1991

University Hospital at Boston
University Medical Center: Annual Report 1991

University Hospital
University Hospital, Boston University Medical Center

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Boston University
CLINICAL CARE
RESEARCH
THE PATIENT
COMMUNITY SERVICE
MEDICAL EDUCATION
The spotlight in this report is directed upon the many ways in which UH employees and staff work together to benefit the patient in a variety of settings — in clinical care, in hospital operations, in medical research and in the community.

The spirit of collaboration, cooperation and partnership pervading the Hospital's daily life arises from its core mission and values. This "working together" way of doing things should serve the Hospital well in the years to come: Health-care "trend-watchers" warn that market forces in the future will favor those hospitals and other health-care providers who have emphasized collaborative efforts with both their internal and external partners with the objective of making the system more responsive and effective.

The beneficiary of all of this collaboration in health care is not some unknown statistic: it is the Hospital's current and future patients. The University Hospital not only is working hard to meet the needs of today, but is actively preparing to serve the needs of the future.

Hugh Shepley  
Chairman, Board of Trustees

J. Scott Abercrombie Jr., M.D.  
President and Chief Executive Officer
PARTNERSHIP

COLLABORATION

COOPERATION
n this annual report, a tapestry recording the year 1991 at The University Hospital, the perspective of 12 months clarifies the singular image: The patient is at the center of all that we do.

Imagine a richly detailed tapestry that depicts a broad array of people, events and scenes. If you get closer, you can see the fabric's intricate stitches, twists and colors, but none of the scenes is clear. At arm's length, you can view only one of those scenes at a time. To see the whole composition, you must step back a good distance.

Our employees and staff are engaged in a number of activities centered on clinical care, research, medical education, and community services. Each of these activities is part of the overall picture. In all cases, there is patient-focused innovation: We see the patient in a tremendous variety of settings— as inpatient, as outpatient, as someone who may be coming here at some future time, as someone whose cure may await the future applications of today's basic research, or as someone whose health someday will rest in the hands of a young physician who is only now in training.

The key to keeping this focus on the patient is simple and time-tested, and it is known at The University Hospital by names that spell out the concept of working together: partnership, collaboration, cooperation. We work with one another in clinical areas to offer new treatments, in the area of day-to-day operations to ensure quality, with other institutions in forming new patient-centered programs and with the community toward achieving common goals.
Expanding Clinical Partnerships Offer New Options for Patients

By encouraging and helping to form alliances among its specialists, UH is building a sound future in medicine. Five years ago, when the Hospital opened its modern patient-care facility, the Atrium Pavilion, the focus was to provide the most advanced form of patient care without abandoning the proven methods of medicine. Today, as it further expands its facilities, programs and services, the Hospital continues to keep that goal foremost in everything it does.

Cardiac Surgery Center
Early in 1991, the federal government selected The University Hospital as one of four national demonstration centers to perform Medicare-funded coronary artery bypass grafts under a new financial arrangement that creates greater value for the taxpayer. To compete for this distinction, the Hospital needed to show its commitment to quality and innovation in cardiac surgery.

The demonstration project is unique in that, for the first time, the government has asked hospitals and physicians to help explore and test new payment methods for improving efficiency while maintaining high quality of care. If this “bundling” concept helps to decrease the cost of such expensive procedures as coronary artery bypass surgery, it may prove vital to managing the health-care cost spiral, while providing citizens with crucial health-care services.

Minimal-Access Surgery
This past year, surgeons from throughout the institution joined to form the Center for Minimal Access Surgery. This type of surgery allows physicians to operate through the smallest possible opening in the body, thereby providing the patient with a quicker recovery time, shorter hospital stay, minimal trauma and lower cost. The Hospital’s surgeons – including urologists, general surgeons, gastrointestinal surgeons, gynecologists and otolaryngologists – have been using minimal-access techniques for several years.

The trend toward performing this type of surgery began gaining greater interest only recently, with the emergence of the laparoscope, a surgical scope with a camera on its tip that is inserted in the body.
through abdominal incisions. This technology allowed UH surgeon Desmond Birkett, M.D., to be the first surgeon in Boston to perform a laparoscopic cholecystectomy for gallbladder removal.

In 1991, UH surgeons were the first in Boston to take a new approach to treating inguinal hernias, a condition that can be life-threatening if left untreated. Traditional inguinal hernia repair has involved open surgery and often requires many weeks of recovery. With the laparoscopic procedure, the surgery is less involved, requires shorter operating room time, and causes minimal scarring to the tissue surrounding the hernia. The recovery period associated with laparoscopic inguinal repair also is dramatically decreased, as are the associated costs.

**Cancer Pain Program**

UH specialists in medical oncology, surgical oncology, neurology, anesthesiology, psychiatry and radiology, among others, are working together to evaluate and treat acute pain and certain chronic pain syndromes. One area of focus is on how to curb pain suffered by cancer patients.

Approximately 60 percent of all cancer patients develop significant pain throughout their illnesses; of that number, some 80 to 90 percent of patients consider their pain overwhelming. New research suggests that pain can exacerbate the disease process, or can at least impair a person’s ability to overcome an illness.

Conversely, aggressive pain management in cancer patients can actually speed the recovery process and improve the quality of life.

The Hospital’s Cancer Pain and Palliative Care Program offers a broad range of pain treatments. Each patient’s pain care is individualized, depending on his or her needs. For instance, one patient may only require pharmacologic treatment using opiates, while another patient may need an anesthesiologist to design a pain program, or may need a neurosurgeon to become involved. For cancer pain, nerve-blocking drugs and short-acting nerve blocks are often used with great success.
Emergency Care
An estimated 140,000 Americans die each year from trauma – the leading cause of death among people under age 44. Last spring, the Hospital and its neighbor, Boston City Hospital, moved to improve trauma response by integrating their emergency medicine programs. This integration brings together each institution’s special skills: UH, with its acute-care specialty expertise, and BCH, with one of the busiest emergency rooms in the nation. By joining forces, both UH and BCH – which already make up a designated Level I trauma center – now are better able to meet the increasing demand for emergency medicine services.

Further supporting the level of care to UH/BCH trauma patients is Boston MedFlight, an emergency helicopter service operated by a consortium of the city’s trauma centers. MedFlight, developed seven years ago by UH, is staffed by trauma professionals who provide life-sustaining treatment – a virtual “ambulance in the sky.” Since airlifting its first patient in 1985, MedFlight has transported thousands of critically ill and injured patients to Boston trauma centers. This year, UH provided vital care for more than a quarter of all MedFlight patients.

Breast Health Center
UH has been in the forefront of research into the causes of and treatments for breast cancer. Because of this, the Hospital has been selected as one of four New England centers for the National Cancer Institute’s first investigation of a drug to prevent breast cancer. This landmark research will involve women with hormone-sensitive breast cancers who have the same or higher risk for developing breast cancer within five years as a 60-year-old American woman. The Hospital also is involved in clinical trials of new drugs used to attack small and undetectable traces of cancer that pose a threat for the future development of breast cancer.

In addition to their activities in breast-cancer treatment and research, Hospital staff also are concerned about the importance of educating women on breast diseases and on maintaining good breast health. The Hospital’s Breast Health Center was formed to advance these goals. At the Center, a woman is given individualized, coordinated same-day service by a team of health professionals in a multidisciplinary setting. During a single visit, a woman can be seen and examined by a physician skille
in breast examination, by a female physi­
cian who is expert in overall risk assess­
ment for breast disease, and, if it is appropri­
ate, can have a mammogram and/or ultra­
sound performed. Standing by is a staff of
surgical oncologists, pathologists and
radiologists who work together, if needed, to
facilitate the examination. Providing a
prompt, efficient and coordinated service,
while reducing the wait and worry, is a
major goal of the Center.

The UH Voice Center

Until their voice fails them, many people
take speech for granted. At the UH Voice
Center, a team of voice experts is employing
the most advanced technology to diagnose
and treat troubling voice disorders.

Since the Center was formed this past
year, new techniques and equipment have
been developed that make visualizing the
larynx easier and permit objective assess­
ment of voice production. Depending on the
severity of the problem, treatment ranges
from speech therapy to percutaneous
surgery to removal of nodules or lesions.

Voice disorders typically stem from a
variety of causes, from the more simple –
overuse – to the more complex – underlying
medical conditions. One UH patient, a full­
time figure-skating coach who trains
Olympic hopefuls, lost his voice completely
as a result of overuse. After seeking the
assistance of UH’s voice professionals, the
patient was able to return to coaching and is
now practicing good “vocal-hygiene”
techniques. Recently, Voice Center re­
searchers began testing the effectiveness of
a drug for patients with spasmodic
dysphonia, a condition that causes extreme
difficulty in speaking because of a disorder
of the larynx, vocal cords, tongue or mouth.
In fact, a Merrimack, New Hampshire,
woman, who was unable to speak for 19
years because of the disorder, was treated
with the drug and has rediscovered her
voice. With her new-found ability to speak,
she was able to accept a faculty position at
the University of New Hampshire.
Boston University Medical Center took a major step in 1991 to ensure that medical care and research will thrive in the South End area during the next century, as groundbreaking ceremonies launched a dynamic and progressive new medical complex on Albany Street.

The University Associates development, a joint effort by the Hospital and Boston University, not only opens a new era for the Medical Center’s health-care and medical-research programs, but it also holds profound meaning for the surrounding community. The project will establish a “gateway” to Boston and will serve as a primary location for the city’s emerging biomedical industry. It will provide a shot in the arm to the local and regional economy through the creation of a significant number of construction and permanent jobs for local residents, and it will provide an economic boost to the area of the South End adjoining the Medical Center.

The University Associates project, one of the largest construction undertakings in Boston in almost two years, received approval following a public-planning effort that involved the Hospital, the University, city and state agencies, neighbors and area business groups.

The complex, to be located on land that has been used for Boston University Medical Center and Boston City Hospital parking, ultimately will include a 180,000-square-foot Center for Advanced Biomedical Research; a medical-office and ambulatory care building; a 1,000-space parking garage with a child-care center and retail space on the ground level; two additional medical/research/office facilities totalling approximately 470,000 square feet, and a 240-room hotel and conference center. It is expected that the project will be completed shortly after the turn of the century.

Elders Living at Home

While working to ensure the quality of medical care in the future, UH is helping society to deal with the problems of the present, with particular emphasis on issues surrounding the aging population. The Hospital’s Home Medical Service, the nation’s oldest continuing home medical program, has a long tradition of providing health care to Boston elders at home. The Elders Living at Home Program (ELAHP), a relatively new program coordinated by the Hospital, works with other agencies to provide temporary housing for homeless elders.
Since its inception in 1986, ELAHP has integrated health and housing services for more than 400 elderly persons who were at risk for homelessness or institutionalization. Some 110 elders have been placed in transitional housing units leased by The University Hospital from the Boston Housing Authority, and have been given the tools they need to live independently.

Taking further steps to assist the elderly, the Hospital was the first site in New England to offer a free service called Benefits Eligibility Screening System (BESS). BESS, a computer software system, informs Boston elders over the age of 60 of their local, state and federal benefits.

**Health Screenings**

Through a number of health screenings and wellness programs, UH continues to make its medical expertise available to members of the community. The Hospital, in conjunction with its Occupational Health Program, and its physical therapy, dermatology and urology departments, among others, routinely offers a variety of services and programs aimed at maintaining health and preventing disease. Such screenings offered during the past year have included tests for skin cancer, prostate cancer, diabetes, high blood pressure and cholesterol, as well as back problems. Through its Home Medical Service, the Hospital also offers Boston elders annual flu shots – the largest program of its kind in the city.

**Interinstitutional Transportation Management Association (ITMA)**

In late 1990, the Hospital, along with Boston University Medical Campus and Boston City Hospital, formed the Interinstitutional Transportation Management Association (ITMA). ITMA’s members are working toward bringing more convenient and more accessible transportation to the 10,000 people who come to the Medical Center daily. Early efforts have included working with the MBTA to provide expanded and improved bus routes to the medical area, and to install new bus shelters; conducting a commuter survey of medical center employees to ascertain ridesharing options, and improving communications about transportation throughout the participating institutions.
Today’s volatile health-care climate has challenged hospitals not only to attract new patients and physician referrals, but also to retain those patients and their physicians. Although most patients initially come to a hospital because of its medical staff and its reputation, they return there in many cases because they had an excellent overall experience. At UH, that excellent overall experience defines quality.

But what are the factors that influence a patient’s view of quality? Certainly, the quality of medical care is the number-one factor, but most patients now expect the very best care from major teaching hospitals like UH. However, Hospital managers also believe that the perfect hospital visit equals the sum total of all the experiences a patient has from the moment he or she walks in the door to register until he or she walks out the door after receiving care. Thus, the aim at UH is to provide perfection from start to finish.

While pursuing this unswerving quality, Hospital leaders found that the true instigators of defective care and service almost always are faulty systems and policies, not mistakes made by the caregivers and employees who deliver care and service.

Managers now confront problems by looking for defects in the system and setting out on a course of corrective action. Hospital leaders determined that providing three essential tools to employees is necessary in order to create a “zero-defects environment:

- Sound and flexible Hospital systems and policies that optimize the delivery of care and service;
- dynamic and effective communication channels through which changes can be made and issues can be addressed; and
- well-focused training programs to educate employees and provide them with progressive job skills.
Philanthropic Participation

The University Hospital’s commitment to teamwork was never more apparent than in the planning and implementation of the largest capital campaign the institution has ever undertaken. With the involvement of the trustees, physicians and employees, the Hospital committed to a $25-million campaign to raise funds for endowment, advanced technology and program development. The “Courage and Caring” campaign was announced at the largest-ever “Jeopardy!” tournament, patterned after the popular television game program of the same name. The UH-sponsored event was named one of the 10 top functions of the year by the Boston Herald.

By the October kickoff date, the nucleus fund goal of $4 million had been reached. Of note was a generous commitment of $300,000 by the Gillette Company, unrestricted bequests totalling more than $100,000, and several large endowment gifts secured through life insurance. The Hospital’s Beechtree Fund (formerly called the Annual Fund) held its own in a difficult financial year, thanks to the generous support of more than 2,600 donors. Additional gifts supported cancer-center activities, neurology, the Home Medical Service and the Elders Living at Home Program, the New England Regional Spinal Cord Injury Center and many other activities. In total, more than 3,500 donors contributed or pledged more than $1.5 million in FY91. The UH Auxiliary continued its commitment to child-care programs through special events and the sale of UH sweatshirts and other “wearables.”
Biomedical research has been hailed as one of the strongest growth industries in the Commonwealth of Massachusetts for the 1990s. Throughout the City of Boston and beyond, universities and their scientists are collaborating with hospitals and their physicians for quick transformation of exciting laboratory research into life-saving therapies. This aim is being pursued aggressively by The University Hospital.

With support from its endowment fund, the Evans Memorial Department of Clinical Research and Preventive Medicine has created a new Postdoctoral Fellowship and Research Training Program, through which outstanding young researchers are invited to join the Evans staff by competing for grants in the areas of gene regulation, molecular genetics, immunology, vascular biology, tumor biology, developmental biology, cell physiology and clinical science. Such a program assures that, despite the difficult economic climate, productive biomedical research will continue at a rapid pace at The University Hospital.

Impressive progress is being made in biomolecular research, particularly as it applies to cancer. UH Chief of Biomolecular Medicine John R. Murphy, Ph.D., developed a theory that certain types of cancer cells, and perhaps those of other diseases as well, could be selectively killed without harming healthy cells in the body. This theory is a completely new way of thinking about cancer therapy, since traditional chemotherapy kills healthy cells as well as cancer cells. In the laboratory, two naturally occurring proteins – interleukin-2 and diphtheria toxin – were combined into a third protein, a fusion-toxin drug. The IL-2 portion of this drug is recognized as “friendly” by the cancer cell and is welcomed into its structure, unaware that a deadly toxin is attached to the IL-2. Once inside the cell, the toxin is released to kill the cell. After several years of experimental study against chronic lymphocytic leukemia, adult T-cell leukemia and adult T-cell lymphoma, fusion toxin therapy has produced encouraging results in patients. Other applications of this research are being pursued, at UH and elsewhere, for other diseases as well, such as rheumatoid arthritis and new-onset Type I diabetes. In the near future, this therapy will be tested against malignant melanoma and cancers of the lung, breast, colon and bone marrow, and it may have indications for diseases of the immune system, such as myasthenia gravis, lupus, multiple sclerosis and perhaps even AIDS.
Other dynamic research is under way at UH:

• Colon cancer strikes an estimated 120,000 Americans each year. If caught early, colon cancer can be effectively treated. But if it is not detected soon enough, patients with advanced colon cancer have a grim outlook. A University Hospital surgical resident, Howard Kaufman, M.D., recently discovered that the human vaccinia virus, a naturally occurring virus, stimulates an immune response against colon cancer. This preliminary research, which now is being fast-tracked by the National Cancer Institute, may hold promise for developing a vaccine against colon cancer — the first-ever vaccine against cancer.

• End-stage malignant melanoma typically kills its victims within three to six months after diagnosis. An experimental therapy, called boron-neutron capture therapy (BNCT), is being tested in patients with end-stage malignant melanoma that has spread to the brain. This therapy, which is being investigated by UH dermatologic surgeon Gary S. Rogers, M.D., along with researchers at Massachusetts Institute of Technology and New England Medical Center, may offer hope to patients who formerly had none. In fact, 10 patients who were treated with BNCT in 1985 Japanese trials are still alive today.

• Some cancer patients describe the nausea typically associated with chemotherapy as being worse than the disease itself. Ondansitron, a drug that in many cases can completely eliminate the nausea associated with chemotherapy, was developed and tested by UH medical oncologist Paul J. Hesketh, M.D., and now is a standard part of many chemotherapy patients' care throughout the country.

• Coronary artery disease (CAD) is America's number-one killer. While balloon angioplasty has been the most effective nonsurgical way to treat CAD, restenosis (the renarrowing of coronary arteries) has been a severe limitation of the technique. The reasons why restenosis occurs are now being studied extensively by UH cardiologist David Faxon, M.D., and his colleagues. Once this phenomenon is better understood, heart specialists can then devise new treatments for CAD. One such treatment, coronary atherectomy, this year became available to UH patients as an alternative to balloon angioplasty, and it may prove to be less prone to restenosis for certain patients.

• Impotence, once thought to be a completely psychological condition, was shown several years ago by University Hospital urologists to have a physical cause in 80 to 90 percent of cases. In addition, further research by UH urology chief Robert J. Krane, M.D., urologist Irwin Goldstein, M.D., and their colleagues has identified several new risks factors for impotence, such as smoking and high-fat diets.
Statement of Revenues and Expenses

For fiscal years ended September 28, 1991 (52 weeks) and September 29, 1990 (53 weeks) (in thousands)

<table>
<thead>
<tr>
<th></th>
<th>1990*</th>
<th>1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net revenues from services to patients:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>$ 4,342</td>
<td>5,479</td>
</tr>
<tr>
<td>Research support from grants and contracts</td>
<td>$ 7,787</td>
<td>7,845</td>
</tr>
<tr>
<td><strong>Total Operating Income</strong></td>
<td>$152,618</td>
<td>$167,809</td>
</tr>
<tr>
<td>Operating Expenses</td>
<td>$141,940</td>
<td>156,776</td>
</tr>
<tr>
<td>Research expenses</td>
<td>8,102</td>
<td>8,160</td>
</tr>
<tr>
<td><strong>Total Operating Expenses</strong></td>
<td>$150,042</td>
<td>$164,936</td>
</tr>
<tr>
<td>Excess (deficiency) of operating revenues over expenses</td>
<td>$ 2,576</td>
<td>$ 2,873</td>
</tr>
<tr>
<td>Nonoperating revenue</td>
<td>5,121</td>
<td>8,202</td>
</tr>
<tr>
<td>Extraordinary loss on advance refunding</td>
<td>(7,441)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Excess (deficiency) of revenues over expenses</strong></td>
<td>$ 256</td>
<td>$11,075</td>
</tr>
</tbody>
</table>

*These figures have been restated in accordance with American Institute of Certified Public Accountants Audit Guide for Providers of Health Care Services.

The Hospital’s revenues from services to patients increased approximately $14 million as a result of inflation, case mix and severity of illness.

Even though operating expenses increased nearly $15 million, the excess of operating revenues over expenses increased $0.3 million from the previous year.

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Income from Board Designated Funds 70%
Net Endowment Activity 12%
Income from Funds Held by Trustees 14%
Other 4%

Sources of Non-operating Gains

Interest 5.12%
Depreciation 7.17%
Bad Debt 4.66%
Other Expense 38.73%

Uses of Revenue

Salaries and Wages 44.33%
**Combined Balance Sheet**

For fiscal years ended September 28, 1991 (52 weeks) and September 29, 1990 (53 weeks) (in thousands)

<table>
<thead>
<tr>
<th></th>
<th>1990</th>
<th>1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and other investments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrestricted</td>
<td>$29,801</td>
<td>60,074</td>
</tr>
<tr>
<td>Held by trustees</td>
<td>31,530</td>
<td>19,933</td>
</tr>
<tr>
<td>Restricted</td>
<td>59,165</td>
<td>64,787</td>
</tr>
<tr>
<td>Patient accounts receivable</td>
<td>23,569</td>
<td>28,916</td>
</tr>
<tr>
<td>Grants, pledges and other accounts receivable</td>
<td>8,787</td>
<td>10,870</td>
</tr>
<tr>
<td>Property, plant and equipment – net</td>
<td>119,609</td>
<td>121,419</td>
</tr>
<tr>
<td>Other assets</td>
<td>13,383</td>
<td>11,160</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td>285,844</td>
<td>317,159</td>
</tr>
<tr>
<td>Accounts payable and accrued expenses</td>
<td>19,514</td>
<td>28,542</td>
</tr>
<tr>
<td>Estimated final settlements to third-party payers</td>
<td>24,916</td>
<td>31,834</td>
</tr>
<tr>
<td>Debt</td>
<td>114,511</td>
<td>113,416</td>
</tr>
<tr>
<td>Fund balances:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrestricted</td>
<td>50,596</td>
<td>58,063</td>
</tr>
<tr>
<td>Specific purpose</td>
<td>50,187</td>
<td>56,210</td>
</tr>
<tr>
<td>Endowment</td>
<td>26,120</td>
<td>29,094</td>
</tr>
<tr>
<td><strong>Total liabilities and fund balances</strong></td>
<td>285,844</td>
<td>317,159</td>
</tr>
</tbody>
</table>

The increase in Unrestricted Cash resulted from strong operating results coupled with efficient balance sheet management.

The decrease in Trustee Held Funds was due to the Hospital's drawing funds from the Periodic Auction Reset Pool for capital.

Patient accounts receivable increased due to an increase in rates. However, gross receivable days – the time it takes to collect on a bill – decreased from 77 to 73 days, indicating improved collection of bills.

Accounts payable and accrued expenses increased due to the recording of an extraordinary liability.

Estimated final settlement to third-party payors increased due to preliminary cash settlements received from third parties.
Summary Statistics

For fiscal years ended September 28, 1991 (52 weeks) and September 29, 1990 (53 weeks) (in thousands)

<table>
<thead>
<tr>
<th></th>
<th>1990</th>
<th>1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient days</td>
<td>92,792</td>
<td>89,330</td>
</tr>
<tr>
<td>Admissions</td>
<td>10,782</td>
<td>10,648</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>8.6</td>
<td>8.4</td>
</tr>
</tbody>
</table>

Ambulatory visits

<table>
<thead>
<tr>
<th>Service</th>
<th>1990</th>
<th>1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evans Medical Group</td>
<td>52,138</td>
<td>52,430</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>14,177</td>
<td>15,123</td>
</tr>
<tr>
<td>Adult Psychiatry</td>
<td>4,220</td>
<td>4,224</td>
</tr>
<tr>
<td>Home Medical Service</td>
<td>4,199</td>
<td>3,814</td>
</tr>
<tr>
<td>Gundersen Eye Clinic</td>
<td>3,712</td>
<td>3,818</td>
</tr>
<tr>
<td>Occupational Medicine</td>
<td>3,685</td>
<td>3,912</td>
</tr>
<tr>
<td>Surgical Day Care</td>
<td>3,399</td>
<td>4,224</td>
</tr>
<tr>
<td>Laser Surgery</td>
<td>2,170</td>
<td>1,096</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>1,965</td>
<td>1,991</td>
</tr>
<tr>
<td>All Other UH Clinics</td>
<td>6,045</td>
<td>6,046</td>
</tr>
<tr>
<td><strong>Total ambulatory visits</strong></td>
<td><strong>95,710</strong></td>
<td><strong>96,678</strong></td>
</tr>
</tbody>
</table>

The Hospital’s average length of stay continued its downward trend by decreasing .2 days.

Ambulatory visits continued its upward trend by increasing 968 visits during the year.
**Clinical Leadership**

**MEDICINE**
- Physician-in-chief: Norman G. Levinsky, M.D.
- Associate Physician-in-chief: Jay D. Coffman, M.D.
- Arthritis: Robert F. Meenan, M.D.
- Biomolecular Medicine: John R. Murphy, Ph.D.
- Cardiology: Thomas J. Ryan, M.D.
- Dermatology: Barbara A. Gilchrest, M.D.
- Endocrinology: James C. Melby, M.D.
- Epidemiology/Preventive Medicine: R. Curtis Ellison, M.D.
- Gastroenterology: J. Thomas Lamont, M.D.
- General Internal Medicine: Mark A. Moskowitz, M.D.
- Geriatrics: John F. McCahan, M.D. [acting]
- Hematology: Lewis R. Weintraub, M.D.
- Hypertension: Haralampos Gavras, M.D.
- Immunology Research: David I. Beller, Ph.D.
- Infectious Disease: Richard D. Diamond, M.D.
- Oncology, Medical: Ronald P. McCaffrey, M.D.
- Nuclear Medicine: Rachel Powsner, M.D.
- Nutrition: Robert H. Lerman, M.D., Ph.D.
- Peripheral Vascular Medicine: Jay D. Coffman, M.D.
- Pulmonary Medicine: David M. Center, M.D.
- Renal Medicine: David J. Salant, M.D.

**SURGERY**
- Surgeon-in-chief: Edward L. Spatz, M.D.
- Cardiopulmonary Surgery: Richard J. Shemin, M.D.
- Critical Care: Richard C. Dennis, M.D.
- General Surgery: Edward L. Spatz, M.D.
- Neurosurgery: Edward L. Spatz, M.D.
- Oncology, Surgical: Robert M. Beazley, M.D.
- Oral Surgery: Donald F. Booth, M.D.
- Organ Transplantation: Sang I. Cho, M.D.
- Otolaryngology: Nabil S. Fuleihan, M.D. [acting]
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