. I don't know exactly how anyone else would answer that, how they regarded me. How I felt I was regarded, it was easier in my second year as a fellow, when I was more in the leadership position of being the chief resident, so to speak, because then I had more of an identity. I think I was well-regarded, particularly in my second year. They sort of had an awards ceremony at the end of the year as people were leaving, and I actually got a standing ovation at the awards ceremony. I think it was more the pediatricians and the nurses that liked working with me. As far as how I was regarded by the surgeons.... I came into my pediatric surgery fellowship with a lot less pediatric exposure than most of the people coming through, and so I was having to do a little bit more catch-up, I think. There's another piece to it. In my first year as a fellow, Dr. O'Neill was the president of the American Pediatric Surgical Association, which meant that he spent most of that year away at committee meetings and conferences and things like that. So my first year, I think maybe I didn't have as much oversight from Dr. O'Neill as I would have had he not been the president of the American Pediatric Surgical Association. So it's hard to tease out what's what there, but that's how I would answer that.

EHRHART: So you're saying it was in regard to like a skill level as opposed to gender, as far as how you were regarded?

TAYLOR: Yes. Partly it was that, meaning I was coming in having only done three weeks of pediatric surgery as an intern. Many fellows coming in had done several months of pediatric surgery at different levels in their general surgery training as a third or fourth year resident, or they had taken a year out to do some extra trainings in pediatric surgery somehow before they got to their fellowship. So even though I was very, very interested in pediatric surgery, my actual experience during my general surgery training was very limited. When I did come to Children's Hospital of Philadelphia, I just didn't have the practical experience that others did, and Dr. O'Neill actually kept me on general surgery rather than having me rotate on urology, which the other fellows would do. That's why it's not easy to answer the question. It was a

combination of yes, I was the only woman there in many, many years, and I came with a lot less background and training than many others.

EHRHART: If you were to try to separate the skill level from the gender, what would come up on the gender side of things?

TAYLOR: Could you rephrase that?

EHRHART: Sure. We were talking about how you were regarded at Children's Hospital as a fellow, and we're talking about two different things. We're talking about your skills, and you said that you were working to, in some ways, catch up to your colleagues, and then we're also talking about the fact that you were the only woman who was there. I'm wondering if you believe that in some cases your gender played more of a role in the way you were regarded as a fellow than did your skill set.

TAYLOR: The gender thing was hard for me to tease out because, at any moment as a trainee, you are wondering how the people around you are treating you, and why they might assign you to a certain case, or not have you go do something independently, so I don't know that I can sort out that answer for you.

FILE: TAYLOR5

EHRHART: The next question is: In what ways did she serve as a role model for you as a woman who has or had a successful career and was respected by her colleagues?

TAYLOR: I'd say the role model that she gave me was just her consistency and her dedication to her career and her profession, meaning she seemed to feel quite comfortable as a pediatric surgeon, and as the only woman she seemed to have very good working relationships with all the male...other attendings there. Of course she had trained three of them as her fellows: Dr. Templeton, Dr. Ross, and Dr. Ziegler. So I'd say just seeing her do her job every day was how she was a role model to me, and just her obviously long commitment to her profession.

EHRHART: How about a role model as a woman?

TAYLOR: I can't answer that one.

EHRHART: Or as a woman in the field?

TAYLOR: I'll have to think on that one, maybe I can answer it in writing.

EHRHART: Okay, no problem. Now I'm back on the question list, to number 14. Hospitals can be competitive and stressful places. How did Dr. Schnaufer deal with that stress and conflicts that arose, either in and out of the operating room, among colleagues and fellows?

TAYLOR: I think she stood her ground is how she dealt with that. I can't recall any specific incident, but she was of short stature, and being a woman, she obviously has a softer voice, and

yet she had to interact with many, many males in the other specialties, other surgical specialties, other medical specialties. I think she just spoke her mind. Again, she had a huge amount of experience from which she could speak. I don't ever recall her raising her voice or getting in a shouting match with anybody, it was always just she could speak from her own experience.

EHRHART: You had mentioned earlier -- I don't know if you want to add about this now -- that you felt that being the only woman fellow there placed a certain amount of stress on Dr. Schnaufer. Would you mind elaborating on that?

TAYLOR: I'm pretty sure that I was the first and only woman to train at CHOP as a fellow since 1957 when she had been there as the fellow. She had certainly worked hard to create her own niche as the woman there, and I think she maybe really didn't know how to interact with me, whether to develop a closer relationship with me than she did with the male fellows, or what. But how can I say it wasn't just a personality issue and had nothing to do with gender, that she felt more close to Dr. Lau, and that Dr. Lau had more experience in pediatric surgery coming into the fellowship than I did, and so she probably felt more comfortable letting him be more independent. So there would be issues along those lines of maybe it was not a gender thing at all, but an experience issue. I don't know if that answers it.

EHRHART: It does. So it's really hard to differentiate what exactly were the factors that weighed in on your relationship together.

TAYLOR: Yes.

EHRHART: What kind of personal relationship did you develop?

TAYLOR: It was slow to develop. I think initially it was just a trainer/trainee relationship, and I think slowly over time when she saw that I was going to stick it out, she warmed up a little bit more. She was always generous with her clinical knowledge, meaning if I had a question about a patient or helping in the operating room, she was always courteous and helpful. We never did anything outside, ever. She never invited me to go out, but neither did any of the male attendings. Actually, Dr. Ross invited me to an auction one time with his family. She never seemed to want to develop a very personal relationship with me. She would do the training, she would treat me appropriately as a fellow, but I don't ever recall her asking me, "What do you want to do? Where do you want to go? What sort of career do you want to have?" anything like that.

EHRHART: What coincides with that is that Dr. Schnaufer was known to provide counsel to many of her colleagues and fellows. How did you benefit from her advice?

TAYLOR: It'd be mostly along the clinical lines. Even after I left the fellowship, when I was an attending on my own in Chapel Hill, I would call her if I had particularly a bowel case or a Hirschsprung's case -- she was very interested in Hirschsprung's disease -- to ask her advice on a case. Certainly in a professional manner or a professional relationship of being able to ask her for advice on patient issues, I would say.

EHRHART: Did that extend to your personal life at all?

TAYLOR: No.

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

TAYLOR: None. During the time that I was looking for my job, which would have been in the middle of 1989, I was interviewing at four or five different places, and I don't recall her showing any interest at all in where I was going or where I was interviewing or what I was going to do from there on.

EHRHART: Why do you think that was?

TAYLOR: I really don't know. I'll have to think on it. I don't know.

EHRHART: If you reflected on your career and how you conduct yourself, perform procedures and relate with patients and their families, what characteristics are based on what you learned from Dr. Schnaufer?

TAYLOR: Again, I think just the stick-to-itedness of sticking it out for the long haul, which gets you the experience so that when you go to a family – about once a month a family will ask, "Well how many of these have you done?" then you can truthfully say, "I've done 80 pyloric stenoses since I've been here 18 months." I think the only way to be able to say something like that is to have really done it, to go in every day, and slug through the rounds or the clinic or the cases and gain that knowledge first-hand. You can't get it out of a book, and I think the families can tell by your demeanor your level of confidence, and the way you get that confidence is to really have done all those cases and been through all the ups and downs that you go through with patients. I think that would be the main thing that I can recall is just her confidence from her years and years of experience.

EHRHART: How would you describe Dr. Schnaufer's influence on your career?

TAYLOR: I feel very privileged to have trained with her during the time that she was at Children's Hospital of Philadelphia, and I consider her a professional friend and feel like I could speak with her as a colleague at any time.

EHRHART: Have you had contact with Dr. Schnaufer?

TAYLOR: After my fellowship when I started at University of North Carolina, I would call her up to discuss cases. I would see her at the APSA meetings, and that's about the extent of the contact.

TAYLOR: I think all the male attendings, Dr. O'Neill, Dr. Templeton, they all respected her, Dr. Bishop. Did anybody tell you the Christmas story?

EHRHART: No.

TAYLOR: I was only there for two Christmases, but they had a tradition where Dr. Bishop would dress up as Santa Claus, and Dr. Schnaufer would dress up as Mrs. Claus at the Christmas party for the department, where the surgeons' children would come and they'd get to see Mr. and Mrs. Claus. Somebody must have a picture of that. I think it was at Dr. Templeton's home that they would have this party, so there probably is a picture somewhere of Dr. Bishop dressed up as Santa Claus, and Dr. Schnaufer dressed up as Mrs. Claus.

EHRHART: What do you think that says about her, though?

TAYLOR: She felt very comfortable in many situations. She just seemed to feel at home in her position there at the hospital. Maybe it came from her relationship with Dr. Koop. Again, I only saw them together once or twice. She just seemed to feel like she belonged there, but it must have taken a lot of sticking it out to gain the respect of the men, and to get to the point where...she was there for so long, and respected all those years.

EHRHART: Compared to the time when you were in your training at Children's Hospital – I know you're not at Children's Hospital anymore and you're here, and you just recently began here, you were at Chapel Hill -- how do you feel that the field regards women now as opposed to when you were in training? Do you see any difference?

TAYLOR: The biggest difference I think is numbers. You may be able to get this better than I, but I think it was about eight years ago the medical schools became 50 percent female. Ever since then there's been increasing numbers of females coming into surgery. There is sort of a uniqueness that Dr. Schnaufer must have felt more than I did, of always being the only woman in the room. At the same time it's sort of a curse in a way, because you're the only woman, and they may make lewd jokes, and what are you going to do? You're one out of seven or something, and somebody makes a lewd joke, you're not going to say anything because you're outnumbered. But on the other hand, to be the only woman, you've stuck it out through all the trials and hurdles, so she can take some pride in probably being the only woman at most functions for years and year and years, or being the only woman that got to that level. And nowadays, when I left University of North Carolina, five of the six chief residents were women. So there's been not a complete reversal because it's still only in the lower echelons, meaning there's certainly not five out of six chiefs of surgery women, in fact, there's still very, very few chiefs of surgery that are women. The difference is just sheer numbers. When I was in my general surgery training at Beth Israel Hospital in Boston, I was the chief resident. I had three male residents. It was never that comfortable. Two of them did well with me, the other would always snipe at me. Now it's just not as unique anymore, to be a female surgeon. The difference is just by sheer numbers of it's more likely if you're in a conference it's going to be half women, half men. There's many, many times now where we're rounding and it's all females – female medical student, female resident, female attending, and in the operating room, female anesthesiologist, female resident, female attending. I'm still trying to figure out -- I think it's good for women, whether it's good for surgery I don't know, because we still haven't gotten to the point where men truly respect a woman as a leader. I mean, I think they tolerate us now, but I'd like to get to the level where the gender isn't even going to be an issue, that whoever is the

leader is the leader and everybody views that person as the leader and you don't have to say, "Well, a female is the leader;" it's just that a female leader would be treated the same way as the male most senior person.

FILE: TAYLOR6

EHRHART: Before you left to do the procedure, you were talking about how the field has changed, in that the sheer number of women who are now in the field. But you also said that women are still not necessarily recognized as leaders in the field. My first question based on what you said was: Why do you feel that's a problem? And then I have another question for you after you answer that.

TAYLOR: Why is it a problem that women are not viewed as leaders in the field of surgery? I think women can be excellent surgeons. For many, many years, surgery was probably one of the last areas of medicine that was a male stronghold, meaning it was a clubbish atmosphere, maybe women didn't want to go through the rigors of training because of balancing a family and it was five years of training. In the past it was in-house training. It's not as rigorous anymore because now there's an 80-hour work week. But there's definitely still an old boys' club existing, and I think women can contribute a lot, and there should not be as much hassle. I mean, it's hard enough just to do the training, they shouldn't be hassled along the way of being belittled, or marginalized, or having to deal with inappropriate comments. I think there are many contributions, unique contributions, that women can make. I just think they shouldn't have to jump through so many hoops to get the training and get positions.

EHRHART: What types of contributions?

TAYLOR: I can give one example. I've dealt with many mothers of newborns who had to have surgery. Some of them had post-partum depression, and some had severe post-partum depression which I don't think was recognized or treated appropriately. Any mother would have some difficulty if her newborn had to have surgery; it's almost always unexpected. I think the care of both the mothers and the patients could be smoother if we gave greater recognition to some of those more uniquely female issues. I don't have the sense that any male pediatric surgeon that I've ever met has had much thought or understanding of what the mother goes through herself, perhaps having had a C-section or a difficult labor, plus all the adjustments breastfeeding. It's very difficult when you operate on an infant and they can't be fed immediately because of their surgical condition, and the mother is trying to figure out whether she's going to pump, freeze the milk, is she going to give up on breastfeeding, and she's dealing with all the emotions of a new mother, plus the emotions of "My child needs surgery." I just think that we could have more sensitivity to those issues, and I think women, women surgeons, they naturally either have experienced those themselves, a pregnancy, post-partum issues or breastfeeding issues. It's an untapped area, it's an unrecognized area, and yet every pediatric surgical patient has a parent to deal with. It's very different from adult surgery, where the adult is making the decisions for themself. You're always dealing with the parents struggling to make a decision for their child, which is unique to pediatric surgery. Not unique, because pediatricians have that same issue with families, but we do things that alter anatomy, and they have a lifetime

implication and the parents have to make a decision. They're making a decision that will affect the child for their entire life.

EHRHART: Along with that question about women in a leadership role in pediatric surgery. What do you think needs to happen in the field for that recognition to occur? What needs to change?

TAYLOR: Somehow, men need to feel less threatened by a confident woman. I think it boils down to that, because I've been in situations myself, and I'm sure Dr. Schnaufer was in situations, where the hard work, the contribution, is minimized so that the male won't feel threatened by the woman's accomplishments. Dr. Schnaufer really is unique in that she must have put the effort into making the relationships with the men that she worked with over all those years, all the dozens of.... If she started there in what, you said...

EHRHART: Early 1970s.

TAYLOR: 1970s, 20 [fellows], at least. Getting them to accept her as someone that they can learn from, I think that's a huge accomplishment of hers, that these are board-certified surgeons coming for their high-level specialty training, and for her to acquire the knowledge and the experience that she would retain that job, and that she'd befriend all these people, all these men, is a huge accomplishment.

TAYLOR: I can just say about Dr. Koop. I believe it was in 1992 at an APSA meeting, the American Pediatric Surgical Association meeting in Florida, they took that opportunity to have sort of a reunion, retirement party.... They took that opportunity when many pediatric surgeons would be there to gather his fellows, and he trained many people. Different fellows would get up and speak of their memories of Dr. Koop and their training. After the presentations we gathered for a picture, and then everybody was sort of talking and tying up the evening. Dr. Koop pulled Dr. Schnaufer and I over to him, and put his arm around each of us, and said, "I'm sorry that I didn't bring more women along," or something to that effect. It was an acknowledgement that women have something to contribute, that women can be good surgeons, and to me that was extremely meaningful and powerful that he would take that opportunity to do that.

EHRHART: There was one more question I had and that's based on a conversation we had before the tape was going. We talked about the problems with women being recognized in leadership roles, and then you had mentioned Dr. Koop's comment, but you had also mentioned, too, that men were, I think the phrase that you used was "sticking their necks out for women." Can you just explain a little bit, if you feel comfortable, what you meant by that, and we'll go from there if there's something else.

TAYLOR: I don't know the exact numbers of how many women trained, or what percentage of women were training in surgery back in 1957 when Louise Schnaufer was taken on in training under Dr. Koop, or when she was brought back by him to be on the staff. I just feel that women are questioned more in their role, meaning, "Does she really have it to do the job?" that if you are a male chief of surgery hiring a woman, you may have to stand up for your reasons for hiring, explain to your colleagues, substantiate your decision more than you would for a man,

just because they may say, "Well why hire her when there's this other good candidate who's a man?" I just think it takes a lot more for the boss, the chief, to take the flack, or the day-by-day support of that person in their role.

EHRHART: Was there anything else? I've reached the end of my questions, is there anything else you wanted to add?

TAYLOR: I can't think of anything right now. What I had hoped to plan to do before you came here, but it ended up being a very busy week, is pull op notes so that I might remember more about the operating room issues. I have a picture of us with Dr. Koop at his reception down in Florida, with just Dr. Schnaufer and myself in the picture as the only women in the picture. And then they took a picture of me as the departing chief with all the operating room nurses and most of the attendings. It was a gift to me. They did this for not just me but every departing chief. I think they would try to get a picture of the operating room staff and the other attendings and the fellow as they're departing.

EHRHART: Was that unusual?

TAYLOR: I think every chief got it as they were leaving.

EHRHART: Is that specific to Children's Hospital of Philadelphia?

TAYLOR: I think so. I don't remember that happening in any other place that I was. Frequently the program will take a picture of the chiefs that are graduating, but this was a picture of as many nurses from the operating room staff as could come, I think maybe there's an anesthesiologist or two in there, plus as many of the surgery attendings as could be there.

EHRHART: Today is March 28, 2007 and this has been an interview with Dr. Lesli Ann Taylor, and the interview is being conducted for the College of Physicians of Philadelphia for the Louise Schnaufer Oral History Project, which is funded by the Foundation for the History of Women in Medicine.

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