Yale-New Haven Hospital Annual Report 1972

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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 Hospital, and, in 1965, a strengthened affiliation between the Hospital and Yale University led to its name being changed to Yale-New Haven Hospital.

The clinical facilities of the Hospital located in two Units, the New Haven Unit and the Memorial Unit, combined with the classrooms, laboratories and research areas of the Yale University School of Medicine, comprise the Yale-New Haven Medical Center. This complex of buildings, including the Connecticut Mental Health Center, occupy approximately three city blocks in the center of New Haven, Connecticut.

Hospital statistics as of September 30, 1972:
Adult and Pediatric beds: 765
Bassinets: 101
Outpatient Clinics: 78
Approximate number of Hospital employees: 3,100
The individuals taking part in this year's discussion for the annual report of Yale-New Haven Hospital concern themselves with exploring the problem of how quality care can be evaluated throughout the entire medical profession itself — as well as at Yale-New Haven Hospital.

Their comments are especially timely in view of the growing concern throughout the country about the availability and quality of medical care being offered the American people.
DR. BISHOP: To start the discussion of "quality control," I would like to ask Mr. Womer to attempt a definition.

MR. WOMER: To me, quality control in the hospital setting means the organized use of a variety of mechanisms or procedures to monitor the ways we deliver care to our patients and evaluate the effectiveness of what we are doing.

It also means being able to assure the public, patients, physicians and everyone concerned that what we are doing is in the best interest of the patient and the public and that we are using all the resources available to us in providing care in an effective and efficient manner.

DR. BISHOP: Dr. Riedel, you might regard this as a question in semantics, but perhaps it’s worthwhile to identify quality control from your vantage point. Would you compare “quality control” with “quality assurance.” Are they interchangeable terms?

DR. RIEDEL: No, I don’t think they are interchangeable. “Control” refers to the mechanisms used to maintain quality, and “assurance,” the mechanisms for accountability. It isn’t only important to assure ourselves, as health care providers, that we are concerned with control; but to provide assurance to others that there are mechanisms for control.

MR. BETTS: Isn’t it important to let the public know the extent to which quality control actually does exist and is being implemented?

DR. BISHOP: This is one of the reasons why the issue is significant at this point in time. It seems to me that hospitals are experiencing increasing pressure from external sources to establish credibility. Are they real pressures?

DR. WELT: I think they are, and perhaps always have been. Those of us who are involved in delivering health care have always felt these pressures and paid attention to them in the sense that we are concerned about direct care of the patient in finding out what is wrong with him, making a proper diagnosis and giving proper treatment. I don’t think many patients can complain on this score.

But I do think patients have come to realize that they are experiencing many inconveniences which they see as unnecessary. There has been some waiting in the clinics for appointments; perhaps rudeness on the part of personnel in the hospital, or a whole array of inconveniences that can arise. Quality control, as far as the patient is concerned, has to include whether or not the bed is comfortable, the food is delivered on time and is warm, and whether the attitudes of the persons taking care of him are proper.

People coming into the hospital are frightened. It’s an anxiety-provoking situation and, for the disadvantaged among our citizens, it is especially frightening because it is another contact with establishments which, in their opinions, have not always been satisfactory.

I think all of these things have a bearing on the kind of quality control, or quality assurance, that patients are asking about. I doubt that people are dissatisfied with the merits of their professional care but they do have feelings about what is happening to them.

MR. WOMER: I would agree. However, I think patients generally have expressed more concern about environmental factors than medical quality because these are the only things that a patient has been able to measure. If the food is cold, the bed is hard or the bill is wrong, nothing is right as far as he is concerned. But external forces are now saying: “Start questioning medical quality.”

DR. BISHOP: What has produced this feeling among the people? Why are they saying, “Improve it?”
DR. RIEDEL: I think this can be answered from the standpoint of a sociologist, a political scientist or an economist. Each response would be different.

The sociologist, for example, might say that we're experiencing a clamor for the professional's justifying his privileged position, something that has never been questioned before.

The economist might interpret this as the public's clamor to justify increased costs which begin to hurt more and more.

A political scientist, on the other hand, might view it as further evidence of social upheaval that is being manifested in many areas; hospitals and medical care are one facet.

MR. BETTS: This situation is by no means limited to hospitals and medical care, but exemplifies an attitude that has developed in many aspects of our life. Consumerism has tended to foster in many people a sense of searching, a desire to become expert in all, or many, of the areas which affect their daily lives. Particularly in those fields which are complicated and technical, such as medical care, that searching is for understanding the criteria by which performance should be judged.

DR. WELT: Do you think that patients, the consumers, are more agitated about whether they get medical care—or whether it is of high quality?

DR. BISHOP: It is my personal opinion that it has moved from whether they get care to whether they get quality care.

DR. WELT: But there are an awful lot of people clamoring for care.

MR. WOMER: I think this is true in other sections of the country. There is a different problem in areas that are significantly rural where the question is, “Where can I get care?” as opposed to urbanized Connecticut where the question increasingly seems to be, “Where can I get the best care?”

But how can the individual citizen assess this? I would hazard a guess that you would draw a blank in nine out of ten cases if you were to ask a patient to evaluate the scientific and technical aspects of his medical care.

DR. FITZPATRICK: It is very difficult to assess quality of a health care program. Current public opinion standards are phrased in terms of peer review. Fellowship in the American College of Surgeons, for example, is one measure of a standard of achievement of a surgeon. Quality is maintained by on-going monitoring of the performance levels of surgeons. We have to have peer review. We have had tissue committees right along. But is that enough?

Patients are asking what type of operations they are going to have, if they are necessary and if they are going to be beneficial. They have the right to an honest answer.

DR. WELT: Books are being written now by people who have had breast operations. They're asking the doctor, questioning him, sometimes looking for another opinion on it. Some lady raised the question, was it valid to have the whole breast removed or could she have a “lumpectomy,” so she went somewhere where she got a “lumpectomy.”

Increased consumerism is also evident in patients obtaining second opinions about their medical problems. This seems to be a tendency especially of minority group persons as they assume higher economic status. Now that they have greater resources available through personal achievement or public funding, they are increasingly demanding a second physician's advice.

MR. WOMER: There is another element here, too. That of increased specialization. As patients are referred from one specialist to another, second opinions become part of this diagnosis and treatment.

The trust that may have been built up between the old-fashioned family practitioner and the patient has somewhat disappeared. Perhaps this, too, is an element in the natural evolution of our society.

DR. BISHOP: Perhaps it all boils down to credibility then. What part is the government playing in all of it?
DR. RIEDEL: Well—it certainly per-
cipitated things with Medicare.

Until the beginning of Medicare, only about three percent of the hospi-
tals in the United States have what is called a "utilization review committee." They had tissue committees, which reviewed all surgical specimens because they were required to have them by ac-
crediting bodies. Many hospitals also had "medical audit committees" or "medical audit processes," but they didn't have this thing called "utilization review."

In July of 1966, such committees were required by Medicare, and later, in 1967 when Medicaid came into being, the picture changed even more. We're just now beginning to realize the ramifi-
cations of these changes.

DR. BISHOP: In light of your experi-
ence in working in the Patient Care Studies Committee Program, Miss Pallet, what are some of the changes?

MISS PALTET: The most significant, of course, is that now hospitals must dem-
strate greater accountability. Initially, third party payers accepted the fact that a hospital had a Utilization Review Committee in effect as some guarantee of effective use of those resources and facilities brought into play in the care of patients.

Now, third party payers, both gov-
ernment and commercial agencies, are requesting copies of patients' records, and are beginning to question specific cases. In fact, they are beginning to withhold funds from hospitals in partic-
ular cases in which the necessity for continued in-hospital care is questioned.

DR. BISHOP: Would you call this a concern for "utilization" of services, or the "quality" of medical care?

MISS PALTET: I think it's still in the area of review of utilization of services and of length of stay.

I don't think that the third party payers are in a position, and they recog-
nize this, to evaluate the level of care provided to patients. They are con-
cerned with it and are hopeful, I believe, that hospitals will devise their own methods of monitoring the quality of care they provide.

I do believe, however, that, unless hospitals gear up and really start looking at quality, standards are going to be imposed from the outside.

MR. WOMER: At the risk of sounding cynical, I think the third party payer is into this for one reason—to minimize costs. And the only third party payers—at least in Connecticut—that are doing it, outside of an occasional question from a commercial insurance company, or from Blue Cross, are those acting on behalf of government, namely, Medicare and Medicaid. They measure what they can measure and that, principally, is length of stay. They just cannot and do not measure quality. Maybe one of these days they will get into such things as measuring operating room time to de-
termine if it is appropriate or not appro-
priate. It will take an enormous bu-
reaucracy to do it.

DR. BISHOP: But isn't it conceivable that evaluating the use of special ser-
vices is, in fact, an element of quality control?

DR. RIEDEL: It's very difficult to sep-
are effective use of services and facil-
ities from quality of care. Blue Cross, as an intermediary under Medicare, for ex-
ample, has an obligation to ensure that hospitals are, in fact, measuring the quality of service for their beneficiaries, as well as the effective use of the hospi-
tal's services and facilities.

DR. FITZPATRICK: If we as physicians don't get into measuring quality of care, someone else is going to come in to do it for us, a third party or even the pa-
tient himself.

DR. WELT: Let us look at quality control in terms of what the mechanic does for our automobiles.

I know nothing about the internal combustion engine. So... who is my advocate going to be? Who is going to guarantee that the mechanic is qual-
ified? That he is doing the right job? Putting in the right materials? And charging me a just fee? Is there a para-
agon to look at this problem?

MR. WOMER: As far as your auto-
mobile is concerned, there are all man-
er of consumer groups getting under-
way in this area and around the country. Perhaps it depends, as Don Riedel pointed out, on whether you're looking at it as a political scientist, an economist or a sociologist.

DR. WELT: It's very difficult to look at this problem objectively. How does an individual, as an intelligent consumer, create a system that will give him a rea-
sponsible guarantee that what he is get-
ing is proper, but one that will not, in the long run, limit the quality and avail-
ability of what he is seeking? It's pos-
sible, you know, to build up so much surveillance that it's too expensive to use.

MR. WOMER: Isn't part of this a lack of public understanding of what really goes on?
DR. WELT: I think so. There was a time when physicians thought they didn’t have to make explanations. We thought why can’t they just trust us? But today, obviously, they’re not going to just trust us. We have to tell them what we’re doing and why we’re doing it.

DR. BISHOP: I think it has to be recognized also that in this evolutionary progress there have been initial responses to address the problem—partly from within the health services industry and partly from outside. There traditionally has been a stylized pattern that we all have adopted. There is a Joint Commission on Accreditation of Hospitals that has been concerned with standards and quality of performance in the member institutions, which is supported by mutual voluntary participation. Institutions invite the presumably unbiased external critical observation of a group who are experienced in these areas.

The professional societies in which our medical staff members are active have become more active in these areas, and to some degree internal, that tend constantly to raise the questions and demand responsiveness. The point that I want this group to concern itself with this afternoon, is that despite our obligation to respond to these external influences, there also has been an evolution from within this institution in which concern for quality care of patients has invited, has initiated, and has sustained on-going programs of control. Not the least of those concerned is the responsible corporate body—the directors. I see an evolution of thinking in directors’ groups in which, in addition to their traditional concern with fiscal aspects, they are accepting and assuming the obligation for the quality performance of their medical staff.

As a member of the Board of Directors, Mr. Betts, how do you see this?

MR. BETTS: This increasing awareness and concern about the quality of medical care on the part of the consumer is not without its effect on directors as individuals.

The questions that are posed to anyone who has an official connection with the hospital today are far more searching and complex and far more difficult to answer than the ones that were usually asked only a few years ago.

Our Board members have increasingly endeavored to become more familiar with the problems that exist in the medical side of the operation of the hospital rather than limiting their interest to the areas of fiscal management and administration. A portion of each Board meeting of the Directors is devoted to a discussion by a member of the professional staff who describes current developments, unusual problems, special needs, future requirements, and other matters of special interest relating to his particular field.

It’s impossible to divorce these issues from fiscal problems because ultimately they affect hospital rates.

This makes the person who is a Board member more inclined to dig more deeply into what the needs are, what the justifications are, and what are the benefits to the public. He is likely to be called upon to give explanations of why certain expenditures are needed or what improvements have been in care or service to justify increased rates. This brings us back to that cost/benefit philosophy which is so much a part of the thinking today.

MR. WOMER: There’s another side we haven’t mentioned and that’s the legal position of the hospital. Ten or 15 years ago most hospitals across the country enjoyed charitable immunity. About the only way that a hospital could be sued successfully in most states was for out-and-out negligence—an open elevator shaft, for instance, without a warning sign—or lack of care in selecting employees. Then came the loss of charitable immunity and hospitals were required to accept legal responsibility for the acts of their agents or employees.

Also, for a long time it was thought that medical institutions should not be responsible for acts resulting from the
professional judgment of their physicians and nurses. It was felt that lay members of the corporate governing body could not make valid medical judgments. Therefore, only the individual doctor or nurse, as the case might be, was liable for his professional acts, not the institution itself.

Then came a court decision in Illinois, which ruled that an institution is responsible for the professional acts of its medical and nursing staffs. For the first time it became a matter of public policy and legal precedent that the governing body of a hospital assume this kind of responsibility.

DR. BISHOP: As a result, they are now deeply involved in quality control because they have the responsibility for the competency of their professional people.

An example of this involvement is the role the Board of Directors has in making appointments to the Medical Staff. The Directors have the responsibility for the adequacy and quality of medical care. They cannot delegate that responsibility. They can delegate the authority to implement their policies. The Board, through a variety of committees and procedures, delegates the evaluation of applicants for medical staff appointment based upon stated criteria. Acting upon the recommendations resulting from such examinations, the Directors make the ultimate decision to appoint.

MR. WOMER: I would like to move to what is being done about quality control within the departments themselves. If quality is to be controlled in the care of patients, it should begin on the patient divisions and other areas where the care is being given. It can be monitored, after the fact perhaps, from an office in a different section of the hospital, but the control that means the most to me is that which goes into the diagnosis and treatment of each individual patient.

DR. WELT: One might start with a patient appearing at the Emergency Service, having been sent in by a physician or having come in by ambulance. A decision must be made as to whether or not this patient should be admitted to the hospital. One of the things this hospital has done, in contrast to other teaching hospitals, is that it has house staff assigned in the emergency service who are not the most junior. It has doctors who have had a certain amount of experience which has sharpened their skills and their judgment and has made them more sensitive to clues about whether or not to admit. Medical patients who are admitted, for example, are reviewed the next day by a group in the ambulatory care unit of the medical department during what we call "morning reports."

Incidentally, I hope to see a system developed for reviewing patients who were not admitted. I think it could be very important to find out whether those non-admissions were appropriate in all cases.

The "morning report" sessions are especially important to us, as Chiefs of Service and to our senior residents, because it gives us a complete review of everything that has taken place in the diagnosis and treatment of patients admitted during the preceding 24 hours. In addition, there are follow-ups on other, previously admitted patients at the same report. Thus, if something needs clarification, the Chief has the opportunity to find out what treatment was given Mr. Y. to know what the x-rays showed, what the results were of this or that test, and so forth. In this way, the Chief of Service, or his delegate, plays a very significant role in maintaining quality control of the management of that patient.

However, it's not something that the public would have any reason to know about. It is extremely important in monitoring quality of care and it's a fantastic element in medical teaching, not only for the house staff, I can assure you, but as the best kind of postgraduate education the Chief of Service can get himself. The Chief must deal with all kinds of problems and there just aren't enough hours in the day to keep abreast of all the medical journals and their accounts of new developments. But the residents, dealing as they do within their specialties apply their knowledge in reviewing the cases.

I think it is interesting to see the depth to which our residents know our patients. I am thinking, in particular, of the Chief Resident in Medicine, and I suspect his attitude is typical of that here at Yale. He is almost compulsive about knowing about every patient who comes on the Medical Service. He has seen their charts, and he has examined at least half of the patients. He goes into great detail about their problems and instructs his house staff about them, giving them things to read pertaining to specific problems. He is really aware of what's going on. And this is a very important element of control. It's hard on him; I'm not quite sure how he does it all. He's in here early and back late at night.

There's another internal phase of quality control within the departments. This concerns what we call "attending rounds." Attending physicians, as you well know, are the doctors who have taken charge of particular patients admitted to the hospital. Some of these attending doctors, of course, are community physicians; others may be members of our full-time medical faculty.

These attending physicians, although responsible for them, did not always see their patients in depth. Certainly they knew their patients' problems and their progress, but the ones to whom the attendings paid the most attention, in some instances, were those patients with an especially complicated problem or in
whom the house staff had a particular interest from the standpoint of specialty training. Now with Medicare, that practice has been modified in a functional way because Medicare requires personal identification of patient and physician and the attending physician must supply it. Now the attending physician, on our “attending rounds,” makes sure he knows every patient and all the facts about him.

MR. WOMER: The attending who was assigned to a patient unit was actually more of a consultant before, now he is the responsible physician of record for many patients.

DR. WELT: That’s right. And this makes a difference. To carry this discussion a bit further, there are a number of specialty sections in each of the major hospital departments, and each of these sections has a meeting, at monthly intervals at least, if not more often, in which they discuss special problems of patient care within their sub-speciality. These meetings usually include nurses as well as physicians since their contributions are valuable to the total picture, particularly in their notes that are included as a part of the patient’s medical record.

So, with all these docket-tailing areas of patient care, I’m not too worried about the quality of care a patient gets while he is in the hospital.

But I did worry about him after he leaves, until the hospital created its new program of discharge planning and home care. I look forward to this helping patients get proper after-hospital care.

MR. WOMER: Another monitoring device is the patient comment form; which patients are encouraged to fill out and return to the hospital. All patient comment letters are read, and those with specific complaints or suggestions are forwarded to the department concerned for action.

Incidentally, we’re planning to try a new approach to the patient “ombudsman” idea.

In the near future we’re planning to set up a “hot-line” in a couple of patient units. The “hot-line” telephone will be available to patients for whatever question or comment they wish to make, after they’ve made an initial query of their charge nurse.

We don’t know quite what will come from this but it will be interesting to see what does.

DR. WELT: Speaking of complaints, we have initiated a discussion of complaints in our Department. I have used it elsewhere to good effect.

Once a week, all of the house staff in Medicine are invited to meet with me and the Chief Resident for clinical discussions. At that time they are encouraged to make whatever complaints they want. It gives them a chance to ventilate. I think that’s important.

MR. WOMER: From the patient’s standpoint, also, we have the Patient Advocate office which was set up several years ago to help in particular, minority group patients and patients who don’t speak English.

DR. BISHOP: How does all this strike you, Dr. Fitzpatrick, in regard to controlling the quality of the patient’s hospital care? You’ve had long experience as a surgeon practicing in the community. What do you think about the subject of quality control?

DR. FITZPATRICK: Well, for example, we have the standards of the Joint Commission on Accreditation of Hospitals which require review of all surgical procedures as well as evaluation of complications and causes of death.

We’re also very assiduous in reviewing medical records of patients and this reflects one of my serious concerns. The medical records are not as complete as we would like them to be and we’re still trying to find ways for improving them. The problem is, the best physician may keep the worst records. How do we correct that? That’s why it’s so difficult to measure the quality of care upon reviewing the record.

I am wondering how we are going to assess physicians in the future in the face of the crushing volume of new knowledge—and the overwhelming demand for reports, notes, meetings, and so on. What is going to be done to keep the young fellows coming along abreast of progress? The half-life of our medical knowledge is about five to ten years. Think of it—a physician’s knowledge can become obsolete if he isn’t exposed to or if he doesn’t get a chance to take advantage of continuing education.

Will physicians have to be re-certified say, every five years?

DR. BISHOP: Should we demand it internally, do you think? Or is this to be determined by external influence?

DR. FITZPATRICK: Well, if we want to be leaders, we’d better do something about it, or someone else, the nonprofessional, is going to do it for us.
This is the accepted fact in business. If a man with an important position in business doesn’t measure up to snuff, his position is soon in jeopardy. The American College of Surgeons, recognizing that peer review activities have increased recently and may well become a permanent feature, have encouraged voluntary examination of the membership. In this way the individual surgeon is offered self-assessment. No one wants to rock the boat, but maybe we have to undertake committee review to assure quality among our physicians. We have been doing this but outside forces are demanding a better yardstick. I hate to think of periodic examinations because this does not give the full measure of a surgeon, and, although I agree with the concept of peer review, our institution should not be too disciplined by outside forces.

One valuable educational mechanism in assuring quality is Grand Rounds. Although it isn’t mandatory for a member of our Staff to take part in Grand Rounds in which medical advances or questions are explored, physicians are encouraged to do so. It is an invaluable source of education. Maybe we need a little disciplinary action for those of us who don’t go to rounds, who don’t take part in these educational programs.

DR. WELT: I think one of the first questions I’d ask if people aren’t coming to those sessions, is: What’s wrong with them? Why don’t they grab you? I think one has to be sure that what is being offered is something that’s worthwhile. Once that is established, I think we’re in a better position to be more demanding about attendance.

MR. WOMER: I believe there should be a re-examination and recertification of physicians on a periodic basis, at least every ten years or so. I think that if there were such a requirement, it would stimulate a far greater interest among doctors in educational programs which are designed to keep their knowledge current. The same thing also can be said in the case of other health professionals.

DR. WELT: I don’t disagree with that, but again we’d have to set the requirements so that a physician, who thought he might spend that time to better advantage in the library, would not be penalized.

DR. BISHOP: I think we ought to turn, now, to discussion of a hospital-wide activity which we have undertaken here at Yale-New Haven called the Patient Care Studies Department. As you know, a requirement of Medicare at its inception in 1966 was that each hospital have a utilization review committee to make that hospital eligible for Medicare reimbursements. We didn’t think that minimum requirement was broad enough, so we expanded it into this program and gave it a new name. Don, will you fill us in on details?

DR. RIEDEL: We consider the Patient Care Studies Department as the hospital’s unique response to both internal needs and some of the external requirements, such as those of Medicare and Medicaid.

It absorbed functions that were previously handled by separate committees, principally the tissue committee and the utilization review committee. We believe this is a more efficient use of the professional resources of the hospital.

In addition, we have done what we think is unique. We have a small full time staff that provides support for the patient care studies functions with the hospital—this includes a physician director of the department, a specially trained nurse and clerical staff.

Much of our effort the past eighteen months or so has been to document the basis for patients receiving care under Medicare and Medicaid.

DR. BISHOP: In this regard it should be noted that in the course of a 12-month experience we have been challenged in respect to something in excess of a million dollars of billings for services to patients under Medicare and Medicaid. I use the term “challenged” deliberately because in some instances the issue is a matter of provision of adequate documentation—in others, it’s a question of the appropriateness of the services provided. But this is an element of quality control. It has become a significant responsibility, and I think the record of achievement is an outstanding one. After third party review of additional data and documentation, reimbursement disapproval was reduced from the original $1.1 million to less than $18,000.
DR. RIEDEL: I guess my sense of disappointment lies in the fact that the institution, the Medical Board, and those of us involved in the creation of the patient care studies program did it in order to monitor professional performance and to promote standards of quality care.

We found instead that we had created a receptacle for various barrages coming from third party payers. We now find we must devote an excessive amount of time to detail which was not originally intended to be a responsibility of this group.

Nevertheless, we are pleased with the progress we have made and hope to refine our activities so that we can review patient care as it is reflected in medical records, and as it is being delivered to patients while they are still in the hospital.

DR. BISHOP: Do you ask members of the Medical Staff to act as reviewing agents? Does this promote quality?

MISS PALLET: Yes we do and I think it does. Interestingly enough, just before I came to this meeting, I spent two and one-half hours with a surgeon reviewing records. We had a hard time dragging him over to the records because he didn't think it was going to be an interesting activity, or an educational one. But after the first hour he made the comment that he thought every surgeon on the staff ought to be over here and expected to do the same thing—because he thought it was that educational.

For the most part, however, I don't think physicians feel that reviewing records after the patient has been discharged from the hospital is a very worthwhile experience either for them, or for the patient. Physicians are more interested in an on-going concurrent review program while the patient is still in the hospital so that changes in patient care can be effected.

We're also interested in involving nurses and other health professionals in the review process; not in a medical review by physicians only. The evaluation process must involve the many people who take part in caring for the patients—we must include all members of the health care team to make the evaluation process really effective.

DR. BISHOP: In other words, the quality of total care depends upon the sum of many parts.

I would like to add one final note to this discussion by saying that I think the atmosphere of a university teaching hospital is also a significant factor in the concept of quality and the ultimate control of quality. It draws to the institution through its medical staff and training programs a high level of professional expertise. It's impossible not to recognize this as a fact. The teaching institution brings to medical care inquiring young minds which insist on knowing "why?" When "why" is constantly being asked you have both quality and an important device for quality control.
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Otolaryngology
Section Chief
John A. Kirchner, M.D.
Associate Section Chief
Charles Petrillo, M.D.

Plastic and Reconstructive Surgery
Section Chief
Thomas J. Krizek, M.D.
Associate Section Chief
Irving M. Polayes, M.D.

Urology
Section Chief
Bernard Lyttton, M.D.
Associate Section Chief
John B. Goetsch, M.D.

Medical Board 1972
Chairman
Courtney C. Bishop, M.D.
Vice Chairman
Nicholas M. Greene, M.D.
Secretary
Richard H. Judd

Charles B. Carrington, M.D.
David H. Clement, M.D.
Jack W. Cole, M.D.
Charles D. Cook, M.D.
Lycurgus M. Davey, M.D.
Thomas P. Detre, M.D.
Thomas F. Dolan, Jr., M.D.
Gilbert H. Glaser, M.D.
Wilbur D. Johnston, D.D.S., M.D.
Nathan G. Kase, M.D.
Samuel D. Kushlan, M.D.
Stanley R. Lavietes, M.D.
Aaron B. Lerner, M.D.
Lewis L. Levy, M.D.
Woodrow W. Lindenmuth, M.D.
Ralph W. Littwin, M.D.
John C. Moench, M.D.
Marvin L. Sears, M.D.
David Seligson, M.D.
Herbert R. Sleeper, D.D.S.
Harold Stern, M.D.
Lewis Thomas, M.D.
Louis G. Welt, M.D.
Harold N. Willard, M.D.
Charles B. Womer
THE AUXILIARY
1972

Officers
President
Mrs. Robert Adnopoz
1st Vice President
Mrs. Lawton G. Sargent, Jr.
2nd Vice President
Mrs. John E. Smith
Corresponding Secretary
Mrs. Henri Peyre
Recording Secretary
Mrs. Charles Gesner
Treasurer
Mrs. S. Michael Gompertz
Treasurer of the Carryall Shops
Mrs. Allan K. Poole, Jr.

MEDICAL STAFF
1972

Consulting
12
Emeritus
8
Attending
408
Associate
163
Courtesy
104
Dentists and Physicians to the Ambulatory Service Staff
176
House Staff
Clinical Fellows
166
Interns and Residents
293
Professional Staff (non M.D.)
26
Total
1,486
Less Duplications
9
Total Medical Staff
1,477

*Full-time Physicians
268
General Practitioners
49

*The numbers given here include physicians with offices at the Veterans Administration Hospital and the Connecticut Mental Health Center who also hold Yale-New Haven Hospital appointments.

ELECTED OFFICERS OF THE MEDICAL STAFF

President
Lewis L. Levy, M.D.
Vice President
Harold Stern, M.D.
Secretary
Andrew J. Graham, M.D.
Past President
Lycurgus M. Davey, M.D.

ANNUAL MEETING OF THE BOARD OF DIRECTORS

Five prominent members of the community were elected to the Yale-New Haven Hospital's Board of Directors at its annual meeting held on Wednesday, February 23, 1972.

Elected to three-year terms were: Mrs. Robert L. Arnstein, Henry Chauncey, Jr., Harry D. Jefferys, C. Newton Schenck, III, and Charles E. Woods.

Retiring Board members were: Charles S. Gage, Lionel S. Jackson, Frank Kenna, Jr., and Daniel W. Kops.

James H. Gilbert, president of the Board, was re-elected to a three-year term. Also re-elected to three-year terms were Henry E. Parker, and Charles H. Taylor, Jr. Stanley S. Trotman was elected to the unexpired one-year term of Richard H. Bowerman who had resigned the previous June.

BOARD OF DIRECTORS
1972

Officers
President
James H. Gilbert
Vice Presidents
John M.C. Betts
Mrs. Angus N. Gordon, Jr.
Stanley S. Trotman
G. Harold Welch, Jr.
Secretary
John Q. Tilson
Treasurer
William A. Thomson, Jr.
Counsel
John Q. Tilson
Directors
Mrs. Robert Adnopoz
Mrs. Robert L. Arnstein
John M.C. Betts
Kingman Brewster, Jr.
Henry Chauncey, Jr.
Milton P. DeVane
John E. Ecklund
Alfred B. Fitt
James H. Gilbert
Louis Goodwin
Mrs. Angus N. Gordon, Jr.
William Horowitz
Harry D. Jefferys
Robert I. Metcalf
Henry E. Parker
William B. Ramsey
C. Newton Schenck, III
Leo F. Stanley
Charles H. Taylor, Jr.
William A. Thomson, Jr.
John Q. Tilson
Stanley S. Trotman
G. Harold Welch, Jr.
Charles E. Woods

VALE - NEW HAVEN HOSPITAL
NEW CONSTRUCTION AND RENOVATIONS

The period from October 1, 1971, through September 30, 1972, saw the major portion of constructing two additional floors on the Memorial Unit nearly completed. The tenth floor was finished in May, 1972, and the ninth floor in June, 1972. The ninth floor was used for the temporary location of beds and services from the eighth floor while renovations took place on that floor, including the construction of a new Coronary Care Unit scheduled for opening later in the year.

Patient care areas on the tenth floor provided a 20-bed Selective Care Unit on one wing, and a 41-bed psychiatric service on the other three wings of the floor. The new psychiatric division, including a Neuropsychiatric Evaluation Unit, replaced the Tompkins I Unit of the New Haven Unit.

Ninth floor divisions, scheduled for opening early in 1973, called for the provision of 68 beds, primarily for gynecological patients.

A complete renovation and conversion of Tompkins 1 from a psychiatric division to a surgical division was started in August with completion projected for November, 1972.

It is contemplated that the total bed complement of Yale-New Haven Hospital will be increased from 765 beds to approximately 886 when all work is completed early in 1973.

The central kitchen in the basement of the Memorial Unit was expanded and remodeled and a central tray service inaugurated.

Admitting Offices in the Memorial Unit, along with adjacent lobby areas, were completely remodeled.

A project to expand Clinical Laboratory services by the construction of an extension to the sixth floor of Fitkin was begun in August with completion anticipated in May, 1973. Final work will also include renovation of the existing laboratories.

RESOLUTION OF APPRECIATION GIVEN TO AUXILIARY

The Auxiliary celebrated its 20th anniversary at its annual spring luncheon April 26, 1972. In recognition of its service to the Hospital, and the more than $600,000 the Auxiliary has contributed to the Hospital in 20 years, the Board of Directors of Yale-New Haven Hospital presented the Auxiliary with the following framed resolution at that meeting:

"Whereas — The Auxiliary, since its inception, has been an integral participant in the affairs of the Yale-New Haven Hospital, and

Whereas — The Auxiliary has provided a special dimension of service, as well as financial support, and

Whereas — The Auxiliary's allocation of more than $60,000 this year for community services and equipment is especially gratifying in view of the more than usual restrictions on the Hospital's budget; therefore be it

Resolved — That the Board of Directors deems it appropriate to officially acknowledge its sincere appreciation to the Auxiliary of Yale-New Haven Hospital in the proceedings of this meeting."
Director
Charles B. Womer

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

Assistant Directors
Carl R. Fischer
Kenneth L. Grubbs
David Stockton
Joseph A. Zaccagnino

Executive Assistant to the Director
Frank M. Isbell

Accounting
Leonard A. Reilly

Administrative Engineer
John W. Manz

Anesthesiology
Nicholas M. Greene, M.D.

Building Services
Grant L. Berger, Jr.

Business Services
Charles N. Starbranch

Clinical Laboratories
David Seligson, M.D.

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

Data Processing
Gordon G. Willard

Dentistry
Herbert R. Sleeper, D.D.S.

Dietetics
Miss Doris Johnson, Ph.D.

Emergency Service
Paul P. Lally

Employee Education
Lawrence A. Loomis

Engineering
Raymond H. Brown

Information and Development
Donald R. Kleinberg

Inhalation Therapy
John J. Julius

Linen Service
Miss Josephine Locarini

Medical Records
Miss Patricia A. Tourey

Nursing, Division of
Miss Anna E. Ryle, R.N.

Operating Rooms
Mrs. Luba Dowling, R.N.

Patient Care Studies
Kenneth Williams, M.D.

Patient Support Services
T. Brian Condon

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

Personnel
Kenneth L. Grubbs

Pharmacy
Donald F. Beste

Physical Therapy
Reivan Zeleznik

Purchasing
Joseph E. Monahan

Radiology
Ralph Littwin, M.D.

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

Security Services
Jules S. Stollak

Social Service
Miss Carol Anderson, Chairman

Special Services
Albert P. Freije

Volunteer Service
Miss Norcott Pemberton

NEW APPOINTMENTS TO SEPTEMBER 30, 1972

Mrs. Margaret Benton, R.N.
Home Care Coordinator
Discharge Planning and Home Care Department

Mrs. Susan Shimelman
Administrative Resident
July 1972 –

Gerald Starr
Administrative Resident
January - June 1972

David L. Stockton
Assistant Director

Joseph A. Zaccagnino
Assistant Director

Louis G. Welt, M.D.
Chief of Medicine

Dr. Welt, former chairman of the Department of Medicine at the University of North Carolina, was appointed Chairman of the Department of Medicine at Yale University School of Medicine to succeed Dr. Philip K. Bondy who left for sabbatical leave in London, England.
## COMPARATIVE STATISTICS

<table>
<thead>
<tr>
<th></th>
<th>1972</th>
<th>1971</th>
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<tbody>
<tr>
<td>Patients discharged during the year</td>
<td>32,676</td>
<td>34,006</td>
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<tr>
<td>Patient days care rendered</td>
<td>258,016</td>
<td>261,989</td>
</tr>
<tr>
<td>Average length of patients’ stay (days)</td>
<td>7.9</td>
<td>7.7</td>
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<tr>
<td>Average daily patient census</td>
<td>705</td>
<td>718</td>
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<tr>
<td>Clinic visits</td>
<td>154,319</td>
<td>154,628</td>
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<tr>
<td>Emergency service visits</td>
<td>84,788</td>
<td>87,760</td>
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<tr>
<td>Operations</td>
<td>13,951</td>
<td>13,817</td>
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<tr>
<td>Recovery Room cases</td>
<td>11,526</td>
<td>11,215</td>
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<tr>
<td>Deliveries</td>
<td>4,264</td>
<td>5,160</td>
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<tr>
<td>Diagnostic Radiology exams</td>
<td>120,085</td>
<td>110,983</td>
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<tr>
<td>Laboratory exams</td>
<td>1,308,012</td>
<td>1,199,472</td>
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<td>Physical Therapy treatments</td>
<td>26,205</td>
<td>22,210</td>
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<tr>
<td>Electrocardiology exams</td>
<td>31,558</td>
<td>28,866</td>
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<tr>
<td>Electroencephalography exams</td>
<td>2,951</td>
<td>2,669</td>
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## INPATIENT STATISTICS

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<thead>
<tr>
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<th>Patient Days</th>
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<tbody>
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<td></td>
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<td>1971</td>
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<tr>
<td></td>
<td>1972</td>
<td>1971</td>
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<tr>
<td><strong>ADULTS</strong></td>
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<tr>
<td>Gynecology</td>
<td>3,213</td>
<td>3,086</td>
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<tr>
<td>Obstetrics</td>
<td>4,603</td>
<td>5,163</td>
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<tr>
<td>Psychiatry</td>
<td>186</td>
<td>155</td>
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<tr>
<td>Radiology</td>
<td>89</td>
<td>100</td>
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<tr>
<td>Medicine</td>
<td>6,127</td>
<td>6,839</td>
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<tr>
<td>Surgery:</td>
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<td></td>
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<tr>
<td>Cardiothoracic (Cardiovascular and Thoracic)</td>
<td>526</td>
<td>455</td>
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<tr>
<td>Dental</td>
<td>150</td>
<td>149</td>
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<tr>
<td>Neurosurgery</td>
<td>962</td>
<td>889</td>
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<tr>
<td>Ophthalmology</td>
<td>639</td>
<td>560</td>
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<tr>
<td>Orthopedic</td>
<td>1,434</td>
<td>1,293</td>
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<tr>
<td>Otorhinolaryngology</td>
<td>621</td>
<td>598</td>
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<tr>
<td>Plastic</td>
<td>534</td>
<td>506</td>
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<tr>
<td>Urological</td>
<td>1,623</td>
<td>1,523</td>
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<tr>
<td>General</td>
<td>3,716</td>
<td>3,717</td>
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<tr>
<td>Total Surgery</td>
<td>10,205</td>
<td>9,690</td>
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<tr>
<td><strong>Total — Adults</strong></td>
<td>24,423</td>
<td>25,033</td>
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<tr>
<td></td>
<td>214,971</td>
<td>213,950</td>
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<tr>
<td><strong>CHILDREN</strong></td>
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<tr>
<td>Medical</td>
<td>1,559</td>
<td>1,789</td>
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<tr>
<td>Surgical</td>
<td>2,194</td>
<td>2,275</td>
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<tr>
<td>Total — Children</td>
<td>3,753</td>
<td>4,064</td>
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<tr>
<td></td>
<td>21,455</td>
<td>23,980</td>
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<tr>
<td><strong>NEWBORN</strong></td>
<td></td>
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<tr>
<td>Normal</td>
<td>3,924</td>
<td>4,092</td>
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<tr>
<td>Special Care</td>
<td>576</td>
<td>817</td>
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<tr>
<td>Total — Newborn</td>
<td>4,500</td>
<td>4,909</td>
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<tr>
<td><strong>TOTAL — ALL PATIENTS</strong></td>
<td>32,676</td>
<td>34,006</td>
</tr>
<tr>
<td></td>
<td>258,016</td>
<td>261,989</td>
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</table>
### CLINIC VISITS

#### MEDICINE

<table>
<thead>
<tr>
<th>Service</th>
<th>1972</th>
<th>1971</th>
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</thead>
<tbody>
<tr>
<td>General</td>
<td>7,347</td>
<td>8,237</td>
</tr>
<tr>
<td>Allergy</td>
<td>2,677</td>
<td>2,920</td>
</tr>
<tr>
<td>Arthritis</td>
<td>580</td>
<td>696</td>
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<tr>
<td>Cardiac</td>
<td>1,322</td>
<td>1,510</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>1,291</td>
<td>1,848</td>
</tr>
<tr>
<td>Convenience</td>
<td>239</td>
<td>364</td>
</tr>
<tr>
<td>Dermatology</td>
<td>6,505</td>
<td>8,661</td>
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<tr>
<td>Gastrointestinal</td>
<td>3,012</td>
<td>3,262</td>
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<tr>
<td>Hematology</td>
<td>923</td>
<td>1,078</td>
</tr>
<tr>
<td>Liver</td>
<td>1,143</td>
<td>1,061</td>
</tr>
<tr>
<td>Metabolism</td>
<td>2,265</td>
<td>2,103</td>
</tr>
<tr>
<td>Neurology</td>
<td>1,515</td>
<td>1,488</td>
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<tr>
<td>Physical Medicine</td>
<td>101</td>
<td>148</td>
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<tr>
<td>Private Referrals</td>
<td>4,812</td>
<td>4,646</td>
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<tr>
<td>Pyelonephritis</td>
<td>169</td>
<td>104</td>
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<tr>
<td>Rheumatology</td>
<td>917</td>
<td>385</td>
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<tr>
<td>Venereal Disease</td>
<td>3</td>
<td>48</td>
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<tr>
<td>Winchester Chest</td>
<td>3,707</td>
<td>4,106</td>
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<tr>
<td><strong>Total — Medicine</strong></td>
<td>38,528</td>
<td>42,575</td>
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</table>

#### SURGERY

<table>
<thead>
<tr>
<th>Service</th>
<th>1972</th>
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</thead>
<tbody>
<tr>
<td>General</td>
<td>10,027</td>
<td>9,493</td>
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<tr>
<td>Cardiac</td>
<td>1,331</td>
<td>1,187</td>
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<tr>
<td>Dental</td>
<td>5,352</td>
<td>5,978</td>
</tr>
<tr>
<td>Hand</td>
<td>452</td>
<td>347</td>
</tr>
<tr>
<td>Minor Surgery</td>
<td>961</td>
<td>887</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>2,111</td>
<td>1,884</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>14,110</td>
<td>12,136</td>
</tr>
<tr>
<td>Orthopedic:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>3,495</td>
<td>3,732</td>
</tr>
<tr>
<td>Fracture</td>
<td>3,484</td>
<td>3,012</td>
</tr>
<tr>
<td>Pediatric</td>
<td>635</td>
<td>551</td>
</tr>
<tr>
<td>Otorhinolaryngology:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>3,589</td>
<td>3,618</td>
</tr>
<tr>
<td>Hearing &amp; Speech</td>
<td>3,777</td>
<td>4,923</td>
</tr>
<tr>
<td>Private Patients</td>
<td>2,897</td>
<td>3,729</td>
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<tr>
<td>Pacemaker</td>
<td>320</td>
<td>272</td>
</tr>
<tr>
<td>Pain</td>
<td>143</td>
<td>16</td>
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<tr>
<td>Peripheral Vascular</td>
<td>463</td>
<td>355</td>
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<tr>
<td>Plastic</td>
<td>3,113</td>
<td>2,616</td>
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<tr>
<td>Surgical Tumor</td>
<td>41</td>
<td>51</td>
</tr>
<tr>
<td>Thoracic</td>
<td>290</td>
<td>405</td>
</tr>
<tr>
<td>Urology</td>
<td>4,134</td>
<td>4,441</td>
</tr>
<tr>
<td><strong>Total — Surgery</strong></td>
<td>60,725</td>
<td>59,633</td>
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</table>

#### OBSTETRICS & GYNECOLOGY

<table>
<thead>
<tr>
<th>Service</th>
<th>1972</th>
<th>1971</th>
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</thead>
<tbody>
<tr>
<td>Family Planning</td>
<td>954</td>
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<tr>
<td>Gynecology — General</td>
<td>6,463</td>
<td>6,232</td>
</tr>
<tr>
<td>Gynecology — Tumor</td>
<td>321</td>
<td>300</td>
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<tr>
<td>Obstetrics</td>
<td>7,472</td>
<td>8,986</td>
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<tr>
<td>Private Referrals</td>
<td>6,476</td>
<td>5,236</td>
</tr>
<tr>
<td><strong>Total — Obsetrics &amp; Gynecology</strong></td>
<td>21,686</td>
<td>21,787</td>
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</table>

#### PEDIATRICS

<table>
<thead>
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<th>Service</th>
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<tbody>
<tr>
<td>General</td>
<td>6,635</td>
<td>6,380</td>
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<tr>
<td>Adolescent</td>
<td>1,214</td>
<td>1,673</td>
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<tr>
<td>Allergy</td>
<td>614</td>
<td>863</td>
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<tr>
<td>Cardiac and Surgical Cardiac</td>
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<td>2,947</td>
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<tr>
<td>Surgical</td>
<td>310</td>
<td>319</td>
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<tr>
<td>Cystic Fibrosis</td>
<td>508</td>
<td>503</td>
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<tr>
<td>Child Care</td>
<td>90</td>
<td>132</td>
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<tr>
<td>Convenience Clinic</td>
<td>35</td>
<td>216</td>
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<tr>
<td>Dermatology</td>
<td>157</td>
<td>221</td>
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<tr>
<td>Endocrinology</td>
<td>337</td>
<td>284</td>
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<tr>
<td>G. Powers Development Evaluation</td>
<td>43</td>
<td>119</td>
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<tr>
<td>Gastrointestinal</td>
<td>437</td>
<td>383</td>
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<tr>
<td>Genetics — Birth Defects</td>
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<td>928</td>
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<tr>
<td>Hematology</td>
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<td>1,263</td>
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<td>Lead Poisoning</td>
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<td>372</td>
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<tr>
<td>Nephrology</td>
<td>490</td>
<td>540</td>
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<tr>
<td>Neurology</td>
<td>777</td>
<td>777</td>
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<tr>
<td>Newborn Special Care</td>
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<td>128</td>
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<td>Oncology</td>
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<td>20</td>
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<tr>
<td><strong>Total — Pediatrics</strong></td>
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<td>18,068</td>
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#### PSYCHIATRIC

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<tbody>
<tr>
<td><strong>Total — Psychiatric</strong></td>
<td>12,301</td>
<td>12,565</td>
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#### RADIOLOGY

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<tbody>
<tr>
<td>Radiation Follow-up Visits</td>
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<td></td>
</tr>
<tr>
<td>Not included in Clinic Visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1969</td>
<td>1,263</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1970</td>
<td>2,578</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1971</td>
<td>2,695</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1972</td>
<td>2,630</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL — ALL CLINIC VISITS</strong></td>
<td>150,129</td>
<td>154,628</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
OCTOBER 1971 —
A training course for ambulance drivers and rescue squad workers was initiated by the Hospital’s Emergency Service staff. Involved in the program were 25 hours of classroom instruction and ten hours of observation in the Emergency Service itself.

The United Way campaign was launched. Hospital employees, at final count, gave $22,495.

The Drug Information Center of the Hospital’s Pharmacy developed and distributed a Hospital Formulary Catalogue listing analyses and combinations of drugs for reference by professional personnel.

NOVEMBER 1971 —
General salary increases of $8, $10, and $12 per week with $2.70 minimum wage for professional, nursing and service employees were announced during the summer but were delayed until this month because of the government’s wage/price freeze. Retroactive wage hikes went into effect along with time and one-half paid to employees working on holidays.

Community health plans which serve some 75,000 residents in the Greater New Haven area were discussed by a panel at the Fall luncheon of the Auxiliary.

DECEMBER 1971 —
New England Hospital Assembly awarded Honorable Mention to the Hospital for its exhibit, “Order Number One,” a Hospital-produced film on fire safety.

Fringe benefits for employees were increased by the end of the year to include $1,000 life insurance for retirees and sick leave accrual to 130 days.

225 pints of blood were collected during the mid-winter Bloodmobile drive.

Members of the Administrative Staff held their annual Christmas season coffee and doughnuts open house for Hospital employees.
JANUARY 1972 –
Service awards were given to 252 employees who were honored at a reception in the Memorial Unit for their terms of service ranging from five to 20 years.

Special meetings at the Medical Center during the month included a luncheon for the clergy of the area, and a two-day regional meeting of the Association of American Medical Colleges.

The Medical Committee of the Board of Directors of the Hospital initiated a study of the Board’s policy on making staff selections.

FEBRUARY 1972 –
More than 250 students from 20 area high schools attended the annual Health Careers Day sponsored by the Heart Association of Greater New Haven and Yale-New Haven Hospital.

The annual six-session Institute for the Intensive Care of Newborn and Premature infants began its one-day-a-week series for physicians and nursing personnel from throughout southern New England.

The 1971-72 Auxiliary budget allocated funds for Hospital equipment; for scholarship aid for students in Hospital-based programs; for the Patient Assistance program; and for DART, the Hospital’s program to identify and appraise suspected cases of child abuse.

MARCH 1972 –
A merger of the Departments of Unit Management and TAC led to creating a new Department: Patient Support Services. Four sections within the new department were identified as: Patient Equipment, Communications, Evening Patient Support Services and Unit Management. Another section, Materials Management, became a part of the Purchasing Department.

The first of regularly scheduled monthly meetings was held by the newly created Mutual Respect Committee which included 18 members representing a cross-section of the Hospital. The committee will work to define and recommend ways of fostering greater mutual respect among employees.

High speed computer retrieval of some 400,000 references from medical journals were made available to the Hospital’s staff through the new MEDLINE system at the Yale Medical Library.
APRIL 1972 —
Yale-New Haven Hospital was one of five area hospitals participating in the first cooperative laundry in Connecticut. The new facility combines laundry service for The Hospital of St. Raphael, Milford Hospital, St. Vincent's and Park City hospitals of Bridgeport, in addition to Yale-New Haven. The new facility was formally dedicated on April 3 at its location on the Boston Post Road in Milford.

Additional benefits for employees included full semi-private maternity coverage under Blue Cross with the Hospital paying an additional $2.05 of the CMS family contract and $1.15 of the husband and wife contract. The individual contract became free of charge to employees. The Hospital also picked up full major medical insurance costs; extended life insurance coverage for 20-hour or more part-time employees; and made eligibility date six months instead of one year.

The Hospital's "Quarter Century Club," for employees with 25-year records and for retirees, held its annual honors-award dinner in the Presidents' Room at Woolsey Hall. A total of 123 members were honored, including eight who became eligible under revised rules allowing for interrupted employment; and 11 with 25 years of continuous service.

MAY 1972 —
Certificates were awarded to 130 management and supervisory personnel who completed the Hospital's Supervisory Training and Development programs.

The Hospital's bowling league wound up its season with an awards dinner on May 12.

The spring Bloodmobile drive yielded 290 pints, 90 more than its goal.

JUNE 1972 —
A centralized tray service went into production making it possible for the Department of Dietetics to prepare food trays for all patient divisions within an hour.

A news media conference was held June 29 to mark the opening of the new psychiatric division on the newly constructed tenth floor of the Memorial Unit.

The Hospital's annual picnic brought out hundreds of Hospital employees, their families and friends.
JULY 1972 —
Full Department status was granted to the
Specialty sections of Dermatology, Neurology
and Ophthalmology.

Medical Center administrative changes included the appointment of Dr. Lewis Thomas as Dean of the Yale School of Medicine; and Miss Donna K. Diers as Dean of the Yale School of Nursing.

Dr. Thomas had been a member of the Yale Department of Pathology and former dean of the New York University School of Medicine. He succeeded Dr. F. C. Redlich.

Miss Diers succeeded Miss Margaret G. Arnstein.

More than 200 Hospital volunteers, staff members and other interested persons took part in the annual Health Careers Carnival sponsored by the departments of Employee Education, Volunteer Service and Personnel.

Stipends for House Staff were increased to $9,865 for first year members and $13,345 for chief or senior residents.

289 youths were employed by the Hospital during its summer employment program.

Sixty youngsters were examined and received inoculations for camp by members of the Pediatric Clinic Staff through a program sponsored by the Inner-City Committee.

AUGUST 1972 —
Charles B. Womer, Director of Yale-New Haven Hospital, was elected President of the Connecticut Hospital Association.

More than 21,000 hours of voluntary aid was given to the Hospital by 178 teenage volunteers during their summer vacation.

SEPTEMBER 1972 —
Summertime graduates from Hospital-based training programs included: 23 from the Grace-New Haven School of Nursing; seven from the program in Inhalation Therapy; and twelve each from courses in Medical Technology, Dietetics, and the Chaplaincy pastoral program.

A new transportation stretcher was put into use after being developed by the Medical Board’s Intensive Care Unit Committee. It was designed at Yale-New Haven to transport critically ill patients from the Emergency Service to other areas of the Hospital.
## COMPARATIVE STATEMENT OF GENERAL FUND INCOME AND EXPENSES

### GROSS REVENUE FROM SERVICES TO PATIENTS:

<table>
<thead>
<tr>
<th></th>
<th>September 30</th>
<th>1972</th>
<th>1971</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room, board and nursing</td>
<td>$22,583,440</td>
<td>$20,602,215</td>
<td></td>
</tr>
<tr>
<td>Special services — inpatients</td>
<td>18,177,828</td>
<td>16,092,411</td>
<td></td>
</tr>
<tr>
<td>Clinic patients</td>
<td>2,698,164</td>
<td>2,376,513</td>
<td></td>
</tr>
<tr>
<td>Emergency room patients</td>
<td>2,423,052</td>
<td>2,102,332</td>
<td></td>
</tr>
<tr>
<td>Referred outpatients</td>
<td>1,696,882</td>
<td>1,310,317</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$47,579,366</strong></td>
<td><strong>$42,483,788</strong></td>
<td></td>
</tr>
</tbody>
</table>

### DEDUCTIONS FROM GROSS REVENUE (Note B):

<table>
<thead>
<tr>
<th></th>
<th>1972</th>
<th>1971</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contractual and other allowances</td>
<td>$4,005,910</td>
<td>$3,182,149</td>
</tr>
<tr>
<td>Provision for uncollectible accounts</td>
<td>2,454,032</td>
<td>2,789,152</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6,459,942</strong></td>
<td><strong>5,971,301</strong></td>
</tr>
</tbody>
</table>

### NET REVENUES FROM SERVICES TO PATIENTS:

<table>
<thead>
<tr>
<th></th>
<th>1972</th>
<th>1971</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>$41,119,424</strong></td>
<td><strong>$36,512,487</strong></td>
<td></td>
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</table>

### OTHER OPERATING REVENUES:

<table>
<thead>
<tr>
<th></th>
<th>1972</th>
<th>1971</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>$159,943</strong></td>
<td><strong>$140,737</strong></td>
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</table>

### TOTAL REVENUES:

<table>
<thead>
<tr>
<th></th>
<th>1972</th>
<th>1971</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>$41,279,367</strong></td>
<td><strong>$36,653,224</strong></td>
<td></td>
</tr>
</tbody>
</table>

### OPERATING EXPENSES:

<table>
<thead>
<tr>
<th></th>
<th>1972</th>
<th>1971</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>$26,539,363</td>
<td>$24,276,062</td>
</tr>
<tr>
<td>Supplies and other expenses</td>
<td>16,502,039</td>
<td>14,057,023</td>
</tr>
<tr>
<td>Depreciation</td>
<td>1,372,448</td>
<td>1,199,547</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$44,413,850</strong></td>
<td><strong>$39,532,632</strong></td>
</tr>
<tr>
<td>Less — Recovery of expenses from grants, tuition, sale of services, etc.</td>
<td>2,837,749</td>
<td>2,684,225</td>
</tr>
<tr>
<td><strong>NET OPERATING EXPENSES</strong></td>
<td><strong>$41,576,101</strong></td>
<td><strong>$36,848,407</strong></td>
</tr>
</tbody>
</table>

### OPERATING GAIN OR (LOSS):

<table>
<thead>
<tr>
<th></th>
<th>1972</th>
<th>1971</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(296,734)</strong></td>
<td><strong>(195,183)</strong></td>
<td></td>
</tr>
</tbody>
</table>

### NON-OPERATING REVENUES:

<table>
<thead>
<tr>
<th></th>
<th>1972</th>
<th>1971</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free bed funds, Endowment income and Other</td>
<td>858,057</td>
<td>927,723</td>
</tr>
</tbody>
</table>

### EXCESS OF INCOME OVER EXPENSES:

<table>
<thead>
<tr>
<th></th>
<th>1972</th>
<th>1971</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>$561,323</strong></td>
<td><strong>$732,540</strong></td>
<td></td>
</tr>
</tbody>
</table>

See Notes to Financial Statements
## COMPARATIVE BALANCE SHEET

### ASSETS

#### GENERAL FUND

<table>
<thead>
<tr>
<th></th>
<th>1972</th>
<th>1971</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$ 516,905</td>
<td>$ 178,621</td>
</tr>
<tr>
<td>Accounts receivable net (Note B)</td>
<td>9,559,114</td>
<td>9,582,459</td>
</tr>
<tr>
<td>Inventories</td>
<td>732,613</td>
<td>719,746</td>
</tr>
<tr>
<td>Other assets</td>
<td>342,675</td>
<td>299,170</td>
</tr>
<tr>
<td>Due from Temporary Funds</td>
<td>226,149</td>
<td>200,000</td>
</tr>
<tr>
<td>Due from Plant Funds</td>
<td>284,153</td>
<td>13,470</td>
</tr>
<tr>
<td>Total - General Funds</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### ENDOWMENT AND SPECIAL FUNDS

<table>
<thead>
<tr>
<th></th>
<th>1972</th>
<th>1971</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$ 9,212</td>
<td>$ 14,710</td>
</tr>
<tr>
<td>Investments at cost - (Note A)</td>
<td>15,097,208</td>
<td>15,094,580</td>
</tr>
<tr>
<td>Land, buildings and equipment - Winchester Annex</td>
<td>918,025</td>
<td>915,375</td>
</tr>
<tr>
<td>Due from General Fund</td>
<td>15,566</td>
<td>6,129</td>
</tr>
<tr>
<td>Total - Endowment and Special Funds</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### TEMPORARY FUNDS

<table>
<thead>
<tr>
<th></th>
<th>1972</th>
<th>1971</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$ 17,339</td>
<td>$ 26,114</td>
</tr>
<tr>
<td>Investments at cost (Note A)</td>
<td>829,499</td>
<td>622,400</td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>72,703</td>
<td>148,200</td>
</tr>
<tr>
<td>Total - Temporary Funds</td>
<td>$ 919,541</td>
<td>$ 796,714</td>
</tr>
</tbody>
</table>

#### PLANT FUNDS

<table>
<thead>
<tr>
<th></th>
<th>1972</th>
<th>1971</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$ 32,759</td>
<td>$ 42,530</td>
</tr>
<tr>
<td>Investments at cost (Note A)</td>
<td>3,851,235</td>
<td>2,060,865</td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>201,699</td>
<td>403,013</td>
</tr>
<tr>
<td>Due from Temporary Funds</td>
<td>- 0  -</td>
<td>82,372</td>
</tr>
<tr>
<td>Land, building and equipment - net (Note D)</td>
<td>27,217,447</td>
<td>18,987,804</td>
</tr>
<tr>
<td>Construction in progress: (Note D)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leased assets</td>
<td>- 0  -</td>
<td>3,844,238</td>
</tr>
<tr>
<td>Other</td>
<td>536,550</td>
<td>1,002,484</td>
</tr>
<tr>
<td>Escrow funds for long-term lease (Note D)</td>
<td>2,063,021</td>
<td>12,350,058</td>
</tr>
<tr>
<td>Deferred financing costs and unamortized bond discount</td>
<td>384,473</td>
<td>379,861</td>
</tr>
<tr>
<td>Total - Plant funds</td>
<td>$34,287,184</td>
<td>$39,153,225</td>
</tr>
</tbody>
</table>

Gross Total - All funds | $62,908,345 | $66,974,199 |
Less, Inter-fund accounts | 525,868 | 301,971 |
Net Total - All Funds | $62,382,477 | $66,672,228 |

*See Notes to Financial Statements*
<table>
<thead>
<tr>
<th>Accounts payable</th>
<th>1972</th>
<th>1971</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accrued expenses payable</td>
<td>$ 1,118,710</td>
<td>$ 1,602,097</td>
</tr>
<tr>
<td>Deferred income</td>
<td>728,941</td>
<td>371,844</td>
</tr>
<tr>
<td>Medicare advance</td>
<td>169,631</td>
<td>155,845</td>
</tr>
<tr>
<td>Reserve for Medicare and other programs (Note B)</td>
<td>554,500</td>
<td>505,000</td>
</tr>
<tr>
<td>Due to Endowment and special funds</td>
<td>1,191,279</td>
<td>495,766</td>
</tr>
<tr>
<td>Deferred Medicare reimbursement (Note A)</td>
<td>15,566</td>
<td>6,129</td>
</tr>
<tr>
<td>Special funds</td>
<td>666,300</td>
<td>587,200</td>
</tr>
<tr>
<td>General Fund capital</td>
<td>539,520</td>
<td>486,996</td>
</tr>
<tr>
<td>Contingent liability (Note C)</td>
<td>6,677,162</td>
<td>6,782,589</td>
</tr>
<tr>
<td>Total — General Funds</td>
<td>$11,661,609</td>
<td>$10,993,466</td>
</tr>
</tbody>
</table>

**ENDOWMENT AND SPECIAL FUNDS**

<table>
<thead>
<tr>
<th>Principal of Funds:</th>
<th>1972</th>
<th>1971</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free Bed</td>
<td>$ 2,891,723</td>
<td>$ 2,891,127</td>
</tr>
<tr>
<td>Non-Expendable and Specific Purpose:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>William Wirt Winchester</td>
<td>8,860,509</td>
<td>8,730,372</td>
</tr>
<tr>
<td>Other</td>
<td>2,524,602</td>
<td>2,524,512</td>
</tr>
<tr>
<td>Expendable</td>
<td>1,763,177</td>
<td>1,884,783</td>
</tr>
<tr>
<td>Total — Endowment and Special Funds</td>
<td>$16,040,011</td>
<td>$16,030,794</td>
</tr>
</tbody>
</table>

**TEMPORARY FUNDS**

|Due to Plant Funds| $ 0| $ 82,372|
|Due to General Funds| 226,149| 200,000|
|Principal of Funds| 693,392| 514,342|
|Total — Temporary Funds| $ 919,541| $ 796,714|

**PLANT FUNDS**

<table>
<thead>
<tr>
<th>Accounts payable</th>
<th>1972</th>
<th>1971</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due to General Fund</td>
<td>$ 638,225</td>
<td>$ 792,202</td>
</tr>
<tr>
<td>Loans Payable — Yale University</td>
<td>284,153</td>
<td>13,470</td>
</tr>
<tr>
<td>Mortgages payable (Note D)</td>
<td>79,787</td>
<td>0</td>
</tr>
<tr>
<td>CHEFA — bond anticipation notes (Note D)</td>
<td>547,548</td>
<td>681,081</td>
</tr>
<tr>
<td>— Long term lease obligations (Note D)</td>
<td>9,250,000</td>
<td>9,250,000</td>
</tr>
<tr>
<td>Reserve for Plant Improvement and Expansion</td>
<td>3,801,540</td>
<td>2,575,310</td>
</tr>
<tr>
<td>Capital invested in property and equipment</td>
<td>19,685,931</td>
<td>19,341,162</td>
</tr>
<tr>
<td>Total — Plant Fund</td>
<td>$34,287,184</td>
<td>$39,153,225</td>
</tr>
</tbody>
</table>

**Gross Total — All funds**

<table>
<thead>
<tr>
<th>1972</th>
<th>1971</th>
</tr>
</thead>
<tbody>
<tr>
<td>62,908,345</td>
<td>66,974,199</td>
</tr>
<tr>
<td>525,868</td>
<td>301,971</td>
</tr>
<tr>
<td>Net Total — All Funds</td>
<td>$62,382,477</td>
</tr>
</tbody>
</table>
**NOTES TO FINANCIAL STATEMENTS**

**YALE-NEW HAVEN HOSPITAL, INC. September 30, 1972**

**Note A – Accounting Policies**

The accounting policies that affect significant elements of the Hospital's financial statements are as summarized below and as explained in Notes B and D.

**Investments in Marketable Securities:** Investments in marketable securities included in the Temporary Funds, Endowment and Special Funds and Plant Funds are carried at cost or if received as a donation or bequest, at the fair market value on the date received.

**Property, Plant and Equipment:** Routine maintenance, repairs, renewals, and replacement costs are charged against income. Expenditures which materially increase values, change capacities, or extend useful lives are capitalized. Upon disposition or retirement of property, plant and equipment, the cost and related accumulated depreciation are eliminated from the respective accounts and the resulting gain or loss is included in the results of operations.

The Hospital provides for depreciation of property, plant and equipment for financial reporting purposes using the straight line method in amounts sufficient to amortize the cost of the assets over their estimated useful lives.

**Deferred Medicare Reimbursement:** Deferred Medicare reimbursement arises from the additional reimbursement from the program under the election to compute depreciation on an accelerated method, on assets acquired prior to the year ended September 30, 1971, which is in excess of the amounts of depreciation recorded for financial purposes.

**Pension Plan:** The Hospital's pension plan covers substantially all employees. Pension expense for the year amounted to $494,000 which includes amortization of prior service cost over a 40 year period. The Hospital's policy is to fund pension cost accrued.

**Note B – Third Party Reimbursement Agencies, Prior Period Adjustment and Economic Stabilization Program**

Patient accounts receivable and revenues are recorded when patient services are performed. The Hospital is a provider under terms of contracts with third party agencies including Connecticut Blue Cross, Incorporated, the Social Security Administration (Medicare) and State welfare programs. The reimbursement of cost of caring for patients covered by the programs referred to above is subject to final determination of these third party agencies. The difference between the Hospital's standard rates for services and interim reimbursement rates is either charged or credited to deduction from revenues.

Provision has been made in the accounts of the General Fund for estimated adjustments that may result from final settlement of reimbursable amounts as may be required on completion of related cost finding reports for the year ended September 30, 1972, under terms of contracts with the Social Security Administration (Medicare) and Connecticut Blue Cross, Incorporated. Final settlement of the amounts reimbursable from third party agencies is not finally determinable until completion of such cost finding reports.

The General Fund balance at September 30, 1971 has been restated from amounts previously reported to include, retroactively, additional income of $361,000, representing a cost reimbursement adjustment for the year ended September 30, 1971 which was based on the cost finding report filed with Connecticut Blue Cross, Incorporated and other minor settlements during the year ended September 30, 1972.

The Economic Stabilization Act of 1970 as amended, including regulations of the Price Commission, restrict institutional providers of health care services from raising prices unless certain conditions are met. In this connection, the Department of Health, Education and Welfare has also issued regulations which restrict the amount of Medicare retroactive settlements payable to health care institutions. In the opinion of Hospital management, the Hospital is in compliance with the regulations of the Price Commission for the year ended September 30, 1972.

**Note C – Contingent Liability – Hospital Cooperative Services, Inc.**

The Hospital and four other area hospitals have established a central laundry facility to serve their area needs. To accomplish their objective, the five hospitals have organized a non-profit charitable corporation. In connection with the organization of this corporation, the five hospitals have jointly and severally guaranteed notes payable to banks by Hospital Cooperative Services, Inc. to a maximum of $4,800,000, of which $4,520,500 was outstanding at September 30, 1972.

**Note D – Long-Term Lease Obligation and Other Mortgage Notes Payable**

The Hospital entered into an agreement and lease dated August 16, 1971 with the State of Connecticut Health and Educational Facilities Authority for construction of additional facilities and conveyed title of the property to the Authority. To finance this construction, the Authority sold $9,250,000 of revenue bonds, which will mature serially from 1974 through 2003 with interest at a net average annual cost of approximately 5.563%.

Annual rentals and other payments by the Hospital to the Authority are based on interest costs and principal repayments on the bonds, amounts required to establish and maintain reserve funds required under the agreement and lease, and an annual fee and certain expenses of the Authority. Future annual rentals and other payments are expected to range from approximately $890,000 in 1974 to approximately $450,000 in 1995, when the funds in the hands of the trustee are expected to be sufficient to repay the remaining outstanding bonds. The Hospital will take title to the property when the bonds are redeemed. In addition to the rental and other payments, the Hospital under the terms of the agreement with the Authority will pay costs of insuring the property and of operation and maintenance.

The Hospital is required under the agreement to establish a rental pledge fund, to which monthly payments are to be made thereto generally equivalent to one-twelfth of certain other required payments. Rental payments to the Authority are payable from the rental pledge fund, or, if such fund is insufficient, from the general funds of the Hospital.

In accounting for this long-term lease agreement, the Hospital's obligation thereunder is recorded in the plant fund at the aggregate amount ($9,250,000) of rentals to be paid by the Hospital in respect of the Authority's liability for bond principal.

In connection with the lease agreement, Yale University has issued a guaranty agreement to the Authority not to exceed $9,250,000. In addition, the Hospital has issued two mortgages to Yale for this guaranty. The mortgages are subordinate to an existing mortgage.

In addition, the Hospital has the following mortgage notes payable outstanding:

- 4½% Mortgage note payable in monthly installments of $1,265, including interest, to April, 1978 $ 72,867
- 6% Mortgage note payable in quarterly installments of $38,750 including interest, with a final payment of $455,584 due and paid on November 1, 1972 474,681

**TOTAL** $547,548

Substantially all property, plant and equipment are pledged as collateral for the above obligations.

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**YALE-NEW HAVEN HOSPITAL** 24
CONTRIBUTIONS AND BEQUESTS

The Tax Reform Act of 1969 added a number of incentives to support non-profit charitable organizations.

One of the major provisions of the Reform bill increases the amount an individual may deduct as a charitable contribution. Other provisions impose serious restrictions on "private foundations."

Any contribution to the Hospital may be restricted to capital equipment or designated to a special fund for such purposes as the donor may direct.

Should you, your attorney, or financial advisor be interested in knowing more about the needs of the Hospital, please contact the Office of Information and Development, Yale-New Haven Hospital, 789 Howard Avenue, New Haven, Connecticut 06504. Telephone: (203) 436-4700.

Prepared by the Office of Information and Development
1096 CB - 436-4700
Donald R. Kleinberg, Director
Mrs. Roby Raymond, Director of Publications
Mrs. Carol Doria, IBM Composer