What Is A Nurse Practitioner? The Patient's Ombudsman Advances Against Epilepsy
From The President

Until this year we have always published our Annual Report as a separate publication for our staff and friends of the Hospital. An independent Annual Report has, until now, seemed an appropriate forum both for the annual statistical summary and for the general stories we presented to describe the outstanding services available at Yale-New Haven Hospital.

We have taken great pride, particularly in the past two years, in giving extra copies of these Annual Reports to our many visitors who have asked for more information about our Hospital.

This year, as an experiment, we are including much of that information as a special supplement to this issue of Yale-New Haven magazine. There are three reasons for departing from our traditional report. First, we have recently developed a more complete patient information brochure that answers many of the questions people frequently ask about Yale-New Haven, and we will be using that as our major general information booklet. Second, the cost savings of a combined Annual Report/magazine are substantial and must be weighed against the benefits of a separate publication. Third, a major publication is planned as part of our coming Capital Campaign.

However, we cannot fully assess the benefits of including the Annual Report in the magazine without hearing your opinion. Bound into this issue is a survey reply card, and we hope that you will take a few minutes to tell us what you think — not only of including the Annual Report in the magazine but also of the content of the magazine itself. Your views will help us present the kind of stories you find most interesting and useful.

We want the same degree of excellence that you find in health care services at Yale-New Haven Hospital to set the standard for all the information you receive from us. Your evaluation will be appreciated.

C. Thomas Smith

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THANK YOU
Nurse Practitioners: Putting the “Care” into Health Care. The 1970s has spawned a new brand of health professional who is expanding access to the health care delivery system for all Americans.

Unraveling the Mystery of Epilepsy. A mysterious affliction which in ancient times was blamed on the gods is under a multi-pronged attack at one of the country’s most comprehensive epilepsy centers.

Patient Relations System: Quick Response to Patients’ Concerns. A unique system for responding to problems is paying off in greater patient satisfaction.


Commentary: It’s Bad To Be Sick—But Worse To Be Blamed for It. Howard M. Spiro, M.D., Yale-New Haven’s head of gastroenterology, responds to those who are eager to find lifestyle at the root of diseases like cancer.
Susan Molde greets a new patient in Yale-New Haven Hospital’s Primary Care Center. Dressed in a white coat and sporting a stethoscope around her neck, she ushers the apprehensive woman into an examining room. She takes a careful medical history and the patient begins to relax. Then she performs a thorough physical examination.

Susan Molde sounds like a typical doctor, but she isn’t. She is a nurse practitioner.

What is a nurse practitioner? “A nurse with at least a baccalaureate degree in nursing who has prepared beyond that degree, often at the master’s level, in a particular clinical specialty,” according to Rachel Rotkovitch, vice president for nursing at the Hospital. “He or she may work in joint practice with physicians in hospitals or communities or as independent practitioners.” Since 1971, when the Yale School of Nursing graduated its first tiny class of these men and women trained in medical and pediatric nursing care, the ranks of nurse practitioners employed at Yale-New Haven have risen from four to more than two dozen.

They include family practitioners, like Ms. Molde, nurse-midwives, psychiatric nurses and other specialists in the Hospital’s inpatient areas and clinics. Many have faculty appointments at the School of Nursing and devote part of their time to training students, research and their own continuing education.

More and more, these health professionals have the first contact with patients coming into primary care centers and clinics. They routinely take histories, give physicals and perform a number of functions formerly considered the sole province of doctors. “Nursing practice has expanded considerably over the last 30 years,” Mrs. Rotkovitch said. “Many things which used to be considered ‘doctoring’ are now legitimate nursing functions.”

Continuity of care was one reason for establishing nurse practitioners in outpatient settings, according to Ms. Molde, who is still the main source of care for about 40 families she began treating when she joined the staff nine years ago. She estimates that 1,200 patients in the Hospital’s Primary Care Center would identify one of its four nurse practitioners as their main health care provider.

Dermatology nurse practitioner Judith Burkholder gives a clinic patient instruction in the use of makeup, which in some cases can camouflage pigment disorders. Helping patients with social problems related to their skin diseases is a vital part of her work.

How do those people feel about receiving care from a nurse instead of a doctor? “There’s usually some initial skepticism — we’re used to that,” Ms. Molde said. “But after the first visit, many patients would rather fight than switch.”

Nurse practitioners usually can schedule longer appointments than the doctors in primary care, and over time they develop a thorough knowledge of each patient’s problems and concerns. Although they are well-qualified to handle 90 percent of the complaints they see, they are also educated to recognize serious problems quickly and make referrals to staff doctors, specialists and social service agencies as appropriate.

“The nurse practitioner does not make medical diagnoses,” Mrs. Rotkovitch explained. “If during a physical she palpates an abdomen and locates a hard mass, she is not in a position to diagnose it as a uterine tumor or an intestinal obstruction. At that point she refers the patient to a physician, who is qualified to make a differential diagnosis.”

On the other hand, when a nurse practitioner tells a patient he can go home, he can be confident that is an informed opinion, Mrs. Rotkovitch said.

Dean Donna Diers of the Yale School of Nursing agrees that primary care is “no great mystery.” “You can teach someone to do this without sending him to medical school,” she said. And any fears among physicians that nurse practitioners will overstep the limits of their knowledge and skills usually dissipate quickly when the two work together, Ms. Diers added.

Preparation at the Yale School of Nursing, which offers a two-year master’s degree program for registered nurses, includes classroom training in physical diagnosis and pharmacology, case management, clinical rotations under the supervision of nursing faculty and doctors, and research. There is also a three-year program for non-nurses with college degrees.

Students are placed in a wide variety of clinical settings in the community, including Yale-New Haven Hospital, the Yale Health Plan, the Fair Haven Clinic, Hill Health Center, Griffin Hospital and area Visiting Nurse Associations.

“Expanded roles for nurses isn’t a new idea,” according to Ms. Diers. “We’ve been training psychiatric clinical specialists here since 1949 and nurse-midwives since 1956.”

But she believes the women’s movement is responsible for the recent upsurge of interest in advanced
nursing training. Yale now receives about 1,500 applications yearly for its 120 places, she said.

Not only are women more interested in satisfying, challenging careers outside the home, but female patients are placing more demands on the health care system as they become more confident consumers. The younger patients especially want to be informed and take part in their own care and the care of their families," Ms. Molde said. "They like to talk about things." And often, the doctor just doesn't have time.

President Carter's budget proposal for 1981 is strongly supportive of nurse practitioner training programs, further evidence that this health care profession is here to stay. While the budget drastically reduces aid to nursing schools — from $100.25 million this year to $27.6 million — the lion's share of that aid, more than $17 million, is for nurse practitioner training.

"For years, access to the health care system has been bottlenecks. Millions of Americans have been denied access because they are poor, uneducated about when to seek health care, or live in rural areas where physicians are inaccessible," Mrs. Rotkovitch said. "Nurse practitioners provide an alternative avenue of entry, and they are working in poor, rural or medically-underserved areas." Indeed, a substantial number of graduates from the Yale program elect to work in such areas, Dean Diers affirmed.

The kind of nursing they provide can improve the overall quality of patient care because of the nurse practitioner's special interest in the patient and his disease in the context of his environment. Relationships with patients tend to be close and personal and there is generally less social distance between nurses and the patients they serve than between those patients and physicians, Ms. Diers noted.

Most nurse practitioners deal not only with their patients' medical problems, but their social problems as well — "The problems of coping and living," according to Susan Molde. The continuity of care they can provide is a boon to hospitals.

Nurse practitioners also offer potential for decreasing the cost of health care; their fees are lower than most physicians command. A few doctors view them as an economic threat, Dean Diers conceded, while others worry that they are not under the direct control of physicians, like physician assistants. "These differences crop up mostly where nurse practitioners are new," she said. "Where you find them working side by side with doctors, by and large they get along just dandy."

Another way they can control the cost of health care is through patient education. "They are teaching the population healthful living," asserted Mrs. Rotkovitch.

Thomas Hitchcock, a nurse practitioner and assistant director of the Dana Psychiatric Clinic, believes his colleagues have another quality they can offer patients which many physicians lack — a tolerance for chronicity.

"Most doctors like to see patients get well and leave," he said. "Maybe the chronic ones represent a type of failure. I think the kind of person who chooses a career in nursing is much more tolerant of the chronically ill and their problems."

In the Dana clinic, Hitchcock and two other nurse practitioners are responsible for the medication maintenance of about 75 patients each. They also conduct individual and group therapy sessions and participate in staff assessments of all new clinic patients. Those assessments usually begin with in-depth, two-hour interviews. Cases are then presented to a team of staff members, including psychiatrists, nurse practitioners and social workers. As a result of these conferences, some patients will be assigned to nurse practitioners for treatment. Many view this as a positive thing, Hitchcock said — "They feel it means they're not that sick. Kind of a backhanded compliment to us!"

Hitchcock was the clinic's first nurse practitioner, and like many, he was able to carve out his own areas of responsibility. "There was no nursing input into the care of clinic patients at all," he recalled. "At first I had to fight not to get head nurse-type jobs, like ordering supplies and so forth." His work as a therapist is similar to what the clinic's psychiatric social workers might do, with more emphasis on medical management of patients.

"I feel nurse practitioners are pretty well accepted in this Hospital," Hitchcock said. "There is a collegial atmosphere in our clinic."

The same is true in the Dermatology Clinic, where
As a nurse practitioner in the Primary Care Center, Susan Molde is often the first health care professional patients see. Taking medical histories and giving physical examinations is a routine part of her job.
In the Dermatology Clinic, Bunny Forget examines Derby police officer Peter Matejek with a Wood’s lamp, a device which reveals certain skin problems.

Bunny Forget and Judy Burkholder work collaboratively with doctors treating pigmentation problems, melanoma and psoriasis.

“The doctors in this department were sensitive to the special needs of these patients,” Ms. Burkholder said. “As nurse practitioners we have the clinical skills to participate in all aspects of skin disease.”

Both women believe they are meeting these needs for the clinic’s 500-plus patients with skin diseases. “Many problems arise when the patients aren’t here,” Ms. Forget continued. “Through telephone and in-person contact, we provide them with immediate assistance or access to others in the Hospital.”

The dermatology nurse practitioners work with physicians not only in patient care, but in research as well. “Research is an important part of our practice because we know how important it is for improving patient care,” according to Ms. Forget.

Another aspect of their work which both women enjoy is dermatology nursing consultation with staff nurses in the Hospital. They are often called by other nurses to give advice on skin care for orthopedic and ostomy patients.

“We have been able to create the kind of care here we feel patients should get,” Ms. Burkholder added.

Since Emily O’Neill came to Yale-New Haven’s cystic fibrosis clinic five years ago as a student nurse practitioner, more attention is paid to the psychological aspects of that chronic, fatal disease.

After a few tough months of “proving herself” to clinic director Dr. Thomas Dolan, the two found they could work well together to improve the already excellent medical care Dolan was providing the clinic’s youthful patients. Upon graduating from Yale School of Nursing, Ms. O’Neill was hired in the clinic.

“It wasn’t perfect in the beginning by any means,” she recalled. “I had to show Dr. Dolan that I could see patients as quickly as an intern or resident, if
necessary, without compromising good care. But he was one of the first advocates here of pediatric nurse practitioners, and that really helped.”

The working relationship enjoyed by Dolan and Ms. O’Neill today is considered model by the School of Nursing, according to Dean Diers. “We’re pretty much on the same wavelength,” Ms. O’Neill agreed. “I view his job as keeping the kids alive and mine as helping them live their lives to the fullest.”

Victims of cystic fibrosis, a terminal lung and digestive disease, seldom live beyond their early 20s. The Yale-New Haven clinic treats about 180 regular patients, who average six visits a year.

“I talk with them about day-to-day living,” Ms. O’Neill explained, “how they feel about school, their parents, how they’re adjusting to their medication. And I talk to their parents, too.”

Some adolescents with cystic fibrosis become very depressed, even suicidal, she noted. “It’s important to listen to them and talk about their deaths if that’s what’s on their minds.”

Because many victims live well into early adulthood, Ms. O’Neill is sometimes faced with the difficult task of advising them on marriage or childbearing in the face of certain death. “Most can live a fairly normal life until the end. Their denial mechanisms are very good, and I catch it, too,” she said. “I try to help them make something out of their lives.”

The need for nurse practitioners like herself is especially strong where chronic diseases are treated, Ms. O’Neill believes. Physicians simply don’t have time to help patients adjust their lives around illness.

Emily O’Neill’s feelings about her own job capture the philosophy behind this growing health career, where caring and listening play such a vital role: “The quality of life is really more important than the quantity, after all,” she said. “And the quantity is often out of our hands anyway.”
The room looks like a television studio control booth with its banks of TV monitors, tape reels, and miscellaneous knobby electronic equipment.

But Laverne and Shirley aren’t bouncing across the four small black-and-white monitor screens. Instead, the scenes show patients resting in bed, occasionally getting up and moving around their hospital rooms. The most activity on the monitors occurs in the corners of the split screens devoted to the wriggling read-outs of the patients’ electroencephalograms.

Sometimes, however, the scene turns dramatic in front of the impassive television cameras mounted on the hospital room walls. The reels of videotape in the control room catch the fleeting event of an epileptic seizure.

The same sort of electronic wizardry that enables us to babble on CB radios and record our favorite television programs on videotape cassettes is aiding epilepsy treatment and research in New Haven. The video control room, the four monitoring rooms, and the rest of the clinical epilepsy program are located at the West Haven Veterans Administration Hospital, with which Yale-New Haven Hospital has a cost-sharing agreement for its patients. A Seizure Clinic at Yale-New Haven Hospital also refers patients to the VA Hospital and vice versa.

A telemetry antenna that looks something like the bottom half of a collapsible music stand hangs from a corridor ceiling at the VA Epilepsy Unit. It picks up signals emitted from electrodes pasted on patients roaming around the Unit, to give “long distance” electroencephalogram (EEG) results.

Patients whose EEGs must be monitored from outside the hospital — such as while they go about their daily routines — can be equipped with nearly invisible electrodes on the scalp that are connected to unobtrusive recorders, containing 24-hour tape cassettes, attached to their waists.

The combined program at Yale-New Haven and the VA Hospital is one of the oldest and most comprehensive epilepsy centers in the United States. Only two or three other centers concern themselves with as complete a range of activities as New Haven’s which is the only one of its kind in the Northeast.

There are at least two million people with epilepsy in America, said Dr. Gilbert H. Glaser, Professor and Chairman of the Department of Neurology at the Yale University School of Medicine and Chief of the Yale-New Haven Hospital Neurology Department.

“Epilepsy presents a great medical challenge,” he said. Great strides have been made in the past decade toward meeting that challenge, but researchers at Yale-New Haven and the VA Hospital are still wrestling with some of the basic questions surrounding epilepsy.

Drs. Glaser (foreground) and Mattson examine an actual electroencephalogram of an epileptic patient.
Epilepsy is a symptom, not a disease, Dr. Glaser explained. It is a malfunction of the brain that can be caused by a formidable range of disorders — from head injuries to metabolic diseases (such as low blood sugar) to brain tumors to blood clots, even to hereditary factors.

"A basic puzzlement about epilepsy is, if a brain has a tendency to seize, why doesn’t it seize all the time?"

An epileptic seizure is a sort of cerebral short circuit. During a seizure, abnormal brain cells emit improper electrical impulses that trigger various body actions, or mental functions controlled by the brain.

Just as the causes of epilepsy are multifarious, so are its manifestations. The most common types of seizures are grand mal, petit mal, and psychomotor (or complex partial).

Grand mal seizures represent the popular stereotype of epilepsy. Involving the whole brain, they’re characterized by a loss of consciousness, violent jerking of the body, and irregular breathing. Patients may bite their tongues, drool, or lose bladder control.

Petit mal seizures also are generalized, but are lapses in consciousness lasting only a few seconds. Often they are mistaken for daydreaming, usually only children and adolescents experience them.

Psychomotor temporal lobe epilepsy is the most common form of partial seizure — more than half of all adult seizures may be of this type. Psychomotor seizures are characterized by “stereotyped behavior” such as repeated lip-smacking, chewing, aimless arm or leg motions, aimless wandering about, or reciting of phrases.

"A basic puzzlement about epilepsy," said Dr. Glaser, "is, if a brain has a tendency to seizure, why doesn’t it seize all the time? We don’t know that."

One fascinating area of study is of the factors that precipitate seizures. Some of them are somewhat bizarre: flickering light (including television screens), reading, and music. The culprit isn’t necessarily raucous rock music; one patient had a seizure whenever he heard Judy Collins sing "Thirsty Boots."

Many famous people are diagnosed or probably epileptics — Socrates, Julius Caeser, Dostoevski, Lord Byron, Berlioz — but that didn’t prevent centuries of myth and stigma from surrounding the disorder. In ancient times it was considered a special infliction by the gods, a “sacred disease”; writers as early as Hippocrates remarked on the shame felt by sufferers. From the Middle Ages until all too recently, epileptics generally were considered to be possessed by the devil.

The social status of epileptics today remains a prob-
The Hospital’s Mission

THE MULTIPLE MISSION OF
YALE-NEW HAVEN HOSPITAL

What is excellence in health care? At Yale-New Haven Hospital the word embraces much. It means sensitivity to patient needs, the most up-to-date medical technology and diagnostic tools, and expert clinical care. It means a tradition of advancing the frontiers of medical science through research that is clinically applied. It means excellence in medical education for practicing health-care professionals, and outreach into the community with the lessons of modern health care. Finally, the commitment to excellence means modern, comfortable facilities for the care of the sick.

Yale-New Haven means many things to many people. The Hospital’s multiple mission, while sometimes a source of confusion, makes Yale-New Haven one of the truly outstanding medical centers in the country today. A sampling of its significant accomplishments reflects the Hospital’s position in the forefront of medical advances in our time.

For example:

- The country’s first clinical dose of penicillin was administered at Yale-New Haven in 1941;
- The first American use of the Read method of natural childbirth and of rooming-in for mothers and newborns;
- The first regional heart clinic in the United States, developed in 1949 from the Rheumatic Heart Clinic;
- The first clinical application of chemotherapy;
- Development of the heart-lung machine, making possible coronary bypass surgery;
- Development of the phrenic pacemaker, which has saved scores of people from dependence on a mechanical respirator;

More recently, physicians at our Children’s Clinical Research Center, funded by the National Institutes of Health, have given the country’s diabetics new hope with the development of a portable insulin infusion pump. These accomplishments, occurring in almost every field of medicine at Yale-New Haven Hospital, all contribute to the same objective: better patient care.

Patient Care: The First Priority

In some ways Yale-New Haven is no different from any top quality community hospital. It exists to provide the best possible patient care to people living within its service area. Last year 30.5% of the patients admitted to the Hospital lived in New Haven and another 48% came from 29 surrounding towns. Yale-New Haven served the majority of all New Haven residents who required hospital care.

Yale-New Haven is the primary “city hospital” for the medically indigent in the community. Its Primary Care Center provided treatment for over 12,000 patients from its local area last year. Its Emergency Service, the busiest in the state, sees an average of 250 people a day. Some 500 patients a day visit the Hospital’s 62 outpatient clinics. These figures illustrate Yale-New Haven’s commitment to the community and, in turn, the community’s reliance on the Hospital for health care services.
But the fastest growing portion of the Hospital's patient population comes from more remote areas seeking the special services that only an institution like Yale-New Haven Hospital can provide. More than 20% come from other parts of Connecticut and about 3% are referred from other states or foreign countries.

The specialized services that bring them to Yale-New Haven make a lengthy list and include such nationally designated services as a comprehensive cancer center, one of 18 in the country, one of 10 human genetics centers, two of 80 clinical research centers and one of only five national kidney stone centers. These centers, supported by federal funding, benefit the entire region which has access to the expertise represented here.

Education—Tomorrow’s Health Care Today

“First rate hospitals are essential for first rate educational programs,” states Dr. Robert W. Berliner, Dean of the Yale School of Medicine. As the primary teaching hospital for the Yale University School of Medicine, the Hospital’s training programs are acknowledged as among the very best in the country. Last year over 2,000 applicants from all 50 states and more than 15 foreign countries sought one of the 100 positions open in the residency training programs. The programs attract highly qualified people, many of whom remain to practice in the area. Twenty-five percent of all the physicians practicing in Connecticut were trained at Yale-New Haven Hospital.

The Hospital also trains nurses through affiliations with the Yale University School of Nursing, by sponsorship of a licensed practical nurse training program and by affiliations with Southern Connecticut State College and Quinnipiac College. It has helped develop paramedic and emergency medical technician training programs and offers allied health education in respiratory therapy, physical therapy, radiologic technology and medical technology. It offers programs for Physician Associates, Nurse Clinicians, Clinical Dietitians and other special training.

The Hospital’s Nursing Education Department works with various other departments to provide community educational programs such as diabetes control, enterostomal therapy programs and other education and training activities that complement the medical services provided in the Hospital. In addition, Yale-New Haven Hospital welcomes the staffs of other hospitals who frequently visit New Haven to learn techniques for specialty care services. The impact of Yale-New Haven’s educational resources can be felt in health care facilities throughout the state and beyond.

Research: The Source for Better Patient Care

The Hospital provides an appropriate setting in which research, conducted by the Schools of Medicine and Nursing, is richly nourished—a collaboration that benefits the residents of the Greater New Haven area and the other users of Yale-New Haven Hospital. While the Hospital does not fund any research of its own, scientific advances made by the medical school faculty get their first clinical exposure at the Hospital and are benefitting patients at Yale-New Haven long before other hospitals can put them into practice.
Several inpatient units are designated as clinical research centers and are funded directly by branches of the National Institutes of Health. From the Children’s Clinical Research Center have come a number of advances in the understanding and treatment of diabetics. Recent CCRC studies have shown that exercise increases the body’s sensitivity to insulin, and researchers are examining the special implications for diabetics. Other research has shown the need to address the problem of protein metabolism, as well as sugar metabolism, in diabetics. A team of four doctors headed by Dr. Philip Felig recently demonstrated that a portable insulin pump can regulate the insulin intake of diabetics, and they are currently seeking NIH funding to develop a light, compact version of the experimental model.

The work of Dr. Howard Rasmussen and Dr. Arthur Broadus in the Kidney Stone Center, another nationally designated research center at Yale-New Haven, has led to medical treatments for kidney stones that reduce the need for surgery. Drs. Rasmussen and Broadus are also investigating calcium metabolism and diseases of the aging of bones.

Dr. Joseph Bertino, head of Medical Oncology, has developed with researchers in pharmacology new drugs to treat lymphoma leukemia. Dr. Bertino, the author of a major textbook on cancer, is a world leader in the development of chemotherapeutic agents.

Dr. Bernard Forget, head of Hematology, has determined the structure of the gene for the synthesis of hemoglobin and described the basic cellular mechanisms of the thalassemia group of diseases, an initial step toward new treatment for patients with these blood disorders.

Dr. Herbert Reynolds, head of Pulmonary Disease, has pioneered in developing studies of immunology of the lung.

Dr. Marvin Sears, head of Ophthalmology, has received the Friedenwald Award, one of the top two prizes given in eye research, for his work on glaucoma and anti-glaucoma drugs. Four years of laboratory efforts produced the new anti-glaucoma drug Timolol.

Research that involves patients is monitored by the Medical Center’s Human Investigation Committee to assure that all patients’ rights, safety and dignity are protected. No research is conducted without the full understanding and permission of the patients.

The above sampling merely suggests the range of research that is conducted at Yale-New Haven Hospital and Yale School of Medicine. The excitement generated by the research that is conducted here continues to attract faculty who are in the forefront of their professions. Patients at Yale-New Haven Hospital benefit greatly from having these leaders as chiefs of the various clinical departments.

Dr. Averill A. Liebow of the Department of Pathology wrote in 1960: “No physician is better than his science and his humanity, and his science is no better than the research which gives it nourishment.” At Yale-New Haven Hospital medical science is a well-nourished discipline.

Community Outreach: More Than Medicine

Yale-New Haven Hospital provides many services to the community that go well beyond traditional hospital services. These efforts include specially created
support groups for parents of children with cardiac disease or leukemia, and groups for parents of children with hemophilia or sickle cell anemia. The support groups offer the strength and understanding that grows from talking through problems and knowing that the experience is shared by others. A source of information and of psychological support, the groups often make the difference between despair and hope. Family groups are also organized for dialysis patients and for "ostomy" patients.

Outreach includes a community health worker team and a Patient Relations system that helps patients who may encounter a problem in hospital procedure or services.

Rape counseling provides medical, legal and psychological support to victims of sexual assault and their families.

The DART program (Detection, Admission, Referral and Treatment) aids abused or at-risk children by a cooperative effort among physician, nursing and social work staff and community agencies. A program has been started to provide counseling and treatment, as well as housing, for battered women and their families.

Under the WIC (Women, Infants and Children) program, the Hospital provides nutrition education and supplemental food to 2,000 women and children who require basic nutritional help.

The Hospital sponsors a continuing dialogue between regional nursing homes and the Hospital, including inservice education for nursing home staff, to ensure the most appropriate levels of care for patients transferred from acute to long-term care facilities.

The Department of Discharge Planning and Home Care assists in a patient's timely and appropriate discharge, easing the physical and psychological burden on patient and family.

The Hospital cooperates with other community agencies and resources for venereal disease screening and treatment, drug abuse referral, abortion referral, counseling and treatment, and blood screening and treatment. The commitment to community outreach includes a foster grandparents program, meals-on-wheels, a youth information program, alcoholism referral services, a Medical Explorer Scout post in the Hospital and support of a teenage center for unwed mothers.

A hospital is more than bricks and mortar and sophisticated equipment—it is people and all of the personal involvement on the part of volunteers, nurses, doctors and other staff members. It is the most essential of all community resources in which all aspects of the community should be afforded the opportunity for personal involvement and the satisfaction that can be derived from that involvement. It is community involvement which places upon this resource the stamp of its community character.

In maintaining its commitment to excellence, the Hospital has now embarked on a $65.5 million modernization program to replace its crowded and outdated patient-care facilities and renovate other areas to provide one integrated, efficient patient-care unit. The need is clear. The project, years in the planning, is long overdue, and its completion in the spring of 1982 will enable Yale-New Haven to provide you with the best possible health care by practitioners who are acknowledged as outstanding in their fields.
## Comparative Statistics

### GENERAL INFORMATION

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### DIAGNOSTIC AND THERAPEUTIC SERVICES

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<thead>
<tr>
<th>Service</th>
<th>1979</th>
<th>1978</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultrasound</td>
<td>8,784</td>
<td>8,164</td>
</tr>
<tr>
<td>X-ray</td>
<td>176,446</td>
<td>166,975</td>
</tr>
<tr>
<td>CAT Scan</td>
<td>4,638</td>
<td>3,938</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>8,579</td>
<td>7,679</td>
</tr>
<tr>
<td>Electrocardiography Exams</td>
<td>44,789</td>
<td>43,432</td>
</tr>
<tr>
<td>Electroencephalography Exams</td>
<td>3,222</td>
<td>2,994</td>
</tr>
<tr>
<td>Physical Therapy Treatments</td>
<td>41,972</td>
<td>39,447</td>
</tr>
<tr>
<td>Respiratory Therapy Treatments</td>
<td>203,392</td>
<td>192,400</td>
</tr>
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</table>

### INPATIENT STATISTICS

#### DISCHARGES

<table>
<thead>
<tr>
<th></th>
<th>1979</th>
<th>1978</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>17,065</td>
<td>16,349</td>
</tr>
<tr>
<td>Surgical</td>
<td>9,805</td>
<td>10,282</td>
</tr>
<tr>
<td>Total Adults</td>
<td>26,870</td>
<td>26,631</td>
</tr>
<tr>
<td>Pediatrics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>1,856</td>
<td>1,875</td>
</tr>
<tr>
<td>Surgical</td>
<td>1,419</td>
<td>1,497</td>
</tr>
<tr>
<td>Total Pediatrics</td>
<td>3,275</td>
<td>3,372</td>
</tr>
<tr>
<td>Newborn</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regular</td>
<td>4,396</td>
<td>4,083</td>
</tr>
<tr>
<td>Special Care</td>
<td>1,040</td>
<td>813</td>
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<tr>
<td>Total Newborn</td>
<td>5,436</td>
<td>4,896</td>
</tr>
<tr>
<td>Total Inpatient</td>
<td>35,581</td>
<td>34,899</td>
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</tbody>
</table>

### OUTPATIENT CLINIC VISITS

<table>
<thead>
<tr>
<th>Service</th>
<th>1979</th>
<th>1978</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Center</td>
<td>31,712</td>
<td>28,395</td>
</tr>
<tr>
<td>Dermatology</td>
<td>9,507</td>
<td>9,381</td>
</tr>
<tr>
<td>Neurology</td>
<td>1,714</td>
<td>1,683</td>
</tr>
<tr>
<td>Women's Center</td>
<td>30,031</td>
<td>28,148</td>
</tr>
<tr>
<td>Dana Psychiatry</td>
<td>7,086</td>
<td>7,854</td>
</tr>
<tr>
<td>Dental</td>
<td>5,051</td>
<td>4,425</td>
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<tr>
<td>Ophthalmology</td>
<td>14,906</td>
<td>13,996</td>
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<tr>
<td>Medicine</td>
<td>24,045</td>
<td>23,561</td>
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<tr>
<td>Pediatric</td>
<td>13,411</td>
<td>12,911</td>
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<tr>
<td>Surgery</td>
<td>20,557</td>
<td>20,083</td>
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<tr>
<td>Orthopaedic</td>
<td>9,821</td>
<td>9,928</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>11,783</td>
<td>11,116</td>
</tr>
<tr>
<td>Urology</td>
<td>5,393</td>
<td>4,831</td>
</tr>
<tr>
<td>Total Clinic Visits</td>
<td>185,027</td>
<td>176,312</td>
</tr>
<tr>
<td>Emergency Service Visits</td>
<td>90,623</td>
<td>90,099</td>
</tr>
<tr>
<td>Total Outpatient Visits</td>
<td>275,650</td>
<td>266,411</td>
</tr>
</tbody>
</table>
### Yale New Haven Hospital Statements of Revenues and Expenses of Unrestricted Fund ($000's Omitted)

#### Revenues from Services to Patients

<table>
<thead>
<tr>
<th>Service</th>
<th>1979</th>
<th>1978</th>
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</thead>
<tbody>
<tr>
<td>Room, Board and Nursing</td>
<td>$43,770</td>
<td>$39,354</td>
</tr>
<tr>
<td>Special Services - Inpatients</td>
<td>44,878</td>
<td>38,545</td>
</tr>
<tr>
<td>Clinic Patients</td>
<td>5,282</td>
<td>4,573</td>
</tr>
<tr>
<td>Emergency Room Patients</td>
<td>4,865</td>
<td>4,316</td>
</tr>
<tr>
<td>Referred Outpatients</td>
<td>8,415</td>
<td>7,079</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$107,210</strong></td>
<td><strong>$93,867</strong></td>
</tr>
</tbody>
</table>

#### Deductions from Gross Revenue

<table>
<thead>
<tr>
<th>Deduction</th>
<th>1979</th>
<th>1978</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contractual and Other Allowances</td>
<td>10,859</td>
<td>6,909</td>
</tr>
<tr>
<td>Provision for Uncollectible Accounts</td>
<td>4,876</td>
<td>4,082</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15,735</strong></td>
<td><strong>10,991</strong></td>
</tr>
</tbody>
</table>

#### Net Revenues from Services to Patients

<table>
<thead>
<tr>
<th>Source</th>
<th>1979</th>
<th>1978</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Revenues from Services to Patients</td>
<td>91,475</td>
<td>82,876</td>
</tr>
<tr>
<td>Other Operating Revenues</td>
<td>271</td>
<td>157</td>
</tr>
<tr>
<td><strong>Total Revenues</strong></td>
<td><strong>91,746</strong></td>
<td><strong>83,033</strong></td>
</tr>
</tbody>
</table>

#### Operating Expenses

<table>
<thead>
<tr>
<th>Expense</th>
<th>1979</th>
<th>1978</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>49,139</td>
<td>46,263</td>
</tr>
<tr>
<td>Supplies and Other Expenses</td>
<td>46,372</td>
<td>40,617</td>
</tr>
<tr>
<td>Depreciation</td>
<td>2,707</td>
<td>2,495</td>
</tr>
<tr>
<td>Interest</td>
<td>624</td>
<td>577</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>98,842</strong></td>
<td><strong>89,952</strong></td>
</tr>
</tbody>
</table>

Less—Recovery of Expenses from Grants, Tuition, Sale of Services, etc.

<table>
<thead>
<tr>
<th>Source</th>
<th>1979</th>
<th>1978</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td><strong>(7,299)</strong></td>
<td><strong>(6,595)</strong></td>
</tr>
</tbody>
</table>

#### Net Operating Expenses

<table>
<thead>
<tr>
<th>Source</th>
<th>1979</th>
<th>1978</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Operating Expenses</td>
<td>91,543</td>
<td>83,357</td>
</tr>
<tr>
<td>Operating Gain/(Loss)</td>
<td>203</td>
<td>(324)</td>
</tr>
</tbody>
</table>

#### Non-Operating Revenues

<table>
<thead>
<tr>
<th>Source</th>
<th>1979</th>
<th>1978</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment Income</td>
<td>1125</td>
<td>792</td>
</tr>
<tr>
<td>Interest</td>
<td>63</td>
<td>36</td>
</tr>
<tr>
<td>All Other</td>
<td>(80)</td>
<td>(74)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,108</strong></td>
<td><strong>754</strong></td>
</tr>
</tbody>
</table>

#### Excess of Revenues Over Expenses

<table>
<thead>
<tr>
<th>Source</th>
<th>1979</th>
<th>1978</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excess of Revenues Over Expenses</td>
<td><strong>$1,311</strong></td>
<td><strong>$430</strong></td>
</tr>
</tbody>
</table>
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Emeritus 20
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Associate 191
Courtesy 95
Adjudnt Physicians 9
Dentists and Physicians to the Ambulatory Service 223
Clinical Fellows 129
Residents 338
Professional Staff 51
(non-M.D.) (less duplications) (-4)
Total Medical Staff 1,761*

* In this total are 365 full-time physicians including those with offices at the Veterans Administration Hospital and the Connecticut Mental Health Center who hold Yale-New Haven Hospital Medical Staff appointments.

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lem, even though medical treatment can control seizures effectively in the majority of patients. Epileptics still face ostracism and discrimination in work and education.

Tony Cuelho, for example, was advised by political pros to keep mum about his epilepsy when running for Congress from California in 1978. He insisted he had nothing to hide, however, and spoke frankly about his condition — and won.

"I've often said we don't make a diagnosis of epilepsy, we make a life sentence," said Dr. Glaser. "So it becomes important, working with each patient, not just to handle the treatment program with anti-epileptic drugs. You've also got to make absolutely sure that you're giving the patient the best possible evaluation and follow-up, and care of psychosocial needs.

"Between seizures, most patients with epilepsy can lead normal lives, especially if the condition is controlled with drugs or surgery."

Drug therapy can eliminate seizures for half of epileptics and can partially suppress seizures in another 30 percent. Surgery increasingly is performed on those patients whose uncontrollable seizures can be traced to a specific injured spot in the brain that can be removed without damaging other brain functions.

Halting a patient's seizures is crucial for a variety of reasons besides the obvious one of enabling him or her to function on a daily basis, according to Glaser.

"The child with petit mal epilepsy having many attacks at school is not going to remember the lessons of the day," he said. "These children are often picked up as children with learning difficulties."

"I've often said we don't make a diagnosis of epilepsy, we make a life sentence," Dr. Glaser said.

In adults, researchers suspect that even tiny amounts of seizure activity can distort intellectual functions if they occur in certain parts of the brain. This area of inquiry, says Dr. Glaser, "is a borderland between psychiatry and neurology — between the 'mind' and the 'brain,' as if there were any Cartesian dichotomy."

From a strictly medical point of view, halting seizures as early as possible may lower a patient's later susceptibility to them. Researchers at the New Haven center think there's a strong possibility that one or two severe seizures in childhood may damage sensitive areas of the brain enough to make them prone to epilepsy in later life.

Dr. Glaser offered a Biblical analogy: "Seizures beget seizures beget seizures. It's not proven, but we think it's a good theory."

Dr. Richard H. Mattson, Clinical Professor of Neurology at Yale University School of Medicine, directs clinical research at the VA Hospital's epilepsy unit.
The offensive against epilepsy is multipronged at the New Haven center. Under Dr. Glaser's direction, a panoply of experimental research projects is pursued at the Yale Department of Neurology. Clinical research, as well as the nitty gritty of patient diagnosis and treatment, is carried out at the VA Hospital's Epilepsy Unit together with the Epilepsy Clinic and Clinical Research Center at Yale-New Haven Hospital under the direction of Dr. Richard H. Mattson, who is also a Clinical Professor of Neurology at Yale and a staff member of the Neurology Department.

The West Haven Unit was set up about ten years ago as the prototype for a series of epilepsy centers at Veterans Administration hospitals around the country. In 1973, when the tie with Yale-New Haven Hospital was formalized, there already was considerable overlapping of staff between the two institutions. Combining forces was more efficient than setting up a competing service at Yale-New Haven. Said Dr. Mattson, "It's a nice example of optimal use of medical resources."

The West Haven VA Epilepsy Unit admits about 300 patients. Staying an average of five days, they tend to be tougher cases who need intensive monitoring to get at the root of their problems. The Unit receives referrals from all over the nation, many of them children, such as the 3½-year-old from Washington, D.C., who is having up to 30 seizures a day. Dr. Mattson noted, "It's unusual to see a little crib wheeling down the hall of a veterans' hospital."

The Unit pioneered split screen video monitoring of patients, which allows observers to watch patients' behavior and EEGs on the same television screen. The Unit's library probably contains more hours of videotaped seizures than any other institution in the world — a valuable teaching tool. While technicians at most epilepsy centers only monitor patients in the daytime, the Unit's nurses are trained to operate the equipment around the clock.

The Unit was one of the first to use blood tests to monitor the level of antiepileptic drugs in patients' bloodstream. Formerly, the proper amount of drugs for each patient was determined by increasing dosages until side effects became too severe and then holding back until seizures began again. Now, after a dozen years in use, periodic blood tests are a standard procedure, allowing fine-tuning of dosages. "They're an extension of clinical judgment that's extraordinarily valuable," said Dr. Glaser.

Currently Dr. Mattson is coordinating a study involving 11 epilepsy treatment centers and thousands of patients in the first systematic attempt to evaluate the performance of standard antiseizure drugs. Physicians have "a reasonably good feel" for administering these drugs, Dr. Mattson said, "but we also have a lot of pre-judices and assumptions. A lot is based on impressions instead of scientifically controlled research."

The New Haven team is particularly concerned about "doctors in frustration adding one drug on top of

B., a mildly retarded 21-year-old, had experienced grand mal seizures when she was 16 that had been controlled well with Dilantin. When she was 18 she developed minor motor seizures that were difficult to control despite attempts with many medications. Nevertheless, despite the five to 10 attacks she suffered each morning, she was able to live with her family and participate in daytime activities at a regional center for the retarded.

Suddenly B. began having a new type of seizure characterized by running and aggressive behavior. These attacks were so disruptive that her future at the regional center was in doubt and she was being considered seriously for institutionalization.

B. was admitted to the West Haven Veterans Administration Epilepsy Center, where monitoring by polygraph and telemetry indicated she was indeed having genuine mild epileptic seizures. But her EEG revealed that her running, aggressive "seizures" were not true epileptic activity, but a psychologically generated phenomenon.

B.'s epileptic seizures responded well to treatment with the drug Tegretol. The aggressive episodes were handled with psychiatric methods including talks with her family, and the regional center staff.

The Epilepsy Center's diagnostic techniques made it possible to sort out B.'s two types of seizures and treat each appropriately. She responded excellently to therapy and was able to continue living at home and attending the regional center.
another three to four," said Dr. Glaser. "We think that's inappropriate, and we hope the study will determine the best single drug or combination of two drugs to use for any given kind of epilepsy."

In recent years the Unit has placed increasing emphasis on surgery for patients whose epilepsy has proven intractable to all other forms of therapy and is interfering seriously with their ability to function. The procedure requires a couple of weeks of intensive evaluation including testing with depth electrodes — long needles inserted deep in the brain — to pinpoint brain lesions causing the seizures. (Psychomotor temporal lobe epilepsy is the kind most eligible for this treatment.)

It is a difficult procedure and the preparations are so lengthy that the Unit can handle only about one surgical candidate per month. But, said Dr. Glaser, "once we saw the success rate we said, 'Look, this is worth it.'" Up to 80 percent of otherwise intractable patients in various studies have found that surgery ended their seizures, and at Yale-New Haven no surgical patients have experienced serious side effects.

Investigation into the basic science aspects of epilepsy is carried on mainly at the Yale Epilepsy Research Program, which was formally established in 1966 with the aid of a grant from the National Institutes of Health. The suite of laboratories and offices on the seventh floor of the Laboratory of Clinical Investigation building, the home of the program, will double its space this year by expanding to the tenth floor of the building. Yale's researchers are looking into the many biochemical and physiological aspects of epileptic discharges. They are also examining the properties of antiepileptic drugs.

One clue to the seizure mechanism, for example, was uncovered through experimentation with mutant mice whose seizures are precipitated by certain sounds. The sound sensitivity of the mice is greatest during a few weeks early in life. The researchers discovered that during this same period the mice had a much greater than normal concentration of thyroid hormone. "That was an extremely exciting and important find," Dr. Glaser said. Several laboratory studies are aimed at determining the exact manner in which diphenylhydantoïn (Dilantin), one of the earliest antiepileptic drugs in use, works. "If we can understand Dilantin, we believe we can understand better how the other drugs work," said Dr. Glaser.

From mice to television monitors, the epilepsy program is multifaceted at Yale-New Haven and the West Haven VA Hospital. That is only appropriate to a disorder that assumes so many forms, and whose origins are myriad and still somewhat mysterious. Through the combined efforts of the two institutions to understand and treat epilepsy, many patients' lives are made more livable while the mystery is gradually dispelled.

Ms. Brown is a regular contributor to Connecticut magazine and the Hartford Advocate.
Patient Relations System: Quick

The calls can come in at any hour of day or night:
- Patient can’t sleep because roommate’s television is too loud and roommate won’t turn it down;
- Patient waiting too long for help after pushing call button;
- Patient complaining about flies in the room;
- Daughter of patient wants assurance that smoking will not be permitted in her mother’s room;
- Patient wants room transfer because noise of heart monitors “driving him crazy”;
- Mother worried that insurance won’t cover cost of daughter’s move to isolation room.

The Patient Assistance Line (PAL) is one element of a many-pronged Patient Relations System at Yale-New Haven Hospital designed to respond quickly and effectively to concerns of patients and their families or visitors to the Hospital. The PAL number (6-2333 from inside phones or 436-2333 from the outside) is a hotline for patient assistance.

“We’ve found that the most important thing we can do is get back to the patient fast,” said Paul Lally, director of the Hospital’s Risk Management department and coordinator of the Patient Relations System. “Sometimes the problems may seem trivial, but to the patient or family member you can bet it’s a major concern. Often the concern can be eased immeasurably simply by letting the patient know you’re working on the problem.”

At Yale-New Haven, with an average daily census of 750 patients, the calls come in at the rate of 30 to 40 per month. Each call is logged on an Action Report sheet to record the time and source of the call, the nature of the complaint, and the action taken. The action report becomes a permanent record of what action was taken when, and includes a section on what remedial steps have been taken to preclude a similar problem.

“Only about half the calls that come in are in the nature of complaints,” said Carol Rascati, department secretary and PAL monitor. For example, one woman called to find out the name of the doctor who pronounced her husband dead on arrival at the Hospital.
because she wanted to recover her husband’s new pacemaker for her own possible future use. After a brief investigation it was learned, as stated on the Action Report, “that the F.D.A. prohibits use of any instrument that has been in contact with body fluids of another patient to be used by a survivor or other patient. This was explained to the widow, who accepted the information with gracious thanks.”

The representatives maintain a written report on each patient visited indicating not just problems and resolutions, but compliments as well. “If a patient tells us that somebody has done a good job,” said Mrs. Malloy, “we want to make sure they hear about it.”

The representatives are led through a two-month training period during which Mrs. Malloy teaches them how to approach and talk with patients to hear their concerns. Patients with unresolved or particularly sensitive problems are followed up by Mrs. Malloy herself. “These might include a patient’s personality conflict with a nurse or doctor, lost personal belongings or anything that the representatives don’t think they can handle,” she said. “Many of the questions have to do with finances — things like Medicare coverage or misunderstanding what their own financial responsibility is. A lot of patients think that just because they have some kind of insurance, they are covered for everything.”

The Patient Representative program began in 1967 as an experiment in the ambulatory clinics to improve
services to the local community. Members of minority
groups were hesitant to use the Hospital because of
confusion about the nature and variety of services
offered, financial difficulties or, in some cases, a
language barrier.

Community workers from the Dixwell Legal Rights
Association, Inc., a local group funded by the federal
Office of Educational Opportunity, were assigned to
the ambulatory clinics to act as intermediaries and in-
terpreters. The success of the pilot program led to the
employment of a full-time Patient Advocate at 1968 in
the department of Ambulatory Services. The role of the
Patient Advocate, an ombudsman for patients, slowly
expanded to include most of the clinics, the Emergency
Room and the inpatient floors. Last summer it was con-
solidated in the Risk Management department as part
of an expanded Patient Relations System. The name
was changed to sound less combative with the Hospital
and to reflect more accurately the role that the
volunteers actually fill.

"I think the Patient Representatives are the most im-
portant part of the system," Ms. Rascati said. "As
we've gotten more representatives on the floors, we've
received fewer calls on the Patient Assistance Line."

"A lot of patients think that just because
they have some kind of insurance, they
are covered for everything," Lally said.

The system also includes a means of measuring pa-
tient's satisfaction with hospital services. The Patient
Comment Card, in use for over 20 years, was recently
revised and expanded to provide feedback on virtually
every service that a patient might encounter at the
Hospital, from medical and diagnostic services to
housekeeping and religious ministries.

"The new card was prepared with the help of a pro-
fessional marketing expert at Quinnipiac College," said
Albert Frieje, of Risk Management. "The purpose
of the card is to keep us on our toes in providing the
same level of excellent care as we have had in the
past."

Every comment card is read by C. Thomas Smith,
president of Yale-New Haven, before being tabulated
by the Risk Management department. Smith responds
personally to about 30 cards a month, writing to pa-
tients in response to both complaints and praise.

"The critical comments are very few in number,"
Frieje stated. "In general, patients' impressions con-
tinue to be overwhelmingly favorable."

Patients' reactions are tabulated monthly on a
"report card" which is circulated to the administrative
staff who, in turn, direct particular comments and sug-
gestions to the departments involved. "Patients may
not believe it," Frieje said, "but every problem area
mentioned on a comment card is examined and acted
on by the department head or supervisor involved."

No hospital is problem free, and a hospital that
employs 4,000 people and has 1,700 on its medical staff
is bound to have more than its share of incidents. If a
patient's property is misplaced, it becomes the concern
of the Patient Property Loss section of Risk Manage-
ment, under Lally's supervision.

"We are currently losing a considerable sum every
year in patient property," Lally stated. "Half of it is
due to lost dentures alone!" The loss of dentures is a
particularly vexing problem which usually occurs
when a patient is transferred within patient care
areas. Occasionally, in the battle to resuscitate pa-
tients in the Emergency Room, dentures are removed,
set aside and then, when the patient is moved to a
room, somehow left behind. Eyeglasses often meet the
same fate.

Albert Frieje and Carol Rascati of the Risk Management
Department tabulate patients' comments for performance
reports to Administration and department heads.
Paul Lally, director of Risk Management, stresses the importance of employees.

"It's not just us," Lally said. "Patients frequently leave personal belongings behind when they leave. But we're beginning to look at a system now to pack personal belongings in easily identifiable containers. If a patient is shifted from a private to a semi-private room, his belongings will be sure to accompany him."

Lally has organized meetings with department heads, nurses and unit service managers on the floors to stress the seriousness of a patient's lost belongings. "If you're an elderly patient and you can't find your eyeglasses to read the menu, you're going to be damn mad." The improved system will also involve Emergency Room personnel and the Hospital's security officers.

"We have pulled together under one roof all the areas that relate to Patient Relations," Lally stated. "That's what makes this program unique. In the old days there was no coordination between these areas and that caused not only duplication of effort, but time lost before a patient's problem was resolved."

The goal is patient satisfaction. No small part of that goal is the prevention of public liability and legal action against the Hospital by following up on incident reports to avoid further problems. "We had one of the first patient advocate programs in the country," Lally said. "Our new system is being studied as a model of effectiveness by a group from the Harvard School of Epidemiology and Public Health."

No system is perfect and there is no doubt that Yale-New Haven's Patient Relations System will evolve further in search of greater patient satisfaction. "It all boils down to one thing," Lally noted. "Showing the patient that we care."

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Paul Lally, director of Risk Management, stresses the importance of the Patient Relations System at an information session for employees.

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An impressive group of speakers gathered on Saturday, February 2 for the dedication of Yale-New Haven Hospital as Regional Trauma Center for southern Connecticut. The designation was made by the Emergency Medical Services Council, Inc. of South Central Connecticut as part of a national program funded by the Department of Health, Education and Welfare.

Dr. David Boyd of HEW was keynote speaker at surgical grand rounds preceding the dedication. His topic was “Trauma: A Controllable Disease in the '80s.” Other speakers at the ceremony included state and local EMS officials, U.S. Rep. Robert N. Giaimo and New Haven Mayor Biagio DiLieto.

Yale-New Haven will serve as a comprehensive trauma center for a 20-town region. Under the same program, the Hospital of St. Raphael was designated a trauma facility, the second classification under guidelines set by the American College of Surgeons.

Boyd explained the difference in care available at local community hospitals, areawide trauma facilities and regional trauma centers. About 5 percent of trauma cases require the specialized total care that a trauma center can provide, he noted.

Those cases include severe multiple injuries involving two or more systems, head and spinal cord injuries, severe burns, facial or eye injuries, amputation of a limb requiring reimplantation, and pediatric chest or head trauma.

The designations are valuable in that they cause the institutions to examine their own services and define their roles in the area's health care system, Boyd said.

Some of Yale-New Haven's advantages include its burn team, CAT scanner, active trauma research program and its average of 1,000 multi-system trauma patients and 50 critical burn patients a year.

"Most of us rarely think about the existence of such services until we are desperately in need of them," commented Hospital President C. Thomas Smith. "Each of us, our families and neighbors should feel a special sense of comfort knowing that when emergencies arise, sophisticated personnel and equipment are available."

The EMS Council and state Department of Transportation are developing a system of road signs for area highways showing the best routes to the center and facility.

Present at the Trauma Center dedication ceremonies were, from left: Joseph Jasiokowski, president of South Central Connecticut Emergency Medical Services, Inc.; Hospital President C. Thomas Smith, The Hon. Biagio DiLieto; and U.S. Rep. Robert N. Giaimo.

Hospital Launches Employee Assistance Program

Yale-New Haven Hospital has initiated an Employee Assistance Program, a new benefit for all employees and their families. The program will provide counseling and referral services for a variety of personal problems that may be affecting job performance.

Two years ago, the Mutual Respect Committee pointed out the need for a program where employees could get help for personal problems such as stress-related diseases, marital problems, financial worries, misuse of drugs or alcohol, emotional difficulties and death of a close family member. Nicole Urdang, the program developer, worked with Personnel Health Services, the Department of Medical Social Work and the Mutual Respect Committee to design an Employee Assistance Program for the Hospital.

The program, which is under the direction of the Department of Medical Social Work, will utilize clinical social workers and other clinicians as counselors. Any employee's contact with the program will be kept strictly confidential.
NEW TRUSTEES NAMED

Wallace Barnes  Cornell Scott Alice Poole  Josef Adler  F. Patrick McFadden, Jr.

Five new members were appointed in February to three-year terms on Yale-New Haven Hospital's Board of Trustees.

At the same time, three members were reappointed and six concluded service ranging from three to 13 years.

New Trustees are Josef Adler of Woodbridge; Wallace Barnes of West Simsbury; F. Patrick McFadden, Jr., of Madison; Alice Poole of Orange; and Cornell Scott of New Haven.

Mr. Adler is Director of Financial Services for Bache Halsey Stuart Shields Inc. in New Haven and is president of the New Haven Jewish Federation. He is also director of the American National Bank and Congregation B'nai Jacob.

Mr. Barnes is Chairman of the Board and Chief Executive Officer of the Barnes Group Inc. in Bristol. He also serves on the boards of directors of a number of corporations, institutions and civic groups, including Aetna Life and Casualty Company, Connecticut Bank and Trust, Insilco, the New England Legal Foundation, Bristol Boys' Club, University of Connecticut Foundation and the Connecticut Public Expenditures Council, Inc.

Mr. McFadden is President and Director of the Hill Health Center and an assistant professor of pediatrics and medical care at Yale University School of Medicine. He serves on the boards of Connecticut Hospice, Inc., First Bancorp, the New Haven Foundation, Gaylord Hospital and the Connecticut Public Health Association, and belongs to a number of professional associations and health care panels.

Reappointed to the Board were Charles K. Bockelman, James C. Lambertti, who was also elected its secretary, and the Rev. timothy A. Meehan.

Trustees whose terms expired are Jose A. Cabranes, Stanley R. Cullen, Abbott H. Davis, Jr., Milton P. DeVane, DeLanay Kiphuth, and former Secretary John Q. Tilson.

HALLELUJAH! MESSIAH SCORES A HIT

Thanks to the cooperation and enthusiastic support of dozens of people, patients had a rare holiday treat this year in the Memorial Unit cafeteria. For one glorious hour, the New Haven Symphony and Yale Glee Club performed portions of Handel's "The Messiah" to a full house of patients and evening staff. And for those who couldn't make the journey to the MU cafeteria, the performance was broadcast live over closed circuit television directly into patient rooms. The concert, weeks in the planning, was made possible with the help of Engineering, Food and Nutritional Services, Public Information, Patient Services, Nursing, Security, Training and Employee Development, Volunteer Services and the Hospital's Medical Explorer Post. Students from Southern Connecticut State College helped with television production.

Celebrate! It may not have been the most decorous Christmas party in the Hospital, but it probably was the most successful. More than 500 children and their parents came to the Primary Care Center's legendary celebration to meet Santa Claus, receive a toy and feast on ice cream, cookies and punch. Despite a few faint hearts, like the little boy above, most of the kids took full advantage of the opportunity to chat with Santa, also known as Dr. Syd Spiesel of Pediatrics. About 600 toys were purchased and individually wrapped by four Primary Care Center employees, and most of the money to buy them came from staff members and interested people.
Commentary

It's Bad to Be Sick
But Worse To Be Blamed for It
by Howard M. Spiro, M.D.

Head of Gastroenterology, Yale-New Haven Hospital; Professor of Medicine, Yale University School of Medicine

The emphasis today on personal responsibility for one’s own health is admirable as long as it doesn’t turn into guilt for getting sick. We’ve defined alcoholism as a disease, but paradoxically many physicians silently condemn a young person who has a heart attack, particularly if he’s fat or hasn’t jogged. The usual judgment is: he brought it on himself.

We know how to prevent many disorders, and so many of us leap to the assumption that whoever gets sick, at whatever age, has only himself to blame. To be sure, emotions may make us sick, but the idea of accountability risks making a patient feel responsible for his illness. The fact is we physicians don’t know what accounts for most diseases.

Two recent events have led me to such melancholy conclusions. A physician friend had a mild heart attack from which he recovered quickly enough. But his convalescence was a trying time in which he reproached himself for not having done more to prevent his illness. In his youth he had given up cigarettes, fats, alcohol; he was thin, bicycled to work, and certainly was the model of a middle-aged man taking good care of himself. Yet when this abstemious, spare man had a heart attack, he worried that he’d brought it on himself. That things wear out, cars run down, people age and get sick gave him no consolation.

A New York Times obituary reporting the relatively early death of another physician from cancer of the pancreas took pains to observe that this disease was not, after all, preventable. The dead physician had jogged, exercised, avoided fat and sugar, and had adhered to the rules of good health. The obituary writer wanted to be sure the physician’s early death would not be laid at his own door.

Increasingly, disease is seen as punishment for bad behavior. This trend is clear in some well-intentioned efforts to help cancer patients. It has been suggested that emotional depression weakens the immunological barrier against aberrant cancer cells. From there it’s a short leap to the idea that depression leads to cancer and that the patient’s emotional state has contributed to his illness.

Most of us have heard the rationale. Somehow you are responsible for your cancer. Therefore, explore your emotional state about the time you first got sick. Try to remember whether you were depressed, angry, or working too hard and had any major crises back then. If you can’t think of any, what about minor disappointments or worries? Almost anything emotional could have weakened your immunological defenses. If you can find the triggering problem, you may be able to overcome the tumor.

Such notions send patients to group and individual psychotherapy sessions and, though supportive in many ways, may end up in a guilt trip. I applaud the motives and many helpful insights such books and therapists give some patients, but they assume too much. Even healthy persons’ lives are filled with stress and crises, and the emotional events so tenuously linked to getting cancer seem to be common events in all of our lives. Unfortunately, linking emotional events to cancer implicitly saddles patients with enormous guilt, regardless of disclaimers.

Another friend has been living with metastatic cancer despite several rounds of surgery and has been bearing up under chemotherapy. He has come upon a therapy group in Texas and has written to them and read their literature. He has been asked to see a psychologist to explore the emotional reasons for his cancer and to see how he can fight it. A sensible man, he would like to live in peace as long as he can, but he is tormented by the idea that to ignore every approach is selfish and that for his family’s sake he should get psychotherapy. Now he feels guilty that he has a tumor and is not doing everything possible to destroy it.

Sheer determination may help sometimes, but it’s too much to ask a cancer patient to believe that a different life style and better thoughts might have prevented his cancer. Doctors should not separate body from mind. Nevertheless, some physicians, proud of what they know, may be laying too heavy a burden of guilt on patients and each other. Disease and death come to all, one way or another. We may not understand the cause of disease as clearly as advice to our patients sometimes suggests.

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1. What do you think of including the Annual Report in Yale-New Haven magazine?
□ I prefer it this way □ I prefer a separate report □ It doesn't matter to me

2. Please rate the articles in this issue from 1 to 4 (1 = very interesting; 2 = interesting; 3 = somewhat interesting; 4 = of little interest). If you like, add comments below.
□ Nurse Practitioners (pg. 4) □ Commentary (pg. 22) □ Patient Relations System (pg. 16) □ News Around (pg. 20) □ Unraveling Epilepsy (pg. 10)

3. What would you like to see emphasized in the magazine?
□ Hospital news □ Medical subjects □ Human interest stories □ Consumer health care information □ Profiles on hospital people □ Other:

4. We'd welcome any additional comments you may have.
Leatrice Malloy, Patient Representative, finds that patients have more questions than complaints. See story on page 16.