Our Multiple Missions
This issue of Yale-New Haven examines the Hospital’s multiple missions of patient care, teaching, clinical research and community service through specific examples. While each story focuses on a single mission, elements of other missions can be detected throughout each narrative, an indication of how central these missions are to the Hospital’s daily operation. Starts page 1.

Annual Report
A special section on Hospital Statistics, the Hospital Family and Friends of the Family including addresses from Hospital President C. Thomas Smith, Chairman of the Board F. Patrick McFadden, Jr., Executive Vice President Joseph A. Zaccagnino, and Chief of Staff John E. Fenn, M.D. Starts page 23.

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Providing the finest available patient care is the fundamental mission of Yale-New Haven Hospital. It is behind our every daily effort. Its importance, however, is felt most profoundly by the patient receiving the care. This article examines one patient and the effect that hospitalization had on his life.

James Layman
For heart attack patient James Layman, the figures were like a ticker tape clicking through his mind.

Layman knew the odds: 50 percent of all persons who have heart attacks die before reaching the hospital, or fail to make it through the first 24 hours. After that, the risk declines in a series of plateaus — the 10 days of hospitalization, the first three months, the next six months, one year, five years.

Lying in Yale-New Haven Hospital’s Cardiac Intensive Care Unit, Layman was thankful to have survived the first 24 hours. Now, the remaining time blocks stretched ahead.

Looking back, he could pinpoint the series of events leading up to his heart attack — the 14-hour days at the office, late-night dinners with business clients, a heavy travel schedule filled with airport and hotel frustrations, too much work and stress, too little sleep and unhealthy eating.

Like a series of dominos, the risk factors had fallen into place. Layman became one of 38 million Americans who suffer from heart disease, one of 500,000 who have heart attacks each year.

As special accounts coordinator for Miles Pharmaceuticals, Layman had been in and out of hospitals professionally for the past 15 years. Yet he had never seen the hospital from this new perspective, that of a patient.

Though patient care is one of Yale-New Haven’s most visible missions, many people who work in the hospital — physicians, nurses, administrators, ancillary personnel — never experience it from a patient’s point of view. The transition from private individual to patient is not always an easy one to make.

For James Layman, it had begun as a typical workday. Like any other workday, he had left his Madison home at 7:30 a.m. for the commute into New Haven. But what had begun as a typical day was to end otherwise. As he drove along I-95, Layman felt that something was wrong. The dull ache that had gripped his chest the day before was gone. But waves of nausea and dizziness still bothered him. A bad cold, perhaps? Maybe pneumonia?

To be certain, he stopped at the office of his internists, Drs. Frederick Heasler and Daniel Rahn, in Guilford. There, Dr. Heasler ran an electrocardiogram. Checking over the results, he suspected that Layman had suffered a myocardial infarction. Soon Layman, age 46, was being rushed by ambulance to Yale-New Haven’s emergency room.

He was met by Dr. Rahn. As nurses and residents took his vital signs and history, put in an intravenous line, and ran an EKG, Layman observed the emergency room.

“There were a lot of people around. It looked like a lot of madness. A lot of confusion. But everybody had a job. It was very well-defined, what they were doing and who was doing what, from the residents and nurses to the attending physicians.”

“I was somewhat fortunate — I knew what they were doing and why they were doing it. That took some of the fear out of it for me. I knew why they were putting in an IV line and why they were continuously monitoring my heart.”

After about half an hour in the emergency room, Layman was transferred to the Cardiac Intensive Care Unit.

“Visualizing the unit from your back, it’s very difficult to orient yourself at first as to where you are,” he recalls.

Alone in a small cubicle, Layman was surrounded by machines that monitored his every heartbeat. Electronic beeps kept him company. Three intravenous lines supplied his body with fluids and made it easier for him to receive medication. A nasal oxygen tube helped him to breathe.

“Because of the technology and the machines, it’s somewhat frightening,” Layman says of the unit. “It’s an area in which you can really feel lost as a patient. You have the ability to watch the monitors over your head. If you feel a little irregularity in your heartbeat, you can look up, and see it on the monitor. That’s scary.”

“For example, I did have one episode of ventricular tachycardia, which is a very rapid heartbeat. I felt it happening, then I watched it on the monitor. That was a little bit scary. I watched it, then I started to count to myself to see how long it would take them to come in and give me some medication. It was very quick — maybe four or five seconds. The resident came in and put some lidocaine into one of the lines.”

“Because of the nature of the illness and the area I was in, there was a tremendous amount of activity. There were a lot of Code Blues, a lot of arrests.”

Yet despite all the activity, there was a deep craving for human contact, what author Norman Cousins describes as the “atmosphere of compassion.” Layman found that compassion in CCU nurse Allison Millar.

“Allison Millar was very supportive,” he says. “She had a tremendous calming effect. She would explain things to me. Anything I asked, she would take a minute or two to explain. One of the complications of a heart attack is a lowering of the blood pressure. You actually become hypotensive. You lose a lot of fluid, so they are continuously pumping fluids into you. I was very interested in what they were putting in, the volume, and the reason for it. And she would tell me as much as I wanted to know.”

Norman Cousins, in his book, Anatomy of an Illness and The Healing Heart, writes about the panic and helplessness that can accompany a serious disease. The physician’s ability to inspire confidence and trust is essential, Cousins believes. It can help foster the optimism needed to overcome illness.

Layman credits his own absence of panic to the physicians and nurses treating him, especially during this period. “They certainly conveyed a sense of well-being and security. There was a lack of any panic. Although they didn’t ignore the fact that I had had a heart attack, my physicians and the cardiologist they called in, Dr. Steven Wolfson, were very reassuring.”

The technology of the unit sometimes overwhelmed Layman’s family and friends. Visitors tended to “treat me as if I were fragile. They were afraid to talk too loud or to make too much noise.”

This annoyed him, because like many heart attack patients, Layman sought to deny the seriousness of his disease.

“I remember feeling almost a detachment to what was going on around me. It was like I was watching all this happen and it wasn’t really me who was there. I never once was concerned. I didn’t feel I was at risk. I can’t remember being scared.”
“I can remember a lot of self-denial — first of all, that this was not happening to me and second, that it wasn’t as serious as everybody made it out to be. “I knew that somebody had had a heart attack, but I wasn’t ready to admit that it had been me.”

Those protective walls of self-delusion began to crumble as the days in the unit passed. On his second day in the unit, Layman’s enzyme reports came back. These results confirmed that Layman had suffered a myocardial infarction of the right inferior wall of the heart, the area that pumps blood into the lungs. Layman spent three days in the unit, then he was moved to a private room on the step-down floor.

For the next four days, he continued to be confined to bed and his heart activity monitored at the nurses’ station. He was encouraged to perform a series of simple exercises in bed.

“I had a lot of time to sit and think,” Layman says. “I did a lot of reading, Norman Cousins, etc. And yet at the same time, you try to avoid thinking about it. You don’t want to dwell on it. It’s in the past and there’s nothing you can do about it.”

His thoughts often focused on his wife and four daughters. “You start to think about what’s going to happen in the future. What can I do now, given the fact that I can’t continue to do what I did before? What changes am I going to make and how am I going to make them?”

“The first thing you tell yourself is, ‘I’m too young to have a heart attack.’ Then, as you look around, you see them bringing people in, and you realize that you’re not too young.

“You ask why after it happens: Why did this happen to me, particularly when you look around and see people who are totally abusing themselves; people who are doing all the ‘wrong’ things: people who are drinking heavily. Why should this happen to me? There’s a lot of anger. But you get over that after awhile.”

“Looking back, he could pinpoint the series of events leading up to his heart attack — the 14-hour days at the office, late-night dinners with business clients, a heavy travel schedule filled with airport and hotel frustrations, too little sleep and unhealthy eating.”

It’s also very humbling to be a patient, Layman found. “You have to depend on others when you’re in the hospital. Because of the type of individual I am, I don’t want to be fussed over. I want to have total control over my destiny. And you don’t have that in the hospital. You’re at the whim of someone else telling you what to do. That’s difficult.”

By the fifth day in the step-down unit, Layman was allowed out of bed to walk to the bathroom and to sit in a chair. He went for tests — x-rays, and others. And he began taking afternoon classes in nutrition, diet, exercise, and stress management sponsored by the hospital’s Cardiac Rehabilitation Program.
“I remember thinking, ‘I don’t need these classes,’” Layman says now with a sense of disbelief. “I don’t need to be taught how to eat or how to deal with stress. Now I’m glad I went.”

In addition to thorough instruction by Barbara Tiven, R.N. rehab staff nurse on the step-down unit, Layman credits the rehab classes with fostering a spirit of camaraderie among the seven or eight participants in his group.

“IT was kind of like a mirror. You could look over at the guy sitting across from you and see that he’s asking the same questions that you could be asking. A lot of us are very compulsive people. The classes gave me the opportunity to sit back and say, ‘Gee, I do that too.’”

During his last few days in the hospital, Layman was given a book to read on the Type A personality by cardiac rehab program coordinator Suzanne Boyle, M.S.N., Clinical Nurse Specialist. Later, Boyle asked him to share the book with another man who had been admitted to the floor with a heart attack. Layman dropped the book off at the man’s room then stopped by the next day to see if he had enjoyed it.

Layman smiles. “He told me that he hadn’t had time to read it yet. He said that he had skimmed it, but that he hadn’t had a chance to read it.”

Layman can empathize with that man’s denial, and with the whole mixed bag of emotions produced by a heart attack. “Unless you’ve been through it,” he explains, “you can’t understand the fears and the uncertainties.”

“It’s a shock to realize that you’re not immortal. You have frailties. That’s tough to admit. We think we’re infallible, that we’re perfect. And we’re not. Basically we’re a machine that needs to be cared for. If we don’t exercise proper care, we break down. It’s very humbling to realize that.

“It’s also depressing to face your limitations. Prior to this, there’s nothing you can’t do. Now, we can no longer do some of the things we used to do, like work 12 or 14 hours a day and party all night. Oh, you can do it, but now you know you shouldn’t.”

During the last two days in the step-down unit at Yale-New Haven, Layman wore a Holter monitor, a portable cassette that records the activity of the heart during a 24-hour period. He also took, and passed, a submaximal stress test. A second test was scheduled for three months after his discharge.

Now, several months after his heart attack, Layman continues to talk positively about his hospitalization.

“You learn in those 10 days what you should and shouldn’t be doing. It’s not forced upon you, but you certainly have enough exposure to dietary controls and stress management to make educated decisions, on your own, about what you should do. I’d say I left a little bit of stress behind me at the hospital. I stopped smoking. And I’ve modified my diet considerably.”

The experience of being a patient has also helped Layman order his priorities.

“Since my discharge from the hospital, I’ve been back to visit the intensive care unit,” he says. “I’ve watched the process going on. Now, any time I get depressed or overworked or feeling sorry for myself, I just go over to the intensive care unit, walk through, and look at my old bed. It puts things in perspective for me. It definitely does.”

by Beth Whitehead Polio
The teaching mission of Yale-New Haven Hospital represents an investment in the continuity of health care excellence. The complex skills and knowledge that physicians and other health care professionals must acquire can only be obtained through rigorous hands-on training. This article examines a day in the life of a second year surgical resident.

Dr. Judy Smith
7:30 p.m.

Dr. Judy Smith, a 27-year-old second-year surgical resident, finishes a quick dinner and walks toward the Emergency Services (ES). She will be in charge again tonight, as she has for many nights during the past three weeks, supervising the treatment of all people seeking immediate care in the surgical section of the hospital ES.

If a major trauma patient arrives or a patient requiring evaluation in a surgical or medical subspecialty, she'll call in back-up, but for the majority of cases, she will rely on her own experience, skills, and medical knowledge.

"Tonight will be my last 12-hour stint in the ES," she says. The staff tells her they will miss her. Tomorrow morning at 7:30 a.m. she begins a general surgery rotation with two operations scheduled back to back.

7:45 p.m.

Dr. Diane Edgar, also a surgical resident, signs over her patients to Judy and sizes up the situation for her—two young men injured in a car crash; an elderly woman with Alzheimer's disease who fell and has a possible broken hip in bed one; a middle-aged man with a urologic problem over in the medical section.

"There are many advantages to serving a residency at Yale-New Haven. Yale has a young, dynamic and energetic faculty who enjoy teaching and are very supportive of us. If you have a particular procedure or area of interest, there is always a physician or surgeon who is willing to discuss it with you. Some surgeons will instill a sense of confidence in a student or a resident; others may pressure you and challenge you to do your best. The pressure can be difficult, but by learning to deal with it, you will, in the end, be a better surgeon.

"For me it was very important to serve a residency in a university-affiliated academic setting like Yale. Major teaching centers attract some of the best physicians and surgeons in the country and there is direct application of the latest research and the most up-to-date surgical procedures. It is a stimulating environment; it forces you to think.

"The patient case mix is also very diverse as patients with serious illnesses or trauma are transferred here from all over the state. They often require multiple levels of expertise in a number of medical subspecialties."

8:31 p.m.

Judy walks to the medical side to examine the middle-aged man with the urologic problem. She draws back the curtain, introduces herself, and asks him a brief medical history. "Diabetes?" "High blood pressure?" "How's your diet?"

"His own physician has seen him, but I have learned to be very thorough in my examinations. Much of my responsibility here in the ES tonight is coordination of care and I don't want anything to fall through the cracks," Judy says. "Some patients find it confusing to have so many professionals providing care for them. It's actually a team approach with many people at different educational and professional levels giving input. I think the patient benefits."

The patient's family doctor has decided to admit him and Judy writes up the paperwork, completes the medical record and phones the resident to whose service the man will be sent. "Communication with other physicians — residents, faculty physicians, or community doctors is essential," she says. "I'm one of five children, the second oldest. I grew up in Manhattan and my family later moved to Connecticut where I went to Greenwich Country Day School. I remember winning the biology prize at the end of the year in ninth grade. It was a dissecting kit. I was thrilled."

"My father is a plastic and reconstructive surgeon in New York City. He used to let me look through his microscope and, at times, I watched him operate. I loved the hospital environment and went to Princeton knowing that I would major in pre-med. But I was never so driven that I did not have other options should it not work out."

8:42 p.m.

The elderly woman with Alzheimer's disease waits in bed one. Her daughter gently strokes her head. The examination is difficult. The woman can neither communicate nor describe her discomfort. "Look how the leg is turned and shortened," Judy says to the daughter. "I'm sure it's a fractured hip."

She reviews the x-rays with the resident in Radiology and the films verify the broken right hip. "We have to take care of this right away," Judy says to the patient's daughter. "A hip fracture can endanger the life of an elderly patient. We want to get her up and walking as fast as possible so she won't become permanently disabled."

A call is made to the patient's physician and together they discuss the options. The physician decides that surgery to repair the hip should be scheduled for later in the evening.

"During the evening, the emergency room is supervised by the resident house staff. If I need back-up, I can call the third-year surgical resident who is working in another area of the hospital tonight, or any of the residents in a specialty service. Some of them may be on duty; others are asleep in one of the several on-call rooms reserved for us, with their ever-present beeper by their side. You are very fortunate if you get to sleep a full night when you are on-call."

"Several ES attending surgeons are always available in or near the ES during the day. They are accessible by phone at all times should a critical situation occur."
9:55 p.m.
An elderly man lies in pain on a stretcher. His two adult daughters wait uncomfortably at his side. "What's wrong?" Judy asks the man. His abdomen is grossly distended. He groans. "It looks like I will have to change this catheter," she says. "You'll have to step out for a moment," she says to the two daughters.

Judy keeps up a constant conversation with the elderly patient as she replaces his catheter, trying to keep his mind off the pain. Within minutes, the problem is resolved. The patient groans his relief.

"In surgical residency, learning is listening, watching, then practicing and perfecting your skills as a surgeon."

"I have never felt any disadvantage in being a woman studying surgery. Yale-New Haven is very supportive of women. We have a woman chief surgical resident this year (Dr. Mary Gregg), several women in the surgical residency program, and Dr. Barbara Kinder is on the surgical faculty."

"In most cases, I think women bring a different approach than men to surgery, a different way of looking at a problem. And I have never had a problem with my patients relating to me. I am a doctor first."

10:34 p.m.
A young man in a flannel shirt and tattered jeans walks in, followed by his wife and daughter. His hand was crushed in a work accident and he sought treatment at a North Haven walk-in medical clinic. The clinic has directed him to Yale-New Haven for further care.

"I caught my hand between machinery at work," he says defensively. "Did it just happen?" Judy asks. "No," he says, "I finished work first and then went home for dinner and a few beers."

X-rays confirm the damage; several bones in his hand are fractured. Surgery is indicated. "You'll need to have pins inserted in your hand," she says, "it's your dominant hand."

"You're not cutting me open," he argues. "I'm not having any pins." "You'll end up with a permanent disability," she says. "Why don't you talk it over with your wife."

10:45 p.m.
Judy makes a call to the resident on duty tonight in plastic surgery on the "hand panel." "I have a patient with a crushed hand here that will need surgery," she says. He says he will be down to evaluate the patient and discuss the surgery with the family.

"I have decided to specialize in orthopedic surgery and later hope to apply for a fellowship in hand surgery. I like the fine, detailed work required in repairing hands. It's the type of surgery that I enjoy most and think I would be good at."

"I have been accepted at the Hospital for Special Surgery at Cornell and will continue my training there starting this July. I will miss being here at Yale. It was a difficult decision, but I am looking forward to continuing my program at Cornell."
Thursday, December 20  
12:15 a.m.

A woman who is bleeding internally arrives. An attractive older woman, she sits in bed, her husband at her side. He's disabled, he says—two heart attacks. They don't have insurance or a family doctor. "She's never been sick before," he says anxiously.

The husband waits in the lobby. Judy holds the woman's hand and questions her gently, always probing for a cause of the problem. "We'll see," Judy tells her.

"When I am in the O.R., I am completely absorbed by the case. The surgery refreshes me."
Judy puts in a call to her third year surgical resident for advice. He suggests placing a nasogastric tube into the stomach to test for blood. Senior level residents play a major role in the education of fellow residents and medical students. It is estimated that as much as 35 percent of post-graduate medical education is rendered by residents.

A nurse assists Judy as she gently inserts the tube, but an obstruction in the patient's nose impedes their progress. Judy talks with her softly, offering encouragement, telling her that she is brave. Finally they get the tube in. No blood is detected.

"In my senior year of medical school at Columbia, I spent two months in Liberia in the city of Zorzor at a small hospital. I saw disease processes and pathology I would never see here in the U.S. We had to rely on our medical knowledge and common sense. Diagnosis was made by what we saw, felt, and heard. There weren't X-ray machines or EKGs to study.

"We were country doctors trying to save lives with limited resources. I learned to be a detective, taking thorough medical histories, performing careful exams, and just listening. We did what lab tests we could — but these were very limited. It was an incredible experience. Never before or since have I had such close contact with life and death. When a patient was dying, we couldn't perform heroic measures, it was impossible without proper technology."

1:00 a.m.

An employee, a nurse on one of the patient care units, sits in bed two; her hand held high. She has sliced open her fingers on a scalpel. Judy puts a patient gown over her white skirt so the blood, which flows freely, won't stain it.

An intern reporting to Judy tonight grabs a surgical pack and prepares to stitch up the nurse's fingers. "Be especially careful where you place the stitches on her fingers," Judy advises. "You don't want a build-up of scar tissue to hamper her finger flexibility."

1:20 a.m.

A patient lies in bed four with a badly lacerated lip. Judy looks it over and decides to stitch it up. She calls for a surgical pack and unfolds it, carefully taking out instruments. "You might think this would become routine for me, but each case is a challenge," she says. "The lip is especially critical. The eye picks up right away on any asymmetry. I'm a perfectionist. It's like putting together pieces of a puzzle. It's my job to make it fit as perfectly as I can. If a stitch is too tight, I'll take it out and start over again."

4:05 a.m.

A 30-year old man waits in Acute Medicine. He is shaking from the pain. His wife waits by his side. They've been out to dinner and "all of a sudden he had this terrible pain in his abdomen," his wife says. "I can't stand the pain much longer," he gasps. "I can't give you anything for the pain just yet," Judy says firmly. "I don't know if it's an inflamed appendix or a stone and we can't mask the pain should the appendix burst."

Judy looks at his x-rays with the radiology resident. "A kidney stone," they agree. She orders a pain killer for the man and tells him it will be some time before he can go home.

"In a surgical residency, learning is listening, watching, then practicing and perfecting your skills as a surgeon. There are conferences and lectures to attend, but the majority of learning is done by observation. Each surgeon has a different surgical technique and by assimilating knowledge from many teachers you can begin to develop your own style."

"I also learn by teaching others. I supervise medical students and interns and assist them in applying medical school knowledge to direct patient care. It's rewarding to teach someone how to tie a surgical knot or how to take care of pre- or post-operative patients."

During a rotation in the ES, residents attend daily conferences and participate in a review by the ES attending staff of all patients treated the previous day. In addition, lectures on various subjects are given Monday through Friday based on six-week rotational curriculum. The residents are also expected to attend Surgical Grand Rounds and the weekly House Staff Conference. The informal educational process is just as important and includes frequent consultations with subspecialists who are called in to evaluate patients in the ES.

7:30 a.m.

Her rotation in the ES completed, Judy scrubs for surgery, beginning her seven week rotation through General Surgery.

8:15 a.m.

Surgery is well underway. Judy assists the surgeon locating and excising a tumor in the colon. An intern watches. Soft classical music plays in the background.

by Janan Talafer
Clinical Research is one of the most important — and least understood — of Yale-New Haven’s multiple missions. It is the method by which bio-medical knowledge and practice are advanced. The unfolding of a clinical research project is a classic example of laboratory research translating into improved patient care. This article examines an investigation into the effects of lithium on kidney function.

Dr. John Forrest
The patient’s urine output was seven times the normal 800 to 1,400 milliliters a day. Water consumption was at an equally elevated level. One function of normal kidneys is to conserve water but in this case something was obviously interrupting this action. Dr. Forrest wondered whether serious and perhaps irreversible damage was being done to the kidneys; he decided to look for a patient with the same or similar symptoms to see what was occurring physiologically.

Dr. Forrest turned to Yale-New Haven Hospital’s Lithium Clinic, one of the first Lithium Clinics established in the United States, to find the subject he needed. He expected it to take months to uncover another case of polyuria or polydipsia. However, after checking 96 patients with normal blood lithium levels, Dr. Forrest and his colleagues found that 25% to 30% of these patients reported problems similar to those of the individual treated for lithium intoxication.

The findings were disturbing. Were kidneys being damaged by lithium, and if so, was polyuria one step on the way to total kidney failure? Lithium had been prescribed for over a decade for manic depressive disorders. Were physicians just beginning to see the damaging effects of long term exposure to the medication? To answer these questions Dr. Forrest combined basic laboratory and classical clinical research methods to look closely at kidney function in the presence of lithium.

Lithium was first discovered in 1817. The word is derived from the Greek lithos, meaning stone. It is a soft, white metal, the lightest of the solid elements. It is so light, in fact, it floats on water. On the periodic table lithium (Li) is next to sodium (Na) and they affect many biological systems in similar ways.

No clearly effective clinical use for lithium was pinpointed until the 1950s. A decade earlier during World War II lithium was used for a short time as a salt substitute. However, because a number of poisoning deaths occurred that were attributed to lithium, this application was abandoned.

An Australian physician, Dr. John Cade heard that lithium was effective in treating gout and in the 1950s prescribed it to a number of his patients. While proving worthless in the treatment of gout, several patients who also suffered from mania and depressive mood disorders found their mood swings favorably altered by the medication. By the early 1970s lithium was being widely prescribed around the world for manic depressive disorder.

It is estimated that as many as one person in a hundred is manic depressive in the United States, meaning somewhere over two-and-a-quarter million people are hampered by this form of mental illness. The severity of individual cases ranges dramatically, but certainly half-a-million Americans or more need the ameliorating effects of the drug, even though today physicians are still unable to put their finger on just how or why it works.

"It was holding lives together," stressed Dr. George Heninger, Director of the Abraham Ribicoff Research Facilities of the Connecticut Mental Health Center and an attending psychiatrist at Yale-New Haven Hospital. If lithium had to be pulled from the market, or its usage drastically reduced, there would be a significant increase in hospitalization for manic depressives.
Once released into the blood stream, ADH travels to the kidney where it attaches to specific receptors in a lock and key fashion. Once ADH is "plugged in," it triggers cellular actions which change the water permeability of certain kidney tubular cells allowing water to enter cells to be redirected back to the blood stream. Lithium may have been blocking ADH from attaching to its receptor or else hindering the complex actions which changed the water permeability of the cells.

A third possible explanation was that lithium, which shares many similarities with sodium, was changing the osmotic gradient of the kidneys. In kidney tubule cells responding to ADH, water flows from the urine side of the cell with a low osmolality (low sodium concentration) to the blood side with a higher osmolality (higher sodium concentration). If lithium was impairing the accumulation of sodium on the blood side of the cell, it could account for the change in the ability of the kidney tubules to absorb water.

Following a series of studies on animals, Dr. Forrest ruled out changes in osmolality or sodium transport as the cause of the problem. Lithium did not significantly alter salt concentrations in kidneys of several animal species that were studied.

For the ADH question, he thought it might be likely that lithium shut down the pituitary gland's release of the hormone just as alcohol does. This option was ruled out after patients treated with injections of long-acting ADH continued to suffer from polyuria.

Turning to the receptor issue, Dr. Forrest found that lithium was not blocking the lock and key interaction necessary for water conservation.
This realization led Dr. Forrest's team to the cellular level and armed with biochemical measurements and electron microscopes they looked to see what was preventing patients on lithium from conserving body water.

To explain the action simply, ADH plugs into the kidney receptor and this coupling produces the chemical cyclic AMP, the second messenger in this cellular choreography. Cyclic AMP travels across the cell to the opposite side where in a complex series of steps it changes the permeability of the cell wall. Instead of allowing water in the renal tubules to drain into the bladder, the action of cyclic AMP draws water back into the kidney cells where it is returned to the body.

Work published both out of Yale and the University of Pennsylvania determined that lithium's action was impinging on the production of the second messenger at the receptor end of the cell. It was also determined that the second messenger's action to change the cell's water permeability was also altered by lithium.

Possessing an enhanced understanding of how lithium affected kidney function, Dr. Forrest and his associates turned their attention to the question of damage.

"Our animal work with rats showed they did not develop conventional renal injury of any significant degree when given lithium in appropriately low doses," Dr. Forrest stated as a positive early sign.

Above, is an electron micrograph of a cortical collecting tubule from a normal control rat. Below, is a principal cell from the cortical collecting tubule of lithium-treated rat. The cell is enlarged. Aggregates of fibrillar material (intermediate filaments) are visible in the perinuclear region (see arrow).
Treated bunches formed a structure of cytoskeleton of the cell. They found that animals treated with lithium parts of the cytoskeleton of the cell broke away from their position and formed bunches or aggregates within the cell, a phenomenon never before seen in kidney cells.

"Before we studied lithium we never knew the role of intermediate filaments in kidney tubules," Dr. Forrest admitted. "It has taught us that these filaments are probably important in helping water get through the cell."

A group of patients who had experienced difficulty absorbing water were taken off lithium and after months away from the drug some still had difficulty absorbing water from the renal tubules. This observation led the researchers to conclude that the lithium-induced damage to intermediate filaments was repaired slowly at best, and probably never completely.

Was there a way to improve the water retention of patients? Researchers found through therapeutic trials with the diuretic drug amiloride that it substantially reduced polyuria. This discovery gave psychiatrists a tool to use in conjunction with lithium to help manic depressive individuals suffering from the most severe cases of polyuria.

The overall conclusion Dr. Forrest and his colleagues arrived at from their research was that kidney function was being altered by lithium but that there was no indication that kidney failure was a real threat.

"No one has seen a patient who has had to go onto dialysis because of lithium," Dr. Forrest points out. Dr. Malcolm Cox at the University of Pennsylvania has done research that indicates the long term loss of kidney function actually may not be much greater than what occurs naturally with aging.

"In terms of its psychiatric effects, lithium is one of the best studied drugs in medicine," according to Dr. Forrest. "What is also quite clear is that it is one of the most powerful agents, maybe among the two most powerful agents psychiatrists have to treat patients."

Because of its outstanding track record and the few side effects associated with it, few patients were taken off the drug during the early 1970s when data were still being gathered. Thanks to a large pool of patients who have been studied for 10 to 25 years, doctors have a better picture of lithium's long-term effects, as Dr. Heninger noted.

"We know lithium is a very effective drug and we will continue to prescribe it. What we don’t know is if there are soft, subtle changes that will take a big statistical analysis to prove. Because of these unknowns, we’ll never give lithium a clean bill of health.

"Yet, when we put manic depressive illness in a medical context as a serious, life threatening and debilitating illness, it justifies taking some risk with the medication," Dr. Heninger said. "Lithium is an acceptable risk. Even at worst, it won’t be removed from the severely ill patient. It’s worth running the risk to get them out of the hospital."

Manic depressive illness is not a constant for those afflicted with it. The erratic mood swings can come every several months or once in five years. But when the manic stage hits — and it is the manic stage that lithium is effective in controlling — the illness becomes more than a personal problem. It becomes a societal problem.
"In language the public would understand, being manic is like being in the high, intoxicated phase of alcohol," explained Dr. Heninger. "If you tell someone they're drunk, they're acting boisterous or showing bad judgement at a cocktail party, they don't realize what that looks like to other people. The manic people are in a similar frame of reference."

A characteristic common to some patients, which defines the onset of the manic phase of the illness, is uncooperativeness. "Manic patients are not like other patients, like diabetics, who start feeling the pain and say to themselves, 'I need to take my medicine.' Manic depressive patients enjoy feeling manic. However, society doesn't like them to be manic, and their family doesn't like them being manic, so that's the problem. It's not only a personal problem, it's a social problem."

Lithium is a drug that may not have to be taken on a daily basis. It may be possible to prevent a manic episode if lithium is prescribed at the first indications of the manic stage. However, because of the defining characteristic of uncooperativeness it is not at all unusual for patients to refuse to take lithium when the manic signs start to appear; he or she is feeling too good. For that reason psychiatrists usually prescribe lithium on a continual basis to manage their patients' problems. As for cost it is one of the less expensive drugs. A lithium user is unlikely to spend as much as a $100 on the drug in a year.

In 1981 the American Psychiatric Association named Dr. Heninger to chair a panel to examine the long term effects of lithium on the kidney. Dr. Forrest agreed to be a member of the panel. "Dr. Forrest knows as much about how lithium affects the kidneys as anybody else in the world, probably more," Dr. Heninger noted. "He is the number one person in how lithium affects the kidneys in animals, in normal people, in sick people. These data are fundamental to understanding whether it injures the kidney."

In 1972, when Dr. John Forrest opted to take a closer look at urine output in manic depressives, there were only several papers available on the relationship between kidney function and lithium. Today more than ten percent of all references to lithium deal with the kidneys.

Widespread concern followed the early suggestion that lithium use might prove severely damaging to kidney function. Through painstaking research, however, the conclusion was reached that the risks of lithium use did not outweigh the benefits. In addition, Dr. Forrest and his associates discovered previously unrecognized alterations in cell structure which led to a clearer understanding of the function of intermediate filaments. Scientists are now applying this research in an array of studies.

Dr. Forrest's work has clarified the risks involved with lithium use. The fact these risks appear marginal in comparison to the drug's effectiveness is welcome news for the hundreds of thousands of users of lithium and their families. As Dr. Heninger said, if lithium had to be pulled from the market "lives would just disappear."

by Tom Urtz
Yale-New Haven's commitment to community service is a difficult Hospital mission to describe, if only because this commitment takes so many forms and involves so many areas of the Hospital. The lead screening program, examined in this article, is a good example of how Hospital resources, addressing an important community concern, can improve the lives and welfare of the people we serve.

Dr. Thomas Dolan
It was the late 1960s and there was anger in the community. New Haven children were falling victims to lead poisoning at a rate four times higher than the rest of the nation. A number of New Haven children had died as a result of lead poisoning after eating lead paint chips, a by-product of substandard, deteriorating housing. It was a problem that affected the poor, primarily. As far as neighborhood residents were concerned, the deaths were the result of community indifference and neglect.

"Officially it was not perceived as a community problem," says Elaine Whitmire who became involved as a student at Yale's School of Epidemiology and Public Health. But there were many in the community, Elaine included, who saw lead poisoning not only as a community problem, but as a problem the community had a responsibility to contain. It would be an effort that would enlist the support of many different elements within the community. It would become an example of what a community, working together, can accomplish.

On October 18, 1969, the various parties agreed to meet, to air their differences, to work together. "Yale Medical School Dean Dr. F.C. Redlich called for 'joint action' by citizens and scientists to fight lead poisoning," reported the New Haven press. A spokesperson for the community demanded "new unities, new alliances." Both the citizens and the scientists in the community realized that New Haven's children needed immediate attention due to the severity of the lead poisoning crisis.

Dr. Thomas Dolan, Director of Yale-New Haven's Pediatric Primary Care Center, recalls seeing children during his residency who were victims of encephalopathy, a medical term for lead toxicity. "Once a child had lead encephalopathy, almost one hundred percent were permanently brain damaged, a very high percentage died, a high percentage had blindness or permanent epilepsy, so the battle was already lost."

There were two reasons why early detection of lead was virtually impossible: first, children with lead levels remain asymptomatic until their medical conditions have reached an acute stage. Additionally, the limitations of technology made it equally impossible for laboratories to measure accurate blood lead levels until it was almost too late.

"We used to sit by helplessly until we picked up a lead level of 60," admits Dolan. That measurement represents the number of micrograms of lead per 100 milliliters of blood. By the time the child's blood lead reaches a level of 80, symptoms have usually begun, and the problem is acute. "We would start monitoring weekly and watch the level go up wondering about putting the child in the hospital," Dolan adds.

At the end of the decade, that changed. With the crescendo of community concern at the Hospital's doorstep, health care personnel were able to respond as a result of growing medical technology. With the advent of atomic absorption, a far more accurate means of measuring elements in the blood, doctors were able to assay much lower lead levels and, thus, to determine the presence of lead poisoning before it was too late. When the Primary Care Center gained access to its own atomic absorption machine, doctors were able to have blood drawn faster and more frequently than having to wait a week for test results to return from the state Health Department in Hartford.

One technical problem remained, however. After setting up the procedure in the Yale-New Haven laboratory in order to save time, Hospital chemists soon realized that the presence of E.D.T.A., the drug used to lower lead in the blood, made it impossible to obtain an accurate measure of lead in the blood after treatment.

"We began to develop the procedure from the published procedures and then found out about this problem with E.D.T.A.," explains Dr. Peter Jatlow, Director of Clinical Chemistry, "so we developed a major modification of the existing procedures."

At about this time, Dr. Dolan read a paper published by the Chicago Health Department describing a trial ambulatory program designed to treat children with significant lead levels on an outpatient basis. The advantages of outpatient treatment were obvious on a number of scores: costs for patient care were reduced dramatically; treatment, albeit fairly painful for the child, was far less traumatic; and mothers bringing their children to the Hospital for treatment would be able to receive educational information to help them prevent further problems with lead.

"It seemed to make sense," Dr. Dolan recalls, "so I guess we were probably about the second people to use it."

As the doors of Yale-New Haven's outpatient clinic were preparing to open to this community for lead testing and treatment, other members of the New Haven community were active just one block away. It was at Yale's School of Epidemiology and Public Health that Elaine Whitmire learned of New Haven's lead problem through one of her professors, Dr. J. Wister Meigs, who had considered the issue of lead in the environment.

His concern with New Haven's lead problem was focused on finding it before it occurred.

The next logical step for Meigs and Whitmire was to look at common factors in the cases of New Haven lead poisoning. By using information from Dr. Dolan's file at Yale-New Haven, they concluded that the young victims of lead poisoning consistently came from families not only in poor housing but also, in their words, with "operational problems." The research pointed to the fact that crowding and other overwhelming domestic difficulty resulted in a lack of supervision of children. As a result of this, children could become poisoned by the
bright, sweet tasting pieces of chipped paint.

"We decided that the disease is an indicator of a family problem," explains Mrs. Whitmire, "and we took it from there."

Prevention became the operative word for all individuals in the New Haven network which had evolved to combat the lead crisis. Prevention would require extensive efforts to educate families and, just as importantly, to remove lead from the homes of New Haven children.

For Hospital employees, education and prevention became a logical outgrowth of medical care. Lucille Tommaso, the clinic nurse who has been with the lead program since it began, saw to it that each child received the complete routine treatment when treatment was necessary. It was she who would contact parents when children missed clinic appointments. When Lucille was unable to contact families, volunteers were given doctors' cars and sent to children's homes in order to get the children to the Hospital for the essential medical treatment. Dr. Dolan's involvement extended to the numerous Saturdays he spent going out into the community with other physicians to draw bloods to test lead levels.

For Elaine Whitmire, education and prevention meant going into people's homes, talking to families, seeing to it that children made it to their medical appointments, and she admits that occasionally she was forced into a difficult situation. "First and foremost we had to consider the health conditions for the child. In some instances it was heart-breaking, but it required having people removed from their homes."

There was no denying that conscientious medical care and extensive educational efforts had little meaning unless something was done to remove the deadly source of lead in each child's environment. The city Health Department joined the community network to address this aspect of the lead poisoning issue.

Edward DeLouise, New Haven's Director of Public Health, explains that this was, indeed, a formidable task. "Our biggest problem was from an enforcement point of view — to get landlords to cooperate or to find decent housing for people who needed to be relocated from one place to another."

As of 1967, Connecticut law prohibited the use of paints with dangerous concentrations of lead in multifamily dwellings, but that was little help for families living in poorly maintained homes that had been painted earlier. Since state law, as of 1970, had no other specific requirements for landlords, it became the responsibility of the city Health Department to see that dangerous housing conditions were eliminated.

Of course, enforcement was impossible until the Health Department knew where lead paint chips posed a threat to New Haven children. According to DeLouise, his department depended heavily on Dr. Dolan for names of children with lead problems. "We had to rely on a referral from the Hospital or another health care center because we didn't have a health network set up."

"Medical efforts had little meaning unless something was done to remove the deadly source of lead in each child's environment."
“New Haven children were falling victim to lead poisoning at a rate four times higher than the rest of the nation. As far as neighborhood residents were concerned, the deaths were the result of community indifference and neglect.”

Yet, in its truest form, a network did exist in the city of New Haven in 1970. This network, a response to community outcry, brought together many community resources, among them the New Haven Health Department, Yale University, and Yale-New Haven Hospital.

Since then, the Health Department, through the cooperative efforts of Mrs. Whitmire, Dr. Meigs, and Mr. DeLouise, received a federal grant and carried out a comprehensive, 2½-year program to control and prevent further lead poisoning cases in New Haven. Mrs. Whitmire points out that this federal grant was the first to go beyond simply scraping walls to remove lead paint. According to DeLouise, “What we initially started out to do was to develop a system of reporting which is still in effect and which most cities still do not have.” Today, a city ordinance insures that lead problems are dealt with no later than one week after they are confirmed.

Doctors, nurses, and social workers at Yale-New Haven have continued their efforts to treat lead poisoning and, just as importantly, to screen and to educate in order to prevent lead poisoning. Today, every child between the ages of one and five who enters the pediatric clinic at Yale-New Haven is given a simple blood test as part of a routine examination to measure the amount of lead in his or her blood. Julia Hamilton, the social worker who supervises the Hospital’s community outreach worker and other clinical social workers, stresses the interdependence of Hospital personnel involved with the lead screening and treatment that takes place today. “We have a team of people working hand in hand with families to educate and to meet medical needs, all on behalf of the children.”

Much has been done on behalf of New Haven’s children. Cases of lead poisoning have been dramatically reduced. Dr. Brian Forsyth, the physician currently in charge of the lead screening program, reports that in his two years at the job he has seen no cases of lead encephalopathy.

In 1969, 50 children were found to have blood lead levels of 60 or over within a nine-month period. In the same period in 1984, this was reduced to nine cases. New Haven, reported to have the highest incidence of lead poisoning in the United States in 1965, successfully addressed a major problem with the help of Yale-New Haven Hospital.

The future of any community rests in the well-being of its children. Today, the New Haven community realizes that the well-being of New Haven children lies, in part, in the prevention of lead poisoning. As a result of a concerned community network, New Haven is preserving the safety of its children.

by Jennifer Allen Soloway
The history of American hospitals is a record of good intentions that have been generally well rewarded. From their charitable beginnings as providers of basic medical care to the nation’s needy, through their evolution to technologically advanced institutions of healing, higher learning and clinical research, hospitals have repaid society’s investment in them by offering the American public the finest available health care. Today Americans live longer and more productive lives than ever before.

However, there has been a price to pay to establish this record and maintain the standards of excellence. This year, health care expenditures will exceed ten percent of the nation’s Gross National Product. Although this investment earns the desired result, many are questioning whether this financial commitment is too expensive. To be sure, it is now so large as to compete with other desired expenditures. Hospitals are still being asked to provide the best services to all who need them, but they are being told they must do so with fewer resources.

Additional pressures are exerted on hospitals because of the changing nature of the health care delivery system. These pressures are felt acutely by non-profit teaching hospitals like Yale-New Haven. Services that once required hospitalization can now be delivered safely and more efficiently outside the hospital. Procedures which heretofore were available only from hospitals are now offered in numerous convenient settings. Competition from proprietary interests claims an increasing number of patients. In addition, revenues hospitals once presumed to be stable and secure now are jeopardized due to governmental needs to balance budgets. These pressures create an environment that puts at risk the traditional missions of hospitals like Yale-New Haven. Yet these missions of patient care, regardless of ability to pay, medical education, clinical research and community service remain vital to our society.

Yale-New Haven Hospital has devised new strategies to meet these challenges and preserve its missions. Last year, under the direction of its Board of Trustees, Yale-New Haven Hospital implemented a reorganization of its corporate structure, designed to create greater institutional flexibility in serving patients and in meeting the environmental challenges. A holding company, Yale-New Haven Health Services Corporation (YNHHSC), was formed and last summer it was granted non-profit status by the Internal Revenue Service. According to its charter, YNHHSC is authorized to engage in a broad range of charitable, scientific and educational activities in the health care field, both for the benefit of, and in cooperation with, the Hospital, with other hospitals and health care facilities, and with Yale University. Its primary purpose is “to benefit, carry out the programs of, and uphold, promote and further the welfare, programs and activities of Yale-New Haven Hospital.”

This new organizational arrangement makes possible the establishment of wholly and jointly owned subsidiary corporations of YNHHSC to pursue non-profit and for-profit ventures in sup-
port of Hospital goals. While various proposals are being considered, the following activities were initiated under the aegis of YNHHSC:

- Medical Center Realty, Inc., was formed. It has leased the Air Rights Parking Garage commercial space from the City and is developing that space for retail tenants.
- Medical Center Pharmacy and Home Care Center, Inc. was initiated to provide a full range of outpatient pharmaceutical products in conjunction with complete home care products. It is located in the Air Rights Garage retail space.
- Hospital Home Health Care of Connecticut, Inc., was formed to meet the increasing demand for health care services in the home. This company will collaborate with existing providers to complement care provided to our patients and to assure them of high quality services at competitive prices. The offices are located within the Medical Center Pharmacy and Home Care Center.
- Century Collection Agency, Inc., of Bridgeport, was formed with United Health Care of Bridgeport to provide patient account collection services for hospitals. Initially it is serving its founding hospitals: Bridgeport, Park City and Yale-New Haven.

The purpose of the new organizational arrangement is to enhance service to patients, to reduce health system costs and to provide new sources of revenue to support the Hospital’s missions. In order to maintain the quality and availability of health care services while containing costs, it is essential to provide competitively priced services in the most efficient setting, to minimize duplication of effort and resources by collaborating with other providers and to develop sources of capital to provide needed resources.

In another sense, the reorganization of Yale-New Haven’s corporate structure permitted us to redefine ourselves. In the current health care environment, it is no longer feasible to occupy a narrow position in the service delivery spectrum, such as acute inpatient services. The delivery of health care services is dynamic and increasingly interrelated. Provider groups are becoming more integrated to achieve the economies of scale that are necessary for financial survival and to guarantee that patients gain access to the most appropriate and cost-effective services. The provision of care is a continuum, with hospitals prominent but only one of many service providers.

To answer the question, what business is Yale-New Haven in, we can no longer reply, simply, the hospital business. Yale-New Haven is in the business of providing health care services in the most appropriate settings, and it will provide services of high quality at reasonable cost.

As the health care environment continues to evolve, new affiliations among providers are inevitable. Health care delivery is becoming systems-oriented, as providers of all levels of care, both institutional and non-institutional, pursue efficiencies through closer linkages. Yale-New Haven is a member of Voluntary Hospitals of America, a national system of large non-profit providers. It is probable that through VHA or other relationships new alliances will be formed to assist the Hospital in meeting the competitive and financial challenges. Yale-New Haven’s corporate reorganization positions us to respond to these environmental changes in a positive and timely manner.

These developments are consistent with both the history and purpose of Yale-New Haven Hospital. Since its founding in 1826, the Hospital has responded to many influences and met many challenges. Throughout our history, our commitment to our founding principles has remained steadfast and provides, today, an important source of inspiration and strength. We believe these steps undergird our commitments and enable us to face our future with confidence.

C. Thomas Smith
PRESIDENT

F. Patrick McFadden, Jr.
CHAIRMAN, BOARD OF TRUSTEES
Increasing regulatory pressures, growing competition in the marketplace, changing payment patterns and new public and political expectations place the traditional missions of Yale-New Haven Hospital in a vulnerable position. Hospitals across the country faced these challenges in 1984. The introduction of federal and state prospective payment systems invalidated the underlying assumption that hospitals would recover their full costs of providing care. Maintaining financial solvency became a paramount concern. Hospitals had to become more efficient, productive and cost-conscious, while maintaining their humane purpose.

At Yale-New Haven, this management challenge was addressed through the implementation of a strategic planning/management process that embraces all levels of management and provides for medical staff and trustee input. It combines an internal assessment of the Hospital’s strengths and weaknesses with an external assessment of the threats and opportunities in the marketplace and identifies important institutional goals and related strategies required to accomplish them. The strategic issues identified were reviewed and refined by senior management, the Strategic Planning Committee and the Board of Trustees and formally adopted. Subsequently, administrative officers and department heads developed specific objectives in support of the corporate goals. A formal monitoring and evaluation process was implemented which required that each member of senior management provide quarterly reports of progress toward achieving the organizational goals and objectives.

The success of this effort is reflected in the Hospital’s positive operating performance in 1984. The year was characterized by patient service improvements, the introduction of important new clinical programs, organizational restructurings, facilities renewal, and excellent financial performance. While encouraged by this progress, we are acutely aware that even more difficult challenges remain ahead.

Our Yale-New Haven staff has risen to the challenge of containing costs while maintaining the highest quality of patient care. The difficult issues the institution faces are being addressed by a team effort. In order to sustain this commitment, efforts were intensified to ensure that all members of the Hospital community were kept informed of the changing issues and trends shaping health care today. The vesting of our employees, medical staff and management group in specific operational goals and objectives is critical to the Hospital’s continuing success.

The consolidation of patient care activities in our new integrated hospital facility has yielded anticipated savings through increased efficiencies and improved service for patients. Efforts
have continued to achieve similar gains through the consolidation of hospital departmental functions in the renovated areas of the New Haven Unit and the transfer of unassigned space to the Yale School of Medicine to support important academic and research programs. The most extensive areas affected by the renovation program are the Clinical Medicine Laboratories on the fourth, fifth and sixth floors of the Clinic Building and adjacent Fitkin Unit. This department provides essential services for nearly every Hospital admission and outpatient visit and its new facilities will ensure that its services will remain among the best and most efficient in the country.

The Tompkins and Clinic Buildings were renovated to make room for administrative services relocated from the Boardman Building which will be transformed by the School of Medicine into the new Eye Center at Yale. The first floor of the adjacent Winchester Building is currently being renovated to house a 12-bed inpatient psychiatric unit for adolescents, a new Hospital service being offered in conjunction with the Yale University Child Study Center.

The reorganization of the Materials Management Department was completed in 1984 with the goal of reducing supply costs, reducing excess inventory and optimizing efficient resource consumption. Impressive savings already have been realized. Supply Management Teams consisting of the Materials Manager, Nursing Clinical Director and Unit Service Manager are forming in each patient care area. In addition, the new successful prime vendor purchasing approach has been expanded to include the laboratories, operating rooms, respiratory therapy, engineering and maintenance supplies resulting in anticipated savings of $728,000. An inventory reduction program focused on supplies for patient areas has yielded a positive financial impact of $511,000. Additional savings were realized through the reorganization of outpatient pharmacy services under the aegis of Medical Center Pharmacy and Home Care, Inc., located in the retail space in the Air Rights Garage.

The Value Improvement Program (VIP) was implemented this past year through our membership in the Voluntary Hospitals of America (VHA). Modeled after similar programs in industry, VIP focuses on issues of cost, efficiency and quality in patient care procedures by comparing specific program performance data from similar institutions across the country. Thus far, multi-disciplinary task forces have developed improvement recommendations concerning coronary artery bypass surgery and chronic dialysis. Preliminary task force recommendations are projected to have an annual positive impact of $400,000 due to reduced length of stay, reduced ancillary testing and improved revenue. Additional task forces have been convened to study myocardial infarctions and cholecystectomies, and others are planned.

Insuring that a patient’s length of stay in the Hospital was no longer than is medically necessary was an important medical management concern in 1984. By discharging patients as soon as it is medically appropriate, hospital beds can be freed up for those who need them most. Increased use of pre-admission testing and expanded utilization of the One-Day Surgery Center augment these efforts. New affiliations and contractual agreements with nursing homes and extended care facilities were established. A coordinated approach adopted by Discharge Planning, Social Work, Finance, the Medico-Legal Office and the Connecticut Department of Income Maintenance is expediting the discharge of patients at risk of prolonged hospital stays for non-medical reasons, such as the lack of suitable facilities to which the patient can be discharged. A similar approach for Medicare patients, the Geriatric Intervention Program, was started a year earlier. As a result of these efforts and others, average Medicare length of stay decreased from 12.4 days to 11.0 days.

All of these steps were critical to the Hospital’s financial success in 1984. New payment systems require both efficient patient length of stay management and effective control of the expense budget. Service improvements, such as the expansion of the transplantation program,
were accomplished through the reallocation of existing resources. Our adherence to these principles enabled the Hospital to increase patient volume and care for patients with a higher level of intensity within our existing expense budget.

As a result, Yale-New Haven recorded the best financial results in its history. After several years of deficits, and a modest surplus in 1983, the Hospital realized an operational surplus of $5.6 million in 1984. Net revenues were $6 million over budget while operating expenses exceeded the budget by only $600,000. Such performance allows the Hospital to continue to meet the enormous capital requirements associated with its tertiary care role.

As we pursue our 1985 objectives we are mindful of our historic commitment to our patients and our community and we are confident of our organization’s ability to face the new challenges presented by the constantly changing environment.

Joseph A. Zaccagnino
EXECUTIVE VICE PRESIDENT
As 1984 came to a close, the pressures and constraints imposed by today's economic environment had been felt by all members of the Yale-New Haven medical staff. New regulations affecting physicians' practice patterns had been implemented and disturbing new reimbursement formulas applicable to physicians' fee structures were being actively examined by state and federal agencies. It was a year of uncertainty as each month brought new and more complex directives on how physicians and hospitals must conduct their affairs. It was a year in which caution might have derailed progress.

Instead the opposite has occurred. The medical staff has pulled together, united behind the Hospital, in an encouraging recognition of the special role Yale-New Haven plays in so many lives through the multiple missions this Hospital embraces. The importance of teaching, clinical research, community service and the best possible patient care has acquired a new urgency that has demanded and received a renewed commitment by all members of the medical staff.

For example, a key element in the strategic planning process initiated by Hospital management has been the acknowledgement of the central position physician leadership must occupy in the effort to maintain Yale-New Haven's high standards of excellence. The response of the clinical chiefs and associate chiefs to this recognition of a partnership in the Hospital's future has been gratifying. Clinical directions are being examined systematically and thoroughly with an eye both to their efficacy and their place in fulfilling institutional missions. Decisions that once might have been parochial, now embody the good of the entire medical center.

The importance of medical staff commitment to the goals and missions of Yale-New Haven can scarcely be overstated. Physicians are the therapeutic directors and they are principally responsible for commanding the use of Hospital resources. At a time when these resources are dwindling, there must be a renewed emphasis on making these decisions wisely and with ever increasing scrutiny.

As a result, physicians have become more involved in decisions affecting the allocation of resources and program development. Through participation in capital expenditure discussions, physicians are helping to make some of the hard decisions on equipment needs. The process inspires closer interdisciplinary cooperation and, ultimately, improves the quality of patient care.

Physicians also have been instrumental in developing the Hospital-wide computer network, the Patient Care Support System. When fully deployed, this system will improve both administrative and medical efficiency for the benefit of our patients. The medical staff also has helped
develop new systems to monitor resource consumption so that the use of services in behalf of our patients can become more closely examined and evaluated.

Increasingly, physicians are being asked to extend their skills and expertise beyond the Hospital. The issues surrounding health care have become so complex and sometimes controversial, it has become essential for the medical staff to contribute to a clearer public understanding of the goals and missions of Yale-New Haven Hospital.

Despite the difficulties encountered, 1984 also must be recalled as a year of outstanding clinical advances. The state’s first heart transplant was performed here in November giving new impetus to Yale-New Haven’s expanding Transplantation Service. Liver and kidney transplantation procedures became more common and patient care was shared among the Departments of Surgery, Medicine, and Pediatrics. Connecticut’s only skin bank was organized at the Hospital last year. Allografting often represents a gift of life for serious burn victims and the skin bank will ensure an adequate supply of this precious tissue for hospitals throughout the region. The Section of Cardiology in the Department of Internal Medicine was selected to participate in a promising clinical study treating recent victims of myocardial infarction with a substance which dissolves clots.

The Department of Ophthalmology noted with great pleasure the beginning of renovations of the Hospital’s Boardman Building. The result will be a regional eye center, which will serve as a referral center for ophthalmologists throughout the state. In the Department of Diagnostic Imaging, important research into the clinical applications of Magnetic Resonance Imaging continues to explore the vast promise of this new technology. The Department of Obstetrics and Gynecology’s expansion of its treatment of infertility problems gave hope to many who seek the joy of raising their own children.

In these instances, and others too numerous to list, the medical staff at Yale-New Haven Hospital continued to perform with the dedication and compassion our patients deserve and expect. The challenges we face are considerable. So are the resources we can muster to confront them. Preserving the goals and missions of this Hospital through this time of change presents an opportunity that stimulates the support of us all.

John E. Fenn, M.D.
CHIEF OF STAFF
### Yale-New Haven Hospital Statement of Revenues and Expenses of Unrestricted Fund (\$000s Omitted)

<table>
<thead>
<tr>
<th>Year Ended September 30</th>
<th>1984</th>
<th>1983</th>
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<tbody>
<tr>
<td><strong>Revenue From Services to Patients</strong></td>
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<td></td>
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<td>Room, Board, and Nursing</td>
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<td>Special Services — Inpatients</td>
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<td>Clinic Patients</td>
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<td><strong>Deductions From Gross Revenues</strong></td>
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<td>Contractual and Other Allowances</td>
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<td>Provision for Uncollectible Accounts</td>
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<td><strong>Total</strong></td>
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<td><strong>Net Revenue from Services to Patients</strong></td>
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<td>Other Operating Revenue</td>
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<td><strong>Total Revenue</strong></td>
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<td><strong>Operating Expenses</strong></td>
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<td><strong>Less: Recovery of Expenses from Grants, Tuition, Sale of Services, Etc.</strong></td>
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</tr>
<tr>
<td><strong>Net Operating Expenses</strong></td>
<td>$165,102</td>
<td>$152,557</td>
</tr>
<tr>
<td><strong>Operating Gain/[Loss]</strong></td>
<td>$5,598</td>
<td>$58</td>
</tr>
<tr>
<td><strong>Non-Operating Revenue</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest Income from Escrow Funds</td>
<td>$1,082</td>
<td>783</td>
</tr>
<tr>
<td>All Other Investment Income</td>
<td>3,158</td>
<td>1,910</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$4,240</td>
<td>$2,693</td>
</tr>
<tr>
<td><strong>Excess of Revenues Over Expenses</strong></td>
<td>$9,838</td>
<td>$2,751</td>
</tr>
</tbody>
</table>
## Yale-New Haven Hospital

### Trends in Financial Ratios

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td><strong>Liquidity Ratios</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current</td>
<td>1.541</td>
<td>1.559</td>
<td>1.482</td>
<td>1.516</td>
</tr>
<tr>
<td>Days Revenue in Net Accounts Receivable</td>
<td>63.8</td>
<td>59.4</td>
<td>62.5</td>
<td>65.0</td>
</tr>
<tr>
<td><strong>Profitability Ratios</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Margin</td>
<td>3.28%</td>
<td>.04%</td>
<td>(1.07)%</td>
<td>(1.14)%</td>
</tr>
<tr>
<td>Return on Assets</td>
<td>.0322</td>
<td>.0004</td>
<td>(.9942)</td>
<td>(.9690)</td>
</tr>
<tr>
<td><strong>Capital Structure Ratio</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long term Debt to Equity</td>
<td>.908</td>
<td>1.115</td>
<td>1.354</td>
<td>1.279</td>
</tr>
<tr>
<td>Long term Debt to Net Fixed Assets</td>
<td>73.2%</td>
<td>74.1%</td>
<td>77.9%</td>
<td>173.1%</td>
</tr>
<tr>
<td>Debt Service Coverage</td>
<td>2.418</td>
<td>1.784</td>
<td>2.096</td>
<td>3.552</td>
</tr>
</tbody>
</table>

### General Information Summary

<table>
<thead>
<tr>
<th></th>
<th>1984</th>
<th>1983</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Patients</td>
<td>36,425</td>
<td>35,998</td>
</tr>
<tr>
<td>Patient Days of Care Provided</td>
<td>266,624</td>
<td>272,487</td>
</tr>
<tr>
<td>Average Length of Patient’s Stay (Days)</td>
<td>7.3</td>
<td>7.6</td>
</tr>
<tr>
<td>Average Daily Patient Census</td>
<td>728</td>
<td>747</td>
</tr>
<tr>
<td>Births</td>
<td>5,352</td>
<td>5,245</td>
</tr>
<tr>
<td>Volunteer Hours Donated</td>
<td>73,346</td>
<td>67,555</td>
</tr>
</tbody>
</table>

### Diagnostic and Therapeutic Services

<table>
<thead>
<tr>
<th></th>
<th>1984</th>
<th>1983</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultrasound</td>
<td>12,269</td>
<td>11,648</td>
</tr>
<tr>
<td>X-ray</td>
<td>176,659</td>
<td>176,055</td>
</tr>
<tr>
<td>CAT Scan</td>
<td>11,088</td>
<td>8,209</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>10,341</td>
<td>9,944</td>
</tr>
<tr>
<td>Electrocardiology Exams</td>
<td>45,434</td>
<td>45,911</td>
</tr>
<tr>
<td>Radiation Therapy Treatments</td>
<td>45,032</td>
<td>41,478</td>
</tr>
<tr>
<td>Physical Therapy Treatments</td>
<td>41,351</td>
<td>41,748</td>
</tr>
<tr>
<td>Respiratory Therapy Treatments</td>
<td>242,447</td>
<td>245,100</td>
</tr>
</tbody>
</table>
## Comparative Statistics

### Outpatient Clinic Visits

<table>
<thead>
<tr>
<th>Service</th>
<th>1984</th>
<th>1983</th>
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</thead>
<tbody>
<tr>
<td>Primary Care Center</td>
<td>30,369</td>
<td>32,177</td>
</tr>
<tr>
<td>Dermatology</td>
<td>9,740</td>
<td>11,457</td>
</tr>
<tr>
<td>Women's Center</td>
<td>26,495</td>
<td>29,447</td>
</tr>
<tr>
<td>Dana Psychiatry</td>
<td>3,643</td>
<td>5,308</td>
</tr>
<tr>
<td>Dental</td>
<td>4,874</td>
<td>5,074</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>17,198</td>
<td>17,722</td>
</tr>
<tr>
<td>Medicine</td>
<td>27,933</td>
<td>27,682</td>
</tr>
<tr>
<td>Pediatric</td>
<td>12,110</td>
<td>13,816</td>
</tr>
<tr>
<td>Surgery</td>
<td>16,863</td>
<td>17,614</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>8,470</td>
<td>9,454</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>8,280</td>
<td>8,937</td>
</tr>
<tr>
<td>Urology</td>
<td>2,573</td>
<td>4,753</td>
</tr>
<tr>
<td><strong>Total Outpatient Clinic Visits</strong></td>
<td>168,548</td>
<td>183,441</td>
</tr>
<tr>
<td>Emergency Service Visits</td>
<td>72,356</td>
<td>77,512</td>
</tr>
<tr>
<td>Personnel Health Visits</td>
<td>14,728</td>
<td>15,249</td>
</tr>
<tr>
<td><strong>Total Outpatient Visits</strong></td>
<td>255,632</td>
<td>276,202</td>
</tr>
</tbody>
</table>

### Inpatient Statistics (Discharges)

<table>
<thead>
<tr>
<th>Category</th>
<th>1984</th>
<th>1983</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>18,020</td>
<td>17,561</td>
</tr>
<tr>
<td>Surgical</td>
<td>9,004</td>
<td>9,028</td>
</tr>
<tr>
<td><strong>Total Adults</strong></td>
<td>27,024</td>
<td>26,589</td>
</tr>
<tr>
<td>Pediatrics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>2,460</td>
<td>2,650</td>
</tr>
<tr>
<td>Surgical</td>
<td>1,422</td>
<td>1,296</td>
</tr>
<tr>
<td><strong>Total Pediatrics</strong></td>
<td>3,882</td>
<td>3,946</td>
</tr>
<tr>
<td>Newborn</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regular</td>
<td>4,211</td>
<td>4,525</td>
</tr>
<tr>
<td>Special Care</td>
<td>1,308</td>
<td>938</td>
</tr>
<tr>
<td><strong>Total Newborn</strong></td>
<td>5,519</td>
<td>5,463</td>
</tr>
<tr>
<td><strong>Total Inpatient</strong></td>
<td>36,425</td>
<td>35,998</td>
</tr>
</tbody>
</table>
Hospital's Family

BOARD OF TRUSTEES
(1984)

OFFICERS
Chairman of the Board
F. Patrick McFadden, Jr.
Vice Chairmen
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Henry Chauncey, Jr.
President
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James C. Lamberti

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A. Bartlett Giamatti
Norwich R. Goodspeed
Stanley R. Lavietes, M.D.
Sister Julia M. McNamara, O.P.
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Cornell Scott
Samuel O. Thier, M.D.
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Patricia O'Keefe
Second Vice President
Marilyn C. Hurst
Corresponding Secretary
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Recording Secretary
Belle Rooks
Treasurer
Eleanor Jones
Treasurer-Gift Shop
Louise Carlin
Ex Officio
Patricia A. Wetzel

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Andrew J. Graham, M.D.
President-elect
Joyce D. Gryboski, M.D.
Secretary
Mary Jane Minkin, M.D.
Immediate Past President
Michael Kashgarian, M.D.

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Vice Chairman
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Secretary
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Peter I. Jalow, M.D.
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Vincent T. Marchesi, M.D.
Paul E. Molumpy, M.D.
Frederick Naftolin, M.D.
Nicholas M. Passarelli, M.D.
Howard A. Pearson, M.D.
Rachel Rotkovitch, R.N.
Frederick L. Sachs, M.D.
Marvin L. Sears, M.D.
David E. Silverstone, M.D.
Stephen A. Stein, M.D.
Samuel O. Thier, M.D.
Joseph A. Zaccagnino
Joseph H. Zelson, M.D.

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Credentials
Michael Kashgarian, M.D.
Critical Care
Frederick L. Sachs, M.D.
Barry L. Zaret, M.D.
Disaster
Ulrich H. Weil, M.D.
Emergency Room
Ulrich H. Weil, M.D.
Equipment and Product Standards
Daniel J. McIntyre
Infection
William H. Greene, M.D.
Liaison
Barbara K. Kinder, M.D.
Henry A. Swett, M.D.
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William H. Greene, M.D.
Nutrition
Rosemarie L. Fisher, M.D.
Operating Room
Robert K. Houlihan, M.D.
Robert I. Schrier, M.D.
Perinatal Mortality and Morbidity Review
Richard A. Ehrenkranz, M.D.
Pharmacy and Therapeutics
Nicholas M. Greene, M.D.
Quality Assurance
William B. Crede, M.D.
Radioisotope
Eugene A. Cornelius, M.D.
Rehabilitation
Hubert B. Bradburn, M.D.
Tissue
Kenneth W. Barwick, M.D.
Transfusion
Christopher C. Baker, M.D.
Utilization Review
Leo M. Cooney, Jr., M.D.

CLINICAL DEPARTMENT HEADS
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CHIEF
Paul G. Barash, M.D.
ASSISTANT CHIEF
Robert I. Schrier, M.D.

Child Psychiatry (eff. 7/1/85)
CHIEF
Donald J. Cohen, M.D.

Clinical Laboratories
CHIEF
Peter I. Jalow, M.D.
ASSISTANT CHIEF
Joseph R. Bove, M.D.
**SECTION CHIEFS**

**Blood Bank**
- Joseph A. Bove, M.D.

**Chemistry**
- Richard K. Donabedian, M.D.

**Hematology**
- Peter McPhedran, M.D.

**Immunology**
- Alexander Baumgarten, M.D.

**Microbiology**
- Stephen C. Edberg, Ph.D.

**Dentistry**

- **CHIEF**
  - Donald W. Kohn, D.D.S.

- **ASSISTANT CHIEF**
  - Harold Horton, D.M.D.

**SECTION CHIEFS**

- **Dental Radiology**
  - Benjamin Ciola, D.D.S.

- **Endodontics**
  - Bertrand Weisbart, D.D.S.

- **Operative Restorative**
  - Alan Frankel, D.D.S.

- **Oral & Maxillo Facial Surgery**
  - Bernard Levine, D.D.S.

- **Orthodontics**
  - Wilbur D. Johnston, D.D.S., M.D.

- **Pediatric Dentistry**
  - Donald W. Kohn, D.D.S.

- **Periodontics**
  - Harold Horton, D.M.D.

**Dermatology**

- **CHIEF**
  - Aaron B. Lerner, M.D.

**Diagnostic Imaging**

- **CHIEF**
  - Richard H. Greenspan, M.D.

  - **CLINICAL DIRECTOR**
    - Henry A. Swett, M.D.

**SECTION CHIEFS**

- **Chest Service**
  - Ann Curtis, M.D.

- **Computerized Tomography**
  - Arthur Rosenfield, M.D.

- **Emergency Room Radiology**
  - Phyllis Korneguth, M.D.

- **Gastrointestinal Radiology**
  - Morton Burrell, M.D.

- **Genitourinary Radiology**
  - Morton Glickman, M.D.

- **Interventional Radiology**
  - Kenneth W. Sniderman, M.D.

- **Magnetic Resonance Imaging**
  - H. Dirk Sostman, M.D.

- **Neuroradiology**
  - E. Leon Kier, M.D.

- **Nuclear Medicine**
  - Paul Hoffer, M.D.

- **Orthopaedic Radiology**
  - Jack Lawson, M.D.

- **Pediatric Radiology**
  - Nancy Rosenfield, M.D. [Acting]

- **Ultrasound**
  - Kenneth Taylor, M.D.

**Internal Medicine**

- **CHIEF**
  - Samuel O. Thier, M.D.

- **ASSOCIATE CHIEF**
  - Frederick L. Sachs, M.D.

- **ASSISTANT CHIEF**
  - Robert M. Donaldson, Jr., M.D.

- **ASSISTANT ASSOCIATE CHIEF**
  - Leonard R. Farber, M.D.

**SECTION CHIEFS**

- **Cardiology**
  - Barry L. Zaret, M.D.

- **Dietetic Diseases**
  - James Boyer, M.D.

- **Endocrinology/ Metabolism**
  - Howard Rasmussen, M.D.

- **General Medicine**
  - Ralph Horwitz, M.D.

- **Hematology**
  - Bernard G. Forget, M.D.

- **Immunology**
  - Fred S. Kantor, M.D. [Acting to 6/30/85]

  - Philip W. Askenase, M.D. [from 7/1/85]

- **Infectious Disease**
  - Vincent T. Andrelo, M.D.

- **Medical Oncology**
  - Joseph R. Bertino, M.D.

- **Nephrology**
  - John P. Hayslett, M.D.

- **Primary Care Center**
  - John Hughes, M.D.

- **Pulmonary Disease**
  - Herbert Y. Reynolds, M.D.

- **Rheumatology**
  - Stephen E. Malawista, M.D.

**Neurology**

- **CHIEF**
  - Gilbert H. Glaser, M.D.

- **ASSISTANT CHIEF**
  - Jonathan H. Pincus, M.D.

**Obstetrics/Gynecology**

- **CHIEF**
  - Frederick Naftolin, M.D., D.Phil

  - **ASSOCIATE CHIEF**
    - Stanley R. Laviotes, M.D.

  - **ASSISTANT CHIEF**
    - John C. Hobbins, M.D.

  - **ASSISTANT ASSOCIATE CHIEF**
    - (Vacant)

**SECTION CHIEFS**

- **Gynecologic Oncology**
  - Peter E. Schwartz, M.D.

- **Gynecology**
  - John Mcl. Morris, M.D.

- **Maternal-Fetal Medicine**
  - John C. Hobbins, M.D.

- **Reproductive Endocrinology**
  - Alan H. DeCherney, M.D.

- **Women’s Center**
  - Alan H. DeCherney, M.D.

**Ophthalmology**

- **CHIEF**
  - Marvin L. Sears, M.D.

- **ASSISTANT CHIEF**
  - Andrew S. Wong, M.D.

**SECTION CHIEFS**

- **Cornea and External Diseases**
  - Ali A. Khodadoust, M.D.

- **Genetics**
  - Rufus Howard, M.D.

- **Glaucoma**
  - Joseph Caprioli, M.D.

- **Ophthalmic Pathology**
  - Douglas W. MacRae, M.D.

- **Retina and Vitreous**
  - James E. Puklin, M.D.

- **Strabismus**
  - Caleb Gonzalez, M.D.

**Pathology**

- **CHIEF**
  - Vincent T. Marchesi, M.D., Ph.D.

- **ASSISTANT CHIEF**
  - Michael Kashgarian, M.D.

**SECTION CHIEFS**

- **Autopsy**
  - G. J. Walker Smith, M.D.

- **Surgical**
  - Kenneth Barwick, M.D.

**Pediatrics**

- **CHIEF**
  - Howard A. Pearson, M.D.

- **ASSOCIATE CHIEF**
  - Joseph Zelson, M.D.

- **ASSISTANT CHIEF**
  - Norman J. Siegel, M.D.

- **ASSOCIATE ASSOCIATE CHIEF**
  - (Vacant)

**SECTION CHIEFS**

- **Adolescents**
  - Walter R. Anyan, Jr., M.D.

- **Cardiology**
  - Norman S. Talner, M.D.

- **Cystic Fibrosis**
  - Thomas F. Dolan, Jr., M.D.

- **Endocrinology**
  - Myron Genel, M.D.
Gastroenterology
Joyce Gryboski, M.D.

Hematology Oncology
Diane Komp, M.D.

Infectious Disease
I. George Miller, M.D.

Intensive Care
George Lister, M.D.

Genetics
Maurice J. Mahoney, M.D.

Neurology
Bennett A. Shaywitz, M.D.

Neurosurgery
Charles Duncan, M.D.

Orthopaedic Surgery
Gary E. Friedlaender, M.D.

Nephrology
Norman J. Siegel, M.D.

Pediatric Radiology
Richard I. Markowitz, M.D.

Pediatric Surgery
Robert J. Touloukian, M.D.

Perinatal Medicine
Ian Gross, M.D.

Primary Care Center
Thomas F. Dolan, Jr., M.D.

Psychiatry

CHIEF
Malcolm B. Bowers, Jr., M.D.

ASSISTANT CHIEF
Hoyle Leigh, M.D.

SECTION CHIEFS
Consultation-Liaison Service and Ambulatory Services
Hoyle Leigh, M.D.

Emergency Services
DIRECTOR
Luis Gonzalez, M.D.

DIRECTOR OF INPATIENT SERVICES
Mary Swigar, M.D.

SECTION CHIEFS
J. Craig Nelson, M.D.
David Greenfeld, M.D.

Psychology
Donald Quinlan, Ph.D.

Social Work
John Steidl, M.S.W.

Surgery

CHIEF
William F. Collins, Jr., M.D. (Acting)

ASSOCIATE CHIEF
Robert K. Houlihan, M.D.

ASSISTANT CHIEF
Jack W. Cole, M.D.

ASSISTANT ASSOCIATE CHIEF
(Vacant)

Cardiothoracic
SECTION CHIEF
Alexander Geha, M.D.

ASSOCIATE SECTION CHIEF
Harold Stern, M.D.

Family Medicine

SECTION CHIEF
M. Wayne Flye, M.D. (Acting)

ASSOCIATE SECTION CHIEF
Stephen A. Stein, M.D.

Neurosurgery

SECTION CHIEF
William F. Collins, Jr., M.D.

ASSOCIATE SECTION CHIEF
Lycurgus M. Davey, M.D.

Oral Surgery

SECTION CHIEF
Donald W. Kohn, D.D.S.

ASSOCIATE SECTION CHIEF
Harold L. Horton, D.M.D.

Orthopaedic Surgery

SECTION CHIEF
Gary E. Friedlaender, M.D.

ASSOCIATE SECTION CHIEF
Ralph DePonte, M.D.

Otolaryngology

SECTION CHIEF
Clarence T. Sasaki, M.D.

Pediatric Surgery

SECTION CHIEF
Robert Touloukian, M.D.

Plastic/Reconstructive Surgery

SECTION CHIEF
Stephen Ariyan, M.D.

ASSOCIATE SECTION CHIEF
Irving M. Polayes, M.D.

Urology

SECTION CHIEF
Bernard Lytton, M.D.

Therapeutic Radiology

CHIEF
James F. Fischer, M.D.

Division of Radiological Physics

DIRECTOR
Robert J. Schulz, Ph.D.

Medical Staff as of July 1, 1984

Attending
707

Associate
197

Courtesy
76

Emeritus
39

Visiting
253

Honorary
18

Clinical Fellows
95

Residents
365

Affiliated Health
73

Care Professionals

Total Medical Staff
1,823

OTHER MEDICAL SERVICES

YALE CHILD STUDY CENTER

DIRECTOR
Donald J. Cohen, M.D.

SECTION DIRECTORS
Child Psychology Unit
John E. Schowalter, M.D.

Edward Zigler, Ph.D.

Sara Sparrow, Ph.D.

Community Unit
Albert J. Solnit, M.D.

Consultation Liaison Unit/YNHH
Melvin Lewis, M.D.

Research Unit
James Leckman, M.D.

CENTER FOR HUMAN GENETICS AND INHERITED DISEASES

DIRECTOR
Leon R. Rosenberg, M.D.

SECTION CHIEFS
Genetic Consultation
Margretta R. Seashore, M.D.

Fetal Diagnostic Service
Maurice J. Mahoney, M.D.

Diagnostic Cytogenetics Laboratory
W. Roy Breg, M.D.

Biochemical Disease Detection Laboratory
Kay Tanaka, M.D.

MEDICAL DIRECTORS

Continuing Care
Leo M. Cooney, Jr., M.D.

Emergency Service
Ulrich H. Weil, M.D.

Epidemiology and Infection Control
William H. Greene, M.D.

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

Quality Assurance
William B. Crede, M.D.

Respiratory Therapy
Herbert Y. Reynolds, M.D. (Acting)

Utilization Review
Leo M. Cooney, Jr., M.D.

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C. Thomas Smith
Executive Vice President
Joseph A. Zaccagnino

Chief of Staff
John E. Fenn, M.D.

Vice Presidents-Administration
T. Brian Condon
Vincent S. Conti
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