

Annual REPORT

727944

SEPTEMBER, 1973



These people represent the hospital team necessary to plan and provide the quality care of referred patients at Oak Ridge Hospital.

Photographs by Patrick Gordon

Hospital plans to meet 'unplanned' needs

Joe L., age 48, was planning a month-long vacation with his wife and two daughters when he was seized with chest pains that signaled a heart attack that was to hospitalize him for the next month.

Mary M., 37, was planning to take a parttime job this fall — now that both her children have reached school age — when an examination by her doctor revealed that she needed immediate surgery.

Nine-year-old Billy had hoped to play little league football this year — until he fell and fractured his arm.

Obviously, none of these three people included illness or injury in their plans — and neither do you. No one does.

And here at the hospital, we hope your plans are NEVER interrupted by sickness or the need for hospital care.

But we're also realistic enough to know that there's a chance that you, or someone in your family, will need our service. So we plan for you.

We plan — in hundreds of ways — for your health care needs. Probably few people outside the hospital realize the extent and scope of the planning

necessary to maintain high quality patient care — the only kind of care we feel our patients deserve.

Some of our plans are made on a day-to-day basis, like staffing — making sure that the right number of qualified people are on hand, 24-hours-per-day, to care for you and your particular needs, just in case those needs arise.

Or like planning attractive, nutritious meals and individualized special diets, according to the doctor's orders.

Our housekeeping is done with a definite daily plan in mind, one that meets the high standards of hospital cleanliness that we set for ourselves.

Some things require planning twice a week, like purchasing food and other supplies we use that depend on the daily number of patients in the hospital.

These are just a few examples of the planning we do to insure that your daily needs are met while you are a patient in the hospital.

And plans are always in the making — some immediate and some long-range — to improve and expand our services, based on the forecasted needs of the

community we serve and, to a degree, what you expect of us.

For example, a hospital must take into consideration the age distribution of the people it serves, a factor that helps to determine the amount and type of health care services that must be offered.

As we determine the amount and type of health care the community needs, or doesn't need, we must plan for new doctors, new equipment and new services and that often means new and enlarged quarters.

And as medical technology continues to advance rapidly and new ways are found to combat disease and illness, we must also plan to replace old, outdated equipment — and that means planning our money wisely.

One example of the result of planning based on the needs of the community served by Oak Ridge Hospital is the new round-the-clock physician-staffed Emergency Department which began operation this month.

The new emergency service, in turn, calls for larger quarters, more equipment and a larger emergency nursing and clerical staff.

Expansion in this area is all part of the hospital's super expansion plan to coordinate the services of the emergency department, the surgical wing, the intensive care and coronary care units, and those of the clinical laboratory and X-ray departments.

This idea of clustering acute care patients — locating them in one wing of the hospital, rather than in several areas of the building as they are now — is one the hospital medical staff and administration have come to believe is the best approach to taking care of patients, based on today's technology and tomorrow's needs.

Plans for the new addition also include installing new elevators, plus increasing elevator service for the building as it now exists.

The hospital also recognizes the need to expand the dietary department, and 10,000 square feet of space are already "shelved in" for this purpose.

These are some of our "intermediate" plans for your health care, plans that are expected to be carried out within the next two years or so.

As one of our immediate plans

improved services, the hospital is in the process of putting the finishing touches on the new "angiographic suite" just installed in the X-ray department. (A detailed explanation of the new service appears elsewhere in this issue.)

And by Jan. 1, work will begin on redecorating patient rooms.

When this new project is finished, patients can expect to find their rooms furnished with new chairs, overbed tables, bedside tables and "headwalls," a console-type affair that contains electrical outlets, oxygen and suction equipment, nurse call and other emergency facilities located at the head of each patient's bed.

Along with the "new look" in furnishings, the rooms will have heating and cooling improvements, new and better lighting, wall-mounted television, new draperies and, in some areas, carpeting.

All these plans, once they are completed, will have results that you, the public, can easily see and touch.

Not so tangible — but equally important to your health care needs — are the plans your

implements which provide for a staff with the best possible qualifications to care for you.

We do this by means of a continuing doctor-recruitment program and by supporting a constantly expanding, continuing education program within the hospital for all hospital personnel.

Planning the successful operation of a hospital can be likened to planning and operating a city.

As a city is established to provide services to meet the needs of the citizens, so a hospital is organized and planned to serve the public.

As a city adds certain services and discards others, so your hospital plans new services and re-plans old ones to meet the health care needs of the some 80,000 people we serve.

Every decision, every new program, every new appointment and new purchase made by your hospital is based on those needs and the impact our actions will have on the community.

It's all part of our plan for your

(Coven) Priv. Info

BOX No. B-6 of 17 Dec. 2714-14

FOLDER B-117-7 #84-30

REPOSITORY OAK RIDGE OPS RECORDS HOLDING AREA

COLLECTION Dec 1944-94

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Management team reports on hospital happenings, plans

By K. W. SOMMERFELD
The primary objective of any hospital is to provide quality patient care.

To do this in a successful manner, hospitals use a team approach — and, essentially, the key element involved in this approach includes modern facilities, dedicated hospital personnel and employes, an active administration and board of trustees and a highly qualified, adequate complement of physicians.

All of these elements must then effectively work together in a cooperative manner if any hospital is to truly achieve a high quality of patient care. The extent to which any of these elements can disrupt — or even terminate — the successful operation of a hospital was

recently illustrated in Jellico, Tenn. where a new, modern facility was available and administration was present, employes were on the payroll, but no physicians were available to admit patients or prescribe the proper treatment.

The availability of doctors is a constant source of discussion in the Oak Ridge community — and comes home to most of us when we attempt to get an appointment with a local physician, for possibly a routine matter or when we need emergency room service or treatment.

The Oak Ridge Hospital has underway an extremely active recruitment program directed at providing the necessary specialties (in appropriate numbers) to totally serve the

patients who utilize our hospital. Experience, however, has shown such a recruitment program does not always bear immediate fruit — and often a single recruitment effort stretches over two or three years before a new doctor officially appears on the scene.

The competition for physicians is very keen, and their decision to locate in Oak Ridge is affected by many factors. The community itself — its attitudes and appearance — have significant impact on the final decision of the doctor to locate here.

Presently, the Oak Ridge Hospital has 98 doctors on its staff. Of these, 51 are members of the active staff, with the remaining 47 making up the courtesy and consulting staffs,

and representing 17 different specialties.

A primary objective of our hospital is to continue to recruit, acquire and maintain the highest possible caliber of physicians to serve our community. And, in the past few months, we have seen some very encouraging results of our recruitment program.

In the past six months, seven new physicians have been added to our active staff — and two more are seriously contemplating locating in Oak Ridge to begin their practice. Included in the recruitment plan were doctors dedicated to emergency room service. This new service, which officially opened September 1, is planned to provide 24-hour-per-day, seven-day-a-week coverage of the emergency room.

And these recruitment efforts, although extremely successful at this point, must not be relaxed if we are to continue to maintain an adequate medical staff. Our doctors themselves play a key role in these efforts, since they represent the most accurate picture of our medical needs as seen by a visiting physician. Also, a tremendous amount of time is spent by the members and wives of the hospital administration in an all-out effort to encourage new doctors to locate in Oak Ridge.

I would like to emphasize, however, that recruiting new doctors is not strictly a "sales pitch."

Physicians who ultimately decide to locate here and apply for the privilege to practice in Oak Ridge Hospital must have their qualifications — licenses and other pertinent data — totally reviewed and approved by the members of our medical board, hospital administration and board of trustees.

And this critical review and approval system is intentionally designed to assure the community that the quality of medical services available are the highest possible.

All those associated with our hospital have pledged themselves to continued efforts in doctor recruitment and we firmly believe that the recent success we have enjoyed in this area can be maintained and furthered, with the result that Oak Ridge Hospital will be in an even better position to offer quality patient care through a full complement of highly qualified physicians.

Failure to achieve this goal will have a significant effect on any individual who might need the services of the hospital.

As chairman of your board of trustees, this past year has been a rewarding one — not only because of the present achievements and plans for the future which we feel will better serve community health care, but because once again I have



KENNETH SOMMERFELD,
Board Chairman

had the opportunity of working with a fine, dedicated group of people.

For their tremendous help and cooperation, my sincere thanks to the other members of the board, the hospital administrators, the medical staff, our volunteers who contribute so much to patient well being, and to those very important members of the hospital team, the more than 500 people who, as hospital personnel, offer their skills in carrying out our plan for the best possible health care for the patients we serve.

President pledges best efforts

By MARSHALL WHISNANT

Comments or letters from patients saying, "I'll never come to Oak Ridge Hospital again," come to us on extremely rare occasions.

Information like this is at once discouraging and challenging. We regret that anything at all may have displeased a patient. We know we cannot please everybody, but this is no justification not to strive to please everybody. We recognize that as the only general hospital serving this immediate area, we have an extra obligation.

Like our other objectives, we will never completely please everybody at all times, but never let it be said we weren't trying to please.

There are times when things beyond our control prohibit us from pleasing everyone — failure of suppliers, equipment, illness of personnel, and other complications do on rare occasions inconvenience a patient.

Since we are in the people business and frequently both patients and personnel are under physical and mental stress, we attempt at all times to select personnel who can best deal with these stressful situations.

In addition to this careful selection process, we support hospital personnel and thereby our patients, through training programs, superior department managers, and attempt to instill in all personnel a sense of pride in Oak Ridge Hospital.

We believe that most of the

times we are successful in this but, since we, like our patients, are human too, we do goof from time to time. When we do this, when we goof, we are sorry and we do our level best to not make that mistake again.

Dissatisfied patients take small comfort in knowing that by all the statistical comparisons, the Oak Ridge Hospital ranks favorably with any other hospitals about which we know. Because an individual patient judges us only on his experience with us and not with the experience of the other 10,000 patients who are admitted to the hospital or the other 20,000 patients who come through our emergency facilities, he can only judge us on his personal experience.

The fact that all of the rest of the people may have been treated perfectly and perhaps treated better than they could have been anywhere else will be of small comfort to the one patient who is dissatisfied with Oak Ridge Hospital or its services.

We have to use the statistics to help us identify problem areas, but we also know that the individual patient is little interested in statistics. He is only interested in his own care, as he very well should be. So, we are truly sorry when a patient is inconvenienced or is not pleased with our service in any way, and we agree that if our service is unacceptable to them, it is most certainly unacceptable to us who work here at the hospital.

We feed back both positive and negative comments which we receive to all those personnel involved in order that we may all be aware of how patients see us. We only hope that those patients who are displeased with us and our service will give us another chance. Given that chance, we will try to do our very best to provide the finest service which will be not only acceptable but pleasing to our patients. We are proud of our service and we are proud of our record and we want to continue to serve those who seek our care.

There are times when a patient is displeased about one of our policies. The policy may need explaining to that patient or it may be the best policy for the most people for the longest period of time. Other times the policy may need to be reviewed and improved. We are always ready to do that.

We appreciate all of the comments which we receive. The compliments are far more frequent than the occasional complaint but each is appreciated and has our attention.

Again this year we are soliciting comments on the back page of this report. Additionally, we provide a comment slip in our patient handbooks. Armed with this type information from patients we can try to correct the bad and reinforce the good at Oak Ridge Hospital.

Chief of Staff reviews year

By DR. EARL LEVERSOLE

At the beginning of the last fiscal year, it was apparent to both the medical staff and to the board of trustees that high priorities should be given to two areas of great concern.

First, it was obvious to all that the physical structure of the Oak Ridge Hospital was no longer adequate to meet the needs for which it was designed. Severe space deficiencies existed in the emergency room, X-ray department, the intensive care unit and the operating and recovery rooms, as well as in other areas of the hospital.

To proceed to correct these deficiencies in an orderly manner, an independent consulting firm was employed to assist in the development of a long range plan for the expansion of the hospital.

The survey was completed, recommendations made, and a good, basic plan developed. As a next step, financial feasibility studies are now underway and priorities will be set on these much-needed alterations.

The second area of concern was the staffing of the emergency room by fulltime physicians.

A committee consisting of Dr. John Crews, Dr. David Stanley, Ralph Lillard, hospital vice president, and John McGinnis, hospital controller, was appointed to study this problem. This group met regularly, interviewed many people and carefully studied several alternatives.

Recently, they reached a successful conclusion to their

agreement with a group of doctors that will staff the emergency room on a fulltime basis. The first member of the group, Dr. Herschell King, began the new service September 1.

Surveys by the Joint Commission of Accreditation of Hospitals are usually exciting — and this year was no exception.

We were critically surveyed by this highly qualified team in 1971, did a "self assessment" in 1972 and were surveyed again in 1972. We received our accreditation and the surveyors were very complimentary of our operation.

Several new physicians have been welcomed to our staff recently. They are: Dr. Victor McLaughlin, internist; Dr. Larry Dry, surgeon; Dr. Sam Massey, ear, nose and throat specialist; Dr. Richard Brantley, urologist; and, the most recent addition to our staff, Dr. James Hilton, the radiologist who joined us September 1.

We continue to try — and hope the community will join us in our efforts — to recruit physicians in the obstetrics-gynecology and family practice fields.

On June 30th of this year, I completed my two-year term as chief of staff. I am succeeded by Dr. Dan Thomas who will be ably assisted by Dr. Charles Gurney as vice chief of staff.

With their strong leadership and the support of the community, we can look forward to a continuing program of high quality patient care in our hospital.

I appreciate very much the support and assistance of our

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MARSHALL WHISNANT



RALPH LILLARD



ELIZABETH GINNIS





DR. LAURENCE DRY



DR. VICTOR MCLAUGHLIN



DR. SAMUEL MASSEY

Follow-up care offered

One of the most innovative hospital services offered by the hospital is the newly-created

position of liaison nurse — one established in only a very few hospitals in the United States.

'Mr. Ed' RN ORH first

Although, as much as we'd like to, we are rarely able to write up the arrival of new employees (due to limited space), a new member of our staff certainly deserves mention as an ORHMC "first."

Not only is Ed Fout, RN, a "first" for this hospital, he's one of a comparatively small handful of men in the nursing field — and particularly of those trained in a special field.

"Mr. Ed," as he's been dubbed by his fellow workers, began his duties as an ICU nurse (on the evening and midnight shifts) January 8, and came to us from Wisconsin where he was employed in a psychiatric hospital.

He received his training at Alexian Brothers Hospital in Chicago and his specialized ICU training while serving in the Navy.

Mrs. Fout is a dietitian and has recently joined our hospital staff.

And, since nursing schools are now, finally, accepting male students (a practice the majority only began about five years ago!), we look forward to welcoming other "Mr. RN's" to the staff.

Katherine Beasley, formerly head nurse for the obstetrical and gynecological service at St. Mary's Hospital in Knoxville, was appointed in February, 1971, to fill the new post, to serve as a link between local doctors, health care agencies in the area and patients for the provision of various patient needs following hospitalization.

A pilot project, the community service was first made possible by a \$17,310 grant from the Tennessee Mid-South Regional Medical Program. Now, however, the hospital has taken over and entirely supports the service.

As coordinator of the program, Mrs. Beasley works closely with members of the hospital nursing and medical staff to identify patients who need follow-up services from such agencies as the Public Health Department, Mental Health Center, Daniel Arthur Rehabilitation Center, Tennessee Department of Vocational Rehabilitation and Medicare and Medicaid Programs.

The use of a liaison nurse has already begun to solve what hospital officials say is a critical health problem — how patients can obtain the most appropriate follow-up care for the least amount of money.

And Miss Betty Cantwell, hospital vice president in charge of patient care services, emphasizes that the services of the liaison nurse are not limited to patients who may be unable to pay for extended health care, but is a program designed to acquaint all patients with the



KATHERINE BEASLEY

health benefits and services available to them.

Although Mrs. Beasley does not personally perform any home nursing care, she says she does make occasional visits to the homes of patients receiving continued health care "just to make sure that all their needs are being met — even those not necessarily related to their illness."

A native of Tazewell, Va., Mrs. Beasley is the wife of George R. Beasley, an operational engineer employed at the Y-12 Plant, and the mother of their young son, Reed.

Still "very excited" about her job after two and a half years, she says she strongly agrees with Miss Cantwell that "the future of health care is leading up to satellite health care stations as a means of offering auxiliary care to patients."



DR. RICHARD BRANTLEY



DR. JAMES HILTON



DR. HERSCHELL KING

New doctors here, still more needed

With seven new physicians beginning practice in Oak Ridge within the past three months, doctor-recruitment at Oak Ridge Hospital can only be termed a super success story.

We're proud of that success — but even more proud of the caliber of physicians the hospital and the community have attracted.

The hospital is extremely pleased to include in this Annual Report the announcement of the addition to the medical staff of Dr. Laurence Dry, surgeon; Dr. Samuel Massey, otorhinolaryngologist (ear, nose and throat specialist); Dr. Richard Brantley, urologist; Dr. Victor McLaughlin, cardiologist; Dr. James Hilton, radiologist; and Dr. Herschell King and Dr. Roger Van Arsdell, specialists in emergency medical care.

These seven new doctors, along with the seven others who have joined the active staff in the past three years, represent a commitment on the part of the hospital to help recruit a highly qualified, diversified team of physicians dedicated to serving your health needs.

But we also promise not to "rest on our laurels," but to continue to recruit, obtain and keep a medical staff that will maintain the highest possible level of well-rounded medical care.

How is doctor recruiting done? By various methods, say hospital officials. These include:

writing to medical schools, answering ads placed in medical journals by doctors who wish to relocate, through a medical placement bureau, and by obtaining the names of possible candidates from local doctors (or other members of the hospital staff) and from interested citizens in the community.

And though the more formal methods are also successful, the hospital never underestimates the power of the layman in spreading the word of the need for more doctors.

And none of the recruitment methods are guaranteed to bear immediate fruit. Often efforts to secure the services of a particular doctor are begun two or more years before his actual arrival in Oak Ridge.

And it should be pointed out that not just any doctor will do. Applicants are carefully screened and their qualifications reviewed by the medical staff and recommendations made to the board of trustees before acceptance.

Although the need for additional doctors for local practice is not nearly so acute as it was a few years ago, hospital staff members say that doctors who have specialized in the fields of family practice and obstetrics are still urgently needed.

And recruitment of the doctors should be an area-wide effort, they say.



DR. ROGER VAN ARSDELL



ED FOUT, RN

Care, planning saves \$

Did you know?—

Your hospital housekeeping staff cleans and maintains 182,600 feet of hospital property daily!

That the clean linens these people furnish for the hospital (and Westmall) amounts to 2,200 pounds (that's more than a ton!) every day?

That the housekeeping team also includes (as of January) a "groundskeeper," who cleans up the property around the hospital, Westmall, Medical Arts and Westmall Park?

And that housekeeping employees also "manufacture" certain linen items used in special service departments — such as special sheets, surgical "drapes" in several sizes, croup tent covers for pedes, etc.?

And this work is all done by a staff which includes 30 full-time employees and 6 occasional workers, including the grounds-keeper.

In the meantime, Nelle Harris, our executive housekeeper, stays busy purchasing new and needed housekeeping supplies as the result of keeping a perpetual inventory of those items so basic to hospital operation.

Although these supplies cost an average \$15,000 per year, they would cost considerably more if the housekeeping staff had not entered wholeheartedly into the hospital's cost-saving, sharing plan and decreased costs by some 30 percent — plus saving a minimum of 15 percent on overall operative costs.

Patient care and concern praised by Mayor Bissell

By MAYOR A. K. BISSELL

Successful operation of any industry or business — like the operation of a city can only be accomplished by careful management and planning.

And Oak Ridge Hospital is a fine example of this type of operation — one that combines the knowledge and skills of a qualified staff, plus modern facilities, with a very real concern and care for the more than 60,000 people it serves.

In spite of stringent federal controls imposed on the health care industry, constantly escalating costs and the many other problems that beset any business that serves the public — including some criticism from the public itself — the hospital has continued to commit itself to offering the best possible health care to the people in this area.

As part of the plan to carry out this commitment, the hospital has been overwhelmingly successful in its doctor-recruitment program — bringing seven new physicians to Oak Ridge in just the past few months.

The fact that the hospital has continued to make every effort to provide the very latest equipment and modern facilities for the care and treatment of the ill is further evidence of this type of commitment.

We take great pleasure in

welcoming our new doctors, and their families, not only because of the medical skills and service they offer the entire community, but as new residents of our city.

The hospital and its entire staff is to be congratulated for another successful year of operation that has so capably met the health needs of the city and the surrounding area.

I know the citizens of Oak Ridge join me in extending best wishes and in pledging our continued support.



BISSELL

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Teamwork, many jobs contribute to patient care



Dr. Victor McLaughlin, cardiologist and new member of the medical staff, demonstrates the hospital's new \$6000 graded exercise testing (GXT) treadmill, using Ben Seitz, lab technician, as his "patient."



Mrs. Gladys Powell of Clinton jokes with two members of the nursing staff on 2-N, Verna Kennedy, left, nursing technician, and Sue White, RN, clinical manager of the floor.

Charles Latimer, business office manager, seems pleased with the work done by his staff.



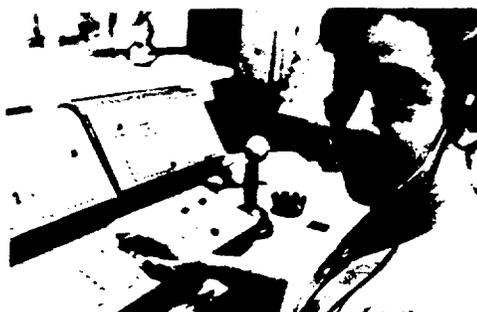
This is the information gathering center where patient diets are planned and Eula Barnett, left, and June Rhea are the two smiling dietary department supervisors.



Clara Jean Young, LPN, performs one of the many personal services offered by the nursing staff as she gives a quick "beauty shop treatment" to Virginia Moles, a patient in the Intensive Care Unit.



"It's just gotta be a boy!" insists Shirl Nance of Dossett as he tries to relax in the father's waiting room while he awaits the birth of his second child. (P. S. It was.)



Alice Tilley finds operating the hospital's new switchboard not only a much more efficient means of communication, but



Two long-time hospital employees, George Washington, nursing technician, and Rosemary Nichols, member of the

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COOPERS & LYBRAND
CERTIFIED PUBLIC ACCOUNTANTS

The Board of Trustees
Oak Ridge Hospital of the
United Methodist Church

We have examined the balance sheet of Oak Ridge Hospital of the United Methodist Church as of June 30, 1973 and the related statements of revenues and expenses, changes in fund balances and changes in financial position for the year then ended. Our examination was made in accordance with generally accepted auditing standards and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances. We previously examined and reported upon the financial statements of the Hospital for the year ended June 30, 1972.

In our opinion, the above-mentioned financial statements present fairly the financial position of Oak Ridge Hospital of the United Methodist Church as of June 30, 1973 and 1972, and the results of its operations and changes in its financial position for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Our examination was made primarily for the purpose of rendering an opinion on the balance sheet and related statements of revenues and expenses, changes in fund balances and changes in financial position of the Hospital, taken as a whole. The statements of revenues and expenses relating to the Medical Arts Building and Westmall included in this report, although not considered necessary for a fair presentation of financial position and results of operations of the Hospital, are presented primarily for supplemental analysis purposes. This additional information has been subjected to the audit procedures applied on the examination of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

Coopers & Lybrand

Atlanta, Georgia
August 3, 1973

OAK RIDGE HOSPITAL OF
THE UNITED METHODIST CHURCH
BALANCE SHEET
June 30,

| | June 30, | |
|--|--------------------|--------------------|
| | 1973 | 1972 |
| ASSETS | | |
| Current: | | |
| Cash | \$ 4,449 | \$ 4,523 |
| Accounts receivable from patients and third parties, net of estimated uncollectibles and allowances of \$250,000 and \$280,000 for 1973 and 1972, respectively | 750,556 | 1,052,620 |
| Inventories, at the lower of first-in, first-out cost or market | 41,764 | 44,175 |
| Prepaid expenses | 42,067 | 30,814 |
| Total current assets | <u>828,836</u> | <u>1,132,132</u> |
| Board-designated funds - cash and certificates of deposit | 1,247,456 | 609,721 |
| Property, plant and equipment (Notes 1 and 2) | 5,461,593 | 5,416,477 |
| Less accumulated depreciation | 2,134,175 | 1,940,421 |
| | <u>3,327,418</u> | <u>3,476,056</u> |
| | <u>\$5,313,710</u> | <u>\$5,217,909</u> |
| LIABILITIES | | |
| Endowment and specific purpose funds - cash | | \$ 15,233 |

The accompanying notes are an integral part of the financial statements.

OAK RIDGE HOSPITAL OF THE UNITED METHODIST CHURCH
STATEMENT OF REVENUES AND EXPENSES - MEDICAL ARTS BUILDING
for the years ended June 30, 1973 and 1972

| | 1973 | 1972 (Note 4) |
|---|-----------------|------------------|
| Rental income | \$74,466 | \$67,557 |
| Operating expenses: | | |
| Salaries | 24,578 | 22,628 |
| Utilities | 10,531 | 11,997 |
| Maintenance and repairs | 750 | 7,767 |
| Real estate taxes | 7,759 | 9,089 |
| Interest expense | 16,561 | 18,776 |
| Administrative services | 10,844 | 4,390 |
| Depreciation (Note 1) | 20,881 | 19,875 |
| Total operating expenses | <u>91,904</u> | <u>92,522</u> |
| Excess of expenses over revenues | <u>\$17,438</u> | <u>\$24,965</u> |

The Notes to Financial Statements are an integral part of this statement.

OAK RIDGE HOSPITAL OF THE UNITED METHODIST CHURCH
STATEMENT OF REVENUES AND EXPENSES - WESTMALL
for the years ended June 30, 1973 and 1972

| | 1973 | 1972 |
|---|------------------|------------------|
| Patient service revenue | \$304,661 | \$284,637 |
| Allowances | 5,972 | 7,327 |
| Net patient service revenues | 298,689 | 277,260 |
| Other operating revenues | 10,044 | 6,690 |
| Total operating revenues | <u>308,733</u> | <u>283,950</u> |
| Operating expenses: | | |
| Salaries | 186,287 | 190,508 |
| Food and supplies | 84,107 | 87,210 |
| Laundry | 11,374 | 8,719 |
| Telephone and utilities | 8,512 | 10,160 |
| Maintenance and repairs | 1,888 | 3,173 |
| Administrative services | 33,006 | 27,708 |
| Depreciation (Note 1) | 11,183 | 10,825 |
| Total operating expenses | <u>336,357</u> | <u>338,303</u> |
| Excess of expenses over revenues | <u>\$ 27,624</u> | <u>\$ 54,353</u> |

The Notes to Financial Statements are an integral part of this statement.

OAK RIDGE HOSPITAL OF THE UNITED METHODIST CHURCH
STATEMENT OF CHANGES IN FINANCIAL POSITION
for the years ended June 30, 1973 and 1972

| | 1973 | 1972 |
|---|---------------------|-------------------|
| Funds provided: | | |
| Income from operations | \$ 63,449 | \$ 68,606 |
| Items included in operations not requiring working capital - Depreciation | 213,501 | 213,456 |
| Total from operations | 276,950 | 282,062 |
| Nonoperating revenue | 68,308 | 32,004 |
| Total from operations and non-operating revenue | 345,258 | 314,066 |
| Property, plant and equipment additions financed by restricted funds | | 11,873 |
| Decrease in working capital | 313,665 | |
| | <u>\$ 658,923</u> | <u>\$ 325,939</u> |
| Funds applied: | | |
| Additions to property, plant and equipment | \$ 64,863 | \$ 125,536 |
| Reduction of long-term debt | 56,325 | 50,942 |
| Increase in Board-designated funds | 537,735 | 139,379 |
| Increase in working capital | 10,182 | |
| | <u>\$ 658,923</u> | <u>\$ 325,939</u> |
| Increase (decrease) in components of working capital: | | |
| Current assets: | | |
| Cash | \$ (74) | \$ (119,302) |
| Accounts receivable | (302,064) | 75,773 |
| Inventories | (2,411) | 3,569 |
| Prepaid expenses | 11,253 | 10,529 |
| | <u>(293,296)</u> | <u>(29,531)</u> |
| Current liabilities: | | |
| Current portion of long-term debt | 860 | 5,000 |
| Accounts payable | (38,755) | 20,274 |
| Accrued payroll | (1,303) | (64,293) |
| Payable to third party payors | 58,611 | 1,700 |
| Accrued expenses | 956 | (2,294) |
| | <u>20,369</u> | <u>(39,613)</u> |
| Increase (decrease) in working capital | <u>\$ (313,665)</u> | <u>\$ 10,182</u> |

The accompanying notes are an integral part of the financial statements.

1227791

3 hospital

methodist church

THE UNITED METHODIST CHURCH
 STATEMENT
 1973 and 1972

LIABILITIES AND FUND BALANCES

| | June 30, | |
|---|--------------------|--------------------|
| | 1973 | 1972 |
| Current: | | |
| Current portion long-term debt (Note 2) | \$ 52,000 | \$ 51,140 |
| Accounts payable | 16,974 | 55,729 |
| Accrued payroll | 48,454 | 49,757 |
| Payable to third party payors | 109,011 | 50,400 |
| Accrued expenses | 39,433 | 38,477 |
| Total current liabilities | 265,872 | 245,503 |
| Long-term debt, less current portion above (Note 2) | 582,500 | 638,825 |
| Fund balances: | | |
| Unallocated | 572,964 | 886,629 |
| Board-designated plant and equipment replacement fund | 1,147,456 | 609,721 |
| Property, plant and equipment, less long-term debt | 2,744,918 | 2,837,231 |
| | <u>4,465,338</u> | <u>4,333,581</u> |
| | \$5,313,710 | \$5,217,909 |

ENDOWMENT AND SPECIFIC PURPOSE FUNDS

| | | |
|---------------------------------------|----------|------------------|
| Endowment and specific purpose funds: | | |
| Due to unrestricted funds | \$ 5,055 | |
| Fund balance | | 10,178 |
| | | <u>\$ 15,233</u> |

OAK RIDGE HOSPITAL OF THE UNITED METHODIST CHURCH
 STATEMENT OF REVENUES AND EXPENSES
 for the years ended June 30, 1973 and 1972

| | 1973 | 1972 |
|--|-------------------|-------------------|
| | | (Note 4) |
| Patient service revenue | 55,336,712 | 55,143,076 |
| Allowances and uncollectible accounts | 548,764 | 547,967 |
| Net patient service revenue | 4,787,948 | 4,595,109 |
| Other operating revenues | 564,108 | 503,010 |
| Total operating revenue | 5,352,056 | 5,098,119 |
| Operating expenses: | | |
| Nursing services | 1,606,341 | 1,600,097 |
| Other professional services | 977,939 | 947,182 |
| General services | 874,454 | 804,422 |
| Westfall and Medical Arts Building | 396,197 | 400,125 |
| Administrative services | 1,220,175 | 1,064,231 |
| Provision for depreciation (Note 1) | 213,501 | 213,456 |
| Total operating expenses | 5,288,607 | 5,029,513 |
| Income from operations | 63,449 | 68,606 |
| Nonoperating revenue - primarily interest income from Board-designated funds | 68,308 | 32,004 |
| Excess of revenues over expenses | \$ 131,757 | \$ 100,610 |

The accompanying notes are an integral part of the financial statements.

1227792

OAK RIDGE HOSPITAL OF THE UNITED METHODIST CHURCH
 STATEMENT OF CHANGES IN FUND BALANCES
 for the years ended June 30, 1973 and 1972

| | Unrestricted | | Restricted | |
|--|--------------------|--------------------|------------------|------------------|
| | 1973 | 1972 | 1973 | 1972 |
| Balance at beginning of year | \$4,333,581 | \$4,221,098 | \$ 10,178 | \$ 14,570 |
| Excess of revenues over expenses | 131,757 | 100,610 | | |
| Restricted gifts and bequests | | | | 7,505 |
| Interest income | | | | 663 |
| Additions to property, plant and equipment from restricted funds | | | 11,873 | (11,873) |
| Transfer to nonoperating revenue | | | (10,178) | |
| Other disbursements from restricted funds | | | | (687) |
| Balance at end of year | \$4,465,338 | \$4,333,581 | \$ 10,178 | \$ 14,570 |

The accompanying notes are an integral part of the financial statements.

NOTES TO FINANCIAL STATEMENTS

Significant accounting policies utilized in the preparation of these financial statements are described in Notes 1 and 3 below.

- Property, plant and equipment is stated on the basis of original cost or estimated original cost as determined by an independent appraisal firm as of June 30, 1968, with subsequent additions at cost. Depreciation is determined using the straight-line method over the estimated useful lives of the respective assets.

Property, plant and equipment and accumulated depreciation at June 30, 1973 and 1972 are as follows:

| | June 30, 1973 | | June 30, 1972 | |
|--------------------------------|--------------------|--------------------------|--------------------|--------------------------|
| | Cost | Accumulated Depreciation | Cost | Accumulated Depreciation |
| Land | \$ 65,101 | | \$ 65,101 | |
| Land improvements | 194,253 | 93,009 | 187,070 | 83,019 |
| Buildings and related services | 4,090,559 | 1,485,341 | 4,090,558 | 1,355,482 |
| Equipment | 1,111,680 | 555,825 | 1,073,748 | 501,920 |
| | <u>\$5,461,593</u> | <u>\$2,134,175</u> | <u>\$5,416,477</u> | <u>\$1,940,421</u> |

- Long-term debt at June 30, 1973 and 1972 consisted of the following:

| | June 30, 1973 | June 30, 1972 |
|--|---------------|------------------|
| First mortgage serial bonds with interest and principal payable semiannually, interest rate increases from 5.65% in 1973 to 5.75% in 1976, annual principal maturities increase from \$36,000 in 1974 to \$39,000 in 1976 with a final maturity of \$165,000 on July 1, 1976. | | \$234,500 |
| Direct obligation serial notes with interest and principal payable semiannually, interest rate increases from 7.50% in 1973 to 7.75% in 1976, annual principal maturities increase from \$16,000 in 1974 to \$18,000 in 1976 with a final maturity of \$357,000 on July 1, 1976. | | 400,000 |
| Unsecured 5% installment note payable | | 416,000 |
| | | <u>5,465</u> |
| Less current portion | | 634,500 |
| | | <u>52,000</u> |
| | | \$582,500 |
| | | \$638,825 |

Substantially all property, plant and equipment of the Hospital is pledged as collateral for the serial bonds. Under the terms of the serial bond indenture, the Hospital is prohibited from incurring any additional liens against these assets.

- The Hospital has a trustee, contributory pension plan available to substantially all employees.

The plan is in two parts. The future service benefit for service after July 1, 1965 is a money-purchase benefit whereby the Hospital and its employees each contribute a percentage of the employee's salary and these amounts are held in individual accounts for each employee. Because of its money-purchase nature, no actuarial calculations are necessary on the future service portion of the plan. The past service benefit, which is actuarially based upon service prior to July 1, 1965, has been totally funded by the Hospital and is being expensed over a ten-year period ending in 1975.

Total pension expense for the years ended June 30, 1973 and 1972 was approximately \$19,000 and \$17,000, respectively.

- Other operating revenues and certain expense accounts for the year ended June 30, 1972, have been restated to conform with 1973 classifications for comparative purposes. Such reclassifications had no effect on the excess of revenues over expenses.

Continuing education is part of hospital plan

"We plan to continue to learn — and help others to learn — about health care."

That in a nutshell, is Oak Ridge Hospital's goal in continuing education.

It's a goal that involves not only nurses and others directly involved in giving patient care, but all hospital personnel plus the patients themselves.

And it involves a brand new concept in hospital-wide health care education, placing Oak Ridge Hospital among the first to put such an idea in practice.

Back a few years ago, "continuing education" in the medical field only applied to those who had attained the rank of doctor or nurse and, in some cases, medical or X-ray technologists.

For others who sought health care careers, there were virtually no formal in-service educational programs available — training which allowed them to continue working (and earning) while updating their knowledge and skills.

Now, in Oak Ridge at least, all this is changed.

Progressive hospitals — and the people who run them — have come to realize that, in order to keep pace with ever-changing, modern, medical technology, to meet the increasing needs of patients and provide them with the highest quality care, ALL hospital personnel must be involved in the process of continual learning.

Because every person who works in a hospital — cooks, maids, maintenance workers and clerical help alike — is a member of the health care team.

And certainly patients, in fact, all citizens throughout the community the hospital serves, should strive to learn more about their health and how to care for it.

This, then, is the idea behind the Oak Ridge Hospital's innovative learning plan — to make continuing health education easy, inexpensive and interesting, not only for the hospital staff but for anyone in the area — including those interested in any phase of health care as a profession.

This is the idea that Doris Croley, head of the hospital's education department, and Judith Walker, a registered nurse and her assistant, keep in mind as they develop, coordinate and put into action a variety of educational programs designed for hospital and community-wide benefit.

One such program is the one initiated nearly a year ago in diabetic education.

The five-day course is offered monthly for diabetic patients, their families and health professionals and stresses understanding of diabetes along with self-care and control of the disease.

The fifteen hours of instruction include a talk by a local physician, movies and slides on the various aspects of diabetes, a demonstration of urine testing, individual interviews with patients and instruction in insulin injection techniques and the proper health habits diabetics should observe.

Also included is individualized instruction in diet and menu planning, plus special recipes

which can be adapted for family use.

And, as part of the diet instruction, the "students" are served a hospital-prepared "exchange luncheon" to illustrate the ways in which diabetics may eat "normal" foods without endangering their health.

All this, plus a number of booklets on diabetes, costs only \$10 per person — and one member of a diabetic's family can attend free of charge!

Although doctor referral is not necessary for admission to the classes, Mrs. Croley does stress the fact that the diabetic education is meant to supplement the patient's treatment by a personal physician and in no way replaces his medical management.

(A report on each patient, however, is sent to each patient's doctor to further aid him in treatment.)

At first, the diabetic program was chiefly financed by an \$8000 grant received from the Mid-South Regional Medical Program, based on a request from Vanderbilt University.

Now, however, the hospital has taken over the program and underwrites the salaries of the three paid instructors. (Mrs. Croley, Mrs. Walker, Anita Alphin, a registered staff dietitian, along with all teaching time and space. The fourth instructor is Cina Anderson, a volunteer RN.)

Proof of the need in the community for the course is the excellent response and interest shown by the 80 people — diabetics, members of their families and 26 professionals from area hospitals — who have thus far attended the sessions.

And it is hoped that the classes will result in the formation of a local independent diabetes association by the "graduates" and others interested in learning more about the effect and treatment of the disease.

One definite boon to the education department has been the recent purchase of a video-tape system — a purchase made possible through the generosity of the same Mrs. Anderson who instructs diabetic classes.

One of the ways in which the TV-tape equipment is used is the current lecture series by local doctors for the benefit of nursing personnel.

Taped before a live audience, the "stars" of the TV shows can then be seen and heard repeatedly by various groups of staff members at times convenient to their working schedules.

(As a long-range goal, Mrs. Croley hopes that money and space can be provided for a professional type TV studio and/or projection booth for additional production of video-tape for "in-house" training.)

The TV-tape equipment can also be used as a media for safety instruction — and all phases of this important part of hospital education, safety for hospital employees, for patients and for visitors, is constantly emphasized.

The "safety everywhere, all the time, for everyone" slogan the hospital has adopted is repeated in all safety meetings (which are held monthly) and demonstrations — a slogan



Doris Croley, director of the hospital's education department, is always happy to sign the certificates her students receive when they've completed a new course.

placing responsibility for safety on every employee.

In addition to the monthly meetings with staff members of the housekeeping, maintenance, dietary and nursing departments, new employees are trained to recognize unsafe conditions and hazardous areas and instructed in how to perform in an emergency situation.

Conducting fire safety classes on drills, equipment use and emergency removal of patients is also a vital part of safety education.

And orientation of new employees is another important phase of the work of the education department.

Although initiating each new employee in hospital procedures and policies, as well as acquainting them with the physical layout of the building, is important in helping the employees to adjust to their new job, Mrs. Croley feels that making the newcomers feel at home and "part of the family" is equally important.

"We not only want to tell them what the hospital expects of them — and what they can expect of us, we truly want them to feel welcome, to instill a sense of pride in being part of the health care team," she says, "and we'd like to become friends that they can turn to — a familiar face in the crowd."

It's this sort of thing — this "family feeling" — that pervades the hospital, that lends itself to the kind of personal care that patients have come to expect at Oak Ridge Hospital.

The same educational goals that have resulted in further training in medical terminology, knowledge of drugs and their uses, secretarial skills and basic training for beginning nursing technicians are also involving community and area

learning to further education in health care.

Included in the current educational programs at the hospital are courses for licensed practical nurses (a 13-month academic and practical experience program taught by Mrs. Sara Wilson), and laboratory technicians, classes in cardiopulmonary resuscitation for all employees who desire it, and managerial training which includes workshops in interviewing and disciplinary techniques.

Still in the final planning stages is a course in training for work in the Emergency Department, using individualized material designed by the American Journal of Nursing to keep personnel up on the latest technology in emergency medical care.

Also in the planning stage is a program to help teach cardiac (heart) patients the do's and don'ts to be practiced following hospital care.

Already scheduled for Jan. 10 is a symposium on "Death and the Dying Patient, a topic which will not only cover the proper treatment of the chief concern in such cases, the patient, but the patient's family, and how the situation should be treated by the attending physician and the nursing staff.

Considered a workshop of

major consequence, the seminar will have as guest speaker a renowned physician-lecturer in this special field, Dr. Elizabeth K. Ross.

This fall the hospital education staff will be coordinating the training of health career students in the area by exposing them to practical experience in various hospital areas after they have completed their classroom work.

The things we've mentioned are only part of a growing list of learning programs and techniques designed for everyone involved in health care.

Because your hospital considers education in health care of prime importance — for those who deliver it and for those who receive it.

This is the way Marshall Whisman, hospital president,

puts it: "The value of continuing education in health care cannot be overestimated.

"If we, the people who offer health care services, do not keep pace with the leaders in our field, we certainly cannot expect to offer the patients we serve the quality care they expect and deserve."

This means planning to learn — and learning to plan — for your own good.

County judge lauds hospital progress

By JUDGE JOE MAGILL

All of Anderson County can once again point with pride to Oak Ridge Hospital and to the many people involved in its successful operation.

During the past three years, the hospital has successfully attracted an unusually large number of fine, well-qualified physicians to Anderson County in an effort to relieve what had been an acute doctor shortage in our community.

The hospital, with its modern equipment and physical plant, well-rounded staff of physicians, nurses, administrators and the many others who make up the staff, serves our entire county, plus a large area outside Anderson County.

As a county official, I am keenly aware of the health needs of our people and can therefore sincerely appreciate the fact that Oak Ridge Hospital constantly strives to fill those needs.

We in the county also appreciate the fact that the hospital represents a very important economic factor in our area. Not only is the hospital's large payroll — well over \$3 million — spent locally, a considerable number of the more than 500 hospital employees live outside Oak Ridge, adding to the county's economic growth.

On behalf of the many county residents who need and utilize the services of the hospital, I would like to extend congratulations to the hospital, its entire staff and to its dedicated board of trustees for the completion of another most successful year of caring for the health needs of our people.

| BOARD OF TRUSTEES (As of June 30, 1973) | |
|--|-------------------------------------|
| Bishop L. Scott Allen | Mr. Ray C. Armstrong |
| Mr. A. Paul Bass | Mr. David O. Bolling |
| Rev. Paul E. Brown | Mrs. F. O. Christie |
| Mr. Leslie S. Dale | Dr. Earl Eversole |
| Mr. P. C. Fournay | Mr. Robert C. Fox |
| Mr. W. Keith Funkhouser | Mr. J. L. Liverman |
| Mr. Donald Maxwell | Mr. K. W. Sommerfeld |
| Rev. Ben St. Clair | Mrs. Nelson Stephens |
| Rev. Kenneth Verran | Mr. Marshall Whisman |
| Mr. Paul E. Wilkinson | Rev. H. Walter Willis |
| Mr. James F. Young | Mr. Thomas L. Yount |
| Legal Counsel: Mr. Jackson C. Kramer | |
| OFFICERS | |
| Mr. K. W. Sommerfeld, Chairman | Mr. Ray C. Armstrong, Vice Chairman |
| Mr. Keith Funkhouser, Secretary | Mr. James F. Young, Treasurer |
| EXECUTIVE COMMITTEE | |
| Mr. K. W. Sommerfeld | Mr. Ray C. Armstrong |
| Mr. W. Keith Funkhouser | Mr. James F. Young |
| Mr. Leslie S. Dale | Mrs. F. O. Christie |
| Rev. Paul E. Brown | Mr. David O. Bolling |
| Mr. J. L. Liverman | Dr. Earl Eversole |
| Mr. Marshall Whisman | |



MAGILL

| GRAY LADY OFFICERS & COMMITTEE CHAIRMEN 1973 | |
|--|-----------------------|
| Chairman | Dorothy Martin |
| Co-Chairman | Ann Anthony |
| Secretary | Martha Snyder |
| Treasurer | Betty Samsick |
| Co-Treasurer | Dessie Henry |
| SURGERY Chairmen—Marilyn Gray | |
| Co-Chairman—Wanda Gray | Co-Chairman—Anne Bell |
| EMERGENCY BIL. CH.—Betty Samsick | |
| Co. Ch.—Anne Bell | |
| INTENSIVE CARE—Alice Turnelle | |
| TRAINING CHAIRMAN—Irene Carroll | |
| Pink Lady Executive Committee: | |
| Chairman | Judy Rosecrance |
| Vice Chairman | Louise Spry |
| Corresponding Secretary | Neall Whitworth |
| Recording Secretary | Carolyn Hoffman |
| Treasurer | Jane McAdams |
| Westwall Chairman | Neall Parks |
| Buyers Coordinator | Grace Rose |

A pictorial view of your hospital at work



Era Nail, technician in central services, pauses in her work to give the photographer a big smile.



Part of their job is to see that the carefully planned and prepared meals for patients are served attractively. From left, Irene Martin, Joyce Dye and Thelma Milner do just that, under the supervision of Rosa Perry.



Mary Fair, RN, checks on a newborn baby boy who's being kept cozy and warm the first few hours following birth under the infant warmer donated by our Pink Lady volunteers.



Chef Rubin Brown looks happy at the prospect of preparing braised short ribs during the recent beef shortage.



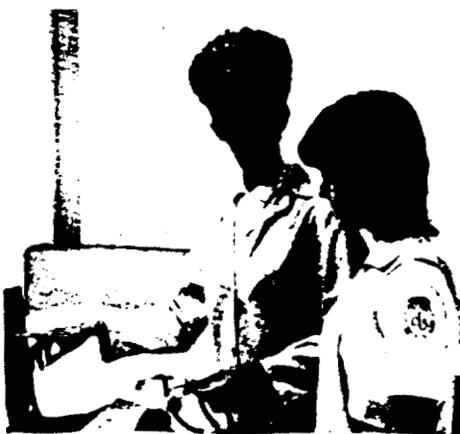
Peggy Hackworth, LPN on 3-N, asks the patience of a hungry patient, Billy Brown, while she records his temperature with an electric thermometer.



Just what the doctor ordered — a short walk in the hospital corridors.



Barbara Mingo, left, unit secretary, Mary Elizabeth Brown, LPN, and Nancy Jenkins, RN, clinical manager, are three members of the patient care team on 3-N.



Joyce Potts, right, a recent graduate of the hospital's laboratory technician training program, listens attentively during her student days as Oral White, assistant supervisor of the lab, instructs her in the finer points of taking blood pressures.



Medical transcriptionists Joyce Pierce, left, and Jo Anne Lujan take their work in the medical records department seriously.

1227794

New X-ray equipment

Anyone for a percutaneous transhepatic cholangiogram? How about a lymphangiogram — or a splenoportogram?

(Or maybe abdominal angiography is what you need. Don't worry, you'll never be called on to make these decisions — but your doctor may one day decide for you that you need one or more of these highly sophisticated tests to aid him in diagnosing some internal disorder.

And, if he does, you'll be taken to the hospital's x-ray department where these newest examinations will be performed in the brand new "angiographic suite" which should be ready for use a few weeks after you read this.

These strange sounding radiological tests are only a few of those offered by your hospital, but they represent the very latest thing in x-ray procedures and techniques — and are a vital part of the hospital's plan for your health care.

Also part of the plan are the services of Dr. James I. Hilton, Jr., a radiologist (x-ray specialist) who joined the medical staff Sept. 1 as the result of the hospital's continuing doctor-recruitment program.

Dr. Hilton's skilled services were sought not only because of the increasing work load borne by Doctor Robert Ball and Dr. Charles Oderr, the radiologists who are already members of the staff, but because he is specially trained in the latest techniques in angiography — a new phase of the x-ray field which has only come about in the past ten years.

To make the new tests possible, the hospital has installed the angiographic suite — including four major pieces of new equipment — at a cost of approximately \$150,000. And plans are underway for even further renovation and new equipment for two additional rooms (one in 1974 and one in 1975) where more commonly known x-ray exams are performed.

(Replacing equipment in the other two rooms, however, is expected to cost far less than the new equipment now being installed.)

Not only are Dr. Hilton and his wife, the former Fretta Frizzell, enthusiastic about East Ten-



DR. ROBERT BALL

nessee (they're both natives of Chattanooga) and Oak Ridge. Dr. Hilton is extremely enthusiastic about his new work and the role the x-ray department plays in patient care.

And although his special love is angiography, Dr. Hilton hastens to point out that "this new — and, to me, very exciting — technology is only a small, though very important, part of the x-ray field."

What exactly is angiography? Dr. Hilton explains that "angio" means a vessel (arteries, veins and lymphatics) and that angiography is simply a way of studying what is going on inside the body by taking pictures of the blood vessels into which a contrast material (dye) has been injected.

The films (which are made very rapidly) can then be immediately read and diagnosed by the radiologist and reported to the patient's attending physician.

The radiologist can be for the attending physician then — as in all aspects of x-ray work — an immediate consultant to aid that doctor in diagnosing the patient's problems "at the time the problem arises, whenever that may be," says Dr. Hilton.

It is this direct and intimate sort of involvement with the patient, plus the knowledge that he, as a radiologist, can work closely with other physicians as

part of the diagnostic team that attracted Dr. Hilton to his chosen work.

"I had always thought that a radiologist was always in the background until, while I was in medical school, I was exposed to the work and personality of one of the most eminent and respected men in the field, Dr. David Carroll," he explained.

Dr. Carroll, who is now president of the Radiological Society of North America, is described by Dr. Hilton as "a dynamic, very fascinating, very knowledgeable guy" and it was chiefly his influence that prompted the young doctor to "specialize in his specialty."

But he attributes much of his continuing fascination for the work — as well as the special skills and knowledge he has acquired — to another well known radiologist, Dr. Edward Buonocore, chairman of the department of radiology at the University of Tennessee and Dr. Hilton's instructor during his three year residency here.

In turn, Dr. Hilton is now in the process of training local x-ray technicians in assisting him to perform the intricate surgical procedures involved in using the new angiographic equipment.

Asked about the cost to the patient of the new x-ray exams, Dr. Hilton said that, because they are actually surgical procedures which are time-consuming and performed with complex and expensive equipment, tests involving angiography will cost more than some other less complicated x-rays.

However, he also pointed out that their value as a diagnostic tool is priceless — and one which might very well help to avoid more extensive (and more expensive) surgery for the patient.

And that's what the hospital is really all about — offering the best possible care in the best possible way.

In fact, in describing what is going on in the x-ray department, we're really describing the hospital's overall plan — a plan that includes new and improved services, new equipment, new doctors and new technology — to provide you, the public we serve, with the finest, most up-to-date health care.



Dr. Herschell King examines a patient in the Emergency Department.

New ED staff plan told

Another new service, another new team of doctors, a new name and more plans for expansion.

These are all part of the plan to provide personalized care for the some 20,000 persons per year who come to Oak Ridge Hospital on an emergency basis.

And it is expected to eventually solve a problem which has long plagued the hospital, the doctors and the public.

In what has been officially renamed "The Emergency Department," the new service is now headed by Dr. Herschell King who, by the time of this publication, will have been joined by Dr. Robert Van Arsdell, a second specialist in emergency medical care, with a third member of the team expected in the very near future.

It was Dr. King who formed "Emergency Associates, Inc.," the group which will eventually staff the department on a 24-hour-per-day, seven-days-per-week basis.

Right now, until he is joined by his associates, Dr. King is working 15 hours per day — the sort of back-breaking schedule that most doctors are all too familiar with — every day of the week. The remaining hours, are still being covered by other doctors on the medical staff.)

How does the new service work?

To begin with, the role of Emergency Associates is to supplement the "on-call" emergency practice which has always been in effect at the hospital.

"On-call" means that physicians representing the various medical specialties take turns at making themselves available to emergency patients on a standby basis.

Patients who feel they need emergency care and have a personal physician should simply call their own doctor.

Then, if that doctor feels that the situation calls for immediate attention, he may elect to treat the patient himself, or he may refer the patient to one of the members of Emergency Associates.

However, if the patient's own doctor is for some reason unavailable at the time, the patient can be seen either by the emergency physicians or by the doctor on call.

Those patients who do not have a personal physician will be treated by the emergency care team.

And Dr. King explains that

called in by members of his group whenever the need is indicated.

The emergency physicians will also be able to assist with patients already in the hospital in the event of a medical crisis when a doctor is needed immediately.

As for the cost, there will be very little difference except that Dr. King and his associates — like any doctors in private practice — will bill the patients they treat for their services.

Their fees will vary (as do any doctor's), based on the extent of the injury or illness, but Dr. King gives \$13 as his minimum charge — an amount he admits he deliberately set higher than the basic charge of other local doctors in order to discourage unwarranted over-use of the emergency facilities.

And he says he'll "make the same collection effort on all patients" — indigent or not — because only by collecting can he stay in business.

Because the already heavy emergency patient load is expected to increase now that round-the-clock staffing of the department is on the way, the hospital — as part of its overall plan for expansion — intends to enlarge the emergency quarters to include additional examining

rooms as well as office space for the doctors who work there.

The need for more space is a problem existing in several areas of the hospital, but one that is not insurmountable. Others are not so simple.

The big problem in emergency care has centered around the fact that Oak Ridge doctors simply cannot handle the increasing number of patients who seek emergency treatment and, at the same time, care for their private patients.

In the case of surgeons, the problem becomes even more acute when they are forced to interrupt their surgery schedules to answer a call to the emergency department.

And, for all the doctors, perhaps the most frustrating part of the problem — and one that is certainly expected to remain — is the fact that only about 15 of the some 60 persons seen daily in the emergency rooms actually need emergency care.

The rest have been — and probably will continue to be — suffering from a variety of minor ailments and injuries which could be treated in a doctor's office.

But the trouble is, many of those patients do not have a

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But the trouble is, many of those patients do not have a

(Continued on Page 11)



A patient seeking emergency treatment is questioned by Dr. Roger Van Arsdell, a member of the newly formed Emergency Associates, Inc., which staffs the department on a 24-hour basis.



The arteriogram Dr. Jim Hilton has just completed is just one of the many types of diagnostic examinations performed by the new radiologists.

1227195



Work is expected to begin soon on refurbishing and redecorating other patient rooms to resemble the one in which Irene Candler, RN, a nursing supervisor, is helping a new patient get settled.

Did you know?— In-patient information

Did you know that more than 10,000 patients were admitted to our hospital last year?

That our admitting office personnel currently admits an average of 28 patients (and has admitted as many as 53!) per day?

And that, for each of these patients, the admitting office must complete 11 forms — plus insurance papers?

Under the supervision of Dot Margrave, our manager of admissions and communications, this five-member team (including one part-time employee) not only performs all the clerical tasks necessary for admissions, but acts as a small "public relations firm" in greeting and interviewing patients and escorting them to nursing floors.

From 7 a.m. to 11 p.m., your admitting office "hostesses" also assign patient rooms (in cooperation with nursing stations), complete the paper work necessary for in-house transfers, maintain a patient waiting list plus a current file on available beds, prepare the daily census sheet for distribution throughout the hospital, are responsible for the inventory and safekeeping of patient valuables and prepare data processing cards on all discharges.

Their clerical work also includes the necessary paper work for the Emergency Department admissions which occur from 11 p.m. to 7 a.m.

And, in addition to their typing, filing, "bookkeeping," key punch, data processing and interviewing skills, the busy gals in the admitting office also relieve at the switchboard during operators' breaks and act as cashiers and mail-sorters on weekends.

In short, the hospital duties in their department are numerous, varied and interesting from first to last — they admit.



Pre-admitting patients by telephone is just one of the duties of Dorothy Margrave, head of the admissions and communications department, and her busy staff.



Michael Peterman routinely takes pressure readings in the newly painted boiler room.

Maintenance plans 'ounce of prevention'

If you think good housekeeping and "interior decorating" are aims and projects restricted to the feminine sex — go take a look at the "new" hospital boiler room!

Eddie Inman and his maintenance crew are living proof that men also care about their working atmosphere — even if their ideas do stem from a practical, rather than from an artistic point of view.

Whatever the reason, your maintenance department (and what would we do without it!) has enthusiastically undertaken a "clean-up-paint-up" project that began in the boiler room but is planned to extend throughout the hospital. Westmail and the Medical Arts Building.

Other mechanical apparatus may not get the paint treatment, but all of it will be carefully inspected, greased and oiled — or whatever measures are necessary to carry out the new preventive maintenance program which began early last month.

"We feel that by taking more time to check and maintain equipment before a breakdown occurs, both time and money can be saved," Eddie commented.

We applaud the maintenance department — not only for the practical, time-and-money-saving aspects of the new project, but for reminding us that we can be creative even in what may appear to be an unglamorous job.



A check list of all patients scheduled that day for physical therapy treatment is rechecked by Edith Roark, physical therapy technician.



Anne Johnson, LPN, is one of the capable, specially trained nurses who help care for patients in the newly organized Emergency Department.

'Condition' terms reported

When your hospital issues a patient's condition report, it is generally termed either "good, fair, serious or critical." Here is what each of these hospital terms means:

Good: If the patient is in good condition it means he's conscious, his vital signs are good, he's feeling pretty well and should have a full recovery.

Fair: If the patient is listed as fair, it means his vital signs are stable and he'll recover, but he's uncomfortable or may have minor complications.

Serious: If his condition is serious, he's acutely ill and his vital signs are unstable. But there is a chance for improvement.

Critical: If a patient is listed critical there are major complications and the outlook is not good.

Understanding these hospital terms may help you better understand your hospital the next time you call or visit.



DR. DAN THOMAS
Incoming Chief
of Staff



HELEN RUSSELL,
Admin. Secretary



Dean Van Hoozer, hospital controller, beams as he recalls his 29 years at ORHUMC.

Did you know?— Looking in on X-ray

Did you know that your hospital X-ray department performs approximately 2100 diagnostic examinations and between 135 and 140 therapeutic treatments per month?

And that this enormous and vital work is done by a staff of only 14 people — three physicians, eight X-ray technicians (four of them registered), a secretary, a receptionist, a film processor and a nursing technician?

The Oak Ridge Hospital is:

Approved by:
The Joint Commission on Accreditation of Hospitals
A Member Of:
The American Hospital Association
Tennessee Hospital Association
Knoxville Area Hospital Council
Affiliated With:
Blue Cross and Blue Shield of Tennessee
Licensed By:
The State of Tennessee

All patient care carefully recorded

Did you know that our medical records department transcribes from 2300 to 2400 patient records every single month?

This staggering amount of paper work covers the complete hospitalization of the some 850 patients who are discharged each month — recording for posterity each one's record of history, physical exam, conditions under which he was admitted, consultations, surgeries, lab findings and discharge summary.

Just thinking about transcribing 2400 records every month kind of boggles the mind, doesn't it?



SILVIA ALIBERTI
Medical Records
Librarian

Emergency

(Continued from Page 10)

personal physician — either because they're too poor to pay for his services, or because they are newcomers to the area and haven't been able to find a doctor who could crowd them into his already overcrowded schedule.

And all this adds up to over-use, not only of the emergency department, but of the hospital's x-ray and lab facilities which are usually used in conjunction with out-patient care.

Since many of the patients cannot or will not pay their bills, this means additional weight on the already sagging financial shoulders of the hospital and, in the long run, the paying patient.

So, some of the problems connected with emergency care may — like the poor — be always with us.

There will be, however, some degree of convenience that the patients who come to the Emergency Department will realize. And, like all our hospital patients, they are assured of receiving personalized, quality care from people who really do care.

Obviously, emergencies cannot be planned. So your hospital plans for you.

1 2 2 7 7 9 6

A highly qualified staff to care for you

MEDICAL STAFF

(As of September, 1973)

VISITING STAFF

General Practice

John P. Crews
Richard Dew
Frank Genella
James Gillespie
Charles Gurney
Joseph S. Lyon
David W. Seay
S. J. Van Hook

Internal Medicine

John D. Depersio
Victor W. McLaughlin
C. Willis Sensenbarr

Pediatrics:

Gene Caldwell
Charles L. Campbell
William P. Hardy
William M. Hicks
Lewis F. Preston
Daniel M. Thomas

Surgery:

Robert R. Bigelow
Lawrence R. Orr
Robert W. Dunlap
Earl Eversole
Ernest L. Hendrix
Henry B. Raley
David G. Stanley

Obstetrics & Gynecology

Robert E. Depersio
William W. Pugh

Gynecology:

C. Julian Ragan

Ophthalmology:

Dexter Davis
Raymond A. Johnson
E. Elliott Koebnick

Otorhinolaryngology:

Samuel O. Massey

Dermatology:

Donald L. Hartman

Orthopedics

Gerion Brown
Paul Spray
George M. Stevens
Joe E. Tuttle

Urology:

Richard G. Brantley
Avery P. King

Psychiatry:

Hyman Rossman
Gary Walters
Joan B. Woods

Psychiatry & Neurology

Samuel J. Pieper

Oral Surgery

Bill B. Blevins

Anesthesiology:

Lowry L. Sheely
Margery Swint

Radiology:

Robert P. Ball
James Hilton
Charles Oderr

Pathology

Alex G. Corabia
Armando F. deVega

Emergency Department

Herschell K. King
Roger Van Arsdell

COURTESY STAFF

Dentistry & Minor Oral Surgery

Willard Burgess
Raymond L. Chambers
Charles W. Cross
Kenneth Frame
Gienn Greer
James D. Johnson
Shirley M. Mills
Theodore B. Rogers
Vance R. Sharp
Henry D. Taylor
Nathan Wilson

Industrial Medicine

T. Guy Forney (K-25)
Reuben Holland (X-10)
T. A. Lincoln (X-10)
Lynn F. Lockett (K-25)

General Practice:

Archer W. Bishop, Clinton
Henry Hedden, Clinton
Samuel G. McNeeley, Norris
John J. Smith, Clinton
Nai Sugarman, Kingston
Charles R. Sullivan, Oak Ridge
Robert E. Wilson, Kingston

Limited to Psychiatry:

Gino Zanoli, Oak Ridge

CONSULTING STAFF

Obstetrics & Gynecology:

Albert W. Diddle, Knoxville
Kenneth A. O'Connor, Knoxville

Pathology:

Ralph M. Kniseley, Oak Ridge
Bill M. Nelson, Oak Ridge

Plastic & Reconstructive Surgery

Edmund B. Andrews, Knoxville
James B. Cox, Knoxville

Public Health:

Parley M. Dings, Clinton

Neurological Surgery

Joe Beals, Knoxville
Frederick Killeffer, Knoxville
John Purvis, Knoxville
M. Frank Turney, Knoxville

Thoracic Surgery

Jacob T. Brodsher, Knoxville
Robert W. Newman, Knoxville
William K. Rogers, Knoxville
William K. Swann, Knoxville
David H. Waterman, Knoxville

Internal Medicine

Gould A. Andrews, Oak Ridge
Leon Bogart, Knoxville
C. Lowell Edwards, Oak Ridge
Francis Goswitz, Oak Ridge
Helen Vodopick Goswitz, Oak Ridge

Pediatrics

Oliver W. Hill, Knoxville
Thomas E. Lester, Knoxville
Felix G. Line, Knoxville

Nursing teams scheduled for patient care

Running a hospital successfully means providing the right kind of care by the right people at the right time in the right atmosphere.

Sounds simple enough, doesn't it?

And it would be, except for one thing: patients are people — and people have individual needs.

So, because those needs may arise suddenly — and change from hour to hour, scheduling nursing care for our patients is, in some ways, a guessing game.

The only thing that is certain is that all patients need the best possible care.

The uncertainties of the game are the daily number of patients that need that care and — the factor that simply cannot be determined in advance — the condition of each patient from day to day.

For example, a patient who has undergone surgery obviously needs more direct nursing care for a longer period of time than the one who is admitted to the hospital for tests.

And complications and emergency situations can arise in either case, requiring even

more constant nursing attention.

Then if, in the meantime, a number of new patients are admitted, in varying stages of illness, the staffing picture changes even more.

So the constant question is, how many nurses and nursing technicians (aides and orderlies) are needed for each shift in order to provide the best possible care for "x" number of patients in "x" condition, 24-hours-per-day, seven-days-per-week?

That's what hospitals mean when they talk about scheduling — and that's what makes scheduling an intricate, complicated business.

The number one purpose in planning the working hours of all hospital personnel (a total of 325) is, of course, to provide coverage of the hospital with properly qualified personnel with a variety of skills in adequate numbers so that every patient receives the best care.

The second objective is to meet the needs of the people who give that care (as best we can), but that is very definitely second and patients needs are always very definitely first.



HAZEL CHASE

Just how do you schedule the working hours of the nearly 300 hospital employees involved in direct nursing care so that these needs are met?

"With great difficulty," according to Hazel Chase and Marsha Lane, the two members of the nursing office staff who have been doing this "juggling act" for the past 18 months

when the interviews are repeated.

Prior to that time, scheduling was done by the clinical managers (head nurses) of each unit. However, because it is such a time-consuming job, and because the hospital feels these nurses should be free to care for patients, not paper work, it was decided to centralize the work.

Each clinical manager still, however, determines the nursing needs for her floor.

These needs are based on the "standard" she sets as a patient-nurse ratio — and that means the number of nursing hours she feels are needed that day per patient, plus the proper "mix" of personnel.

Then based on these projected needs, Mrs. Chase and Mrs. Lane set up a master staffing pattern.

But before they ever set up their master plan, each nurse and nursing technician was interviewed to determine his or her special needs and preferences regarding working hours.

A file card noting this information is then updated approximately once each year

when the interviews are repeated.

Then, working with all the information at hand, a daily schedule is planned.

The new system of scheduling was first done monthly, but for the past eight months an attempt has been made to set it up on a three-months-in-advance basis. The main purpose in planning three months ahead is to try and give nursing personnel as much notice and information about scheduling as possible.

As it is now, a notice listing the planned working hours of each employee is posted in each department one month prior to the time that particular schedule goes into effect.

In this way the scheduling staff and department managers hope that nursing personnel can plan time off and possibly anticipate any problem that might interfere with their work days.

But emergencies, of course, cannot be anticipated — so whether or not the new long range scheduling is the best plan remains to be seen, according to Betty Cantwell, hospital vice president and director of patient care services.

However the scheduling is done, it must remain very flexible and always subject to change — particularly in the event of emergency situations (in the hospital) which all nursing personnel are expected to meet.

And because the hospital has been filled to capacity or near capacity for the past three months, the nursing floors are experiencing increasing staffing and scheduling difficulties in securing new personnel, particularly RNs.

(Although it is important to have the proper "mix" of personnel on duty on each shift, it is the registered nurse who bears the full nursing responsibility for the patients and at least one RN is required in each unit at all times.)

So we'll keep trying to anticipate your needs and, on behalf of our nursing staff, pledge ourselves to continue to offer you adequate, personalized, concerned care of the highest quality.

After all, that's why we're here.

It's part of our plan for your health care.

The Hospital has only one reason to exist.

That reason is to serve you.

Therefore, we have a real interest in your opinion of us and our service. You would help us if you would complete this questionnaire and give us your ideas.

If I Owned the Hospital, I would change it by _____

() I have been a patient in the Oak Ridge Hospital in the last year.

Signed _____

() I have not been a patient in the Oak Ridge Hospital in the last year.

Street Address _____

City _____

Your comments and suggestions are sincerely requested and we urge that you respond. Your comments will be carefully considered and we will endeavor to solve what you see as any problem in our operation. Thank you.

Return to Oak Ridge Hospital, P.O. Box 529, Oak Ridge, Tenn. 37830.



Miss Elizabeth Cantwell, hospital vice president and director of patient care services, confers with Mrs. Virginia Smith, a nursing supervisor.

ADMINISTRATIVE STAFF

As of September 1972

| | |
|--|--|
| President Marshall Whisnant | Admissions Officer Dorothy Margrave |
| Sr. Vice President Ralph Lillard | Physical Therapist G. Donald Russell |
| Vice President Elizabeth Cantwell | Manager, Westmall Zeta Shipley |
| Administrative Secretary Helen Russell | Purchasing Agent R. E. Simpson |
| Chief Pharmacist Hyman Africk | Controller E. D. Van Hoozer |
| Medical Record Librarian Silvia Aliberti | Personnel Director Shirley Walker |
| Liaison Nurse Katherine Beasley | Director of Volunteers Jeanie Wilcox |
| Director, Department of Radiology Robert P. Ball, M.D. | Nursing Office Supervisors Irene Candler Stella Belitz June Ellis Pauline Hahn Miriam Hallau Virginia Smith Joan Crasias |
| Director, Department of Pathology Alex G. Corabia, M.D. | Clinical Managers Nancy Ayers Neil Brandenburg Norma Costo Mary Ann Dennis Barbara Hughes Nancy Jenkins Christine Nance Pauline Ryan Sue White Martha Tucker |
| Chief X-Ray Technician Olibert Coker | |
| Education Director Doris Craley | |
| Executive Housekeeper Nelle Harris | |
| Food Service Manager Kenneth Matchett | |
| Chief Dietitian Anita Alphin | |
| Superintendent, Building & Grounds Edwin R. Inman | |
| Office Manager Charles Laffner | |