Yale-New Haven Special Issue : 1983 Annual Report

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Pediatrics at Yale-New Haven
Special Issue: 1983 Annual Report
In the eyes of a child, the hospital represents a separation from home and family, fears of bodily injury, feelings of helplessness and fantasies of illness and death. Art, expressive media and play can be powerful aids to children at this time of vulnerability. Creative play while in the hospital allows young patients to communicate and cope with their fears and feelings about hospitalization.

Children can choose dramatic play, manipulative or constructive play or expression through such media as paints or clay. Each provides the child with a sense of choice, a sense of control and mastery, and an outlet for active participation. Play is the child’s way to learn about self, integrate experience and master stress.

A hospital does not have to be a traumatic and devastating experience for a child. At Yale-New Haven Hospital, through the efforts and dedication of the health care team, it may actually be an experience of growth.

— Bebe Feinberg
Child Life Program Coordinator
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**Yale-New Haven** is published quarterly for staff and friends of the Hospital by the Office of Public Information. Editorial Director: George G. Pawlush; Editor: Gene Cooney; Writers: Mark Bittman, Tom Urtz, Janan Talafer, Hallie Black, Jennifer Soloway, Sheila Burke; Research Assistants: Hazel Daniley, Betty Parrett, Glenda Bethune; Staff Photographers: Tom Urtz, Sheila Burke.

**On The Cover:** Restoring a child to health is a multifaceted job addressing the child's total needs — physical, social, and emotional.

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A World of Medicine for Children

by Hallie Black

The Pediatric Department at Yale-New Haven Hospital is often referred to as a hospital within a hospital and it is an accurate description. Every aspect and stage of children's health care, from prenatal diagnosis to the developmental problems of adolescence, is handled within the department and every medical specialty in the Hospital has at least one member trained specifically in pediatric care. The resulting services are so extensive, pediatrics can be looked at as a microcosm of the state of medicine today.

Children from all over the world come here for advanced treatment of complex conditions: organ transplants for kidney failure, biochemical management of metabolic disorders, neurological screening for learning disabilities. These services mirror the revolution in pediatrics over the last two decades. "There are young doctors on our housestaff who will never see a case of measles or polio," said Dr. Howard Pearson, Chief of Pediatrics. "Many of the old scourges of childhood, such as many serious infectious diseases have largely been conquered. What is left is a hard kernel—malignancies, congenital abnormalities, trauma."

In caring for children, Yale-New Haven Hospital's pediatric staff has achieved a rare degree of coordination among physicians, surgeons, nurses, and clinical social workers. Behind that coordination is the staff's conviction that treating children involves more than attending to illness. It also requires cooperation with their families and attention to their physical and emotional development.

In addition to evaluating the more than 5,000 babies born annually at Yale-New Haven Hospital, the pediatric staff cares for more than 4,000 children, a fifth of the Hospital's total admissions, on its own new ward. A tertiary care center, the Hospital admits children for conditions ranging from severe burns to major surgery. Up to twelve a year receive new kidneys and a surgical team, led by Dr. Wayne Flye, recently performed the state's first liver transplant. Unlike many other hospitals, Yale-New Haven separates children from adults and places both medical and surgical patients in age-graded units with recreation and education facilities appropriate to each.

The largest (for infants up to six weeks) is the 44-bed Newborn Special Care Unit, the first in the country. Directed by Dr. Ian Gross, the unit cared for some 1,500 infants last year, over 150 brought from other hospitals by a nurse-transport team and another 150 born to high-risk mothers moved here for delivery. Many infants are premature and have difficulty breathing due to immature lungs. About 150 required surgery for life-threatening congenital abnormalities such as esophageal obstructions that could cause suffocation. Because of the urgency of diagnosis and treatment, pediatric radiologists have rooms in the unit to develop and read x-rays for immediate consultation with the rest of the staff. Equally important to the staff is easing stress on parents. They can visit anytime and hold even the sickest babies, who have one-on-one nursing around the clock. In the convalescent area, parents cuddle their babies in rocking chairs and there are rooms for breastfeeding mothers. Volunteer foster grandparents come in daily to play with the babies.

The nine-bed Pediatric Intensive Care Unit, under Dr. Peter Rothstein and Helen Dorman, RN, treats catastrophic illness and trauma in older children and cares for 500 a year, a tenth of them from other parts of the state. Problems seen here include overwhelming pneumonia and severe burns. The unit also cares for children after major procedures such as open heart surgery. Children may also stay for observation of trauma. Pediatric surgeons may monitor a child with splenial injury for up to three weeks and operate only if natural healing fails to occur.

Other children, six weeks to nineteen years, are placed in a twenty-seven bed infant and toddler unit; a twelve-bed school age unit; a twelve-bed younger adolescent unit; and a fourteen-bed older adolescent unit. All but the last are on the doughnut-shaped seventh floor that wraps around an open space with outdoor play porches. Bright with the patients' own art work, the ward combines efficiency with a home-like atmosphere. There are even kitchens stocked by the pediatric dietitian with fruit, peanut butter and other favorites. Parents room-in on plush chairs that open into beds. Nurses wear flowered smocks. "We want children to be comfortable," said Kathy Fallon, Director of Pedi-
When 3½ year old Neilon Rice entered the hospital he was typically anxious. Like most youngsters, however, he quickly adjusted to life in his new surroundings.
families together at Pediatric Nursing. "We try to keep families together in a non-threatening atmosphere.”

This is a crucial goal since stays here range from several weeks to over a year. The model Child Life Program helps children cope with hospitalization by offering normal childhood activities. Pre-admission tours help reduce their initial anxiety. “We reassure children that being here is not a punishment and we encourage them to express their feelings,” explained Bebe Feinberg, Child Life Program Coordinator.

The program also offers play and school sessions. Preschoolers spend the morning with a child life specialist in a play group. In a nearby schoolroom, a teacher provided by the New Haven Public Schools teaches kindergarten through sixth grades and tutors individuals in the afternoon. There are music, art, and crafts sessions in the Creative Arts Room. Children can also go outdoors to dig in a sandbox, play in a helicopter built by Hospital Engineers, and even garden. Last summer, children grew tomatoes and marigolds in tubs along the porch ledges. Older adolescents meet in weekly support groups and have special activities such as film-making.

Clinical social workers play an important role in pediatric care. “Our work is preventive and restorative,” said Ruth Breslin, Chief Social Worker. “We help families deal with the disruption of hospitalization and the demands of caring for a child at home.” Clinical social workers, including two who are bilingual, work in each unit and make rounds with the medical staff. Because children with chronic conditions may be admitted several times over the course of treatment, clinical social workers are also assigned to specialty outpatient services to provide continuity of care.

The concerns of inpatient care — working with families and promoting a child’s normal development — also guide these outpatient services which see a total of 60,000 children a year, about a third each in the Pediatric Emergency Room, the Pediatric Primary Care Center, and the Pediatric Specialty Center along with the One Day Surgery Center.

The Pediatric Emergency Room, with its own waiting area and fully equipped central treatment room, provides twenty-four hour service to 20,000 children a year of whom 3,000 need hospitalization. Many are brought in with trauma or viral infections but the Pediatric Emergency Room is also a Regional Poison Control Center. The staff here includes clinical social workers, child psychiatrists and members of the medical and surgical specialty areas.

A registered diagnostic medical sonographer pays careful attention to a monitor while performing a head ultrasound procedure.

The Pediatric Emergency Room staff, directed by Dr. Paul McCarthy, works closely with the Pediatric Primary Care Center founded in 1976 to serve the urban poor lacking a family physician. The Center promotes community health through such programs as blood lead screening. Dr. Thomas Dolan, Director, called this a “real success story.” “A decade ago we saw as many as 70 children a year with advanced lead poisoning. This year we have only ten,” he said. The Center not only provides treatment, it also helps affected families relocate or remove lead sources from their environment.
Other special programs offered at the Center are a twice-weekly Pediatric Chest and Cystic Fibrosis Clinic, a once-weekly Pediatric Arthritis Clinic, and a once-weekly clinic for children with functional pain — real pain whose organic cause is unknown. Clinical social workers offer two programs, as well, for children with behavior or learning problems. At a weekly diagnostic play group, social workers and pediatricians observe two to five year olds from troubled families and counsel parents separately. In a School Problems Clinic, observers diagnose children with learning difficulties and then locate or design appropriate school programs.

In the Pediatric Primary Care Center, clinical social workers often encounter disorganized, impoverished families needing help. This need has prompted the Department of Social Work to offer support groups for young mothers and to hold parenting classes for teenage mothers in Lee and Wilbur Cross High Schools through the New Haven Board of Education.

The Pediatric Specialty Center offers programs for the evaluation of referral patients and outpatient treatment by members of the medical specialty departments. Led by Dr. Norman Siegel, the Renal Clinic sees over 1,200 children a year with renal disease, nephrotic syndrome and other abnormalities of the genitourinary tract. Pediatric nephrologists work with transplant surgeons and clinical social workers to select candidates for organ transplant. This procedure offers children the hope of complete rehabilitation as well as normal physical development. The forty children who have received transplants over the past ten years continue to come to the Clinic. Several are now in college and one is about to have a baby.

Detection and treatment of genetic disorders is carried out in collaboration with Yale Medical School's Department of Human Genetics. One program screens 600 children a year with developmental delays and other conditions that may have a genetic basis. Yale-New Haven is a regional treatment center for phenylketonuria, a metabolic disorder whose effect — mental retardation — can now be completely controlled with a managed diet. A second program offers screening and counseling to couples who know or suspect they may have offspring with genetic disorders. When such conditions are detected at the fetal stage, there is often the possibility of improved corrective management in utero or at birth.

Programs offered by the pediatric endocrinologists, headed by Dr. Myron Genel include a Pediatric Diabetes Clinic that has pioneered the use of a portable infusion pump to provide small, precise doses of insulin continually. Drawing 281 children from southern New England and New York, the Clinic also provides controlled diet and exercise plans and conventional treatment with insulin injections. Adequate insulin treatment can help prevent blindness and other degenerative diseases that have plagued children who fail to produce human growth hormone naturally. Finally, this department initiated and participates in a regional screening program for congenital hypothyroidism which can cause profound retardation if not detected and treated.

"Many of the old scourges of childhood have largely been conquered. What is left is a hard kernel — malignancies, congenital abnormalities, trauma."
James Sivo, a radiologic technician, performs a neonatal head ultrasound on an infant in the Newborn Special Care Unit. A fairly recent procedure, head ultrasound looks for abnormalities in the patient's ventricular system.

A Pediatric Gastroenterology Clinic, supervised by Dr. Joyce Gryboski, treats over 1,000 children yearly for inflammatory bowel or liver disease, persistent vomiting, allergic diarrhea and other conditions which could prevent normal growth. Children are also evaluated in this clinic for the new liver transplant program. The Pediatric Hematology-Oncology Clinic, directed by Diane Komp, treats nearly 200 children a year for malignancies and offers them the option of being in national research protocols at the forefront of cancer research. Advanced cancer treatment is aided by Yale-New Haven Hospital's cancer pharmacology department, recognized as one of the finest in the world. The Clinic also treats blood diseases such as sickle cell anemia, thalassemia, and hemophilia and last year staffed a two-week hemophilia camp for the third summer in a row.

The Pediatric Infectious Disease Clinic under Dr. George Miller, consults on some 200 children a year with acute or chronic infections sometimes complicated by lowered disease immunity from conditions such as cancer or hemophilia. A major activity is the diagnosis of children with viral illnesses and the department runs a laboratory for the isolation and identification of viruses so that proper therapy can be given. Another major activity is the treatment of children who, through travel, have acquired organisms causing such diseases as malaria.
Pediatric cardiologists, led by Dr. Norman Talner, offer a clinic that is a major referral center for conditions such as heart murmurs and cyanotic congenital heart disease—"blue baby syndrome." A special procedure, cardiac catheterization, enables pediatric cardiologists to take 35mm films of the heart to determine the cause of the problem. If it is structural, pediatric cardiologists work with cardiac surgeons to prepare children for surgery that will repair the defect.

Pediatric neurologists, under Dr. Bennett Shaywitz, work closely with staff at the Yale Child Study Center evaluating up to 15 children a week with problems such as muscle weakness, attention deficit and learning disability. Many learning and behavior problems once thought to be psychological are now known to have a neurological basis. Another program provides diagnostic and follow-up services to high-risk newborns.

A third, highly successful program carried out with the Connecticut Reves Syndrome Foundation offers treatment which can accomplish complete recovery from this sometimes fatal illness.

Dr. Walter Anyan’s Adolescent Clinic offers a range of medical and psychotherapies to 2,000 teenagers a year who are referred for evaluation or come on their own. Twenty to 30 patients a year are treated for the eating disorders anorexia nervosa and bulimia. The clinic also screens teenagers with general complaints—tiredness and headache—to determine if there is an organic cause. Recently, with funding from the Robert Wood Johnson Foundation, the clinic has extended services to high-risk teenagers through the Fair Haven Community Health Clinic, Wilbur Cross High School, and the New Haven Detention Center.

The One Day Surgery Center is used by pediatric surgeons and specialists for up to thirty percent of their procedures on children. "We’d like to increase this further," said Dr. Robert Touloukian, Chief of Pediatric Surgery. "The less time children spend in the hospital, the less their families are disrupted, the lower the risk of infection, and the lower the cost." Surgical procedures done at the Center are relatively minor: hernia repair, strabismus correction, biopsies and so forth. Clinical social workers and nurses prepare the children for surgery to reduce the need for sedatives and thus lower the time required for recuperation.

In addition to departmental research, Yale-New Haven Hospital has a Children’s Clinical Research Center, one of only thirteen in the country, funded by the National Institutes of Health. Director Dr. Myron Genel calls it "an enabling facility" with areas for out-patient and in-patient treatment and trained research nurses. A mechanical implant tested here, by Dr. William Glenn, stimulates the phrenic nerve in paraplegic children so that they can breathe normally without the aid of machines. This implant recently enabled a young boy paralyzed by a car accident to return home after more than a year in the hospital.

Pediatric radiologists serve all in- and out-patient services by performing a wide variety of diagnostic tests. Special Radiology staff are dedicated to handling infants and babies with these special problems and needs. Yale-New Haven Hospital is one of the few in the country owning a unique fluoroscope with a computer-enhanced image. "With this machine, we can use half the normal radiation dose," explains Dr. Ron Ablow, Chief of Pediatric Radiology. "This is an incredible advance when you consider that organs such as gonads are irradiated during fluoroscopic tests."

The pediatric staff’s ability to offer sophisticated treatment is enhanced by its research work. Pediatric surgeons are perfecting formulas to provide a proper balance of nutrients and trace elements when children must be fed intravenously or through catheters. A pediatric neurologist is testing a screening program to develop a comprehensive method for describing a child’s behavior and development. Out of this may come predictive factors for school performance. A pediatric endocrinologist is testing use of insulin infusion pumps in diabetic pregnant women to promote normal growth of the fetus.

Perhaps most importantly, the Pediatric Department represents a medical resource to pediatricians throughout the state and region. Children, despite medicine’s best efforts, still fall prey to exotic diseases and disabling illnesses. That "hard kernel" composed of the sickest children need the specialized expertise Yale-New Haven can offer. □
The Gift of a Lifetime

by Tom Urtz

TIME CAPSULE is a regular editorial feature of Yale-New Haven which recounts significant moments in the history of the medical center. In this article, we focus on the founding of the Pediatrics Department and the development of this medical discipline over the years.

It is the first week of January, 1920. The decade that would "roar" has just begun. From the New Haven Register we learn a family is selling its home on Chapel Street near the Yale Bowl for $4,900. A construction job is open in North Haven at 50¢ an hour for a 54-hour week. Majestic Cleaners is looking for a "fancy ironer" and is willing to pay $2.50 a day.

A full-page ad touts the wisdom of purchasing shares, available at $5 apiece, in the Rubber Products Corporation of Shelton. For three times the previous record price, Babe Ruth is sold by the Boston Red Sox to the New York Yankees for $150,000. And we learn that 45 people in New Haven died this week.

When reduced to simple statistics, death can be dealt with easily. However, when it is a family member, a loved one who is taken away, there is no escaping the emotional impact. And when does death produce more anguish than when it is a child who dies?

Twelve of the people who died during the first week of January, 1920 were less than 15-years old. The death of children was common in 1920, frighteningly common. No boundaries were sacred — political, ethnic or economic. When a killer disease appeared in a community, no family was safe.

The early 1900s saw a maturation in attitude toward the health care needs of children. Locally, a major step was taken in 1920 when New Haven Hospital established a Pediatrics Department, setting up a private wing to treat young patients. In the same year, Dr. Edwards A. Park became Yale University's first Professor of Pediatrics and the first Chief of Pediatrics at New Haven Hospital.

Building on these two events, Yale-New Haven Medical Center has grown to become a regional hub and a national resource for researching and treating pediatric illnesses.

History provides a long record of society's ongoing concern for the health of the young. Hippocrates, the father of medicine, wrote an article on dentition and described the teething problems of infants. Pliny the Elder, the Roman historian who lived from A.D. 23-79, was the first person to record the still intriguing observation that if you double a child's height at the third birthday, you will have an accurate gauge of height when fully grown.

In what was probably the first autopsy performed in colonial America, Dr. Bryon Rossitor of New Haven traveled to Hartford to determine the cause of death of eight-year-old Elizabeth Kelly. The year was 1662 and the child's parents accused a neighbor, Goody Ayers, of causing the girl's death by witchcraft. Connecticut's General Court commissioned Rossitor to "open the Kellies' child," for which he was paid twenty pounds.

Based on his examination, he attributed the girl's death to supernatural causes. Goody Ayers' fate is unknown as she and her husband fled Hartford when she heard the charge raised against her.

At the founding of Yale-New Haven Hospital in 1826, physicians did not — in fact, could not — specialize in pediatric medicine as medical schools gave the topic little emphasis.

Dr. Eli Ives, who was affiliated with New Haven Hospital from its first day, was one of a handful of physicians who focused attention on the diseases of children, doing so through a series of lectures he delivered to students at the Yale School of Medicine between 1817 and 1840.

Joseph Denison, Jr., a medical student at Yale in 1825, recorded verbatim a series of pediatric lectures presented by Dr. Ives. At the time, children's ailments tended to be treated as often by nurses and midwives as by doctors. Ives deplored this and presented this explanation.
The difficulty of acquiring knowledge of the seat of pain and disease in children from their being unable to express their sensations has been weakly alleged by physicians as a reason for not paying more strict attention to this subject. This very reason is a strong argument in favor of committing the medical care of children to men of science and information. Infants cannot communicate their sensations by language, yet symptoms by which we determine the seat of diseases are uniform in their appearance and more certain in their indications in children than they are in adults.”

Largely through the lectures of Dr. Ives, several generations of Connecticut physicians were attuned to the specific health problems of children. His stimulation of interest in pediatrics played a part in the shifting of care from nurses and midwives to doctors and helped set the climate for the care of children to emerge as a medical specialty.

By the mid-nineteenth century, scientists working in labs scattered across the globe began unraveling secrets of the body and disease. These successes, taken cumulatively, broadened the corpus of medical knowledge and further hastened the evolution of specialized medicine.

By the last half of the nineteenth century both federal and local authorities were showing an active interest in gathering accurate statistics on births and deaths. This statistical spadework turns up clear examples of how laboratory successes were applied to save lives.

**Diphtheria**

This disease starts in the upper respiratory tract and spreads its toxins throughout the body. Children are the most frequent victims. Also known as Throat Distemper, it caused what was probably the worst epidemic in Colonial America. Between 1730-1735, the Connecticut communities of Madison and Guilford averaged three deaths per year among children. In 1736, Diphtheria alone claimed the lives of 38 children.

In 1877, the death rate for Diphtheria per 100,000 people in New Haven was 184. In the 1890’s the German physician, Dr. Paul Ehrlich developed a serum from the blood of live horses infected with the disease which would impart immunity to humans when injected. By 1920, New Haven’s death rate was down to 12.

**Tuberculosis**

This is an infectious disease for which there still is no safe or effective vaccine. Coughs and sneezes can release TB germs, but a more sinister source of the disease in America was cows milk.

In 1886 a German chemist recommended pasteurizing milk to extend its shelf life and by the end of the century it became clear that the process also killed TB germs. In 1905 the New Haven Health Department set up an agency to inspect milk and by 1922 it was mandatory that all milk sold in the county be pasteurized. Through these and other efforts to control the sources of infection, the death rate from this disease fell from 264 in 1877 to 65 in 1920.

**The death of children was common in 1920, frighteningly common. No boundaries were sacred — political, ethnic or economic. When a killer disease appeared in a community, no family was safe.**
Children have comprised a shrinking percentage of the annual deaths in the United States since the turn of the century. The chart indicates the number of deaths for children under 15 per 100 deaths in New Haven, Connecticut and the U.S.

**Dysentery**

Also known as the Body Flux, this diarrheal ailment caused numerous deaths by rapidly dehydrating its victims. Dr. Ernest Caulfield, a New Haven pediatrician in the 1920’s and 30’s wrote:

"This was a disease that year after year made August and September the most dangerous months in New England. It was a disease of the aged, of young mothers, as well as a disease of childhood. One need only read some detailed first-hand accounts of fear, sadness, misery and multiple deaths that have always accompanied these frightful epidemics to realize that, while not like smallpox, a spectacular disease that generally made the headlines, dysentery nevertheless surpassed all other diseases as a cause of childhood deaths."

Considering only children under two years of age, the death rate from diarrheal ailments in 1877 was 155 per 100,000 population. Thanks to pasteurized milk, development of a safe municipal water supply and an improved sewage system, by 1920 the death rate was down to 43 and still falling.

Since 1920 the principle causes of death for children under 15 have changed significantly. The former scourges of infections, pneumonia and dysentery (all of which were exacerbated by nutritional problems) have been supplanted by accidents and cancers.

To view this in proper perspective, however, some interesting numbers must be considered. In 1920, 26.8 of every 100 deaths occurred in children under 15-years-old. In 1980 the percentage had plummeted to 3.1 per hundred. This fact goes a long way in explaining how the life expectancy of Americans has grown from 54.1 to 73.7 in the last sixty-plus years.

The comparative mastery over infectious diseases that medicine now possesses has been integral in saving millions of children from early death. The development of vaccines, sera, nutritional supports including intravenous feeding, and improved methods of sanitation have quietly erased some of the worst fears of parents for the health of their children.

Reflecting on this progress, Dr. Howard Pearson, Chairman and Chief of the Pediatrics Department at Yale-New Haven, points out that once common childhood problems have become rare. "Unless the house staff go to a foreign country, they're apt never to see a case of measles, whooping cough or mumps."

Dr. Pearson, chairman since 1974, is fifth in a line that includes Dr. Park (1920-27), Dr. Grover Powers (1927-52), Dr. Milton Senn (1952-63), and Dr. Charles D. Cook (1964-74).

"This Medical Center's greatest accomplishment in pediatrics," according to Dr. Pearson, "is the number of future leaders we have attracted, trained and sent out. A surprising proportion of the nation's leading pediatricians underwent training in New Haven. This number is far out of proportion to the size of our institution."

For children, there have been other tangible developments in pediatrics since the department's founding.
Linda Athanas may be pointing out an imaginary fire or showing her son, Alexander, someone who will help him get well. In any case, having parents nearby during a stay in the Pediatric Intensive Care Unit is crucial to a child’s recovery and both mothers and fathers are encouraged to lend supporting hands.

Since the early 1930s, teachers have been employed at Yale-New Haven to instruct school-aged children. The Hospital often provides long-term care to children so a teacher for the pediatrics floor is recognized as essential.

In the 1950s the first "rooming in" program for new mothers and their infants was introduced. Rooming in is now internationally recognized as a part of humane obstetric and pediatric care.

Yale-New Haven is the site of the world’s first Newborn Special Care Unit, opened in January, 1962. This unit has served as a model for similar units in hospitals around the world.

In October, 1966, a Pediatric Intensive Care Unit was created. Originally located on Fitkin 4, the nine bed unit has been relocated to the 7th floor of Yale-New Haven’s new facility.

Through the Child Life Program developed in 1967, specially trained hospital personnel work with young patients to help identify and treat their social, emotional and developmental needs, and assist them in coping with the stress of hospitalization.

Pediatrics has grown in a span of sixty-four years into one of Yale-New Haven Hospital’s major areas of concentration. Rewards coming to practitioners in this field are tangible and satisfying.

Dr. Pearson notes, "When you save a 70-year-old you are only gaining them a few years. When you save a one-year-old you’re giving them 70 extra years of life."

Extending life, giving children a chance to experience adulthood, is perhaps medicine’s greatest achievement of the last century.
Love and Medicine Create a Magical Mix

By Mark Bittman

"Treat the patient, not the disease," is a frequently heard slogan in the medical community these days, and it is an appropriate one. Yet the Pediatric Intensive Care Unit (PICU) at Yale-New Haven Hospital takes this concept one step further, treating not solely the patient but, in many cases, his or her entire family. For serious illnesses and injuries have psychological and social effects which often may cause as much pain and last as long as the disease or traumas themselves. And this is particularly true when they strike children, who we almost universally perceive — or strive to — as happy and carefree.

The PICU is an unusual unit. Throughout the Hospital, intensive care units are made up of patients with similar types of diagnoses: there are the Surgical Intensive Care Unit, the Cardio-Thoracic Intensive Care Unit, the Medical Intensive Care Unit, the Neuro-Surgical Intensive Care Unit, and the Newborn Special Care Unit. Patients are assigned to one of these units when they require an extraordinary amount of care. A person with a severe infection is on the Medical ICU; a recuperating trauma victim is likely to be on the Surgical ICU, and so on.

Gentle concentration earns Pina Mendillo the trust of her patients in the Pediatric Intensive Care Unit.
Yet in an age group which begins just after the newborn stage, at a few weeks old, and ends at early adulthood, all patients needing special care are sent to the PICU. "The list of diagnoses we have here," says Dr. Peter Rothstein, chief of the unit, "could go on for pages, with no two diagnoses alike. Many adults have similar types of operations, for example, they've had heart attacks or aneurysms, that kind of thing. But the list of operations and procedures involved in treating congenital heart disease alone is a long one."

The PICU, in grouping patients by age rather than by disease, is in effect both a medical and a surgical ICU. And therein lies its strange beauty.

For although most staff members are specialists, they all must have a broader range of knowledge than they would on any other floor. A group of six physicians — all specialists in different fields (Rothstein, for example, is an anesthesiologist) — rotate through the unit as attendings, taking primary responsibility for prescribing a course of treatment at least twice each day for each patient.

The patient mix on the PICU is so varied that, even allowing for the frequent middle-of-the-night calls the attendings receive at home, prescribing these courses of treatment can never become routine. Consider the patients on this recent, typical day when the unit's nine beds were filled: one child had a head injury resulting from a car accident; one had ingested drugs; one was recovering from abdominal surgery; another was a "graduate" of the Newborn Special Care Unit whose respiratory system was underdeveloped; two were suffering from encephalitis (one of those had the relatively rare and particularly severe eastern equine variety); one had been admitted with seizures; one was recuperating from neurosurgery, and one — a five-year old, bewildered at being in a place with "so many sick kids" — had been admitted with a late-night attack of croup.

"A lot of our diagnoses depend on the season," comments Rothstein. "In the winter we see more epidemics of infectious diseases; in the summer more trauma victims, bicycle and swimming pool accidents."

One would expect such a unit to be overwhelmingly gloomy and depressing. Most visitors, however, find it to be quite the contrary. One wall of the unit is almost entirely made up of windows, and, except for closets, offices, and two isolation rooms, the floor is wide open. Children can see one another, the always-busy nurses at work, the balloons and decorations that hang from IV poles. And although there is no question that this is a place for sick children — some, but not all dangerously so — and serious work, the atmosphere is hopeful, busy, cheerful, sometimes noisy, and altogether uplifting.

"Except for during rounds, we have pretty much open visiting here. So all of us — nurses, physicians, social workers — spend some time talking with the child's parents and siblings."

Nurses in the Pediatric Intensive Care Unit know the importance of creative play and caring attention during a child's healing process even at the most critical stages of illness. Maria Lynch, R.N. makes things easier for a young, bedridden patient.
"The focus here is on the family: we never treat just the child but always the whole family. The work is all geared to keeping the family unit intact during and after a very stressful period."

Pina Mendillo, R.N., a pediatric intensive care nurse, examines a young patient.

The open design is something for which long-time members of the unit fought hard. "Before 1975," recalls Dr. Howard Pearson, chief of pediatrics at Yale-New Haven, "the PICU consisted of two small, crowded rooms on Fitkin 4. That year the Hospital gutted and renovated Fitkin 3 for the unit. The new unit allowed us to create a staff and gain invaluable experience, experience we used in designing the PICU in the new building. And, I'm pleased to say, there are no glitches in the new unit."

Staff members agree. Maria Lynch, a staff nurse on the unit since the Fitkin 4 days, calls the new unit "the greatest. We had to fight with the architect for this open floor, but it was worth it. We have easy access to every patient." Lynch tells a story of a bed rail dropping and nurses running from two or three directions to help; with all closed, isolated rooms, that — and more serious incidents — would be responded to more slowly.

This "dedicated and superb nursing staff" (Pearson's words) is the core of the team that makes up the PICU. For it is the nurses who are constantly with the patients, often "specializing" them (giving one-to-one care), playing with them (or for them — blowing bubbles for the kids to watch, bouncing a balloon off a child's toe), relating to the family and, of course, checking signs, giving meds and fluids, doing skin care, and performing the myriad of tasks that make up the workday of the professional nurse. And then some.

"Except for during rounds, we have pretty much open visiting here," reports Linda Lewandowski, pediatric clinical nurse specialist, "so all of us — nurses, physicians, social workers — spend some time talking with the child's parents and siblings. I often do play preparation and follow-up for sib's visits; their fantasies about what's wrong with their brother or sister are often worse than reality, so the visits are especially helpful to them."

All the staff members spend an enormous amount of time and energy caring for the families of the children. "Especially with a poisoning or something like that," says Lewandowski, "there is a tremendous amount of guilt and blame on the part of the parents. 'Why didn't I watch him better?' And we all help them work through their guilt and worry.

Social worker Cheryl Ford points out that psychological and social damages are often longer lasting, and even more traumatic, than physical ones. "A father who recently had a cooking accident, scalding his child's legs, suffered well beyond the time it took for the child's skin to heal. The whole family is affected by accidents like this one — people feel guilt and blame, they must take time off from their work, the way they treat their other children changes, finances may become more complicated — and all of this underlies that treatment given by the unit's staff."
Many of the procedures pivotal to a successful recovery in the Pediatric Intensive Care Unit command patience and teamwork. Here, Dr. Moshe Siev and nurse, Louise Lanzieri work together to monitor the condition of a youngster’s liver.

“You have to remember,” stresses nurse Louise Lanzieri, “that most of the kids here are not in critical condition, most don’t die or go home brain damaged. It is very important for us to be supportive of the parents, to prepare them for the child’s discharge to the (regular pediatric) floor or to home.’’

Head Nurse Helen Dorman, a woman with over 30 years of nursing experience in a wide variety of situations, and one who obviously deserves and is enthusiastically given the respect of her staff, sums up the philosophy of the unit: "The focus here is on the family; we never treat just the child, but always the whole family. There is no isolation. The family is informed — we don’t raise false hopes, but we always try to give whatever support we can — and can spend as much time as they like at the child’s bedside. The work of the social worker, the clinical specialist, and some of our volunteers is all geared to keeping the family unit intact during and after a very stressful period."

The entire PICU staff recognizes the importance of relating to the family during a child’s illness or recuperation from an injury, operation, or illness. "That’s one of the things that make the atmosphere so stimulating here," says Dorman. "It’s critically important to be aware of the child’s developmental needs, and to the psycho-social needs of the family." Add that to the fact that the case mix on the PICU is duplicated nowhere else in the Hospital except for the Emergency Room, and "stimulating atmosphere" becomes almost an understatement.

In a hospital filled with caring and committed professionals, the PICU staff adds new dimensions to the term "patient care." One can’t help but feel that the astonishingly positive atmosphere on the seventh floor unit affects other staff, visitors, and patients alike. □
It is a tradition in New Haven — a celebration. It is the Saturday before Thanksgiving, November 19, 1983, and Yale and Harvard alumni swarm to the Yale Bowl to continue 100 years of football tradition. Not far away, a celebration based on a mere 20 years of tradition is quietly taking place at Yale-New Haven Hospital. The lack of seniority and fanfare does not make this occasion any less auspicious, however. Michael Peck is going home.

Michael’s parents, Betsey and Wells Peck, are unaffected by the thousands of football enthusiasts enroute to the 100th Yale Bowl reunion who crowd the highways outside Michael’s window. Within the hour, the Pecks will be traveling toward Mystic to their own family reunion — a reunion which most likely would never have taken place twenty years ago.

Michael Peck was born in July of 1983 with a heart murmur. Twenty years ago, his pediatrician would have had limited resources with which to help Michael. But thanks to the growth of pediatric cardiology and the development of facilities and services at Yale-New Haven, Michael’s prognosis is a very hopeful one.

Eight in every thousand babies are born with a heart defect. According to Dr. Charles Kleinman, a pediatric cardiologist at Yale-New Haven, “The vast majority of these defects are minor abnormalities that have very little impact on the quality of life, and many may be spontaneously resolved.”
This was not Michael’s case. During the second month of life, his pediatrician requested an electrocardiogram to further evaluate the condition of Michael’s heart. The abnormal E.C.G. and a faint blue coloration made it clear to his physician and to Betsey and Wells that Michael’s heart required further study.

By October it was seen that Michael required extensive diagnostic workup, and the Peck’s physician referred them to Yale-New Haven. “At that point we were sure the problem would take care of itself,” Betsey confesses. Her pediatrician was beginning to wonder.

The Pecks were able to schedule an appointment for further diagnostic study, but many parents are not allowed that luxury. It is possible for a crisis to occur within a day or two of birth to a seemingly healthy baby. Since the lungs of a fetus are still developing before birth, the fetus receives oxygen directly from its mother. At birth, the baby begins to use its own lungs, and the tube, referred to as a shunt, which allows blood flow from the right to the left side of the heart normally closes off within one or two days. If this closure does not take place, a crisis, known as patent ductus arteriosus, occurs as a result of blood bypassing the lungs.

The result is a cyanotic (blue) infant. Left untreated, the child will certainly die. To assure immediate treatment, Yale-New Haven, with the largest newborn special care unit in the state, has established the Transport Team which is a group of primary nurses and physicians out of the Newborn Intensive Care Unit who pick up and immediately begin treating the distressed infant.

The development of certain pharmacologic agents in the past few years provides additional hope for infants in distress. Prostaglandin E1, according to Dr. Norman Talner, Chief of Pediatric Cardiology at Yale-New Haven, is a relatively new drug which has contributed significantly to the success of Yale’s Transport Team. By causing the ductus to remain open for an extended period of time, nurses and physicians are able to transport distressed babies to Yale-New Haven, if they are still in the womb, temporarily bypassing congenital heart defects.

When the child reaches Yale-New Haven, be it by transport ambulance in the middle of the night or with his parents for a scheduled daytime appointment, the extensive diagnostic procedure begins. After the E.C.G. and other preliminary testing, a pediatric cardiologist performs an echocardiogram. This test, a form of ultrasound, is a two-dimensional imaging technique. During the procedure, which is painless and noninvasive, pulses of sound are transmitted into the body and the returning echos are recorded.

“A number of years ago, Yale recognized that echocardiography was an area that was going to revolutionize pediatric cardiology care,” says Dr. Kleinman. Clearly, the challenge for the pediatric cardiologist is to recognize a cardiac problem as early as possible, and the echocardiogram has helped physicians meet this challenge. In fact, as a result of the 1975 thesis of a Yale medical student, this procedure is now being used before the baby is born. As Dr. Kleinman further explains, “We’ve revolutionized thinking in that the pediatric cardiologist has become an integral part of the perinatal management team. We use this information to help formulate plans for delivery and for the neonatal period.”
Surprisingly, echocardiograms can also affect prenatal management. Doctors at Yale-New Haven have determined that certain rhythm disturbances can be treated in utero with medications that are given to mothers rather than to the babies after they are born. "We have come to the conclusion that the safest place to treat these fetuses is inside the womb because that is really the safest environment for the premature fetus," says Kleinman. This preferable treatment can only be accomplished when diagnosis is made in utero with the echocardiogram.

Echocardiograms show both structure and movement of the child's heart. One parent was particularly vocal about the impact of seeing her child's echocardiogram. "It's incredible," she explained. "You actually see a slice of the heart. You can see the chambers, and you can even see the valves opening. It's absolutely amazing."

This enthusiasm is not exactly the initial reaction that Betsey Peck describes. It was Michael's echocardiogram on October 31 which made it clear to the Pecks that surgery was unavoidable. As Wells explains, "All this time we had been telling ourselves that the echo was not going to say anything. It really hit me when I saw what was there."

What Wells and Betsey saw with the help of the pediatric cardiologist was the presence of tetralogy of Fallot inside Michael's heart. This defect, which includes a hole between the two sides of the heart and a narrowing of the path leading from the heart to the lungs, obviously required attention. It was becoming increasingly clear that Michael needed surgery.

"It was an incredible blow," confesses Wells. He and Betsey both described the initial idea of surgery as overwhelming, but they add that through the help of the pediatric cardiology nurse they began to feel a little more comfortable."

"Fantasies and fears are much worse than reality in most cases," says Pat Richard, the nurse practitioner who specializes in pediatric cardiology. "The more a person knows about a situation, the more in control he is, and so the less frightened he is." As she sees it, her role is to prepare families for diagnostic work and for surgery when it is necessary. With this role in mind, she and other members of her department have prepared patient questionnaires and instructional booklets to help inform children and parents about what to expect when a child is admitted to the hospital.

With children older than Michael, the issue becomes more complex. The fears of a young child who faces elaborate diagnostic procedures can be varied, and the child may require constant attention. Children often see hospitalization as a form of punishment, and they fear the pain, mutilation, and separation that they associate with hospitals. As with their parents, the loss of control can be very threatening to them.

In addition to the cardiology nurses, Child Life specialists and a social worker are available to help quell these fears. Child Life specialists are trained to help children express themselves through role-playing exercises, and they try to keep children as active as possible during their hospital visits.

Returning to home a once-critically ill child along with a long-term prognosis for good health and a sound nature is the ultimate goal of the Yale-New Haven Hospital Medical staff. Michael Peck underwent major surgery less than a year ago and is now plucky and bright at home in Mystic, Connecticut.
The role of the social worker involves both the child and the parent. Pat McFarland, Yale-New Haven’s social worker who specializes in pediatric cardiology, explains that while she sees herself primarily as an advocate of the child, most of her work is directly with parents. “I try to help families manage,” she explains, adding that her role may be basic as finding parking or as complex as helping people to find financial assistance or psychiatric assistance. After assessing a family’s support systems and informational base, Ms. McFarland says that she can determine a family’s need. With the Pecks, she soon realized that she could help them with parking problems, but the family unit was sufficiently informed and supported without her.

She stresses, however, that each family has different needs when it comes to social work. “We get quite a cross section of people — different nationalities, different cultures, different family dynamics, and I offer a different service to each family that comes here.”

For families that have to deal with chronic illness and crisis, there are no simple answers. Nancy and Jim Shapiro realized this fact eleven years ago when their daughter Jennifer was born with numerous heart problems including transposition of the great arteries, a defect which sends oxygen-poor blood through the body and oxygen-rich blood to the lungs. The success rate for this heart defect was substantially greater in 1983 than it was in 1972, but as a result of Jennifer’s early complications, she is still struggling to survive. It has been a long and difficult experience for the Shapiro — one through which they have fought to remain optimistic.

Realizing the devastating effects chronic illness of a child can have on the family, the Shapiro’s became actively involved in developing Yale-New Haven’s Parents of Cardiac Children United, Inc., an independent support and education parent group. As Jim explains it, “You can be angry all you want, but you have to learn to live with heart disease, and you have to understand it.”

In that spirit he and Nancy have kept the parents’ group together with the help of the pediatric cardiology staff for over ten years, funding publications, mailing newsletters, and organizing informative meetings. “We believe that it is comforting for parents to see others who have had similar problems and experiences, and it helps to know that every doctor at Yale appreciates the importance of parents as well as children.”

Michael’s parents explain that their experience at Yale-New Haven happened so quickly that they had no direct involvement with the parents’ group. On November 1, the day after Michael’s echocardiogram, Dr. William Hellenbrand, Director of Yale’s Pediatric Cardiac Catheterization Laboratory, performed a diagnostic catheterization to evaluate the defects which cardiologists know are associated with anatomy of Fallot and to rule out associated defects.

Overseeing the procedure, Pat Richard, who specifically attends to the Catheterization Lab, checked Michael’s vital signs as Dr. Hellenbrand guided the catheter into Michael’s heart and observed the flow of contrast fluid through his heart. It was this procedure that determined what would happen during Michael’s surgery.

“We go into the laboratory to find out what’s normal and what’s abnormal,” says Hellenbrand, and in Michael’s case the report would go directly to his surgeon and therefore had to be accurate. As Hellenbrand admits, “The worst thing in the world is to surprise the people in the operating room.”

Dr. Hellenbrand is looking ahead to the day when catheterization may be an answer in itself and not merely a step toward the operating room. Currently he is doing extensive research into the use of therapeutic catheterization as well as diagnostic. This research, which is only being performed at three medical centers in the country, involves the use of a teflon and stainless steel piece to close certain holes between sections of the heart. Currently this procedure is very strictly controlled by the Food and Drug Administration, but pediatric cardiologists are very pleased with the results thus far.

Other areas of therapeutic catheterization study are in the field of septostomy, which is the creation of necessary openings in the heart through the use of balloons and microsurgical techniques. Cardiac angioplasty, the opening of narrowed valves and arteries with balloons, is also being developed. With the advance of therapeutic catheterization, Hellenbrand sees a time when fewer children will require cardiac surgery.

But this would not be the case for Michael. The cardiologists and the surgeon decided that it would be best to send him home and to schedule surgery for December 6. As cardiac surgeon Dr. Gary Kopf explains, “Size is not nearly as important as it used to be, but Michael was a little under 15 pounds, and in a small baby, the tissue is quite delicate, so we decided it would be wise to allow him to grow a little bit more.”
"We have come to the conclusion that the safest place to treat these fetuses is in the womb because that is really the safest environment for the premature fetus."

Dr. Hellenbrand chuckles as he recalls, "Unfortunately, Michael didn't think so."

On Wednesday, November 9, Michael was admitted to Yale-New Haven after a "full-blown" tetrology spell. The signals were clear — he had become cyanotic, drowsy, and he fell asleep. Dr. Kopf explains, "It was clear that we had to do something right away, so we went ahead and planned to repair him."

Major advances in cardiac surgical technique have significantly reduced mortality rates. The mortality rate for children with Michael's defect, for example, has been reduced to five per cent from 30 to 40 per cent 10 years ago. In Jennifer Shapiro's case surgery today would be equally promising.

"Our tendency now is to operate on more and more complex lesions at an early age to try to correct the defects earlier," says Dr. Kopf. "That way children are not subjected to the complications that can occur before these lesions are repaired."

Additionally, less palliative surgery is performed on infants as a result of surgeon's increased understanding and ability to cure certain congenital heart defects. This reduces the chance of multiple surgeries, thereby reducing risk to the children with heart defects.

Dr. Kopf believes that further development of the heart-lung machine and methods of profusing patients have contributed to the promising statistics in most types of pediatric cardiac surgery. He also feels that the technique of using deep hypothermia in surgery has been a significant advancement. In use for approximately 10 years, the procedure involves lowering the body temperature of the child in order to slow down blood flow. Says Kopf, "It gives you a totally bloodless, relaxed field which is what you need to deal with some of these very intricate lesions."

Ultrasound sonographer Kathy Finn applies a transducer to young Paul Emery's chest which will reveal on the monitor a dynamic picture of the heart and any structural abnormalities. Mom helps supply some diversionary tactics to keep Paul occupied during the painless procedure.
It is precisely this technique which Dr. Kopf used on Michael on Friday, November 11, as he performed cardiac surgery. In a little less than four hours, Dr. Kopf closed the hole between Michael’s left and right ventricle with small dacron patches about the size of a quarter, and he cut away the blocked pathway to Michael’s lungs, using Michael’s own tissue as a patch.

While it seems like a small amount of time for such a major task, it was an eternity to Betsey and Wells who waited nervously for the results. They gratefully mention the operating room nurse, the cardiology fellow, and an attentive medical student who followed Michael through his ordeal. Wells laughs about the moment he got the good news from the cardiology fellow. “He still had marks on his face from his surgical mask as he told us that everything was fine.”

Elated and relieved, Betsey and Wells prepared themselves to meet Michael in the Pediatric Intensive Care Unit. “Fortunately,” Wells admits, “we knew what to expect. We had been given a tour of the I.C.U., so we knew what Michael would look like. If we hadn’t seen other babies, it could have been quite devastating.”

In fact, Michael’s stay in the Pediatric Intensive Care Unit was a very positive one according to Betsey and Wells. They were particularly confident about their son’s recovery as they observed the constant, attentive care of the I.C.U. nurse who stayed with Michael all day.

Just eight days later Michael is as pink as the healthiest four-month-old and is obviously impatient with the attention of physicians and nurses. As Betsey wraps him up in his travel blanket, she adds a final word. “We can’t say enough about the treatment we’ve gotten for him and for us,” and she refers to the “team” of people who helped.

“This group probably takes the team concept as far as it can go,” says Dr. Talner proudly. In fact, there are members of the team whom Betsey and Wells never had the opportunity to meet.

One member of Yale’s pediatric cardiology group is involved in research to further identify the relationship between the lungs and the heart, an investigation directly related to Michael’s condition. Another physician has spent years conducting a study of the children of parents with congenital heart disease. The final statistics of this study may well be important to Michael in the future. And this is just the start. Medical students, cardiac and surgical fellows, and all the physicians who have been trained in clinical cardiology and research at Yale-New Haven may be adding to Michael’s longevity.

Nurses, physicians, teachers, social workers, parents, technicians, students—they all play a significant role in helping children like Michael Peck and providing hope for children like Jennifer Shapiro. There is no question that they work as a team. As Pat Richard explains, “It’s a very intense relationship and involvement because the child’s life is the focus.”

As Betsey, Wells, and Michael Peck traveled away from New Haven they had much to celebrate and many reasons for a happy Thanksgiving. Michael was coming home.

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The seventh floor Pediatric Complex in this facility is dedicated in grateful tribute to C. Rachel Trowbridge (1899-1982) whose love of children, devotion to their care and generosity throughout the New Haven Community have touched the lives of so many.

Like most memorial plaques, this one gracing the children’s floor of Yale-New Haven’s New Facility is an austere and understated reminder of generosity. Miss Trowbridge, in a life dedicated to helping others, gave new meaning to the word, “philanthropist.” When she died, in 1982, New Haven lost one of its foremost citizens.

Yale-New Haven Hospital, a frequent beneficiary of Miss Trowbridge’s generosity, received, upon her death, one of the largest gifts in its history. Hospital financial officials estimate this unrestricted bequest of securities may total as much as $900,000. Although the gift was not specifically earmarked for any purpose, and may, in fact, be directed to a number of worthy and needy Hospital services, the Board of Trustees last year voted to name the Pediatric Complex after her.

According to Mary B. Arnstein, Vice Chairman of the Board, “Children have always been the major focus of her life. And because of her known interest in children, the Board of Trustees felt naming the pediatric wing after her was the proper way to recognize her appropriately.”

A testament to her dedication to children is the Children’s Center in Hamden which her family helped found in 1833 as the New Haven Orphan Society. She fostered its growth through world wars, polio epidemics and its gradual evolution into a residential facility for emotionally disturbed children. She served as a member of the Center’s board since 1923.

Sam Chauncey, President of Science Park, was her neighbor for many years when, as Secretary of Yale University, he lived across the street from her family home at 40 Hillhouse Avenue. He recalls, “The truly extraordinary thing about her was the capacity she had to deal with change, the way she believed change was good. She had a great sense of the past but also understood that time does not stand still. And she had a tremendous faith in the young.”

Miss Trowbridge’s many charitable involvements included a close association with Trinity Church on the Green where she was one of the first female wardens of the church and taught Sunday School for over 30 years. She served as the first president of the Junior League and was on the boards of the New Haven Symphony, the Clifford Beers Clinic, the New Haven Preservation Fund, and the Woman’s Seamen’s Friend Society of Connecticut.
**Art Collection**

Ambiance can contribute significantly to one’s mood, frame of mind, clarity of thought and, in many instances, innate tendency to strive for a feeling of well-being. This is ultimately why the fine arts were created — to nurture a healthy ambiance wherever they are presented. With the opening of the new facility at Yale-New Haven Hospital over a year ago came the first elements of an impressive collection of artwork displayed in public places throughout the Hospital. Signatures on framed photos, paintings, sketches and etchings are those of novices and masters, preschooolers and octogenarians. All pieces of art work were donated by individuals who are friends of the Hospital — some are collectors of major works of art, others simply purchased art for their own enjoyment, initially. All donors take pleasure in the knowledge that through their generosity, they were instrumental in the healing process of many ill patients, as well as in boosting the morale of Hospital personnel.

There are tens of thousands of square feet of space in patient rooms, the Clinical Laboratories and Ambulatory Care areas that have not yet received the attention of the Hospital art program. The collection is boundless in both the positive array of emotions it inspires in patients and staff and the list of artists from whom it will accept donations. Please call 785-2606 for more information about this important program.

**Exercise-induced Asthma**

Jogging, tennis and other forms of strenuous exercise may be potent triggers in a respiratory condition now known as ‘exercise-induced asthma,’ according to Dr. Neil Schachter, Medical Director of the Respiratory Therapy Department. About five percent of the country’s population is plagued by asthma, that figure includes people who suffer from exercise-induced asthma. Unleashed by the flow of adrenalin and exacerbated by the respiratory tract’s loss of heat and moisture during a work-out, exercise-induced asthma is often found in people who have had no prior history of asthma, yet who undergo wheezing attacks, congestion and lung discomfort five to ten minutes following exercise. Dr. Schachter notes that attacks may be “subclinical and regarded simply as a nuisance, but some subjects may experience severe, full-blown asthmatic episodes after exercise.” To sportsminded individuals prone to this disease, he recommends swimming as the ideal alternative to many forms of exercise. Ice skating, cycling and walking are also good ways to maintain physical fitness without undue risk to respiratory tracts.

**Nutrients in Cooking**

Fresh fruits, vegetables and meats are storehouses of important vitamins and minerals. However, unless certain steps are taken during storage, preparation and cooking, these building blocks to better health can slip away unnecessarily. According to Michele Fairchild, Assistant to the Director of Clinical Nutrition, meats and grains contain vulnerable B vitamins; milk has light-sensitive riboflavin; and fruits and vegetables are sources of the extremely perishable vitamin C. When storing these items, remember to keep them in opaque, airtight containers, protected from air and light. The shorter the storage time, the better. Also, avoid soaking fruits and vegetables in water before and during storage. In preparing food, cut, slice or chop close to the time of cooking or serving. This will help to minimize bruising and will retain vitamins C and A. Keep in mind, too, that some food pairs are more nutritious than others. When sources of vitamin C and iron are coupled, the body absorbs it very readily. Some palatable combinations of C and iron include liver and broccoli, enriched cereal and grapefruit, eggs and orange juice, meat and potatoes. And keep cooking times short. Overcooked meats and vegetables are robbed of just what your body needs most.

**Cyclosporine**

The spotlight on the recently performed first liver transplant at Yale-New Haven has also reflected brightly on a medication now heralded by some as the "new miracle drug." Cyclosporine, a clear oily solution, was crucial to the success of October's transplant operation due to its ability to prevent organ rejection in human transplant patients. Dr. Wayne Flye, head of the transplant team, obtained the drug on a "compassionate need basis"—a stage of approval between the time studies are completed on a drug and its subsequent introduction to the public market. However, the Food and Drug Administration officially cleared it for bulk-release on November 28 and it will soon be stocked in large quantities in the M.U. Pharmacy area and other hospitals across the country. Extremely expensive, (under the trade name, Sandimmune, 50 ml of oral cyclosporine runs around $160); the drug has been reported to be highly effective when used with steroids in fighting infections that surface after heart, liver and kidney transplants. The only serious drawback to using the drug is the adverse side effects it can produce. Increased incidence of malignancy, tremors, muscle weakness and hypersensitivitiy to extreme temperatures have been reported and are currently being investigated. As was the case with its "cousin" penicillin years ago, it will be some time before all the facts on cyclosporine are in.
Yale-New Haven Hospital Annual Report 1983
Once we gain the perspective of time, we may look upon 1983 as a turning point in hospital history. During this year, the United States Congress changed the method of paying for hospital care for federally sponsored Medicare patients. This event, culminating years of debate about an appropriate method to contain escalating health care costs, will have profound consequences for the entire health delivery system. While this action affects only one category of patients, its influence likely will be felt throughout the entire system as it will stimulate similar actions by other major buyers of care.

This Congressional action is consistent with past important historical events in shaping national health care arrangements. Federal policy initiatives have sponsored the growth in biomedical knowledge through the National Institute of Health, expansion of hospital physical resources through the Hill Burton Program, of manpower resources through the Health Manpower Program and improved access for the elderly and poor through the Medicare and Medicaid programs. While these prior initiatives contributed to escalating the amount of resources consumed by the health sector, this latest strategy is an effort to try to contain that growth. Shifting hospital financing from a retrospective cost-based system to a prospective fixed price payment makes conceptual sense. While the incentives under the prior arrangement rewarded both patients and providers for cost consuming behavior, the new system will reward providers for cost avoidance. Whether or not this will be in the patient’s best interest remains to be seen.

In anticipation of major changes in the health system, Yale-New Haven Hospital began a strategic planning process in 1982. The events of 1983, however, gave the effort added momentum. Several task forces assisted the Strategic Planning Committee in evaluating the external environment, in assessing our organization’s strengths and weaknesses and in identifying potential strategies for institutional success.

One of the first analytic steps was to examine our institutional mission. Both the Strategic Planning Committee and the Board of Trustees carefully reviewed this document. A key affirmation of this review is that Yale-New Haven Hospital’s mission is to provide health services, not just acute hospital services. This distinction is important in light of shifting patterns of service be-
beyond the acute inpatient environment and acknowledges the appropriateness of emphasis on patient care in the non-hospital setting. As technical capacity makes it possible to care for more patients out of the hospital setting, it will be important for Yale-New Haven Hospital to expand its capacity for service in these areas. It is anticipated that much of the development in this area will be done in collaboration with other providers.

Another environmental influence which was recognized by the Trustees is that of inter-institutional affiliations. While the historic pattern has been for hospitals to function autonomously, hospitals are beginning to share programs and expertise in order to enhance their capacity to serve their community and to contain costs. In order to enable Yale-New Haven Hospital to benefit from these advantages of networking arrangements among hospitals, the Board of Trustees approved membership by Yale-New Haven Hospital in Voluntary Hospitals of America. VHA is a cooperative of 60 large, non-profit, teaching and referral centers across the country which have agreed to cooperate in certain program areas in order to gain advantages for their institution’s patients. Programs offered by VHA include operational and financial analysis and planning, manpower development, supply and equipment procurement, insurance, and improved access to capital. The potential benefits from this affiliation are significant and it also provides an opportunity to benefit other providers in our area.

Whereas 1982 saw the renewal of our physical structure, 1983 was a time for renovation of our organizational structure. The Trustees and management spent a considerable amount of time examining the current organizational format in light of environmental changes. It was concluded that the traditional corporate structure would not serve us well in these times. The need to pursue activities in non-hospital health services, to facilitate relationships with other health providers, and to create opportunities for capital formation caused the Trustees to form the Yale-New Haven Health Services Corporation. This entity will be the parent body for Yale-New Haven Hospital and other activities which the Trustees decide to pursue. Several programs are already being planned and others will develop during the coming year. The flexibility accorded by this new format should assist Yale-New Haven Hospital in being able to take advantage of opportunities and to garner the resources necessary to support the missions of the Hospital.

Without question, it is a time of great ferment in the health sector. Conducting business as usual will not be a strategy for institutional success. Major changes are required in order to comply with the concerns of those who finance care and to balance that with our commitment to high quality services.
The Trustees, management, and medical leadership of this institution are committed to taking whatever steps are necessary to assure that the century and a half of service by this institution will be sustained for future generations.

It is also in order to mention the retirement of Dr. David Seligson as Chief of Clinical Laboratories. Dr. Seligson served with distinction in this capacity for twenty-five years. He literally created the department and made it into one of the finest in the country. His dedication to patient care, perseverance and ingenuity in pursuit of his goals and commitment to excellence as the only acceptable criterion, have set a high standard for Yale-New Haven Hospital. We are grateful for his service.

C. Newton Schenck
Chairman, Board of Trustees

C. Thomas Smith
President

Postscript

The 1983 report cannot be concluded without acknowledging the retirement of C. Newton Schenck in February as Chairman of the Hospital Board of Trustees. Newt served the maximum of twelve years on the Board, and he contributed in innumerable ways. As Chairman for the past two years, he has led us in strategic planning, corporate restructuring and medical staff reorganization.

Fortunately, Newt will continue to be a part of our family as a director of the Yale-New Haven Health Services Corporation. Our patients and the entire community have been blessed by his stewardship.

C. Thomas Smith
President
Economic pressures are changing both the methods of health care delivery and the public’s perception of health care needs. Rising costs, limited availability of capital, increasing competition, and the Medicare prospective payment system have created an environment that is presenting enormous challenges for hospitals. Non-profit, urban teaching hospitals like Yale-New Haven are particularly vulnerable. Traditionally, Yale-New Haven has been committed to serving all patients, including the poor, as well as to maintaining excellence through educational programs and support for clinical research. Unfortunately, these commitments may be at odds with the necessity of maintaining financial viability.

Fulfilling the Hospital’s traditional missions in this economic environment requires an informed and responsive hospital staff, progressive management and the support and commitment of all members of the Yale-New Haven medical staff. Only by making the Hospital’s operating performance more efficient and productive can we ensure high-quality patient care.

The heart of this institution is its staff, which is responsible for Yale-New Haven’s reputation for health care excellence. Developing a thorough understanding by the 4,000 employees and 1,500 medical staff members who work here about the challenges facing the Hospital is of paramount importance. Consequently, numerous meetings were held to discuss significant trends and issues which affect health care in general, and Yale-New Haven specifically. Articles focusing on the changes in health care financing were included in Hospital publications, and management development programs were augmented to orient management staff and medical staff members to the positive steps the Hospital is taking to meet these challenges.

The Hospital’s commitment to an improved environment for patient care stimulated our facility renewal program. The new facility and the Air Rights Parking Garage both marked their first anniversaries in 1983 and the improvements they have brought in patient care and convenience, staff morale and cost-effectiveness have exceeded our expectations. The impetus generated by these projects continues with major renovations in the Memorial and New Haven Units, including the construction of a new cafeteria for outpatients and staff. A multi-year Clinical Laboratory renovation and expansion project cost-
ing over $5 million was begun and the Surgical Pathology Department is now preparing to move into newly renovated space in the Memorial Unit, in close proximity to the new operating rooms.

Improved functioning among discrete parts of the Hospital will be enhanced in 1984 by the phased implementation of the Patient Care Support System (PCSS). This Hospital-wide clinically-oriented computer system will store and process all of the information generated in caring for a patient, including admitting data, the ordering of medicines and supplies, reporting of test results, discharge plans and billing. The developmental work for this system is being accomplished with assistance from Medical Staff, Nursing and many others engaged in designing and planning the new system.

A number of service improvements and organizational changes were introduced in the past year. Major alterations were made in the Hospital’s Materials Management system which will result in more cost-effective purchasing and control of supply utilization. Based upon the recommendations of a Medical and Surgical Supply Task Force, a comprehensive materials management plan was developed which consolidates the purchasing, transportation and inventory control functions. Additionally, the prime supplier concept was implemented, providing cost-effective and simplified purchasing. Prime Supplier contracts group products and services in such a way as to enable manufacturers to provide their products at rates more favorable to the Hospital. The first contract, which was for medical fluid products, will save the Hospital $800,000 over 32 months. Two more major contracts are being prepared for bidding in 1984.

The Hospital’s varied social work functions were consolidated into a single department which has led to an improved coordination of patient care responsibilities and created better communications by lending a unified voice to this essential service. A similar consolidation and improvement of services occurred in the Credit and Admitting Departments which has produced financial efficiencies and improved patient relations.

Another important event was the opening of an expanded, new One-Day Surgery Center. Ambulatory (or outpatient) surgery is one of the most rapidly expanding services in the health care field and Yale-New Haven’s expansion anticipates the growing need and patient desire for this service. It also improves our inpatient operating room utilization by more effectively allocating that area’s space and services to our inpatients.

Another step to decrease a patient’s length of hospital stay was accomplished with the introduction of the Geriatric Intervention Program which identifies patients at risk for extended hospital stays for non-medical reasons,
such as absence of family members or the lack of suitable facilities to which patients can be discharged. These “social stays” at the Hospital must be identified early and efforts initiated to make the appropriate placement for them in skilled, nursing facilities. This program augments our continuing efforts to pursue new and innovative relationships with a variety of extended care facilities to ensure that patients have access to appropriate levels of patient care once the acute phase of their illnesses is over.

Emphasis on patient length-of-stay management is also reflected in the new Clinical Information Service which consolidates Medical Records, Patient Care Evaluation and Tumor Registry into a single department. This service enables us to build a comprehensive data base on a patient’s length of stay in the Hospital, cross-referenced to individual diagnoses, individual physicians, and ancillary services utilization. Since the prospective payment system is based on national average costs associated with treating patients with similar diagnoses, the Clinical Information Service is essential to effective hospital and clinical management.

Two financial areas of perennial concern for the Hospital, free care and contractual discounts to third party payors, continued to exert financial pressures on the institution. Approximately $6.7 million in free care was provided in 1983 to indigent patients in the form of discounts to governmental payors who reimburse the Hospital for less than its costs. This underpayment necessitates price increases to payors who do not receive discounts, such as commercial insurance companies. Pressures against this cost-shifting practice are increasing, but it is unclear what financing alternative will replace it.

Despite these and other financial pressures, Yale-New Haven was able to keep its operating expense budget increase to less than 8.5 percent, which is below both the Connecticut and national hospital expense increase averages. Actual operating expense performance for 1983 was within budget and revenues exceeded expectations. After two successive years of sustaining operating losses, the Hospital was able to generate a $58,000 surplus in fiscal year 1983. While the reversal of an operating loss and this small surplus are encouraging and reflect tight fiscal controls and improved productivity, the relative insignificance of the operating gain can be gauged by comparing it to the $450,000 per day it takes to run the Hospital and our enormous capital needs.

To assist the Hospital in preparing for the future, a strategic planning program was initiated. Strategic planning provides the mechanism to objectively assess major changes in the health care industry and to identify major issues and strategies for coping with them. A planning cycle has been established in which management integrates the Hospital’s long-term strategic directions
with annual operational objectives for each Hospital department.

The financial and operational improvements realized this year both encouraged and motivated the management staff as it prepared its 1984 objectives. The previous accomplishments of our entire staff give confidence that we will respond to new challenges appropriately and effectively. Our community and our patients expect and deserve no less.

Joseph A. Zaccagnino
Executive Vice President
While the assets of Yale-New Haven Hospital are extraordinary, what we are missing is unique in our history. We have lost “the other side of the street.” Undoubtedly, this omission bodes well for the overall health of a united medical staff.

For as long as I can remember, university- and community-based members of the medical staff referred to each other in terms of “the other side of the street.” Our gleaming new building combined with the Memorial Unit has allowed us to eliminate the duplication of resources. We now have a consolidated clinical facility with one surgical suite, one admitting office and one radiology department serving the patients of one medical staff. While there were some growing pains related to this consolidation, it is exciting to witness the increasing cooperation, understanding, and mutual respect which is evolving. It is refreshing that there is no longer another “side of the street” but instead a recognition that we are all on the same side.

Within this medical staff unity, there are clearly different priorities. However, I sense that there is increasing acceptance of the need to support collectively institutional missions coupled with a determination to face the serious challenges which lie ahead.

Many medical staff members have been assisting in planning new resources which will greatly enhance our capacity to care for our patients. For example, the computer-based patient care support system has generated excitement among the medical staff for the potential of this program to enhance our medical care leadership on a regional, and national basis.

The most pressing challenge arises from the introduction of the Medicare fixed price payment system last October. Although limited to inpatient Medicare recipients, there is no doubt that eventually it will be adopted by other third-party payors and include payments for outpatients and for physician services. It is imperative that we devise appropriate responses to the issues posed by this revolution in health care financing, because at stake are some of the traditional missions of this Hospital: care for the indigent, graduate medical education, the advancement of medical knowledge and even the quality of medical care. Physicians, more than ever, will play a critical role in determining the financial viability of hospitals. As the determinors of care modalities, physicians initiate the use of hospital resources. It is financially imperative that we use
these resources judiciously! I am convinced that a more efficient and effective utilization of resources can simultaneously enhance the quality of our patient care.

Another key issue facing us is the growing surplus of physicians. Since the mid-1960s, and in response to a perceived, critical shortage of physicians, almost 40 new medical schools have been established. In 1970, the physician-to-population ratio was 168 to 100,000 population. It now exceeds 190 to 100,000. By 1990, it is estimated we shall have well over 75,000 “excess” physicians in this country. In addressing the likely profound impact of this issue on our institution, the Medical Board unanimously supported a change in our bylaws, adding an additional criterion for Medical Staff membership which is designed to help contain the size of our staff. No longer are the qualities of excellence and exemplary performance the only criteria to be measured during the credentialing process. Now all applicants for Medical Staff membership must be qualified to participate in the formal teaching program. This additional criterion acknowledges the distinction of membership in this Medical Staff as it pertains to our mission of training future medical manpower.

In order to enable us to cope with these and other challenges, I have enlisted the help of several colleagues to work with me. Dr. Leo Cooney has accepted an appointment as Medical Director of Utilization Review and will address his attention to keeping the patients’ hospital stay as brief as good medical practice allows. In addition, Dr. William Crede has been appointed as Medical Director of Quality Assurance and will work with me in helping to contain the use of resources and to assure quality of patient care. Finally, Dr. Robert Sadock has recently been appointed as the physician coordinator of the computerized Patient Care Support System and will also assist me with other matters related to the promotion of excellent patient care in a cost conscious environment. These new staff appointments, together with the dedicated Chiefs of Service and the Medical Board, will enable us to cope effectively with the issues which lie ahead on behalf of our superb Medical Staff.

I have been associated with this institution in various roles for over thirty years and I continue to find it challenging and exciting.

John E. Fenn, M.D.

Chief of Staff
Yale-New Haven Hospital Statement of Revenues and Expenses of Unrestricted Fund  
($000's Omitted)

<table>
<thead>
<tr>
<th>Year Ended September 30</th>
<th>1983</th>
<th>1982</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue From Services to Patients</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room, Board and Nursing</td>
<td>$83,167</td>
<td>$63,772</td>
</tr>
<tr>
<td>Special Services-Inpatients</td>
<td>83,714</td>
<td>72,072</td>
</tr>
<tr>
<td>Clinic Patients</td>
<td>6,112</td>
<td>5,577</td>
</tr>
<tr>
<td>Emergency Room Patients</td>
<td>6,824</td>
<td>5,907</td>
</tr>
<tr>
<td>Referred Outpatients</td>
<td>14,486</td>
<td>12,223</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$194,303</td>
<td>$159,551</td>
</tr>
<tr>
<td><strong>Deductions From Gross Revenues</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contractual and Other Allowances</td>
<td>$35,088</td>
<td>$17,645</td>
</tr>
<tr>
<td>Provision for Uncollectible Accounts</td>
<td>6,731</td>
<td>6,757</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$41,819</td>
<td>$24,402</td>
</tr>
<tr>
<td><strong>Net Revenue from Services to Patients</strong></td>
<td>$152,484</td>
<td>$135,149</td>
</tr>
<tr>
<td><strong>Other Operating Revenue</strong></td>
<td>131</td>
<td>250</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>$152,615</td>
<td>$135,399</td>
</tr>
<tr>
<td><strong>Operating Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>$78,436</td>
<td>$69,376</td>
</tr>
<tr>
<td>Supplies and other Expenses</td>
<td>74,208</td>
<td>70,779</td>
</tr>
<tr>
<td>Depreciation</td>
<td>6,431</td>
<td>4,546</td>
</tr>
<tr>
<td>Interest</td>
<td>4,667</td>
<td>2,151</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$163,742</td>
<td>$146,852</td>
</tr>
<tr>
<td><strong>Less: Recovery of Expenses from Grants, Tuition, Sale of Services, Etc.</strong></td>
<td>(11,185)</td>
<td>(10,006)</td>
</tr>
<tr>
<td><strong>Net Operating Expenses</strong></td>
<td>$152,557</td>
<td>$136,846</td>
</tr>
<tr>
<td><strong>Operating Gain/(Loss)</strong></td>
<td>58</td>
<td>(1,447)</td>
</tr>
<tr>
<td><strong>Non-Operating Revenue</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest Income from Escrow Funds</td>
<td>783</td>
<td>381</td>
</tr>
<tr>
<td>All Other Investment Income</td>
<td>1,910</td>
<td>2,300</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$2,693</td>
<td>$2,681</td>
</tr>
<tr>
<td><strong>Excess of Revenues Over Expenses</strong></td>
<td>$2,751</td>
<td>$1,234</td>
</tr>
</tbody>
</table>
### General Information Summary 1983 vs. 1982

<table>
<thead>
<tr>
<th>Category</th>
<th>1983</th>
<th>1982</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Patients</td>
<td>35,998</td>
<td>35,517</td>
</tr>
<tr>
<td>Patient Days of Care Provided</td>
<td>272,487</td>
<td>271,640</td>
</tr>
<tr>
<td>Average Length of Patient’s Stay (Days)</td>
<td>7.6</td>
<td>7.6</td>
</tr>
<tr>
<td>Average Daily Patient Census</td>
<td>747</td>
<td>744</td>
</tr>
<tr>
<td>Births</td>
<td>5,250</td>
<td>5,356</td>
</tr>
<tr>
<td><strong>Outpatient Clinic Visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic Visits</td>
<td>183,441</td>
<td>182,290</td>
</tr>
<tr>
<td>Emergency Service Visits</td>
<td>77,512</td>
<td>78,845</td>
</tr>
<tr>
<td><strong>Total Outpatient Visits</strong></td>
<td>260,953</td>
<td>261,135</td>
</tr>
<tr>
<td>Volunteer Hours Donated</td>
<td>67,555</td>
<td>72,185</td>
</tr>
</tbody>
</table>

### Outpatient Clinic Visits 1983 vs. 1982

<table>
<thead>
<tr>
<th>Specialty</th>
<th>1983</th>
<th>1982</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Center</td>
<td>32,177</td>
<td>32,245</td>
</tr>
<tr>
<td>Dermatology</td>
<td>11,457</td>
<td>11,415</td>
</tr>
<tr>
<td>Women’s Center</td>
<td>29,447</td>
<td>30,592</td>
</tr>
<tr>
<td>Dana Psychiatry</td>
<td>5,308</td>
<td>6,350</td>
</tr>
<tr>
<td>Dental</td>
<td>5,074</td>
<td>5,056</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>17,722</td>
<td>15,990</td>
</tr>
<tr>
<td>Medicine</td>
<td>27,682</td>
<td>25,152</td>
</tr>
<tr>
<td>Pediatric</td>
<td>13,816</td>
<td>13,744</td>
</tr>
<tr>
<td>Surgery</td>
<td>17,614</td>
<td>18,672</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>9,454</td>
<td>9,919</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>8,937</td>
<td>9,191</td>
</tr>
<tr>
<td>Urology</td>
<td>4,753</td>
<td>3,764</td>
</tr>
<tr>
<td><strong>Total Clinical Visits</strong></td>
<td>183,441</td>
<td>182,290</td>
</tr>
<tr>
<td>Emergency Service Visits</td>
<td>77,512</td>
<td>78,845</td>
</tr>
<tr>
<td><strong>Total Outpatient Visits</strong></td>
<td>260,953</td>
<td>261,135</td>
</tr>
</tbody>
</table>
### Comparative Statistics

#### Inpatient Statistics (Discharges)

<table>
<thead>
<tr>
<th></th>
<th>1983</th>
<th>1982</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adults</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>17,561</td>
<td>17,366</td>
</tr>
<tr>
<td>Surgical</td>
<td>9,028</td>
<td>9,034</td>
</tr>
<tr>
<td><strong>Total Adults</strong></td>
<td>26,589</td>
<td>26,400</td>
</tr>
<tr>
<td><strong>Pediatrics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>2,650</td>
<td>2,399</td>
</tr>
<tr>
<td>Surgical</td>
<td>1,296</td>
<td>1,158</td>
</tr>
<tr>
<td><strong>Total Pediatrics</strong></td>
<td>3,946</td>
<td>3,557</td>
</tr>
<tr>
<td><strong>Newborn</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regular</td>
<td>4,525</td>
<td>5,031</td>
</tr>
<tr>
<td>Special Care</td>
<td>938</td>
<td>529</td>
</tr>
<tr>
<td><strong>Total Newborn</strong></td>
<td>5,463</td>
<td>5,560</td>
</tr>
<tr>
<td><strong>Total Inpatient</strong></td>
<td>35,998</td>
<td>35,517</td>
</tr>
</tbody>
</table>

#### Diagnostic and Therapeutic Services

<table>
<thead>
<tr>
<th>Service</th>
<th>1983</th>
<th>1982</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultrasound</td>
<td>11,648</td>
<td>10,317</td>
</tr>
<tr>
<td>X-ray</td>
<td>176,055</td>
<td>176,051</td>
</tr>
<tr>
<td>CAT Scan</td>
<td>8,209</td>
<td>5,688</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>9,944</td>
<td>7,647</td>
</tr>
<tr>
<td>Electrocardiology Exams</td>
<td>45,911</td>
<td>43,715</td>
</tr>
<tr>
<td>Radiation Therapy Treatments</td>
<td>41,478</td>
<td>45,149</td>
</tr>
<tr>
<td>Physical Therapy Treatments</td>
<td>41,748</td>
<td>40,121</td>
</tr>
<tr>
<td>Respiratory Therapy Treatments</td>
<td>245,100</td>
<td>242,797</td>
</tr>
</tbody>
</table>
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CHIEF
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ASSISTANT CHIEF
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Flowers, Rainbow, Grass.
The flowers are happy.
'cause there is a rainbow.
by Diana, age 6
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all bundled up

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by Andrea
Bebe Feinberg was graduated from Cornell University in 1977 and received a Masters of Education from Wheelock College Graduate School a year later. At present, she is Coordinator of the Child Life Program at Yale-New Haven.

Dr. William Hellenbrand was graduated Summa Cum Laude from Downstate Medical Center, State University of New York in 1970 and is currently Director of the Pediatric Cardiac Catheterization Laboratory and Clinical Director of Pediatric Cardiology at Yale-New Haven Hospital.

Patricia Ann McFarland, Pediatric Social Work Specialist, received her M.S.W. from the University of Connecticut School of Social Work in 1971. She is Vice-President of the New Haven Chapter of the National Alliance of Black Social Workers and was a recipient of the Outstanding Young Women of America Award in 1981. She resides in Hamden.

Linda Lewandowski, Pediatric Clinical Nurse Specialist, was graduated from the University of California at San Francisco with an M.S. in Pediatric Critical Care. She renders direct advanced nursing care to children and families, but focuses particularly on the Pediatric Intensive Care Unit. She is Acting Chairperson of the Yale University School of Nursing Pediatric Nursing Program.

Dr. Robert J. Touloukian has been Chief of the Section of Pediatric Surgery since 1973 at Yale-New Haven Hospital. A resident of Woodbridge, he served as President of the Connecticut Society of the American Board of Surgeons in 1980 and is currently a Professor of Surgery and Pediatrics at Yale University School of Medicine.

Dr. Charles Kleinman of Guilford, attending physician at Yale-New Haven, is Associate Professor in Pediatrics and Diagnostic Imaging at the Yale University School of Medicine. He received his M.D. from New York Medical College in 1972 and is a native of New York City.

Dr. Howard A. Pearson, was graduated from Harvard Medical School in 1954 and appointed Chief of Pediatric Service at Yale-New Haven Hospital in 1974. He has made outstanding contributions to research in sickle cell anemia and hemophilia.

Dr. Norman S. Talner, attending physician at Yale-New Haven, is the former Director of the Pediatric Cardiac Catheterization Laboratory and is currently Professor of Pediatrics at Yale University School of Medicine. He is a native of Mount Vernon, New York and graduated from the University of Michigan.
A contribution to the Pediatric Department at Yale-New Haven Hospital can be considered the gift of a lifetime. Restoring health to an ailing child, allowing a lifetime to unfold in full, may be the finest gift anyone can give. Thank you to all our friends who have extended their financial support to Yale-New Haven Pediatrics. Welcome to all of you who are considering a donation now.