Yale-New Haven Hospital Annual Report 1968

Yale-New Haven Hospital

Follow this and additional works at: https://elischolar.library.yale.edu/ynhh_annual_reports

Recommended Citation
Yale-New Haven Hospital, "Yale-New Haven Hospital Annual Report 1968" (1968). Yale-New Haven Hospital Annual Reports. 68.
https://elischolar.library.yale.edu/ynhh_annual_reports/68

This Article is brought to you for free and open access by the Yale-New Haven Hospital at EliScholar – A Digital Platform for Scholarly Publishing at Yale. It has been accepted for inclusion in Yale-New Haven Hospital Annual Reports by an authorized administrator of EliScholar – A Digital Platform for Scholarly Publishing at Yale. For more information, please contact elischolar@yale.edu.
This is the 100th time that this hospital has published an annual report. Although the hospital was incorporated in 1826 (under the name of the General Hospital Society of Connecticut), and began admitting patients to a newly constructed “substantial stone building” in 1833, it was not until 1868 that a report was printed for general distribution to replace a yearly statement submitted to the Connecticut State Legislature.

“This has been done,” said the Directors in 1868, “not without the hope that the usefulness of the Institution may be increased by diffusing a knowledge of the good it is doing, and by turning the attention of the benevolent to the necessities of this great public charity.”
More than 100 years have passed since the Civil War soldiers pictured on the opposite page stood at attention in front of this hospital, honoring, perhaps, their good luck in surviving both the war and their battle injuries.

They may have been among the 25,340 wounded soldiers who were brought from the battlefields to this place in order to benefit from its "admirable location on high, dry ground," to which was attributed much of the hospital's success in maintaining a low mortality rate. The battle wounded were treated in 1,500 beds set up in the hospital building and in tents and huts that spilled over the hospital grounds and forced civilian patients to temporary quarters in another part of the city.

Much has happened since then, and much has changed, including the hospital building itself which finally outlived its usefulness and was torn down in 1930 to be replaced by the main section of the New Haven Unit as it stands today.

The scene may have shifted but, philosophically, the staff and the Board of Directors of this hospital today are still striving, as their predecessors did in 1868, to "conduct it in the most economical way, consistent with the welfare of patients."

The Annual Report of Yale-New Haven Hospital for 1968 is also a departure from tradition. Instead of presenting narrative accounts from various hospital departments, this year's report is presented in the form of interviews with the individuals who are responsible for the conduct and direction of this institution, and who serve it with pride and energy.

At the outset is a recorded conversation among three men to whom the patients of this hospital, the community it represents, and the professional persons associated with it look for official guidance. They are: Mr. Charles H. Costello, President, Board of Directors, Yale-New Haven Hospital; Mr. Charles B. Womer, Director, Yale-New Haven Hospital; and Courtney C. Bishop, M.D., Chairman of the Medical Board, Yale-New Haven Hospital and Clinical Professor of Surgery, Yale University School of Medicine.
Mr. Costello: I'd like to begin by pointing out that the hospital has been governed by a lay board of directors since its inception, although the early members took a much more active part in day-to-day operations than we could hope to do today.

As a matter of fact, 100 years ago the chairman of what was then called the Prudential Committee had to give his permission for patients to be admitted to the hospital, and he even set their weekly rates.

While this direct involvement is out of the question in our time, our board of directors still has much in common with those early citizens in that our 24 members try to balance the scales between what the hospital is able to offer in service and what the people of this area need.

I guess the three of us represent the forces of activity that weigh upon those scales and keep them moving in a constant striving toward perfect accord.

You, Doctor "Pete" Bishop, represent the more than 1,300 physicians who are associated with this institution, either as fulltime teaching physicians, physicians in specialty training, or as community physicians who entrust the hospital care of their patients to us.

I represent the board of directors which in turn represents the patients themselves and the community which looks to this institution for reassurance when its health is threatened.

And you, Chuck, are caught in the middle. You have to tend the store and see that nearly 3,000 employees are ready, equipped and trained to handle every possible medical problem that arises.

Since our primary function is to provide the best patient care we can, I wonder if you, Pete, would describe the Medical Board and how it correlates the activities of the physicians of the Medical Staff.

Dr. Bishop: The Medical Board is charged with the responsibility of developing and recommending the professional policies of the hospital to its board of directors as the ultimate authority, and receiving from the board in return its mandate to deliver quality patient care to patients.

It represents all of the professional activities of the hospital and includes as its members the chiefs of service of the clinical departments: medicine, obstetrics & gynecology, pediatrics, psychiatry, radiology and surgery.

In addition, three other departments are involved because of their peculiar responsibilities in developing and supplying professional and technical assistance in the care of patients, the departments of anesthesiology, clinical laboratories and pathology which are represented by their respective chiefs.

Mr. Costello: What is the difference between the various staff groups within the hospital? This often confuses people on the "outside."

Dr. Bishop: Because of the unique characteristics of this institution, which is a teaching hospital for the Yale School of Medicine and at the same time a community hospital concerned with the care of private patients who have their own private physicians, there is something of a marriage between university titles and hospital titles.

Those persons who are salaried members of the teaching faculty of the Yale School of Medicine are defined as fulltime faculty.

Physicians who are primarily private practitioners in the community but
because of their interest, unusual skills and abilities are included in the teaching faculty on a part-time, non-salaried basis, are called the part-time faculty.

Over and beyond these, which fundamentally are university titles, are appointments made within the hospital structure itself, and these persons are known as the resident staff. For broad purposes of conversation, these persons are referred to as the house staff and clinical fellows; they are postgraduate students acquiring advanced training in a variety of specialties.

In addition, we have the professional staff. This is a limited number of persons who have a high degree of expertise in scientific efforts that relate, on occasion, to the treatment of patients. These might include physicans interested in equipment in the radiology department, for example, or audiologists who provide important assistance to the otolaryngologist in problems of deafness, and so on.

We also have members on the staff who do not hold faculty appointments.

**Mr. Costello:** What is the value of the combination of a teaching hospital and a community hospital as far as patients are concerned?

**Dr. Bishop:** It provides extraordinary strength in the medical education of physicians of the next generation — and provides top-flight professional care for patients seeking treatment at the present time.

Many years ago a surgeon friend of mine from another city described the physician of the teaching hospital as the locomotive on a train, pointing out that no train would be effective without the leadership and application of energy derived from the locomotive. The cars of the train, he thought, represented the various medical disciplines which need the direction and stimulus of university oriented research to develop new ideas in basic, scientific effort as well as in clinical application.

I suppose I am dating myself when I speak of locomotives. Perhaps I should use the modern jetliner with its complement of passengers as an example, but the analogy is the same, and I think, a good one.

**Mr. Costello:** You have been around a long time and have seen Yale-New Haven grow, develop and change considerably over the years.

As you look ahead, what do you see as the major changes and developments that might take place in say five or ten years?

**Dr. Bishop:** It seems to me there will be two principal areas in which progressive change will occur.

First, fruition of the effort — which has been expended in the last 25 years — to develop the integrated approach, the combination of the teaching hospital and the community hospital, to an even greater extent.

Secondly, it would seem clear to me that the trend of medical care in this country is such that the hospital is destined to become the central agency, or the purveyor of health services for regions or communities, designed to house highly trained specialists equipped with the best of new devices and oriented to the delivery of optimal patient care; an organization through which the specialist can achieve the ultimate effect of his skill.

**Mr. Costello:** How about the immediate past? What do you think our more significant accomplishments this last year have been?

**Dr. Bishop:** In the clinical area I would say the transplant program, which so far has been confined to kidney transplantation. This accomplishment has laid the groundwork for similar transplant procedures in other organ systems.

On a wider scale, the dialysis program for treating severe kidney disease represents an extraordinary contribution to the health services of the entire State, and will become even more so as other institutions are equipped to provide similar service.

In terms of philosophy, I think it is extremely significant that surgical and non-surgical groups are thinking together in terms of the old and rigid lines of division between disciplines. They are now working toward alignments that are more logically directed to the whole patient, and in the case of transplants, entire organ systems. This is truly a growing team approach among a variety of disciplines and I am sure it will continue.

I think we are also seeing significant changes in the pattern of appointments being made to the hospital staff. They are being made according to the needs of the hospital for certain skills and the candidate's ability to function as a teacher and as a member of the teaching group. The emphasis is toward strengthening the teaching faculty and I consider this a step forward and in the right direction.

In addition, I think it is also significant that within the past year there has been expansion in the number of beds available for teaching by assigning medical students to the surgical divisions of the private patient services in the Memorial Unit. The information I have received indicates this effort has been accepted easily, readily and well by patients, physicians and students involved.

**Mr. Costello:** You've been pretty quiet, Chuck, but I can see that you have something to say about progress this past year. From your spot as director of the hospital what do you consider significant?

**Mr. Womer:** I guess I would describe the most significant accomplishment as being a subtle one — and that is the changing point of view, or approach, on the part of the whole hospital staff in addressing the health needs of the community. During the past year we have become really involved in a wide variety of programs and we are committed to tackling many of them somewhat differently than we have in the past. We are listening hard to the concerns expressed by the community, and we're making changes.

**Mr. Costello:** Are you speaking of changes within the hospital function itself, or of those that take us beyond its walls?

**Mr. Womer:** I think we are talking about changes that affect attitudes on both levels.

For example, we have established a formal program to identify promotional opportunities for employees who are capable of holding better jobs, and we have created a new position in our personnel department for just this purpose. We hope to reach and keep employees who see the possibility of advancement opportunities. We have also made improvements in wage and employee benefits.

We are also making a real effort to improve communications with patients. An example has been the addition of bilingual patient relations personnel in the Emergency Service and in the clinics to assist all patients who find communications difficult in a large organization as well as those with specific language barriers. We hope to expand this activity to the inpatient services during the coming year. In addition, a Department of Religious Ministries has been created to expand our chaplaincy program.

All in all, we are seeing an improved and increased emphasis on providing sensitive as well as good technical care among
Mr. Costello: But we still have the problem of the shortage of beds. A number of persons have complained to me that it takes a long time to be admitted to the hospital.

Mr. Womer: As we both know, a bed shortage does exist in New Haven. There are waiting lists at both hospitals for admission for non-emergency conditions.

Hopefully we will be able to relieve the situation somewhat by adding two floors to the Memorial Unit. You will recall that when the Memorial Unit was constructed it was designed for the possible expansion of a ninth and tenth floor. We hope to make definite recommendations to the board of directors in regard to this in the very near future.

Mr. Costello: The problem is more than just adding beds, isn't it?

Mr. Womer: That's right. We have to develop new and better patterns of providing care designed to keep "patients on their feet," instead of hospitalizing as many as we do today.

Mr. Costello: The financial statements for this past year show a steady improvement in the hospital's financial condition. Would you say we are "out of the woods" in that regard?

Mr. Womer: There's been an improvement in both our operating results and cash position, but I don't think we could say we're "out of the woods." I am pleased that during the past year we did not have to worry on Tuesday about how we were going to meet the payroll on Friday, as we have done in some instances in the past, but we certainly are not what you would call financially "healthy."

Changes in reimbursement procedures by both Medicare and Blue Cross have helped ensure that we have cash available to meet payrolls and pay bills, but we still are unable to keep up with our needs for new services and new equipment.

Mr. Costello: One of the basic problems seems to be the inexorable growth in accounts receivable. I noticed they increased more than $600,000 this past year and money in accounts receivable is not money that is available to spend.

Mr. Womer: While a considerable proportion of the increased accounts receivable is merely a reflection of the significant increase in our total billings, we are making strenuous effort to improve our billing and collection procedures, and hopefully we'll see results during the coming year.

Mr. Costello: Many people are confused about the financial relationship between Yale and the hospital. I often explain to them that Yale and the hospital are financially independent of one another and that the expenses of the hospital must be met by income generated by the hospital.

Mr. Womer: You are correct. The affiliation with Yale is very beneficial to the hospital and to the community in many, many ways, but there certainly is no outright grant of funds from the University to support the hospital.

Mr. Costello: I asked you before what you thought the significant accomplishments of the past year were. Now I'll give you a chance to complain a little — what do you consider the most significant frustration?

Mr. Womer: Our inability to move forward decisively with regard to the development of new and modern facilities. The Medical Center planning group, which as you know is a joint enterprise of the Yale School of Medicine and the hospital, has started developing a new master plan for the Medical Center. But I foresee a considerable problem of financing to implement the plan once it is developed.

Mr. Costello: In the meantime, we have to keep renovating and refurbishing as the needs arise.

Mr. Womer: Actually we have accomplished a great deal this past year. Fitkin II has been modernized, the Dana podium has been completed with new space for x-ray services and renovated clinic areas, and a new surgical intensive care unit is being constructed in the New Haven Unit. But I am speaking of the desperate need for new facilities to replace the New Haven Unit. It is outmoded and cannot be expanded in any reasonable way. What we are doing is putting new parts in an old car and continually repainting it.

As we have discussed many times, the cost of such facilities improvements will be very expensive. To meet this cost I believe the financial needs of urban medical centers, such as ours, and teaching hospitals, such as ours, must be given serious national attention if we are ever to come close to realizing our common health goals.

Certainly our problems are shared by most other private university medical centers. The only solutions I know are generous community support and a tremendous infusion of tax funds through the government.

Mr. Costello: What do you predict in regard to hospital costs?

Mr. Womer: I know it won't make anybody very happy, but I see nothing ahead but a continuation of the rising trend. Salaries and benefits will probably keep going up until the gap between hospitals and business and industry generally is closed.

New medical advances are extremely expensive to translate into patient care, both in terms of the skills of personnel and in the costs of equipment and facilities.

I really see no way of solving this increasing cost until we as a nation view these expenses as we do the cost of providing other services for the nation as a whole.
Dr. Bishop: One of our most exciting programs, Phil, is the dialysis program for treating acute kidney disease. Can you tell us what progress is being made in this effort?

Dr. Bondy: It is difficult for me to say exactly how many patients have been treated. The hemodialysis program—which uses the artificial kidney machine outside the patient's body—has a capacity of four patients at a time and can be used for two such sets, so we can take care of eight patients at once. This program is always functioning at full capacity in the new dialysis unit on the second floor of Fitkin.

In addition, there are a varying number of patients who are being treated by repeated peritoneal dialysis, the procedure which does not require the use of an artificial kidney machine.

This entire program has resulted in considerable prolongation of life. One patient has been kept alive by peritoneal dialysis for more than two years. It is possible that she would not have survived more than a month or six weeks if this treatment had not been available.

We have been successful in training a number of young doctors in the principals of dialysis, and peritoneal dialysis programs are now actively underway in a number of area hospitals such as Waterbury Hospital, Hospital of St. Raphael, Danbury Hospital and so forth.

These programs are integrated with our own. Patients who are treated in these programs frequently start dialysis at Yale, then are referred back to their local hospital and finally may come back to Yale for a transplant when this becomes available.

We anticipate expanding the network of dialysis programs and hope ultimately that most hospitals in Connecticut will be able to offer this service to their patients.

Mr. Womer: What areas of basic research are underway in your Department?

Dr. Bondy: People in the Department of Medicine are pursuing a variety of different questions which range in scope from the most basic kinds of research to questions which are of immediate practical importance.

For example, we are studying the application of transplantation techniques to kidney disease and of a variety of different drugs which may be used in the treatment of hypertension of peptic ulcers and so forth.

Work on new drugs is of particular immediate practical importance. A great deal of progress has been made in developing new methods of treating malignant tumors at Yale. New drugs are under study which prevent the release of acids of the stomach and these may revolutionize the treatment of certain kinds of ulcers. There is a great deal of interest in the study of factors concerned with blood clotting and some of the research in this area may have important practical value in treating patients whose blood does not clot properly. It is difficult to single out any particular area because almost everyone in the Department is doing active research and much of this is at least reasonably practical in terms of application to patients.

Mr. Womer: Since the unification of the Medical Staff in 1960, and the affiliation of 1963, what is your opinion of the progress of the coordination, or integration, of the Medical Staff?

Dr. Bondy: The most important single step forward in the Department of Medicine has been the development of a productive teaching program in the Memorial Unit. This has occurred partly because we were able to provide more house staff and students and partly because the doctors in the Memorial Unit were anxious to undertake such a teaching program. The result has been a great improvement in the relations between the faculty and the house staff on the one hand and the physicians in practice in the community on the other.

There is no question that patient care has been improved and the opportunity for mobilizing the entire resources of the Medical Center has been expanded. The improved physical situation on Fitkin I and II and the opening of beds on the eighth floor of the Memorial Unit for medical patients have all been helpful in relieving partially the pressure for beds.
The most pressing problems are concerned with beds however. We are seriously deficient in the number of beds available for patients with medical disease, and the accommodations I just mentioned don’t really begin to handle the problem. As a result, many doctors in the community are upset at the difficulty they have in admitting patients to the hospital, but in all fairness it should be said that the doctors on the full time staff are terribly pinched as well.

Dr. Bishop: *Within the discipline of Internal Medicine, what do you foresee as the trend of inpatient service as opposed to ambulatory care?*

Dr. Bondy: A number of diseases which used to be very major have become relatively minor because of our improved ability to treat them. For example, improved antibiotics have made pneumonia and certain other bacterial diseases amenable to ambulatory treatment, and the increased flexibility provided by stronger diuretics and more rapidly acting digitalis preparations have made it possible to keep many patients with congestive heart failure in a fairly adequate state of function without admitting them to the hospital. These and other types of diseases which previously required hospitalization can now be handled as ambulatory problems and in fact should be so treated.

On the other hand, a number of problems have arisen because we can keep patients alive longer. The entire hemodialysis program, for example, provides a major group of new patients who are now alive whereas they previously would have been dead.

Our increased ability to handle problems of patients with heart attacks is permitting these patients to live much further into congestive heart failure before they ultimately become so sick that we cannot treat them.

Some of these may later be candidates for heart transplants in which case they will once again have a new lease on life and present problems in prolonged treatment for the hospital and its supporting services. The population in general is becoming older, and our increased ability to keep patients alive is resulting in a great many more patients with chronic disease. As a result the characteristics of the patient population are changing. We have more old people, we have more people with chronic disease, we have more people with major complications. The full time service in particular also serves as a referral center for difficult problems from all over the State, and in fact, from all over the world. This increases the pressure on the hospital because these patients require special types of supporting treatment and diagnostic methods. As Yale has grown in stature the demand for such special techniques has increased.

It is impossible to be sure what will happen in the next few years, but it seems likely that the trends I have mentioned will continue. We will be forced increasingly to use our ambulatory service potential to treat patients whom we can avoid hospitalizing.

Dr. Bishop: *What do you see as the newer and significant elements in tomorrow’s approach to medical education?*

Dr. Bondy: The undergraduate student should come in contact with patients early and should be offered an opportunity to learn both the technical aspects of medical care and the psychological and social factors which enter into this. We are making considerable progress in some of these areas, but in others it is difficult to advance because our orientation in the past has been more toward acute medicine and less toward the type of chronic disease we are now apt to deal with. However, the students themselves are interested in expanding their horizons and the opportunity for this will have to be offered to them.

In graduate and house staff training, there is an increasing tendency toward specialization which is entirely appropriate and should be encouraged as long as the overall responsibility for the sick person is not lost sight of in the special interest in medical technology. There is an increasing cooperation between medicine and its sister clinical disciplines which will ultimately result in developing multidisciplinary teams concerned with clinical problems rather than the specific orientation of Medicine, Surgery, Pediatrics and so on. Steps in this direction have already been made and further such develop-
Mr. Womer: One of the real accomplishments this past year, Ed, has been progress made on the fetal monitoring system — the ability to monitor the heartbeat of the unborn infant by means of electronic equipment. Where do we stand on this unusual project?

Dr. Quilligan: Actually, this year has been the climax in that it has been one of visual accomplishment. Equipment is now refined to the point that it is being readied for extensive use. This has followed many years of hard work on the part of Dr. Edward H. Hon, Associate Professor of Obstetrics & Gynecology and chief of the section on perinatal biology, and his colleagues.

Mr. Womer: How many years have gone into it?

Dr. Quilligan: Dr. Hon has been working on the electronic monitoring phase of this program for about 13 years, but people were trying to establish fetal heart rate patterns as long ago as the turn of the 18th century by using stethoscopes of various design.

Currently, we are working toward the possibility of monitoring several babies simultaneously. Within a short time we hope to have equipment installed in at least four labor rooms and one delivery room so that we can monitor five patients at the same time.

Hopefully, this will make it possible for us to monitor all our “high risk” babies, those for whom there is some doubt as to normal delivery.

Dr. Bishop: Of course, we’re encouraged by what this means to the mother of the “high risk” baby as well.

Dr. Quilligan: Indeed we are! Obstetricians have long been concerned for mothers who were delivered by cesarean section for what appeared to be, by stethoscopic soundings, fetal distress. But when the babies were delivered, it was quite obvious there was no distress at all. We hope to reduce this kind of needless surgery.

We have learned, by using the fetal monitoring equipment, that certain patterns of the fetal heartbeat are produced for various reasons. By recognizing which patterns are innocuous as far as the baby is concerned, and which may be danger signals, we are able to manage the mother more intelligently in terms of whether or not surgery is needed.

As far as the infant is concerned, it also means a great deal. We would be the first to say that not all mentally retarded children are mentally retarded because something happened in labor. But there are a certain number of children who undoubtedly fall into either the severe or minimal brain damage syndrome who suffered “insults,” during the process of labor and delivery. By being able to recognize whether or not they are being subjected to insults, we can shorten labor or lessen the risk in certain cases.

It also permits us to use means other than cesarean section to relieve the situation. Sometimes giving high concentrations of oxygen to the mother, or something as simple as changing her position during labor may alter the crisis pattern for the baby.

Mr. Womer: Infant mortality rate in this country is considerably higher than it is in some other countries. What is the figure and what do you think contributes toward it?

Dr. Quilligan: The figure that’s usually given is that we’re 14th in the world in perinatal mortality, Holland and the Scandinavian countries being the first three. The reasons for our poor record are varied and difficult to assess, however, there are some apparent factors.

In the first place, perinatal mortality among our non-white population is five times as high as it is in the white population. The perinatal mortality among the poverty groups, regardless of ethnic background, is also significantly higher than it is among the non-poverty groups.

Mr. Womer: Do you think environment, malnutrition are factors?

Dr. Quilligan: Some people believe it is due to poor nutrition and poor use of medical assistance available. Other things enter into the picture which we readily don’t understand. Even with the huge disparity between the private and non-private patients, if we took the private patients only, we still wouldn’t be the best in the world. I think this demands an explanation, but here again, explanations are varied. It has been pointed out that we are a mixed culture; that we do not have the relatively pure background that one finds in Holland and the Scandinavian countries. This may have an influence on perinatal mortality.

Mr. Womer: Has our record been improving?

Dr. Quilligan: Not significantly.

Mr. Womer: Do you expect that it will over the next five or ten years?

Dr. Quilligan: Well, I hope so. But you know, I don’t think we should delude ourselves into thinking we can improve it immediately. One of the things frequently pointed out as a difference between us and the countries with lower mortality rates is the ability to obtain and use hospital care.

The Scandinavian countries have no problem admitting a woman to the hospital for six weeks or three months if she’s a high risk pregnancy. They feel she should be in the hospital.

In this country, to admit a woman to the hospital for six weeks or three months would be catastrophic financially and frequently catastrophic for the rest of the family because there would be no one to take care of other children.

So — we find ourselves not being able to provide what we know is optimal medical care simply because of the shortage of beds and the high cost of hospitalization.

I think all of these factors contribute to our higher perinatal mortality rate.
Dr. Bishop: In addition to the fetal monitoring program, what other significant programs are underway in your department?

Dr. Quilligan: A particularly exciting one is in our section on neo-natal biology which involves early reproductive biology; the phenomena that go with fertilization and implantation.

There are a group of investigators in our reproductive biology section, headed by Dr. John McLean Morris, Professor of Gynecology, and his staff of Dr. Robert H. Glass, Assistant Professor of Obstetrics & Gynecology, and Dr. Mildred K. Gordon, research associate, in the department, and others who are working on various new methods of contraception.

At the other end of the spectrum, work is going forward on studies in endocrinology and infertility.

While we hear a great deal about the population explosion, however, there are some families who are desperate because they can’t explode the population in their own particular instance. Dr. Nathan G. Kase, Associate Professor in the department, and his colleagues have been investigating means of producing ovulation in a patient who does not do so spontaneously, in an effort to understand the mechanisms of ovulation and steroid chemistry.

Mr. Womer: A great deal of attention has been given in recent months to the hospital’s “stepping out” beyond its own walls. I think the Department of Obstetrics & Gynecology was one of the first at this hospital to do so. I’m speaking of the unwed mothers’ program. Has this progressed in the past year?

Dr. Quilligan: I think we have been able to provide an excellent service for these young girls. We have changed the program, somewhat, in that we now have midwives actively engaged in it. It is essential to call upon trained personnel in the paramedical fields to assist us if we are to give the kind of service we should.

We have taken other steps into the community, as well. One is the direction of family planning in which we have cooperated with the City Health Department and the Family Planning Association of New Haven to assist them in any way we can. I think this has been a reasonably successful effort.

Mr. Womer: Now, I’m going to ask you a sneaky question. Would you care to hazard a guess as to what will be the most significant developments in the field of obstetrics and gynecology during the next five to ten years?

Dr. Quilligan: I suspect that within the next five years or so, we will see more chemotherapeutic efforts toward correction of cancer. Certainly the treating of chorio carcinoma, a highly malignant tumor, with methotrexane, has been an important advance. Hopefully, some of the other feminine cancers such as ovarian carcinoma, carcinoma of the cervix, will be treated in a more rational way with chemotherapy in the next period of time.

Dr. Bishop: I think, Ed, one of the concepts that many people find difficult to understand is the realistic contribution that basic research has made to taking care of patients. Certainly the fetal moni-
Charles D. Cook, M.D.
Chief of Pediatrics; Professor and
Chairman, Department of Pediatrics,
Yale University School of Medicine

Dr. Bishop: I know your department has given a good deal of attention to developing a program for the care of adolescents.

Dr. Cook: That's correct; we have been very fortunate to have a new ward designed primarily for them.

Dr. Bishop: In your experience what problems arise in taking care of adolescents that make a special unit and a special program desirable?

Dr. Cook: Adolescents, of course, have many of the same physical illnesses other patients have, but they often feel uncomfortable when they're in the same area with small infants or children. And also, they frequently have emotional problems related to their illnesses and need especially trained personnel to cope with their total care.

We have been fortunate in having Dr. J. Roswell Gallagher, one of the country's leaders in the care of adolescents, here to consult about this program and for the past six months we have had Dr. Walter Anyan as director of it. The program has been primarily concerned with inpatients and includes special attention on many levels: nursing, social service, psychiatric and general environment. We feel it is proving extremely worthwhile.

Dr. Bishop: Would you describe your department's role in developing the Hill Child Health Center here in New Haven?

Dr. Cook: Several years ago a number of full-time and part-time members of the department felt it would be important for pediatrics in general, and pediatrics at Yale in particular, to be involved in more community health programs than we had been previously.

In cooperation with the Connecticut Mental Health Center and with encouragement from Dr. F. C. Redlich, Dean of the School of Medicine, we set out to try to get support for a comprehensive program to take care of children in one of the needy areas of the city.

The Hill area was chosen because it had major unmet health needs, because it was contiguous to the hospital and because the Connecticut Mental Health Center already was involved in a program of its own in the same area.

Mr. Womer: I am often asked about the Hill Child Health Center, and the question seems to be, "Why is it needed?"

Many ask, "Isn't it a duplication to have a separate health center less than a mile from the hospital?"

Dr. Cook: This certainly is a valid question, but it's our belief that many parents in areas such as the Hill tend to seek medical care at the hospital for their children only for emergencies and "episodic" treatment.

We hope, by having a well-staffed and equipped health facility in the neighborhood itself, parents will be more apt to use it for continuing, comprehensive child care. The Center incidentally is located at 428 Columbus Avenue in a nicely renovated building.

Dr. Bishop: Some of the basic aims are preventive and health education, too, aren't they?

Dr. Cook: Certainly. We feel an important aspect of the Hill Child Health Center is involvement by the neighborhood itself so that, instead of imposing a health care system on them, the people themselves will help with a medical program, both from the standpoint of planning as well as actual functioning. Many persons from the neighborhood already are actively involved.

This involvement, incidentally, is what makes our Hill program unique among other proposals made to governmental agencies.

Mr. Womer: Your department has also worked hard toward improving the emergency service and creating a "convenience clinic" during this past year. Would you discuss these?

Dr. Cook: As you know, we are trying to decrease the number of pediatric patients going through the Emergency Service. It is becoming too great a number to be handled in the ordinary way. Now we are directing patients with less emergent problems to a "convenience clinic" in the pediatric outpatient department.

Patients coming to the emergency suite between 8 in the morning and 4 in the afternoon will be seen immediately, of course, and then if the problem is not of an emergency nature, they will be given an appointment to be seen in the convenience clinic later that same day.

Scheduling of this kind is absolutely necessary when you realize that between 50 and 60 children are brought to our Hospital's Emergency Service every day.

Dr. Bishop: Turning now to another important area, what has the kidney transplant program meant to your department?

Dr. Cook: Approximately half of the patients who have had kidney transplants in this hospital have been children.

We not only have to cope with the very complicated medical problems of these children, but with the emotional problems attendant with them and those of the families who have had to face such acute situations. The program has given us the opportunity to work closely with members of the Departments of Medicine and Surgery.

Mr. Womer: I am aware that you have managed, through planning and persuasion, to establish a new internship, a combined medical and pediatric internship. I think we have one intern this year and will have two in the program next year. What do you consider is the long range significance of this?
Dr. Cook: I believe that the practice of pediatrics in the future will, at times, be combined with the practice of internal medicine. Thus, we are anxious to train physicians in both pediatrics and medicine who may then go on into the practice of “family medicine.” These doctors may also be interested in community medicine or in the public health aspects of medical practice.

To some extent these “internists for all age groups” may replace the old time general practitioner who was expected to know pediatrics, internal medicine, obstetrics, surgery, orthopedics and just about everything else.

Mr. Womer: Going from the general to the specific, what changes in the practice of pediatrics do you foresee here at Yale-New Haven?

Dr. Cook: I think there will be a shift of pediatric patient care from the inpatient to the outpatient areas.

I would also hope that we will work out more efficient means of providing pediatric care through intelligent use of allied health personnel, better record keeping, better communication systems, better case finding, and so forth.

In the future, we should, while continuing to be a community hospital in part, become an ever more important center for referral of patients who need our special facilities.

I also look toward our having more cooperative care and teaching programs with community hospitals throughout Connecticut so that they, themselves, can undertake some of the responsibilities that we currently are carrying.

Mr. Womer: This is a time when great emphasis and attention is given to the young of our society. How would you summarize the area of health care we offer them and their parents?

Dr. Cook: This could be divided into three broad areas of service that make this institution, in many ways, an outstanding medical center. 1) intensive care for newborn infants and for older children, 2) special treatment in almost all types of pediatric diseases; and 3) great strength in pediatric psychiatry and child development through our close association with the Child Study Center.

As a philosophic canopy above all this, is our department’s traditional concern for the whole child and his family. We feel special responsibility for all infants and children admitted to this Medical Center, regardless of their disease or socio-economic status.

Dr. Bishop: You assumed the office of Chief of Psychiatry for the hospital last July, Tom. Could you tell us what you have undertaken since that time?

Dr. Detre: By and large, the problem is really a continuation of what had begun before, namely, the integration of psychiatric services and teaching programs throughout the Medical Center involving the inpatient, outpatient, and consultation services.

Mr. Womer: I know one of the areas of particular concern to you has been the psychiatric emergency service—service for patients who come to the hospital in an acutely disturbed state. You have reorganized the efforts in this regard. Would you explain?

Dr. Detre: In response to the mandate from the Chairman of our Department, Dr. Theodore Lidz, to create comprehensive emergency treatment, we now have a cooperative venture sponsored jointly by the hospital and the Connecticut Mental Health Center.

Daily rotation of residents and supervisors has been replaced by a permanent staff consisting of a senior psychiatric social worker, a chief resident, and a group of senior psychiatric supervisors and residents who spend one month full-time on the service. Besides offering consultation for all unscheduled admissions, we operate a clinic which meets urgent treatment needs immediately.

Dr. Bishop: What do you have in mind for new programs for the coming year?

Dr. Detre: We are on the verge of several new developments. By next year every medical specialty in the hospital will have a senior psychiatric consultant.

Because the staff in a training hospital changes constantly, we put emphasis on
continuity of care in terms of the patient’s relationship to the Medical Center, not just to his respective physician. That is, we provide services as long as the patient needs it, and he has the opportunity of re-referring himself to our facilities any time in the future after his treatment is terminated, if he so wishes.

Starting in February, I will be personally staffing a consultative service for non-psychiatric physicians in the community, giving practical advice in diagnostic and treatment problems in cases they are carrying in their practice.

Mr. Womer: Although you haven’t mentioned it thus far, I know you are very concerned about the shortage of beds for psychiatric patients.

Dr. Detre: Indeed, I am. One of our burning problems is shortage of space. We are constantly ‘over census.’ Since some of our patients spend the night on the unit and are absent during the day, and others come in during the day only, we actually average 120 percent occupancy! Even with overcrowding we can only accommodate one out of every five—or possibly seven—patients who apply to our division.

Dr. Bishop: We are very much aware of the burgeoning demand for psychiatric service in this community, throughout the State and nationally.

What do you foresee, over the next few years as the way of meeting this demand, or do you think it is just plain hopeless to think we can meet it adequately?

Dr. Detre: I don’t think the demand is increasing as much as the nature of the demand is changing. The mandate in the past called for hospitalization, and disturbed people were “sent away.” The emphasis was on good nursing and custodial care and on “safety.” Today both the medical profession and the laymen are far more informed and sophisticated and quite rightly insist that the patient remain in his own community.

The public is aware that many medical illnesses have psychiatric complications, and physicians, for obvious reasons, are more comfortable when their patients are in a psychiatric unit which operates in a close relationship to a medical center because it gives them an opportunity to keep in touch.

There is also a somewhat snobbish point to all of this.

It is one thing for a patient to say that he is hospitalized at the Yale-New Haven Medical Center on the psychiatric division and quite another for him to say he is hospitalized in a psychiatric hospital.

What I am saying is, that despite all efforts to reduce the stigma, it is far more palatable from everybody’s point of view to say, “I am a patient at the Yale-New Haven Hospital.” And if you look at our division, it is not very different from any other medical division—except, perhaps, that people are wearing their street clothes, they walk around a great deal more and have far better appetites than elsewhere.

Dr. Bishop: But aren’t the state institutions, Connecticut Valley and our own Connecticut Mental Health Center, also faced with more demand than they can handle.

Dr. Detre: Yes, they have more of a demand, but the demand consists primarily of a more rapid turnover of patients. It is very difficult to compute what is happening. Actually, more than half of all acute admissions in the United States are handled by the psychiatric services in general hospitals.

That is why it is essential that the communities realize they must help support these facilities and the expansion of beds to handle the problem within their areas.

Dr. Bishop: Don’t you see patients at a different time in their development?

Dr. Detre: Indeed we do, and this is important, too. There is much more attention paid to earlier diagnosis. We are seeing patients today who twenty years ago the psychiatrist probably would have laughed off, saying, “I doubt that there is anything wrong with you.” But early prevention and treatment also give rise to a number of new kinds of patients and new kinds of problems.

And frankly, the treatment problem also becomes somewhat more difficult because many patients now continue in outpatient care and don’t require hospitalization, thus specialty Medical Center psychiatric services are likely to get about 20 to 30 percent of patients whom either the outpatient psychiatrist or another institution could not help.

Dr. Bishop: The increase in demand you describe for the general hospital that sponsors a psychiatric unit—does this increased demand generate within the profession or within patient groups?

Dr. Detre: Both. I think that the public demands it and the professionals have done a great deal to educate the public. And too, everyone is becoming aware of health facilities and health care. Psychiatric care is part of this whole picture.
Mr. Womer: Are there any particular kinds of educational background you look for in hiring nurses at Yale-New Haven Hospital?

Miss Ryle: Our nursing services, of course, select nurses who have a good basic education in nursing. They may be recent graduates of schools of nursing who have completed a baccalaureate program, an associate degree program, or a diploma program.

Others may have a varying amount of experience in a clinical area in addition to their basic education. And still others, and these are in relatively small numbers, might bring a combination of graduate education and experience. This kind of person may be called a "nurse clinician." All kinds of nursing preparation are needed, and welcomed at Yale-New Haven.

Dr. Bishop: Wouldn't you say we are seeking more specialized qualifications in nurses today than we did, say ten years ago?

Miss Ryle: To an increasing extent, yes. We are seeking experienced nurses who can serve as leaders and planners for a health team; who can serve as the chief nurse involved in the management of patient care. These nurses must be capable of planning programs with the physician, the diettitian, the social worker, and so on. They must have knowledge and skill to teach and assist both nurses and other nursing personnel.

Mr. Womer: What altruistic attributes do you seek?

Miss Ryle: We need nurses who are well informed professionally; who understand people, are friendly, instill confidence and are of unquestionable integrity. We need thoughtful persons — individuals with a sense of humor, who can cope with instant change and responsibility.

Mr. Womer: It sounds like a large order, when you list all these qualities together.

Miss Ryle: It is, but we find young people who have chosen the nursing profession usually are interested in being of service to others and have a real sense of commitment.

Dr. Bishop: With such a large nursing staff here at Yale-New Haven, about 900 as I understand it — which of course includes registered nurses, licensed practical nurses, nurses' aides and associated personnel — your lines of organization are sharply defined. Would you describe them?

Miss Ryle: There are two main lines — Nursing Services and Nursing Education.

In Nursing Services, Mrs. Luba Dowling is the department head for the operating and recovery suites in both the Memorial and New Haven Units. The supervisors in each suite report directly to her.

Last April, we appointed Miss Claire O'Neil as Director of Inpatient Nursing Service for all patient care divisions within both the New Haven and Memorial Units.

Mrs. Lisa Trayser, the Associate Director for Nursing Services, is responsible for the clinics; and Miss Evelyn Sturmer is in charge of the Inservice Educational Program. All of these individuals report directly to the Director, Division of Nursing.

This allows nurses responsible for specific areas to concentrate on the improvement of nursing practice and care — and to develop relationships and continuity of purpose from inpatient service to special services to ambulatory service.

Mr. Womer: Would you review again the programs for nursing education we have here at the Medical Center?

Miss Ryle: We have a 124-week diploma program, the Grace-New Haven School of Nursing program which is offered to qualified high school graduates.

We also take part in the Practical Nurse Education Program at the Eli Whitney Technical School in Hamden which is under the supervision of the Vocational Services of the Connecticut State Department of Education. Students spend four months at Eli Whitney and eight months at Yale-New Haven.

For many years we have also had an association with the University of Connecticut School of Nursing. Their students may spend a summer session and three semesters of their junior and senior years at this Medical Center in earning a combined baccalaureate and nursing degree.

In addition, Yale University offers a graduate program in nursing and uses many clinical facilities of the Yale-New Haven Hospital as part of their educational program.

Dr. Bishop: How about men? I notice we have a male student in training this year.

Miss Ryle: The field of nursing is interested in attracting men as well as women. Men in nursing can play a vital role in the care of patients in the operating room, in the emergency service, and in all clinical services.

Dr. Bishop: Despite the fact that there is a great need for nurses, I've had many tell me they find it difficult to get back into the nursing profession, after they've left to take care of their own homes and families, because of so many changes in the meantime.

Miss Ryle: This is a very real problem and we are trying various ways of helping nurses return to active hospital duty.

For a long time we have offered refresher courses, and while these are successful, many nurses are interested in taking part in an orientation program without having to wait for a course to begin. These orientation programs are designed to fit their particular needs and nurses fit into selected areas extremely well.
Dr. Bishop: RadioLOGY has come a long way since the old x-ray tube and glass film. It has become a major discipline in its own right and one of the principal sections of our hospital. How do you view its progress here, Kligerman?

Dr. Kligerman: I think our progress should be seen as the result of ten years' effort, because it was just ten years ago that the Department of Radiology was established as a fulltime department at the Yale School of Medicine and made responsible for greater clinical duties here at this hospital.

The value of an x-ray department oriented as we are — primarily for service and teaching — is the impact it makes upon research because it is an academic department as well.

When our program was started, I believe there was only one other in the country which could be called an academic department. That was at Stanford University. Since then, we have developed a training program, first in therapy and then in diagnosis. We have gone from a house staff of nine men, originally, to 27 today, and we have seen recognition made of the very distinct difference between therapeutic radiologists and diagnostic radiologists.

We have also established a firm teaching role. It's a rare medical student at Yale who does not take an elective in radiology.

Mr. Womer: We were particularly pleased this past year to complete the construction of x-ray facilities in the podium of the Dana Clinic Building and to improve areas adjacent to the Emergency Service. Would you describe some of the unusual features incorporated in this move?

Dr. Kligerman: The real departure in the concept of this unit is that we have put the neurological x-ray suite and the orthopedic suite next to the Emergency Service. This makes it possible to x-ray trauma cases — which should not be moved — better than any other place I know. The entire facility has been built next to the Emergency Service so that x-ray examinations can be made practically on the spot.

In this connection, we have another unusual innovation. This is the "dispersed darkroom." Instead of having one central darkroom for processing x-ray film, we have a number of small units equipped with the most advanced processing equipment available. We can get a dry x-ray film within 90 seconds, practically in the same room in which it was taken.

This dispersed darkroom idea is now being copied all over the country, but it was started here at Yale-New Haven.

Dr. Bishop: Would you tell us a little about the new program for training x-ray technicians which started in conjunction with Quinnipiac College in September?

I understand that the basic program in x-ray technology is still two years, with time divided between the Quinnipiac campus and our hospital, but the student completing the joint program earns an associate degree which he can use as a base line for moving up to a bachelor's degree in the particular area of his specialization.

Dr. Kligerman: That's quite right. I would like to emphasize that students can acquire particular skills — to become pediatric x-ray technologists, for example, or cardiovascular x-ray technologists, or neurological x-ray technologists.

I think this will help train the kind of paramedical personnel we need to meet the growing demands of our diagnostic x-ray section.

Mr. Womer: I'd like to turn now to a different and fairly new section of your department, and that is nuclear medicine. Since I am a layman, would you explain what nuclear medicine is?

Dr. Kligerman: It is the use of radioactive isotopes to diagnose or treat specific diseases, of the thyroid or liver, for example. Patients may be given a clear, tasteless liquid to swallow, or they may be injected with a solution containing minute quantities of radioactive materials. This material may concentrate in specific organs. Its presence is monitored by "scanning" equipment and by recording the amount and location of radioactivity in a certain gland, we can trace its function or detect changes in its size or shape.

Mr. Womer: Do isotopes tend to settle in different organs of the body?

Dr. Kligerman: Well, "settle" isn't quite as good a word as selectively "retained." It's the physiological retention of certain isotopes in various organs that makes it possible for us to "see" them.

Incidentally, Dr. Richard P. Spencer, chief of the nuclear medicine section, has developed a method of scanning the pancreas by combining two isotopes with a detector device coupled to a computer. We can now begin to see this organ which has never been adequately traced before.

I hasten to add that this needs further development to make it as good a procedure as some of the existing studies, for the thyroid for example. But we have come quite a way toward perfecting it.

As far as treating disease is concerned, radioisotopes are used in such instances as depressing hyperactivity in hyperthyroidism.
space, more personnel.

One of our suites was installed five or six years ago at a cost of $205,000. Now we are trying to create a second one to handle some of the increased load and we estimate it will cost $350,000 today.

Mr. Womer: What you're telling me, in effect, is that we haven't seen anything yet; that the $80,000 we look for today to replace that $20,000 machine of ten years ago could well mushroom into $150,000 five years from now to replace that five-year old machine.

Dr. Kligerman: That's exactly right.

Dr. Bishop: As well as the volume continuing to go up.

Dr. Kligerman: The annual rate of increase in radioisotopes alone is 15 per cent.

I'd like to give you an interesting example in x-ray therapy. Sometime ago I predicted that radiation therapy would level off, simply because of a finite incidence of cancer in the general population. But the number of new patients has not levelled off. It is still going up about 10 per cent a year.

Moreover, as it has been pointed out before, our hospital has taken a lead in community affairs. Our community, although it is primarily greater New Haven, stretches across the State and we even have patients from New York and Boston. As part of this, we undertook the staffing of the Radiotherapy Unit at Uncas-on- Thames. Many of the patients receiving radiotherapy from that eastern part of the State came to us originally -- but now, after five months of operation, Uncas is seeing patients at an annual rate of 350 new cancer patients a year without a significant drop in the caseload at Yale-New Haven.

This means that our Hospital is making greater therapeutic care possible for, let us say conservatively, 350 patients a year who would not otherwise have received it.

This increase in the number of patients receiving care, it seems to me, is the real and continuing achievement of our department as part of this Medical Center.
October 1967
Improved Blue Cross and Major Medical Insurance provided for all employees working more than 20 hours per week.

Medical Center Housing and Community Development Corporation announced to handle coordination of physical development of Yale-New Haven Medical Center and relationship with neighborhood.

Winchester I, a 21-bed medical/surgical patient unit, was renovated.

500 high school teachers, students, guidance counselors toured Medical Center on "Medical Careers Day."

November 1967
12-week ambulance driver course sponsored jointly with Connecticut Ambulance Association and Yale-New Haven Hospital. More than 250 ambulance personnel were trained under previous institutes.

1967 junior volunteer awards were presented to 43 girls and four boys for volunteer service from 100 to 400 hours.

Women's Auxiliary gives $80,000 for renovation and modernization of 29-bed division for medical patients on Fitkin I to include Coronary Care Unit in the New Haven Unit.

December 1967
Workshop on infant mortality sponsored by National Institute of Child Health and Human Development brought physicians, nurses, administrators, architects and government representatives from many parts of the country to Yale-New Haven for 3-day symposium. Focal point was the Newborn Special Care Unit of the Eleanor Naylor Dana Perinatal Center opened eight months earlier.

900 employees enrolled in improved pension plan program which increased monthly retirement benefits with decreased cost to employees.

176 pints of blood were contributed by Hospital "family" during Red Cross Bloodmobile Drive.

The first kidney transplant at Yale-New Haven Hospital, and the first in Connecticut, was performed by Dr. Bernard Lytton, Associate Professor of Urology and Chief of the Section, on December 21.

January 1968
New wage scale for Hospital employees went into effect increasing minimum wage from $1.55 per hour to $1.70 per hour, and salaries from $6 to $13 a week. Sick leave accumulation extended from 36 to 50 days.

February 1968
Three new members were elected to the Board of Directors of the Hospital. They included Philip Paoella, President, Plasticerite Corporation; William B. Ramsey, New Haven attorney; and G. Harold Welch, Jr., broker with White, Weld & Co. They replaced the following members whose terms had expired: Frank O. H. Williams and G. Harold Welch.

"Critical Occupations Program at Yale-New Haven Hospital" evaluated after one year of operation. Campaign to "Bring In A Friend" benefited 44 employees.

Office of Information and Development created to combine public relations and fund raising activities with Donald R. Kleinberg named Director. Albert P. Freije named Director, Hospital Special Services.

Employee education program expanded to include 22 training groups composed of 290 supervisors and department heads as ongoing effort to improve the hospital's communications, work operations and interdepartmental coordination. Lawrence Loomis, Director.

16 of 21 graduates of Yale-New Haven's Licensed Practical Nurse Program accepted positions in hospital after completing 12-month course.

168 hospital employees were honored at service award ceremony recognizing employees with service records ranging from five to 40 years. Special recognition went to Walter Dombroski for 40 years' service; Miss Mary DeCrosta, Miss Martha Hoffman and Edward McKeon for 35 years'; Conrad Fadel, Miss Sophie Pluhowska, and Arthur Tacinelli for 30 years'; and Miss Cora Bagley, Mrs. Loring Cody, Mrs. Josephine Gardner, Miss Virginia MacFarlane, Miss Emily Ruby, Michael Villano, Miss Elizabeth Weber, and Mrs. Thelma Webster for 25 years' service.

March 1968
Women's Auxiliary voted $2,500 as partial funding for salary of Spanish-speaking "Ombudsman" for ambulatory patients.

April 1968
William B. McAllister, M.D., appointed Acting Chief of Pathology to succeed Averill A. Liebow, M.D., who accepted position as Chairman of the Department of Pathology, University of California School of Medicine, San Diego.

80 registered and student nurses from throughout the United States attended "Open House" weekend sponsored by Yale-New Haven Hospital.

Miss Claire O'Neil, R.N., appointed Director of Inpatient Nursing Services. Miss O'Neil came to Yale-New Haven from Strong Memorial Hospital in Rochester, New York.

13 women volunteers were honored for 15 years of continuous in-service work at the hospital.

May 1968
C. Robert Bruckmann appointed Assistant Director with responsibilities for departments of accounting, business services, data processing and systems engineering. Mr. Bruckmann was formerly in charge of Management Services Department in the New Haven office of Ernst & Ernst, international public accounting and consulting firm.

Theodore R. Coleman named to new position as
Assistant Director of Personnel for Career Advancement. Mr. Coleman formerly was vocational counselor for Dixwell Employment Office of Community Progress, Inc.

14 supervisors completed job instruction program conducted by State Department of Education under employment education program.

Yale-New Haven Hospital sponsored press conference for radio, TV, newspaper and national publications representatives on “New Directions in Approach of Modern Health Care.”

55 students were graduated from Grace-New Haven School of Nursing.

June 1968

Second “Open House” of the year for approximately 40 students and R.N.’s. Contract awarded for construction of Intensive Care Unit in New Haven Unit.

Nurse recruitment program evaluation revealed that 40 more full-time staff nurses were employed at Yale-New Haven than had been employed the year before, and 90 more than two years previously.

Proposal to construct parking, housing and other facilities over the Oak Street Connector prepared for presentation to neighborhood as joint effort of the City of New Haven and the Medical Center with arrangements made through New Haven Redevelopment Agency.

E. Richard Weinerman, M.D., resigned as Director of Ambulatory Services to succeed Isidore Falk, Ph.D., as Head of Section on Medical Care of Department of Epidemiology and Public Health of Yale University. Herbert Paris appointed Administrative Director of Ambulatory Services and Daniel S. Rowe, M.D., appointed Chairman of Ambulatory Services Council.

July 1968

Job posting program begun to acquaint employees with job opportunities by displaying lists of positions open throughout the hospital. The job posting forms were prepared for display on seven hospital bulletin boards and are kept up-to-date as new openings occur.

Community Relations Program expanded to include four bi-lingual persons to give assistance to patients in the outpatient clinics and Emergency Services.

Largest house staff in Yale-New Haven’s history took on duties July 1, including 58 interns, 202 residents. They represented 28 medical schools.

10 seminarians and one ordained priest enrolled in Summer Clinical Pastoral Educational Program conducted by Rev. Edward F. Dobihal, Jr., hospital Chaplain.

City-wide disaster drill, “Operation Woodward,” tested coordinated efforts of police, fire, Civilian Defense and emergency facilities of Yale-New Haven Hospital, the Hospital of St. Raphael, and the Veterans Administration Hospital in West Haven.

14 dietitians completed 1-year internship at Yale-New Haven.

Howard A. Pearson, M.D., formerly Professor of Pediatrics at University of Florida College of Medicine, appointed Professor of Pediatrics.

Jules Stollak, formerly Corporate Director of Security for United Nuclear Corp., appointed Director of Security at Yale-New Haven.

August 1968

Certificates of Merit from State Department of Education given to 15 supervisory personnel who completed an 8-week course to improve leadership roles.

Emergency Blood Drive successful. 136 pints of blood collected.

New area in Dana podium completed to include four new x-ray examining rooms, rapid-processing equipment capable of producing dry x-ray films within 90 seconds, and a triage room for evaluating emergency patients. The x-ray suites, x-ray clinic, and the modernization of a portion of the Emergency Service concentrate all these facilities in one service area.

Two Unit Managers assigned to nursing divisions, one on Tompkins 5 and the other on 7 West, in move to help relieve nurses of administrative duties and free them for more bedside nursing care.

Robert Victor Paul Hutter, M.D., distinguished morphologist and diagnostician formerly of Memorial Center for Cancer and Allied Diseases in New York City, named Chief of Pathology at Yale-New Haven Hospital and Professor of Pathology at the Yale University School of Medicine.

28 students in Yale-New Haven’s affiliated program for Licensed Practical Nurses were graduated in joint ceremonies with class from Hospital of St. Raphael.

September 1968

Yale-New Haven Hospital and Quinnipiac College joined forces to conduct expanded programs in Radiologic and Cardiopulmonary Technology.

New wage increase at Yale-New Haven effective September 30, 1968, set minimum wage at $1.95 per hour, up from $1.70 adopted in January, and up 40 cents an hour from the $1.55 per hour adopted prior to that.

Data processing department acquired larger capacity computer to develop improved billing systems and faster processing of paperwork.

Yale-New Haven Hospital joined 20 other Connecticut Hospitals in direct line radio network for communicating disaster and/or administrative information.

135 junior volunteers honored for giving time to the Hospital during summer vacation.

Scholarship fund created at Grace-New Haven School of Nursing as memorial to Miss Helen Rosenthal, Chief Admitting Officer, who died September 5.

Graduation ceremonies held for 15 students who completed one year of clinical laboratory training at Yale-New Haven Hospital and three previous years of college. They received Bachelor of Science degrees from their respective colleges.

First male student to enter Grace-New Haven School of Nursing was among 33 freshmen enrolled for class of 1971.

Renovation of Fitkin II completed. Included 4-bed dialysis unit.
HIGHLIGHTS OF THE YEAR FROM OCTOBER 1, 1967
Dr. Bishop: Before you came in, Jack, Chuck Womer asked me what I thought some of the more significant accomplishments of the past year have been. Among others, I referred to the transplant program. I think it would be appropriate if you gave us some details on the actual accomplishment in this area.

Dr. Cole: That transplant program is one of several major "thrusts" that surgery has embarked upon during the past couple of years, as you well know, and I think it has enjoyed considerable success.

Under Dr. Bernard Lytton, our Associate Professor of Urology and chief of that section, we were able to implement our goals by performing a kidney transplant in December, 1967. That was the first kidney transplant in the State of Connecticut.

I think it should be pointed out, however, that the mechanical transplantation of an organ is but a small part of an undertaking such as this. It's only through the cooperation and help of a great many disciplines that such an effort, I believe, is justified. Were it not for the first-rate dialysis unit headed by Dr. Howard Levitin, the enthusiasm of people in the chemotherapeutic field, in x-ray and infectious diseases, this might not have been possible.

We are pleased and proud of the progress these men have made and I am sure it will continue to expand.

To date there have been ten transplants performed. My most recent information suggests that about 60 per cent of these patients are doing extremely well.

Dr. Bishop: When you refer to "doing well," do you mean that they have reached a capacity to return to former normal activity?

Dr. Cole: For the most part, this is true.

Dr. Bishop: What about other transplant programs?

Dr. Cole: We do hope to expand transplantations to include heart transplants, and in the future, liver transplants and perhaps other organs that will lend themselves to this kind of surgical replacement.

I think it is important to emphasize, particularly in view of the tremendous publicity surrounding it, that transplantation of tissues is not necessarily all that new. As you well know, they have been doing corneal transplants for many years; actually, blood transfusions in themselves, in a manner of speaking, are transplantations. I introduce this note merely to keep the effort in proper perspective. But I think Yale-New Haven has every reason to be justly proud of its accomplishments to date and can look forward to a brighter future.

Mr. Womer: What are the other — you mentioned transplants as just one of the "thrusts" of your department — what are the other major "thrusts?"

Dr. Cole: Another area in which we are extremely interested is in the whole field of trauma — the physical, psychological, and sociological aspects of injury. Trauma, in terms of automobile accidents and injuries has reached epidemic proportions in this country. It's an extremely complex problem. It has to do with highway safety and all of the circumstances surrounding the accident itself, the legal implications, and so on.

We feel that as surgeons we have an opportunity to assume some leadership along with local, state, and federal agencies in trying to make our highways — in fact our environment — better suited to healthful living and to minimize the tremendous toll in lives and morbidity associated with accidents.

We are deeply involved in a program in trauma headed by Dr. Wayne O. Southwick, Professor of Orthopedic Surgery, and Dr. Kristaps Keggi, Assistant Professor of Orthopedic Surgery. Both men are experienced in the problem.

They are working closely with representatives of state and local governments in an effort to improve safety programs and to help develop better means of transporting accident victims from the scene of an accident to an appropriate place for medical treatment.

The work is exciting. It has had an additional benefit, I think, of making medical students as well as our house officers more aware of this enormous problem confronting our society.

Dr. Bishop: In this respect, when do you think we'll need a heli-pad on the top of this building?

Dr. Cole: Well, it can't come too soon, in my mind. As you know, we raised this question with the architects working on the long range plans for this institution.

Undoubtedly, as I see it, this State will, through the offices of the Connecticut Regional Medical Program and other such undertakings, link all of the medical facilities into one broad state health care network. When this day comes, it's going to be very important to be able to transport a seriously injured individual from some remote highway to an appropriate medical installation within a matter of minutes. Yale-New Haven Hospital, as one of the teaching centers and one of the major medical centers in the State of Connecticut, will in all likelihood serve as one of the hubs in such a state-wide network.

The prospects of having a helicopter carrying injured patients to this Hospital is not at all out of the question. Indeed, in some areas of the world, and in some areas here in the United States, hospitals have already embarked upon such a program.

Mr. Womer: What about other "thrusts?" You have covered the transplant program and the trauma program, what else?

Dr. Cole: Another area certainly deserves emphasis. This is our program in the neuro-sciences. And here again, I am very gratified with the progress we have made during the past year, or year and a half. Dr. William F. Collins as head of the section, has brought some very able young neurosurgeons into the program.

It is also fortunate that we are gaining considerable strength in the basic sciences here at Yale-New Haven Hospital with the acquisition of talented neuropharmacologists and neurophysiologists and the prospects of collaborative efforts in the neuro-science are excellent and portend a bright future. During the past year we have introduced several new diagnostic and therapeutic techniques that are now operational at this hospital. The consortium of people interested in the neuro-sciences,
and chemical unification we have seen take place between Dr. Gilbert H. Glaser, Professor of Medicine and Chief of the Section of Neurology, and Dr. Collins and his surgical group, is an important development in maintaining high quality patient care.

I believe this is what you had in mind earlier, Dr. Bishop, when you spoke of the lines between disciplines breaking down and men of different specialties working together on the management of a single patient or a single problem.

Mr. Womer: As Chief of Surgery, Jack, what do you see as the primary challenges that you and your staff will face during the next five to ten years? How do you think they will affect the hospital?

Dr. Cole: Well, I would say one of the major problems will be to work out a satisfactory coordination of effort with surgeons around the state. This is going to be one of our biggest challenges. I will try to explain what I mean.

Surgery is a fairly "definitive" discipline. We are called in for specific purposes at specific times. We do not practice preventive medicine to the same extent that they do in medicine or pediatrics, or indeed, even in obstetrics. As a consequence, surgery has, and will remain, an inpatient effort.

Since costs are high and beds are scarce, we must make certain there is a distribution of surgical expertise throughout the State through which we can implement cooperative effort in education and the exchange of ideas without undue duplications.

As far as our own hospital is concerned, I think we must continue to fulfill our obligation as a teaching hospital to help other institutions take over the more complex surgery for patients too numerous for us to handle. The kidney transplant program is an example. We could not hope to take care of all the patients in Connecticut who might benefit from this new procedure. Ultimately, other hospitals will have to assume part of the responsibility.

Dr. Bishop: There is one point I would like to bring up, Jack, and that is to ask you to comment on the changing approach to surgical education, since this is an important part of this Hospital's responsibility. We certainly are living in a restless age, and this applies to students in medicine as well as those in other disciplines. What is the impact of this on the Department of Surgery?

Dr. Cole: Medical schools and departments are reacting and responding to the demands and unrest we see in our medical students today. Perhaps this unrest can be summed up in part by the students' demand for some relevance to what they are studying.

Often they are impatient with the time spent on hard-core scientific courses that do not, in their opinion, have an immediacy about them.

We're getting a very serious minded bunch of young people in our medical schools today who are fairly sophisticated and knowledgeable in terms of what the public wants. I think this is a healthy movement.

Part of our response has been to involve the student in patient contact much earlier in the course of his medical education. He sees a certain purpose, a certain sense of direction in his day-to-day studies if he sees that it applies directly to people. I think he will be a better physician because of this.

We must recognize that these students come to us with better backgrounds in biological sciences than you or I had in our day. As a consequence, they are much better equipped to assume a sort of responsibility in their work than we have noted before.

I have been impressed, generally, with how mature and how responsible these students can be, given the opportunity. I think the thing that is really going to affect the picture is whether or not these young men can develop the ability to work with emerging groups of health professions. It seems to me that this is one of their major challenges—the development of a cooperative philosophy which is quite different from that of the solo practitioner of a few years past.
Mr. Womer: Why don't we start out with the growth of anesthesiology as a specialty, Nick? It's one of the newer specialties in medicine. I can remember when most hospital anesthesiologists were given by nurses and there were relatively few physician anesthesiologists. What is the reason for the growth in this field?

Dr. Greene: There are several reasons for it. One is an increasing awareness that even the most "routine" anesthetic for the most "routine" type of surgery is associated with a real and significant anesthetic risk, and that the risk can be reduced by increasing the quality of the medical care with which the anesthetic is administered.

Another factor is the greater number of "high risk" patients being operated upon at the present time. This is most notable among patients in the geriatric age group. Patients are being operated upon today who would not have been brought to an operating room five or ten years ago.

The third reason is the fact that the field of surgery is expanding and is getting into areas in which physician anesthesiologists are necessary. This is particularly true in the field of cardiovascular surgery.

A fourth factor is that the field of anesthesiology, itself, is expanding in scope and purpose. Anesthesiologists are now engaged in many activities other than operative anesthesia, such as inhalation therapy and intensive care. This means an increasing number of anesthesiologists take care of non-surgical problems.

Dr. Bishop: Would you discuss for a moment the changes in obstetric anesthesia?

Dr. Greene: The biggest changes in this regard have been the introduction of techniques and methods which not only relieve pain during delivery, but which relieve pain during labor as well.

In the past, the pain of labor was relieved, or partially relieved, by the use of narcotics and other drugs that depressed the infant as well as the mother, and pain relief at the time of delivery itself being achieved by using a deep general anesthesia. These techniques were unsatisfactory from the point of view of both mother and child. We have techniques now that provide continuous relief of pain by what we call "conduction anesthesia." The mother stays awake, the course of the labor is unaffected, but she does not have pain either during labor or during delivery. The result is decreased maternal and neonatal mortality and morbidity. I might add that the quality of obstetrical anesthesia offered patients at this institution (with a senior anesthesiologist as well as a resident and nurse anesthetist on hand, 24 hours a day, 365 days a year) is probably unique in this country.

Dr. Bishop: As a surgeon, I am well aware of the national shortage of anesthesiologists throughout the country. Would you comment on our training program at Yale-New Haven?

Dr. Greene: Our training program consists of two parts. One of these is related primarily to clinical training; the other to advanced research training. We have five first-year residents and five second-year residents in training in clinical anesthesia; i.e., ten residents who are full-time in clinical training. In addition to this, we have eight physicians who have finished their clinical training and who are in various stages of advanced training, some entirely in research. I might add, incidentally, that the program at Yale-New Haven again differs from programs throughout the rest of the country in that the number of residents in training in relation to the total number of senior attending anesthesiologists is low. As a result, we are much more selective in the people we take into our program, and the quality of the people we train is higher. In addition, the quality of care we provide our patients is higher. The majority of anesthetics administered in this institution is by attending anesthesiologists.

Mr. Womer: With residents assisting?

Dr. Greene: Not necessarily. We do not depend upon residents to provide clinical coverage. To phrase that another way, and perhaps a more abrupt way, we do not rely upon residents as a form of slave labor to provide clinical services, which is not always true in other institutions. We are rather unusual in this regard because we have a ratio of 22 attending anesthesiologists to ten clinical residents.

Dr. Bishop: What do you consider the major research effort is in your department, Nick?

Dr. Greene: There are three major areas of research effort. One -- and this is my own particular area of interest -- is the effect anesthetics and other drugs have upon membrane transport mechanisms, mechanisms by which substances are moved across cell membranes. We have done quite a bit of work on how drugs and other factors affect the transfer of substances into cells. Another major area of research is the effect of drugs, including anesthetics, and other factors on the fetus. In other words, how what we do to provide pain relief to the mother affects the infant. Members of our department have done some outstanding and unique work in this area.

The third major area of research in our department is in neurophysiology, how and where an anesthetic acts within the brain itself. This is still an area in which our ignorance is overwhelming. We do not really know how an anesthetic works nor are we even fully sure as to where it works within the brain. We have a major research project in this particular field. We have a number of other research projects underway, but these are the major ones.

Dr. Bishop: Looking ahead for say the next five years, what do you foresee as
Dr. Greene: Looking at anesthesiology as a whole and not as changes within this department alone, I would anticipate that one of the major new challenges in anesthesiology will be related to organ transplants and the surgery required for organ transplants. There is an area in this connection that may prove to be quite fruitful in terms of anesthesia; and that is the effect anesthetics and other drugs may have on the rejection phenomenon or the effects anesthetics may have on immunologic response. This is an area that has only recently been considered, much less fully investigated.

Mr. Womer: Do you mean there's a possibility - if I may interrupt for a second - that the type of anesthesia or the anesthetic agent used may have an effect on whether a person receiving a transplant rejects it or not?

Dr. Greene: There seems to be this possibility; and there are certain indirect suggestions that make this a possibility that we should explore.

Purely aside from this, however, anesthesiology is going to be confronted with major problems in clinical anesthesia for organ transplants, particularly of the heart. The major problem in anesthesiology as a specialty as a whole will continue to be related to the discrepancy between the supply of competently trained anesthesiologists and the demand for these competently trained anesthesiologists. And our major interest and our major responsibility in the next five or ten years should be in the area of increased recruiting into the field and increased quality of training within this specialty.
David Seligson, M.D.
Chairman, Clinical Pathology;
Professor of Medicine and Pathology
Yale University School of Medicine

Dr. Bishop: For most people, Dave, your clinical laboratories are mysterious realms of glass tubes and strange paraphernalia, and I must admit they all look pretty complicated to me. However, they constitute the hub of hospital care because sooner or later every patient in the hospital, and most of them in the clinics, depend upon tests made in your laboratories.

As one of the latest medical developments, how does the transplant program affect your department?

Dr. Seligson: It has a profound effect upon all the clinical laboratories—you know we have ten laboratories in all: the central one on the sixth floor of the New Haven Unit, and nine others spread throughout both the New Haven Unit and the Memorial Unit.

Patients who are followed prior to transplantation are critically ill with kidney failure. Their management is determined by how well the physician can keep them free of acidosis and free from the chemical complications of uremia. This requires a great many tests from the chemistry laboratory, the hematology laboratory, the bacteriology laboratory and blood from the blood bank for transfusions. All these activities go on during periods of dialysis when these patients are on the artificial kidney and are being sustained for the transplant.

When a transplant takes place, it usually reflects an abrupt decision involving emergency service from all these laboratories. We must go into high gear immediately, calling forth the highest skill and the highest priority of work we can manage. This has an enormous effect on our entire staff—and it usually happens at night when we are on small staff.

We are under additional pressure in that transplant patients require constant testing in order to determine how they are doing from moment to moment.

I can't give you an exact figure, but my guess is that such patients require about ten times as much service per bed as the usual sick person does.

Dr. Bishop: What about the idea of establishing a tissue typing laboratory?

Dr. Seligson: We are exploring the possibility of developing a tissue typing laboratory. At the moment, tissue typing is far from an exact science, but we hope, someday, to provide it as a service function.

Mr. Womer: When you say "tissue typing," is this similar to blood typing to match blood for transfusions?

Dr. Seligson: Somewhat. In principle it involves the immune process and the technique of immunology. However, there is a great deal of uncertainty as to the antigens of patient and donor which do not match. Our problem at this stage of research is that we do not know which major antigens are the ones we should be looking for routinely.

We don't have the materials for detecting, accurately, the major antigens and antibodies that we wish to detect. But I am sure continued research will soon clarify this.

However, it's a long, long way from the exact nature of blood banking.

Mr. Womer: While we're on the subject of blood banking, is there concern about a growing shortage of blood? Is this because we're using more blood? Or is it because the number of blood donors is decreasing?

Dr. Seligson: I wish Dr. Joseph Bove, the director of our blood bank, could answer that question. There is a large number of potential blood donors in this country. The amount of blood obtained from this group depends upon their generosity and their social consciousness.

In Connecticut, there are a good number of people who give blood generously; give to patients they do not know; and give in emergencies. Even so, we could use many more.

Mr. Womer: Connecticut is unusual in one way in that it is one of very few states, if not the only one, in which blood is made available to patients without charge to them. The only charge made is for service in connection with processing or administering the blood.

What about blood substitutes? I recall Dr. Bove showing pictures at a medical staff meeting of attractive girls saying "Use Packed Cells." Are packed cells something new?

Dr. Seligson: Packed cells have been used for a long time, but not widely. Dr. Bove is on a one-man campaign in Connecticut to teach physicians that blood consists of many fractions and that when a patient has a deficit of one fraction, the physician should give that fraction only rather than all of them, which of course, is whole blood.

He is achieving some degree of success in this. Ultimately we will use fractions of blood for specific purposes throughout the country. This will make our supplies of blood go farther.

Dr. Bishop: You have been a leader, Dave, in developing the automation and computerization in the laboratories. What is your aim in all this?

Dr. Seligson: Our goal is to demonstrate that the general purpose digital computer is one of the major—if not the major—tools in the medical laboratory today. We have been applying it in two ways.

One, to use the computer as an extension of each laboratory instrument; and the other to take the data which accumulates in the computer and process it rapidly into a report for interpretation by the doctor. In the future, we hope to digest all the laboratory data and utilize the computer for interpretation.

We hope to improve patient care with this system by improving the quality of data, and by improving the speed with which we can get information back to the...
physicians.

Mr. Womer: In compiling year-end figures for this annual report, we found that your laboratory had performed more than one million laboratory tests! This is an incredible number and yet we are seeing an average increase of from 15 to 20 per cent each year. Do you see any slowdown in this work load?

Dr. Seligson: No. It's a worldwide phenomenon. And to a great extent, this continued rise is valid because it represents the doctors' search for more detailed information that will help him make decisions for the benefit of his patients.

Mr. Womer: Do you think there will be further strides that will help us handle this burgeoning volume?

Dr. Seligson: I think what you're asking is whether there will be machines that will do tests better, faster, and less expensively than human beings can now; and whether computers can process data more rapidly so that the same information does not have to be copied and transferred and moved by hand. I am confident the patterns we are setting will be successful in helping to accomplish these improvements.

Dr. Bishop: What do you consider your greatest challenges in the years ahead?

Dr. Seligson: Attracting skilled personnel with high intellectual qualities. The development of new equipment, computerization and so on, is development hardware. We need people who have the imagination to see the potential of such hardware.

One of the ways, locally, that we hope to develop such personnel is through our newly expanded medical technology program. We now are conducting, along with the Department of Radiology, a joint program with Quinnipiac College. We hope to offer students a greater incentive to obtain advanced degrees and take advantage of this greatly expanding field.
Mrs. M. Scott Welch  
President  
Women's Auxiliary  
Yale-New Haven Hospital

Mr. Womer: You probably know, Mary, that when this hospital published its first report 100 years ago, it included an account from the Board of Lady Visitors. This was a fairly formidable group of ladies who kept a close eye on how the hospital was run and whether or not any patients broke the rules—such as swearing.

They were generous individuals, however, and the first report says they gave furniture and bedding amounting to about $1,200 in value, which was quite a sum in 1868.

The Women’s Auxiliary today is a more sophisticated organization, of course, but it also generates generously of its time, effort and money on behalf of the hospital.

How would you describe its philosophy?

Mrs. Welch: The Auxiliary looks upon itself as a link between the hospital and the community. Our members try to promote the welfare of the hospital, in line of course with general policies; we try to interpret the hospital to the community, and in turn, the community to the hospital.

Mr. Womer: How many members are there at the present time? And how many are actively involved in various projects?

Mrs. Welch: We have approximately 775 members and I would say that more than one-half are active, in that they participate in programs of one kind or another. Many are volunteers, but that is only part of our effort. Others serve on groups or committees, or generally promote the interests of the hospital.

Dr. Bishop: Although the name of “Bishop” appears quite prominently in that first report of 1868, I can claim neither kin nor connection with it. Do you think that members of the Auxiliary have some connection with the hospital through their husbands’ professions?

Mrs. Welch: Although many members’ husbands are doctors or are professionally connected with the hospital or the School of Medicine, we have just as many who have no connection with the Medical Center at all. We welcome all women of the area who are interested.

Mr. Womer: When did the Auxiliary get started?

Mrs. Welch: Actually, the Auxiliary was formally organized in 1952 and Mrs. Edith Valet Cook was installed as our first president the following year.

There were volunteers in the hospital for many years before that, and before this group was formed. As a matter of fact, during World War II, many women and prominent businessmen in the area took instruction on how to perform certain hospital tasks to help out during wartime personnel shortages.

Dr. Bishop: Maybe you could clear up some confusion by describing the difference between the Volunteer Department, which is a regular department of the hospital, and the Auxiliary. How do they work together?

Mrs. Welch: First of all, we share the same office space. There is a direct connection between the Volunteer Office and the Auxiliary. It was set up in this way. The Director of Volunteers sits on our board of managers as an ex-officio member and she is considered our executive secretary.

Thus, she has a dual role—not only to supervise all the volunteers, who may or may not be members of the Auxiliary, but as a paid member of the hospital staff, she supervises an office for us.

Dr. Bishop: In addition to the Auxiliary’s supporting the hospital philosophically, it helps economically by giving good hard money. How much money has the Auxiliary given to the hospital during the 16 years of its existence?

Mrs. Welch: $375,000. This has gone into a wide variety of projects.

Dr. Bishop: Where does it get its money?

Mrs. Welch: We earn all of it through the Carryall Shops—the coffee shop, the gift shop and the gift cart that volunteers take to patient divisions in both the New Haven and Memorial Units. With the exception of paid managers of both shops and some help in the coffee shop, all the work in maintaining the shops is given voluntarily. Some women have given more than a thousand hours of their time—and many high school girls, and even a few boys, have given hundreds of hours as well.

Dr. Bishop: Does the Auxiliary contribute money for special hospital projects—or does it give money for unrestricted use?

Mrs. Welch: Well, we generally have a good idea of how much money we will have to work with from year to year. And—I might add, the amount is gradually increasing every year.

The Hospital administration gives us a list of high priority projects from which to choose. Then our projects committee, our executive committee and the board of managers all vote on the ones they think are most suited to our anticipated income and interests.

We are interested primarily in those projects which directly affect patients—either by improving areas or modernizing facilities. Occasionally we help out on smaller projects such as one this year when we gave funds toward the salary of a person who could speak Spanish to help patients with a language barrier.

Mr. Womer: Do auxiliaries in other hospitals contribute this much to their parent institutions?

Mrs. Welch: It depends on the size and purpose of the auxiliaries, to a great extent. Now, we are different from many in that they are allowed to do outside fund raising. But we do not. And I think for the community and for the Hospital it’s a very good thing that we don’t. There would be too much confusion about public appeals. It certainly makes it much easier for us. We do not involve ourselves with teas, balls, follies, bazaars and so forth. Our only direct effort is through membership drives once a year; and this is fairly low pressure.

Dr. Bishop: As an ex-officio member of the Hospital’s Board of Directors, and a member of its Public Relations Committee, you are aware of the continuing needs of the hospital. Would you list some of the major projects that were made possible by the Auxiliary’s $375,000 contributions?

Mrs. Welch: Our current project is to renovate Fitkin 1. This should be ready early in 1969. Among the major projects we have contributed toward in the past are the lobby of the Dana Clinic Building; renovation of the house staff lounge; pharmacy renovation; pediatric craft room and other areas in pediatrics; women's clinic; and the volunteer office.
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.

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 combined facilities of the Yale School of Medicine, the Hospital, the Yale Child Study Center, the Yale School of Nursing, the Grace-New Haven 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 fulltime members of the Department of Psychiatry at Yale.

Charles B. Womer, Director
Yale-New Haven Hospital

F. C. Redlich, M.D., Dean
Yale University School of Medicine

Number of adult and pediatric hospital beds: 737
Number of bassinets: 116
Number of hospital clinics: 75
Administrative Staff and Department Heads 1968

Director
Charles B. Womer

Assistant Directors
Richard F. Binnig
C. Robert Bruckmann
David Dolins
Richard H. Judd
William T. Newell, Jr.
Herbert Paris
Anna E. Ryle, R.N.

Assistant to the Director
James M. Malloy

Accounting
Edward J. Hammerbacher

Administrative Engineer
John W. Manz

Administrative Planning Associate
Warren C. Kessler

Ambulatory Nursing Service
Mrs. Lisa Trayser, R.N.

Anesthesiology
Nicholas M. Greene, M.D.

Building Services
Grant L. Berger, Jr.

Business Services
Harold L. Larsen

Clinical Laboratories
David Seligson, 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

Information and Development
Donald R. Kleinberg

Inhalation Therapy
Donald F. Egan, M.D.

Inpatient Nursing Service
Claire O'Neil, R.N.

Linen Service
Warren H. Eastman

Medical Records
Patricia A. Tourey

Operating Rooms
Mrs. Luba Dowling, R.N.

Personnel Health Service
Herbert D. Lewis, M.D.

Personnel
Robert W. Fox

Pharmacy
James W. Allaben

Physical Medicine and Rehabilitation
Josephine M. Fuhrmann, M.D.

Purchasing
Joseph J. Leydon

Radiology
Morton M. Kligerman, M.D.

Religious Ministries
The Rev. Edward F. Dobihal, Jr.

Security
Jules S. Stollak

Special Services
Albert P. Freije

Systems Engineer
Robert R. Schwarz

Transportation, Aides and Communications
Harold L. Hahn

Volunteer Service
Mrs. Patricia A. Nabstedt

Medical Staff Leadership 1968

Department of Anesthesiology
Chief
Nicholas M. Greene, M.D.
Assistant Chief
Frederick W. Hehrke, M.D.

Department of Clinical Laboratories
Chief
David Seligson, M.D.
Assistant Chiefs
Marshall G. Barnes, M.D.
Joseph R. Bove, M.D.

Department of Medicine
Chief
Philip K. Bondy, M.D.
Associate Chief
Samuel D. Kushlan, M.D.

Inhalation Therapy
Director
Donald F. Egan, M.D.

Continuing Care
Director
Harold N. Willard, M.D.

Physical Medicine and Rehabilitation
Acting Director
Josephine M. Fuhrmann, M.D.

Department of Obstetrics and Gynecology
Chief
Edward J. Quilligan, M.D.
Associate Chief
Paul E. Molumphy, M.D.

Department of Pathology
Chief
Robert V. P. Hutter, M.D.

Department of Pediatrics
Chief
Charles D. Cook, M.D.
Associate Chief
David H. Clement, M.D.

Department of Psychiatry
Chief
Thomas P. Detre, M.D.
Medical Board

Chairman
Courtney C. Bishop, M.D.
Vice Chairman
Edward J. Quilligan, 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.
Thomas P. Detre, M.D.
Hugh L. Dwyer, M.D.
Nicholas M. Greene, M.D.
Robert V. P. Hutter, M.D.
Morton M. Kligerman, M.D.
Samuel D. Kushlan, M.D.
Woodrow W. Lindenmuth, M.D.
Paul E. Molumphy, M.D.
Fredrick C. Redlich, M.D.
David Seligson, M.D.
Herbert R. Sleeper, D.D.S
Harold N. Willard, M.D.
Charles B. Womer

Elected Officers of the Medical Staff
President
Robert R. Berneike, M.D.
Secretary
Isao Hirata, Jr., M.D.
Past President
Hugh L. Dwyer, M.D.

Medical Staff Organization

The composition of the Medical Staff on September 30, 1968 as compared with figures for 1967 are as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Honorary</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Consulting</td>
<td>39</td>
<td>40</td>
</tr>
<tr>
<td>Emeritus</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>Active Staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attending</td>
<td>261</td>
<td>247</td>
</tr>
<tr>
<td>Assistant Attending</td>
<td>149</td>
<td>153</td>
</tr>
<tr>
<td>Associate</td>
<td>152</td>
<td>142</td>
</tr>
<tr>
<td>Total Active Staff</td>
<td>562</td>
<td>542</td>
</tr>
<tr>
<td>Courtesy</td>
<td>126</td>
<td>132</td>
</tr>
<tr>
<td>Dentists and Physicians to Outpatient Department</td>
<td>162</td>
<td>151</td>
</tr>
<tr>
<td>Total</td>
<td>288</td>
<td>283</td>
</tr>
<tr>
<td>Less Duplications</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Total Medical Staff</td>
<td>905</td>
<td>874</td>
</tr>
<tr>
<td>House Staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Fellows</td>
<td>161</td>
<td>168</td>
</tr>
<tr>
<td>Interns and Residents</td>
<td>239</td>
<td>225</td>
</tr>
<tr>
<td>Total House Staff</td>
<td>400</td>
<td>393</td>
</tr>
<tr>
<td>Professional Staff (Non M.D.)</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1,326</td>
<td>1,289</td>
</tr>
</tbody>
</table>

Included in the above are:
*Full-time physicians *234* 228
General practitioners *58* *58

*Includes physicians with offices at the Veterans Administration Hospital and the Connecticut Mental Health Center who also have Yale-New Haven Hospital appointments.
## Comparative Statistics

For Years Ended September 30, 1968 and 1967

<table>
<thead>
<tr>
<th>Service</th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients discharged during the year</td>
<td>31,350</td>
<td>30,488</td>
</tr>
<tr>
<td>Patient days care rendered</td>
<td>260,879</td>
<td>251,990</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>713</td>
<td>690</td>
</tr>
<tr>
<td>Clinic visits</td>
<td>130,892</td>
<td>119,545</td>
</tr>
<tr>
<td>Emergency service visits</td>
<td>64,920</td>
<td>56,666</td>
</tr>
<tr>
<td>Operations</td>
<td>13,158</td>
<td>12,841</td>
</tr>
<tr>
<td>Recovery Room cases</td>
<td>9,845</td>
<td>9,074</td>
</tr>
<tr>
<td>Deliveries</td>
<td>4,742</td>
<td>4,326</td>
</tr>
<tr>
<td>Anesthesias given</td>
<td>16,305</td>
<td>15,488</td>
</tr>
<tr>
<td>Radiology examinations</td>
<td>94,818</td>
<td>81,032</td>
</tr>
<tr>
<td>Laboratory examinations</td>
<td>1,070,582</td>
<td>906,148</td>
</tr>
<tr>
<td>Physical Therapy treatments</td>
<td>27,020</td>
<td>25,598</td>
</tr>
<tr>
<td>Electrocardiology examinations</td>
<td>23,813</td>
<td>18,953</td>
</tr>
<tr>
<td>Electroencephalography examinations</td>
<td>1,933</td>
<td>1,837</td>
</tr>
</tbody>
</table>
## Discharges

For Years Ended September 30, 1968 and 1967

<table>
<thead>
<tr>
<th>ADULTS</th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynecology</td>
<td>2,397</td>
<td>2,268</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>4,727</td>
<td>4,704</td>
</tr>
<tr>
<td>Psychiatry (Tompkins)</td>
<td>148</td>
<td>131</td>
</tr>
<tr>
<td>Radiology</td>
<td>88</td>
<td>80</td>
</tr>
<tr>
<td>Medicine</td>
<td>5,688</td>
<td>5,205</td>
</tr>
<tr>
<td>Surgery:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>450</td>
<td>450</td>
</tr>
<tr>
<td>Dental</td>
<td>218</td>
<td>239</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>760</td>
<td>720</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>595</td>
<td>650</td>
</tr>
<tr>
<td>Orthopedic</td>
<td>1,281</td>
<td>1,279</td>
</tr>
<tr>
<td>Otorhinolaryngology</td>
<td>855</td>
<td>829</td>
</tr>
<tr>
<td>Plastic</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Thoracic</td>
<td>192</td>
<td>197</td>
</tr>
<tr>
<td>Urological</td>
<td>1,402</td>
<td>1,310</td>
</tr>
<tr>
<td>General</td>
<td>4,187</td>
<td>4,072</td>
</tr>
<tr>
<td>Total — Adults</td>
<td>22,991</td>
<td>22,139</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHILDREN</th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>1,576</td>
<td>1,461</td>
</tr>
<tr>
<td>Surgical</td>
<td>2,185</td>
<td>2,314</td>
</tr>
<tr>
<td>Total — Children</td>
<td>3,761</td>
<td>3,775</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NEWBORN</th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>3,955</td>
<td>4,092</td>
</tr>
<tr>
<td>Special Care</td>
<td>643</td>
<td>482</td>
</tr>
<tr>
<td>Total — Newborn</td>
<td>4,598</td>
<td>4,574</td>
</tr>
<tr>
<td>Total — All Patients</td>
<td>31,350</td>
<td>30,488</td>
</tr>
</tbody>
</table>

## Patient Days

For Years Ended September 30, 1968 and 1967

<table>
<thead>
<tr>
<th>ADULTS</th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynecology</td>
<td>13,250</td>
<td>12,855</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>18,638</td>
<td>18,872</td>
</tr>
<tr>
<td>Psychiatry (Tompkins)</td>
<td>10,164</td>
<td>9,378</td>
</tr>
<tr>
<td>Radiology</td>
<td>671</td>
<td>595</td>
</tr>
<tr>
<td>Medicine</td>
<td>64,809</td>
<td>62,378</td>
</tr>
<tr>
<td>Surgery:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>6,850</td>
<td>7,826</td>
</tr>
<tr>
<td>Dental</td>
<td>566</td>
<td>653</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>10,310</td>
<td>9,678</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>4,644</td>
<td>5,107</td>
</tr>
<tr>
<td>Orthopedic</td>
<td>16,020</td>
<td>15,716</td>
</tr>
<tr>
<td>Otorhinolaryngology</td>
<td>3,953</td>
<td>3,681</td>
</tr>
<tr>
<td>Plastic</td>
<td>40</td>
<td>38</td>
</tr>
<tr>
<td>Thoracic</td>
<td>2,795</td>
<td>2,403</td>
</tr>
<tr>
<td>Urological</td>
<td>14,924</td>
<td>12,226</td>
</tr>
<tr>
<td>General</td>
<td>41,593</td>
<td>39,632</td>
</tr>
<tr>
<td>Total — Adults</td>
<td>209,243</td>
<td>201,038</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHILDREN</th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>15,482</td>
<td>14,547</td>
</tr>
<tr>
<td>Surgical</td>
<td>11,502</td>
<td>11,966</td>
</tr>
<tr>
<td>Total — Children</td>
<td>26,984</td>
<td>26,513</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NEWBORN</th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>16,439</td>
<td>17,399</td>
</tr>
<tr>
<td>Special Care</td>
<td>8,213</td>
<td>7,040</td>
</tr>
<tr>
<td>Total — Newborn</td>
<td>24,652</td>
<td>24,439</td>
</tr>
<tr>
<td>Total — All Patients</td>
<td>260,879</td>
<td>251,990</td>
</tr>
</tbody>
</table>
## Clinic Visits

### For Years Ended September 30, 1968 and 1967

<table>
<thead>
<tr>
<th>Department</th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICINE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>5,872</td>
<td>5,537</td>
</tr>
<tr>
<td>Allergy</td>
<td>1,433</td>
<td>1,424</td>
</tr>
<tr>
<td>Arthritis</td>
<td>714</td>
<td>760</td>
</tr>
<tr>
<td>Cardiac</td>
<td>1,518</td>
<td>1,270</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>1,128</td>
<td>1,551</td>
</tr>
<tr>
<td>Dermatology</td>
<td>7,158</td>
<td>7,168</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>2,144</td>
<td>2,001</td>
</tr>
<tr>
<td>Hematology</td>
<td>655</td>
<td>598</td>
</tr>
<tr>
<td>Hematology Tumor</td>
<td>915</td>
<td>230</td>
</tr>
<tr>
<td>Liver</td>
<td>178</td>
<td>153</td>
</tr>
<tr>
<td>Metabolism</td>
<td>2,294</td>
<td>2,034</td>
</tr>
<tr>
<td>Neurology</td>
<td>1,257</td>
<td>1,312</td>
</tr>
<tr>
<td>Physical Medicine</td>
<td>586</td>
<td>458</td>
</tr>
<tr>
<td>Private Referrals</td>
<td>6,092</td>
<td>6,326</td>
</tr>
<tr>
<td>Pyelonephritis</td>
<td>133</td>
<td>96</td>
</tr>
<tr>
<td>Winchester Chest</td>
<td>3,251</td>
<td>3,040</td>
</tr>
<tr>
<td><strong>Total — Medicine</strong></td>
<td>35,328</td>
<td>33,958</td>
</tr>
<tr>
<td><strong>SURGERY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>6,157</td>
<td>4,644</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>672</td>
<td>790</td>
</tr>
<tr>
<td>Dental</td>
<td>5,775</td>
<td>5,618</td>
</tr>
<tr>
<td>Minor Surgery</td>
<td>245</td>
<td>227</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>589</td>
<td>554</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>11,278</td>
<td>9,997</td>
</tr>
<tr>
<td>Orthopedic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>1,884</td>
<td>1,248</td>
</tr>
<tr>
<td>Fracture</td>
<td>2,738</td>
<td>2,481</td>
</tr>
<tr>
<td>Pediatric</td>
<td>582</td>
<td>573</td>
</tr>
<tr>
<td>Otorhinolaryngology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>4,294</td>
<td>3,931</td>
</tr>
<tr>
<td>Hearing and Speech</td>
<td>3,875</td>
<td>3,727</td>
</tr>
<tr>
<td>Private Patients</td>
<td>2,805</td>
<td>2,617</td>
</tr>
<tr>
<td>Plastic</td>
<td>638</td>
<td>489</td>
</tr>
<tr>
<td>Private Referrals</td>
<td>7,998</td>
<td>9,013</td>
</tr>
<tr>
<td>Surgical Tumor</td>
<td>114</td>
<td>112</td>
</tr>
<tr>
<td>Thoracic</td>
<td>311</td>
<td>224</td>
</tr>
<tr>
<td>Urology</td>
<td>3,869</td>
<td>3,674</td>
</tr>
<tr>
<td><strong>Total — Surgery</strong></td>
<td>53,824</td>
<td>49,919</td>
</tr>
</tbody>
</table>

### For Years Ended September 30, 1968 and 1967

<table>
<thead>
<tr>
<th>Department</th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OBSTETRICS &amp; GYNECOLOGY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Planning</td>
<td>1,293</td>
<td>645</td>
</tr>
<tr>
<td>Gynecology — General</td>
<td>4,388</td>
<td>3,645</td>
</tr>
<tr>
<td>Gynecology — Tumor</td>
<td>388</td>
<td>365</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>9,368</td>
<td>8,823</td>
</tr>
<tr>
<td>Private Referrals</td>
<td>5,288</td>
<td>4,974</td>
</tr>
<tr>
<td><strong>Total — Obstetrics &amp; Gynecology</strong></td>
<td>20,725</td>
<td>18,452</td>
</tr>
<tr>
<td><strong>PEDIATRICS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>6,547</td>
<td>4,984</td>
</tr>
<tr>
<td>Allergy</td>
<td>1,086</td>
<td>1,265</td>
</tr>
<tr>
<td>Birth Defects</td>
<td>312</td>
<td>271</td>
</tr>
<tr>
<td>Cardiac</td>
<td>2,602</td>
<td>2,275</td>
</tr>
<tr>
<td>Surgical and Surgical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac</td>
<td>415</td>
<td>542</td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
<td>365</td>
<td>324</td>
</tr>
<tr>
<td>Child Care</td>
<td>86</td>
<td>90</td>
</tr>
<tr>
<td>Emergency Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow Up</td>
<td>864</td>
<td>354</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>619</td>
<td>503</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>275</td>
<td>190</td>
</tr>
<tr>
<td>Hematology</td>
<td>531</td>
<td>565</td>
</tr>
<tr>
<td>Mental Retardation</td>
<td>136</td>
<td>96</td>
</tr>
<tr>
<td>Metabolism</td>
<td>505</td>
<td>379</td>
</tr>
<tr>
<td>Nephrology</td>
<td>421</td>
<td>370</td>
</tr>
<tr>
<td>Neurology</td>
<td>727</td>
<td>730</td>
</tr>
<tr>
<td>Newborn Special Care</td>
<td>34</td>
<td>58</td>
</tr>
<tr>
<td><strong>Total — Pediatrics</strong></td>
<td>15,524</td>
<td>12,996</td>
</tr>
<tr>
<td><strong>PSYCHIATRIC</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric Total</td>
<td>3,468</td>
<td>2,632</td>
</tr>
<tr>
<td><strong>RADIOLOGY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiation Follow Up</td>
<td>1,685</td>
<td>1,688</td>
</tr>
<tr>
<td><strong>Total — Miscellaneous</strong></td>
<td>119,645</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL — ALL</strong></td>
<td>130,892</td>
<td>119,645</td>
</tr>
<tr>
<td><strong>CLINIC VISITS</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## COMPARATIVE STATEMENT OF GENERAL FUND INCOME AND EXPENSES

**September 30**  

### GROSS REVENUE FROM SERVICES TO PATIENTS:

<table>
<thead>
<tr>
<th>Service type</th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room, board and nursing</td>
<td>$13,539,369</td>
<td>$11,102,060</td>
</tr>
<tr>
<td>Special services — inpatients</td>
<td>11,283,190</td>
<td>9,461,756</td>
</tr>
<tr>
<td>Clinic patients</td>
<td>1,732,959</td>
<td>1,411,198</td>
</tr>
<tr>
<td>Emergency room patients</td>
<td>1,118,684</td>
<td>860,055</td>
</tr>
<tr>
<td>Referred outpatients</td>
<td>782,132</td>
<td>624,980</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$28,456,334</td>
<td>$23,460,049</td>
</tr>
</tbody>
</table>

### DEDUCTIONS FROM GROSS REVENUE:

<table>
<thead>
<tr>
<th>Type of Deduction</th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contractual and other allowances</td>
<td>$3,594,194</td>
<td>$2,960,477</td>
</tr>
<tr>
<td>Provision for uncollectible accounts</td>
<td>1,583,850</td>
<td>1,662,767</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5,178,044</td>
<td>4,623,244</td>
</tr>
</tbody>
</table>

**NET REVENUE**  

<table>
<thead>
<tr>
<th></th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>$23,278,290</td>
<td>$18,836,805</td>
<td></td>
</tr>
</tbody>
</table>

### OPERATING EXPENSES:

<table>
<thead>
<tr>
<th>Expense Type</th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>$15,156,186</td>
<td>$12,788,972</td>
</tr>
<tr>
<td>Supplies and other expenses</td>
<td>9,163,973</td>
<td>7,129,474</td>
</tr>
<tr>
<td>Depreciation</td>
<td>1,017,533</td>
<td>943,199</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$25,337,692</td>
<td>$20,861,645</td>
</tr>
</tbody>
</table>

| Less — Recovery of expenses from grants, tuition, sale of services, etc. | 1,876,110 | 1,611,115 |

**NET OPERATING EXPENSES**  

<table>
<thead>
<tr>
<th></th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>$23,461,582</td>
<td>$19,250,530</td>
<td></td>
</tr>
</tbody>
</table>

**OPERATING LOSS**  

<table>
<thead>
<tr>
<th></th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>$183,292</td>
<td>$413,725</td>
<td></td>
</tr>
</tbody>
</table>

### NON-OPERATING INCOME:

<table>
<thead>
<tr>
<th>Income Type</th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free bed funds, Endowment income, United Fund and Other</td>
<td>$1,085,747</td>
<td>$803,524</td>
</tr>
</tbody>
</table>

YALE-NEW HAVEN HOSPITAL
## COMPARATIVE BALANCE SHEET

### ASSETS

#### GENERAL FUNDS:

<table>
<thead>
<tr>
<th></th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$945,825</td>
<td>$109,787</td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>5,400,000</td>
<td>4,767,370</td>
</tr>
<tr>
<td>Inventories</td>
<td>797,897</td>
<td>634,651</td>
</tr>
<tr>
<td>Other assets</td>
<td>250,491</td>
<td>251,946</td>
</tr>
<tr>
<td>Due from Temporary Funds</td>
<td>968,551</td>
<td>421,522</td>
</tr>
<tr>
<td>Due from Endowment and Special Funds</td>
<td>88,518</td>
<td>39,105</td>
</tr>
<tr>
<td><strong>Total – General Funds</strong></td>
<td><strong>$8,451,282</strong></td>
<td><strong>$6,224,381</strong></td>
</tr>
</tbody>
</table>

#### ENDOWMENT AND SPECIAL FUNDS:

<table>
<thead>
<tr>
<th></th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$33,480</td>
<td>$102,659</td>
</tr>
<tr>
<td>Investments at market value</td>
<td>19,939,646</td>
<td>19,281,523</td>
</tr>
<tr>
<td>Land, buildings and equipment –</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Winchester Annex</td>
<td>913,691</td>
<td>876,353</td>
</tr>
<tr>
<td><strong>Total – Endowment and Special Funds</strong></td>
<td><strong>$20,886,817</strong></td>
<td><strong>$20,260,535</strong></td>
</tr>
</tbody>
</table>

#### TEMPORARY FUNDS:

<table>
<thead>
<tr>
<th></th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$28,686</td>
<td>$30,921</td>
</tr>
<tr>
<td>Investments</td>
<td>907,385</td>
<td>252,815</td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>430,239</td>
<td>649,161</td>
</tr>
<tr>
<td>Due from Endowment and Special Funds</td>
<td></td>
<td>1,766</td>
</tr>
<tr>
<td><strong>Total – Temporary Funds</strong></td>
<td><strong>$1,366,310</strong></td>
<td><strong>$934,663</strong></td>
</tr>
</tbody>
</table>

#### PLANT FUND:

<table>
<thead>
<tr>
<th></th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land, buildings and equipment (net)</td>
<td>$19,126,686</td>
<td>$18,506,464</td>
</tr>
<tr>
<td>Construction in progress</td>
<td>331,313</td>
<td>625,586</td>
</tr>
<tr>
<td><strong>Total – Plant Fund</strong></td>
<td><strong>$19,457,999</strong></td>
<td><strong>$19,132,050</strong></td>
</tr>
</tbody>
</table>

**Gross Total – All Funds** | **$50,162,408** | **$46,551,629**

**Less, Inter-fund accounts** | 1,057,066 | 462,393

**Net Total – All Funds** | **$49,105,342** | **$46,089,236**
LIABILITIES, CAPITAL AND PRINCIPAL OF FUNDS

GENERAL FUNDS:

<table>
<thead>
<tr>
<th>Account Type</th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounts and notes payable</td>
<td>$1,094,713</td>
<td>$936,685</td>
</tr>
<tr>
<td>Accrued expenses</td>
<td>260,011</td>
<td>228,681</td>
</tr>
<tr>
<td>Deferred income</td>
<td>170,863</td>
<td>205,069</td>
</tr>
<tr>
<td>Medicare advances</td>
<td>585,000</td>
<td>285,000</td>
</tr>
<tr>
<td>Connecticut Blue Cross advances</td>
<td>218,500</td>
<td></td>
</tr>
<tr>
<td>Reserve for Medicare</td>
<td>191,402</td>
<td></td>
</tr>
<tr>
<td>General Fund capital:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Designated purpose</td>
<td>398,210</td>
<td>351,436</td>
</tr>
<tr>
<td>Unrestricted</td>
<td>5,532,583</td>
<td>4,217,510</td>
</tr>
<tr>
<td>Total — General Funds</td>
<td>$8,451,282</td>
<td>$6,224,381</td>
</tr>
</tbody>
</table>

ENDOWMENT AND SPECIAL FUNDS:

<table>
<thead>
<tr>
<th>Account Type</th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due to General Funds</td>
<td>$88,518</td>
<td>$39,105</td>
</tr>
<tr>
<td>Due to Temporary Funds</td>
<td></td>
<td>1,766</td>
</tr>
<tr>
<td>Principal of Funds:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free Bed</td>
<td>4,399,274</td>
<td>4,169,637</td>
</tr>
<tr>
<td>Non-Expendable and Specific Purpose:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>William Wirt Winchester</td>
<td>12,107,459</td>
<td>11,517,538</td>
</tr>
<tr>
<td>Other</td>
<td>3,694,944</td>
<td>3,519,016</td>
</tr>
<tr>
<td>Expendable</td>
<td>596,622</td>
<td>1,013,473</td>
</tr>
<tr>
<td>Total — Endowment and Special Funds</td>
<td>$20,886,817</td>
<td>$20,260,535</td>
</tr>
</tbody>
</table>

TEMPORARY FUNDS:

<table>
<thead>
<tr>
<th>Account Type</th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due to General Funds</td>
<td>$968,551</td>
<td>$421,522</td>
</tr>
<tr>
<td>Principal of Funds</td>
<td>397,759</td>
<td>513,141</td>
</tr>
<tr>
<td>Total — Temporary Funds</td>
<td>$1,366,310</td>
<td>$934,663</td>
</tr>
</tbody>
</table>

PLANT FUND:

<table>
<thead>
<tr>
<th>Account Type</th>
<th>1968</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortgages and other payables</td>
<td>$1,094,920</td>
<td>$1,227,679</td>
</tr>
<tr>
<td>Capital invested in property and equipment</td>
<td>18,363,079</td>
<td>17,904,371</td>
</tr>
<tr>
<td>Total — Plant Fund</td>
<td>$19,457,999</td>
<td>$19,132,050</td>
</tr>
</tbody>
</table>

Gross Total — All Funds                           | $50,162,408| $46,551,629|

Less, Inter-fund accounts                         | 1,057,066  | 462,393    |

Net Total — All Funds                             | $49,105,342| $46,089,236|

Note: The unfunded past-service liability related to the hospital's pension plan, which is to be funded over a period of 30 years beginning December 1, 1968, amounted to approximately $966,000 at September 30, 1968. Pension plan and annuity expense for the fiscal year ended September 30, 1968 amounted to $180,582.
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

$...