A new light shines on transplantation

Sakuo Cero, MD (left),
Director, Yale-New Haven
Transplantation Centre and
Prevention Ministry, MD,
section staff, anatomic pathology

SUMMER 2008
A Message from the President

As you read the articles in this issue of Yale-New Haven, you will see the intersection of mission and business plan. Our mission is straightforward and addresses safe, high-quality patient care; Yale-New Haven Hospital’s unique teaching commitment; providing a setting for clinical research; and, being a responsible healthcare provider and corporate citizen. Our business plan guides our operations in the support of our mission. The four pillars of our business plan are: to provide high-quality, safe patient care to all of our patients; to serve as both the provider of choice and the employer of choice for the region; and to perform in a fiscally responsible fashion so that we will be able to fulfill our mission.

When you walk through the doors of Yale-New Haven Hospital today, you are going to receive higher quality, safer health care than we have ever provided before. Yet assuring patient safety is an ongoing journey; one that requires vigilance throughout our organization as you will see in the interview with our chief of staff Dr. Peter Herbert, one of our staunchest advocates for patient safety.

Yale-New Haven Hospital continues to be challenged with growing patient demand. Last year, we discharged 63,005 patients – the highest number in the hospital’s history. While it is a reflection of our “success” as the provider of choice in our region, it means we need more beds, equipment and staff. We are looking forward to the completion of the new Smilow Cancer Hospital in late 2009 – not only for the excellent facilities and services it will allow us to offer patients with cancer – but also because it will add capacity and free up space in our other three patient care pavilions to support our growing clinical services.

This increase in the number of patients we serve did not happen by chance. Yale-New Haven has invested heavily in its patient services. For example, since the recruitment of Dr. Sukru Emre last summer, our organ transplantation service has grown exponentially. As of the first quarter of this calendar year, we are the highest-volume kidney and liver transplant program in New England and our liver patient and graft survival statistics are the best in the Northeast, including all of New York State. Many of our surgeons attract patients from around the country – and around the world – because of the innovative procedures they perform, as is demonstrated in the story of Dr. Michael Dewar’s minimally invasive parathyroidectomy.

And how does a woman who has had six pacemakers implanted in her chest find the courage and the care she needs to become a mother? Read Maureen Caruso’s story and see yet another way Yale-New Haven has made a real difference in the lives of our patients.

Yet another facet of Yale-New Haven is reflected in the story of Dr. Michael Dewar, who has given a week of his vacation every year for the past 13 years to serve as a medical missionary in Russia. Dr. Dewar and countless other YNHH physicians, nurses and other staff have found their own ways, large and small, to improve the lives of people around the world – or right here in the Hill neighborhood.

A NEW LIGHT SHINES ON TRANSPLANTATION — Last year, Yale-New Haven Hospital and Yale School of Medicine joined forces to bolster the Transplantation Center and increase transplant services available in New England. Under the leadership of Dr. Sukru Emre, it is well on its way.

SURVIVING CHILDHOOD TO BECOME A MOTHER — Maureen Caruso of Branford was born at Yale-New Haven Hospital with a serious congenital heart defect. She had her first open-heart surgery to patch a hole in her heart when she was just six months old. Caruso, who is now on her sixth pacemaker, is part of a new generation of women with congenital heart disease living to bear children.

OPERATING AS A TEAM — Eighty-seven-year-old John Benson was skiing less than a week after he had minimally invasive parathyroidectomy – a highly successful surgical procedure that requires exquisite interdepartmental coordination at Yale-New Haven Hospital.

CREATING A CULTURE OF PATIENT SAFETY — Shortly after Dr. Peter Herbert became chief of staff at Yale-New Haven Hospital in the fall of 1999, the Institute of Medicine released its report on hospital safety. To Eirik Hunske. In this interview, Dr. Herbert discusses how YNHH took on the challenge of making the hospital a safer place than ever before.

EXPORTING THE BEST IN AMERICAN HEALTH CARE — For the past 13 years, Michael Dewar, MD, a cardiovascular surgeon at Yale-New Haven Hospital, has spent a week of his yearly vacation as a medical missionary in St. Petersburg, Russia, helping train Russian cardiac surgeons in advanced surgical techniques. Now, young Russian surgeons can come to YNHH for more advanced training.
A few weeks before Easter 2008, Lia Cirelli, a smart, happy 11-year-old from Redding, Connecticut, who rarely got tired, sick or bored, began complaining about stomach aches.

One Tuesday afternoon, Laura Cirelli watched her daughter step off the school bus clutching her stomach, pushing against her upper rib cage. The next day Lia's skin turned yellow, almost orange.

After listening to the story on the phone, the Cirellis' pediatrician told them to go directly to Bridgeport Hospital. There the situation intensified, and emergency room doctors told the family they would need to transfer Lia to Yale-New Haven Children's Hospital (YNHH) by ambulance — or, if possible, by helicopter.

Within hours, Shavio Cirelli, an equipment mechanic, and Laura, a tax assessor's assistant, found themselves listening in shock as pediatric liver expert Pramod Mistry, MD, told them their only child, adopted from China when she was 11 months old, appeared to have a rare condition called Wilson's disease. Lia's body had been retaining copper since birth, and now a buildup of copper was causing her liver to fail. Conclusive tests would take time, and although Lia was awake and articulate, she only had a few days at most to live. The only cure was a liver transplant.

Lia's age and acute illness thrust her toward the top of the donor list, but the initial liver that became available wasn't suitable. So family and friends came, one by one, to New Haven to be tested to see if they qualified as living donors. Incredibly, a 27-year-old social worker and distant relative of the Cirellis' — who was in Connecticut for the Easter weekend — turned out to be a match.

On Easter Sunday, Lia Cirelli became the second patient in Connecticut — and the first child — to receive part of a liver from a living donor. She'll stay home until September to avoid infection, and she'll take immunosuppressant drugs for the rest of her life. Otherwise, her parents are walking with her a mile a day now, and her doctors say she is "perfect."

"There were probably a thousand pieces that had to come together to make this work, and they all just fit. It was just a miracle," said Laura Cirelli.

Advancing in a new direction

If it had to happen at all, the Cirelli family believes they landed in the right place at the right time. Lia's surgeon was 55-year-old Sukru Emre, MD, appointed last July as director of the Yale-New Haven Transplantation Center (YNHTC), and section chief of organ transplantation and immunology in the department of surgery at Yale School of Medicine.

Dr. Emre, a native of Turkey, came to YNHH from Mount Sinai Medical Center in New York, where he turned the transplantation program into one of the best in the nation. He became a rising star in the demanding field of adult and pediatric liver transplant surgeries, performing cutting-edge variations such as domino transplants, in which the imperfect liver removed from one transplant patient might still serve another patient with a shorter anticipated lifespan.

Passionate about his work and humbled by life-and-death situations that fall into his hands on an almost weekly basis, Dr. Emre feels he chose the right field.

"Organ transplantation is one of the most spectacular medical advances of the 20th century," he said, "and it has been changing rapidly since the 1990s, with revolutionary surgical techniques and vastly improved immunosuppressant drugs."
Two of the 32 transplants Dr. Emre has performed so far at YNHH were milestones for Connecticut. Last September, Sebastian Rovira, a 7-month-old whose family traveled to YNHH from Puerto Rico because his liver was failing due to a condition called biliary atresia, became the first in the state to undergo a split-liver transplant. Dr. Emre used a small section of an adult liver harvested from a deceased donor in Boston, and sent the remainder elsewhere for transplantation in an adult. He performed the eight-hour operation on baby Rovira using a microscope, small needles and sutures thinner than human hair.

In January, Dr. Emre performed the state’s first living donor transplant at YNHH on Daniel Gray, who was 59 years old and awaiting the birth of a new grandchild, when he was diagnosed with a liver tumor large enough to knock him off the waiting list for a conventional transplant. In an 11-hour operation, Dr. Emre took a portion from the liver of Daniel’s 29-year-old nephew, Corey Gray, and transplanted it into Daniel.

All three surgeries were successful, and the patients are now doing well. But these lengthy, painstaking operations require such intense concentration and focus that surgeons need to take breaks to get through them.

“Surgeons – we live the mastery level,” said Dr. Emre. “There can be a lot of problems, unknowns and surprises in the OR, many potential complications and variations in the way a transplant surgery can be done,” Dr. Emre said. “Any surgical procedure done for a living donor liver transplantation requires perfect preoperative planning, including preparing both the donor and the recipient for surgery, with a complete work-up and logistics. This requires a great team effort led by a skilled and experienced transplant surgeon,” he said.
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"Surgeons – we live on the edge, with a person’s life in our hands," Dr. Emre added. "Success will come from passion for your job, dedication to your patients, a questioning mind, skill and experience. Once you put all of these elements together, you will reach the mastery level."

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"Su Ciordi’s lifesaving transplant was a tipping point for YNHH as an institution and a decisive demonstration that we have entered a new era in treatment of children with life-threatening liver disorders," said Dr. Mistry, director of the Inherited Metabolic Liver Disease Clinic at Yale-New Haven Children’s Hospital and professor of pediatrics and internal medicine at Yale School of Medicine. "Lucy’s life was saved by the quick diagnosis and life-sustaining medical treatment before transplant, guided by Michael Schilsky, MD, medical director of the adult liver transplant program and renowned expert in Wilson’s disease. Dr. Mistry said. Other contributing factors included the coordinated efforts of the transplant team to get critical information on potential donors quickly, and the ability to perform the transplant at YNHH, avoiding a risky transport elsewhere.

"As the leader of this effort, Dr. Emre has the ambitious goal of increasing the current number of liver transplants at YNHH to between 80 and 100 a year. He expects to boost an already thriving kidney transplant program, increasing transplants to 150 a year, and pancreatic transplants, which are far less common, to 20.

"My goal at Yale-New Haven is to replicate what I did at Mount Sinai by creating one of the best transplant programs in the country, with the best possible patient care and excellent outcomes," said Dr. Emre. Data from the United Network for Organ Sharing (UNOS) have shown that Dr. Emre’s survival rates in pediatric liver transplantation have been 99 percent after one year and 93 percent after five years, both of which are well above the national averages.
Revolution in kidney transplants

While Dr. Emre is shining a bright new light on liver transplantation, new doors have been opening in kidney transplantation. While a patient can still wait years for a kidney from a deceased donor, YNHHC is the only transplantation center in New England to do laparoscopic—virtually bloodless—surgery on live kidney donors, and doing more transplants as a result.

Jennifer Humphrey, a Southport resident, was 27 and had an 18-month-old when she donated one of her kidneys to her father, Peter Lanza, a type 1 diabetic who had stopped traveling, avoided swimming pools because of risk of infection, and was spending eight hours each night on peritoneal dialysis. "Truly, I never gave a second thought to being the donor," Humphrey said.

Sanjay Kulkarni, MD, director of kidney transplants at the YNHHC Transplantation Center, removed Humphrey’s kidney through three incisions, each less than an inch wide. Humphrey spent two nights in the hospital. Kidney donors are instructed to rest at home for two weeks. But Humphrey, a registered nurse, bounced back quickly, and was back at the University of Connecticut earning her master’s degree six days after surgery.

Dr. Kulkarni, assistant professor at Yale School of Medicine, introduced the technique at YNHHC when he arrived in 2005 and is training his fellow transplant surgeons to use it. "Laparoscopic surgery has been a revolution in the world of kidney transplantation," he said. "We will probably do more than 100 kidney transplants this year, which would place us as the largest kidney transplantation center in New England.”

Meanwhile, YNHHC is the only center in Connecticut to perform pancreas transplants. For less common than kidney or liver transplants, these operations are usually performed for type 1 diabetics who have renal disease. Typically patients wait three to five years for a kidney, then another three to five years for a pancreas.

Still waiting for organs

For now, the wait for an organ is still the major roadblock, and a traumatic and emotional roller coaster. When 7-year-old Abdullah Farid of Hamden was a bright, bubbly toddler, he visited a specialist for diabetes and polyneuropathy, a condition marked by high levels of "bad" cholesterol beginning at birth. Abdullah already had cholesterol deposits on his arteries and uvula deposits on his teeth.

After a test put his cholesterol level at 3,000, doctors said he was headed for a heart attack before the age of 10. Powerful cholesterol lowering drugs did not work and caused severe side effects.

"We are learning more about individualizing the way we administer these treatments, and the tricky tightrope balance between advantages and side effects of immunosuppressants," said Dr. Emre. Now his patients avoid serious side effects such as seizures, kidney failure and diabetes by gradually tapering down the dosages.

Because the liver is a resilient organ, liver transplant patients tend to have fewer rejection issues. But Dr. Kulkarni is also seeing dramatic improvements with new drugs and advances in managing kidney disease. "I would say 10 years ago, the rejection rate was about 40 percent. Last year it was 8 percent among our patients," he said.

Meanwhile, Dr. Emre is making it part of his mission in Connecticut to increase the number of organ donations. He and Dr. Kulkarni plan to develop a laparoscopic approach used on kidney donors for liver donors. Another plan is to create what Dr. Emre calls a "preservation machine" filled with a solution that would extend the life of a donated organ on hold for a transplant from 12 to 18 hours to at least a week. This would allow researchers to study organs more closely, and in the case of livers, grow small sections of organs to the appropriate size for the recipient, which would also allow them to accept organs from farther away.

"You are not able to breathe fully; you just take little breaths while you are dealing with something like this," said his father, Farrukh Farid, a co-owner of the Walling­ton-based company, Eddie’s Arrangements.

After searching the Internet for answers, and traveling to hospitals in several states to talk to doctors, he was surprised to find that Dr. Motyl at YNHHC had treated nine children in the United Kingdom with the same condition as his son. Two had been treated with transplants, and one of those had later married and had children. Farrak considered LDL—low-density lipoprotein—atherosclerosis treatment for his son at Johns Hopkins Medical Center and also visited hematopoietic and renal specialists in Dubia and Southeast Asia, but he believed that a liver transplant was the best solution.

The Farids expected for at least a year for a liver donation. Farrukh was surprised three months later when the phone rang while he was home playing with his son.

"When I got the call, I was kind of stunned for me. My wife saw my face and she knew what it was. It was like the floor had dropped out," he said. Abdullah had his transplant on March 20 and is now running around like any normal little boy. His cholesterol is now 170, and the cholesterol deposits on the skin are melting away.

Still waiting for organs

About 17 a day—6,000 a year—the waiting. Dr. Emre is working with several organizations, including the New England Organ Bank, to recruit potential donors, and will host the first organ donation awareness event on the New Haven Green on September 6.

"Connecticut is one of the worst states in the country as far as organ donation rates," said Dr. Kulkarni. "Part of our job is to develop a culture of organ donation, and that comes with a successful transplantation program. When Dr. Emre performs these pediatric split liver transplants, it gets the word out, and helps people think about it.”

Orazio Cirelli, Farrukh’s father, is thinking about it. "Before when I renewed my license and they asked if I be a donor, I always said no. I’m going to change that. So are my wife and my kids, and probably everyone else in our family.”

Transplantation
As February 14 approached this year, Maureen and Josh Caruso of Branford were awaiting a special Valentine's Day gift – their first child. But Maureen, 28, was no ordinary maternity patient. Bringing her healthy baby daughter into the world took a specialized team of obstetricians and cardiologists at Yale-New Haven Hospital.

Born with a congenital heart defect called double outlet right ventricle (DORV), in which both the aorta and pulmonary artery connect to the right ventricle, Caruso underwent her first open-heart surgery to patch a hole in her heart when she was just six months old. She subsequently developed a narrowing under her aortic valve that required repeat open-heart surgeries at two and six years of age. Her surgery was complicated by a complete heart block, and Caruso has required a permanent pacemaker ever since.

Although congenital heart disease is often considered a childhood disease, advances in surgical treatments mean most babies who once would have died of congenital heart disease are surviving well into adulthood. Some researchers estimate there are more adults than children living today with congenital heart disease.

"Patients like Maureen are part of a new population," said Lynda Rosenfeld, MD, associate professor of internal medicine, cardiology, at Yale School of Medicine. "A large percentage of patients with congenital heart disease live and live well. It is really amazing to see them so actively involved in so many activities."

Dr. Rosenfeld, attending electrophysiologist and board-certified cardiologist at Yale-New Haven Hospital, has been treating Caruso since she was 12 years old. Dr. Rosenfeld sees her for heart rhythm issues and monitors her pacemaker – Caruso's sixth – in her abdomen. "I'm also a second pair of eyes for her pediatric cardiologist, John Fahey, MD, to offer an adult perspective on Maureen's heart," explained Dr. Rosenfeld.

"Growing up, I wanted to be involved with sports," recalled Caruso. "I always liked gymnastics, but I couldn't participate because my heart rate was irregular. I remember being disappointed I couldn't keep up with the others."

"I always felt timid to push myself too much or believe I could keep up," she said. "But once technology began improving my pacemaker, I felt better and started to get more active."
Despite her long history of congenital cardiac problems, Caruso survived childhood. She danced and played softball and basketball, and was the star of her high school's field hockey team. Caruso went on to graduate from Duquesne University in Pittsburgh, with a degree in communications.

"After college I belonged to a gym," said Caruso. "I never had the fastest mile, but I was told I was self-limited. Dr. Fahey encouraged me the most when it came strictly as a tool for diagnosing cardiac malformations - is now the preferred procedure for older patients like Dr. Fahey, along with the continuing care of experts in congenital heart disease, like Dr. Fahey. In fact, Caruso sees him every six months and her pacemaker is checked by phone every month using a transmitter machine. Today's pacemakers usually last about five to seven years.

"The only time I feel the pacemaker is when I'm near a magnet," said Caruso. "It causes a bubble in my throat."

As women like Caruso, who have surgically corrected heart conditions, reach childbearing age, the issues surrounding this growing population of pregnant women with congenital heart disease become increasingly important. Most can have a baby without bringing on heart failure, a stroke or other serious complications that can be triggered by the strain pregnancy puts on the heart.

When Caruso married her husband, Josh, on May 11, 2007, she joined the ranks of the growing number of corrective procedures like those Caruso underwent are no longer performed in the operating room. Cardiac catheterization, once seen strictly as a tool for diagnosing cardiac malformations, is now the preferred therapeutic treatment for many heart conditions. Yale-New Haven Children's Hospital continues to push the boundaries in the cath lab, including repairing congenital heart defects through catheterization instead of open-heart surgery.

The pediatric cardiac catheterization laboratory at Yale-New Haven has been a nationally recognized leader for technological advances in diagnosis and intervention, making treatment available for young cardiac patients who would have otherwise required open-heart surgery. The laboratory routinely performs diagnostic and interventional catheterization procedures in children and adults with congenital heart disease, including transcatheter closure of atrial septal defects (ASDs) and ventricular septal defects (VSDs). In addition, patent ductus arteriosus, an opening between the pulmonary artery and the aorta that normally closes after birth but remains open in some newborns, is also being corrected in some newborns, is also being corrected in babies' hearts through catheterization instead of open-heart surgery.

As she considered a career in nursing, Caruso volunteered for a year in the pediatric emergency department at Yale-New Haven Children's Hospital. When Caruso became pregnant in 2007, her care was directed by Dr. Fahey. The program uses a multidisciplinary approach, and draws on the expertise of intensivists and adult and pediatric cardiologists, who provide collaborative care. As a result, patients like Caruso receive care from adult physicians like Dr. Fahey, along with the continuing care of experts in congenital heart disease. Dr. Fahey encourages me the most when it came strictly as a tool for diagnosing cardiac malformations - is now the preferred procedure for older patients like Dr. Fahey, along with the continuing care of experts in congenital heart disease, like Dr. Fahey. In fact, Caruso sees him every six months and her pacemaker is checked by phone every month using a transmitter machine. Today's pacemakers usually last about five to seven years.

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Her message to others: "Believe that anything is possible. If you have a heart condition, it is possible to have a baby, and if the baby has the condition they can have a great life.

Because there was a 5% chance that Maureen could pass on a heart condition to her unborn child, the ultrasound specialist offered transcatheter closure of atrial septal defects (ASDs) and ventricular septal defects (VSDs) during her pregnancy. They showed no cardiac abnormalities. "Someone was on our side," said Maureen.

On February 19, 2008, five days after Valentine's Day, Maureen Caruso delivered a healthy baby girl named Madelyn Rose. "I didn't know you could love someone so much," said Caruso. "She's a miracle, a happy angel. She's the love of my life along with her grandparents and father.

Caruso, who expects to begin nursing school this fall, added, "It's neat for me to know that Dr. Fahey watched me grow up and got to see me become a mom. He always conveyed the attitude that helped me have a normal life and a normal pregnancy. He has been there for all the important moments of my life.

With Maureen's story, women like Caruso, who have surgically corrected heart conditions, reach childbearing age, the issues surrounding this growing population of pregnant women with congenital heart disease become increasingly important. Most can have a baby without bringing on heart failure, a stroke or other serious complications that can be triggered by the strain pregnancy puts on the heart.

When Caruso married her husband, Josh, on May 11, 2007, she joined the ranks of the growing number of pregnant women with congenital heart disease who want to have children. When she got pregnant, she was referred to the Yale maternal-fetal medicine department early on in her pregnancy to monitor any anatomical problems of her baby's heart and to make sure the baby is normal.

"We are the first line of caretakers for women with medical complications," said Christian Pettker, MD, assistant professor of Obstetrics and Gynecology and Reproductive Medicine, Yale-New Haven Hospital. "During a woman's pregnancy, we have two patients who sometimes have competing interests. It presents an interesting challenge. There were certain risks and unknowns as to how well Maureen and her baby would do."

"Although there were risks with her pregnancy, we knew Maureen would be fine with careful surveillance," said Dr. Pettker, who delivered Madelyn Rose. "It's serious medicine with a happy ending."

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Ever since Yale-New Haven Hospital was founded in 1826, volunteers have participated in various aspects of the hospital's work. Since its inception, the hospital has been governed by a volunteer board of trustees. Hospital records back as far as 1833 report that a volunteer “Board of Lady Visitors” visited the hospital's patient wards regularly and reported on the hospital conditions. Jeannette Hodge, director, volunteer, patient and guest services; Dora Ferrara (sitting), volunteer services assistant and guest services; Marcia Rattary, patient aide; and guest services; Dora Ferrara (sitting), volunteer services assistant and guest services; Marcia Rattary, patient aide; Deborah Donne, Hospital visitor; David Wu, volunteer ambassador; John Dugan, volunteer coordinator; John Robert Paul, volunteer director; Jeannette Hodge, director, volunteer, patient and guest services; Dora Ferrara (sitting), volunteer services assistant and guest services; Marcia Rattary, patient aide; Deborah Donne, Hospital visitor; David Wu, volunteer ambassador; John Dugan, volunteer coordinator; John Robert Paul, volunteer director; Dorothy Letts, volunteer coordinator; Jerry Robles, volunteer coordinator; and Kathleen Jeter, volunteer director.

In the 1990s, volunteer services added more programs to enrich the lives of patients. Among them was the interpreter program, which made a measurable difference in assisting patients and families who have limited English. The elderly and pet visitation programs succeeded in bringing an added dimension of love and caring to elderly and pediatric patients alike. In 1933, however, New Haven Hospital established an official volunteer department, making it one of the oldest organized hospital volunteer programs in the United States. By creating a formal department and later hiring the first full-time paid director for volunteer services, Jeannette Hodge became a leader in the development of the profession of volunteer administration. This included established policies and procedures for volunteers as well as position descriptions, training and supervision by paid staff.

Volunteers in the late 1980s included a ramped up volunteer program for pediatric AIDS patients as AIDS became a national health issue. Volunteer services achieved other milestones during this era by eliminating the candy stripe uniform and establishing the red jacket as the uniform for volunteers throughout the hospital. In the 1990s, volunteer services added more programs to enrich the lives of patients. Among them was the interpreter program, which made a measurable difference in assisting patients and families who have limited English. The elderly and pet visitation programs succeeded in bringing an added dimension of love and caring to elderly and pediatric patients alike.

In the 1990s, volunteer services developed the successful ambassador program in which volunteers greet, escort or transport patients around the hospital. “Today, we have about 1,500 volunteers who together give more than 75,000 hours of service each year,” commented Hodge, “I anticipate that volunteer services at Yale-New Haven will continue to strengthen and expand and serve as a stellar example of how volunteers enhance a hospital environment.” Today’s volunteer program includes volunteers from all age groups and all walks of life. Volunteer opportunities are matched with individual time schedules, abilities and interests, and volunteers serve in many capacities at Yale-New Haven.

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In the 1940s, U.S. involvement in World War II caused a significant expansion of Yale-New Haven’s volunteer services. In order to help offset the serious shortage of manpower related to the war, volunteers were widely recruited to fill voids in various areas of the hospital. New volunteers responded in droves and were put to work in patient units and laboratories and performing housekeeping and maintenance tasks. During this period, the department averaged 1,000 volunteers working an average of 6,000 hours a month. Also in the 1940s, volunteer services added the men’s volunteer corps to work with male patients. Soon after, the Yale aides, composed of university students and faculty, and the first volunteer program for teens, the youth volunteers, were created and became model volunteer programs for the nation.

In the 1960s, volunteer services was extensively revamped in an effort to provide more productive and professional service to the hospital. Volunteer orientation meetings were implemented to share comprehensive, consistent information with all volunteers. A volunteer manual was created with a written record of hospital policies and procedures, as well as those of volunteer services.

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In the late 1990s, volunteer services developed the successful ambassador program in which volunteers greet, escort or transport patients around the hospital. “Today, we have about 1,500 volunteers who together give more than 75,000 hours of service each year,” commented Hodge, “I anticipate that volunteer services at Yale-New Haven will continue to strengthen and expand and serve as a stellar example of how volunteers enhance a hospital environment.” Today’s volunteer program includes volunteers from all age groups and all walks of life. Volunteer opportunities are matched with individual time schedules, abilities and interests, and volunteers serve in many capacities at Yale-New Haven.

Assignments may involve intense or moderate patient contact or behind-the-scenes work. Front-line volunteers include ambassadors, patient transporters, information desk clerks and emergency department volunteers. Many volunteers assist hospital staff with tasks that are essential to the overall operations of the hospital. Additionally, volunteers provide service at two of the hospital’s satellite locations – the Shoreline Medical Center and Temple Medical Center.

Youth volunteers, age 14 to 18, participate in the academic year program after school or in the eight-week summer program. For college students, Yale-New Haven collaborates with area colleges and universities for a variety of volunteer assignments. Students considering a career in health care find the hospital volunteer experience helpful in solidifying career choices. Adult volunteers provide support throughout the year in various capacities including guest relations, patient support, parenting support and pediatric support. “Hospital volunteers are extraordinary people,” said Hodge, “We cannot say enough about the magnificent contributions of our volunteers. Their commitment makes Yale-New Haven Hospital a better place to visit, to work and to heal.”

In 1933, however, New Haven Hospital established an official volunteer department, making it one of the oldest organized hospital volunteer programs in the United States. By creating a formal department and later hiring the first full-time paid director for volunteer services, Jeannette Hodge became a leader in the development of the profession of volunteer administration. This included established policies and procedures for volunteers as well as position descriptions, training and supervision by paid staff.

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When John Benson went skiing with his wife Betty in Vermont in late January, he glided down the mountain with a little extra skip in his step. Less than a week earlier he’d had minimally invasive surgery at Yale-New Haven Hospital and was feeling on top of the world. All things considered, it was a great day to be 87 years old.

"I'm in remarkably good health," Benson said proudly — and deservedly so. The Woodbury, Connecticut resident, who celebrated his 87th birthday in May, has been an avid skier most of his life, ever since learning the basics while serving with the U.S. Army's famous 10th Mountain Division in Italy during World War II. He played tennis regularly until a few years ago when a wood-splitting accident damaged his right hand, though not badly enough to keep him off the golf course during the summer.

About the only health issue the spunky octogenarian has encountered is what led to his surgery last winter. And although he wasn't aware of it, the procedure is a prime example of outstanding cross-departmental coordination at Yale-New Haven.

"Several years ago I had a blood test, and my doctor discovered that my calcium levels were high," Benson recalled. Subsequent tests indicated low bone density, a warning sign for osteoporosis. Weakened bones — and the associated peril of falling and breaking them — are a familiar concern for the elderly, even more so for a skier. Benson’s doctor couldn’t stop him from skiing, but he did recommend that he see an endocrinologist at YNHH.

"About a year ago, another test showed continued bone loss," Benson said, "and that’s when I was referred to Dr. Udelsman."

Robert Udelsman, M.D., is the chief and chair of surgery at YNHH and Yale School of Medicine, as well as the Carmalt Professor of Surgery and Oncology at Yale. His specialty is the endocrine system. After examining Benson, he determined that he suffered from primary hyperparathyroidism, a disease that affects the body’s parathyroid glands.

Typically, there are four pea-sized parathyroid glands (rarely a fifth) located in the neck on either side of the thyroid gland. They produce parathyroid hormone, a substance that helps maintain the correct balance of calcium and phosphorus. Hyperparathyroidism occurs when one of the glands becomes enlarged and secretes too much parathyroid hormone into the bloodstream, leading to a rise in calcium levels. High calcium levels can result in calcium leaching from the bones, and potentially low bone density and osteoporosis. Nearly 100,000 cases of the disorder are diagnosed in the United States each year; afflicted women outnumber men three to one; risk increases with age.

Besides low bone density, Benson did not exhibit any other symptoms associated with hyperparathyroidism, which can range from minor to severe. They include decreased appetite, thirst, lethargy, fatigue, muscle aches and pains, forgetfulness and depression. Indeed, he said, the disorder "had no affect on my well-being." Still, Dr. Udelsman gave Benson the option of having the parathyroid gland causing the problem surgically removed. The procedure, called a parathyroidectomy, is the main treatment for hyperparathyroidism and cures it in 95 percent of operations.

The first successful parathyroidectomy was performed in 1925, and the conventional procedure has advanced over several decades. After the patient is given general anesthesia, the surgeon makes a lateral incision of several inches on the neck, examines the parathyroids and removes the enlarged gland or glands. In most cases, calcium levels quickly return to normal. Sometimes, however, the levels actually become too low, requiring the patient to take calcium and/or vitamin D supplements.
Operating as a team

“...different level than virtually every other institution,” Dr. Udelsman said, referring to MIP. “We are leaders in this field.”

Along with rapidly getting skiers back on the slopes, the benefits of MIP, done on an outpatient basis 66 percent of the time, are impressive. A study conducted by Dr. Udelsman and published in 2002 concluded that MIP was associated with approximately a 50 percent reduction in operating time, a sevenfold reduction in length of hospital stay, and a mean cost savings of nearly $2,700 per procedure, thereby cutting total hospital charges in half.

Lending to MIP’s efficiency are improved preoperative scanning and imaging techniques, which can identify enlarged parathyroid glands and thus allow the surgeon to pinpoint his target. Dr. Pinkernell had scans done the same day as his initial visit with Dr. Udelsman last summer. The MIP was performed about a week later.

The operation began around 8:30 a.m. The team’s anesthesiologist, Dr. Christine Rinder, administered sedative agents, and local anesthetic techniques were employed by the surgical team. Dr. Pinkernell was awake throughout the operation, which necessitates an incision of only about one inch and normally takes less than a half hour. Although the patient’s 3-Dr scans made it easier to find and remove the enlarged gland, Dr. Udelsman had to be careful not to damage sensitive arteries and nerves in the neck that control the vocal cords.

The MIP procedure at YNHH differs considerably from the conventional method, as demonstrated by the recent experience of Bruce Pinkernell, MD, a 70-year-old cardiologist living in Chatham, New York. Like Benson, he was referred to Dr. Udelsman when blood tests showed elevated calcium levels and the likelihood of hyperparathyroidism. “The fact that I’d already lost bone density concerned me a great deal,” Dr. Pinkernell said of his decision to undergo surgery. “Osteoporosis can be a serious problem, and I wanted to deal with it in the most definitive way.”

The advantage of having patients awake, but sedated and comfortable, is we can talk to them and hear their voices to make sure the nerves are intact,” explained Dr. Udelsman. Another distinctive and time-saving feature of the YNHH program is the use in the operating room of a sophisticated assay machine that quickly measures parathyroid hormone levels during the procedure. Immediately after Dr. Pinker­nell’s gland was removed, lead technician Florencia Santos measured parathyroid hormone levels in his blood and confirmed that he was cured.

“...a good outcome, and I had enormous confidence in the doctor and his staff.” Alpert was back at her home in New Mexico and skiing within 10 days. “I believe that my bones are getting stronger now, and that gives me a great psychological boost.”

Those sentiments are echoed by 77-year-old Barbara Alpert, who had an MIP at YNHH in February. Coincidentally, her sister-in-law had had the operation successfully performed by Dr. Udelsman’s team a year earlier. After Alpert’s doctor analyzed her scans and made the diagnoses of hyperparathyroidism, Dr. Udelsman was her unequivocal choice.

“I was hopeful that there would be a good outcome, and I had enormous confidence in the doctor and his staff.” Alpert was back at her home in New Mexico and skiing within 10 days. “I believe that my bones are getting stronger now, and that gives me a great psychological boost.”

“We have four departments working side by side in the O.R. — surgery, anesthesia, nursing and laboratory medicine.” Dr. Udelsman said. “It’s quick to acknowledge the integral contributions of Donovan, O.R. technician Leo Adrian, and the team’s nurses, as well. “Yale-New Haven makes it easy to collaborate. The people here make our lives — and our patient care — better,” Dr. Udelsman said.

“This type of interdisciplinary cooperation is what Yale-New Haven does best,” he said. “The hospital is unparalleled in treating complex diseases that cross many disciplines. We make it seamless to the patient, but behind the scenes there’s enormous coordination.”

Thanks to those collective efforts, it’s a pretty good bet that John Benson will be gliding down the slopes with full confidence, and strong bones, this winter.
Experts estimate that nearly 100,000 people die in any given year from medical errors—more than die from motor vehicle accidents, breast cancer or AIDS. For many years, Yale-New Haven Hospital has made patient safety its top agenda. One of Yale-New Haven's patient safety champions is Dr. Peter N. Herbert, chief of staff.

How did you become such a champion of patient safety at Yale-New Haven?

I came to Yale-New Haven Hospital in the fall of 1999 and, within a month of my arrival, the Institute of Medicine released its report on hospital safety, To Err Is Human. I believe that the history of American medicine will trace the beginning of the patient safety movement in this country to that publication. Shortly after that, the president of the hospital asked me to convene and co-chair a patient safety committee with Sue Rossman, RN, the senior vice president of patient services, and Sally Roumanis, RN, our director of patient safety. The next spring our entire management retreat was devoted to patient safety, and we identified our first major priorities for patient safety. We are still pursuing those initiatives.

What were some of those safety initiatives?

The big issues included medication errors, patient identification, hospital-acquired infections and creating a culture of safety. We have exceeded our goals in ensuring that patients wear and staff check identification and allergy wristbands at all times. We have reduced catheter-related bloodstream infections by 80 percent over the past several years. We improved the processes of blood transfusion documentation, laboratory specimen labeling and pneumococcal and influenza immunization. We have completed many initiatives to improve medication safety. Loraine Lee in our pharmacy department has been an inspirational leader in medication safety.

Tell me about patient identification.

Initially, we simply needed to make sure that every patient at every site of care had an I.D. bracelet on his or her wrist. Historically, some areas of the hospital had problems with this—such as patients in labor or in the emergency department—because of the urgency of the care needed. But just having a bracelet on the patient is not enough. Now we check the bracelet any time something is given to or done to the patient to make sure we have the right patient for the right treatment. We have also implemented a universal protocol for “time-outs” before surgeries and other procedures.

What is a time-out?

Before all procedures and surgeries, staff call a time-out in which all members of the team stop all work and all conversation to verify the correct patient identity, correct side and site, the procedure to be done, correct patient position, and availability of correct equipment or special requirements.

How about hospital infection control?

To combat nosocomial [hospital-acquired] infections, we implemented hospital-wide initiatives for better hand hygiene and contact precautions. Dr. Louise Dembry and her team led this effort, and our hand hygiene compliance rate has gone from about 40 percent to over 80 percent. Those are the rates for observed hand hygiene compliance when we measure—they are likely higher. Our goal is to get as close to 100 percent as possible. We’ve made our approach to contact precautions—gowns, gloves, masks, isolation rooms—for more standardized and uniform.
How did you approach medication safety?
About 20 percent of serious adverse events that occur in hospitals relate to medication safety. For many years, Yale-New Haven has had a computerized physician-ordering medication system, which is one of the most effective ways to reduce medication errors and to prevent interactions between medications. Our staff need to 'reconcile' what is in the patient's chart when he or she comes into the hospital with what they are taking when they are discharged. It's not enough for a patient to tell us they take two blood pills and one pain pill. Patients can help us out by becoming more knowledgeable about their medications. We created a free medication card for patients to keep and carry an accurate record of their medications. (For the free medication card call the Yale-New Haven Call Center at 203-488-2000.)

How does YNHH achieve such improved safety in obstetrics?
Through team training — we developed a curriculum to train staff to communicate more effectively so they can better deliver on patient safety. Two of the key techniques that employees learn include the "check-back" that ensures members of the team verify information exchange about the patient by repeating it and the "call-out" a tactic used to communicate critical information during an emergent event. Another focus of the training is maintaining situational awareness. We use the acronym "SARA," which stands for the critical issues staff need to know and share: situation, background, assessment and recommendation. We've also hired a dedicated perinatal patient safety nurse and implemented some 30 new evidence-based clinical guidelines. We have trained our perinatal teams in the proper use and interpretation of fetal monitoring tests. Training and certification in fetal monitoring have had a huge impact. More than 200 obstetricians, nurses and midwives underwent the fetal monitoring training at YNHH, and when they took a national certification test, they had an initial 99 percent pass rate, compared with a national 87 percent pass rate.

How are staff trained?
Many of the training sessions place on the individual nursing units, because the safety needs vary with different patient populations. For example, one of our major concerns is falls, particularly among the elderly. The nursing service developed protocols for identifying patients who are at risk for falls. They developed our "fully staffed" program in which the patients must see a nurse for all red slipper interventions and have signs posted at their doors, so that all staff know to assist them at all times.

What are some other safety risks in hospitals?
Pressure ulcers, or bedsores, are a major concern because they can lead to infection and even become life-threatening. We examine patients for any skin breakdown on admission and have specific protocols that are followed and documented to minimize the risk of pressure ulcers. Pressure ulcers, or bedsores, are a major concern because they can lead to infection and even become life-threatening. We examine patients for any skin breakdown on admission and have specific protocols that are followed and documented to minimize the risk of pressure ulcers.

How do you motivate staff to be compliant with all these patient safety measures?
It has been a process of continual communication and education. To properly motivate staff, they have to have a shared need to appreciate the justification and the rationale. Once they do, they want to do the right thing.

How does YNHH organize its patient safety efforts?
We have a patient safety steering committee that reviews the work of all the hospital's patient safety initiatives. These initiatives are reported to the senior management of the hospital and the Board of Trustees. We also have a performance improvement leadership group whose work is primarily focused on specific adverse events. Here, too, our clinical computer system is a big help. For example, preventing blood clots is one of our high risk areas — and our computer system has prompts to identify what meds the patient is taking when he signs out, so that all staff know to assist them at all times.

What do hospitals still need to do to improve safety?
Perhaps the single biggest challenge is to develop technology or processes to ensure there is systematic, comprehensive communication between all caregivers. If you look at adverse events that occur in hospitals — we call sentinel events — by and large, they relate to problems in communication. For example, at Yale-New Haven we will soon implement a new communication system called Veriphy that will alert physicians when one of their patients has an urgent diagnostic radiology finding. We need to come up with universal systems like this to protect the welfare of patients — so that patients will never get wrong medication, never have the wrong operation, never get pressure ulcers, never fall out of bed and never see a misplaced or late test result.

Are you pleased with the progress at YNHH?
Yes. We have long participated in a program with the Centers for Disease Control (CDC) aimed at reducing central line infections, surgical site infections and ventilator-associated pneumonia. Even before this 100,000 lives campaign began, we had initiatives in place for all six of these areas.
How did you approach medication safety?

About 20 percent of serious adverse events that occur in hospitals relate to medication safety. For many years, Yale-New Haven has had a computerized physician-ordering medication system, which is one of the most effective ways to reduce medication errors and to prevent interactions between medications. Our staff need to “terminate” what the patient is taking when he or she comes into the hospital with what meds they are taking when they are discharged. It’s not enough for a patient to tell us they take two blue pills and one pink one. Patients can help us out by becoming more knowledgeable about their medications. We created a free medication card for patients to keep and carry in an accurate record of their medications. If the free medication card calls the Yale New Haven Call Center at 203-688-2000.

How do you approach medication safety?

They have worked very well, but not as isolated initiatives. We really had to create a culture of patient safety at Yale-New Haven Hospital. It quickly became a major strategic goal in the hospital’s business center at 203-688-2000. It has been a process of continual communication and education. To properly motivate staff to communicate medication issues, it is important that they have a shared need for patients to keep and carry an accurate medication card, call the Yale New Haven Call Center at 203-688-2000.

How are staff trained?

Much of the training takes place on the individual nursing units, because the safety needs vary with different patient populations. For example, one of our major concerns is falls, particularly among the elderly. The nursing service developed protocols for identifying patients who are at risk for falls. They developed our “ruby slippers” program in which the patients must sit at risk wear red slippers and have sign posted at their doors, so that all staff know to assist them at all times.

How can patients help improve medication safety?

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How does YNHH organize its patient safety initiatives?

We have done a very good job in establishing that patient safety is a priority for the entire institution — including support services as well as primary caregivers. We have done very well in improving our hospital acquired infection rates by greatly improving our hand hygiene compliance rate. We have also done a lot of team training in certain areas such as obstetrics, so staff feel empowered to speak up when they feel a patient is at risk. In the past few years, we have seen a 30 to 40 percent reduction in adverse events in obstetrics — including stillbirths, birth injuries and low birthweight scores.

How safe would you say American hospitals are today?

American hospitals are safer than ever before — especially since the publication of the Institute of Medicine’s report and the subsequent 2004-2006 Institute of Healthcare Improvement’s safety campaign. That effort, called “100,000 Lives,” involved more than 3,000 hospitals across the country — including Yale-New Haven — and focused on six safety strategies. They included: creation of rapid response teams; reliable, evidence-based care for heart attacks; and preventing adverse drug events, central line infections, surgical site infections and ventilator-associated pneumonia. Even before this “100,000 Lives” campaign began, we had initiatives in place for all six of these areas.

What does YNHH still need to do to improve safety?

We have a patient safety steering committee that reviews the work of all the hospital’s patient safety initiatives. These initiatives are reported to the senior management of the hospital and the Board of Trustees. We also have a performance improvement leadership group, whose work is primarily focused on specific disease risks. Here, too, our clinical computer system is a big help. For example, preventing blood clots in the legs, or deep venous thrombosis (DVT), is one such risk area — and our computer system has prompts to identify patients at risk for DVT and to aid prompt prescription of a medication and guide the ideal dosing of the medication for that patient. There are also many nursing protocols related to safety on the patient care units. We have found it is much more useful to standardize safety processes than to leave it up to individual practitioners to decide what is best.

How can you use the word “never” when it comes to patient safety?

Can you use the word “never” when it comes to patient safety? Probably not. Systems and computers can take you so far. Computers can fly planes and land them safely, but they cannot provide patient care. It is always possible for a healthcare worker to err or to disregard the safeguards that are built into the processes. But the hospital and its systems must try to ensure responsibility and accountability on the part of everyone caring for patients. Ultimately, though, as long as we are human, we are fallible. But that same humanity also drives compassionate, patient-centered care.

Are you pleased with the progress at YNHH?

Yes. We have long participated in a program with the Centers for Disease Control (CDC) aimed at reducing central line infection rates and ventilator-associated pneumonia cases, and we have consistently performed better than the CDC’s benchmark. We are both in preventing adverse drug events and safety medication delivery. We have assumed a leadership role in the delivery of reliable, evidence-based care for heart attacks, and consistently rank in the 90th percentile in publicly reported Centers for Medicare and Medicaid Services measures of care for heart attacks. YNHH has also implemented protocols to reduce surgical site infections through use of prophylactic antibiotics, proper hair removal and control of perioperative blood glucose levels.

I am very proud of the healthcare workers at this institution that have accepted the challenge to safeguard patient safety as much as we possibly can. We have statistical results that have shown we have done very well and I think as an institution we have really embraced it.
Dr. Morozov is among 10 Russian physicians who have participated in an intensive one-month cardiac fellowship at Yale-New Haven, which is sponsored by the Almazov Foundation of St. Petersburg and Yale-New Haven Hospital's Heart and Vascular Center.

The Almazov Foundation was created by Maria Prokudina, MD, PhD, a cardiologist from the Research Institute of Cardiology in St. Petersburg, to expand the expertise of young physicians by learning new techniques of their American counterparts that they can share with their Russian colleagues.

The idea to create a global partnership first took seed nearly 13 years ago, when Michael Dewar, MD, an attending cardiovascular surgeon at Yale-New Haven Hospital, began spending a week of his yearly vacation as a medical missionary in St. Petersburg, helping train Russian cardiac surgeons in advanced surgical techniques.

"A friend of mine, Dr. Robert Jarrett, a Brookfield cardiologist and associate clinical professor at Yale School of Medicine, had done medical missions in China and Egypt and saw a need for experienced cardiovascular surgeons in St. Petersburg—a place where their cardiac surgical results were very poor—and he invited me to go along," he said. "I view myself as a world citizen, and so I thought, 'Why not?'"

In 1995, Dr. Dewar made his first trip to St. Petersburg. He spent the next 10 years leading surgeries with a team of Russian colleagues at St. George's Hospital, part of the Research Institute of Cardiology. Although they saw positive results from their medical efforts—a drop in mortality rates from 20 percent to 5 percent—Dr. Dewar felt limited by the traditional medical mission model: a small team of physicians, one perfusionist and a nurse—working at one foreign medical center for a restricted period of time.

"In my field of work, you never stop studying or gaining new knowledge," said Alexander Morozov, MD, a pediatric cardiac surgical resident from the Research Institute of Cardiology in St. Petersburg, Russia, and a recent fellow at Yale-New Haven Hospital. "Yale-New Haven is legendary. It's one of the most famous medical centers in the world and I am so happy that it has provided me the opportunity to learn advanced technology and treatment of congenital heart disease while also offering me training in pediatric cardiac surgery."
Theodore Y. Dewar, MD, served as Dr. Morozov’s mentor during his Yale-New Haven fellowship.

"We were very happy with our surgical results, but we felt we weren’t breaking new ground," said Dr. Dewar, who admits to not being fluent in Russian but knows enough to help him through more than 100 cardiac surgeries. "We felt constrained by working with the same group of Russian doctors and we wanted a way to increase our teaching capacity."

St. Petersburg, located in northwest Russia, is about the same size as New England and has a population of 4.5 million people, yet it has less than half the number of heart doctors that exist in New Haven County.

After several trips to St. Petersburg, Dr. Dewar and two of his Russian colleagues began to think about ways to expand the educational programs between their two hospitals. During a dinner one evening, Dr. Dewar asked them, "Don’t you want to emigrate? They told me, ‘We’re Russians. If we don’t stay in Russia and help our people, who will?’ It was at that moment I became committed to find a way to enhance their medical education with short-term fellowships at an established first-rate medical center like Yale-New Haven,” said Dr. Dewar, who serves as coordinator of the intercontinental partnership.

"It has been a great opportunity for me to participate in the pediatric cardiac surgical training program at Yale-New Haven Children’s Hospital. This program allowed me to return home with new skills and an appreciation of the great minds and pioneers at Yale-New Haven. I am happy to have experienced the best in American health care," said Dr. Morozov.

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Where is hope? Hope is everywhere — on a steel beam, in the schoolyard and in your hearts.

When Yale-New Haven Hospital announced the beginning of construction of a new cancer hospital three years ago, the campaign to construct and help fund the building was named Building Hope. This was indeed a project and a journey to bring hope to patients everywhere who are diagnosed with this insidious disease called cancer.

Iron workers caught the spirit of the campaign, painting messages to patients, staff and the world on the steel beams that support the new 14-story, 600,000-square-foot building that will cost almost $600 million. They moved the campaign theme from the present progressive tense — BUILDING HOPE — to a more active phase — HOPE IS COMING, as the building began to rise up to the New Haven skyline.

Another of their messages said GET WELL KIDS and a huge NICHOLAS, for a kindergartner who has been battling cancer. When Nick’s schoolmates heard about this, they requested a special beam from the iron workers to sign for Nick. His elementary school held a day-long fund-raiser for the family, and at the end of the day, the children spelled out HOPE IS HERE for Nick.

For more information about the Building Hope Campaign for Smilow Cancer Hospital, contact:
Yale-New Haven Hospital • Office of Development • P.O. Box 1849 • New Haven, CT • 06508-1849 • (203) 688-1644 • email: giving@ynhh.org

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