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Yale-New Haven Hospital Annual Report 1967

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History

The Yale-New Haven Hospital has served as the teaching hospital for the Yale University School of Medicine since the Hospital was incorporated in 1826 as the General Hospital Society of Connecticut. Several early members of the Yale medical faculty were instrumental in obtaining its first charter and in helping to raise funds for the construction of its first building in 1833. The original structure was located on the site of the present Hospital complex, but it was oriented in the opposite direction.

In 1945, the New Haven Hospital and the Grace Hospital merged to form the Grace-New Haven Community Hospital, and later, in 1965, a strengthened affiliation agreement between the Hospital and Yale University led to its name being changed to Yale-New Haven Hospital.

The Hospital is governed by a board of directors. There are two main units, the New Haven Unit and the Memorial Unit. More than 2,900 persons are employed to offer professional and supportive services to patients using 737 adult and pediatric beds, 116 bassinets and 75 outpatient clinics.

The combined facilities of the School of Medicine, the Hospital, the Yale Child Study Center, the Yale School of Nursing and the Yale Psychiatric Institute constitute the Yale-New Haven Medical Center. The Connecticut Mental Health Center is closely affiliated with it and is directed by full-time members of the Department of Psychiatry at Yale.

Board of Directors

1967

Officers

President
Charles H. Costello

Vice Presidents
John M. C. Betts
Lewis E. Caplan
Stanley S. Trotman

Counsel
John Q. Tilson, Jr.

Treasurer
William A. Thomson, Jr.

Directors
John M. C. Betts
Kingman Brewster, Jr.
Lewis E. Caplan
(to November 1967)
Frank G. Chadwick, Jr.
Charles H. Costello
John E. Ecklund
Franklin Farrel, III
Charles S. Gage
James H. Gilbert
Mrs. Angus N. Gordon, Jr.
Reuben A. Holden
William Horowitz
Lionel S. Jackson
Frank Kenna, Jr.
Daniel W. Kops
Robert I. Metcalf
Spencer F. Miller
Charles H. Taylor, Jr.
William A. Thomson, Jr.
John Q. Tilson, Jr.
Stanley S. Trotman
G. Harold Welch
Mrs. M. Scott Welch
Frank O. H. Williams

At the annual meeting in February, 1967, William Horowitz, President, General Bank and Trust Company, and John Q. Tilson, Jr., a partner in the law firm of Wiggin & Dana, were elected to the Board of Directors of Yale-New Haven Hospital. Attorney Tilson filled the unexpired term of his law partner, Arnon D. Thomas, who died November 11, 1966, and he also succeeded Mr. Thomas as Counsel to the Hospital.

Six directors whose terms expired in 1967 were re-elected to three-year terms: They were John M. C. Betts, Kingman Brewster, Jr., Frank G. Chadwick, Jr., Franklin Farrel, III, Charles S. Gage and Robert I. Metcalf. Frank O. H. Williams was re-elected to a one-year term.
Report of the President
Charles H. Costello

Not since this Hospital opened its doors 134 years ago as a "refuge and asylum for the sick and distressed of all lands" has it faced a future more challenging than it does today. Prompted by public awareness, encouraged by Congressional action, and buoyed by the excitement of unparalleled medical achievement, we are preparing for bold new measures that may well mark this period as a turning point in the Hospital's long and distinguished history.

We are going to see changes in the very near future that will reflect realistically in this community the intent of the 89th Congress when it declared "that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person" and outlined effective use of Federal funds to help achieve it.

Already we are involved deeply in changes prompted by a public that believes facilities for good health care are among the rewards of a productive society. This Medical Center, a fusion of medical education and research through Yale University and the treatment of patients through the Hospital, is reaching into this and outlying communities to foster comprehensive health planning in an effort to determine what is needed and how it may be provided by combining our efforts with those of local, State and Federal agencies.

As for our efforts, here again we are dealing with an unprecedented situation: The announcement in November by Kingman Brewster, Jr., President of Yale University, that the University will seek $388 million within the next ten years from its alumni and friends to expand and improve its total educational effort. Included in this amount is $50.9 million allocated for salary endowment, training facilities and other construction for the Medical Center. And in turn, $19 million of that figure will be directed toward Hospital expansion and new construction.

The significance of this staggering task is that we envision new construction as more than the piling of one new floor atop another; we believe it must accommodate new philosophies. The Yale School of Medicine is revising its teaching curriculum to bring students into the sickroom earlier in their training which calls for a new approach in design and function. The Hospital, as well, is aware of the shifting need to provide more acute care facilities and devise new ways of treating patients with less severe or long-term disabilities.

The purpose in all this accelerated activity is to create the climate, provide the incentive and support the efforts of talented men and women who are developing, almost daily, better ways of coping with illness and accident. The Medical Center has retained the architectural firm of Douglas Orr, deCossy, Winder and Associates to create a vital, progressive long-range program that will include room for expanding ideas as well as increased endeavor.

We pride ourselves at Yale-New Haven that we have medical teams ready to respond to a crisis at a moment's notice no matter what the problem may be. As a teaching Hospital with the resources of a great University and its School of Medicine, we consider this our primary obligation to all who come to us for help, whether they come through the routine channels of admission or through the Emergency Service. The quality of emergency treatment was dramatically illustrated one foggy, tragic night last December when three Yale students were admitted, all near death from multiple injuries received when their car collided with a truck. Despite the fact that the emergency suite was already crowded with victims of an earlier accident and with other patients seeking attention, two surgical teams were assembled within a very short time to perform delicate neurosurgical operations on the students. Unfortunately, one young man was too badly injured to be saved, but the other two survived—and only because this Hospital had the facilities and the personnel trained to cope with the situation.

The student who did not survive has made a place in history as the donor of the first kidney transplant to take place in Connecticut. I am told that we have highly qualified teams with the experience and skill to undertake other operations of this type but they are more concerned at the present with problems of tissue rejection and the possibility that these problems may be circumvented in the future by new methods of classifying and typing tissues much as blood types are matched for transfusions. Certainly the ability to transplant human organs is capturing the imagination of the world, but many other advances are adding to the total picture of medical progress in what seems to us, as lay
members of the Hospital, an astonishing march of events.

In other important activities during the year, the Board of the Hospital marked the change in designation and relationship of Dr. Albert W. Snoke from Executive Director to Consultant effective January 1, 1968. Mr. Charles B. Womer, Administrator, was directed to assume full responsibility of the Hospital's activities, also effective January 1, 1968.

The Board regretfully noted the death of two men long associated with this institution: D. Spencer Berger and George S. Stevenson. Both had been presidents of the Hospital. Mr. Berger was active in many civic affairs, but took special pride in the efforts he undertook to help effect the merger of Grace and New Haven Hospitals and in the campaign to raise funds for the Memorial Unit. He was awarded honorary membership in the American Hospital Association in 1948, and eight years later the Hospital inaugurated the D. Spencer Berger Lectureship in his honor. After a long illness, he died in February at the age of 84.

Mr. Stevenson will be remembered as a kindly gentleman who, as president of the Hospital for many years, became a familiar sight to staff personnel during his personal visits to patient divisions. He succeeded Mr. Berger as president and served from 1950 to 1960. At the time of his death, May 1, 1967, he was 85 years old. I had occasion, recently, to re-read a speech he made some years ago to nurses graduating from our Grace-New Haven School of Nursing, in which he took particular interest. At that time he called upon Solomon's biblical phrase which serves us well today, and which he felt had singular reference to medical progress: "With all thy getting get understanding."
Administrative Staff and Department Heads 1967

Executive Director
Albert W. Snoke, M.D.

Administrator
Charles B. Womer

Assistant to the Administrator
James M. Malloy

Assistant Directors
Richard F. Binnig
David Dolins
Richard H. Judd
William T. Newell, Jr.
Herbert Paris
Anna E. Ryle, R.N.
Robert M. Sloane (to June 1967)
E. Richard Weinerman, M.D.

Administrative Planning Associate
Warren C. Kessler

Accounting
Edward J. Hammerbacher

Administrative Engineer
John W. Manz

Ambulatory Services
E. Richard Weinerman, M.D.

Anesthesiology
Nicholas M. Greene, M.D.

Building Services
Grant L. Berger, Jr.

Business Services
Harold L. Larsen

Chaplaincy
The Rev. E. F. Dobihal, Jr.

Clinical Laboratories
David Selgison, M.D.

Data Processing
Gordon G. Willard

Dietetics
Doris Johnson, Ph.D.

Emergency Service
Jerome S. Beloff, M.D.

Employee Education
Lawrence A. Loomis

Engineering
Raymond H. Brown

Inhalation Therapy
Donald F. Egan, M.D.

Linen Service
Warren H. Eastman

Medical Records
Patricia A. Tourey

Nursing
Anna E. Ryle, R.N.

Personnel Health Service
Herbert Lewis, M.D.

Personnel
Robert W. Fox
William E. Verespy (to June 1967)

Pharmacy
James W. Allaben

Physical Medicine and Rehabilitation
Josephine M. Fuhrmann, M.D.
Carl V. Granger, M.D. (to February 1967)

Program Development
Donald R. Kleinberg

Public Relations
Albert P. Freije

Purchasing
Joseph J. Leydon

Radiology
Morton M. Kligerman, M.D.

Systems Engineer
Robert R. Schwarz

Transportation, Aides and Communications
Harold L. Hahn

Volunteer Service
Mrs. Patricia A. Nabstedt

Medical Board

Chairman
Courtney C. Bishop, M.D.

Chief of Staff

Vice Chairman
Stephen Fleck, M.D.

Members
Robert R. Berneike, M.D.
Philip K. Bondy, M.D.
David H. Clement, M.D.
Jack W. Cole, M.D.
Charles D. Cook, M.D.
Hugh L. Dwyer, Jr., M.D.
Nicholas M. Greene, M.D.
Morton M. Kligerman, M.D.
Samuel D. Kushlan, M.D.
Averill A. Liebow, M.D.
Paul E. Molumphy, M.D.
Edward J. Quilligan, M.D.
Frederick C. Redlich, M.D.
David Seligson, M.D.
Herbert R. Sleeper, M.D.
Albert W. Snoke, M.D.
E. Richard Weinerman, M.D.
Harold N. Willard, M.D.

Elected Officers of Medical Staff

President
Robert R. Berneike, M.D.

Secretary
Isao Hirata, Jr., M.D.

Past President
Hugh L. Dwyer, Jr., M.D.
Report of the Administrator
Charles B. Womer

...A year of assimilation of Medicare and the other bold health programs of the 89th Congress,
...A year of significant advances in service to patients and the community and in planning for future forward strides;
...A year in which the pluses considerably outweigh the minuses, even though progress in some areas was not as rapid as it was hoped it would be.

Words such as these, I think, best summarize 1967 at Yale-New Haven Hospital as viewed from the inside; a year of growth to which we can point with pride, but a year which leaves us with a formidable agenda for 1968 and future years.

New and Improved Services and Facilities

May, 1967, saw the opening of the Newborn Special Care Unit of the Eleanor Naylor Dana Perinatal Center, a modern facility and program for the intensive care of as many as 36 sick and premature infants. This facility and the program it accommodates were considered so unusual it was chosen by the National Institute of Child Health and Human Development as the location for an international conference in December on the design and organization of special care units for newborn infants. This Unit, which represents the fulfillment of a dream and concept developed and nurtured by its director, Dr. Louis Gluck, serves as a model for other medical centers. Of course, no facility of this type can be translated from dream to reality without generous financial support, which in this case was given by Mrs. Charles A. Dana and contributors to the Hospital's Annual Fund of 1965-66.

Other major projects completed during the year included:
...Construction of six additional and badly needed diagnostic radiology rooms and supporting facilities in the New Haven Unit. One of these rooms contains sophisticated neuroradiology equipment made possible through the generosity of the Fannie E. Rippel Foundation.
...A new and much expanded Medical Records Department.
...Renovation and modernization of the pediatric patient division on the fifth floor of the Fitkin Building and the adult unit on the first floor of the Winchester Building.

In addition to new facilities, a number of important programs and services were established in 1967 including:
...The Medical Center's Chronic Dialysis Program.
...Program for Continuing Care.
...Exciting advances in the computerization of laboratory examinations by the Hospital's Department of Clinical Laboratories.

In cooperation with the Dixwell Legal Rights Association, Spanish speaking counselor-expeditors were added to our Ambulatory Services to improve the care and advice given to our increasing number of Spanish speaking patients, many of whom previously were unable to benefit fully from their care because of their inability to understand instructions.

People

Although we who administer hospitals may, at times, overwork phrases and statistics to describe the importance of people to a hospital, it is impossible to overemphasize the role of those who tilt the scales between excellent care and poor care, between friendly service and indifferent service. For this reason, at Yale-New Haven we continue to devote increasing attention to the brain, heart and circulatory system of the Hospital — its employees and staff.

During 1967, bold wage and benefits schedules authorized the previous year by the Board of Directors were implemented. An equally impressive and expensive program was approved for implementation during the fiscal year which began October 1, 1967. This latter program, in addition to significant wage and salary increases which go into effect January 1, 1968, includes greatly improved health and hospitalization insurance benefits and important improvements in the Hospital's retirement program for employees. These changes have done much to close the long-standing gap between Hospital salaries and benefits and those prevailing in the community for similar types of work, but significant additional improvements will be required in future years to close it completely.

Late in 1966, the Hospital retained the Industrial Relations Center of the University of Chicago to conduct a comprehensive employee attitude survey. This highlighted a number of areas of misunderstanding, communications deficiencies and needed improvements in employee facilities
and programs. As a result, new and improved employee orientation and training programs were started in 1967 under the leadership of Lawrence Loomis who had been appointed Director of Employee Education late in 1966.

National Shortage of health manpower has been a subject of increasing concern by both governmental bodies and the public press. At Yale-New Haven, a great deal of attention is being paid to the problems of recruitment and retention of personnel with the result that we have succeeded in hiring an increased number of nurses, licensed practical nurses, pharmacists and inhalation therapists. Much of this improvement, however, has been offset by the increased demands by greater numbers of acutely ill patients.

Problems of recruitment and turnover increased significantly during 1967 in some occupations, a reflection of the overall labor shortage in the New Haven area and a general belief that some hospital occupations are unchallenging, unrewarding and do not provide sufficient opportunity for advancement. The extent of the problem is demonstrated by the statistics of one service department which has a complement of 150 but hired 298 persons and had a similar number leave during 1967, a turnover rate of almost 200 percent.

One of our greatest challenges in the personnel area for 1968 is to develop training, guidance, and other programs which will make many of these service occupations more attractive to potential employees. These must include opportunities for applicants selected from the community’s disadvantaged to bring their motivations and skills up to the appropriate “entry job” levels; for training and guidance to prepare those in “entry jobs” for promotion; and the provision of greater opportunities for promotion for those who deserve it.

New appointments to the Hospital’s administrative staff during 1967 included:

.. William T. Newell, Jr., Assistant Director, replacing Robert M. Sloane, who resigned to become Associate Administrator of Monmouth Medical Center, Long Branch, New Jersey. Immediately prior to joining us, Mr. Newell was Assistant to the Administrator at Fairfax Hospital, Falls Church, Virginia.

.. James M. Malloy, Assistant to the Administrator. Mr. Malloy, a graduate of the Yale Program in Hospital Administration, was our Administrative Resident before being promoted to his new position.

.. Robert W. Fox, Director of Personnel, replacing William E. Verespy who resigned to accept a position in industry. Mr. Fox was Manager of Employee and Community Relations at the General Electric Company, New Britain, Connecticut, before joining the Hospital.

.. Mrs. Luba Dowling, Department Head, Operating and Recovery Rooms. Mrs. Dowling previously was Supervisor of the Memorial Unit Operating Rooms.

Organizationally, the assignments and activities of the Hospital’s Administrative staff were revised. Each Assistant Director was assigned coordinative responsibility for one or more patient services such as the surgical service, pediatric service, etc. This change brings the Hospital administration closer to, and involves it more deeply in, direct patient care activities.

Statistics and Finances

Statistical and financial reports for the year ended September 30, 1967, are listed in detail elsewhere in this report.

Statistically, the year produced few surprises. Total patient days increased slightly to 251,990 from 246,005 the previous year, an increase largely due to the additional children’s facilities provided by Hunter 5 which opened in October, 1966; the expanded Newborn Special Care Unit; and an increase in census of adult medical patients. Obstetrical deliveries and patient days continued to decline. The rate of decline, however, was less than in each of the previous two years. Clinic visits by service patients decreased 3,957 (4.7%) while private patient visits increased by 11,646 (10.9%), a continuation of a trend which was predicted following the enactment of Medicare. Emergency Service visits increased nearly 6% over 1966.

While the number of patients receiving care did not change significantly in 1967, there was a considerable increase in special services provided to patients. For example, laboratory examinations increased 11%, inhalation therapy treatments 16%, electrocardiograph examinations 11%, and isotope therapy treatments 13 percent.

Financially, the fiscal year which ended September 30, 1967, was one of real improvement when viewed from the income and expense standpoint, but a year of mounting concern in other respects.

The operating loss as shown in the financial statements was considerably less than in 1966. However, there was an increase in accounts receivable. Net accounts receivable totaled $4,767,370 on September 30, 1967, compared to $3,736,191 on the same date in 1966.

This increase of more than one million dollars, however, offset the improved financial performance referred to above and consumed a significant amount of funds which should have been used for the improvement of facilities and services. While it can be argued that much of
this increase in accounts receivable represents potentially “good money” since it is due from Medicare, Blue Cross, State Welfare, etc., its inaccessibility at any given time keeps the Hospital in a continuing “cash crisis” and seriously impedes the development and maintenance of necessary patient care and service programs.

A very serious disappointment in 1967 was the continuing unrealistic and negative posture of the State’s Hospital Cost Commission in regard to reimbursement for outpatient services to indigent and medically indigent patients. An act passed by the 1967 State Legislature, and effective July 1, 1967, provides that the State shall pay hospitals for outpatient clinic visits by State patients at a rate “to be established annually by the Hospital Cost Commission for each hospital, such rate to be determined by the reasonable cost of such services.” Despite legislative mandate to end its previous arbitrary attitude in this regard, the Hospital Cost Commission established a rate of $7 per visit for the year beginning July 1, 1967. Even though this response represents an increase of $1 per visit over the previous rate, it is still completely inadequate in view of the fact that it costs this Hospital on an average, more than $11 per visit to provide such service. The decision of the Commission has been appealed to the Superior Court by Yale-New Haven Hospital and three others most affected. It is hoped that the case will be heard and a more satisfactory decision rendered in 1968.

Such is the pace and vitality in the hospital of a great medical center. New modalities of care and treatment are returning patients to a productive life who would have died even two or three years ago; we are restoring others to good health sooner than was considered possible before; and we are striving constantly to improve the length and quality of life for those who carry the burden of chronic or degenerative disease. These are expensive endeavors. They are expensive in the demands they place upon employees and medical staff, on facilities and equipment, and they are expensive in terms of money. And yet the effort and cost are worthwhile to the Hospital’s Board of Directors, to its dedicated volunteers, its employees and medical staff and to its gracious benefactors.

To them we all owe a profound “Thank you.”
Report of the Chief of Staff
Courtney C. Bishop, M.D.

Medical Staff
Dr. Hugh L. Dwyer, Jr., completed his second term as President of the Medical Staff at its annual meeting in April, 1967, and was succeeded in that elective office by Dr. Robert R. Berneike. Dr. Isao Hirata, Jr., continued to discharge in his own inimitable manner the duties of the Secretary. The staff met for dinner and the subsequent transaction of business in October, January, February and April in accordance with its traditional pattern. Drs. Lewis L. Levy, Elisha Atkins, Harry R. Newman and Arnold B. Rilance, respectively, served as liaison members of the Medical Staff to the standing committees of the Board of Directors for budget and finance, public relations, personnel and nursing. Dr. Rilance also served on the liaison committee to the Hospital Council of Greater New Haven.

Medical Board
The Medical Board maintained its regular schedule of monthly meetings except for the two summer months. In December, Dr. Henry T. Clark, Jr., Program Coordinator of the Connecticut Regional Medical Program, became a regularly invited guest of the Board to facilitate liaison between the professional aspects of the Hospital and the regional planning under the provisions of the Federal program for Heart Disease, Stroke and Cancer. During the late spring, the Medical Board approved, for the purposes of improvement in house officer training, a recommendation of the Department of Surgery to establish a hand clinic, supervised jointly, but full-time and part-time faculty, to provide initial hospital and long-term ambulatory care for patients with hand injuries who were admitted through the Emergency Service but were not identified with individual private surgeons. Effective July 1, 1967, the Board approved a recommendation of the Chiefs of Service that members of the house staff above the rank of intern wear long white coats over conventional business clothes and that the traditional uniform of white pants and short white jackets be reserved for the first year group. In September, the Director of Continuing Care was added to the membership of the Medical Board. On November 30 and December 1, the Joint Commission on Accreditation of Hospitals completed its regular triennial survey and the Hospital was fully accredited again for a three year period.

Patient Care
Organizationally, two changes of significance were made during the period of this report. In the Ambulatory Services, the position of Director of Clinic Service was created to provide continuity and integration of the various clinic programs. His administrative responsibilities are comparable to those of the Director of Emergency Service and the Director of Personnel Health. All three report to the Director of Ambulatory Services. Secondly, there was created on July 1 a Hospital Department of Continuing Care to plan and develop within the Medical Center a realistic and effective approach to this rapidly expanding facet of total health care. Professional appointments within this discipline will be assigned to the Department of Medicine.

The Medical Center's dialysis program under the direction of Dr. Howard Levit continued to expand during the year; the hemodialysis division of the program grew from infancy to maturity. This latter program, which is the only one of its kind in Connecticut, employs a mechanical method of controlling, at least temporarily, the lethal effects of progressive, chronic kidney disorders and offers extended life and productivity to patients following a full day, twice a week treatment regimen. At the beginning of the year there was only one patient benefiting from this unique therapy; by the end of the year there were four. The facilities required for this program have considerable impact upon Medical Center resources. This is emphasized by the fact that these four patients require, for their treatments twice a week, the full time services of two graduate nurses and one technician; the part-time services of two physicians and the full time use of two artificial kidney machines. The peritoneal dialysis division of the overall program is planned for 15 patients, each requiring one treatment of 24-36 hours duration each week. If the total program were to expand as it is presently conceived, the projected requirement for beds and personnel will necessitate full time use of four hospital beds, two additional nurses, one technician and another physician. Two possible solutions may entail 1) increased simplification of equipment that would permit home use, and 2) fruition and further expansion of the program for kidney transplantation developed by the
Department of Surgery. The first such transplant operation at this Medical Center took place in December.

The Coronary Care Unit, the establishment of which was noted in last year's report, has, during its first year of operation, proved to be another patient service that saves lives. Up to October 1, 1967, there had been 189 admissions to this unit with 49 deaths representing an overall mortality rate of 25.93 percent. The mortality rate for this type of patient in acute general hospitals without coronary care units is reported to be approximately 30 percent.

Dr. Harold N. Willard, former Director of Chronic Care at Thayer Hospital in Waterville, Maine, was appointed Director of Continuing Care on July 1 and given responsibility for developing this new department at Yale-New Haven. A graduate of the medical residency at New York Hospital in 1948, he has devoted his career to problems of the chronically ill and the development of new techniques not only for extended institutional treatment but also for effective rehabilitation. Dr. Willard now brings to this Hospital rich experience in a challenging and expanding field.

Dr. Benedict R. Harris, a career-long member of the Medical Staff and Chief of Medicine for the Community Division since December, 1959, withdrew from his post to accept appointment as Chief of Medicine of the Atomic Bomb Casualty Commission at Hiroshima, Japan. Dr. Harris was succeeded by Dr. Samuel D. Kushlan, a graduate of the Yale School of Medicine in 1935 who, after training experiences on the medical services both of this Hospital and Massachusetts General Hospital, entered the private practice of gastroenterology in this community and simultaneously became a part-time member of the medical faculty. With his combined background of community practice and teaching, Dr. Kushlan can be relied upon to offer effective leadership to the medical service in the Memorial Unit.

Dr. Josephine M. Fuhrmann was appointed Acting Director of Physical Medicine and Rehabilitation on March 22, 1967, to succeed Dr. Carl V. Granger who had resigned earlier. Formerly a member of the full-time staff at Gaylord Hospital and primarily interested in the treatment and rehabilitation of chronic disease, Dr. Fuhrmann became a member of this Hospital Staff on July 30, 1965, and has devoted her entire attention to this department since that time. She is particularly well suited to continue its direction.

On September 15, 1967, Dr. Nelson K. Ordway, Attending Pediatrician and Assistant Chief of Pediatrics, resigned from the staff to accept appointment as Professor of Pediatrics at the University of Oklahoma. Dr. Ordway was appointed to the staff of this Hospital in January, 1958; served as Chief of Pediatrics from July 1, 1958, until July, 1964, and thereafter as Assistant Chief of Service until his resignation.

Effective July 1, 1967, Dr. Gerald Klatzkin was appointed Assistant Chief of Medicine and Dr. Robert S. Gordon was appointed Assistant Associate Chief.

In the Department of Surgery, Dr. William J. German retired as Chief of the Section of Neurosurgery on July 1, 1967, for reasons of age and was succeeded by Dr. William J. Collins. Dr. German came to this Hospital as an Assistant Resident in Surgery in July, 1928, already committed to an academic career in Neurosurgery. Following completion of the General Surgical Residency in 1931, he embarked upon the development of the Section he subsequently served so faithfully and established so firmly. Dr. Collins graduated from the Yale School of Medicine in 1947, completed his residency and postgraduate training in Neurosurgery at Barnes Hospital in St. Louis in 1954, and then served for nine years as a member of the faculty at Western Reserve University School of Medicine. From 1963 to 1967 he was Professor and Chairman of the Division of Neurosurgery at the Medical College of Virginia. Also on July 1, Dr. B. Marvin Harvard, Jr., withdrew as Chief of the Section of Urology to devote more time to private practice. He was succeeded by Dr. Bernard Lytton, F.R.C.S. Dr. Harvard was appointed to the staff of this Hospital in July, 1952, and in the following year assumed the directorship which he retained until the time of his resignation. Dr. Lytton graduated in medicine from the University of London in 1948 and received his surgical training at the London and King's College Hospitals with an interning year as Assistant Resident Surgeon at the Royal Victoria Hospital, Montreal. He was appointed Clinical Associate at Yale-New Haven on March 28, 1962, to serve as assistant to Dr. Harvard in supervision of the Urology Section. He was advanced to Associate in September, 1962, and was promoted to Attending rank in April, 1967, upon certification by The American Board of Surgery.

In the Department of Ambulatory Services, Dr. Desmond Callan, a graduate of the College of Physicians and Surgeons in 1960 and the training program in Neurology at Presbyterian Hospital in 1964, was appointed an Associate in Medicine on March 29, 1967, with assignment as Director of Clinic Service. Dr. Daniel S. Rowe was appointed Assistant Attending in Pediatrics on January 25, 1967, and assigned Director of Pediatric Ambulatory Service to replace Dr. Frederic M. Blodgett who resigned to accept appointment as Professor of Pediatrics at Marquette University. Dr. Rowe is a graduate of Jefferson Medical College and
completed specialty training in Pediatrics at the Babies Hospital in New York after five years' experience in private practice.

During the period of this report Dr. Stevenson Flanigan, Attending Surgeon (Neurosurgery) resigned to become Chief of Neurosurgery at the University of Arkansas; Dr. James W. Hollingsworth, Attending in Medicine, withdrew to assume new duties as Professor and Chairman of the Department of Medicine at the University of Kentucky; and Dr. John J. Kneisel, Attending in Surgery, also withdrew to become associated with the developing medical faculty of the University of Connecticut.

Medical Staff Organization

The composition of the Medical Staff on September 30, 1967, as compared with figures for 1966 are as follows:

<table>
<thead>
<tr>
<th></th>
<th>1966</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Honorary</td>
<td>12</td>
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<tr>
<td>Consulting</td>
<td>37</td>
<td>40</td>
</tr>
<tr>
<td>Emeritus</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td><strong>Medical Staff</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attending</td>
<td>230</td>
<td>247</td>
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<tr>
<td>Assistant Attending</td>
<td>154</td>
<td>153</td>
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<tr>
<td>Associate</td>
<td>121</td>
<td>142</td>
</tr>
<tr>
<td>Total Active Staff</td>
<td>505</td>
<td>542</td>
</tr>
<tr>
<td>Courtesy</td>
<td>134</td>
<td>132</td>
</tr>
<tr>
<td>Dentists and Physicians to Outpatient Department</td>
<td>154</td>
<td>151</td>
</tr>
<tr>
<td><strong>Total Medical Staff</strong></td>
<td><strong>845</strong></td>
<td><strong>874</strong></td>
</tr>
<tr>
<td><strong>House Staff</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Fellows</td>
<td>121</td>
<td>168</td>
</tr>
<tr>
<td>Interns and Residents</td>
<td>219</td>
<td>225</td>
</tr>
<tr>
<td><strong>Total House Staff</strong></td>
<td><strong>340</strong></td>
<td><strong>393</strong></td>
</tr>
<tr>
<td>Professional Staff (Non M.D.)</td>
<td>21</td>
<td>22</td>
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<tr>
<td><strong>Grand Total</strong></td>
<td><strong>1,206</strong></td>
<td><strong>1,289</strong></td>
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</table>

Included in the above are:

* Full-time physicians
  - 197

* General practitioners
  - 59

*Includes physicians with offices at the Veterans Administration Hospital and the Connecticut Mental Health Center who also have Yale-New Haven Hospital appointments.
New Appointments 1967
as of September 30

Altogether 82 new appointments were made to the Medical Staff during the year in the rank and departments indicated below. Of these, 51 were members of the full-time faculty, 16 were members of the Outpatient Department and 15 were practicing physicians. There was a net increase of 25 physicians serving on the Medical Staff.

<table>
<thead>
<tr>
<th>Name</th>
<th>Department</th>
<th>Rank</th>
<th>Department</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ronald C. Ablow t*</td>
<td>Radiology</td>
<td>Associate</td>
<td>Medicine</td>
<td>Assistant Attending</td>
</tr>
<tr>
<td>Joel Allison</td>
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<td>Obstetrics &amp; Gynecology</td>
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</tr>
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<td>Dentistry</td>
<td>Associate</td>
</tr>
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<td>Associate</td>
<td>Surgery</td>
<td>Associate</td>
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</table>

*Status changed during year. See list of changes.
†Full-time
Changes

Changes in rank were effected in 77 appointments and are listed as follows:

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<tr>
<th>Name</th>
<th>Department</th>
<th>Rank (from)</th>
<th>Rank (to)</th>
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<tbody>
<tr>
<td>Ronald C. Ablow</td>
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<td>Assistant Attending</td>
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<td>Associate</td>
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<td>A. Griswold Bevin</td>
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<td>Courtesy</td>
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<tr>
<td>Philip Felig</td>
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<td>Josephine M. Fuhrmann</td>
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<tr>
<td>William H. Gallaher</td>
<td>Pediatrics</td>
<td>Associate</td>
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<tr>
<td>Charles W. Gardner, Jr.</td>
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<td>Robert H. Glass</td>
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<td>Norman J. Marieb</td>
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</table>

*Changes in rank were effected in 77 appointments and are listed as follows.*
<table>
<thead>
<tr>
<th>Name</th>
<th>Department</th>
<th>Rank (from)</th>
<th>Rank (to)</th>
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</thead>
<tbody>
<tr>
<td>Charles J. McDonald</td>
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<td>Frank P. McKeen</td>
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<td>Gustavo S. Montana</td>
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**Deletions**

Deletions from the Staff roster numbered 57 during the year and are listed herewith:

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<th>Name</th>
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<th>Rank</th>
<th>Reason</th>
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<tr>
<td>Paul Beres</td>
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<td>David L. Bloom</td>
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<tr>
<td>Stephen H. Deschamps</td>
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<tr>
<td>Richard F. Ferraro</td>
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<tr>
<td>Thomas F. Ferris</td>
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<tr>
<td>Reginald Gillson</td>
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<td>Sanford W. Harvey</td>
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<td>Carl A. Jaeger</td>
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<td>Kenneth G. Johnson</td>
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<td>Byong M. Kim</td>
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<td>John J. Kneisel</td>
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<td>Howard J. Wetstone</td>
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In Memoriam

D. Spencer Berger
Member, Board of Directors
1923 – 1962
President
1946 – 1950
Died February 22, 1967

George S. Stevenson
Member, Board of Directors
1945 – 1962
President
1950 – 1960
Died May 1, 1967
Responses of the Yale-New Haven Hospital to Changing Public Needs and Demands

Albert W. Snoke, M.D.
Executive Director,
Yale-New Haven Hospital
1967
There is a growing preoccupation with health affairs throughout the country. This is evidenced by the virtual epidemic of federal health legislation recently passed or under consideration, the proliferation of local, regional, state and national planning agencies, and the increasing involvement of consumer representatives or of "the public" in all matters concerned with health.

Cost of health care, quality of health care and the efficiency and optimal utilization of the resources of health care, through proper organization and administration, are among the issues continually raised by both critics and defenders of the present health system. The rapidly increasing costs of hospital and medical care prompt the frequently heard questions of, "Can an individual afford to get sick?" "Is the present health care system pricing itself out of existence?" "Is the patient getting his money's worth?" or "Is there not a different health care system that would be more efficient, more economical and provide a better utilization of personnel and facilities?"

All components of our health care system are receiving public and private criticisms. The pharmaceutical industry is involved in questions of excessive charges and profits, and all types of controls. The physicians face accusations of striving to preserve the status quo, of a lack of understanding of their influence on all aspects of health care and of their inability to participate constructively in planning to meet current needs. Nursing organizations are bitterly assailed for overemphasis upon professional status and upon collegiate education for nurses, without giving equal attention to the increasing problem of shortage of all types of nursing personnel who are desperately needed at the sick patient's bedside. Much of the criticism of all three professions is exaggerated and unfair—there is also justification.

Hospitals particularly are in the limelight of the public's attention today. They are the target of serious criticisms relative to their costs, efficiency of operations, utilization, quality of care, and their responsibility and accountability to and for the public. The Secretary of Health, Education, and Welfare has made public comments on the inefficient management of hospitals. There also are continuing efforts in Washington to control the use of depreciation funds of the individual hospital through governmental or regional bodies which are unrelated to the hospital's own governing board. These attitudes and efforts cannot be explained simply as the result of lack of communication or of understanding, nor of a strong bias toward "socialized medicine"—whatever the definition of this most overused or undefined phrase may be.

It must be admitted that hospitals are vulnerable to much of the criticism. Their costs continue to mount astronomically. No knowledgeable hospital representative will hold out any hope that there
will be a plateau, let alone a decrease in costs. The hospital is a most visible health resource which is almost unique in its susceptibility to public scrutiny, criticism and control. Such accountability is much more difficult to pinpoint in other components of the health field. For example, the individual physician determines the quality of medical care, the number and variety of procedures or drugs ordered, the admission and discharge of the individual patient and the resultant length of stay in the hospital. He functions, in the great majority of the hospitals in this country, as an independent entrepreneur and yet has a profound influence upon the hospital economy. Hospitals and their programs are designed hopefully to meet medical and patient needs rather than to dictate medical care programs and philosophy. However, hospitals rather than their physicians, who do determine the medical care programs and philosophy, continue to be the focus for criticisms as well as for efforts to control medical practice through such mechanisms as accreditation programs and a mounting number of legislative and other third-party requirements.

It is not the purpose of this report to defend the present hospital system of this country nor to present solutions or programs on a national basis. These can and are being done in a comprehensive and constructive manner by the American Hospital Association in association with other health organizations, by the Department of Health, Education, and Welfare, and by Congress. One of the problems that the American Hospital Association faces is that our national hospital system is made up of a variety of institutions with differing philosophies and programs, all affected by or dependent upon local conditions, needs and circumstances. This report will focus upon the major criticisms or concerns which are directed from various sources toward hospitals in general, and will describe, as factually as possible, the plans, accomplishments and failures of the Yale-New Haven Hospital in recognizing and in meeting these criticisms and concerns. Although the discussion will center around this institution, few of the Yale-New Haven Hospital's activities can be discretely isolated from the other health care activities of the local community and of the State of Connecticut, nor will they differ very much from efforts being undertaken by other hospitals of the region. John Donne's statement that "No man is an island" is particularly applicable to the hospital. The answers of the Yale-New Haven Hospital to concerns of the public hopefully can be of assistance in responding to similar questions directed to voluntary hospitals in general.

The high cost of hospital care and the difficulties faced by patients in meeting these costs are of paramount importance. Some of the questions that must be answered are: Are our personnel being used most effectively? Is our operation efficient and economical? Are our facilities being utilized most efficiently? Do we have adequate incentives to improve utilization, efficiency and quality? The greatest potential savings to society in general for total health care is in the appropriate use of the spectrum of high and low cost services. This would result in a decrease in the inappropriate utilization of the expensive bed in the acute care general hospital. The objectives of the Yale-New Haven Hospital are very clear in this regard—to admit and retain patients in this very expensive, complicated acute bed facility only when necessary for proper care of the patient. Such a policy is dependent upon the practical implementation of the philosophy and program of providing for a "continuum of health care." This would necessitate available facilities in the community which could render a full spectrum of service from maintenance of health to care for acute or chronic illness to care for the dying. Each individual should be cared for in the most effective, economical and appropriate facility for his own particular condition. This in turn requires flexible and easy transfer so that the right patient can be in the right place at the right time.

The Yale-New Haven Hospital is thus concerned simultaneously with programs of preventive medicine, of ambulatory care in the emergency room and clinics, of specialized diagnostic and therapeutic services
on an ambulatory basis for patients of referring private physicians, of acute inpatient care, of early discharge with planning for convalescent and chronic care, and of organized home care. The progressive patient care concept, which was originally conceived as functioning within the acute care institution, is now being extended to pre- and post-general hospital care throughout the community. The hospital is concerned about the total health service and thus the total health expense bill—whether it is financed by the individual or by voluntary and governmental insurance.

Any such extension of the general hospital into this broad spectrum of health care cannot spring full-panoplied like Athena from the brow of Zeus. It requires the careful development of integrated programs and close relationships to allied health institutions. These may well take years to develop. Such programs have long been advocated by this hospital. The implementation has been hampered by lack of funds and space, and by the laborious process of arriving at a general consensus of the persons and organizations which are concerned. Such planning is now beginning to show tangible results.

Increasing emphasis is being placed by the Yale-New Haven Hospital upon the ambulatory service from the point of view of service, teaching and research. It is no longer the step-child of the university teaching hospital but a major division of the medical center. The emergency department has adapted the “triage system” whereby immediate care is given when necessary, while all non-emergent patients are checked by a physician and referred to appropriate follow-up facilities. The clinics are rapidly losing the traditional separation of “private clinics” and “ward clinics,” and are now combining facilities and services into single clinics with resultant savings of space, equipment and personnel. A major objective continues to be to provide the practicing physician of the community and the state with increasingly sophisticated diagnostic and therapeutic services for those of his private ambulatory patients that he refers to the medical center.

Ideally, a facility such as a motel should be available near the medical center. This would be helpful for ambulatory patients coming from a distance who are undergoing diagnostic studies and therapeutic treatment over several days’ time as well as for families of inpatients. Such a service has not been developed, although the possibility has been under discussion for some time.

At the other end of the hospital care spectrum is the formation of a department of continuing care in the medical center. Staff, facilities and programs are being designed to enable physicians to transfer their patients at early stages in their illness from the acute care divisions of the hospital to continuing care facilities either inside or outside the institution. A continuing care facility is being planned within the hospital. Formal affiliation agreements are being explored with other chronic care and rehabilitation institutions in the area as well as with certain convalescent and skilled nursing homes. The formation of a medical center based, organized home care program is also being explored.

The hospital faces a substantial handicap in its planning in these areas due to the lack of flexibility in insurance and prepayment programs for the financing of the patient’s health care in the most appropriate environment which may not necessarily be within the hospital walls. Health insurance in Connecticut has been oriented to hospitalization in the acute care general hospital. Connecticut Blue Cross has been trying for some time to broaden its coverage so as to remove the financial pressure for inpatient bed use as contrasted to home care and expanded ambulatory and continuing care. Only recently has the Connecticut Legislature passed enabling legislation. Thus the first step has been taken for the establishment of a truly flexible system of a “continuum of health care.”

Parallel with the efforts to avoid the use of expensive inpatient facilities when less expensive facilities could be used equally effectively is a continuing effort to operate the institution with a maximum of efficiency and economy. Automation in delivery and transportation systems, in record keeping, in business services and in management controls plus an extension of the use of more sophisticated computers all are being intensively explored by the
administration of the hospital. The use of the Hospital Administrative Services of the American Hospital Association has been of value in comparative management studies with other university teaching hospitals. A study of an expanded statistical and quality control program is currently being undertaken by the Connecticut Hospital Association, the Connecticut Blue Cross and the Department of Epidemiology and Public Health of Yale University. This study holds promise of building upon the pioneering work done by the Professional Activity Study (PAS) of the Commission on Professional and Hospital Activities. Hopefully, all the Connecticut hospitals will eventually have a more sophisticated and comprehensive approach to statistical and quality control.

The utilization committee of the Yale-New Haven Hospital is working currently with the staff of the Department of Epidemiology and Public Health to devise a utilization review mechanism that will substantially improve the effectiveness of a program that, so far, has been characterized in many hospitals only by gestures.

The development of a formulary system by an active pharmacy committee has resulted in a rational drug therapy program using non-proprietary drugs from reputable drug companies. This is producing substantial savings to the hospital and to the patient.

Improved personnel administration and supervisory training as well as more effective utilization of skilled personnel for those duties for which they have been specially trained have been on-going programs in the hospital. For example, for some time many clerical, housekeeping and dietary functions are no longer the responsibility of nurses. Ancillary personnel and service departments are being utilized more and more to allow doctors, nurses, and technical personnel to devote their efforts to their own specialized functions. The tangible results in thus reducing operating costs have not been as great as was hoped. The complexity of acute hospital care requires that much of the physician and nurse substitutes be by other well-trained specialists, such as pharmacists, dietitians, inhalation therapists, computer and professional technologists. Their wage levels are such that only minimal reductions result.

The seven-day week, with daily utilization of expensive operating facilities and higher occupancy of the hospital holds promise of additional economies. Such departments as laboratories, radiology, dietary and nursing already function on essentially a seven-day week. However, one barrier to a successful expansion to a genuine seven-day week is the present shortage of personnel and the unwillingness of many to work on weekends. In spite of this, the seven-day work week should be explored further.

With all of the sophisticated management and administrative tools that are being used, or being considered, any spectacular decrease in hospital expenses should not be expected, partly because any effect would be gradual and partly because any effect would be based on the particular nature of the hospital industry. The public and third-party reimbursement agencies must realize that hospitals are a service industry in which from 68 to 75 percent of the hospital expenses are in personnel costs. If hospitals are to be competitive with increasing wages in the community, the result must, of necessity, be reflected in increased personnel costs. Automation cannot be the total substitute for personal service at the patient's bedside — its more likely result is to assist the scarce professional (doctor, nurse and technician) in doing a better job in his primary responsibility of patient care.

The current practice of evaluating or comparing hospital costs on a per diem basis is outmoded today. As patients are kept out of the hospital, or have early discharge, there will be an inevitable concentration of the more acutely ill patients in the acute hospital beds. The total cost to the individual patient for all of his illness or the overall cost to society may well diminish as more economical facilities are utilized. But the per diem cost of the acute care general hospital will inevitably increase markedly as it becomes more exclusively an intensive care institution.
Incentives to improved management and to greater efficiency in hospitals are currently being advocated by the public and by third-party reimbursing agencies as necessary if they are to have confidence in the economics of the voluntary hospital system. This is a valid consideration on their part, particularly as the percentage of the patient population covered by total cost reimbursement by third parties rises. Hospitals cannot expect a blank check for total cost reimbursement. However, it is unrealistic to conclude that strong and important incentives for increased efficiency of utilization and for economy of operation do not currently exist in the Yale-New Haven Hospital, although its present costs are high and are rising. A waiting list for non-emergency surgery of from six to twelve weeks and the demand by both doctors and patients for admission causes pressure for early discharge. Annual subsidies of more than $1,200,000 required to provide care to indigent and medically indigent in- and outpatients certainly is an incentive for economy. This is particularly true when the income from the hospital endowment and the contribution from the United Fund are so small that it is necessary to charge self-pay patients from $15 to $22 a day over the hospital cost in order to provide the subsidy required for “free care.” In addition, the accounts receivable are mounting and there is a resultant chronic deficiency of operating cash which interferes with adequate replacement of equipment and with the renovation of facilities. It is hard to imagine what further incentives to the administration of the hospital would be necessary to stimulate any further efforts to improve utilization, economy and efficiency.

Comprehensive planning of health facilities, effectively integrating services within the hospital with services in the community, has been a continuing program of this hospital over the past nine years. The Yale-New Haven Hospital is currently re-assessing its internal master plan of program and facilities to provide as efficient as possible a general hospital for patients requiring acute care in the context of the teaching and research responsibilities of the Yale University School of Medicine. The hospital also is placing emphasis upon facilities for ambulatory and continuing care whereby the patient may properly be cared for outside the hospital or be discharged as promptly as possible.

In addition to its intramural planning, the hospital is working actively with the other local hospitals, the Veterans Administration Hospital facility in West Haven, and with the Community Council of Greater New Haven in the preparation of a comprehensive health care plan for the region. This planning will be coordinated with the planning of the Connecticut Hospital Planning Commission (a voluntary body made up of representatives of the citizens of the state) and approval of the Commission will be sought.

The hospital and the medical school, in partnership with the University of Connecticut School of Medicine, is lending major support to the Connecticut Regional Medical Program, which is developing into as comprehensive a health planning effort as exists in any of the 49 programs for Heart, Stroke and Cancer and Related Diseases in the United States. The Connecticut Hospital Planning Commission and the Connecticut Regional Medical Program are two statewide agencies, operating under voluntary auspices and with broad citizen representation but with close partnership with local and state governmental officials. They both have great potential to establish effective comprehensive health planning with avoidance of unnecessary duplication of expensive programs and facilities, and to provide mechanisms for the control of the unnecessary use of capital funds for facilities and programs.

Cooperative operational activities for economy of hospital operation are being undertaken that already indicate substantial savings. A significant example is the participation of the Yale-New Haven Hospital in cooperation with other area hospitals in the planning for a cooperative laundry. If current plans mature, the new laundry will be in operation within 30 months; it will have an eventual capacity of approximately 15,000,000 pounds a year, will provide services at a unit cost approximately the same or less than any of the existing hospital laundries, and will result in capital savings to the four hospitals because they will not have to raise approxi-
mately $2,000,000 that would have been necessary if separate laundries were to have been constructed, renovated or enlarged.

Another example is the group purchasing program under the leadership of the Connecticut Hospital Association through membership in the Hospital Bureau, Inc. This has resulted in estimated annual savings for the hospitals of Connecticut:

Medical, surgical, pharmaceutical equipment and food supplies
$ 80,000

Oxygen and medical gases
$  60,000

Fuel oil for heating purposes
(in process of negotiation)
$  50,000

$190,000

A third example is a feasibility study, undertaken by the Yale-New Haven Hospital in partnership with the Connecticut Regional Medical Program, of a regional laboratory designed to provide improved laboratory service at less cost to the physicians and to the institutions of the area. Such a program could well become a prototype for other parts of the country.

The future patterns of medical care and the future organization of health services will undoubtedly have as much, if not more, impact upon the cost of health care in the country than any changes in operation or in construction of hospital facilities. As noted earlier in the report, the Yale-New Haven Hospi-
tal is perceptive to changing pa-
tient, physician and community needs. It is attempting to react to them. The hospital does not change medical practice. However, it does have an important role in planning, establishing and supporting of appropriate medical practice changes. This institution, as part of the Yale-New Haven Medical Center, has encouraged the development of models of community-based comprehensive prepaid and group practice programs to care for segments of the population. Two such programs are a university comprehensive health care program and a labor-community sponsored prepaid comprehensive group practice program. In addition, the hospital has evidenced willingness and desire to explore closer affiliation with other health care institutions and has expressed sympathy with the development of branch or satellite institutions by or in cooperation with the Yale-New Haven Hospital if community planning so indicates. It has consistently provided hospital privileges to general practitioners and has encouraged the strengthening of the personal, identifiable physician for each service patient, the traditional "ward" patient of the past.

Progress in the training of the family physician and in the treatment of the service patient as a sick person with family and community responsibility has been slow. However, it has been encouraging to note the increasing interest taken by medical students and resident staff in total patient care and community activi-
ties. The faculty and the medical staff also are actively exploring extension of their services into the community through the medium of the Connecticut Regional Medical Program and through better organization of the medical center’s staff. This, understandably, can be expected to be a long and rather laborious process of change in an academic environment fundamentally oriented to research and teaching.

Recent concrete examples of the desire to extend the medical center’s patient care, teaching and research interests into the community are the Family Health Care Project and two neighborhood health programs in the nearby “Hill” area. Although currently limited to selected families, to pediatrics and to psychiatry because of funding requirements, a commitment to extend the university teaching medical center beyond its local four walls is well established and undoubtedly will receive more attention in the future.

This report of responses by the Yale-New Haven Hospital to changing needs and demands is not a record of final achievement nor can the efforts be viewed with complacency. Needs are too great and there is too much change for any hospital to be satisfied with its progress, which may too often be characterized by agonizing delays and indecisions. However, the Yale-New Haven Hospital, its administrators, personnel and medical staff are facing, realistically, the many issues and problems and are attempting to respond constructively.
It was with great pride that the Women’s Auxiliary celebrated the fifteenth anniversary of its founding during the year 1967. Due to our founders’ foresight we have continued to expand our service to the hospital not only as active workers within the hospital, but as goodwill ambassadors in the community.

At the annual meeting of the Auxiliary in April, thirteen of our members were presented with award pins representing completion of fifteen years of continuous in-service volunteer work within the hospital. During this year 472 volunteers have given 36,000 hours to the hospital. Of this number 135 were Junior members who represented all areas of the community.

During the financial year ending March 31, 1967 the Carryall Shops netted $28,342. Additional income of $1,359 was realized as our commission from the nursery photos. From these monies, the final payment of $25,000 toward the renovation of the pharmacy area and $2,150 for the drawing accounts for the pediatric divisions and clinics was made to the hospital. In addition, the sum of $1,163 from the Remembrance Fund was used to provide television sets for the solaria in the New Haven Unit and blenders for outpatient use.

In December, the Board of Managers of the Auxiliary, on the recommendation of the Projects Committee, authorized a pledge of $80,000 to be paid over a three year period toward the renovation of the Fitkin I area.

A total donation of $335,000 has been made to the Hospital by the Auxiliary since 1952.

The Women’s Auxiliary 1967

Officers
President
Mrs. M. Scott Welch
1st Vice President
Mrs. Rudolph F. Zallinger
2nd Vice President
Mrs. H. Everton Hosley, Jr.
Corresponding Secretary
Mrs. Lane Ameen
Recording Secretary
Mrs. Donald Kusterer
Treasurer
Mrs. S. Michael Gompertz
Treasurer of the Carryall Shops
Mrs. Robert A. Richards
Medical Staff
as of September 30, 1967

Department of Clinical Laboratories
Chief
David Seligson
Assistant Chiefs
Joseph R. Bove
Alfred Zettner
Attending
Philip K. Bondy
Joseph R. Bove
Franklin H. Epstein
Stuart C. Finch
Gerald Klatskin
Averill A. Liebow
David Seligson
Alfred Zettner
Assistant Attending
Fred S. Kantor
Nathan G. Kase
Yale R. Nemerson
Alexander W. vonGraevenitz
Associate
Arthur H. Mensch
Director of Blood Bank
Joseph R. Bove
Director of Clinical Microscopy
Alfred Zettner
Director of Clinical Microbiology
Alexander W. vonGraevenitz
Clinical Fellows
Richard K. Donabedian
Robert C. Rock
Robert K. Schoentag
Professional Staff
Pauline M. Hald, B.A.

Department of Anesthesiology
Chief
Nicholas M. Greene
Assistant Chief
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Milton Lisansky
George M. Montano
James A. Piccolo
Samuel C. Rockoff
David Stamm
Herman B. Tenin

Associate
Wilbur N. Falk
Stanton B. Fater
George O. Gelinus, Jr.
Harvey A. Lichter
James A. Washington, Jr.

Courtesy
Louis Angell

* leave of absence
** also a member of Courtesy Staff
Joseph J. Dickstein
Harry H. Goldner
Richard D. Grossman
Harold L. Horton
John J. McDougall
Richard F. McGuire
Daniel C. McMahon
Jack R. McNeish
Irving W. Mohr
Harold T. Moore
Francis R. Mullen
Conrad W. Newberg
Samuel H. Pinn
William H. Pitts
David A. Rozen
Gerald L. St. Marie
Robert W. Seniff
Jerome M. Serling
Charles M. Slon
Albert K. Snyder
William R. Tyson
Angus F. White

Orthopedic Surgery

Section Chief
Wayne O. Southwick

Consulting
Denis S. O'Connor

Attending
Alexander L. Bassin
Russell V. Fuldner
William S. Perham
A. David Powerman
Earl J. Rhoades
A. Lewis Shure
Ned M. Shutkin
Charles K. Skreczko
Wayne O. Southwick

Assistant Attending
Hubert S. Bradburn
Eugene J. Frechette
Willard F. Greenwald
Martin L. Sumner

Associate
James A. Albright
Ralph J. DePonte
Alan H. Goodman
Kristapps J. Keggi
Robert N. Margolis
Ultrich H. Weil

Physicians to the Outpatient Department
George E. Becker
Oscar D. Chrisman
Donald S. Dworken
MacEllis K. Glass
John H. Moore
John R. Raycroft
Philip L. Staub

Otorhinolaryngology

Section Chief
John A. Kirchner

Associate Section Chief
Charles Petrillo

Emeritus
Harry L. Berman

Consulting
Paul B. MacCready
Samuel J. Silverberg

Attending
John A. Kirchner
Charles Petrillo
Howard W. Smith

Assistant Attending
David A. Hilding
Robert S. Rosnagle
Eiji Yanagisawa

Associate
Lawrence G. Lydon
James M. Ozenberger

Physicians to the Outpatient Department
Gregory K. Dwyer
Henry Merriman
Paul S. Norman

Courtey
Genesis F. Carelli
Louis Schlessel

Professional Staff
Robert F. Nagel

Urology

Section Chief
Bernard Lytton

Associate Section Chief
John B. Goetsch

Honorary
Clyde L. Deming
Lloyd L. Maurer

Consulting
Hyman A. Levin

Emeritus
Albert J. Howard

Attending
Robert R. Berneike
John B. Goetsch
Bell M. Harvard, Jr.
Bernard Lytton
Harry R. Newman

Assistant Attending
Arnold M. Baskin
Elliot S. Brand
Joseph A. Camilleri

Associate
Richard P. Lena

Courtey
Peter J. Cavallaro
Peter Demir

House Staff
as of September 30, 1967

Anesthesiology

Residents
Wilfredo Cadelina
Stanley E. Matyszewski
Sompong Nukrongsin

Assistant Residents
D. Ian Campbell
James H. Drews
Juliana Kang
Koretada Kondo
Caroline O. McCagg
Ezio R. Panegos
A. Richard Pschorr, Jr.
Gaylord H. Rockwell
William M. Smith
Romulo Villar

Clinical Pathology

Resident
George E. Westlake

Assistant Residents
George S. Acton
Sheldon M. Glusman
Harvey B. Spector

Dermatology

Resident
Melvin P. Coolidge

Assistant Residents
Walter R. Anyan, Jr.
A. Russell Brenneman
Brian J. McGrath
Leonard M. Selsky
Richard B. Swint

Internal Medicine

Resident
Walter J. Hierholzer, Jr.

Assistant Residents
John D. Baxter
Robert D. Brennan
James E. Brown
Robert S. Brown
Robert A. Buccino
Joshua Fierer
William T. Friedewald
Robert W. Hayward
Harvey I. Hurwitz
Harold P. Kaplan
Moreson H. Kaplan
Charles J. Lightdale
William H. Likosky
Robert W. Lyons
Arthur J. Merrill, Jr.
James W. Myers
Edward J. O'Keefe
David H. Riddick
Frederick L. Sachs
James G. Sansing
Robert T. Solis
Wesley M. Vietzke
John V. Weil
Kenneth H. Williams, Jr.

Interns
David S. Cannom
Thomas C. Coniglione
Richard D. Diamond
Peter N. Herbert
Arthur M. Kleinman
John M. Leonard
Richard J. Mangi
Christopher D. Meyers
Milton G. Mutchnick
John O. Pastore
Brian F. Rigney
Michael W. Rosen
Martin Rosman
Stephen C. Schimpff
Carl B. Sherter
Lawrence R. Solomon
Redford B. Williams, Jr.
Veterans Administration Hospital

Resident
Frederick M. Rosenbloom

Assistant Resident
Michael Weiner

Neurosurgery

Residents
Peter M. Carney
David M. Geetter
John N. German

Assistant Residents
John F. Brix, Jr.
Isaac Goodrich
Robert B. Page
Arthur H. Palmer
Saul W. Seidman
Richard M. Swengel

Obstetrics and Gynecology

Residents
John C. Hobbins
Robert F. Maudsley

Assistant Residents
Frank H. Boehm
Peter A. Fleming
John A. Freeman
Gary L. Gross
Robert J. Gross
Marshall R. Holley
Kenneth A. Pruett
Robert Resnik
Eric A. Sailer
Peter E. Schwartz
David H. Shapiro
Lawrence J. Warfel
Leonard H. Zamore

Oral Surgery

Resident
David R. Chase

Interns
Joseph N. Brant
Oswaldo Maneiro
James R. Mullane

Orthopedic Surgery

Residents
John W. Gainor
Gerard J. Lawrence
Elliott Schiffman

Assistant Residents
Alan L. Breed
Chang S. Choi
Joseph D. Ferrone, Jr.
Gary A. Gallo
Richard P. Hockman
Arthur J. Leupold
Richard M. Linburg
John V. Mangieri
Frederick W. Tiley

Pediatrics

Resident
Allen D. Schwartz

Assistant Residents
Laurence A. Boxer
Frederick M. Burkle, Jr.
John V. Federico
Jeffrey B. Gould
Maria Gumbinas
Ivan R. Harwood, Jr.
Alberto Hayek
Edward A. Jacobs
Harold A. Kanthor
Anthony P. Kenna
Joan M. Leary
Alan Meyers
Margaretta R. Seashore
Gary R. Wanerka

Otolaryngology

Residents
Daniel J. Buchalter
Jerrold N. Finnie

Assistant Residents
Dewey A. Christmas, Jr.
Raymond C. Matteucci
Jerold J. Principato
Tadashi Shimada

Pathology

Resident
John T. Gmelich

Assistant Residents
Eugene P. Cassidy
Mark J. Cohan
Anthony P. Fappiano
Philip S. Feldman
Reid R. Heffner
John J. Mooney
Walter N. Noll
James A. Robb
Harvey S. Schiller
Gerald E. Simon

Interns
Michael A. Bean
Marian C. Davidson
Timothy J. Dondero, Jr.

Radiology

Resident
Patrick J. Moriarty

Assistant Residents
Paul L. Dratch
John V. Forrest
Richard L. Goldman
Lawrence Gould
Warren A. Hinchcliffe
Robert L. Kallett
William C. Klein
Arthur H. Knowlton
Stuart S. Sagel
Louis N. Scotti
Frederic S. Shmase
Philip W. Silverberg
Lewis N. Terry
Arne S. Youngberg

Surgery

Residents
Constantine E. Anagnostopoulo
Robert S. Bolt
Richard S. Dutton
John A. Galloway
William G. Mefferd
Joshua Miller
Richard M. Robinsson
Edward O. Terino

Assistant Residents
Robert C. Bone
Dennis J. Card
A. Lawrence Cervino
David W. Connors
Robert E. Dragon
Gerard A. Engh
Clifford L. Hoyle
Rollin M. Johnson
John P. Judson
Joseph Kabamba
Thomas J. Koonitz
Bipin M. Patel
Donald C. Rankin
John H. Seashore
Robert L. Shelton
Charles P. Shoemaker, Jr.
Joel B. Singer
Richard L. Snider
Daniel W. VanHeeckeren

Interns
John P. Albright
Richard A. Brand, Jr.
Robert L. Carangi
John W. B. Cheng
Michael R. Curci
James M. Dowaliby, II
Stephen F. Gunther
George M. Hricko
Carl E. Lane
Charles M. Moss
Robert A. Poirier
Jeffrey P. Robbins
Stephen A. Stein
Robert S. Steinberg
M. David Tilson
M. Dennis Wachs

Urology

Residents
Norman A. Bloom
Marvin B. Brooks

Assistant Residents
John A. Libertino
Athanase N. Nicolaides
Martin Schiff, Jr.
Stephen A. Weiss
Comparative Statement of Income and Expense
For Years Ended September 30, 1967 and 1966

DURING THE YEAR CHARGES TO PATIENTS WERE:

<table>
<thead>
<tr>
<th>Service</th>
<th>1967</th>
<th>1966</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room, board and nursing</td>
<td>$11,102,060</td>
<td>$8,800,659</td>
</tr>
<tr>
<td>Clinic Services</td>
<td>604,360</td>
<td>657,523</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>579,204</td>
<td>424,185</td>
</tr>
<tr>
<td>Special Services</td>
<td>11,345,678</td>
<td>9,695,891</td>
</tr>
</tbody>
</table>

Making a total of: $23,631,302 $19,578,258

FROM CHARGES WE DEDUCTED:

<table>
<thead>
<tr>
<th>Allowance</th>
<th>1967</th>
<th>1966</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contractual and other allowances</td>
<td>$2,960,477</td>
<td>$2,226,528</td>
</tr>
<tr>
<td>Provision for uncollectable accounts</td>
<td>1,662,767</td>
<td>1,528,055</td>
</tr>
</tbody>
</table>

Making a total deduction of 4,623,244 3,754,583

LEAVING US A NET INCOME FROM PATIENTS OF: $19,008,058 $15,823,675

IN ADDITION TO INCOME FROM PATIENTS, WE RECEIVED INCOME FROM:

<table>
<thead>
<tr>
<th>Source</th>
<th>1967</th>
<th>1966</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free Bed Funds</td>
<td>$142,044</td>
<td>$139,783</td>
</tr>
<tr>
<td>United Fund</td>
<td>61,766</td>
<td>58,773</td>
</tr>
</tbody>
</table>

Making a total of 203,810 198,556

WHICH PROVIDED US WITH A TOTAL OPERATING INCOME OF: $19,211,868 $16,022,231

HOWEVER, TO TAKE CARE OF OUR PATIENTS, IT COST US FOR:

<table>
<thead>
<tr>
<th>Expense</th>
<th>1967</th>
<th>1966</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>$12,049,016</td>
<td>$10,120,451</td>
</tr>
<tr>
<td>Supplies and Other Expenses</td>
<td>7,201,514</td>
<td>6,452,455</td>
</tr>
</tbody>
</table>

Making a total cost to us of $19,250,530 $16,572,906

WHICH LEFT US WITH AN OPERATING LOSS OF: $38,662 $550,675

INCOME FROM ENDOVERTMENT AND OTHER NON-OPERATING SOURCES AMOUNTED TO: $428,461 $459,431

RESULTING IN A GAIN OR (LOSS) OF: $389,799 $(91,244)

In 1967, after applying all sources of income, the Hospital met its operating costs plus 2 percent as opposed to a loss of .6 percent in 1966.
## Comparative Balance Sheet

### Assets

#### For Years Ended September 30, 1967 and 1966

### General Funds:

<table>
<thead>
<tr>
<th></th>
<th>1967</th>
<th>1966</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$109,787</td>
<td>$111,061</td>
</tr>
<tr>
<td>Accounts Receivable (Net)</td>
<td>4,767,370</td>
<td>3,736,191</td>
</tr>
<tr>
<td>Inventories</td>
<td>634,651</td>
<td>651,221</td>
</tr>
<tr>
<td>Other Assets</td>
<td>251,946</td>
<td>233,420</td>
</tr>
<tr>
<td>Due from Temporary Funds</td>
<td>421,522</td>
<td>170,503</td>
</tr>
<tr>
<td>Due from Endowment Funds</td>
<td>39,105</td>
<td>154,240</td>
</tr>
<tr>
<td><strong>Total — General Funds</strong></td>
<td><strong>$6,224,381</strong></td>
<td><strong>$5,056,636</strong></td>
</tr>
</tbody>
</table>

### Endowment and Special Funds:

<table>
<thead>
<tr>
<th></th>
<th>1967</th>
<th>1966</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$102,659</td>
<td>$(11,672)</td>
</tr>
<tr>
<td>Investments</td>
<td>19,281,523 (1)</td>
<td>11,723,683</td>
</tr>
<tr>
<td>Due from General Funds</td>
<td>0</td>
<td>2,208</td>
</tr>
<tr>
<td>Land, buildings and equipment</td>
<td>876,353</td>
<td>876,353</td>
</tr>
<tr>
<td><strong>Total — Endowment and Special Funds</strong></td>
<td><strong>$20,260,535</strong></td>
<td><strong>$12,590,572</strong></td>
</tr>
</tbody>
</table>

### Temporary Funds:

<table>
<thead>
<tr>
<th></th>
<th>1967</th>
<th>1966</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$30,921</td>
<td>$18,746</td>
</tr>
<tr>
<td>Investments</td>
<td>252,815</td>
<td>650,379</td>
</tr>
<tr>
<td>Accounts Receivable</td>
<td>649,161</td>
<td>275,506</td>
</tr>
<tr>
<td>Due from Endowment and Special Funds</td>
<td>1,766</td>
<td>1,024</td>
</tr>
<tr>
<td><strong>Total — Temporary Funds</strong></td>
<td><strong>$934,663</strong></td>
<td><strong>$945,655</strong></td>
</tr>
</tbody>
</table>

### Plant Funds:

<table>
<thead>
<tr>
<th></th>
<th>1967</th>
<th>1966</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land, buildings and equipment (Net)</td>
<td>$18,506,464</td>
<td>$17,875,120</td>
</tr>
<tr>
<td>Construction in progress</td>
<td>625,586</td>
<td>500,130</td>
</tr>
<tr>
<td><strong>Total — Plant Funds</strong></td>
<td><strong>$19,132,050</strong></td>
<td><strong>$18,375,250</strong></td>
</tr>
</tbody>
</table>

### Gross Total — All Funds:

<table>
<thead>
<tr>
<th></th>
<th>1967</th>
<th>1966</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gross Total — All Funds</strong></td>
<td><strong>$46,551,629</strong></td>
<td><strong>$36,968,113</strong></td>
</tr>
<tr>
<td>Less inter-fund accounts</td>
<td>462,393</td>
<td>327,975</td>
</tr>
<tr>
<td><strong>Net Total — All Funds</strong></td>
<td><strong>$46,089,236</strong></td>
<td><strong>$36,640,138</strong></td>
</tr>
</tbody>
</table>

---

(1) Includes $7,102,156 for adjustment to market value.
Liabilities, Capital and Principal of Funds

<table>
<thead>
<tr>
<th></th>
<th>1967</th>
<th>1966</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GENERAL FUNDS:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts and notes payable</td>
<td>$1,221,685</td>
<td>$796,636</td>
</tr>
<tr>
<td>Accrued expenses</td>
<td>228,681</td>
<td>166,628</td>
</tr>
<tr>
<td>Deferred income</td>
<td>205,069</td>
<td>196,870</td>
</tr>
<tr>
<td>Special purpose funds</td>
<td>351,436</td>
<td>336,931</td>
</tr>
<tr>
<td>Due to endowment and special funds</td>
<td>0</td>
<td>2,208</td>
</tr>
<tr>
<td>Working capital</td>
<td>4,217,510</td>
<td>3,557,363</td>
</tr>
<tr>
<td><strong>Total — General Funds</strong></td>
<td><strong>$6,224,381</strong></td>
<td><strong>$5,056,636</strong></td>
</tr>
</tbody>
</table>

| **ENDOWMENT AND SPECIAL FUNDS:** | | |
|-----------------|-----------------|
| Principal of Funds | | |
| Free Bed         | $4,169,637 (2)  | $2,634,975  |
| Restricted and non-expendable | 3,519,016 (2)  | 2,223,804  |
| Unrestricted     | 1,013,473 (2)   | 26,002      |
| William Wirt Winchester | 11,517,538 (2) | 7,550,527  |
| Due to General Funds | 39,105 | 154,240 |
| Due to Temporary Funds | 1,766   | 1,024      |
| **Total — Endowment and Special Funds** | **$20,260,535** | **$12,590,572** |

| **TEMPORARY FUNDS:** | | |
|---------------------|-----------------|
| Due to General Funds | $421,522 | $170,503 |
| Principal of Funds  | 513,141         | 775,152 |
| **Total — Temporary Funds** | **$934,663** | **$945,655** |

| **PLANT FUNDS:** | | |
|------------------|-----------------|
| Mortgages and other payables | $1,227,679 | $1,354,625 |
| Capital invested in property and equipment | 17,904,371 | 17,020,625 |
| **Total — Plant Funds** | **$19,132,050** | **$18,375,250** |

| **GROSS TOTAL — ALL FUNDS:** | | |
|-------------------------------|-----------------|
| Less inter-fund accounts      | 462,393         | 327,975      |
| **Net Total — All Funds**     | **$46,089,236** | **$36,640,138** |

(2) Includes appreciation resulting from adjustment of investments to market value.
## Comparative Statistics
For Years Ended September 30, 1967 and 1966

<table>
<thead>
<tr>
<th>Service</th>
<th>1967</th>
<th>1966</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients discharged during the year</td>
<td>30,488</td>
<td>29,811</td>
</tr>
<tr>
<td>Patient days care rendered</td>
<td>251,990</td>
<td>246,005</td>
</tr>
<tr>
<td>Average length of patients' stay (days)</td>
<td>8.3</td>
<td>8.3</td>
</tr>
<tr>
<td>Average daily patient census</td>
<td>690</td>
<td>674</td>
</tr>
<tr>
<td>Clinic visits</td>
<td>119,545</td>
<td>111,856</td>
</tr>
<tr>
<td>Emergency service visits</td>
<td>56,666</td>
<td>53,566</td>
</tr>
<tr>
<td>Operations</td>
<td>12,841</td>
<td>12,140</td>
</tr>
<tr>
<td>Recovery Room cases</td>
<td>9,074</td>
<td>9,028</td>
</tr>
<tr>
<td>Deliveries</td>
<td>4,326</td>
<td>4,663</td>
</tr>
<tr>
<td>Anesthesias given</td>
<td>15,488</td>
<td>15,311</td>
</tr>
<tr>
<td>Radiology examinations</td>
<td>85,548</td>
<td>82,618</td>
</tr>
<tr>
<td>Laboratory examinations</td>
<td>906,148</td>
<td>815,169</td>
</tr>
<tr>
<td>Physical Therapy treatments</td>
<td>25,598</td>
<td>25,186</td>
</tr>
<tr>
<td>Electrocardiology examinations</td>
<td>18,953</td>
<td>17,418</td>
</tr>
<tr>
<td>Electroencephalography examinations</td>
<td>1,837</td>
<td>1,636</td>
</tr>
</tbody>
</table>
### Discharges
For Years Ended September 30, 1967 and 1966

<table>
<thead>
<tr>
<th></th>
<th>1967</th>
<th>1966</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADULTS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gynecology</td>
<td>2,268</td>
<td>2,128</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>4,704</td>
<td>4,764</td>
</tr>
<tr>
<td>Psychiatry (Tompkins)</td>
<td>131</td>
<td>115</td>
</tr>
<tr>
<td>Radiology</td>
<td>80</td>
<td>42</td>
</tr>
<tr>
<td>Medicine</td>
<td>5,205</td>
<td>5,052</td>
</tr>
<tr>
<td><strong>Surgery:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>450</td>
<td>410</td>
</tr>
<tr>
<td>Dental</td>
<td>239</td>
<td>200</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>720</td>
<td>801</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>650</td>
<td>612</td>
</tr>
<tr>
<td>Orthopedic</td>
<td>1,279</td>
<td>1,343</td>
</tr>
<tr>
<td>Otorhinolaryngology</td>
<td>829</td>
<td>791</td>
</tr>
<tr>
<td>Plastic</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Thoracic</td>
<td>197</td>
<td>212</td>
</tr>
<tr>
<td>Urological</td>
<td>1,310</td>
<td>1,369</td>
</tr>
<tr>
<td>General</td>
<td>4,072</td>
<td>3,992</td>
</tr>
<tr>
<td><strong>Total – Adults</strong></td>
<td>22,139</td>
<td>21,838</td>
</tr>
</tbody>
</table>

| **CHILDREN**           |       |       |
| Medical                | 1,461 | 1,358 |
| Surgical               | 2,314 | 1,943 |
| **Total – Children**   | 3,775 | 3,301 |

| **NEWBORN**            |       |       |
| Normal                 | 4,092 | 4,246 |
| Special Care           | 482   | 426   |
| **Total – Newborn**    | 4,574 | 4,672 |
| **Total – All Patients** | 30,488 | 29,811 |

### Patient Days
For Years Ended September 30, 1967 and 1966

<table>
<thead>
<tr>
<th></th>
<th>1967</th>
<th>1966</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADULTS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gynecology</td>
<td>12,855</td>
<td>11,383</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>18,872</td>
<td>19,844</td>
</tr>
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<tr>
<td><strong>Total – Adults</strong></td>
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| **CHILDREN**           |       |       |
| Medical                | 14,547| 13,011|
| Surgical               | 11,966| 11,268|
| **Total – Children**   | 26,513| 24,279|

| **NEWBORN**            |       |       |
| Normal                 | 17,399| 19,392|
| Special Care           | 7,040 | 4,717 |
| **Total – Newborn**    | 24,439| 24,109|
| **Total – All Patients** | 251,990 | 246,005|
**Clinic Visits**

For Years Ended September 30, 1967 and 1968

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TOTAL — ALL CLINIC VISITS | 119,645 | 111,856 |

*New Classification
**New Service
†Difference in admission resulting from admission to Connecticut Mental Health Center of patients formerly listed in this category.
+Adjustment to accommodate reclassifications for 1967.
Educational programs sponsored by Yale-New Haven Hospital or conducted in association with other institutions

Cytology Technician
Dietetic Intern
Inhalation Therapy
Intern, Resident and Clinical Fellow training for postgraduate physicians
Medical Technology
Nursing Education:
    Master’s program for nurses at the Yale School of Nursing
    Three-year diploma program at the Grace-New Haven School of Nursing
    Four-year baccalaureate program in association with the University of Connecticut
    One-year Licensed Practical Nurse program in association Eli Whitney Technical School
On-the-job training for Nurse Aides, Division Secretaries, Male Aides
Dietary Aides
Operating Room Technician
Pharmacy Extern training
Physical Therapy
Public Health Specialists
Residency in Hospital Administration
Social Work field experience
X-ray Technology
Form of Bequest

I GIVE, DEVISE, AND BEQUEATH TO THE YALE NEW HAVEN HOSPITAL,

IN THE CITY OF NEW HAVEN, A CHARITABLE INSTITUTION ORGANIZED

UNDER THE LAWS OF THE STATE OF CONNECTICUT, THE SUM OF

$ .................................................................