THE AFFILIATION AGREEMENTS OF YALE UNIVERSITY
AND NEW HAVEN HOSPITAL

Notes for a Lecture in the History of Medicine and Surgery
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The Medical School was chartered by an act of the State Legislature in 1810 through the efforts of a Joint Committee of the Connecticut Medical Society and Yale College. It opened its doors to 37 students in 1812 in a building which was rented from James Hillhouse, who built it as a hotel. The distinguished faculty of five included 1) Nathan Smith, who left what Oliver Wendell Holmes described as “his settee at Dartmouth”, where he had held all of the chairs, to occupy a single chair in Surgery at Yale, 2) Eneas Munson, 3) Eli Ives, 4) Benjamin Silliman, and 5) Jonathan Knight. Through the efforts primarily of Nathan Smith, the State Legislature made a grant of $20,000 to enable the School to buy the Hillhouse building for $12,500 in 1814.

The founding of the hospital occurred a few years later. New Haven was a town of less than 10,000 people, and it was primarily a seaport with an active trade with the West Indies. A federal law required an assessment on the wages of seamen, and then seamen were entitled to hospitalization when sick or injured. The founders engaged a lobbyist and fund-raiser, a Mr. Swan, to seek federal aid in building a hospital to serve this purpose. His efforts met with no success; and this is the first example I know of the Federal Government refusing to appropriate the money to carry out a federally mandated program, although students of history will no doubt be aware of prior examples.

The five faculty members (with Hubbard replacing Munson, who died), four local practitioners, and one businessman sought and received a charter from the State Legislature as the General Hospital Society of Connecticut to raise money for a state hospital. Each clinical faculty member pledged $100 or 10% of his income each year for five years, making a total pledge of $2,000; and Smith secured a grant from the State Legislature for $5,000. With these resources and some smaller gifts, the Howard Avenue property was purchased; Ithiel Towne designed a
building with 75 beds; and the hospital was built for less than $13,000 including the cost of the land. State Hospital, as it was called until 1884, opened its doors in 1833. It was described as so far beyond the needs of its time that several rooms were rented; one to a Dr. James Gates Percival, a poet, who lived barricaded, Robinson Crusoe-style, until evicted by a committee of the General Hospital Society in 1851.

Here are two of the founders, Nathan Smith and Benjamin Silliman.

The historical account by Francis Bacon, a town surgeon, referred to only four “medical school” founders of the hospital, omitting Silliman on the grounds that he did not have a medical degree. Silliman did have an honorary M.D., and he had studied anatomy and medicine at Philadelphia and Edinburgh. Fisher’s life of Silliman states that he “expected from the first to be ultimately connected with a medical school” at Yale; and he had served on the special committee in 1806 to establish the medical school. Accordingly, I consider it a “cheap shot” for Bacon to dismiss him as a “Yale professor” and not a legitimate member of the medical faculty. This situation presages much more to come, as town-based interests formed a pattern of demeaning the full-time professorial staff, as teachers only, and not practitioners. As you will soon see, a “continuous service” will be the word used to reference a nucleus of full-time staff.

The motives of the Yale founders of the Hospital were characterized as “enlightened self-interest”, on the grounds that access to a hospital would enhance their reputations as teachers and increase their incomes from tuition. This insulting attitude may have been true in part, but it was written by Walter Steiner of Hartford that Nathan Smith’s reputation “was so well established when he came to New Haven that patients flocked to him from all parts of the country; and that he not only treated the best families in Connecticut, but was called to visit professionally almost every town in Connecticut, as well as many places in neighboring states.” It is unlikely, therefore, that Smith, who was the moving force, depended on tuition for his income.
Jonathan Knight eventually succeeded Smith as Professor of Surgery and was associated with the Medical School and hospital for 51 years. Knight was twice President of the AMA, and he was described by his contemporaries as a compassionate and much beloved physician and after Nathan Smith “easily until his death the foremost surgeon in Connecticut”. Welch of Johns Hopkins declared that Knight “probably never had his superior in any medical school in the country as a finished lecturer”.

The data for the graphic above are from his annual report for the General Hospital Society in 1850, and indicate the classes of patients served. The hospital had an operating deficit of approximately 15% of its total budget, and Knight laments in his report that because of insufficient funds many of the sick and destitute had been refused admission. The cost of hospitalization for paying patients was about $4 a week; but most of the operating income came from the Seamen’s Hospital Fund under direction of the Collector of the Port of New Haven. So, it came to me as a surprising insight that during much of its early history the hospital was actually operated as a prepaid health plan, in other words, New Haven’s first HMO.
The hospital was renamed Knight Hospital and taken over by the Federal Government during the Civil War. In 1868 the General Hospital Society resumed use of the hospital; and an appropriation was received from the State for $2,000 for the “ward cases” marking the beginning of a period of direct State support which would continue well into the 20th century. In 1884 an act of the Legislature severed the ties of the hospital to the Connecticut Medical Society, and the hospital was renamed New Haven Hospital. New Haven Hospital also served as a military hospital during the Spanish-American War, at which time Gifford Chapel held 150 beds.

The latter part of the nineteenth century saw the founding of two more institutions which will re-enter our story at a later point. In 1872 the New Haven Dispensary was founded and served as a teaching resource for the Medical School. In 1887 the Grace Hospital was founded by a group of homeopathic physicians. During this entire period the hospital staff served in an entirely voluntary capacity and it was fiercely proud of its tradition of charity care. The same year that Grace Hospital was founded, Bacon wrote in Atwater’s History of New Haven: “The list of
doctors who taught the people of New Haven to regard their profession as one of philanthropy rather than money-making is not a short one.”

With these elements now in place, the main line and pace of our story pick up in the early years of the twentieth century when two ingredients were present at the same time. On the one hand, the hospital had a serious problem with increasing operating deficits which I have graphed from 1880 to 1910, primarily due to increases in the cost of food; and on the other hand, the university could not fill its chairs in Medicine and Surgery and recruit successors for Carmalt and Ely. These ingredients are the stuff of which affiliation agreements are almost always made: an academic imperative joined to a financial necessity.

Hadley
President Hadley had Harvey Cushing up for a visit in 1906, and Cushing wrote back:

Cushing
So far as I could see during my brief visit, the one pressing need of the school is a hospital with a continuous service for those occupying the clinical chairs. Without a hospital in which they have clinical and teaching privileges the year round, clinical professors are as destitute of opportunities for instruction and investigation as a chemist or a physicist without a laboratory. And without such a hospital, a medical school can hardly be expected to develop. Then from a hospital point of view, nothing so certainly as ensures its growth and reputation as such an alliance, for unless it be primarily a teaching institution and issue publications, it can hardly have more than a local reputation. Whether it will be possible to influence the directors of the New Haven Hospital to put its wards to such use, or whether it will be possible to raise funds to build a university hospital remains with you to determine.

The comment by Cushing is the first I have found to raise obvious issue of building of a separate university hospital. There is evidence that New Haven was in need of additional private hospital beds, since a private entrepreneur opened a facility in 1906 known as the Elm City Hospital, which operated until 1918. Hadley apparently decided against that option, and wrote the Board of Directors of the New Haven Hospital that a committee appointed by the Corporation of Yale University was going to consider the condition and plans of the Yale Medical School, and this committee “desires an opportunity of conference with representatives of your honorable body, and request that, if this suggestion meets with your approval, you appoint a Committee for that purpose.” The Board did approve, and it appointed Francis Bacon, Simeon Baldwin, Henry White, Harry Day, and Timothy Bishop to study the matter. The Hospital Committee made its decision early in 1907, and a few days later Dean Herbert Smith wrote the following letter to President Hadley:

**It has not been possible for me to get as yet an exact copy of the resolutions passed by the hospital directors on the evening of February 1st. The votes, however, as to the surgical service provide as follows: 1) the division of the hospital service into continuous and alternating services 2) the appointment of a surgeon to the continuous surgical service on nomination of the Executive Board of the Medical School; it being provided that the nominee shall be a Professor of Surgery in the Medical School; 3) the assignment of one-quarter of the surgical beds to the continuous service.**

The compensation received by the hospital for this agreement was the first of a number of agreements on operating costs.
So Hadley thought that he now had what he needed to recruit Cushing and wrote the following letter to him two days later:

My dear Doctor Cushing: In the first place, they have given to Yale Medical School the right of nomination of a Professor of Medicine and a Professor of Surgery for places in the New Haven Hospital; so that teaching facilities will be given as a matter of statute and not as a matter of favor. Second, they have provided that the professors thus nominated by the Yale Medical School shall have their proportion of the hospital work in the form of continuous service. The Professor of Surgery, instead of having control of all the beds for a quarter of the year, will have control of one quarter of the beds for all the year... May I add one word, to say how much the possibility of your coming means to me personally.

Cushing wrote back to Hadley:

My feeling of loyalty to my college, the promise of a new regime at the New Haven Hospital, the attraction which living in a place like New Haven holds out to both Mrs. Cushing and myself, all these things and more have influenced me in my desire to align myself with the Yale Medical School... As matters stand, I can see that, for some years at least, the incumbent of the chair at Yale... will need give up his entire time to the reorganization of clinical teaching under circumstances which are as yet unfavorable to the task; in an institution not under the control of the school, with far too few public patients at his disposal, and with students as not yet recognized as a necessary part of the hospital organization.

How right Cushing was the circumstances were “as yet unfavorable to the task” will shortly be demonstrated. Nevertheless, Hadley succeeded in the recruitments of Flint in surgery (from Johns Hopkins) and Blumer in medicine.

Flint
The year of Flint’s arrival, he was immediately embroiled in the consequences of a major change in the policy of the hospital. On 30 December 1908, at a special meeting of the Board of Directors, a report was approved from the Prudential Committee. Concerning a new plan, the report stated “we definitely recommend it, because we believe it will in time solve the ever recurring problem of an annual deficit and because we believe there is no other way of solving it.” This departure from the established tradition of the hospital was “to permit the physician or surgeon who sends a patient to a private room in the hospital to charge a reasonable fee for operations upon or attending such patient”. The reason that this was a departure relates to a strong tradition of the hospital that it had always been a charitable institution. The change in hospital policy may be seen as a kind of affiliation with the New Haven Medical Association, which had voted two years previously: “Resolved, that whereas the members of the NHMA as a body feel the need of a private hospital in which they can attend and care for patients with remuneration for their services, that the sense of this meeting be that the Board of Directors of the NHH be consulted with the view of causing a revision of their charter so that such improvement can be made.” The fall back position was voted on 29 May “that a committee of 15 members... to be known as the Committee on Establishment of a New Hospital be appointed by the chair.”

The immediate results were threefold: 1) There was an increase in the utilization of the private beds. 2) Once the fee mechanism was in place, there was a significant increase in demand for hospital privileges. The trustees met at the Graduate Club to hear a special report from the committee appointed to study the “matter of the terms under which physicians not members of the hospital staff may practice in the private rooms”, and then shortly thereafter the quarterly meeting of the Board of Directors voted: “Resolved, that licensed practitioners of medicine shall be allowed the privilege of treating patients in the private wards. 3) Flint became embroiled in turf disputes over the house staff and in the assignment of patients to the continuous service. These disputes were, in essence, over space and time: space with respect to the hospital beds and time with respect to the operating room.’ In 1909 the directors voted “House officers shall be assigned to assist surgeons not in regular service while operating on private room patients”; and in 1910 it was necessary to reiterate as hospital policy that “every fourth case be assigned to the continuous service. Within one more year, this protective mechanism for the professorial service broke down in the following change in hospital policy as voted by the Board of Directors: “Patients sent in by physicians not on the regular staff with the request that they be assigned to a particular service may be so assigned if the case is one properly belonging to such service.”

During the course of these developments, the students were also becoming more assertive of their entitlements. Blumer, who had now become Dean of the Medical School, passed along a copy of the Student Council Report to President Hadley, with the comment that “Some of the statements must, of course, be taken with a grain of salt, but on the whole I consider it a fair and impartial report from the student point of view.”

The evaluation of general and special surgery reads as follows: “This course, which is intended to be an introductory survey of the whole field of general and special surgery, aimed to correlate the work which is taken up in more detail in the various special courses is a complete and miserable failure ... This year, we demand, in the interests of the school, that means be taken to raise this course to at least a mediocre position.” The instructor “lacks all capability in the art of teaching; is deficient in interest and energy and as we can determine, is devoid of knowledge compatible with teaching so broad and important a study.” The author of that Student Council report was a promising fourth year medical student, Samuel Harvey. The teacher in question was not Flint, but a surgeon named Butler.
The architect of a serious plan to increase the influence of the Medical School within the hospital was Dean Blumer. I found in his files a draft of a statement, to whom sent unknown, from which I will quote some salient paragraphs:

The New Haven Hospital is a private corporation unconnected in any way with the University... The medical and surgical services which are thus obtained are entirely inadequate... Were it not for the fact that the University physician and the University surgeon are on good terms with their colleagues in the hospital, the Medical School would be crippled... It is easily seen that the control which the University possesses covers an entirely inadequate amount of teaching material, and that any time changes in the director of the hospital or in the personnel of the physicians and surgeons on the alternating service might upset the whole arrangement and leave us stranded with practically no clinical material. It is evident then that only two courses are open to us. 1) The building and equipment of a University hospital. 2) Gaining absolute control over the present hospital.

In a town of New Haven’s size (that) would result in cut-throat competition which would certainly have a very serious effect on the relationships of the University to the profession in general, and to many public-spirited and influential citizens who are interested in the existing hospitals. … The most desirable plan would be for the authorities of Yale University to enter into a contract with the authorities of New Haven Hospital, whereby the University authorities would have the power of nomination of all the medical attendants of the hospital, and should also probably have the power to exercise some control over the policy of the administration of the hospital.
In terms of how that control could be achieved, Blumer stated:

> In the instances mentioned where a contract has existed between a medical school and the hospital, it has usually been based on the payment to the hospital by the medical school of an annual sum, and inasmuch as the New Haven Hospital, like all general charity hospitals, has an annual deficit, it will be apparent that any proposition which involves the payment of a substantial sum annually by the University would be likely to be received favorably by the directors.

The Flexner report also alarmed both the Medical School and the Hospital, so the Blumer proposal found favor as indicated in the following committee report to the Quarterly Meeting of the Board of Directors of the Hospital on Apr 19, 1912.

> Your committee have (sic) had several meetings. One of these all members of the Medical Board were invited to attend, and several took that opportunity to state their views at length... We have given some study to bulletin no. 4 of the Carnegie Foundation... As a result, your committee have (sic) unanimously voted to recommend and now recommend to the directors that closer relations be established between the Yale Medical School and the New Haven Hospital and that an increase in the continuous service be made, providing a satisfactory financial arrangement can be made between the two institutions.

The Blumer plan was consummated in the agreement of 1913, which was signed by President Hadley for Yale and Eli Whitney for the Hospital. It provided that the staff be closed and that the chiefs of service be the full-time chiefs appointed by the University. The quid pro quo for the hospital was $600,000, which Yale met with the Brady gift. Flint’s status changed in the annual report of the Board of Directors from “Surgeon to the Continuous Service” to “Surgeon-in-Chief” of the hospital. Five weeks later the Board voted a sum not to exceed $175,000 from the general fund “to the purpose of building a new private ward building”.

The matter of a separate operating room in this proposed facility was discussed in a letter from Blumer to Day. Regarding the duplication of facilities, Blumer stated:

> A separate operating room would necessitate a separate staff. However much the surgeons may deny this I feel confident they would not be satisfied unless they had a properly qualified staff in the private operating room. This might mean the employment of a separate operating room nurse and assistants, and also private ward interns... I feel sure that any system which proposes to man the private operating room by drawing on the interns of the public wards would lead to confusion and friction... I think it is quite probable that the separate operating room would encourage incompetent surgeons to bring in patients from the outside to a much greater extent would be the case if they had to use our public operating room. You are fully aware of my feeling regarding allowing such individuals to use the New Haven Hospital.

Other correspondence further illustrates the friction of the times. A local physician named Arnold was a friend of President Hadley, and he passed on rumors to Hadley that there had been a series of operating room horrors. Hadley, as usual, turned to Blumer to investigate; and Blumer reported:

> I think I have succeeded in running down the actual facts in connection with the situation that was discussed by Dr. Arnold and yourself. He had been led to believe that there were three cases which had been in the hospital and in which serious
errors of judgment had led to fatal results. Investigation reveals the fact that two of the cases are purely mythical... I doubt very much that the lawsuit will ever materialize, and I am quite sure that there is no just ground for such a suit because the accident which occurred in this particular case occurs to practically all gynecologists at some time or other.

Blumer also wrote back to Dr. Arnold, whom he addressed summarily as ‘Arnold’, that he had been able to:

track down the truth about the gynecological cases... On investigation, cases 1 and 2 turn out to be complete fabrications... case 3 was probably the basis for all of the stories.’. He went on to point out that the patient did not die but subsequently returned home with only a small sinus in the kidney region. … I thought you would be interested to know the actual facts.

Although the Blumer plan had been incorporated in the agreement 1913, the beleaguered Blumer often despaired of the inadequate level of endowment for both the Medical School and the Hospital. At one point, he wrote President Hadley “After careful consideration, I am convinced that we cannot run a really first class medical school on less than $100,000 a year”, and two years later he wrote the first of his several letters of resignation citing his discouragement that no endowment had been raised.

The kinds of friction that related to the University’s effort to run a University hospital, coupled with a rapidly accelerating deficit, provide the scenario for the next affiliation agreement. The authorities called for an outside review, and a consultant was brought up from Johns Hopkins Hospital, Winfred Smith, who reported:

At present there are, in addition to the Medical School representatives, certain other physicians who have hospital services. These form what is called the alternating staff. ... The presence of this form of service in a teaching hospital makes it practically impossible to operate the full-time system, especially if the situation is complicated, as it is in New Haven, by the allotment of ward beds to the alternating staff, which are badly needed to round out the full-time services; by the conjoint use of the same members of the house staff; by the presence in the hospital of men unsympathetic to the University ideals and methods, which sets a bad example to students working in the hospital and to members of the house staff, and prevents the maintenance of standards of procedure and causes friction.

The present system of operating the hospital by means of a fixed staff composed of full-time teachers and clinicians, part-time teachers and clinicians, and an alternating service composed of men who are not teachers, is bad and absolutely impossible in a good teaching hospital ...There has been a tendency to be swayed too much by fear of the local situation.
This local situation deteriorated the same year, when the University decided to purchase the Elm City Hospital to house the new School of Public Health. A number of doctors were thereby displaced and went to the Grace Hospital, and shortly after 1918 the staff at Grace tripled.

The desperate condition of the Medical School is depicted in a cartoon of the time, in which the Medical School is hopelessly adrift in the setting sun, being abandoned by all. Here it is, under attack by submarines, in the metaphor of the World War: the University, the Hospital, the Community, and even its own faculty, which are incidentally also torpedoeing each other.

The only hope of rescue seemed to lie with the General Education Board, which had been petitioned for a five million dollar grant to put the medical school on a true full-time basis. So, at a special meeting in 1918, Hadley for Yale and Carmalt for the Hospital, executed another agreement. This agreement turned over to the Hospital the sum obtained from the General Education Board, and it provided for the University that the ‘continuous service’ be extended throughout the year, and that the University take over “medical control of the public and semi-private rooms.”

The Hospital also sought from the University additional financing because of its extremely precarious financial position at that time. Henry Gallon of the Union and New Haven Trust Company declared that the hospital was virtually bankrupt, and Secretary Stokes sent word that the Yale Corporation had voted an additional sum not to exceed $400,000 to finance the construction of a private ward building.

Not all matters voted on by the Board of Directors were of such great significance, and I will share this one with you, which I found amusing (minutes, Feb 6, 1919):

**Voted, that all dead bodies are to be sent at once to the morgue.**
It was becoming obvious during this time to the University authorities that operation of the Medical School was going to be a very expensive proposition. Accordingly, serious consideration was given to closing the Medical School. The Murphy report to the Yale Corporation in 1920 swung the balance in favor of continuing the Medical School. The Murphy committee found that the Yale School of Medicine had “a valuable nucleus of men and material and sound traditions, which richly justify the development of an Institution for medical education of the highest type.” Thus, a modern medical school and hospital were envisioned; and the University came forward with funding to build a private pavilion and to reconstruct the east and west wards. In addition, the University planned the Sterling Hall of Medicine. Thus, a period began which has been referred to as the dawn of the golden age of the Medical School. The Sterling Hall of Medicine was completed in 1923, and the private pavilion also opened in 1923 with four operating rooms on the top floor which were “available to any reputable physician practicing in the community”. This was also the beginning of a 25-year period of relative peace, growth, and attainment of distinction as a medical school and teaching hospital.

However, I will tell several brief stories from this period that illustrate certain unsolved problems. First, the school and hospital were both under-financed. Second, the full-time faculty did not prosper. And third, a rift had developed with the community physicians that had not healed. There was also a change in the cast of characters. Angell became the President of the University; the Chairman of the Board at the Hospital was Henry Farnham. Winternitz was Dean, and Willard Rappleye was one of the first hospital administrators of this period. Samuel Harvey succeeded Flint in Surgery, and Blake succeeded Blumer in Medicine.

The first story relates to the difficulty the Medical School had in attracting and retaining chiefs of the highest quality. In 1923 Blake wrote Angell:

My decision as to whether I will remain at Yale or accept the position at the University of Chicago must be based primarily on whether the opportunity for the advancement of medical education appears to be better at one place or the other. The ultimate solution to the hospital situation lies, I believe, in us becoming a University hospital, in fact, if not name... This situation can be met only by greater University support of the hospital.
The President of the University, as always, turned to the Dean to find out what was going on. Winternitz wrote to Angell that the University would have the best chance at retaining Blake if:

...the University planned to make the New Haven Hospital a University hospital and that steps would be taken to carry out this intention and consummate it within a reasonable period of time... Blake has attracted to him a group of men of very superior qualifications who are making themselves felt in the teaching, research, and care of patients... He is undoubtedly an outstanding man and it would handicap the school greatly should he leave... The last few weeks have been very trying... I shall be back here in New Haven about the 20th and in the interim a hundred miles from nowhere in the Maine woods. I hope you are well and enjoying your mountain home.
My next story is about the hospital administrator Willard Rappleye, whom I have come to admire greatly from the insights expressed in his correspondence. He was recruited for the hospital by George Vincent of the Rockefeller Foundation, who wrote the President of the Hospital that Rappleye would be interested in the job provided that the hospital trustees are looking for someone who would have an opportunity to participate actively in the development of a University teaching hospital. He would rather not care to assume the rather conventional and restricted duties which heretofore have been regarded as the functions of a hospital superintendent. A man with these instincts and vision soon found himself in trouble. Arriving on the scene to find the hospital finances in a precarious state he developed two strategies: first, he considered the possibility of expanding the practice of the full-time faculty; and, second, he sought compensation from the university for the increase in expenses of the hospital attributable to serving as a teaching facility. With respect to the full-time faculty, Rappleye wrote President Angell: Dr Harvey, Dr Morse, and others were not doing much surgery ….

and they are beginning to feel that their own technique is likely to suffer, which is a reasonable fear. For example, Dr. Harvey told me today that he personally had done his first gallbladder operation since June. Dr. Deeming did his last nephrectomy almost a year ago… Since there are a great many men in practice who did little or no surgery previous to the war are now doing much of their own work, which probably explains both the shrinkage of the volume and the change in the character of the work referred here… Another factor, which is operative throughout the country, is the dropping off of the migration of patients to medical centers for diagnosis and treatment, due in part to more of the better trained men going to smaller communities, and to the development of better hospital facilities at points away from the large medical centers.

This is the first reference I have seen to the shrinkage of the technology gap between university and community hospitals, which was extensively discussed in the recent article in the New England Journal of Medicine on the academic medical center as a “Stressed American Institution”. (Added in June 2004 by mdt: My goodness! Remember, this lecture was written in 1981).

What Rappleye tried to do for the hospital in terms of its indirect cost recovery was to calculate the costs of operating as a teaching facility, and then he sent Winternitz the bill for these indirect costs. The ensuing dispute between Rappleye and Winternitz found itself on President Angell’s desk for adjudication. Angell bundled up the whole group of documents and sought an outside opinion from Flexner. In 1924 Flexner replied:

My dear Angell: I have examined with such care as I could the papers you left me on the New Haven Hospital... The fact is that a hospital in which teaching is done needs to cost little more than any other kind of hospital, except insofar as it is at the same time it tie also tries to be a good hospital. The general contrast in expense is not really between a teaching and non-teaching hospital, but between a good hospital, a less good hospital, and a poor hospital.

Consequently, Angell backed Winternitz and the University did not increase its financial support of the Hospital. Rappleye felt defeated and departed shortly thereafter. You might be interested to know that he subsequently became Dean of Columbia Physicians and Surgeons at the age of 39 and held that post for 29 years, serving twice as President of the AAMC. Rappleye’s vision was not wasted at Columbia, and today the appellation Columbia Presbyterian is second only to Johns Hopkins in public name recognition for excellence in academic medical centers.
My third story relates to the continuing and increasing deficits of the hospital. In a note to
President Angell to discuss the plight of the hospital, Farnham invited Angel to dinner at the
Hotel Taft “We should be prepared to remain all evening... can I count on your presence?”
Another note urged Angell to testify on behalf of the hospital at legislative hearings in
Hartford about House Bill 725 in 1925, which contained an appropriation for the hospital.
The hospital lost part of its grant, and the university promised another subsidy.

If the hospital did not find favor with the state, it also did not find a friend in the community.
A request for an increase in the appropriation for the dispensary was rebuffed by the Mayor:  “I
do not think the city is in debt to Yale, for we are rendering a number of services to the
University including fire and police protection.” Journal Courier, July 24, 1937.

The years under discussion include the proposal of the Grace merger. In 1927, the Grace
Hospital was bankrupt and its Board of Trustees petitioned for a merger against the unanimous
wishes petitions to the unanimous will of its staff. The New Haven Register reported:

New Haven Hospital deliberately plotted with Yale the extermination of Grace
Hospital for the express purpose of building up a hospital connected with Yale that
would put Yale Medical School in the class A classification of the American College
of Surgeons.

The Bridgeport Herald ran a 2-inch headline: “Sick and dying to be medical... test cases”. It
also hysterically reported that “Doctors say students will train on patients for experimental
purposes if merger goes through.”

As I have been reading through the correspondence of the principal figures as archived in the
Yale historical libraries, I have collected some amusing examples of the sorts of things that grace
the desks of university presidents and hospital administrators. In 1929 President Angell wrote the
hospital CEO Buck:

I am sending this note, not to add to your troubles needlessly, but to call your attention
to an experience of mine last week which, while trifling in nature, is exactly the sort of
thing which makes enemies for the hospital... Inasmuch as nothing is less expensive than
civility over the telephone, and inasmuch as the ordinary citizen receiving such a
message as came to me would have inevitably been offended, I pass it on for your
information.

Buck responded two days later:

I very much regret that an employee of the hospital should take the attitude that was
taken towards you. I did not realize that the person in question was in the habit of
treating the public in this manner, and I shall immediately take steps to see that either
that attitude is changed or the employee replaced.

This is a different attitude on the part of hospital administration than within my memory a
Hospital Administrator (often referred to as that xxxx’d Snokes) achieved immortality by saying:
“It is easier to replace a resident doctor than to hire an elevator operator.”

A memo from a distinguished Professor of Public Health, C.E.A. Winslow, also crossed
Angell’s desk congratulating him on Yale’s assistance to the community in dealing with the vice
situation in and around New Haven. Winslow went on to say that Yale should clean its own house
as well, and that there should be “a more vigorous effort to reduce the level of intoxication in
the Bowl”.

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hospital CEO Buck:

I am sending this note, not to add to your troubles needlessly, but to call your attention
to an experience of mine last week which, while trifling in nature, is exactly the sort of
thing which makes enemies for the hospital... Inasmuch as nothing is less expensive than
civility over the telephone, and inasmuch as the ordinary citizen receiving such a
message as came to me would have inevitably been offended, I pass it on for your
information.

Buck responded two days later:

I very much regret that an employee of the hospital should take the attitude that was
taken towards you. I did not realize that the person in question was in the habit of
treating the public in this manner, and I shall immediately take steps to see that either
that attitude is changed or the employee replaced.

This is a different attitude on the part of hospital administration than within my memory a
Hospital Administrator (often referred to as that xxxx’d Snokes) achieved immortality by saying:
“It is easier to replace a resident doctor than to hire an elevator operator.”

A memo from a distinguished Professor of Public Health, C.E.A. Winslow, also crossed
Angell’s desk congratulating him on Yale’s assistance to the community in dealing with the vice
situation in and around New Haven. Winslow went on to say that Yale should clean its own house
as well, and that there should be “a more vigorous effort to reduce the level of intoxication in
the Bowl”.
Angell replied “My only consolation, and it is rather pitiful, is that other institutions face exactly the same disgusting circumstances.” (The President’s Chrono, September 25, 1935).

As we enter the 1940’s we reach another critical period in University-Hospital relationships. My account will become skeletal at this point, because the correspondence of this period has not yet become part of the public record open for inspection and study in the Archives. Nevertheless, the scenario is easily outlined. First, as in previous affiliations, it was a period of rapid inflation and accelerating operating deficits. Second, there was an urgent need for capitalizing a building program as the facilities were becoming obsolete. Third, the University, as always, but especially with respect to the agreement of 1965, needed to strengthen its position in the hospital to maintain excellence in its programs of teaching and research and to attract outstanding personnel.

I have calculated Yale’s cumulative cash contributions to the operating deficits of the hospital through the 1920’s and early 40’s. I adjusted these figures for inflation to a Consumer Price Index of 250 as of mid-1980, and they show that some $16,000,000 had been provided for the hospital during this period. In addition, the solid line depicts inflation-adjusted figures for capitalization of major building programs like the Fitkin and Tompkins stacks in the early 30’s. (The raw data are from the 1952 MOA between the University and the Hospital.) In the early 40’s the hospital’s operating deficit was mounting at an alarming rate approaching a million dollars a year.

Grace Hospital was in trouble again. Its facilities were obsolete and (because of fire and structural hazards) in danger of imminent condemnation by the city. Blake had succeeded Blumer as Dean, and in 1944 he reported to the President that Samuel Harvey had suggested bringing in the Grace physicians as a mechanism to increase the number of paying patients. Thus, the Grace merger preserved privileges for the Grace staff and the device of two divisions, like the continuous and alternating services, was revived. In addition, the University agreed to cooperate with the hospital in formulating plans for the erection and operation of a pavilion for private and semi-private care and for raising funds for this purpose. Shortly thereafter, the University gave the land for the Memorial Unit. The Memorial Unit was then constructed with funds largely raised in the community. The needs of the University and the Hospital were also apparent in 1965. The Hospital needed to raise money to renovate or replace the Fitkin and Tompkins stacks. It was believed that the University was in a better position to attract support for this project, and the University’s position was (to quote Courtney Bishop):

To serve this purpose as well as its own needs in recruitment of outstanding clinical faculty, it must be able to identify the institution as a Yale hospital. Reduced to the simplest terms, this translated into single chiefs of service who would be Yale appointees and a change in the name of the institution which would include the name Yale and eliminate the word community.
After execution of this agreement in 1965 by Kingman Brewster for Yale and James Gilbert, President of the Hospital, a plan was originated by the firm of Perkins and Will in New York City for development. The model on your left indicates two new floors on the top of the Memorial Unit and a clinical tower bridging Cedar Street to join the Medical School to the Hospital for the faculty. This plan was rejected as too expensive by the University authorities of the time, and that master plan has now been replaced by the present building going up on the former property of the St. John’s Church.

Here is a summary Figure. The Medical School, the New Haven Hospital, and the Grace Hospital were 19th century institution. When Yale and the Hospital merged in 1906, the result was a division of the professorial and alternating services. Under terms of the affiliation agreement of 1918, when the University achieved control of the ward services, the private practice component spun off as an entity which during the 20’s and 30’s began to stand on its own in a separate physical facility. After the Grace merger in 1944, the separation of the University and private practice facilities grew greater because of the construction of the Memorial Unit. Our present difficulties reflect the problem of attempting to merge again into one physical plant. One historical perspective worth noting is that in the past periods of friction have been associated with the periods of growth. The Yale Corporation almost dissolved its Medical School in 1920.
Consider with me for a few minutes the problems of the groups that have been involved in these compromises. First, the Hospital has been underfinanced. It has been an orphan of the city, the state, and the federal government. All parties have wanted to see this unwanted child as Yale’s problem. The Hospital’s goal has been fiscal solvency. Second, the University has been called upon to support a city hospital, which it has done to the tune of many millions of dollars. In the context of the competing priorities of the University, the resources that the University could invest have had limits, so the goal of the University has also been to see the hospital stand on its own feet. Third, from the point of view of the Medical School, whatever the Hospital has been, it has been necessary for the Medical School to identify it as a Yale institution in order to raise funds for it and particularly in order to attract and to retain faculty of national reputation. Fourth, the community physicians have been embedded in the cross-purposes of these large corporate forces.

Under these daunting circumstances, it is no less than astonishing that all parties have done as well as they have. Consider that the Hospital has succeeded in achieving a state of relative fiscal stability. This is a transition that some charitable hospitals have never been able to achieve, even with generous state support. The University has been relieved of its direct subsidy to the hospital, and at the same time, the Hospital is designated a Yale hospital with single chiefs. And finally, private practice has gone on uninterrupted in this hospital for 75 years, and it will continue to do so. What has been achieved for all of us is that we are privileged to work in a medical center of international distinction. During this present era of resumed town/gown conflict, my earnest hope for this lecture is that it will help to lift the level of debate from ad-hominem and impassioned argumentation to a rational consideration of the principles that apply.

The inevitable conflicts between the interests of a medical school and those of the local physicians will always arouse dissatisfaction in our professional relations. It is hoped that no matter how vexatious these problems may be, that they can be worked out in good temper and fairness on the basis of relations of cordiality and esteem.

That quotation was from Dean Bayne Jones to President Angell in 1937.