DOCTORS, DREAMERS & DOERS

A History of Long Beach Community Medical Center

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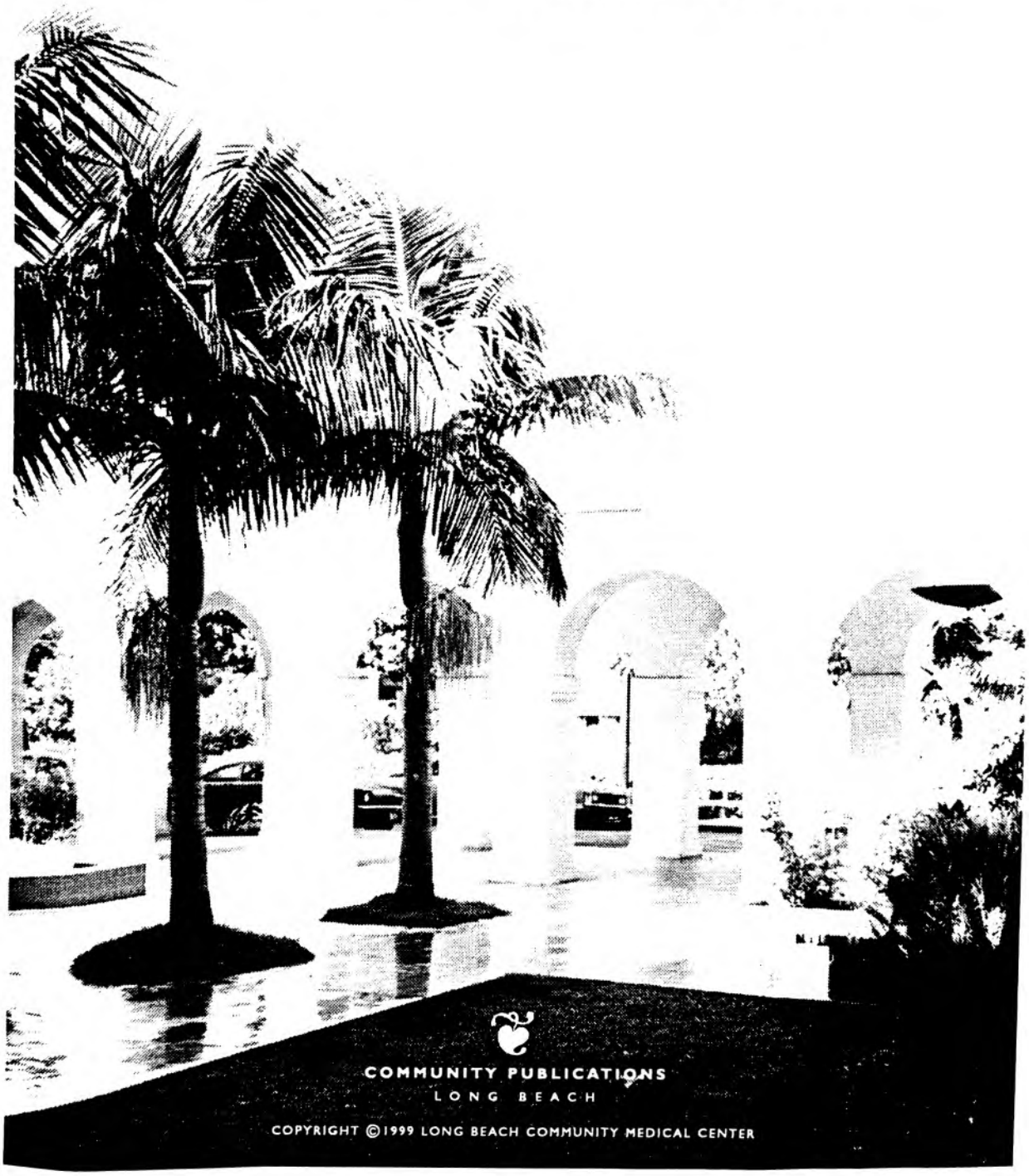

COMMUNITY PUBLICATIONS
LONG BEACH

Preface

We wish to thank and acknowledge the many people who have contributed to the making of "Doctors, Dreamers and Doers" a History of Long Beach Community Medical Center. A special thank you to Pamela Dilday-Davis who painstakingly brought together all the information contained within this text by conducting exhaustive research and in-depth interviews, and to the committee members who made this book possible: Madeleine Bowman, Jess Grundy, Betty Keller, Jim Lockington, Suzanne Nosworthy, R.H. Schumacher, M.D., Don Temple and William Wallace.

As with any undertaking of the magnitude of this project, which covers 75 years of history, there may be important people who are not mentioned due to unintentional oversight. To those people, we ask for your understanding. Every effort was made to identify all the key people who helped Long Beach Community Medical Center become the outstanding organization it is today. The time period covered in this book is from 1924 to 1997. We hope you will enjoy reading this wonderful book that chronicles the rich history of our Community Hospital as much as we enjoyed making it.

Doctors, Dreamers and Doers

A History of Long Beach Community Medical Center

The story of Long Beach Community Medical Center is a story of remarkable people. Dreamers who envisioned a non-profit hospital that would provide quality medical care to all who needed it. Practical doers who built and guided the hospital, and whose legacy has kept the doors open through World War II, earthquakes, changing demographics and a shifting healthcare environment. And it is a story of doctors who, with uncommon skill and deep humanity, have improved the lives of thousands of patients.

It is to these doctors, dreamers and doers
that this history is dedicated.

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Chapter 1

The Early Days: A New Hospital for a City Built on a Dream

THE BIRTH OF LONG BEACH

Long Beach was founded by **William Erwin Willmore,** an Englishman who arrived in the United States as a boy in 1855. Orphaned a few years later, the life-long bachelor came to California in 1870 to visit a colony being established in Anaheim. After landing in Wilmington, Willmore set out on foot along a path that followed what is now Anaheim Street.

Near Long Beach Boulevard, Willmore glanced back along the valley and out to the broad six-mile beach that formed the southern boundary of Rancho Los Cerritos. The rancho, with its mesas, bottomlands and pristine beach, had been purchased for $20,000 in 1866 by **Llewellyn Bixby, Dr. Thomas Flint and Benjamin Flint.** Sheep still grazed along the ocean bluffs in the 1870s when Mr. Bixby's younger brother, Jotham, and two partners formed a partnership to buy the rancho.

Willmore saw past the rancho's sheep, cornfields and expanses of wild mustard. As he gazed out upon the Pacific Ocean, a great dream captured his imagination: to build "one of the great ports of the world filled with craft from every clime and laden with the minutiae of a magnificent commerce."

Ten years later, Willmore began advertising the charms of the "American Colony" in newspapers in the east and Midwest. In 1882, he organized an excursion of sixty potential investors from the midwest to see the fertile "Valley by the Sunset Sea" firsthand. Willmore worked under the auspices of the California Immigrant Union, a San Francisco-based initiative established to attract more farmers, merchants and artisans to California.

The American Colony, the future Long Beach, originally was intended to be sold in farms of 10, 20, 40 and 80 acres at prices ranging from $12.50 to $25 per acre. The terms were easy: one-third cash down, one-third cash in two years, and the balance in three years. The prospective investors found the proposed town site to be "unsurpassed in the Los Angeles Valley in eligibility and soil...(with) three flowing artesian wells." They, too, saw the potential for a seaside resort, claiming the Colony's magnificent beach was "unsurpassed on this continent."

Despite the visitors' glowing descriptions, only a dozen houses were erected by 1883. Unable to make the payments called for by his contract with the J. Bixby Company, Willmore gave up his claim in 1884. The holdings were sold to the Long Beach Land and Water Company, which proceeded to develop the city.

Long Beach, at the cusp of the new century, had 2,252 people. In 1902, the Pacific Electric came to the small seaside town, connecting Long Beach to the Terminal Railroad, a part of the transcontinental Union Pacific System. Not only did it provide a vital freight connection for the area's agriculture and industry, it also brought tourists.

Now linked by rail to the rest of the country, growth was inevitable. Visitors came from the east and Midwest to enjoy the area's natural beauty, resources, and mild climate. The city was soon dubbed "Little Iowa" as hundreds of people moved to Long Beach to escape the harsh winters of the Midwest. In 1910, the census had climbed to 17,809; by 1920, Long Beach had 55,503 citizens. The population more than doubled to 135,000 by 1925.

Two other great events created a new destiny for Long Beach. On June 23, 1921, a huge geyser of oil burst forth on Signal Hill, one of the area's most desirable residential subdivisions. In a year and a half, the Signal Hill fields were producing more than 250,000 barrels a day. The oil brought tremendous wealth to the city and spurred a spirit of civic philanthropy. Many of the oil roustabouts who came to work in the oil fields used their paychecks to purchase property. More than a few of these "diamonds in the rough" eventually lost their rough edges and became some of the city's most respected and influential citizens.

The second great event was the improvement of the Long Beach-Los Angeles Harbor. The original harbor was developed by federal funds and a $20 million investment by the city of Los Angeles. A $5 million bond issue voted by Long Beach citizens and $6.5 million in federal funds increased the harbor's capacity. By 1925, the port ranked second only to New York in tonnage, increasing from 150,000 tons per month in 1920 to 2 million tons per month in 1925. By the second decade of the 20th century, Long Beach had become one of the greatest oil exporting ports in the world, as well as a major lumber importing port.

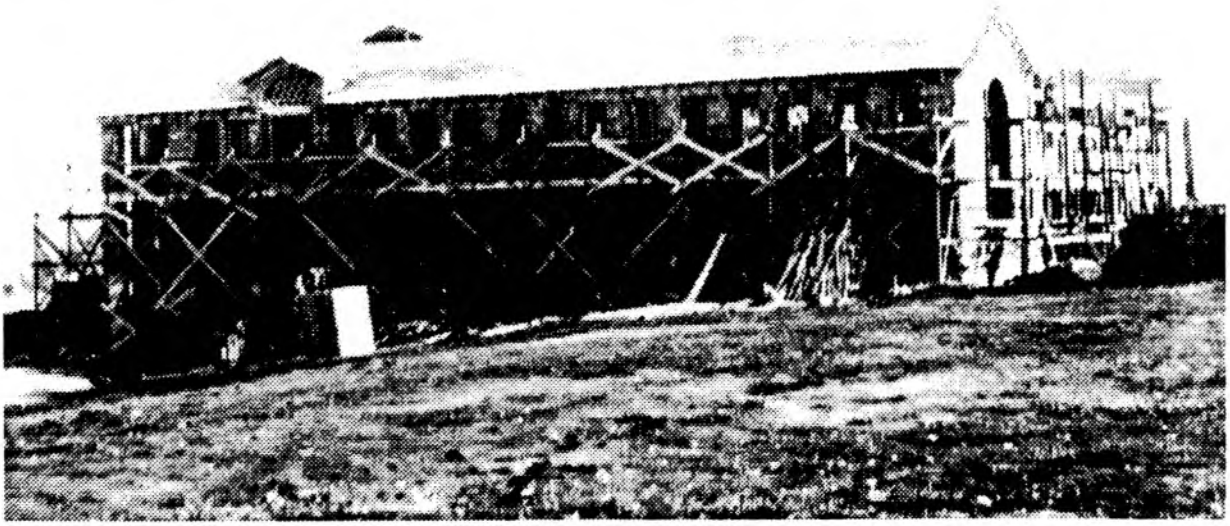
Just as nature endowed Long Beach with ample natural resources, destiny brought men and women who shared a vision of what the city could be and a commitment to bring it about. By the mid-1920s, these individuals had established Pacific Park and a Municipal Library, nine more parks covering 400 acres with a municipal golf course, public picnic grounds, baseball field and playgrounds, 60 churches, and 25 public schools. The city even had its own Municipal Band, which gave free daily concerts in the municipal auditorium.

Long Beach's citizens formed groups and organizations to work for the common good and the city had its own planning commission and welfare board. Its Chamber of Commerce, with 2,100 members, was as active in social causes as it was in promoting the town's business. Eight women's clubs provided scholarships and added to the city's cultural resources. Long Beach also built superb buildings for a Young Men's Christian Association and Young Women's Christian Association.

BUILDING A HOSPITAL FOR ALL

Long Beach Community Hospital had its origins in the civic activism of its people. As the population mushroomed, the citizens foresaw the need for a new hospital to keep pace with the community's increasing medical needs. In 1922, the city had fewer than two hospital beds per 1,000 inhabitants, just half the four beds per 1,000 that were recommended by health authorities. St. Mary's 75 beds and Seaside Hospital's 150 beds were not sufficient to meet the growing community's needs.

Civic leaders determined Long Beach needed a "community" hospital. The distinction between a community, a private and a county hospital was an important one. At that time, before health insurance, patients were responsible for paying for all their own medical expenses. Private hospitals were operated as businesses, charging rates that would ensure the institution posted a profit. County hospitals were built and supported by public taxes to provide free care for the poor. Patients paid an average of $6.25 a day for care in a privately owned hospital versus $3.80 in a community hospital. Indigent patients were treated in county hospitals for about 13 cents a day.



Long Beach Community Hospital under construction in 1924.

Unlike St. Mary's, a Roman Catholic hospital, and Seaside, which was privately owned, a community hospital would provide Long Beach citizens with service at cost, below cost, or at no cost. In 1923, the county hospital had turned away 30,000 people in need of care. A non-profit community hospital, such as the one envisioned by Community's founders in 1922, would provide service "neither on a pauperization nor a profit basis."

The hospital's planners believed a community hospital would be supported by "those whose philanthropy may be sympathetically inclined to help the sick and afflicted without attaching the stigma of charity." Non-profit, non-sectarian, and non-political, the community hospital created by these early philanthropists was a humanitarian endeavor from the very beginning.

The campaign slogan became "Hospital Service at Cost" and its organizers appealed to local citizens whose "generosity and public spirit" had funded the city's parks, playgrounds, churches and schools. Stating that "in all civilized lands, hospital support is considered an imperative duty, its neglect discreditable," the campaign called on private citizens, business groups and social organizations to demonstrate the same moral responsibility.

In April 1922, the city's citizens voted a bond issue of $100,000 for the community hospital by a margin of 11,583 to 3880. An appropriation from the 1923 city budget added another $100,000. But the amount still fell $169,000 short of the $369,000 needed to build a modern hospital for the people of Long Beach.

Original Cost to Build Long Beach Community Hospital in 1923

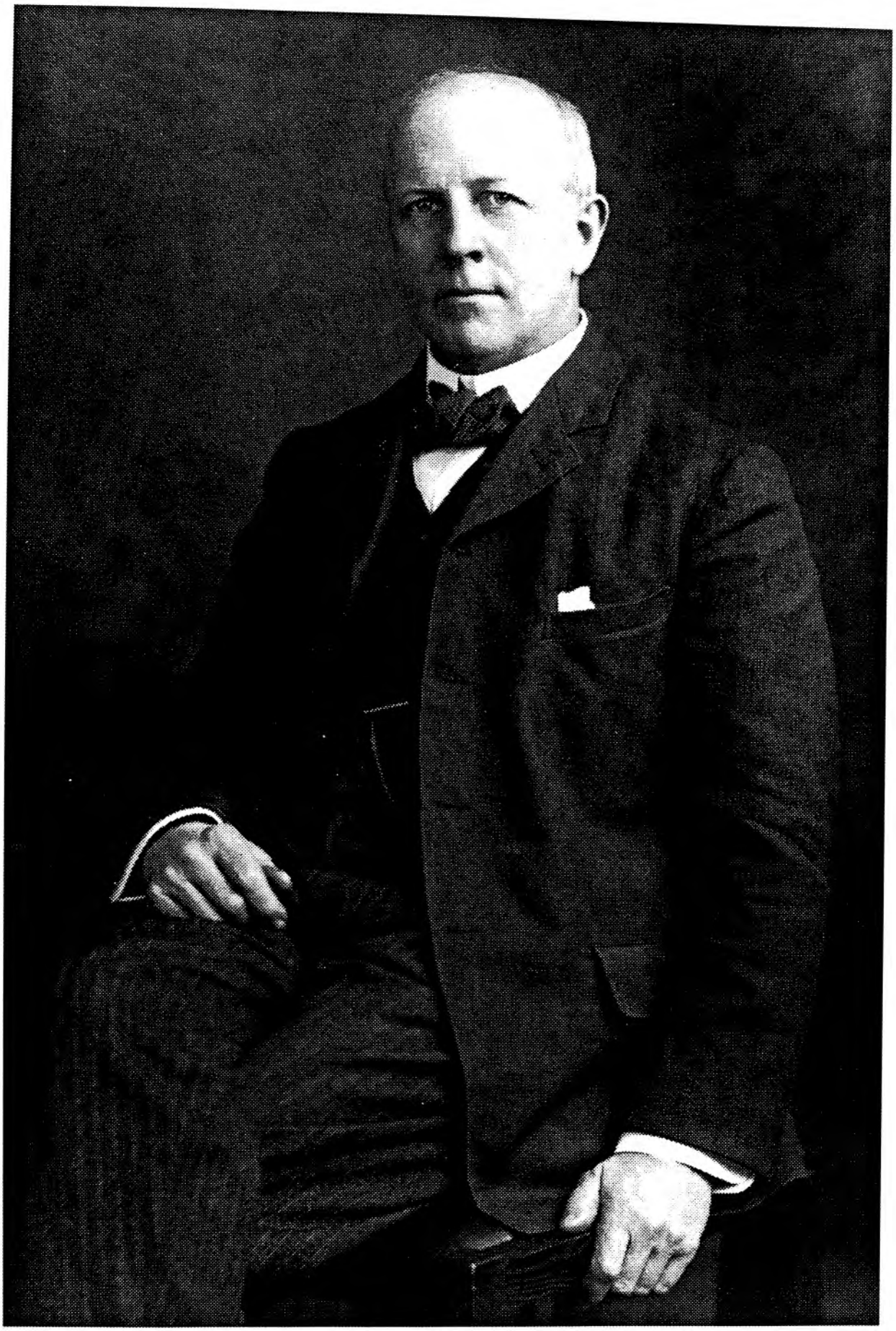
Building contract and architect fees	$245,000
Separate isolation hospital for patients with contagious diseases	15,000
Furniture and equipment	40,000
Nurses' home and furnishings	15,000
Improvement of street and grounds	7,000
Free treatment and endowment funds	40,000
Contingent fund (fundraising expenses and depreciation allowance)	7,600
Total	**$369,000**

Other nearby communities also were raising money by public subscription to build their own hospitals. Pasadena had raised $525,000, Hollywood $400,000, Riverside $250,000, and Whittier $245,000.

FILLMORE CONDIT:
The Father of Long Beach Community Hospital

Destiny, which had served Long Beach so well, provided just the leader it needed to rally the citizens behind the drive for a community hospital. Fillmore Condit was born in Centreville (later named Roseland), New Jersey in 1855. His mother had lost her first husband and her modest fortune to a man who drank himself to death. Six years later, with two children from her first marriage, the young widow married Fillmore's father, a farmer.

Fillmore's father rented out a room of the farmhouse as a saloon, turned to drink, and lost most of his property. By age 11, Fillmore was already working to help keep the impoverished family afloat. His father died when Fillmore was 13. These childhood events help explain Fillmore Condit's life-long temperance and compassion for the disadvantaged.



Fillmore Condit - The Father of Long Beach Community Hospital

Self-educated and industrious, Fillmore Condit lived most of his life in New Jersey where he prospered financially first as a shopkeeper and then in real estate, banking, asphalt, and as one of the founders of the Union Oil Company. A great humanitarian, Condit and his wife Ida worked tirelessly to improve the lives of the less fortunate and supported a hospital for women and children in Newark. He was asked to run as a Prohibition candidate for governor of New Jersey but dropped from the race when a fellow Republican agreed to run as a "dry" candidate supporting the 18th Amendment.

Fillmore and Ida Condit moved to Long Beach in 1919, where Ida died in 1921. Fillmore continued the philanthropic and civic activities he and Ida had shared throughout their marriage. A devout Methodist, he was active in Grace Methodist Episcopal Church, generously supported the public library and the YMCA. He served both as a member of the Long Beach City Council from 1921 to 1927 and as mayor from 1924 to 1927.

An individual of rare abilities and exceptional humanity, Fillmore Condit is the true founder of Long Beach Community Hospital. He turned his full attention to the "Community Hospital Proposition" in 1922 and was instrumental in securing the $200,000 advanced by the city.

A HOSPITAL CAMPAIGN BUILT ON CIVIC PRIDE AND PERSONAL PHILANTHROPY

Fillmore Condit contributed the first and by far the largest personal donation to the hospital fund in the amount of $50,000. With typical modesty, he implored reporters "please don't put anything in the papers about this."

Condit's moral leadership guided the campaign to fund the hospital, and one can almost hear his voice in the original hospital proposal:

"Contributions toward hospital service manifests the spirit of the Good Samaritan.

You may personally never need the services of the Community Hospital — but you never can tell. Some of your friends may find this hospital a great boon and blessing in time of sickness. You will never miss money given for a community-serving hospital. It may be bread cast upon waters.

Those who are strong should help the infirmities of those who are weak. Inasmuch as ye have done it unto one of the least of these ye have done it unto Him.

We ask your courteous consideration of the claims for a Community Hospital with service at cost. We ask your sympathetic cooperation as a citizen, as a "good neighbor," as a friend for those who need your friendly assistance.

Give just what you can conscientiously devote to this worthy cause. Be a "partner" in the relief of pain and sickness. Give in gratitude for the good things you enjoy. Give in confidence that the Hospital management will give expert, conscientious, sympathetic consideration to every case presented — this is a worthy cause — give gladly and generously."

Three major donations formed the nucleus of private support that launched Long Beach Community Hospital:

Fillmore Condit: $50,000, Mrs. Jotham Bixby $13,000, Hugh R. Davies $3,000

Writing in behalf of her mother, Mrs. Jotham Bixby, Sr., **Fanny Bixby Spencer** sent this note with her contribution:

"I think there is no better philanthropy than doing for the sick in one's own city. When I was in social work in Long Beach, we had no place but the county hospital to send our sick people to, so far away that their relatives could not visit them often, and frequently the county hospital was too crowded to give them proper care"

With $66,000 pledged and $200,000 advanced by the city, the hospital fund needed an additional $103,600. Fillmore Condit was elected chairman of the hospital finance committee. Along with fellow committee members **Galen H. Welch, Spencer Kennelly and Mrs. W.S. Stevens,** Condit devised a whirlwind, community-wide campaign to take place September 17 - 21, 1923.

The fundraising plan was simplicity itself. Three citizen groups were formed, each competing to achieve the most contributions. Division A (the "Gift Grabbers") was headed by **William P. Graef;** Division B (the "Life Savers") was headed by **C.C. Lewis,** and Division C (the "Spark Plugs") was headed by **William H. Wallace.**

To reach out to the various businesses, individuals, trade and social organizations in the city, the groups were further divided into five teams, each with its own team captain. The community-spirited campaign stretched across social barriers, attracting union members and established Long Beach residents such as **B.F. Tucker, William F. Prisk, William M. Cook, Llewellyn Bixby, Mrs. Amelia Bixby, A.T. Jergins, and Dr. Howard Bold.** One of the teams consisted solely of women.

The first meeting of the teams was held September 7 at the YMCA, Campaign Director E.L. Mogge explained their goal, "The present outstanding need is for a community hospital with service on a non-profit basis, which means that in no sense will sickness be capitalized commercially."

The campaign officials set up offices at the Chamber of Commerce and donations began pouring in. Individuals gave what they could afford, some sending in nickels, others sending twenty dollar bills.

At the end of the five-day, citywide campaign, more than $170,000 had been raised to build the new hospital. The campaign was so successful in fact that officials from Los Angeles asked for advice on how to raise funds for three new hospitals in that city. The officers of the first Board of Directors of the Community Hospital Association were:

Fillmore Condit, President	B.F. Tucker, Treasurer
L.M. Swope, Vice President	W.H. Dickey, Secretary

It was determined that Long Beach Community Hospital would be built on city-owned land at the corner of Termino and State Street (now Pacific Coast Highway). The location would allow the hospital to serve the heavily populated western part of Long Beach and the emerging new neighborhoods to the east. Situated a safe distance from the noise and fire hazards of the densely built downtown district, the hospital would be served by a main highway (State Street). At the time, the planners did not realize that the hospital's location on the sharp slope of a hill would make later expansion difficult.

THE HOSPITAL THE COMMUNITY BUILT

Two thousand people attended the official dedication of Long Beach Community Hospital on July 15, 1924. The two-story, mission style, 100-bed hospital was designed by architect **Hugh R. Davies** and was built around an open courtyard. The original hospital staff included 175 physicians and surgeons. **Miss Blanche Stair, R.N.,** was the hospital's first administrator.

Long Beach Community Hospital -1924

Promoted as "safe, attractive, and luxurious," the hospital remained true to its slogan of "Hospital Service at Cost." Hospital ward costs were $3.00 per day with private rooms costing $4.00 per day. A newspaper article reported the hospital was "built to serve the great so-called 'middle class' of citizens, those who are neither rich nor poor."

In 1924, Long Beach Community Hospital was a solitary structure sitting atop a barren hill. Oil derricks dotted nearby Signal Hill and cow pastures and bean fields fanned eastward from the bottom of the slope. The day after it opened, a gardener named **Jared Johnson** came to work and transformed the hospital grounds into cheerful gardens. Depending on the season, the hospital was graced by bright blooms of Pansies, Petunias, Roses, Hibiscus, Lantana, Zinnias, Martha Washington Geraniums, Dahlias, and Calendula.

Things were sprouting inside the hospital as well. In the first month, 16 babies were born at Long Beach Community Hospital. Appropriately, the first baby to be born was **Fillmore Condit's granddaughter, Barbara, the daughter of Mr. and Mrs. Donald Condit.** By the end of the first year, 325 babies were delivered at the hospital.

Long Beach Community Hospital was busy from the very beginning. During the first year, the hospital cared for 1,935 patients. **Dr. C.S. Losey** performed the first operation at the new hospital, a right mastoidectomy. Sixteen operations were performed each month in 1924. Twenty years later, the hospital performed an average of 375 surgeries each month.

Miss Rose Witte, R.N., Long Beach Community's legendary maternity nurse, came to work during the hospital's first year. During her tenure as the head of the maternity ward from 1925 to 1962, 30,000 babies were born at Community.

Miss Rose Witte, R.N.

Fillmore Condit served on the hospital's board of directors until 1936. He visited the institution every day and would often accompany the administrator to the bank on payday. If the hospital fell short of funds to make payroll, Condit made up the difference out of his own pocket. It is believed that Fillmore Condit personally contributed more than $109,000 to the hospital over the years. Long Beach Community demonstrated its mission from the very beginning. When a smallpox epidemic struck the city from 1925 to 1926, the hospital provided 1600 free vaccinations to local citizens. This was the first of many free public health services the hospital would provide to the people of the city throughout its history.

In 1926, **Dr. Bartlett Shackford,** a pathologist, opened a diagnostic laboratory at Community. A true entrepreneur, Dr. Shackford had another lab at the Security Bank Building in downtown Long Beach and even offered a messenger service to pick up specimens from patients' homes who were too sick to come in. Typical lab fees in those days were $10 for a basal metabolism and $5 for a complete blood count. Dr. Shackford ran Community's lab until he voluntarily joined the armed forces during World War II.

During the busy first years of the hospital, the X-ray department was under the supervision of **Dr. W.E. Hart,** who held the post for ten years. Long Beach Community went through some growing pains during its first five years. In 1927 chiropractors and osteopaths who had been excluded from practicing at the hospital filed a lawsuit. Their complaint was that a community hospital should also be open to their disciplines, not just medical doctors. A compromise was reached allowing osteopaths, but not chiropractors, to join the medical staff.

In 1929, the Galen Club was organized by young doctors who sought to expand their social and cultural interests. The social aim was "to bring about a better acquaintance between the younger members of the profession, that the jealousies and misunderstandings, so common among the older group could be avoided." The young doctors also sought to "provide a place where the young physician could read his own papers."

Long Beach Community Hospital quickly developed a reputation for the beauty of the facility and the quality of its medicine. The North American Review reported the hospital "is splendid, its appointments and equipment are the last word, all that modern science can offer."

1924 - Long Beach Community Hospital

In 1929, a row of rare Brazilian pepper trees was planted for several blocks along Termino. The symmetrical shape and glossy green foliage of the trees provided the only greenery on the undeveloped lots that marked the Termino approach to the hospital.

"There was practically nothing around the hospital," **Dr. Harry Jacob** recalled. "Just a big vacant lot across the street."

EARLY ADMINISTRATORS

Of the many colorful and strong individuals identified with Long Beach Community, **Miss Sarah Ruddy** is memorable for her fierce dedication, business sense, and the force of her personality. Several administrators preceded Miss Ruddy, who assumed management of the hospital in 1929. In those days, hospital administrators came from the ranks of nursing supervisors.

The early administrators, called "superintendents," were **Miss Blanche Stair, RN,** (1924), **Mary J. Fraser, RN,** (1926), and **Miss Elsie Peacock, RN,** (1928). But it was Miss Ruddy who put the hospital on firm financial footing for the first time.

A woman ahead of her time and equal to the task, Miss Sarah Ruddy served as the administrator of Long Beach Community Hospital from 1929 to 1950. She dedicated her life to the hospital and her watchful presence was felt long after she retired.

THE CRASH OF WALL STREET

On October 29, 1929, the crash of the United States stock market touched off a worldwide financial crisis. Nearly one-third of all the banks in the country suspended operations during the depression that followed.

In Long Beach, the medical profession responded by providing free medical care adopted from the "San Fernando Plan." The plan allowed "individuals in temporary misfortune" an opportunity to maintain "essential personal contact" with their own physician. Physicians were "compensated in a very small manner for actual expense." The San Fernando Plan that allowed needy people to obtain medical care evolved into the California Physician's Service, an early effort to provide less costly medical care to wage earners and low income workers.

Chapter 2

The 1930's: Lean Years and Helping Hands

The Great Depression continued to darken the early 1930s, putting an end to an era marked by easy prosperity. According to newspaper accounts of the time, bad check losses had cost the average American businessman roughly $1 million a day in 1929.

Putting the needs of local unemployed citizens first, the city's promoters discouraged out-of-towners from coming to Long Beach in search of jobs. Unlike many less fortunate towns, the city's abundant natural resources helped it weather the economic downturn. The port's tonnage increased ten-fold to 4 million in the five years ending in 1930 and the Signal Hill oil fields continued to provide jobs and revenue from city-leased wells.

Before the market crashed in 1929, the city had voted a $2.8 million bond issue to build a new Civic Auditorium and semi-circular pier. Lit by colored lights, Rainbow Pier curved seaward from Linden to Pine Avenue, with the nine-story high auditorium sitting on several acres of land fill within the pier's lagoon. From 1929 to 1939, gambling ships floated three miles offshore offering glamour and excitement during hard times. Each week some 50,000 people went looking for luck aboard ships with names like Johanna Smith, Tango, Rex, Monte Carlo and the City of Panama.

IN SICKNESS AND IN HEALTH

Sickness does not wait for times to change. Physicians found themselves providing more charity care as their patients lost their jobs and savings. In keeping with its mission to care for the people of the community, Long Beach Community Hospital continued to treat the sick even though many were unable to pay.

People in need turned up in increasing numbers at the hospital's social welfare clinics. The clinics had seen a steady rise in patients, providing free care to 107 patients in 1924, rising to 891 patients in the third year, and increasing to 1,804 patients in 1930. The hospital's ledger for the fiscal year ending August 1,1930 showed expenses totaling $171,493 against an income of only $160,542 (including $148,325 collected from patients in addition to gifts and endowment income).

EARLY PUBLIC RELATIONS

As the hospital's three-year ground lease with the city was nearing expiration in 1930, Long Beach Community launched a city-wide drive to attract donations to the hospital fund. **A.L. Ferver,** the acting president of the hospital's board of directors, issued this rallying cry in the **Press-Telegram**:

"Community Hospital exists and operates through the unselfish efforts of the people, by the people and for the people, that human suffering may be alleviated...It is a human trait to let the other fellow do the work that must be done, if done at all, without gain. The willing horse is allowed to pull all the load until his strength gives out, and then the load either stops or other horses must be harnessed to carry on.

It is obviously unfair that any small group or any individual should be expected to continue indefinitely to carry the financial burden and assume responsibility for an institution that belongs to the public and that operates for the benefit of the public. It is the business of all public bodies, religious institutions, and civic organizations to become interested in and carry the burden of Community Hospital."

COMMUNITY HOSPITAL
LONG BEACH, CALIF.

NAME	ADDRESS	Telephone	Room No.	Rate	Date Admitted
Patient Blumenstein Mrs. Iva	231 W 19th		301	3.25	12-21-33
Responsible Party	1:20AM		Case ob		Date Discharged
Physician Dr. McCree			Case Number 33821		No. Days

DATE	21-22	22-23	23-24	24-25	25-26	26-27	27-28	
Room and Care	300	300	300	300	300	300	300	2100
Board of Spec. Nurse								
Operating Room	500							500
Delivery Room								
Infant's Care	100	100	100	100	100	100	100	700
X-Ray Charges								
Laboratory	200							200
Drugs	385			100				485
Surgical Supplies	150							150
Physiotherapy								
Telephone								
Today's Charges								
Allowances								
Net Charges								$1135
Previous Charges								
Total Charges								
Cash Paid								5000
Balance Due								Credit $865

1933 hospital bill for a typical maternity stay of one week - only $41.35!

Mr. Ferver was undoubtedly referring to Fillmore Condit's continued financial support when he added:

"Due to the low rates for service given, much lower than the average hospital in Southern California, the hospital incurs a small deficit, thereby assuring its patients of service without profit. This deficit has heretofore been met by donations, and up to the present, the burden has fallen almost entirely on one pair of shoulders. But these shoulders cannot continue beyond a certain distance, and it therefore becomes necessary for others who can, to come to their assistance. If this burden is assumed by civic organizations and religious bodies as well as by private individuals and members of the association, the work will be easily done because 'many hands make light work."

He closed with this appeal:

"Community Hospital is a challenge to the public spirit of Long Beach. Shall this valuable aid to humanity be allowed to deviate from its original policy? Shall it fail to receive the attention and support of a people that has shown itself in the front ranks, as regards humanitarian interest?"

The newspaper article concluded that the hospital was running at a deficit partly because it had provided free care to some 4,000 needy individuals since its inception. Nevertheless, the hospital, which housed 90 patients and twelve to fifteen babies on any given day, was making good progress on closing the gap between operating expenses and income. In 1928, for example, a typical patient paid $5.22 each day for care that cost the hospital $5.70. The difference was made up by private contributions.

Long Beach Community Hospital's directors recognized the importance of advertising in stimulating business. A full-page ad in the April 20, 1930 edition of the Press-Telegram promoted the hospital's services:

service without profit

As the law permits neither profits nor dividends, the hospital rates to the public are far lower than the average in Southern California.

three operating rooms

Modern equipment...makes it possible to care for all eye, ear, nose and throat operations as well as major operations.

maternity ward

The maternity ward does its bit in launching at least a half hundred babies every month on their great adventure in life. The infants are kept in the nursery except when wheeled into the ward for important engagements with mother. In the nursery is a modern incubator, which is usually occupied. In addition to the ward, there are private rooms for the mothers.

x-ray laboratory

One of the most modern X-ray machines known to science. It is known as a Wappler, with valve tube type of rectification.

ward "J"
One of the smaller wards on the woman's floor...it has three exposures, assuring a plentiful supply of sunlight and fresh air. There are six wards in the hospital with a total of 125 beds. In addition, there are 38 private rooms.

hospital laboratory
One of the busiest and most important departments. About 1,600 examinations are made a month, and every patient entering the hospital has at least one or two tests.

culinary department
In the main kitchen meals are prepared for the hospital staff, nurses and patients. There are diet kitchens on each floor however, which assure patients of steaming hot meals."

An advertising handbill from the same period proclaimed Long Beach Community Hospital's "safe, attractive and luxurious" facilities and "175 physicians and surgeons on staff." Ward rates were set at $3 per day with private rooms available for $4 and up.

INSIDE THE HOSPITAL

According to the local paper, a visitor to Long Beach Community Hospital in the 1930s would be impressed with its "modern, immaculate equipment in every department, and especially with the well-lighted and well-ventilated rooms in every part of the building." The hospital boasted 125 beds in six wards and 38 private rooms. To reduce the $1,200 monthly linen expense, it had established its own private laundry.

At the beginning of the decade, the area surrounding the hospital was a quiet sector of the city. The hospital's windows overlooked the ocean with occasional glimpses of Catalina Island to the south and to the green San Gabriel Mountains northeast of the hospital. The newspaper lauded Long Beach Community's facility as "among the most beautiful hospital buildings in Southern California" with nurses who were "on a par with that of more expensive hospitals."

Next door to the hospital was a nurses' residence. "It was a very nice two-story building," **Madeleine Bowman** later remembered. "Women didn't have cars then and it was difficult for the nurses to commute, (so) they put up the building. It was clean and safe and cost the nurses about $30 a month to live there. They had their tea in the afternoon and did their work and ate all their meals at the hospital. One of the lab techs dubbed it the home for 'vagrant virgins.'"

In an interview shortly before his death in 1995, Dr. Harry Jacob recalled his impressions of Long Beach Community Hospital in the 1930's:

"It has always been kind of a friendly place. The personnel seemed to take an interest in the patients. I always appreciated the way the patients were taken care of. I would say it is equal to any (hospital) in the care of their patients and superior in terms of the kindness they show patients.

"There was one operating room and two general surgical rooms. We did a lot of gastric surgery in those days, which we don't do now because medication cures ulcers without surgery. Appendectomy and gall bladder were the most common surgeries."

New doctors typically took emergency cases to build their practices. The informal referral system involved a call in the middle of the night from the front desk of the hospital. Since there was no emergency room at the time, patients in varying degrees of distress waited in the lobby for the doctor to arrive. Dr. Jacob remembers the calls:

"For many years I was the Emergency Room at Community Hospital. When they had an emergency they knew they could always get me and I would go running up there in five minutes. I had stab wounds, gunshot wounds, almost everything you could think of to take care of.

I think (the patients) walked in the front door. We had this one room, which was the minor surgery room, and we used that for most of the emergencies unless they were major and we would take them next door. When they first put in the Traffic Circle they had so many accidents at the hospital we could hardly handle them all. I remember we had one man going around (the Traffic Circle) who had his arm out and he brought it in connected by a thread. I sewed the darn thing back on and he finally got a good result."

THE MARCH 10, 1933 EARTHQUAKE

When old-timers talk about the 1933 earthquake, they remember solid brick buildings reduced to rubble, pedestrians being struck down by hurling pieces of masonry, and fire breaking out all over the city. The 6.3 magnitude quake rocked Long Beach for just 12 seconds, killing 53 people and injuring 1,000 of the town's estimated 150,000 inhabitants.

Many people fled to high, open ground, fearing additional shocks or a rumored tidal wave. Automobile crashes dotted the intersections, as people raced across town searching for loved ones. Hospital superintendent Sarah Ruddy summarized the scene at Long Beach Community Hospital:

"The great trembler came at 5:55 p.m. on March 10, 1933. Writing this now it may lack the color it would have had, had it been written the same evening or the next few days when fear, confusion, or whatever it was permeated the atmosphere.

The gas was turned off, leaving us with no heat, no water or means to sterilize instruments for the heavy demands made by major surgical work. Telephone service was disconnected too, causing us to be overrun with relatives rushing in to find their sick ones safe, themselves too terror stricken to appreciate it.

Our building was not damaged except for falling of ornaments on the exterior of the building. This, however, with no lights and intermittent tremblers was frightening. Terror reigned. Many patients demanded to be taken out of the hospital. Other patients felt that if the building stood the great quake it would stand anything. Those who wished to be taken out were carried, bed and all, and placed in safety. Later on in the night tents were supplied for these patients as the hospital was filled with the injured.

While this work was being carried on, the care of the injured was steadily going on, the injured being cared for by the staff doctors and nursing personnel. It was but a very short time until many of the nurses of the city doing special nursing had volunteered their help, and by midnight or before, doctors and nurses from nearby cities were here to relieve our doctors and nurses. The Navy was here too. Their various personnel helped unstintingly throughout the entire emergency.

The injuries were many. Those severely injured were taken care of first as quickly as could be, with no lights, the tension of intermittent shakes, and frantic relatives. Such work was done under great difficulty. Fractured skulls, arms, legs, and ribs; sprains; injured chests; lacerations; bruises, deep and slight, were the cases cared for. No names were taken, but the number treated was estimated at about 125. Most of these were sent home."

Aerial view of Long Beach Community Medical Center and surrounding area.

Miss Ruddy recalled how the hospital continued to help in the shaky days after the disastrous earthquake:

"An emergency corps was organized among the attending staff, and **Dr. Plane** was appointed Chief. This corps was composed of 25 doctors, who were assigned to different wards, emergency rooms and operating rooms, each in accordance with his specialty.

An emergency clinic was kept open night and day for ten days. This was for the injured to be dressed, for new accident cases, and for those who needed medical care, as there were many sick from exposure since many people were living in their yards, with no heat, fearful to return to their houses. Five hundred and forty-two patients were treated or examined through this clinic."

Dr. J.C. Sosnowski was one of the physicians who helped during the crisis. In a letter to a New York colleague, he described the tremendous rallying together that took place in the quake's aftermath:

"Within a half hour of the first quake, American Legionnaires and Veterans of Foreign Wars were patrolling the streets and organizing relief centers. Within three-quarters of an hour,

nurses and physicians were on duty at relief centers and hospitals. Within an hour several thousand armed marines and sailors from the (Atlantic and Pacific Battle fleets anchored in the harbor) were patrolling the streets, guarding property, preventing careless acts, and being generally useful. Rescue crews were searching streets and wreckage for killed and injured, and within a short time thereafter the few fires started by the quake were under control.

By midnight truckloads of food, tents, firewood, and medical and surgical supplies were being delivered from various outlying districts. By midnight relief corps of physicians and nurses were taking the load off the shoulders of the Long Beach men and women, the Navy furnishing a large and competent group and much needed supplies. By ten o'clock Saturday morning the Army and National Guard had field kitchens established at strategic points all over the area and rehabilitation work was running smoothly."

The damage to the hospital was mostly superficial. Cracks appeared in the interior, but none deeper than the plaster. The exterior facade lost pieces of ornamental stone from the roof and arched main doorway. Inside the hospital, all the dishes in the dining room were broken and a large percentage of the table silver was lost. Some hospital supplies, such as instruments and blood pressure devices were taken and never returned. Fortunately, Long Beach Community Hospital was one of the few large buildings in the city to escape with its structure intact.

Miss Ruddy sent letters thanking the many organizations and individuals who had stepped in to meet the initial crisis and help the hospital get back on its feet. Several organizations and companies donated equipment, services, supplies and personnel. Help came in the form of loaned equipment, supplies such as pharmaceuticals, bandages, and beds and blankets, and temporary housing for the exhausted nursing staff. Many volunteers from hospitals in Los Angeles and Orange County worked long hours beside Community's doctors and nurses. Rock gas was supplied at no charge to sterilize hospital equipment, fuel water heaters, and run the cooking ranges.

THE COMMUNITY REBUILDS

As the terrible tremors faded from several times every day to every few days, to every few weeks, the citizens of Long Beach began to focus once again on the future. Long Beach Community College opened on September 16, 1935, becoming only the second junior college in Los Angeles County. In 1936, seismic studies on Terminal Island detected vast stores of oil in Long Beach Harbor. The oil discovery touched off 25 years of political wrangling between the city and the state over the rightful recipients of tidelands revenue. In 1938, a federally funded breakwater sheltered the entire harbor at a cost of $7 million. The government's investment protected the homeport of 43 naval vessels anchored off the Long Beach coastline.

According to the hospital's ninth annual report issued in 1934, more than 5,000 patients were admitted; 401 births were recorded; 2,552 surgeries were performed; and there were 21,856 lab and 1,561 X-ray tests. Long Beach Community managed to reduce its debt by $3,000 even though earthquake repairs cost the hospital $2,800. Free services were provided in the amount of $19,499 for the year as the hospital fulfilled its mission of community care.

By 1935, the hospital was adding to its services with a physiotherapy department under the direction of **Mrs. Gladdes Neff,** physiotherapist, and a medical library. Fillmore Condit celebrated his 80th birthday in the same year.

A MODERN HOSPITAL

Long Beach Community Hospital continued to grow throughout the 1930s. In 1936 it boasted a newly decorated nursery, mobile X-ray unit, and a surgery unit that was "up to the most exacting standards."

The 1936 Annual Report elaborated:

"Operating rooms and equipment are modern and kept up to date. The operating room personnel is carefully selected and well trained. Results have shown their competency. Constant care is exercised to maintain safety. Large, well-lighted rooms, good sterilization, good equipment, and a good force are essential in obtaining good results. Last year nearly 3,000 surgical operations were performed."

TUMOR AND CANCER CLINIC OPENS

On June 3, 1937, after a year of study, the Board of Directors and a "malignancy committee" chaired by **Dr. Frank Young,** realized a long held dream to establish a Tumor and Cancer Diagnostic Clinic at Long Beach Community Hospital. A clinic committee, headed by Dr. Sosnowski, established that it would operate every Thursday morning and be staffed by nurses supplied by the hospital and Community physicians who would serve at no charge. The clinic was equipped with "the most recent safeguards to its patients," and the latest type of Kelley-Loett shockproof fluoroscopic table was installed.

A local reporter wrote of the cancer clinic, "It stands ready to recognize the first tiny sign of trouble and to take the proper steps to bring an assurance of health to men and women who, without this service, might wait too long."

The same reporter was equally impressed by the hospital, writing, "It is such a delightful place to stay, with rooms that look more like a nice hotel than a thoroughly modern hospital. It is a community institution that has done its part in making Long Beach a healthy, happy city."

A DEDICATED RADIOLOGIST

Dr. Herbert A. Judson can be credited with bringing Community's X-ray department into the modern age. When he joined Long Beach Community Hospital, Dr. Judson was the only radiation therapist in Long Beach and the first to use high radiation to treat cancer. At about the same time he introduced external radiation therapy to the area, Dr. Judson started the hospital's diagnostic radiology department which was mostly used for chest X-rays, with tuberculosis a particular concern. Before retiring in 1966, Dr. Judson built a radiology department without equal in Long Beach.

SAD END TO A CHALLENGING DECADE

The 1930s closed with the sad passing of Fillmore Condit on January 6, 1939. Physicians, nurses and the community at large grieved the loss of the hospital's guiding light and moral compass. The following resolution was read into the minutes of the Board of Directors on January 12, 1939:

Resolve:

I. That we have lost, in the passing of Fillmore Condit, a helper, a counselor and a friend of great worth.

II. That we will bend our energies to carry on the good work that he initiated.

III. That we bow to the dictates of a higher power and rejoice in his rest from his labors.

IV. That we join in sympathy with his bereaved family, and

V. That we extend to his family the hands of sympathy and affection.

Chapter 3

The War Years: World War II and a Changed City

Just as World War II changed the map of the world, it also brought the city of Long Beach into new national prominence. Home to the Pacific Fleet, the Terminal Island Naval Air Station, the Naval Dry-docks (later named the Naval Shipyard), and the Douglas aircraft plant, Long Beach was crucial to America's war effort.

At peak production in 1943, Douglas employed 43,000 workers, over half of them women. Douglas employees produced 9,400 military aircraft for the government including 3,000 B-17 Flying Fortresses. The war brought thousands of workers, military personnel and their families to Long Beach. Thirty thousand workers employed in the harbor area and an additional 50,000 military personnel stationed in Long Beach created a severe housing shortage.

While the war raged on, rationing affected every household, limiting supplies of sugar, coffee, canned foods, meat and dairy products, gasoline and automobile tires. In 1942, local hospitals also experienced food shortages as civilian quotas took a back seat to the needs of the military. Faced with scarce resources, the hospital's annual Christmas party for neighborhood children was discontinued during the war. However, the hospital maintained its commitment to meeting the community's health needs regardless of hardships at home. During the war, the hospital rendered an average $16,000 in charity care each year.

A large number of Long Beach Community's staff volunteered for active duty. Sixty-two physicians and 20 nurses served their country from 1942 to 1945, including some of the hospital's most successful physicians. Their wartime experience elevated the quality of medicine in Long Beach when they returned to private practice.

"Dr. Harry Jacob was probably the premier surgeon after the war," noted **Dr. Donald Belville.** "Harry had just one finger and thumb so he was able to get down into small cavities. He did an enormous amount of trauma surgery during World War II. Trying to save the lives of soldiers in the field was a turning point in medicine. Portable X-rays in the field and improved surgical techniques were also developed during the war."

Dr. Charles Morrell served his internship at San Diego Naval Hospital during the latter part of the war. Like so many physicians who later came to practice at Long Beach Community, Dr. Morrell's wartime service gave him exceptional experience.

Dr. W.P. Garrison was a surgeon with the U.S. Marine Corps assault landing forces stationed in Saipan. Interviewed by a reporter after his return, Dr. Garrison recounted that one of the major medical accomplishments of the war was the ability to provide medical and surgical treatment at the scene of battle, often getting a wounded marine on an operating table within fifteen minutes.

"It was due to this factor and the high quality of surgeons and the equipment provided by our government that the mortality rate was kept low and that many men are returning to their homes and families who, in other words, would have remained to be buried on the battlefields," Dr. Garrison said.

ON THE HOME FRONT

With so many nurses serving in the military, the war created a nursing shortage at home. Many of the hospital's retired nurses returned to general duty nursing during the war years, assisted by local Senior Service Girl Scouts serving as hospital aides. Red Cross volunteers and the Pink Caps, a group of Long Beach sorority women, also contributed to the daily work of the hospital. Local churchwomen sewed and mended the hospital's linens. The hospital staff purchased war bonds through payroll deductions.

In the early 1940s, the hospital looked much as it had when it first opened. The lower floor was dedicated primarily to orthopedics with two large 18-bed wardrooms at the front of the building. Pediatrics, surgery, and general medicine were upstairs. The X-ray department, featuring the latest "shockproof" equipment, was in the south wing. Long Beach's 20-30 service club donated an infant respirator to the hospital to be made available to any infant in need. In 1940, Community had 55 registered nurses who cared for a total of 4,000 patients. The hospital's portable X-ray unit was sent out into the community to conduct mass TB screenings. Toward the end of the war, old X-ray films were sold for 26 cents a pound to ease the plastic shortage.

The hospital's administrator, a dedicated penny pincher, found novel ways to cut waste. For a number of years, the hospital stationery was mimeographed rather than printed.

"This is what happens to mail, no matter how pretty the paper is," Miss Ruddy would explain as she tossed an opened letter in the wastebasket. In her view, there was no need for fancy stationery.

In 1942, a new $70,000 wing brought Community Hospital's capacity to 150 beds to keep pace with the city's rapid growth. The addition to the north wing added three floors including 16 private and ward rooms, a nurse's dining room, and basement. In 1944, the hospital celebrated its 20th year serving the people of Long Beach.

THE BABY BOOM'S FIRST BABIES

"With the Navy here, there were a heck of a lot of babies born at Community during the war," remembered **Dr. Geneva Beatty,** an obstetrician on staff at the hospital. She recollected:

"The (Navy) guys would come to Long Beach and then their wives would join them. Some of those kids were so sweet. They'd say 'we feel just like you're our mother.' They were all alone with their husbands away at sea and they were going to have this baby and they had no one.

We had two delivery rooms and (doctors) could stand and look out the windows while (we) waited for our patient We could see the cows down by the Traffic Circle and out to the bean fields beyond. The Labor rooms were separate (from Delivery) with one or two patients, depending on how busy we were, divided by curtains."

Fathers were not welcome in the delivery room in those days, according to Dr. Beatty. The prevailing view was that doctors didn't have time to hold a nervous father's hand while they were concentrating on delivering a baby. Fathers waited to see their babies until nursery visiting hours, which were at 3 p.m. and 7:30 p.m.

After a delivery, "We kept (the mother) flat in bed for 10 days to two weeks," Dr. Beatty said. "They didn't even get up to go to the bathroom during the first week. Next we would sit them up on the side of the bed, and then we would finally let them get up and walk on about the 12th day."

UNCOMMON WOMEN

"It was very interesting during the War Years because so many (male) doctors had gone off and many women had no choice but to come to a female doctor," Dr. Beatty noted. "But once they were used to it, many women found they were more comfortable talking to another woman about a woman's problems."

Dr. Beatty delivered well over 3,000 babies, and had several named for her, before she retired in 1975. Twice chief of Community's medical staff in the 1950's, Dr. Beatty was honored by the American Medical Women's Association as one of eight U.S. Medical Women of the Year in 1959. During her 35 years as an obstetrician in Long Beach, she grew accustomed to the middle-of-the-night call summoning her to Community Hospital.

"It got so that if too many nights went by without a call, I would wake up and really wish somebody would (go into labor) so that I could go down and see what was going on in the night shift."

Dr. Beatty was one of several outstanding female doctors, most of them obstetricians or pediatricians, who came to prominence at the hospital during the War Years.

"Dr. Dorothy Hewitt was another monumental person who really supported Long Beach Community," **Madeleine Bowman** elaborated. "She was an exceptionally qualified physician with high standing in the community. Those (lady doctors) were pioneers."

Dr. Beatty was one of five female medical students in her class of 75 at Loma Linda University (then called the College of Medical Evangelists). She had to overcome her father's strong opposition to attend medical school.

"My Dad was absolutely against it," Dr. Beatty explained. "He envisioned (female physicians) with their hair wound up some crazy way and wearing man-tailored suits with heavy, flat shoes. He said I was a feminine person and he didn't want me to turn out that way."

Dr. Beatty chose medicine because she wanted to help women by doing missionary work in India, where women were forbidden to be treated by male doctors. As part of her training she was sent to China and was caught in the war between China and Japan. She helped open a refugee camp for pregnant women in Shanghai before returning to the United States to marry Dr. Harriman Jones, the nephew of the founder of the Harriman Jones Clinic in Long Beach. The two physicians never practiced medicine together but they spent one month of every year relieving missionary doctors in remote parts of the world.

"Dr. Beatty has done so many things but she is very quiet about it," said her friend, Madeleine Bowman. "But she was dedicated to her patients and practiced the highest caliber medicine."

COST OF CARE

Obstetrical rates in the 1940s were less than $10 a day for a ward bed. A ten-day stay cost $87.50 for a private room or $77.50 for a ward bed. "The rates included everything for a normal delivery," Dr. Beatty explained.

Maternity cases were expected to pay $50 on admission and the balance when mother and baby left the hospital. In a gentle reminder to patients, the hospital fee chart suggested:

"It is our hope that all bills will be paid before the patient leaves the hospital. If financial arrangements are necessary, they must be made before admission. We do not find it desirable to extend credit to patients in private rooms or to maternity cases. The latter have nine months to prepare."

Other typical hospital charges in the pre-war 1940's were:

$ 7.50 for a minor operation (such as a tonsillectomy)
$15 for the first two hours for a major operation plus $5.00 for every hour thereafter

Daily rates were:

$ 6 for the adult ward
$ 4 for the children's ward
$ 7.50 for a semi-private room
$ 8-11 for a private room
A $1 charge was made to move a patient to a different room

PEACETIME DIVIDENDS

By the time the war ended in 1945, the city of Long Beach had grown and prospered while helping the nation achieve victory. As sailors mustered out of the service, many chose to stay in Long Beach rather than return to the hard climates and more limited opportunities of their native states. The open fields to the east, north and south of the city were subdivided

into housing developments for thousands of navy personnel and wartime employees who now sought jobs in a peacetime economy.

"Long Beach was the kind of place where kids could leave their toys out on the sidewalk and they'd still be there the next day," Madeleine Bowman remembered. "We only locked our doors when we went to bed at night and nobody ever worried about someone breaking in."

While the new arrivals settled in among the descendants of the city's founding families, the medical community made way for a new breed of physician: the medical specialist. Prior to the war, most surgeons did not confine their practices to surgery. The newer doctors had received specialty training from some of the finest physicians in the country and were knowledgeable about the potent new weapons being developed to fight infection and disease.

In a 1992 speech to the Long Beach Surgical Society, **Dr. Max Gaspar** described the changing face of Long Beach medicine:

"Shortly after World War II, there was a large influx of doctors into Long Beach. Many of them had been stationed at the Naval Hospital or aboard ships in Long Beach Harbor.

"Although most of the early surgeons were doing orthopedics, urology, and gynecology, as well as general surgery, there were very few pure specialists. After the war, a number of specialists came to town. In orthopedics there were **William Rhorer, William Durnin** and **Harry Alban.** In neurosurgery there were **Frank Polmateer, Charles Spicer** and **John Ross-Duggan.** In thoracic surgery there were **Phil Lefkin** and **Thomas Buhl.** In urology, **Walter Welton** and **Milo Ellik.** In plastic surgery, **Frank LeBlond** and **Leo LaDage.** In gynecology, **Lowell Hill, Sterling Pillsbury** and **George Paap.** Older doctors tended to resent having so many new doctors in town."

Many of the new doctors at Community first became acquainted as interns and residents in VA Hospital medical training programs. The VA also trained the technicians and technologists who became skilled in the new diagnostic equipment that was emerging at this time.

"The VA Hospitals were the premier training grounds (for new doctors)," **Dr. Donald Belville** confirmed. "There were so many people involved and they were well trained. They were older and had gone through the war, which is a maturing experience if there ever was one."

Once they were on staff at Long Beach Community, the VA-trained doctors tended to recruit new physicians from their own ranks and to refer patients to one another. These military physician specialists tuned their skills to improve the health of local citizens.

Dr. Morrell said:

"Surgical and other specialty residencies were set up after the war. Before that, if you were a bright young guy and wanted to be a surgeon, you became a sort of apprentice to an older surgeon and then after a number of years, you became a surgeon just by doing it all the time. There were some of those doctors still around town, but after the war, the American Boards became very prominent and then the VA system established a lot of residencies that had not been available before. In surgery, you had to take four years of training on what they called "graduated responsibility." By the time you were in your fourth year, you were known as the Chief Resident and you were doing the more complicated cases, with staff and faculty there to guide you. That was a post-war phenomenon."

In 1947, according to Dr. Max Gaspar, the town's younger board-certified surgeons who had completed surgical residencies or received surgical training in the war, formed the Long Beach Surgical Forum (later called the Surgical Society). Many of Long Beach Community's surgeons were affiliated with this professional organization.

WORLD WAR II's WONDER DRUGS

The war not only provided the civilian population with specialists trained in new techniques, it also brought antibiotics into widespread use. Dr. Morrell said:

"The greatest advance in my career, which is long, is the onset of antibiotics. When I started medical school, there was a lot of morbidity and mortality just due to plain old infections. While I was in medical school they came out with this marvelous new thing known as the sulfa drugs. By the time I was getting ready to graduate, they had something even better called penicillin. During the war, penicillin was in widespread military use but (civilian doctors) couldn't get it because it was difficult to produce and was consequently limited to the war effort."

THE WAR AGAINST POLIO

Before the Salk vaccine became widely available in 1955, polio was a dreaded crippler of children. In 1948, polio was on an increase and had reached "emergency proportions" locally, according to the **Press-Telegram**. Long Beach Community responded by establishing the first post polio ward for children in the harbor area. Treatment for the crippling disease included hot packs, range of motion exercises, and pool therapy. The March of Dimes provided the cost of care for patients whose parents were unable to pay.

The hospital also installed a Hubbard tub to treat adult victims of infantile paralysis. Considered the latest therapy of the time, the $5,000 tub was purchased with March of Dimes funds and donated to the hospital by the National Foundation for Infantile Paralysis. Patients were lowered into the violin-shaped stainless steel tub, which provided hydrotherapy to massage paralyzed muscles.

A TORCH IS PASSED

On November 13, 1949, **Mr. B.F. Tucker** retired as president of Community Hospital's Board of Directors, a post he held for 20 of the hospital's 25 years.

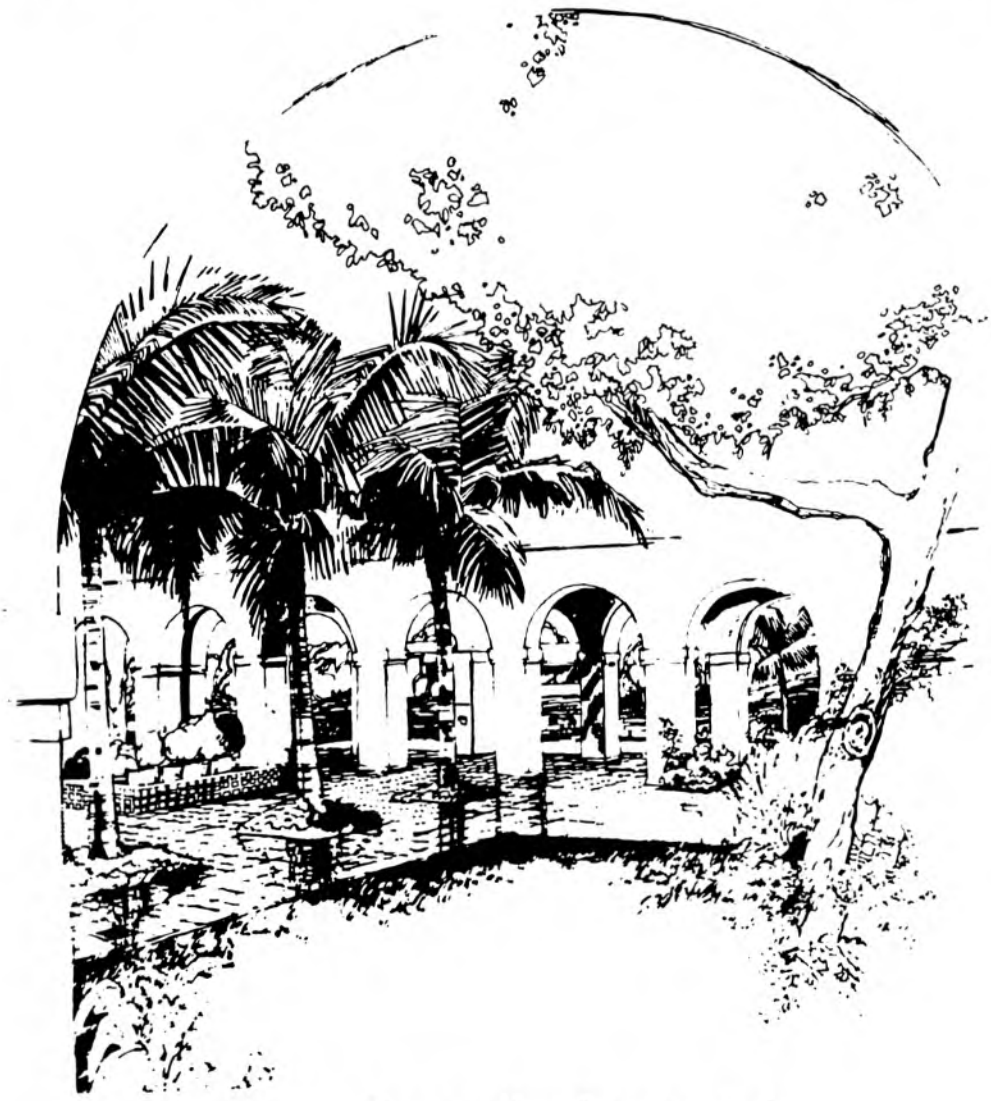
Benjamin Tucker had received the torch of leadership from Fillmore Condit and served the hospital with the same selfless dedication. Along with Miss Ruddy and an equally dedicated Board, he helped guide the hospital's transformation from a small town hospital to a hospital capable of meeting the needs of a diverse and growing metropolis. The pioneer California banker had also helped found and guide the Tichenor Orthopedic Clinic for crippled children next door to Community Hospital.

POSITIONING FOR THE 1950's

As the decade neared its close, civic support was building for a state college. The next year voters approved $1 million to purchase land for a campus northeast of the VA Hospital. By 1949, the city's postwar growth had outstripped the capacity of its local hospitals, which had only 3.1 beds per thousand residents. The U.S. Public Health Service recommended a minimum of 4.5 beds per thousand to render adequate hospital care.

The city's four major hospitals all announced plans to expand their facilities at a total anticipated cost in excess of $5 million. Seaside proposed a new 200-bed women's and children's hospital costing from $1.5 million to $2 million. Community proposed an addition that would increase capacity by 130 beds at an estimated cost of $900,000. It had already commissioned architectural drawings, which were ready for inspection. St. Mary's sought an addition costing $1 million that would add 53 beds and 42 bassinets. Harriman Jones Clinic planned three new wings at a cost of $1.5 million.

During the following decade the city's hospitals expanded significantly, but the politics, financing and building plans would shift many times before the first concrete was poured.



Community Hospital's quaint courtyard

Chapter 4

The 1950's: Lean Years and Helping Hands

The tides of Long Beach Harbor were awash with wealth in 1950. In 1952, President Dwight D. Eisenhower returned the ownership of shore land control to California. This enabled Long Beach to launch a successful appeal to use the impounded profits from the Wilmington oil fields for inland projects. The appeal was followed by an inter-hospital council identifying the city's need for additional hospital beds along with alarming press stories about the bed shortage (one 1953 headline screamed "Jammed Hospitals Bar 163 Patients in Single Day"). Political posturing to access tideland oil funds and expand hospital facilities lasted for several more years.

Long Beach submitted a $16,382,000 hospital construction issue to the voters on April 3, 1953. Proposition H, which was to use tidelands money to finance the program, was supported by **Monsignor O'Dwyer** of the Los Angeles Archdiocese, dozens of civic and labor organizations, physicians, numerous civic leaders, and the local paper. After the voters overwhelmingly approved the measure, Kaiser Foundation stepped in to appeal for competitive bidding for non-profit organizations who wanted a share of the multi-million dollar pie.

The city was later denied use of the tidelands money by the California State Supreme Court, which awarded the profits to the state citing a 1911 trust. In 1956, however, the state legislature proposed and passed a bill splitting tidelands profits 50/50 with the City of Long Beach.

James Ludlam, Esq., was hired to represent the interest of all the Long Beach hospitals. As he later described the situation:

"It's a fascinating story. When the law was changed that the tidelands money had to be shared with the city of Long Beach, there was this large amount of cash flow coming into the city. The question was: Who would get the money? It was a very hot political battle within Long Beach because the oil industry did not want the money to go for hospitals — they had their own ideas of where the money would go. The leadership was taken by Memorial to get it to be used for hospital purposes and they wanted it to help finance their building.

The hospitals divided the funds up three ways between Memorial, Pacific and Community, with Memorial getting the biggest chunk of it. When I first went to Long Beach, Community was the dominant hospital and Seaside was in an old structure and didn't have very good doctor support. Memorial ultimately sold the old Seaside facility back to the county and built a new hospital for themselves."

As it turned out, the city put the hospital bond issue back to a vote in a special election on February 9, 1956. Of the $10.5 million approved by voters in 1956, $6,642,855 went to build Memorial Hospital, Osteopathic (Pacific) Hospital received $1,285,715, and Community Hospital received $2,571,430.

"Naturally we are very pleased," **Howard Hatfield,** Community's administrator, said in Hospital News the day after the voters approved the bond. "It means the addition of 150 beds to our hospital, and they are badly needed. Our occupancy this morning was 102 percent."

MISS RUDDY STEPS DOWN

Long before the expansion of the three Long Beach hospitals took place, however, Community Hospital went through a significant administrative shift. In November 1950, the hospital's administrator, Miss Sarah Ruddy, retired from the post she had held for 21 years.

Miss Ruddy had recommended **Howard Hatfield** as her replacement. Mr. Hatfield represented the new profession of hospital administration, with training in accounting and business management. One year after becoming Community's administrator, Mr. Hatfield was elected president of the Hospital Council of Southern California. He was elected a fellow in the American College of Hospital Administrators in 1954. And in 1958, Mr. Hatfield became the president of the California Hospital Association. Madeleine Bowman remembered the hospital's first professional administrator:

"Mr. Hatfield related well to everybody and had a wonderful rapport with the employees and the medical staff. He could pour oil on troubled waters and was a good mediator."

Hospital rates for adults in 1951 ranged from $12 a day for a ward room to $17 for a private room. A week in the maternity ward cost $126.50 or $141 for a semi-private room. The nursery cost $2.50 a day or $3.50 for premature babies (incubator costs were an additional $1 per day).

Housing was affordable and the GI Bill made it easy for veterans to buy their first home. Lakewood was one of the largest postwar housing developments in the United States, with homes being built at a rate of 500 per week in 1950. New houses ranged from around $10,000 to $12,000.

The construction boom also provided ample employment for veterans rejoining the civilian work force. Dr. Max Gaspar recalled that a Dodge V8 cost $2,541 and a pair of Florsheim shoes cost $20 in the mid-50's. At the grocery store, a half-gallon of milk was 15 cents and a loaf of bread cost 18 cents.

Long Beach Community Hospital was still a two-story structure sitting atop a hill when the 50's began. On balmy evenings, parents loaded up the family station wagon to catch a 50's-era monster movie at The Circle Drive-In Movie Theater at the foot of the hill. The area was largely undeveloped, with mustard fields extending all the way to where Long Beach State University now stands. Rabbit hutches were located on the grassy hillside leading down from the hospital, containing the rabbits used for pregnancy tests.

AN INFLUX OF TALENTED YOUNG DOCTORS

A second wave of outstanding, VA-trained doctors arrived in the city when the Birmingham VA Hospital moved from San Fernando Valley to the former Long Beach Navy Hospital on July 1, 1950. One of these physicians was **Dr. Eugene Temkin,** who recalled what the influx of talent meant to the city:

"When the VA Hospital moved here, the physicians who had residencies came into the community and they were all either board eligible or board certified. Suddenly Long Beach, which before had had maybe a handful of certified doctors, now had 20, 30, 40 board-certified physicians. Well, the quality of care obviously had to improve all over the city. Community Hospital benefited tremendously by the (infusion of VA doctors).

Physicians like Dr. Charles Morrell and Dr. Herbert Movius were extraordinary. They did things that were out of this world. They made surgery a very well respected thing, and when they left, good people took over. But they left an indelible mark, believe me. Dr. Morrell set a pace and a level that went into all the sub-specialties."

Another change after the war was the growth of the health insurance industry. According to hospital counsel James Ludlam:

"During the war there was a wage price freeze because of inflation. To encourage people to work, they made health care insurance an exception to the wage price freeze, with employers providing health insurance who hadn't done it before. The employers did it to get employees. And at the end of the war, they made health insurance a deductible cost so there was a tax advantage to the employer and a tax advantage to the employee."

TEN YEARS OF MODERNIZATION

Community steadily improved its equipment, services and capabilities throughout the 1950's. In 1950, the hospital invested $10,000 in the latest X-ray equipment, a "serial filmer" that simultaneously took pictures during a fluoroscopic examination. The same year, Community installed laundry facilities and purchased two adult electric oxygen tents, an Emerson packer used for treating post-polio patients, two junior oxygen tents, a cold steam humidifier and electric sterilizer for the pediatrics department, and an infrared lamp used in physical therapy.

In 1951, Community added a new X-ray table known as the Picker "Constellation," the first of its kind in Southern California. Other improvements included a new central supply department, central food service (promising to deliver the patient's meal within five to seven

minutes of preparation), a milk formula department, and a larger linen and sewing room. The Long Beach Insurance Association presented Community with a "modern iron lung" and refrigerated oxygen tent. From 1952 to 1955, the hospital added an oxygen-air pressure lock (an early incubator to help premature infants breathe), launched a community health needs assessment, installed new stainless steel dishwashing equipment, a new hospital-wide hot water system, modernized patient and ward rooms and improved the parking. The hospital remodeled the maternity department, nursery and delivery rooms The first epilepsy clinic in the Long Beach area opened at Community on February 11, 1958. In a precursor to today's team approach to patient care, the clinic's staff included two physicians, two clinical psychologists, and a medical social worker.

In 1959, Community became the first hospital on the West Coast to have "fog rooms" for pediatric respiratory patients. The rooms' fog generators provided controlled humidity and temperature, replacing old-fashioned hot steam rooms.

Registered nurse **Alice Brown** came to Community in 1957. She recalled:

"I was a staff nurse in pediatrics. It was a different set-up then than it is now. They had a ward where they had cribs and a few semi-private rooms.

They hardly do tonsils anymore, but at that time we had a lot of T and As, tonsils and adenoids. The kids would go to surgery and come back and have their ice cream and Popsicles and their mothers would take them home the same afternoon.

We always had at least a few polio patients. Sometimes they'd be in the hospital for months getting treatment until it was determined they'd gone as far as they could go. I didn't see any iron lungs there at that time.

With polio, we used to do the Kinney hot-pack treatment. We'd get pieces of blankets and put them in this container until they were steamed real hot. Then we'd wrap the affected limbs in the hot blanket cloth. It was supposed to help with paralysis."

A new device called a "respiration assister" was purchased in 1959 for the surgery department. Rather than relying on the anesthesiologist to manually operate a breathing bag, the pneumatic device breathed for patients who developed respiratory difficulty while under general anesthesia.

OTHER MEDICAL ADVANCES

Dr. Max Gaspar in his history of the Long Beach Surgical Society recalled the 50's as a time of enormous advances in medicine. New antibiotics continued to be introduced such as streptomycin, erythromycin, neomycin and tetracycline. In cardiology, serpasil was one of the first drugs developed to treat hypertension and in ophthalmology, the first plastic lens for cataract surgery became available. The relationship between smoking and lung cancer was receiving serious study. In 1956, the electroencephalogram was introduced, and by the end of the 50's, new anesthetics such as fluothane became available.

AUXILIARY LAUNCHED

Long Beach Community always enjoyed the generous support of a loyal board, grateful city, involved physicians, and dedicated staff. In 1957, a new group of private citizens formed to provide service to the hospital. The Long Beach Community Hospital Auxiliary officially incorporated in March with **Mrs. Donald Penrose** as its elected president. Just a year after it had begun, the Auxiliary had already dedicated more than 16,000 hours of service and had presented a check for $2,529 topurchase a new operating table.

Dressed in pink and white-striped uniforms, the hospital's auxiliary volunteers were especially welcome on the pediatric unit where they gave free puppets called Pinkies to every hospitalized child. The group, which is still operating today, opened the hospital's gift shop, decorated the corridors, photographed new arrivals in the maternity ward, founded a Junior Auxiliary, and volunteered countless hours in hospital service.

Groundbreaking ceremony for the Howard B. Hatfield Wing

A DREAM REALIZED

First discussed in 1949, the hospital finally realized its dream of expansion ten years later. On November 18, 1959, the new $2.5 million six-story East Wing opened amid festivities that included public open houses and congratulatory telegrams from such luminaries as Vice President Richard M. Nixon, Arthur S. Flemming, the U.S. Secretary of Health, Education and Welfare, California Governor Edmond G. Brown, and U.S. Senators Clair Engle and Thomas H. Kuchel.

The gleaming 95,375 square foot building was a wonder of modern hospital planning and design. The architectural team headed by Hugh R. Davies used extensive plate glass to provide patients with floor-to-ceiling views. A total of 148 new beds and 34 bassinets brought hospital capacity to 300 beds. The East Wing featured private, as well as two- and four-bed rooms linked by intercom to the nurses' station, piped oxygen to all patient rooms, and the city's first isolation unit for patients with contagious diseases. In a break from institutional gray, the interiors were awash with color, from stripes in the pediatric unit to happy, bright colors in the obstetrical area, to soft pastels in patient rooms.

The first floor housed the new hospital kitchen and outpatient exam rooms. Admitting, administration and business offices were located on the second floor along with the medical library, occupational and physical therapy, and outpatient services such as lab and X-ray. The third floor was dedicated to surgery and surgical patient rooms. It included five new major operating rooms, an orthopedic room, cystoscopic room, minor operating room, and a recovery room. Oxygen was piped into all operating and delivery rooms.

Maternity was located on the fourth floor and was one of the state's first to have post-anesthesia recovery rooms and an isolation nursery in addition to five separate eight-bassinet nurseries. The fifth floor pediatric unit featured a sun deck, two isolation rooms, and its own television room. A 275-seat auditorium adjoined the northern side with the boiler and laundries in a separate building to the east.

While the city bond issue covered the cost of the city's new hospital structures, it fell short of funding the cost of equipment. Standard operating costs and the cost of providing non-reimbursed emergency care were constant drains on hospital financial resources. A citywide campaign named the United Hospital Fund was formed in 1957 to raise $4 million to buy equipment for the new hospital buildings approved by voters the year before. Local physicians donated more than $1 million to what was called the "biggest philanthropic drive in Long Beach history." Of the total $3,785,781 raised to equip Long Beach hospitals, Community received $675,000. The Children's Benefit League donated $10,000 to Community's pediatrics ward and the hospital's own employees contributed $28,500 for their new hospital.

In a sad twist of fate, Howard Hatfield did not live to see the capstone of his exceptional career. Although he had played a major role in the creation of the new hospital, he died on March 12, 1959. To recognize his contribution to Community Hospital, the Howard B. Hatfield Memorial Wing, which had opened on May 25, 1958, was renamed in his honor.

The one-story, 50-bed Hatfield unit embodied Mr. Hatfield's visionary ideas of enlightened hospital care. It separated convalescing patients from the acutely ill, and provided them with a cheerful, non-institutional environment. Each of the 25 patient rooms had its own sunny patio where patients could take their meals in nice weather. The patients could also relax, read or socialize in the large, relaxing lounge furnished with rattan sofas and chairs. A fireplace and landscaped garden added additional touches of home.

Because the non-acute patients required less intense nursing care, costs on the unit averaged $2 less per patient day. The unit had the additional benefit of making more beds available for acutely ill patients by transferring convalescing patients out of the acute care facility.

Chapter 5

The 1960's: Professionalism and Progress

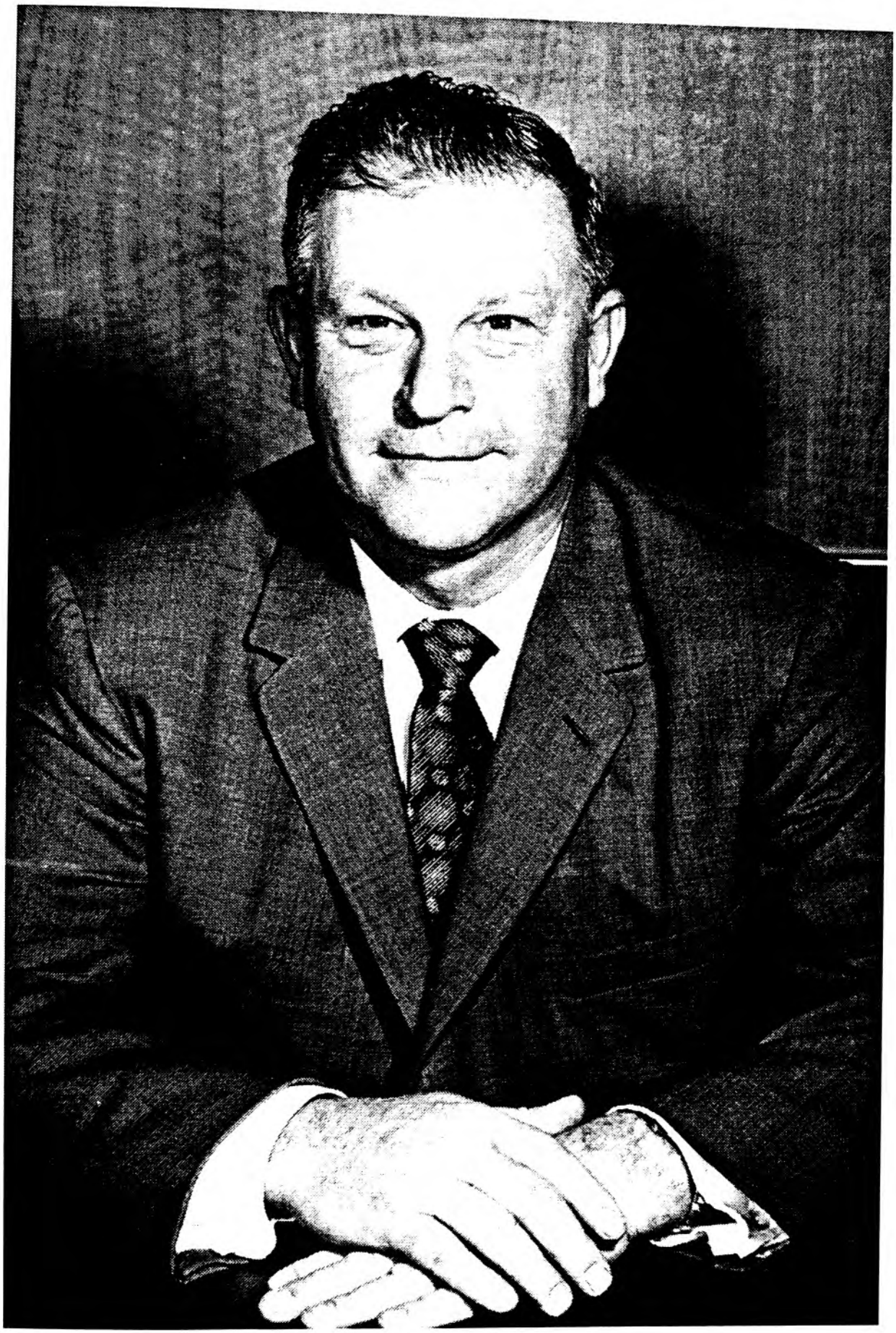
The 60's saw a continuation of a national movement away from the city to the suburbs. In Long Beach, the population spread to the east and north in new neighborhoods around Long Beach City College and Long Beach State College. In 1963, the city of Long Beach celebrated its 75th birthday in month-long festivities. However, Long Beach's growth spurt was beginning to sputter, increasing from 341,168 residents in 1960 to just 361,384 by 1980.

In an early effort to draw people back downtown, the city filled in the old Rainbow lagoon and built a new $8 million circular multi-purpose arena. In 1967, civic leaders scored what they thought was a major coup by outbidding Boston and Brooklyn for the Queen Mary. The illustrious ocean liner was purchased for $3.45 million and paid for by tidelands money that had been set aside for a maritime museum. However, maintenance costs for the aging dowager of the seas were prohibitive and it failed to attract the huge numbers of tourists the city fathers had hoped for. Nevertheless, an expanded airport and continued port growth gave credibility to Long Beach's self-proclaimed slogan, "The International City."

SETTING THE STAGE FOR PROGRESS

Things looked bright for the area's hospitals at the beginning of the decade. At Long Beach Community Hospital, a new professionalism was transforming traditional health care. Board certified medical specialists practiced increasingly sophisticated medicine. Joined by health care professionals with specialized training in hospital administration, medical technology, and allied health services, they introduced new ideas and embraced medical advances with enthusiasm.

As the decade opened, Long Beach Community Hospital was under the leadership of **Mr. Walter M. Oliver.** Like Howard B. Hatfield before him, Mr. Oliver was a professionally trained hospital administrator and a Fellow of the American College of Hospital Administrators. Formerly the administrator of the Palo Alto-Stanford Hospital Center, Mr. Oliver was an "organization" man, dedicated to hospital efficiency. He hired competent department heads and then left them alone to do their jobs. Although always accessible,



Walter M. Oliver

the business-minded Mr. Oliver was more inclined to keep to his office than to stroll the halls of the hospital.

"Mr. Oliver was the administrator when I started in the pharmacy in June of 1960 and he clearly had a strong influence on the hospital," chief pharmacist **Jack Schick** remembered. "He was a classic businessman but he also had to deal with the personalities of the physicians in those days, and they were pretty independent individuals."

"He was very cost conscious and kept the hospital running on a cash basis," Madeleine Bowman agreed. "Mr. Hatfield lifted the standards and Mr. Oliver carried it on from there. He was the one who really brought the hospital into the 20th century."

Under Mr. Oliver's astute fiscal management, the hospital completed and paid for a $500,000 remodeling of the original buildings in 1962. The cost of remodeling was financed through the hospital's operations over a two-year period. The potted ferns and wicker furniture in the main lobby were replaced with sleek, modern chairs, sofas and tables.

BUILDING A SOLID ORTHOPEDICS PROGRAM

The first part of the remodeling had opened a year earlier on April 5, 1961. The third floor of the north wing (original building) was remodeled to accommodate a new 33-bed orthopedic unit at a cost of $31,000. Designed to conform to the hospital's new addition, the orthopedic unit contained a large operating room for orthopedic surgery, cast room, and lounge and recreation area equipped with "walking lanes" and weights used for rehabilitation.

The hospital expanded its orthopedic facilities again in 1965. Orthopedic bed capacity increased to 64 beds with a larger cast room and better traction equipment. The second floor of the north wing was renovated to consolidate the physical therapy department, housing six "treatment booths," a Hubbard Tank, whirlpool, and therapeutic equipment.

"My first experience at Community was scrubbing next to my Dad (orthopedic surgeon William Durnin) in 1956 when I was 15," **Dr. Charles Durnin** recalled. "It was my summer job until I went to graduate school.

"In those days Community was one of the busiest orthopedic hospitals in Southern California," Dr. Durnin continued. "Patients stayed in bed two to three weeks after (orthopedic) surgery, so the occupancy rate was high. Dr. John Rowe, who was the director of the Tichenor Clinic was here, the Albans, Dr. Gus Bock, Dr. Max Negri."

COMMUNITY HOSPITAL IN THE COMMUNITY SPOTLIGHT

In 1961, the 250 members of the Community Hospital Auxiliary held their first annual charity horse show at Los Alamitos Race Course with John Wayne on hand. The proceeds from the first show went to purchase hospital equipment and Community's Children's Epileptic Clinic. The successful annual horse show was the hospital's first large-scale fundraising event and became a mainstay of the Long Beach charity calendar in the 60's.

For eight years beginning in 1965, the hospital hosted a citywide Mile-a-Thon, encouraging physical fitness for men over 40. Later attracting women as well as men, the event was held at the Cal State Long Beach track and was presided over by fitness guru Jack La Lanne. The run generated an enormous amount of publicity for the hospital with many Community physicians writing articles encouraging physical exercise. By the end of the decade, jogging had replaced running in a trend that continues today. As one of the first public health promotion events in Long Beach, the Mile-a-Thon foreshadowed the hospital's long history of community health education and prevention efforts.

FINE-TUNING HOSPITAL SERVICES

Meanwhile, under the guidance of the hospital's trustees, administration, and medical staff, Long Beach Community's services expanded rapidly to keep up with the increasing specialization of medicine. In the five-year period ending in 1964, the hospital added an EKG and EMG laboratory, pulmonary function laboratory, intensive care unit, 12-bed communicable disease unit (the only one in Long Beach), and enlarged the emergency room. The cafeteria and food service was upgraded with personalized dietary planning by a dietician for patients on special diets.

In the mid-60's, hospital rates were about $32 a day, and an appendectomy patient stayed three days (down from two to three weeks a decade earlier). Physically, the hospital had expanded three times to more than double its original size.

As Walter Oliver wrote in the May, 1965 issue of the employee newsletter Communiqué, "These additions and improvements are (among) the many that have made the mission-styled building a landmark towering on a hilltop and visible for miles in many directions. They have been accomplished without altering the charm and character of the original concept."

Medical staff committees also proliferated as physicians honed the delivery of health care services. In 1964, in one month alone, 17 different medical committees met to review clinical cases and discuss department policies, procedures, and patient care. The nursing department began a comprehensive program of inservice education to keep nurses current on medical advances. By 1965, Long Beach Community increased staff size by one-third to 700 employees. Extended over a 12-month period, the hospital payroll represented a $4 million industry.

LOYAL PHYSICIANS, LEGENDARY DOCTORS

Although Long Beach Memorial had opened its new 400-bed hospital in June of 1960, Long Beach Community Hospital continued to attract young, highly trained physicians who enjoyed the smaller, more personal medical care it offered. At the time, many of the city's prominent physicians enjoyed staff privileges at all three of the city's hospitals, Long Beach Community, St. Mary's and Memorial.

"It gradually became more and more restrictive," Dr. Charles Morrell noted. "The hospitals preferred that physicians only be active at one hospital and courtesy staff elsewhere. I said, 'Fine, I'll be active at Community.'"

Long Beach Community's physicians were among the best and the brightest in a city known for its fine physicians. The physicians who came to the hospital in the 1960's ushered in a golden era of medical progress that would continue throughout the 70s, 80s and 90s. Highly respected physicians like vascular surgeon **Dr. Herbert ("Chop") Movius,** cardiologist **Dr. Eugene Temkin,** internists **Dr. Robert Schumacher, Dr. William Carnes** and **Dr. Richard Wigod,** general surgeons **Dr. Mel Casberg** and **Dr. Charles Morrell,** obstetricians **Dr. Carl Natter** and **Dr. George Paap,** orthopedic surgeon **Dr. Bill Durnin,** radiologist **Dr. Donald Belville,** and oncologist/internist **Dr. Nathaniel Kurnick. Drs. Frank and William Stanton** also practiced at Long Beach Community Hospital during this period.

"The Stanton brothers had the Obispo Clinic," Dr. Donald Belville recollected. "They were general practitioners who had followed their father into practice. They started one of the first clinics with physicians from several different specialties, like **Dr. George Evashwick."**

"Until that time, physicians mostly practiced solo," Dr. Belville pointed out. "The Stanton family started one of the first clinics with multiple doctors and then joined together with the Harriman Jones Clinic later on."

The Obispo Clinic at Obispo and Anaheim also attracted Dr. Richard Wigod, who joined the group when he got out of the Navy in 1967.

"The group included a lot of old time Long Beach doctors, who formed a core group at Community, including the Stantons. I was the first internist to join the group and stayed with them for about six and a half years," Dr. Wigod stated.

Dr. Charles Morrell, who had been a surgeon at the VA Hospital, decided to return to Long Beach because opportunities were scarce in his native New England.

"Southern California was just booming," he recalls. "When I came back to town, there were several doctors at Community I had known before including **Owen Walker,** an orthopedist, and his wife **Phyllis Walker,** a marvelous doctor of internal medicine," Dr. Charles Morrell remembered. "She was such a fine doctor and so successful that she was working from 6 in the morning to 10 at night and had no time of her own. She escaped by selling her practice to a young squirt named Robert Schumacher."

"I decided to come to Community because I had been in the service here and I liked Long Beach," Dr. Schumacher picked up the story. "Things were very under-saturated then. In fact, when people asked me if there was room in Long Beach to practice, I'd say, 'Come next door. There's too much for me to handle.'"

Dr. Morrell was the first physician to open a practice in the new medical building on Termino directly across from the hospital.

"I was so eager that I moved in before the cement walkways were poured," Dr. Morrell said. "My first patient had to walk across a couple of planks to get over the dirt to enter my building.

"Back then, one of the things you did when you were trying to get started in surgery, was to get on the Emergency Room panel because people came in who needed surgery for things like acute appendicitis or a strangulated hernia," Dr. Morrell added. "Dr. Harry Jacob was very helpful and saw that I got my credentials right away."

At the beginning of the decade, the hospital had no permanent emergency service. The panel physicians spent 24 exhausting hours on duty, sleeping "in house" if things were quiet in the emergency room.

The hospital lacked several other services considered essential by today's standards. There was no intensive care unit, coronary care unit, or nuclear medicine department. CT scanning, magnetic resonance imaging, and ultrasound were yet to be invented. The hospital pathologist owned the only EKG machine and supplied an EKG tech to read the results of the tests.

"The cardiologists and internists were way ahead of the tech in terms of reading the EKGs correctly," Dr. Eugene Temkin remembers. "Around 1962, six physicians got together and gave an ultimatum that we must have our own department for EKGs. It started with Dr. Schumacher, Dr. Koenker, Dr. William Davis, Dr. Kurnick and Dr. Carnes and myself. We each took two months on duty and worked up from doing three EKGs a day to 30 or 40 a day."

DR. EUGENE TEMKIN: A COMMITMENT TO CARDIOLOGY

If one man deserves the lion's share of the credit for envisioning and building Long Beach Community's heart program, it is certainly Dr. Eugene Temkin. After graduating from USC medical school, Dr. Temkin completed a four-year residency at the VA Hospital and elected to stay on staff for another six years. During this time, he took apart an old X-ray machine from the VA Depot on Santa Fe and used the components to build the VA Hospital's first cardiac catheterization (cath) lab. After practicing a few years at Memorial and then St. Mary's, he moved to Community in 1961 because it offered the personal approach he was looking for.

Cardiac defibrillation was not in wide use until Dr. Temkin brought it to Community in the late 60's. Before it became available, CPR consisted primarily of chest compression.

"The advent of cardiac defibrillation and cardiac resuscitation came around 1966 or 1967," Dr. Robert Schumacher confirmed. "Gene Temkin was the one who designed the system." As Dr. Schumacher related:

"I can remember doing the first patient at Community who was defibrillated. He was a 47-year-old truck driver who had come into the emergency department with a heart attack. He didn't have a very large MI, but in the days before cardiac defibrillation, it would have been curtains. I was still in the hospital reading EKGs and I went to check on him and the ER doctor said he was dead. I looked at the monitor and said 'Give me the paddles' and went 'zap' and the guy responded. The timing was perfect because he wasn't out very long and came out of it just fine. I called Gene Temkin to tell him we had successfully resuscitated our first case and to thank him (for the defibrillator)."

Dr. Temkin's inquisitive mind, aptitude for medical technology, and skill as a pioneering cardiologist led to a consulting relationship with Birtcher Corporation. Dr. Temkin received no compensation; his only reward was the thrill of being at the forefront of medical technology. The company's president, Cecil Birtcher, was honored as the only non-medical individual ever to be made a Fellow of the American College of Surgeons.

In addition to the defibrillator (which Dr. Temkin later introduced to Europe), he and the Birtcher group collaborated on a number of innovative medical devices. They invented a percutaneous pacemaker and the Phonatrace, which allowed EKGs to be sent via telephone from the hospital to a physician's office.

After establishing Community's EKG department, Dr. Temkin and a few other physicians began lobbying for improvements in the hospital's ability to care for critically ill patients. They urged the hospital to develop a critical care unit, which was the precursor to a dedicated coronary care unit. When their proposal to administration fell on deaf ears, Dr. Temkin recruited the support of the chief of staff, Dr. Mel Casberg.

Dr. Casberg was born in India and had been dean of the medical school in Bombay. He also had served with the U.S. Army Medical Corps in China and North Africa in World War II. A four-star general, he had been named Assistant Secretary of Defense before returning to civilian life.

"He carried about him an aura of authority and decency and was one of the most wonderful people I ever met," Dr. Temkin continued. "After I told him our efforts to improve critical care had been rebuffed, he went to see Mr. Oliver. The next day Mel called me up and said, 'You can start working on your intensive care unit now.'"

The new and improved intensive care unit opened in 1965, elevating the entire system of cardiac care at Long Beach Community. Expanded from four to seven beds, the new unit was designed as one open room rather than three individual rooms. This enabled the nursing staff to monitor patients continuously from a central nursing station. In the event of a medical emergency, all the necessary equipment was within immediate reach to treat the patient at bedside.

DR. HERBERT MOVIUS: SURGICAL PIONEER

Another giant in the hospital's history of cardiac care also had started working at Long Beach Community around this time. Like Dr. Temkin, Dr. Herbert "Chop" Movius had a VA background. In 1957 Dr. Movius left his position as the VA's chief of surgery and applied for staff privileges at Community, where he had often assisted Dr. Harry Jacob in surgery. He went into practice with Dr. Max Gaspar doing vascular surgery.

"Dr. Movius and Dr. Gaspar were like salt and pepper," stated fellow heart surgeon **Guy Lemire, M.D.** "They were pioneers in doing vascular surgery in Southern California. As a matter of fact, when the specialty was just getting started in the late 50's, they were in such demand that they flew Dr. Gaspar's plane all over the West and up and down the coast doing vascular surgery."

Coincidentally, another Community surgeon, Dr. Charles Morrell, was also one of a very few physicians who had received some training in vascular surgery during his residency. But in Dr. Morrell's words, Dr. Gaspar and Dr. Movius "were the leading vascular surgeons in the area." In 1961, Dr. Gaspar and Dr. Movius started a fellowship program at USC to train vascular surgeons in the new specialty.

Dr. Eugene Temkin

"At the beginning (before vascular surgery), doctors would shy away from large blood vessels in either veins or arteries because that's the aorta and it bleeds," Dr. Movius explained. "They didn't think about actually clamping them off, opening them up, cleaning them out, and sewing them back up. There were several doctors including De Bakey, and Norman Freeman and Edmond Wylie in San Francisco, who started doing major artery surgery around the time I did, but they became more famous."

DR. CHARLES MORRELL: ADVOCATE FOR QUALITY CARE

When Dr. Charles Morrell first performed surgery at Long Beach Community, patients were wheeled back to their room right after the operation. A floor nurse was stationed in the room only until the patient woke up from the anesthesia.

"The concept of a Recovery Room came about in the mid-60's," Dr. Morrell explained. "I remember coming back from a medical meeting in Chicago saying 'We have to do this here in Long Beach, (convert) a couple of rooms into Recovery Rooms and have specially-trained staff assigned to monitor patients during recovery.' Eventually, the Recovery Rooms further evolved into a special room with oxygen and monitors and all the rest."

When the tower was originally built, it only had one elevator. Since it was always in use, physicians sometimes could not respond quickly to resuscitate a code blue (cardiac arrest). Dr. Morrell crusaded to resolve the elevator problem, which posed a threat to patient care.

Dr. Morrell proposed the hospital build another elevator for staff only.

"Eventually they built another tower and put new elevators in," Dr. Morrell continued. "Mr. Oliver's secretary, a great, tough lady named **Dorothy Johnson,** came and told me to follow her because I was going to have my picture taken. She took me to the new elevator and we had our picture taken inside it."

For many years the new elevator was known as "Morrell's Elevator."

Like many physicians, Dr. Morrell was convinced there was a connection between cigarette smoking and lung cancer. He campaigned to get the Auxiliary pink ladies to stop selling cigarettes in the gift shop. According to Dr. Morrell:

The Board said, 'Charles, you must be crazy. Cigarettes are the biggest moneymaker the gift shop has. The Ladies Auxiliary would be in a conniption and the hospital would lose a tremendous amount of revenue if they didn't sell them.

"I said, 'We are a health organization and (by selling cigarettes) we are promoting lung cancer and coronary disease.' Eventually (the ban on smoking in hospitals) came and it was statewide."

A graduate of Harvard Medical School, Dr. Morrell is universally admired by physicians and staff alike as a brilliant surgeon and dedicated colleague.

FINE-TUNING PATIENT CARE

In 1965, Long Beach Community set a precedent by establishing a Patient Care Evaluation Council composed of physicians. According to a pamphlet describing its function, the committee (was) "an additional measure to insure that every patient gets the finest care that skill and concern can combine to produce...This is a wholly modern concept of hospitalization, one in which the doctor becomes actively involved in the patient's entire care."

THE MEDICARE EVOLUTION

The forward tilt of medical progress was paralleled by a radical new government program that ensured access to health care to millions of seniors. In 1965, Medicare was enacted providing hospital and medical insurance for all eligible Americans over age 65. Hospital experts were wary about the entitlement program's bottom line ramifications. Walter Oliver felt the public had been lead to expect a level of service that would be impossible for hospitals to provide and still remain fiscally sound.

Given that the country was in an era of "bursting technology," the cost of running a hospital was higher than ever before in the nation's history. Nevertheless, Mr. Oliver told the Long Beach Independent that a (non-profit) hospital was "just about the last frontier for those who are sincerely interested in serving others." He reassured hospital employees in the staff newsletter that "(government) restrictions...will never affect the quality of care at Long Beach Community Hospital. Attention given to our patients will always be our number one concern."

In 1966, hospital room rates increased to $38-$39 for ward beds, $40-$41 for two-bed rooms, $47-$48 for a private room. Intensive care cost $37 a day, the nursery charged $18 a day, and the delivery room cost $60.

FINDING ANSWERS IN A DROP OF BLOOD

In an era of significant medical advances, one had widespread application for nearly every patient, regardless of the initial diagnosis. The sequential multiple analyses (SMA) blood test was a fast, cheap way to detect subtle abnormalities and medical conditions. Community Hospital acquired an SMA-12 blood chemical analyzer in 1967. The cost for a blood panel ranged from $12 to $32 depending on how many specific tests were ordered.

"The SMA-12 provided 12 pieces of information," Dr. Robert Schumacher explained. "It yielded valuable information about calcium, cholesterol, protein, and so forth from a teaspoon of blood. That really gave us a huge advantage to look for things we might not have expected. You could pick up gout from the uric acid information. You could pick up diabetes from the blood sugar information, and also hepatitis. The SMA-12 gave all that for just a small price."

A COMMITMENT TO RADIOLOGY

On September 30, 1967, Long Beach Community formally dedicated the $250,000 Herbert A. Judson Unit. Dr. Herbert Judson had retired the previous year and was succeeded by Dr. Donald Belville as chief of Radiology. He was assisted by radiation therapist **Dr. Rollin K. McCombs.**

The underground facility housed the hospital's new Department of Nuclear Medicine as well as the Radiology Department's new Cobalt Bomb, EEG, EKG, EMG, VCG, inhalation therapy, and pulmonary function testing services. **William H. Olson, M.D.** was named chief of Nuclear Medicine, a relatively new technology that utilized radioisotopes for diagnostic imaging. The nuclear scanner was used to pinpoint blood clots and detect tumors not found with conventional X-ray such as those located in the organs or thyroid.

The Cobalt-60 teletherapy unit utilized radioactive cobalt to generate gamma ray energy capable of penetrating more deeply into the body. Purchased at a cost of $35,000 with funds raised by the Auxiliary, the Cobalt Bomb had the advantage of delivering a higher therapeutic dose to treat deep-seated tumors without increasing damage to the skin. The treatment time was also significantly reduced, a giant step forward from the days when patients treated for tumors on their vocal cords were obliged to sit in front of an X-ray tube for three or four hours a day.

The hospital added a $20,000 mobile X-ray image intensifier and television monitor the following year. By intensifying the X-ray beam, the equipment produced a brighter, faster image than older fluoroscopic machines, didn't require a dark room, and produced less radiation exposure for the patient. The monitor enabled additional viewing for observation, consultation and teaching.

As Dr. Belville explained, "The image intensifier was a big step forward. The images were incredible compared to what we used to get. And the radiologist didn't have to go in wearing red goggles and wait thirty minutes for his eyes to adapt to be able to see the detail."

GIFTS LARGE AND SMALL

In 1967 the local paper ran a feature estimating Long Beach Community's total value (buildings and equipment) at $7 million. Of the amount, the city had contributed $2.7 million in cash and $1 million in land. Public subscription drives had raised another $2.5 million. The Auxiliary continued to make annual contributions to the hospital to purchase equipment, such as $14,000 for a complete X-ray unit, $4,000 for a defibrillator, and $11,000 for hospital furnishings. However, a formal Foundation with the sole purpose of fundraising was not yet in place.

In the fall of 1969, a virulent influenza epidemic swept through the hospital. The facility was quarantined and visitors were unable to see hospitalized patients. The hospital's employees and Auxiliary volunteers worked double shifts to ensure there was no interruption in medical care. Dozens of employees also stepped up to donate blood to replace the diminished blood supply, thereby enabling the hospital to meet every need for emergency blood.

Bruce Sanderson

CHANGING OF THE GUARD

Bruce Sanderson, who had served as the assistant administrator from 1959 to 1962, returned to Long Beach Community as associate administrator as 1969 closed. In addition to his three-year stint at Community, he had served in the same position under Mr. Oliver at Palo Alto-Stanford Hospital Center.

Like Mr. Oliver, Mr. Sanderson was a professional health care administrator. He had held administrative and director posts with Kaiser Hospital, the American Hospital Association, and the Joint Commission on the Accreditation of Hospitals.

In the following years Mr. Sanderson and Community's Board of Directors would work hard to navigate a sea of change in health care, as competition for patients hardened and the hospital added increasingly sophisticated technologies.

"It was quite a decade when you think about it," Dr. Schumacher concludes. "There were a lot of things going on, with the technological advances, and the increased access to health care that Medicare provided."

Chapter 6

The 1970's: Social Changes and a Technological Revolution

Long Beach went through tremendous social changes in the 70s. The predominately caucasian population declined from 93 percent to 68 percent while the numbers of Hispanic and African American citizens increased to 14 percent and 11 percent respectively. When the Vietnam war ended in 1973, a large influx of immigrants from Vietnam, Cambodia, Laos and Thailand brought the city's Southeast Asian population to 7 percent and the numbers continued to rise. The social demographics changed too, with the city's older middle-class population giving way to a younger, ethnically diverse, working-class community.

The new residents congregated in the city's older neighborhoods, adding a rich cultural diversity to Long Beach's staid, Midwestern homogeneity. Old-time residents moved away from the city's center, to suburban communities like Los Alamitos, Palos Verdes, and Cerritos. The city's schools, public agencies, and health care providers were faced with the challenge of providing services to a population with diverse cultures, values, and languages.

The city also faced economic challenges. It lost its second-largest employer in 1973 when the U.S. government closed down the Long Beach Naval Station. Home to 100 Navy ships and some 25,000 Navy personnel, the Navy base had contributed to the city's fortunes for more than 44 years. Small businesses closed as customers deserted the downtown area for large regional shopping centers.

In 1976, the city embarked on an ambitious effort to revitalize the entire downtown area. Shabby buildings were replaced by a new city hall, library, convention and entertainment center. High-rise office, hotel, and luxury apartment buildings were under construction along Ocean Boulevard. A promenade was planned to encourage pedestrians back to the downtown area. In 1975, Long Beach hosted its first annual Grand Prix, an international racing event that beams the city's shoreline panorama to television viewers around the world every year.

On July 6, 1970, **Bruce Sanderson** was formally promoted to administrator and Walter M. Oliver became the executive director of Long Beach Community Hospital. Mr. Sanderson was responsible for the day-to-day operations of the hospital and Mr. Oliver was charged with long-range planning. The hospital had an annual operating budget of $8 million and most patients had some form of health insurance. Two years later, on July 1, 1972, Mr. Oliver retired and Mr. Sanderson became the hospital's new executive director.

"It was very flattering to be asked back to Community," Mr. Sanderson remembered. "One of the nicest things that happened to me when I returned was running into Dr. Charlie Morrell in the corridor. He gave me a hug and said 'Bruce, it's nice to have you home again.' It was a wonderful feeling."

WINDS OF CHANGE

An unparalleled explosion in medical technology, spurred by advances in the space program, was felt in nearly every area of medicine and in every department of Long Beach Community Hospital. It was a period of astounding growth, not only in producing high-tech equipment to detect and treat medical problems with far more precision, but also in expanding hospital resources for rehabilitation, obstetrical care, and patient support services. On the administrative side, computers streamlined billing, record keeping, and strategic planning. Not surprisingly, cardiology was at the vanguard of the technological tidal wave.

BUILDING A HEART PROGRAM FROM THE GROUND UP

Establishing a state-of-the-art heart program had been Dr. Eugene Temkin's dream ever since he came to Community in 1961. Along with radiologist Dr. Donald Belville, heart surgeon Dr. Chop Movius, and other dedicated internists, cardiologists and hospital staff, Dr. Temkin began laying the foundation for the hospital's most ambitious program to date. On June 29, 1970, after three years of planning, the Coronary Care Unit was inaugurated as the first phase in establishing a comprehensive heart program.

Designed by the physicians themselves, the 10-bed Coronary Care Unit cost a total of $350,000 to build and equip. Located in one wing of the Hatfield unit, the CCU was unlike any other critical care unit in existence. According to Dr. Temkin, "Patients could see out a glass door into the street. Grandchildren could come up to the door and the patient could see the wind blowing the leaves and dogs and cats going by. They could see life, and that had a marvelous effect on the patient."

The new CCU featured four specially designed intensive care beds and six intermediate care beds as well as a Cardiovascular Procedures Room for the treatment of complications or shock. As Dr. Temkin remembered:

"I decided there was no decent bed built for coronary care. The regular hospital bed was not suitable and so I set about designing something that was. One day a patient came in who was in the business of rewinding electric motors. He was involved in many big plants including the Department of Transportation. So I showed him my design and at the next visit he said 'You know, I'd like to build that bed for you.' He even bought a special vertical milling machine to make the bed lighter. I've always been interested in mechanical things so I knew a little bit about the equipment. We built a beautiful bed together."

The specially designed beds could be raised to 40 inches and lowered to 18 inches. They were also radiolucent, allowing patients to be X-rayed without being moved. Dr. Temkin

used actuators from Douglas to "gatch" the bed up and down. A split mattress was designed to facilitate positioning of the patient's head for intubation. Dr. Temkin explained:

"We took everything into consideration and designed it so there was only one wire coming out, the umbilical cord. I got that idea from the space program. Everything was connected instantly - the EKG, the whole works, and the patient was connected to the sides of the bed so that there were no wires running around. We even built a commode that hooked onto the bed. We did all those things. I tell you it was wonderful."

Thus, all the information about the patient was electronically wired through a single cord and constantly monitored at the nurse's station including EKG, central venous pressure, direct arterial pressure, and pulmonary arterial pressure. The beds were also equipped for defibrillation and pacemakers if necessary. Dr. Temkin and the hospital's engineers assembled the instrumentation for the unit themselves:

"We made all the monitors right at the hospital. In fact, Community had the first biomedical engineering department in the area. We had the circuitry built and then inserted the parts in my home, which I had turned into an electronics shop.

Some cardiologists came down from Cedars Sinai Hospital and they wanted to buy what we had built. They couldn't believe that all this could be done on a hospital level. To this day I am amazed, but back then it didn't seem like such a hurdle. We did so many things. We responded to the needs. We didn't adapt a bed to hospital use. We built a bed according to needs."

Building a comprehensive heart program is more than buying equipment and setting aside space in a hospital. Establishing a Coronary Care Unit required the involvement of skilled physicians and specially trained nurses.

"First we had to decide how to train the nurses," Dr. Temkin observed. "You can have beautiful monitors and you can have beautiful windows, but if you haven't got wonderful nurses, forget it. I had started the training program at the VA years before that and trained some 800 nurses."

Dr. Temkin was still working as a consultant to the VA and had developed a course to train cardiac nurses from hospitals both inside and outside the VA system. Naturally, he included Community's intensive care nurses, teaching them to intubate and defibrillate dogs to gain experience.

"Putting an endotracheal tube into the wind pipe of a dog is much more difficult because it has a peculiar anatomy," Dr. Temkin explained. "The Community nurses came to all the presentations and one of our stars was **Karolyn Morrison,** who was the Chief Nurse.

Karolyn Morrison

"After they took the course, they took a written exam, and I can tell you it wasn't easy," Dr. Temkin continued. "If they passed it, we gave an oral exam. Two of us would examine each nurse, and of course, they were scared silly when they would see the two of us terrible people confronting them. But we also did it in a manner that was very supportive. If they passed the oral, we gave them a specially designed pin. That heart pin became a very special mark of distinction among the nurses at the hospital."

By the spring of 1971, fifty-nine registered nurses had completed the 80-hour course in advanced coronary care. They were either assigned to Community's Coronary Care Unit, Emergency Room, Recovery Room, or the Intensive Care Unit.

"I think we had the best nurses in the city," Dr. Chop Movius asserted. "Dr. Temkin put in many hours training them and I also gave lectures early on. I think our post-op ICU for heart patients was better than any other hospital because the nurses were trained so well and they stayed on. Many of them are still there today."

THE FAIRFIELD HEART DIAGNOSTIC UNIT: INGENUITY SUPPORTED BY GENEROSITY

Dr. Chop Movius joined Dr. Temkin in pushing for a complete heart program at Long Beach Community Hospital around 1970.

"It took a lot of work on Dr. Temkin's part to put together the heart program," Dr. Movius remembered. "To do heart surgery, you first have to get a diagnostic lab going, meaning heart catheterization and all that goes with it, including expensive X-ray equipment."

As Dr. Donald Belville, chief of radiology, remembered, "Dr. Temkin was most interested in the chambers of the heart to start with but you had to identify the chambers. Since you can't go in and look inside and you can't look from the outside, you need to inject contrast material into the heart and that is where angiography came into being."

At the time, cardiac angiography was a primitive modality. As Dr. Belville described it:

"The patient would lie on the table, halfway under anesthetic, with tubes hanging out of just about every orifice. We had to turn them up on their side in order to get another view of the heart, the coronary arteries, and the heart chambers. It was really very cumbersome and awkward and, I thought, rather hazardous. Dr. Temkin and I were talking about it one day and we both thought there had to be a better way. None of the X-ray companies had anything that went around the patient.

Dr. Temkin went home and worked in his garage until he developed this (rotating) concept. I worked with X-ray sources in order to make the images brighter and to make sure it could be controlled easily. And since the injected substance passes through the coronary arteries in a matter of seconds, it had to function in rapid sequences.

Dr. Temkin credited Dr. Belville for conceiving of a ring capable of rotating 360 degrees around the patient:

"I had built a model of a U-shaped thing with an X-ray on each end of the U, which was an axial and rotated around the patient. But the patient was never at the center of it and when you changed the patient's position in order to get different views, you lost the center.

I told Dr. Belville I didn't like the U because of its limitations and he said, 'Why don't you use a circle?' So I went home and took a darning hoop and put a little doll that belonged to my daughter in the center of it and rotated it. Then the X-ray equipment could be mounted on the ring so that it would accommodate the patient rather than moving the patient to accommodate the equipment.

We went to all the X-ray companies (with the idea) but none of them were interested so I knew we had to build it ourselves. To get the hospital behind the project, **John Gladstone,** the hospital carpenter, and I built a full scale working model that rotated around the patient. I put it in the auditorium and presented it at a Board meeting. They accepted it with no questions asked."

Ultimately, Dr. Temkin interested a representative from the Picker Corporation who furnished dimensions for the component parts. The hospital's new biomedical engineering department staffed by technicians **Larry Walters** and **Arnie Isherwood,** and biomedical engineer **Ray Van Hook** helped Dr. Temkin assemble and install the Angiocor.

Dr. Temkin provided the creative ingenuity with Dr. Belville's X-ray expertise, but Dr. Movius is responsible for the financial contribution that made the cath lab possible.

"A couple of weeks after the Board approved the idea, Dr. Movius called me up and said he had a lady in his office by the name of Fairfield and that she wanted to give me some money to distribute," Dr. Temkin related. "Could I use it? Two hundred and fifty thousand dollars! She didn't want her name on anything, she just gave her money and that's all she wanted out of it. She loved Dr. Movius, like most people who get to know him."

Dr. Movius had operated on **Mrs. Ruth Fairfield** several times. The widow of Freeman Fairfield, a Long Beach oil man, Mrs. Fairfield was a philanthropist who believed in supporting the city's hospitals.

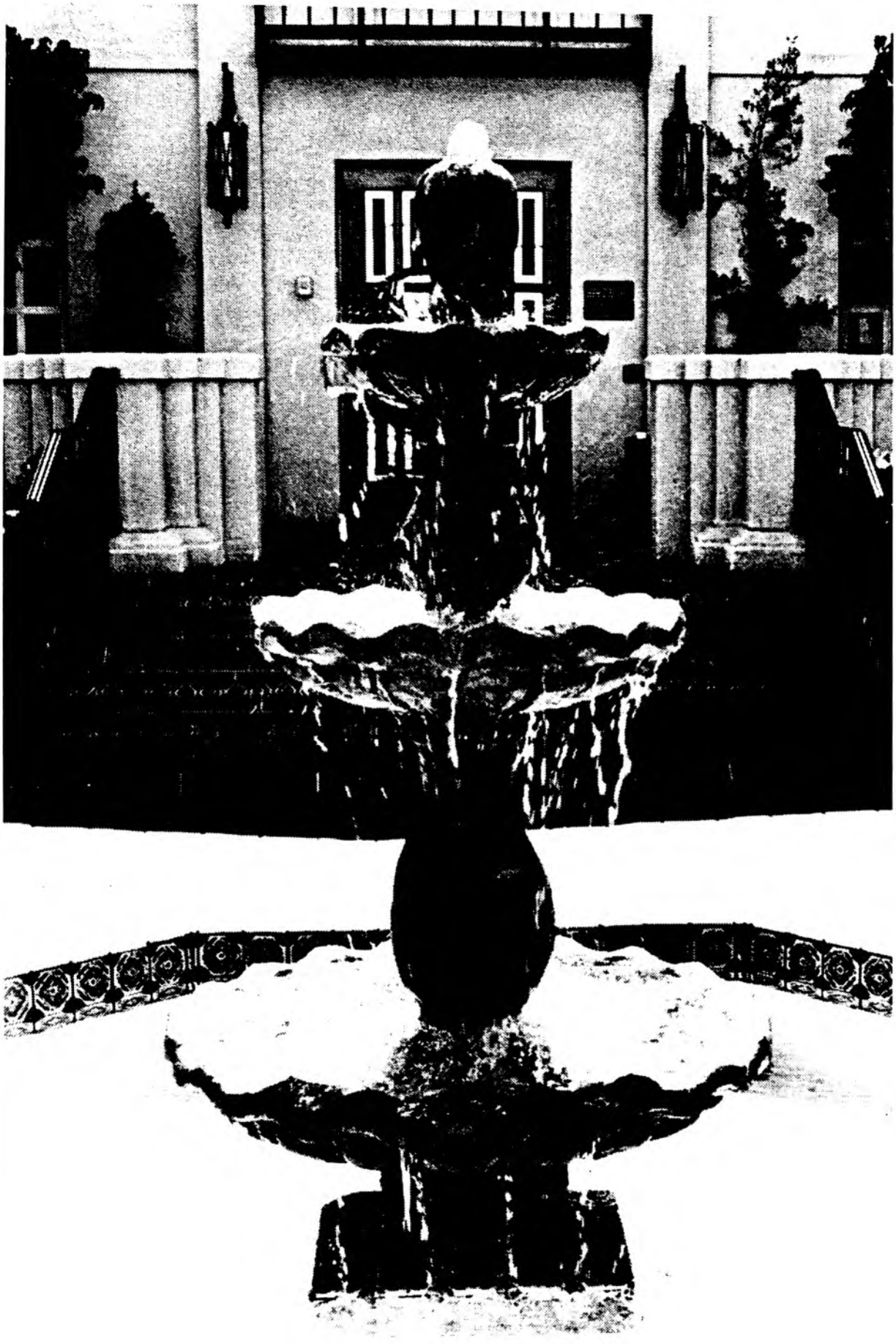
"Ruthie Fairfield gave the money to Community Hospital on my suggestion," Dr. Movius confirmed. "She was a very, very nice gal and she gave the money to the hospital with no strings attached."

Mrs. Fairfield added another $57,000 from the Fairfield Foundation to bring the total contribution up to $307,000. The X-ray machine cost $227,000 to build and the remainder went to purchase electronics, which were custom-built by a Boston engineering firm.

"The Angiocor was very practical and safe and it served the patients well," Dr. Belville noted. Dr. Temkin recalled that the Angiocor was in use for more than 20 years, although the life of an X-ray machine is usually only 10 years.

The new cath lab was an important prerequisite to developing a cardiac surgery program. With the cath lab in place, the hospital approved a dedicated heart surgery suite and the same physicians and engineers set about designing one from the ground up. At the same time, work was started on an expanded 14-bed intensive care unit for patients recovering from heart surgery.

On Valentine's Day, 1975, Long Beach Community Hospital formally opened the new Heart Care Facility comprised of the Fairfield Catheterization Unit, Heart Surgery, Biomedical Department, and Thoracic Surgery Intensive Care Unit. One by one, the pieces had all fallen into place thanks to an exceptional group of inventive physicians and engineers, a supportive Board of Directors, an enlightened administrator, and the generosity of a grateful patient.



Courtyard Fountain

In 1974, a year before the heart program opened, the hospital had celebrated its 50th Anniversary. There were 100 physicians on the active staff and 450 doctors held staff privileges. Of the 750 hospital employees, 48 percent were on the nursing staff.

While the heart program was expanding by leaps and bounds, advances were coming just as rapidly in the hospital's other specialty areas. Obstetrics, emergency medicine, radiology, and oncology were undergoing revolutionary changes. The hospital was also taking its first steps toward establishing a formal foundation.

MAKE ROOM FOR DADDY

In 1969, Long Beach Community introduced prepared childbirth classes to help women deliver their babies without drugs. The hospital sent Dorothy Gilmore, the chief OB nurse, for training on how to teach prepared childbirth to expectant parents. The prepared childbirth classes taught by the OB nurses proved so popular that Community soon had three or four sessions going a week, each one lasting four weeks.

"People were getting interested in more natural things and didn't want a lot of medication," according to **Dr. Carl Natter,** an obstetrician who endorsed the natural approach. "Prepared childbirth came at a time when we didn't have good anesthesia coverage so the mothers got a lot more narcotics, tranquilizers, which were passed on to the babies. I do think babies do better if they can be delivered without medication."

In 1971, the hospital scored two more significant firsts: it established "rooming-in" for mothers and their newborn infants and allowed fathers into the delivery room for the first time.

"Many of the physicians thought it was heresy," Dr. Natter recalled. "They were worried about fathers passing out, or interfering with the delivery because they didn't understand what was going on. The doctors feared we might see an increase in the infection rate. But that didn't happen."

One of the opponents was Dr. Geneva Beatty:

"I tolerated (fathers in the delivery room), but I didn't really go for it either. Once, in the early days of this, I had a father who was very busy with setting up his automatic camera. He was going to get a picture of this baby as it came out, but all of a sudden he went 'clunk' on the floor. His camera fell off and I told one of the nurses to take a picture of him. She said 'How?' I told her to just aim and shoot it as I was busy delivering the baby at that moment. Eventually they got him up on a gurney and had him relax for a while. But his wife got the biggest kick out of it and put the picture of the father on the delivery room floor in their baby book."

"Dr. Beatty carried that picture of the father passed out cold to show everybody what could happen during husband-coached childbirth," Dr. Natter elaborated. "It amused people but didn't change any minds."

Although the physicians were wary at first, family-centered childbirth was a huge success with new mothers and fathers. Instead of seeing their baby for the first time through a thick plate of glass, fathers were involved from the moment of birth. Within nine months of the program's inception, the hospital celebrated the 100th birth with the father present. 1974 celebrated the 1,000th birth with the father present.

Dr. Carl Natter

"One of the things that always tickled me about having fathers in the delivery room was having them blurt out 'Let's have another baby right away!' immediately after the baby was delivered," Dr Beatty joked. "The mother was absolutely exhausted from pushing and everything else and that was the last thing she wanted to hear at that moment."

The obstetrics program was innovative in other ways as well. In spring, 1973, the hospital purchased a fetal monitor for $6,500.

"The development of ultrasound gave us a window into the uterus," Dr. Natter explained. "We can see what's going on, we can see the heart beating and the baby moving, take measurements of growth and size. Fetal monitoring with ultrasound gives us a minute-to-minute evaluation of how well the baby is doing."

THE EMERGING SCIENCE OF EMERGENCY MEDICINE

Emergency medicine was in its infancy as a medical specialty when **Dr. William Hurst and Dr. Jerry Hughes** first came to Community's emergency department in 1972.

"Up until the early 70s emergency medicine was 'catch as catch can,'" Dr. Hurst said. "It was mostly guys who were trying to get their practices started. As a result of the war in Vietnam, the level of emergency medicine improved, as did patient care. That's when the practice of emergency medicine began to change and the standards improved."

At the same time that the American College of Emergency Physicians was just getting started, Dr. Hurst joined Dr. Hughes at St. Mary's in one of the first full-time ER groups in the nation. Bruce Sanderson contacted the St. Mary's group and invited them to expand the practice to Community.

"Once again, Community Hospital was on the cutting edge, just as it was with Gene Temkin and the Heart Center," Dr. Hurst affirmed. "They were several years ahead of most hospitals in the country in terms of emergency medicine. In fact, we put on the first advanced cardiac life support class in Long Beach in about 1973 or '74."

At that time, the emergency department consisted of a waiting room staffed by a clerk with a typewriter. A small wall separated the intake area from a four-foot by three-foot room where the doctor sat. The department consisted of one major room with two critical beds with monitors and a smaller room for pelvic exams and overdose lavage. Across the room were two over-sized closets with a curtain across the front holding two more gurneys for minor emergencies. The department was cramped, dark, and frequently crowded.

"In 1978 we decided to go down the hall and get some more room," Dr. Hurst said. "We doubled the size of the department."

By that time, St. Mary's decided the two hospitals should not share the emergency medicine director. Dr. Hughes and Dr. Hurst were two of the physicians who elected to stay at Community.

"In this part of town, we have nice clientele and the family atmosphere of a community hospital," Dr. Hurst explained.

That's not to say that Long Beach Community's emergency physicians have fewer challenges. In fact, the hospital's location means it sees an unusually high number of critically ill patients in the emergency department.

"We admit about 16 percent of the emergency patients to the hospital, as opposed to 8 percent to 9 percent in most community hospitals," Dr. Hurst explained. "We see a lot of sick people, many of them the frail elderly. We also receive about 60 percent of the intubated patients throughout the whole Long Beach EMS system, people who are full arrest or respiratory failure patients."

THE PATIENT SERVICE REPRESENTATIVE: PAVING THE WAY FOR PATIENT ADVOCACY

Long Beach Community Medical Center was the first hospital in the Long Beach area to recognize that, by providing patients with a sympathetic liaison with the hospital staff, they could improve the quality of care. **Jo Whelan Plato** formed the position, having been encouraged by Calvin Swanson. "I told him I didn't think I could do it, but after volunteering for a while, he hired me."

By listening to the concerns of the patients and relaying them to the appropriate area for resolution, Mrs. Plato was able to improve the experience of both the patients and medical center alike. "Even small problems could get out of proportion if no one listened," Mrs. Plato said. "Even simple matters can have a great effect."

Mrs. Plato spent 17 years as the patient service representative, spending hundreds of hours assuaging fears, comforting anxieties and assisting with the problems patients experienced. Her work formed the framework for an important factor in the high quality of care Long Beach Community Medical Center provides.

CANCER DETECTION CENTER: A LEGACY OF CANCER CARE BEGINS

By establishing a tumor board in 1972 to review unusual cancer cases, Community had taken the lead among Long Beach hospitals in cancer care. In the same year, Community purchased one of the area's first dedicated mammography machines, a senography X-ray and xeroradiography unit.

"Mammography enabled us to pick up a breast lesion before it could be felt by the patient or the physician examining her, "Dr. Donald Belville pointed out. "If we could find it when it was small enough, we could remove the lesion and cure the patient. Mammography has proved to be a tremendous asset and has saved many women's lives."

By 1973, ultrasound was being used to image abdominal organs to differentiate between tumors and cysts. The Pho-Gamma scintillation camera was also being used to detect the existence, size, and location of tumors with nuclear medicine imaging.

Cancer treatment took a giant step forward with the installation of the area's first linear accelerator at Community Hospital in 1974. Capable of producing five times the radiation as the cobalt bomb, the linear accelerator was the most potent radiation therapy available to treat cancer patients.

"People probably don't remember that we ended up building a room for the linear accelerator under the cafeteria," Mr. Sanderson disclosed. "There is probably close to a half million dollars worth of lead down there."

On November 4, 1975, Long Beach Community opened the Cancer Detection Center, the first facility of its kind in the city and one of only two west of the Mississippi. The Cancer Detection Center provided a complete history and screening physical examination as well as laboratory testing for patients who might have cancer. **Marvella Bayh,** the wife of U.S. senator Birch Bayh, helped inaugurate the center, generating an enormous amount of publicity and hundreds of referrals. The center was the capstone of Dr. Harry Jacob's dedication to patient care, and became a symbol of the hospital's tradition of early detection and treatment.

"It was a preventive cancer center, actually," Dr. Jacob explained. "We tried to diagnose early cancer and in many cases we were able to operate and cure the patient. We used a lot of clinical judgment in addition to X-ray because we didn't have many of the tests that are now available to diagnose cancer."

Initially, Dr. Jacob ran the Cancer Detection Center with **Dr. Lillian Walley,** who had also been instrumental in developing the program. According to Dr. Jacob, they achieved the highest cure rates for gastrointestinal and breast cancers through early detection. When Dr. Walley became ill, Dr. Jacob ran the Cancer Detection Center for eight years after he retired from his surgical practice. He had developed an interest in cancer as a general surgeon removing stomach, colon, breast, and thyroid cancers. Convinced early on that smoking contributed to lung cancer, Dr. Jacob had quit smoking right after World War II.

"If someone was worried about a lump, it might take several months to get in to see a private physician," Dr. Schumacher elaborated. "The center provided a faster way to do a cancer screening on the patient and get them into the system. Patients could self-refer or be referred by their physician. Quite frankly, I think quite a few of the patients loved Harry so much that they just went there to see him for their annual physicals."

Near the end of his life, at the final interview for this history, Dr. Jacob said he felt that early detection was still the best approach for defeating cancer and that chemotherapy represented one of the most significant advances in medicine during his long career.

In 1976, oncologist Dr. Nathaniel B. Kurnick introduced filtration leukopheresis to the hospital. By transfusing white disease-fighting blood cells from healthy donors, the process had the potential to rescue cancer patients with extremely low blood counts from life-threatening infections.

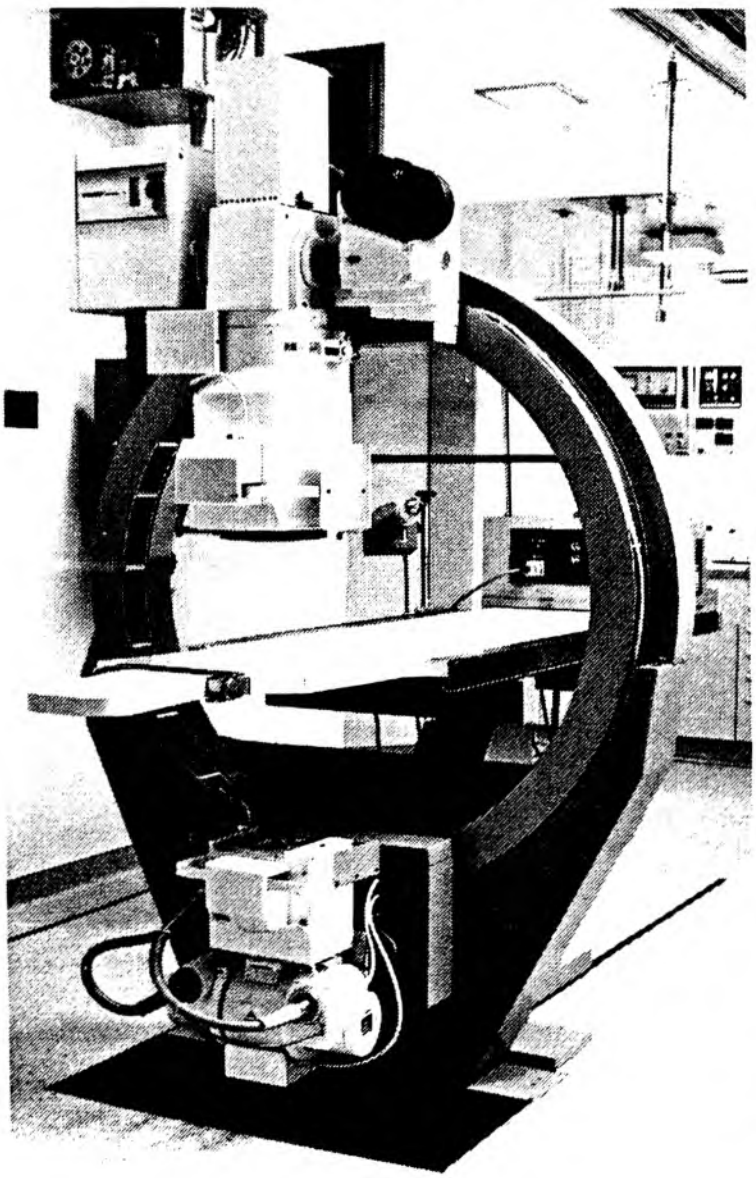
CT IMAGING: SEEING THE BODY AS NEVER BEFORE

The advent of computer-assisted axial tomography, or CT, scanning marked a breakthrough in imaging that gave radiologists more detailed pictures of the body than had ever been possible before.

After enthusiastic lobbying by Dr. Belville, the Board approved the purchase, and the first CT scanner in Long Beach was installed at Community on October 22, 1976. The potential of such exquisitely detailed imaging was immediately apparent. As Dr. Belville recounted:

"Dr. William Carnes, an internist, came to me and said he had a comatose patient in the intensive care unit. Something was wrong with his head and they expected him to die. So Dr. Carnes brought the patient down and I put him on the (CT) machine and I couldn't believe my eyes. There was an image of a subdural hematoma, that is a blood collection, over one hemisphere of the brain. I took extra pictures to make sure that was what we were dealing with and called Bill Carnes and said, 'This guy has a treatable lesion.' That afternoon one of the neurosurgeons took the patient up to surgery and evacuated the hematoma. Two days later the patient came down to thank me for finding the problem. He would have died. It sounds dramatic, but that is exactly what happened."

"CT imaging is so totally different from the two-dimensional view you see with X-rays," Dr. Morrell agreed. "You can see the inside of the body and all the organs, in full magnificence or in the pathologic state. It saved many a person from having surgery because we could rule out things that we would have had to (surgically) explore before."



The first CT scanner in Long Beach was installed at Community on October 22, 1976.

Radiologist **Dr. Paul Lee** initially came to Long Beach Community in 1974. He has seen imaging advance from traditional X-rays to CT scans to MRIs to the advent of interventional radiology.

"CT used to be what we considered a sophisticated machine compared to X-rays," Dr. Lee noted. "Now CT is the bread and butter and no radiology department can go without a full body scanner."

ORTHOPEDIC ADVANCES

Long Beach Community was widely known for the high quality of its orthopedic program. When **Dr. Charles Durnin** started his orthopedic practice in 1974, the hospital was treating more than 700 orthopedic patients. It offered specialized orthopedic nursing care and a full range of physical rehabilitation services.

"The most common surgical procedures were spinal fusions at the time," Dr. Durnin recollected. "Fractures were treated with traction, but when nursing homes opened, the hospital base dropped dramatically due to reimbursement issues."

The 70s heralded a new technique which allowed people with crippling degenerative joint disease to regain their mobility. According to Dr. Durnin:

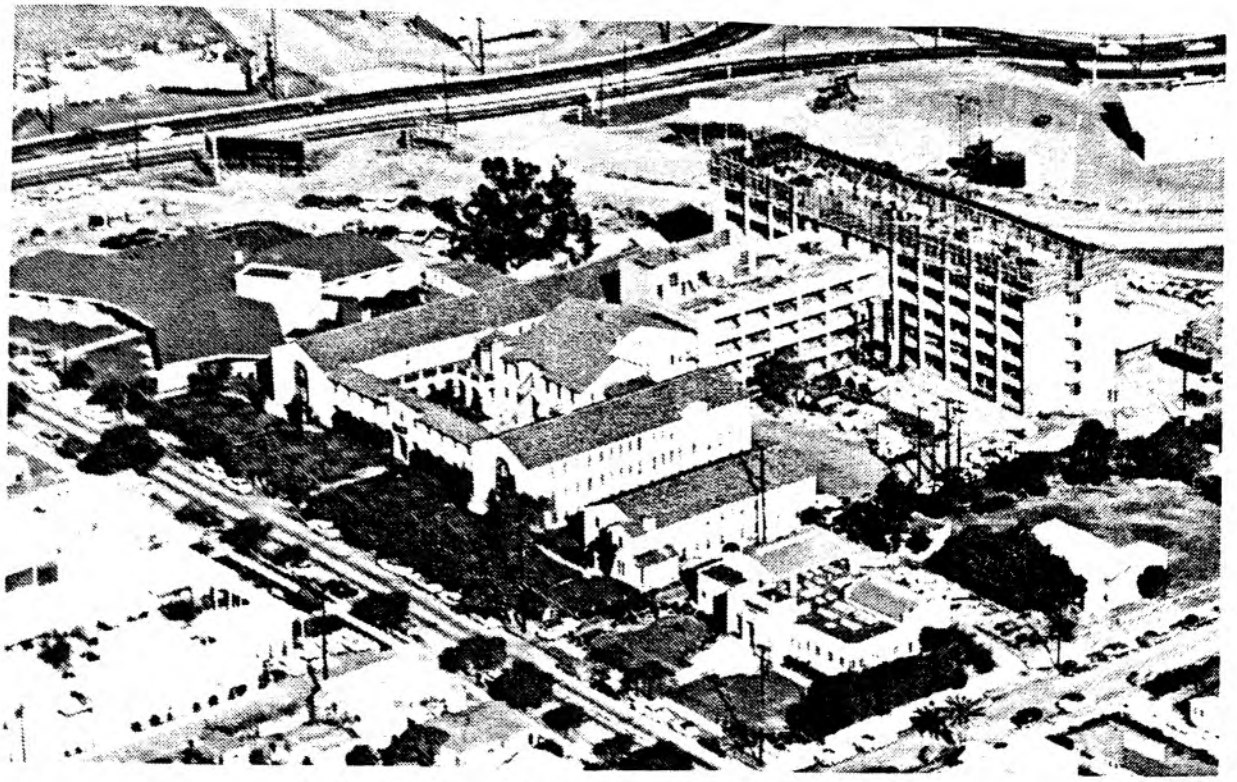
"Joint replacement was the most dramatic advance. They became available in this country about 1970, but we were doing some types of various replacements around 1968. The biggest changes have come from the metals and implants in joint replacements and fracture fixation. Our original device, which was metal, has proved superior to any of the newer advances."

A WAVE OF IMPROVEMENTS

The hospital truly was in an expansive mode, assimilating new technology, adding services, and improving on traditional diagnostic and therapeutic services. One of the innovations was a 17-bed Independent Therapy Unit for ambulatory patients, which opened in 1972. The homelike unit enabled patients to safely transition from the acute care setting yet still receive hospital-based medical and nursing care. The less costly alternative to acute hospitalization reduced costs to some patients by as much as 50 percent.

In 1973, Community instituted a stroke rehabilitation program, which soon evolved into a department of rehabilitation medicine. Patients then were able to receive intensive rehabilitation services such as speech pathology, occupational therapy, physical therapy, social services, and rehabilitation nursing both in the hospital and after their return home. In the same year, the Children's Benefit League donated $10,000 to establish a new pediatric unit on the sixth floor of the hospital.

The clinical laboratory added an Automatic Clinical Analyzer, which greatly increased the speed and accuracy of test results. The equipment was particularly useful in obtaining a diagnosis in emergency cases when minutes can spell the difference between life and death.



Aerial view of Long Beach Community Hospital campus. 1969.

The inhalation therapy department was renamed the pulmonary department in 1969 and expanded to offer 24-hour service every day of the week. The hospital boasted the first fully automated and computerized pulmonary function system in the area. Laminar airflow was added to the surgical units in 1974 to reduce the risk of infection by reducing air-borne contaminants.

Long Beach Community noted in the Annual Report for 1973-1974 that it had spent $1.2 million for new technology. Due to widespread advances throughout medicine, 80 percent of the drugs and one-third of the lab tests being used had not been available just a decade before. Even with these improvements, Community's rates were at least 75 percent lower than most area hospitals.

Caring for patients after they left the hospital assumed new importance in the mid-70s as patient stays grew shorter due to more stringent reimbursement criteria. In 1976, Community introduced the city's first home health care program providing a variety of services to more than 100 patients a week. A more economical alternative to hospitalization or discharge to a nursing home, patients recuperated in the comfort of their home with nursing care supervised by the physician. Outpatient services were also on the rise and had reached 20,000 cases annually by 1978, double the number of patients treated on an inpatient basis.

The physical plant underwent several improvements in the 70s as well. In 1972, a $480,000 air conditioning system was installed throughout the hospital. In 1976, Community embarked on a five-year retrofit to strengthen the hospital against earthquake damage. The renovation involved relocating main utility lines and putting overhead electrical service underground. The old nurse's residence was demolished as part of the retrofit program.

THE COMPUTER AGE

In 1969, the first microprocessor was invented launching computers into the fourth generation. Long Beach Community had wisely waited until the kinks had been worked before investing heavily in equipment that might soon be obsolete. However, as early as spring of 1971, the hospital hired **Arnold Loveridge** as Director of Computer Applications to computerize the hospital. Mr. Loveridge wrote original computer programs for the hospital, including one that could identify operational problems early.

"Arnold created programs that could predict trends or immediately spot a department that might be getting out of control," Mr. Sanderson explained. "The IBM people hadn't even figured out how to do that yet. He always got more out of everything than the manufacturer said you could do."

A Univac 9480 was purchased in 1974, which further streamlined hospital systems, reduced human error, and cut costs.

A FOUNDATION TO BUILD ON

It was during a regular meeting of the hospital Board of Directors that **Herbert Murphy,** a long time board member, inquired as to why Community Hospital didn't seem to receive the degree of philanthropic support as did other local institutions. **Bruce Sanderson,** the Associate Director of the hospital – and later President and CEO, offered the opinion that the reason for the Board's frustration on this subject was that, "We are not properly organized for this purpose, and we will not be successful in fundraising until we are." When asked what could be done about changing this situation he suggested the creation of a new corporate structure – a foundation whose function would be to bring the hospital's story to the community we serve and to encourage the philanthropic support that would be required to fully meet our patients needs.

The Board readily agreed and **Bud Young,** President of Buffums, was asked to be the first chairman of this new organization. Characteristically, he agreed – on the condition that he had the authority to appoint the first committee of local civic leaders, upon whose shoulders would rest the job of getting the idea moving. The Board enthusiastically approved, and the first person appointed by Mr. Young to spearhead this vital project was **Jess Grundy,** a Long Beach stockbroker.

"There's no way a hospital can be competitive in the industry without community help," Mr. Grundy explained. "To keep up (with technology), a hospital would have to charge such exorbitant rates, it wouldn't be able to serve all the people in need."

When Bruce Sanderson replaced Mr. Oliver as executive director of the hospital, he gave Mr. Grundy "carte blanche" to set up the foundation in the"Villa," previously the nurse's residence. According to Mr. Grundy:

"I grabbed all the people I knew who were doers, who I knew could be relied on to do the job. By this time Bud Young had resigned because of poor health and I had taken over as chairman. **Roland Bach** became the first director of the foundation.

We formed committees to concentrate on fundraising. One of the first committees had the responsibility of getting the doctors involved and Bob Schumacher volunteered to head that up."

Thus began the fundraising efforts of the Foundation on behalf of Long Beach Community Medical Center. To date, since its inception in 1974, the Foundation has raised over $25 million in support of the hospital.

Jess Grundy attended every hospital development convention for the next five years to study fundraising. He "lifted" the concept for the Fillmore Condit Club from a hospital in Miami, which had started a similar group that set $100,000 as the price of admission.

"Our group started at the $10,000 level, because that's what the market would bear in 1976 in Long Beach," Mr. Grundy recalled. "But we got a bunch of money donated right away, and since then some people have pledged upwards of $100,000 to the Condit Club."

Betty Keller was a charter Condit Club member who found her involvement with the medical center to be so rewarding that she went on to be appointed to the Foundation Board, serve various chairmanships and eventually become Chairwoman of the hospital's main Board of Directors.

Jess Grundy enlisted attorney **Bill Williams** and Dr. Robert Schumacher to be the first co-chairmen of the Condit Club. Earlier, when Mr. Williams was looking to donate property to a charity, Mr. Grundy had suggested he give that to Community as well. In return, Mr. Williams found himself sitting on the hospital board and fundraising for the hospital. Since he was an attorney, he was also asked to write the by-laws for the Condit Club.

"The Condit Club dinner was a big, spiffy deal," Mr. Williams related. "The first one was held at the International City Club in 1976 and we've stayed with the same idea ever since then. It works so well because we have categories of membership beginning at $10,000 and all the way up to $500,000. It's an interesting phenomenon because people work very hard every year, actually strain financially, to get up to the next category. They receive recognition at this very nice formal affair and have their names put on a tile in the hospital lobby. The employees give as a group and I think they've reached the $250,000 mark."

Jess Grundy was also the spark plug for another Foundation tradition: the annual golf tournament.

"We had been groping around for another fundraising event to hang our hat on," Mr. Grundy recalled. "An event promoter for the Dick Whittinghill Golf Tournament had called **Harry Kayajanian** and offered the event to the Elks Club in return for 20 percent of the proceeds, but the Elks turned it down.

"I said 'let's go' and it raised $60,000 in the first year alone," Mr. Grundy continued. "It turned into a real celebrity event, attracting people like Bob Hope, Telly Savalas, Glenn Campbell, and Billy Barty. Arnold Palmer donated items for our auction."

Through the years, hundreds of people have generously contributed valuable resources – not only financial, but also their time, drive, and creative ideas – to help fund the hospital's capital campaigns. Some of them were there when the Foundation began and their names have become part of the lore of the hospital.

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When asked why he and other members of the community have supported the hospital for so many years, Jess Grundy replied:

"It's a matter of pride for the community to have a hand in their hospital. They have a true empathy for the service the hospital provides for others. Can you imagine what a terrible world it would be if nobody did anything for anyone but themselves?

I can't use a saw and hammer, so I can't build a hospital. I'm not a doctor so I can't make people well. But the Lord gave me the ability to organize, so that has been my contribution to Long Beach Community Hospital."

FUTURE SHOCK

As the decade came to a close, the forward momentum of health care was about to experience a dramatic shift. The high cost of technology was draining hospital resources and pitting hospitals against each other in fierce competition for patients. Health care would become a high stakes game with the hospital's very survival on the line.

Chapter 7

The 1980's: Forging Alliances for the Future

The decade that would determine the hospital's survival began with an event that honored its historic past. As the 80's opened, many of the city's classic old structures had disappeared during a period of large-scale civic redevelopment. Gone forever were several famous Long Beach landmarks including the First Christian Church, the Romanesque Municipal Auditorium where Liberace made his debut performance and a new Miss Universe had been crowned every year from 1952 to 1959, the Pike amusement zone, and the all-wood Cyclone Racer roller coaster.

In 1978, the city established the Cultural Heritage Committee to preserve the city's historic structures. Long Beach Community Hospital was named a Historic Landmark on October 28, 1980 by the Long Beach City Council. The designation recognized the architectural significance of the original building and protected the hospital's exterior facade and courtyard from future alteration.

While the hospital's Spanish colonial exterior was protected by its landmark status, Community's financial future was not so certain.

SURVIVAL OF THE SMALLEST

"When I joined the Community Board in 1976, we were a small, healthy free-standing institution," recalled **Jean Bixby Smith.** "It was bumping along and making a nice profit which we were able to put back into the hospital. But as we got into the early 80's, Bruce Sanderson had the wisdom to realize that it was going to be increasingly difficult for a small hospital to survive."

To help the hospital Board understand the problems that loomed ahead, Mr. Sanderson arranged for eight Board members to tour several similar hospitals in the Midwest and on the East coast. Like Community, the hospitals they visited were small, non-profit community hospitals. They provided a glimpse of the future challenges for small hospitals facing shrinking reimbursement, new regulatory challenges, and reduced purchasing power.

Jean Bixby Smith

These constraints were coming at the same time small hospitals were trying to keep up with large institutions that could afford the increasingly high cost of medical specialization.

Initially, the Board turned to Long Beach Memorial and St. Mary's to work out a merger that would benefit the community as well as the individual hospitals.

"The idea was that size was an advantage when your competition was as large as Memorial and St. Mary's," hospital counsel James Ludlam pointed out.

Mrs. Smith recalled Community's early talks with other Long Beach hospitals:

"We felt at Community that there was a real reason for our institution to continue to exist in its present form. At the time we had just completed our earthquake rehab. We felt that from the standpoint of physical location, we had the best place in the city. And we felt strongly that we provided a kind of care that Memorial could not provide. Although Memorial provides high-tech care, the feel (there) is much more institutional, whereas Community has always prided itself on being 'high touch' as well as being technologically sound. But when we spoke to the people at Memorial, it was fairly clear that their idea was that Community would have a very limited role as an acute care facility and that probably they would phase it out or close it down, convert it to a nursing hospital or something. We felt they didn't have an appreciation for what it was that made Community unique and special and why it should be preserved. They saw it as a means of getting capacity out of the market and they had their minds made up in advance."

Just when Community's hopes of a merger reached a stalemate, Bruce Sanderson heard from Health West.

"At that time, Health West only had four hospitals," Mr. Sanderson explained. "Once we started talking, we got real serious real fast because they wanted to grow. They knew that the market was changing and if they didn't get into (our) market fast, they were going to lose it to somebody else."

Dr. Charles Morrell elaborated, "Mr. Sanderson had the foresight to find Health West. We wouldn't be here if it weren't for them. Community would have been a nice, sweet, gentle hospital with a lot of friendly people around, but the doors would be closed."

"It was critical to affiliate for financial clout and to stay viable," **Richard Wigod, M.D.,** agreed. "It was the right move to affiliate with Health West and I give Bruce Sanderson credit for having a good grasp of where health care was headed. Without the merger, I don't know where we would be."

FROM HEALTH WEST TO UNIHEALTH

Community joined the Health West network in 1984, giving the member hospitals the critical mass they needed to compete more effectively in the marketplace. In 1988, Health West and the Lutheran Health System merged to form UniHealth, creating a stronger system with experience in negotiating contracts.

UniHealth's collective purchasing muscle brought additional benefits, including new computer-based technologies that streamlined hospital procedures. In 1985, UniHealth purchased a computerized lab system for all its member hospitals.

"By computerizing the steps in the lab, we eliminated the potential for human error all along the line," explained **Jim Ewert,** former director of Community's clinical laboratory. "For example, before the computer came along, we phoned all the 'panic' values to the nursing floor. Because these values are critical to the patient, the doctor needs to be notified right away. But when everyone is so busy, sometimes nursing wouldn't get the message. Now the computer tracks everything – the time of the order, the time we get the specimen in the laboratory, when it was drawn, the time the processing was finished, and when the answer went back to the floor. If it's a panic value, it logs who it was phoned to and at what time. We keep everything on optical disc. It was a big transition, going from a manual system to being almost completely automated."

In the mid-1950's, when Mr. Ewert started at Community, the clinical lab did about 400 tests each day. By the mid-1990s, the lab at Community was performing 1,300 to 1,500 tests a day, or about 425,000 each year. Computers and improvements in instrumentation have dramatically shaved the time it takes to get lab results back to the floor. A blood cholesterol test that used to take 30 to 35 minutes to execute is now completed with results back to the unit in three to four minutes.

AN AMBITIOUS FUNDRAISING CAMPAIGN

The hospital Foundation had its eyes trained on the future as well as the past in the early 80's. In April 1980, it launched a $3.5 million capital fund development campaign to support the hospital's $12.5 million modernization program. This large-scale effort was needed to both update hospital services and bring the structure, including the original hospital building, into compliance with the California Hospital Seismic Safety Act of 1973.

Even before Community achieved landmark status, the Board had already decided in 1978 to rehabilitate rather than tear down the historic building. The hospital hired San Francisco architect **Rex Allen-Drever-Lechowski** to bring the 1924 building up to code. The seemingly impossible feat was like putting a girdle around the hospital. It was accomplished by gutting the building, reinforcing the shell, and rebuilding the interior. The structural strengthening that saved the landmark building cost $12.6 million, about half what a replacement building would have cost. The resurrection was made possible, in part, by funds provided by the Bank of America based on the Foundation's pledge to raise the money.

The modernization part of the plan called for a new emergency department, intensive care, gastrointestinal laboratory, the Llwellyn Bixby IV Oncology Laboratory, five-story parking structure, and a new heart surgery suite. The goal was not to add more patient beds, but to increase such cost effective services as outpatient and home care.

By April, 1981, more than $1.2 million had been pledged to the program by members of the Long Beach Community medical staff, Auxiliary, employee Foundation, and hospital Foundation. The hospital celebrated its landmark designation and modernization drive with a rededication ceremony on October 24, 1981. In 1981, Community was serving 58,000 patients each year, had a medical staff of 600 physicians and more than 1,200 employees.

In spring of 1982, the second year of the fund-raising effort, the Foundation's $3.5 million capital campaign passed the $2 million mark. One year later, the medical staff had raised $1.2 million, surpassing their original $500,000 goal. The employees had reached $175,000, $25,000 more than their original goal of $150,000. The campaign was completed on schedule in three years and exceeded everyone's expectations. Mobilized by a vigorous and dedicated Foundation, the successful fund-raising had tapped into the enormous loyalty of the medical staff (who donated one-third of the total sum), volunteers, employees, and corporate and individual supporters of Long Beach Community Hospital.

As William A. Williams, Foundation board member and director of the Campaign Executive Cabinet said at the time of the successful fund-raising effort, "We are especially pleased to receive such enthusiastic support and generosity from those closest to the hospital."

In 1982, a dynamic group of women formed Las Damas de la Plaza, a fundraising auxiliary of the Foundation. Since then, the group has raised more than $650,000 contributing to the hospital's overall fundraising campaigns and purchasing such important equipment as an infant-care system for critically ill babies.

MEDICINE ON THE MOVE

The health care environment underwent enormous changes in the 1980's, and the competition for patients intensified. Inpatient days were decreasing and there was an increased utilization of outpatient services. Community adapted to shrinking revenues through affiliation, fundraising, and organizational restructuring. However, medical technology continued its headlong drive and the hospital was determined to keep pace.

SURGERY THROUGH A SCOPE

Surgical instrumentation evolved throughout the decade, culminating in the introduction of laparoscopes, which gave surgeons a minimally invasive method to view, diagnose, and treat many medical problems. Known as 'keyhole' surgery, the pencil-slim scopes utilize miniature cameras and slender surgical instruments to see and work inside the body.

Orthopedic surgeons were the first to use the technology, using arthroscopy to perform simple to complex repair and reconstruction procedures inside a joint such as repairing torn knee cartilage. Instead of a major surgical incision, laparoscopic procedures are done through two to four narrow slits. For patients, the elimination of a major surgical incision means a quicker recovery with fewer complications than general, open surgery. This surgical development introduced the era of outpatient surgery and eliminated the need to hospitalize many surgery patients.

"All of the knee surgeries except for total knee replacements are now outpatient procedures," noted orthopedic surgeon Charles W. Durnin, M.D. "About 90 percent of hand surgeries are outpatient and many of the shoulders are arthroscopic surgeries. Spine surgery is still an inpatient procedure although we're getting ready to use an endoscope where we'll be able to put a small tube in a portal and see exactly where to go."

Community's general surgeons also learned the new scope techniques and have gradually begun doing more and more outpatient procedures using them.

By the middle of the following decade, the number of outpatient surgeries at Community would soar to 400 per month and outpace the number of inpatient procedures. Although Community was well positioned to take advantage of this new market, the shift to outpatient services hurt larger hospitals that needed to fill hospital beds to stay profitable.

THE CHANGING FACE OF RADIOLOGY

Many of the most exciting changes were occurring in the field of radiology. Interventional radiology was introduced at Long Beach Community during the last few years of Dr. Donald Belville's service. Dr. Paul Lee established the hospital's interventional radiology program in the early 80s. In fact, Dr. Lee had performed one of the first interventional procedures a decade earlier while a second year resident at UCLA in 1972. Dr. Lee recounted:

"The angio service had put a central line in the thick vein in a patient's chest and (then) sheared off the plastic when they tried to pull the catheter back out. A three-inch fragment of plastic tubing got stuck in the patient's lung.

"I was able to put the catheter through a vein in the thigh right up to a branch of the lung where the piece of plastic tubing was lodged. After about an hour, we snared the tubing and pulled it all the way out. I thought what I'd done was a common thing, but the next day everybody was talking about it because no one at UCLA Hospital had ever done it before. This was before the term interventional radiology had even been coined."

Today, interventional radiology is one of the most exciting and promising medical specialties. Using X-ray guidance, the radiologist threads catheters, wires, or other devices through a vein, artery, or other duct to both view and treat a medical problem without open surgery. It also allows the radiologist to take a biopsy in any part of the body that a needle can be inserted, such as the thyroid, bone, the breast, the liver, and the pancreas.

Interventional radiology introduced a new generation of non-surgical therapeutic procedures, many of them life-saving. In angioplasty; it is used to insert extendable metallic stents as an alternative to a surgical bypass graft. Interventional radiology can prevent a clot from traveling from the leg into the lung and causing an embolism. It can be used to infuse chemotherapeutic agents or embolized particles to block the blood supply to tumors, or to block off arteriovenous malformations (abnormal blood vessels). Interventional radiology is even used to drain a blocked kidney or bowel and to extract stones from bile ducts.

Dr. Donald Belville, who had seen the advent of interventional radiology and other dramatic advances in his 30 years as chief of Community's Radiology Department, summed up his impressions this way:

"I started out as a black and white, chest X-ray-reading radiologist, and wound up doing CT, angiography, and even some of the new breast biopsies. The radiologist used to have the image of some mite in a dark room who didn't have a personality because all he was doing was reading X-ray films. Now the radiologist interacts with doctors and patients. He is out there with his hands on. That is radiology today."

The changing face of radiology

In 1988, Long Beach Community upgraded its breast imaging capability by installing the city's most advanced mammography machine. Funded by the Foundation through a gift from the Las Damas de la Plaza support group, the system's improved image quality allowed radiologists to detect breast abnormalities in the earliest, pre-mass stage. Early detection remains the most valuable weapon in the ongoing war against breast cancer today.

Don and Ruth Temple Family Cancer Treatment Center Staff

REFINING CANCER TREATMENT THROUGH RESEARCH

In 1982, the Bixby Land Company was looking for a meaningful tribute to honor the memory of the company's former president, Llewellyn Bixby IV, who had succumbed to pancreatic cancer as a young man in his 40's. When Community's administrator, Bruce Sanderson, asked oncologist **Nathaniel Kurnick, M.D.,** if he had any ideas how the money might be used to advance knowledge about cancer, Dr. Kurnick had the perfect answer.

"I told them I was getting close to retiring from my practice and going back to the laboratory," Dr. Kurnick related. "Chemo sensitivity was an area I was interested in exploring. We have many different drugs to treat cancer, but not all cancer cells are susceptible to the same drugs, just as not all bacteria are susceptible to the same antibiotics. To select the most effective drug for the patient, we needed a way to predict the response or failure to respond of a specific patient's tumor to a specific drug."

The Bixby Land Company contributed $100,000 seed money to establish a cancer research laboratory at Long Beach Community Hospital. The first facility of its kind in the region, the Bixby Cancer Lab is used to research and evaluate the effectiveness of different chemotherapeutic drugs as well as to study radiotherapy sensitivity issues.

The Bixby Cancer Lab allowed Dr. Kurnick to return to his first love, cancer research, a field he entered his first year out of Harvard Medical School. One of the most accomplished physicians in the hospital's long history, Dr. Kurnick served as the lab director of a 2,000-bed hospital in the South Pacific in World War II. After his military service, he held positions doing DNA research at the Rockefeller Institute and in Stockholm, Sweden and was later named an Assistant Professor of Medicine and Director of Laboratory Cell Research at Tulane University School of Medicine. In 1954, he joined the Long Beach VA Hospital and the UCLA School of Medicine as a clinician, teacher, and cancer researcher. Dr. Kurnick has personally contributed close to $1 million to the Bixby Cancer Lab since it opened at Community and donates his own time to continue its work.

THE ER GEARS UP

By 1982, the Long Beach Community Emergency Department was treating 20,000 people each year. Emergency medicine had become a board-certified medical specialty in 1980 and Community's ER physicians were actively involved in training Long Beach's paramedics in advanced cardiac life support (ACLS) and stabilization techniques.

"The number of patients treated in the emergency department rose steadily over the years," Dr. Hurst recalled. "In 1982, the hospital increased the size of the department from 10 to 18 beds in three large rooms. The beds in the critical care area are set up so we can see all the beds and all the monitors."

"Someone made the design decision to have windows in the emergency department and pale blue wallpaper with a cloud design," added Dr. Hurst. "We were worried patients would think they'd died and gone to heaven. But the design actually created a calming atmosphere in what can be a hectic place." The census continued to go up, but the improvements in the physical plant were such that we handled the increased load better and even felt like we weren't working as hard as before."

By 1997, Community's emergency department was seeing 1,500 to 1,700 patients every month. A high number of them were critically ill people from the area's nursing homes. Fifteen percent of the ER patients were children.

"One of our more memorable cases involved multiple victims." Dr. Hurst shared. "In about 1983, a paramedic ambulance with a patient in the back was racing down the street and was hit by a car with six or seven passengers. They were pretty badly hurt. In about 30 minutes, we had two paramedics, the original patient with a heart attack, and five or six from the other car, all of whom had lacerations, pain, and head or chest injuries. It was a true disaster with all the victims coming in at once, but the emergency system worked wonderfully."

Dr. Hurst likes to cite a young patient whose admitting complaint was 'bubble gum in the hair' as the case that truly shows the scope of emergency medicine:

"It happened early in my career when I was working with Dr. Jerry Hughes. A mother brought in a five-year-old child with a big wad of pink bubble gum in her hair. The child was very upset and crying and the mother didn't know how to get it out. The nurse put the little girl on a gurney and Jerry went in and asked, 'How long has the gum been there?

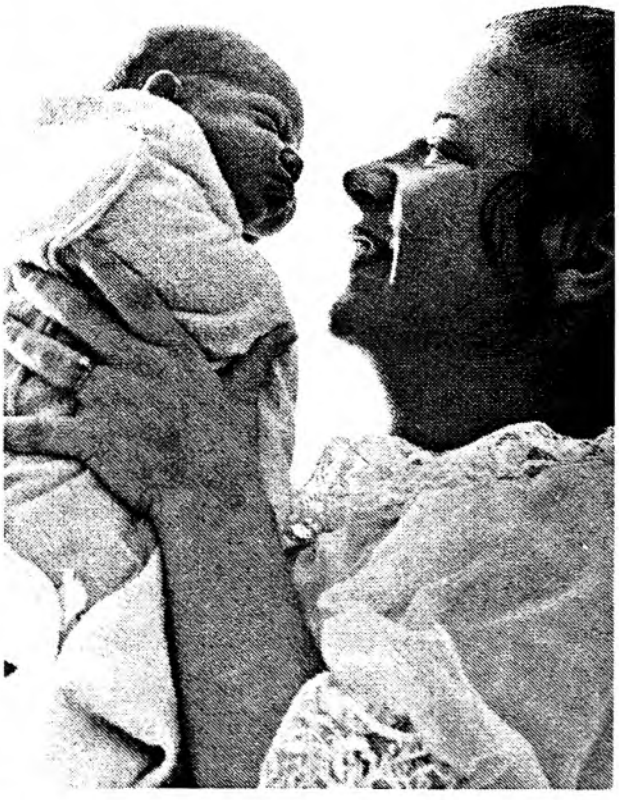
Does it hurt?' He examined the gum carefully and kind of hemmed and hawed a bit. Then he pulled a pair of scissors out of his pocket and cut the gum out of her hair and said, 'There, it's out now.'

To that mom, it was an emergency. Jerry looked at me and said, 'The patient determines the emergency.' That stuck with me because it sets the tone for what we do here. It think it's the humanistic approach that Community Hospital has had over the years and continues to have. Even when things get hectic and you have a lot of people to take care of, you try not to lose track of the human aspect. Even if it's not a major life-threatening emergency, say someone has anxiety or is concerned about something, we're here to take care of it."

NICU LAUNCHED: GIVING SICK BABIES A FIGHTING CHANCE

The number of babies delivered at Long Beach Community increased in the 80s. Instead of 80 to 90 babies per month, 300 babies were being born.

"When you're delivering that many babies, a certain number are going to be sick," noted **Patrick Walsh, M.D.,** head of Community's Neonatal Intensive Care Unit. "About ten percent of them will be unable to survive without help. The hospital administration recognized this and gave us what we needed to support these babies."



Community's employees and Auxiliary raised $800,000 in less than eight months to open a state-of-the-art, 16-bed neonatal intensive care unit. The Level III NICU is staffed 24-hours a day by specially trained NICU nurses and board-certified neonatologists.

"The NICU nurses completed a year of intensive training before the unit opened," according to Dr. Walsh. "The hands-on training makes a big difference because it can be quite frightening when you're taking care of a sick baby. It is so stressful that some of the nurses training for the NICU would come out crying after a few hours and be ready to quit nursing altogether. It's a huge responsibility and the baby has to be watched constantly. If you don't do it just right, the baby might end up with brain damage or chronic lung disease or other serious problems."

Sick babies require very personalized care. Community created a course for parents of babies in the NICU to teach them how to understand what their baby needs and how to touch, feed, and hold them. It also has a volunteer cuddler program for babies whose parents aren't available to provide emotional support to the baby.

"These babies react to any type of noise or light," Dr. Walsh elaborated. "They can actually have a panic attack, turn blue, start shaking, and cry uncontrollably. The parent or volunteer needs to understand what stage of development the baby is in and how to help him. They need to know whether to touch or sing or hold or massage him, or whether the baby needs to rest quietly because he's recovering from stress."

The development of ventilators that could keep sick newborns alive sparked the birth of neonatology as a medical specialty in 1976. Before that time, there was no way to help very premature or critically ill babies breathe. It may seem cruel today, but as recently as the early 70's, newborns who were considered too sick to survive were left alone without medical intervention for three days. It was thought that such small, sick babies would be so severely brain damaged that rescue efforts were inhumane. If the babies survived three days on their own, they were fed and treated to the best of medicine's ability in the hopes the baby would continue to improve and not be severely impaired.

Today, many babies that were once considered hopeless now survive thanks to advances in infant ventilators, resuscitation, monitoring, and feeding technology. Drugs have been created specifically to help a baby's tiny lungs function. Other drugs fight infection in newborns. But, in Dr. Walsh's opinion, it is the nurses who are most critical to the welfare of premature and sick infants.

"Community's NICU nurses have a lot of responsibility and take great pride in what they do," Dr. Walsh confirmed. "The nurses are encouraged to speak their minds. Our NICU has an excellent reputation because it's a democratic unit with professionals controlling the quality of care. We've set it up to allow the NICU nurses to be able to take better care of sick babies than they could anyplace else. We never have to advertise for NICU nurses because it's known as a good place for professionals to work."

For Dr. Walsh, the challenge of caring for a sick newborn is its own reward.

"It's all consuming. It's extremely emotional. It's energizing. Your adrenaline runs high taking care of sick babies, and they occupy your thoughts all the time. There's nothing you do on the outside, no hobby or activity, that comes close to it. You can ride a roller coaster, but it doesn't compare because there's no emotional or intellectual involvement. In the NICU, you're working in a fish bowl with the NICU nurse, the pediatrician, the obstetrician, the administrative staff, parents, relatives, social workers, therapists. To be really good you have to have everybody involved, and everybody has to put their heart and soul into it."

These professionals, committed to helping the smallest, sickest, most vulnerable patients survive, epitomize Community's tradition of providing the highest standard of personalized care. It is this type of care that enabled one of Community's youngest NICU babies to go home with his parents. Born at 22 weeks, nearly four months premature, the baby survived without brain damage. Thanks to Community's neonatal expertise, he now has a fighting chance to grow and realize his full potential as a human being.

A HELPING HAND FOR SENIORS

Even as Community embraced the modern miracles of high technology to save sick babies, it validated the need for human touch to comfort people nearing the end of their lives. The Alzheimer's Family Care Center opened in 1983 with funding provided by a $21,500 grant from the California Community Foundation and additional funding from the Community Hospital Foundation. One of only seven day care centers in the country equipped to care for Alzheimer's patients, the center was one of the first to offer an alternative to institutionalizing seniors who can no longer live alone without some type of assistance.

The hospital expanded its older adult services with an Adult Day Care Center to care for individuals who had suffered a stroke, severe heart attack, prolonged depression or Alzheimer's Disease. The Adult Day Care Center also gives caregivers a much-needed respite from the emotional and physical demands of caring for an impaired senior in the home.

Beth Hambelton is a busy working mother who was able to keep her grandfather with her family longer with the help of the Adult Day Care Center.

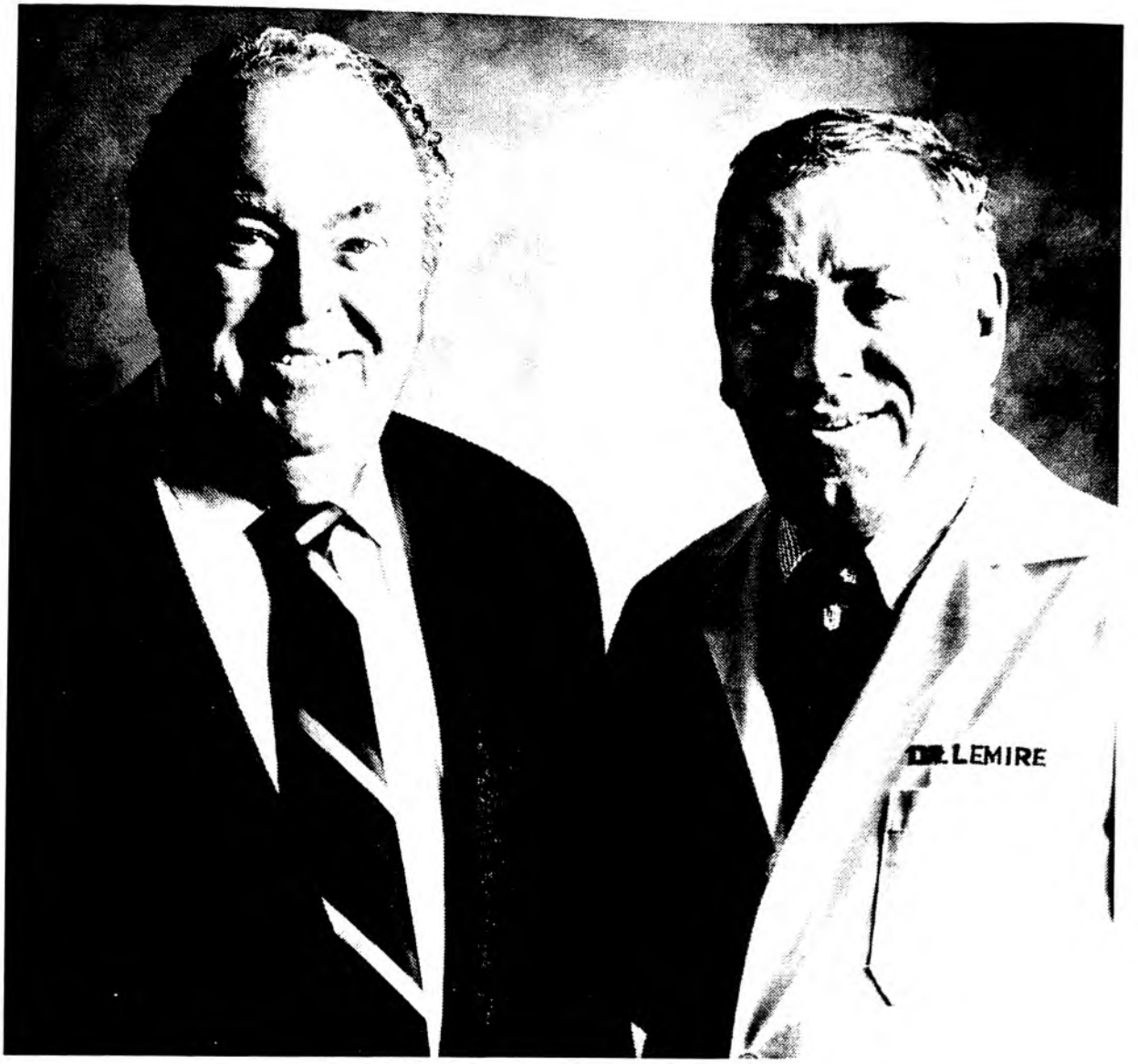
"The staff there have hearts of gold," Ms. Hambelton elaborated. "They respect the elderly and the families who care for them and always treated Grandpa with dignity and love. They also give the families a tremendous amount of emotional support – and practical advice about coping and caring for older loved ones at home. They have definitely blessed our life."

The Older Adult Health Services program has since grown to include a Neuro-Behavior Assessment Center and Community Plus Club program with special benefits for seniors, and outreach services such as an annual flu vaccination clinic, the 55 Alive Mature Driving class, health screenings fairs, and free transportation for home-bound seniors requiring medical care. The hospital added a 27-bed Transitional Care Center in 1993 for older patients and others who no longer require high level hospital care but are not quite ready to be on their own.

CARDIAC SURGERY COMES OF AGE

When cardiovascular surgeon **Guy Lemire, M.D.,** joined the medical staff at Long Beach Community in 1978, the hospital was doing 25 to 30 open-heart surgeries a year. Educated at McGill University in Canada and a former medical professor at the University of Montreal, Dr. Lemire recognized an opportunity to practice 'high- tech, high-touch' medical care when he was invited to join Dr. Herbert Movius and Dr. Max Gaspar at the Long Beach Surgical Group. His training in cardiovascular, cardiac, and valve surgery added depth to the hospital's fledgling program.

"When I arrived, there were three or four cardiologists who were trying to build up the coronary surgery program at Community," Dr. Lemire said. "We doubled the number of open hearts the first year I was at Community, and doubled it again the following year. But it wasn't until 1985 or 1986 that we reached the threshold of 100 cases a year. Ten years later, we were close to doing 200 heart surgeries a year, 85 percent of which were cardiac bypass surgeries and 15 percent were valvular surgeries."



Mr. Bill Williams and Dr. Guy Lemire

Several components were required to develop a top quality cardiac surgery program: a well-trained open-heart surgery team, a state-of-the-art ICU, and a dedicated cardiac surgery suite. The hospital administration supported these efforts, opening a new heart surgery operating room in 1982.

"In the early days of cardiac surgery, you had to put a heart in arrest so you could work on it," Dr. Lemire pointed out. "Otherwise, you'd be trying to do a coronary bypass on a moving target. But by putting a heart in fibrillation, you're operating on an organ that's quivering like a can of worms. You could work that way, but you couldn't protect the heart very well. Then at the beginning of the 80s, a physician at UCLA surmised that you could arrest the heart with a very cold solution filled with potassium. Hypothermia totally stops the heart, allowing us to work on a cardiac surgery patient for hours. The heart/lung machine provided more time for the surgeons to do the surgery with much more control, and with much more protection for the patient."

Dr. Lemire was one of the cardiac surgeons who worked directly with the ICU, CCU, and OR nursing staff to bring them up to speed in caring for a heart surgery patient.

"One of the byproducts of training the staff was that it improved the overall quality of the hospital's postoperative care," Dr. Lemire explained. "If you can take good care of a heart patient, you can do just about anything."

This dedication to creating a premier program at Community got everyone involved in cardiac medicine at Long Beach Community, from the anesthesiologists with special training in cardiac anesthesia to the cardiac surgeons themselves.

"Dr. Movius went back to school when he was in his early 60's to learn how to do coronary artery bypass surgery," Dr. Lemire elaborated. "He was a full-fledged general surgeon and a vascular surgeon. But he spent nine months in training at Good Samaritan Hospital. He was probably the oldest resident in cardiac surgery that's ever taken a course and he did that to help start the program here at Community Hospital."

A PIONEERING APPROACH TO MENTAL ILLNESS

In 1988, Community opened one of the first psychiatric programs in the country dedicated to addressing the emotional, psychological, and medical needs of individuals struggling with a mental disorder. The Community Neuropsychiatric Center featured a multidisciplinary treatment team and a comprehensive approach to psychiatric care. This approach, unusual at the time, has since become the gold standard in psychiatric care and helps restore stability and function to mentally ill individuals and their families. The center also included a 14-bed unit for individuals requiring a more intensive level of care, as well as assessment and rehabilitation services for individuals recovering from brain injuries or other neurological problems.

FLEXIBILITY AND FORTITUDE

As the 1980s drew to a close, Long Beach Community was in a stronger position than anyone could have predicted at the beginning of the turbulent decade. The Board's decision to affiliate had proved the local sages wrong when they pronounced that Community would be the first Long Beach hospital to close because it was too small to compete against larger institutions. Community's visionary administration and enlightened Board sparked a remarkable synergy. This synergy ignited the medical staff, loyal employees, and the Foundation and allowed the hospital to adapt to the challenges of shrinking reimbursement and rising technological costs. Long Beach Community found it had the flexibility and fortitude it needed to survive these profound changes without losing its identity or its time-honored mission to meet the community's health needs.

Chapter 8

The 1990's: Staying the Course in Changing Times

By the 1990's, the ethnic, economic, and cultural backgrounds of Community's patients continued to shift to reflect the city's changing demographics. Civic redevelopment had permanently altered the face of the downtown area, replacing old apartment buildings with high-rise luxury hotels, office buildings, and the World Trade Center. Closer to the hospital campus, the Kilroy Airport Center opened a 52-acre corporate park. Small business and retail centers ringed the Traffic Circle area, which had been revitalized by Bixby Land Company developments. Every day an estimated 58,000 vehicles navigated the traffic roundabout.

At the decade's midpoint, the local population was projected to grow at a rate of about 7 percent per year. Even as the hospital continued its mission to serve the health needs of an increasingly diverse community, it was doing so in a drastically changed health care environment.

If there is one driving force in the industry, it is the rapid rise of the managed care movement. When the decade opened, Long Beach Community was in an aggressively proactive stance to respond to the widespread shift from traditional fee-for-service indemnity insurance to health maintenance organizations and preferred provider networks. As other larger hospitals were just beginning to trim their unwieldy organizations to fit a sleeker paradigm, Community already had streamlined its systems and processes to adapt to managed care. Long-range strategic planning and its affiliation with UniHealth gave Community the competitive edge to successfully negotiate contracts with most major managed care companies.

LOOKING FORWARD TO THE 21ST CENTURY

The contributions of **Janet Parodi** deserve special mention. Janet came to the hospital through the influence of Paul Viviano, then CEO. Her background included being a high school cheerleader, which served her well as a motivator and persuasive leader. She had excellent credentials having attained her RN and had experience as a critical care nurse. She was just short of an academic Ph.D. Mrs. Parodi also had a business of her own, which enhanced her knowledge of management. Janet brought enthusiasm and charisma to the hospital.

Janet Parodi

There is no question that the image of LBCMC was raised through her leadership. She wanted the message of the hospital to be more evident in the community. To accomplish this she encouraged every VP of her administration to get involved in at least one or two community service organizations. She had a real interest in the information age and spear-headed the project to spend considerable funds to get the hospital properly prepared through fiber optic cabling. She encouraged her senior staff to think with a bend toward virtual reality in as many services as possible. The Johnson Library was modernized, eliminating old textbooks and journals and installing computers not only in the library but the Physician's Dining Room,

the Surgeons and Obstetrician's lounges so that doctors could access literature from national and international sources.

Janet knew that, being the only woman CEO in the UniHealth system, she had to work 'harder and smarter' and this became her encouragement to employees as well. Because of a personal loss of her own mother to cancer, she was very interested in oncological programs throughout the hospital, the most important of which was the creation of The Don and Ruth Temple Cancer Center, built just across the street from the hospital. She took the lead in establishing the Rape Victims Evaluation and Treatment Center, which eliminated the need for those patients to have to suffer the indignities of answering endless questions in an emergency room setting. This center served the entire city of Long Beach. The hospital provided the space for their offices in the Cawry building.

Janet Parodi worked tirelessly to effect adaptation of the institution to the changes necessary to attract managed care organizations to use the hospital for inpatient and specialized outpatient services. She was instrumental in creating the Senior University program and CSULB where older citizens could continue to learn in an appropriate setting on the campus of the university.

The appearance and safety of the hospital campus was important to her. The buildings were always clean, well painted, and at Christmas, special lighting was quite spectacular. In order to control potential gang activity on the hospital campus, specially trained dogs were present around the clock to meet any challenge. These canines and their trainers were a wonderful public relations advantage as the dogs were featured in outreach programs for local schools and other organizations.

Part of Mrs. Parodi's inspiration leadership was to make sure she and her management group practiced MBWA or "management by walking around." She was also a great believer in inspiring employees to think about ways to make themselves happier and more effective by bringing faculty of "Psychology of Mind" from La Conner Washington.

Through Janet's influence and commitment, the Joint Commission on Accreditation scores were always higher than in previous hospital history. Even members of the Board of Directors got involved. Clearly her biggest contributions were improving not only the community image but also the self-image of the organization and preparing for the information age.

RESPONSIVENESS TO MARKET CHANGES

"Community has been at the forefront of learning to manage care," said **Richard Wigod, M.D.,** who served twice as the hospital's chief of staff and later became its vice president of medical administration. **"Janet Parodi** of administration did an outstanding job of learning the business aspect of managing care and of making the changes necessary to manage care well. The management staff, employees and physicians worked on ways to reduce costs and make things more efficient."

The hospital's director of pharmacy, Jack Schick, explained the changes his department had made to adapt to managed care.

"There isn't a week that goes by that we're not reevaluating how the pharmacy is doing something," Mr. Schick said. "It may not change how we do it, but we at least look at why we're doing it and if there's a better way to do it. The feedback in our department is very good and the staff is not afraid to take another look at anything. And that's not just our department, it's the entire staff of the hospital."

As a result of hospital-wide efforts to streamline costs, **Modern Healthcare** named Community one of the 50 most cost efficient hospitals in the country.

THE NEW REALITY OF MANAGED CARE

Managed care has trimmed health care costs, that in the 1980's were rising at an average rate of 12 percent each year. By the mid-1990's, health care costs were rising at a rate no higher than four to five percent annually. Managed care has irrevocably changed how health care is delivered in the United States. The numbers tell the story:

In 1988, 71 percent of the U.S. population were in a traditional fee-for-service indemnity plan, 18 percent were in a health maintenance organization, and 11 percent belonged to a preferred provider organization (which allows individuals to choose a physician participating in the plan's network).

In 1997, the figures reversed. Only 18 percent of the population had indemnity insurance, 33 percent belonged to a health maintenance organization, 31 percent were in a preferred provider network, and 17 percent had point-of-service coverage (an HMO with the freedom to go outside the network for care at an additional cost).

"When you capitate care, you take responsibility for the health of, say, 10,000 lives for a set amount of money per member per month," explained Robert H. Schumacher, M.D. Dr. Schumacher continued:

"Capitation puts the focus on the health status of the individual members. How many alcoholics are there? How many smokers? How many elderly? Those issues are significant because when they get sick, you will provide the necessary level of care even though you won't be reimbursed anything over the established monthly fee. So you want to make sure the patients receive routine screening tests to detect such diseases as breast cancer earlier. The emphasis of the hospital used to be on achieving a high census, to fill every bed if possible. That's entirely changed under managed care. Now we want to manage people's health in such a way that they don't have to be hospitalized. Every dollar spent in prevention saves $6 in the eventual cost of treating the patient."

One of the primary concerns about managed care is the impact it has on the quality of care hospitals provide.

"I believe you can give good care in a managed care environment," said **Joseph Dahlquist, M.D.,** an internist on staff at Harriman Jones Medical Group, one of Community's partners. "The care is every bit as good, but we don't waste money," Dr. Dahlquist stated. "For instance, we don't do an EKG on a 25-year-old man having a routine physical because it's wasteful. We practice good medicine, but we're more discriminating about which tests are really necessary. With managed care, physicians are very involved in the cost of things, but I still think we're delivering quality care."

KEEPING THE FOCUS ON THE COMMUNITY

Karolyn Morrison defined the hospital's role in the managed care environment:

"It is particularly important in the era of managed care to maintain our identity as a community hospital. When people worry that someone they don't know in the managed care company can either supply or deny their care, it's crucial that they understand their hospital is still community-based. We need to be able to offer services to the community in such a way that they can still feel personally involved in their health care."

If managed care has affected the health care consumer, it has had an even more profound impact on physicians.

"The younger doctors today aren't coming into medicine expecting to go into private practice," Dr. Schumacher said.

General surgeon Charles Morrell, M.D. agreed:

"There are still a few doctors around who are in private practice, but they are part of a disappearing breed. All the state and national physician publications, including the **New England Journal of Medicine,** say that there won't be any solo doctors left in 10 years. These days you have to be part of a large group such as an IPO (independent physician organization) or PPO (preferred provider organization) or HMO (health maintenance organization) to survive."

"Not all of our physicians embraced managed care in the beginning," Ms. Morrison remarked. "Some of them thought it was a novelty that would just go away. But as it impacted them more and more directly, they had to learn to work with managed care. By doing so, they're helping themselves and they're helping the hospital. They know when we make contracts that it involves them."

Managed care has done more than hold costs down. At Community, it has prompted an investment in increased services and more sophisticated equipment to serve a larger patient population.

"The practitioners are now realizing that things we take for granted like the NICU and top-quality anesthesia coverage wouldn't be available if it weren't for the large volume of patients that managed care brought in," according to obstetrician Carl Natter, M.D. "We're reaping the benefits and it's improved the resources we have available for our patients."

DR. ROBERT SCHUMACHER: RESPECTED PHYSICIAN, DEDICATED CONSENSUS BUILDER

Community has always found the right person to steer a steady course toward the future especially during periods of great change. Dr. Robert H. Schumacher, vice president of medical administration from 1982 to 1996, represents such an individual. Prior to assuming the administrative post, Dr. Schumacher was a board-certified internist in private practice at Community for 20 years where he also served two terms as the chief of the hospital's medical staff. Until 1980, he was an assistant clinical professor of medicine at UCLA.

When Dr. Schumacher left private practice to direct Community's medical services, the medical staff gained a trusted liaison to represent their views to the hospital administration.

"Bob was well liked as an internist, and that made him a good bridge between the doctors and the hospital," Dr. Herbert Movius confirmed. "He knows what doctors want and need, but he's also realistic. He did a really good job and was a big reason why doctors had more of a voice at Community than they did at any other hospital in Long Beach."

EXPANDING PROGRAMS TO BATTLE SOCIETY'S WORST KILLERS

Long Beach Community Hospital changed its name to Long Beach Community Medical Center in 1995. The name change represented a new focus on delivering comprehensive, multi-level medical care in a state-of-the-art facility. In addition to providing basic and specialty medical services, the hospital made a serious investment in resources to wage war on two scourges of modern man: heart disease and cancer.

COMMUNITY HEART CENTER

When the decade opened, the hospital enjoyed a solid reputation for treating heart disease, the number one killer of Americans. Its long tradition of pioneering cardiology encompassed Dr. Eugene Temkin's contributions (including the custom-designed Angiocor cardiac imaging machine and innovative critical care unit); new alternatives to surgery such as angioplasty and interventional radiology; and advanced cardiac surgery including bypass and vascular procedures. Community's commitment to excellence in cardiac services was formalized in September 1990 with the opening of the Community Heart Center. This $2.5 million comprehensive cardiac care facility consolidated diagnosis, treatment and rehabilitation in one location.

The new Community Heart Center featured 32 portable telemetry units, a 10-bed coronary care unit, a state-of-the-art cardiac catheterization lab, cardiovascular lab, and an updated cardiac surgery suite. Once again, the Foundation had stepped up to run a successful capital campaign to fund the hospital's most ambitious project since the massive modernization and seismic strengthening project completed in the 1980s.

In 1993, the Foundation contributed $1 million to the construction of a second open-heart surgery suite at the hospital. The Heart Center expanded to a 42-bed unit delivering multiple levels of care. By mid-decade, 85 percent of Community's cardiac surgeries were coronary and 15 percent were simple to complex valve repair surgery. Because of the hospital's large contract business, the patients tended to be older and sicker than average. Yet, even though Community's average heart surgery patient was 69 years old (versus the national average of 62), its outcomes equaled or surpassed other heart centers.

"Through the years, the number of heart surgeries at Community had risen significantly," Dr. Lemire explained. "We found we needed a back-up heart surgery suite primarily due to the advent of coronary angioplasty. If someone having an angioplasty in the cath lab

Robert Pugach, MD, Thomas Norum, MD, George Hancock, MD, Robert Schumacher, MD

the advent of coronary angioplasty. If someone having an angioplasty in the cath lab (had complications) and needed to go to surgery, we had to be able to accommodate them without delay. We put the new cardiac surgery suite next to the other heart room where a patio had been."

Dr. Lemire worked closely with the hospital administration to build the heart program to its present level of excellence. Not only did he help determine what was needed, but he also rolled up his sleeves to raise the money for it.

"Guy Lemire brought renown to the hospital through his talent in cardiac surgery," according to Bill Williams. "He also dedicated himself to the fundraising the hospital does through the Foundation." Mr. Williams and Dr. Lemire co-chaired the campaign to raise $1 million for a new heart surgery suite.

"When we had to raise money to build a new heart room, we decided to ask some grateful patients if they wanted to make a donation," Dr. Lemire elaborated. "We did a survey asking the patients how they felt about their surgery and the care they got at Community. Most of the people responded that they loved it and they'd have it done at Community again if they had to. To make a long story short, the patients donated more than a quarter million dollars to the total $1 million that was raised. The staff of the hospital, the workers, nurses, everybody who worked in the hospital, donated over $50,000. So they believed in us too."

Karolyn Morrison credits the hands-on involvement of strongly motivated physicians for creating strong programs such as Community Heart Center. This physician involvement ranges across the board, from training the ICU and CCU nursing staff, to purchasing advanced technology, to providing comprehensive rehabilitation services.

"Cardiac care at Community is very personalized," Dr. Lemire pointed out. "It's a well kept secret that we have a program that's grown substantially over the years, especially with the high volume of managed care patients we treat. We pride ourselves on investing in all the best equipment – including the imaging in the cath lab and all the work-up services – but also in having the best people."

Dr. Lemire concluded, "If you ask any cardiac surgeon who comes here to operate, they'd say our team is tops. That's the true test of how good a cardiac surgery program is. The team functions seamlessly no matter who the operating surgeon is."

By 1997, Community Heart Center's three service areas – the 32-bed Coronary Care Unit and Heart Center, Cardiac Catheterization Lab and Cardiodiagnostics Center, and the Cardiac Rehabilitation Center – were providing sophisticated cardiac care to 8,800 heart patients annually.

THE COMMUNITY CANCER RESEARCH AND TREATMENT CENTER

With cancer projected to be the leading cause of death by the year 2000, the Long Beach Community Board began analyzing the need for a comprehensive cancer center to address this challenging disease. The objectives were two-fold: (1) to offer the most advanced technology available to improve the long-term survival rates of cancer patients, and (2) to make cancer services more accessible to a larger number of patients.

In 1995, the hospital embarked on a $5 million campaign to build a premier outpatient cancer center encompassing diagnosis, research, treatment, and support services. Twenty-three years after it began operating the first linear accelerator in Long Beach, Community again took the lead by offering the most sophisticated radiation therapy system in the area. Again, because of dedicated and loyal community supporters and the extraordinary generosity of **Mr. Don Temple** and his family the Community Cancer Research and Treatment Center opened in 1996. This high tech family cancer center featured a computerized radiation treatment planning, simulation and delivery system. The radiation therapy system is sourced by a state-of-the-art Clinac 2300 CD linear accelerator with built-in, full-body CT scanning.

A key feature of the new system is conformational therapy to deliver radiation doses precisely shaped to the patient's tumor without harming healthy tissue. The system is also equipped to perform stereotactic radiosurgery, which uses high-dose radiation beams to destroy complex or inoperable brain tumors without surgery.

"When people ask me to define the mission of this center as opposed to every other cancer center, I tell them we are capable of providing high dose precision radiation therapy to any cancer regardless of the location of the tumor," explained **Robert H. Goebel, M.D.,** director of radiation oncology.

Robert H. Goebel, M.D.

Dr. Goebel is representative of the current generation of dynamic physicians practicing at Community in the 90's. A graduate of the New Jersey College of Medicine, Dr. Goebel completed his internship at Cornell Cooperating Hospitals (which includes Memorial Sloan-Kettering Cancer Center). He served as a research associate in the division of Cancer Biology and Detection at the National Cancer Institute and completed his residency in radiation therapy at Harvard where he was also a clinical fellow. He is an associate clinical professor of medicine at UCI School of Medicine. Dr. Goebel guided the fact-finding process that culminated in Community's Cancer Research and Treatment Center and was active in the capital campaign that made it possible.

"I think physicians tend to congregate in places that will let them practice in the style they like to practice," Dr. Goebel says of his decision to join the Community medical staff in 1985

"The hospital's strengths in cancer care are the same as its overall strengths. It's large enough to have the facilities to give all the high tech treatment necessary for treating cancer, but small enough that the patient doesn't get lost in the shuffle."

Augmenting the center's advanced radiation therapy systems are Community's other cancer services that include traditional treatment approaches such as surgery and chemotherapy; an inpatient oncology unit; contemporary diagnostic modalities including stereotactic (non-surgical) breast biopsy, mammography, CT, MRI, and nuclear medicine imaging, fluoroscopy, arthography, ultrasound, and biopsy; the Bixby Oncology Lab which helps determine the most effective chemotherapy drugs for the patient; reconstructive surgery; and patient education and support resources.

"I was originally attracted to radiation oncology because it involves mathematical science but you also have a lot of patient contact," Dr. Goebel related. "At our cancer center, the patient isn't a number. They are individuals who have faces, names, and families."

WELCOMING BABIES TO A BEAUTIFUL WORLD

Community's leadership in family-centered care, which began in 1971, was firmly established when the hospital opened the New Arrivals maternity program in 1990. The New Arrivals program offers expectant parents extensive childbirth education and personalized care to ensure a safe and healthy pregnancy for mother and baby. In 1992, Community added nine Labor, Delivery and Recovery suites to give new parents a more intimate setting for uninterrupted childbirth.

"My doctor handed my baby to me as soon as he was born and Nolan never left my side the whole time I was in the hospital," reflected Barbara Scott on the birth of her son. "He was bathed, weighed and evaluated and placed in an infant warmer right next to my bed. I was able to begin breastfeeding my baby in the same room he was born in."

The hospital's fetal monitoring services, full perinatal support, and 24-hour anesthesiology and neonatology help new babies start life with every medical advantage. Community, which has always taken good care of mothers and babies, is also highly regarded for its attention to the needs of women at increased risk for complications. The Level III NICU meets the complex needs of medically compromised newborns and helps reassure anxious parents. In 1992, Community opened a Pediatric Intensive Care Unit to provide the same high level of care to sick children.

IMAGING TECHNOLOGY FULFILLS ITS PROMISE

Imaging technology has reached an unprecedented level of precision, with new applications emerging every day. Interventional radiology has continued to grow, allowing more and more therapeutic procedures to be performed using wires as thin as a human hair. Now considered a medical sub-specialty, interventional radiology requires additional certification.

Community's ultrasound, nuclear medicine, mammography, CT, MRI (including cardiac MRI) and coronary angiography equipment provides images of exquisite precision. With its tradition of innovative radiology, the hospital is among the area's leaders in providing the latest imaging technologies. It recently purchased a spiral CT machine, which produces images in about one-tenth the time of a conventional CT scanner.

"The difference between the usual CT scanner and a spiral scanner is related to improvements in timing, computerization, and hardware," according to Paul Lee, M.D., director of community's radiology department. "Instead of producing an image slice-by-slice, the spiral CT moves continuously. It gives a more accurate picture, faster, and with much greater control over the image. You can also display the image in three-dimensions which allows a physician to evaluate different surgical approaches."

Dr. Lee believes managed care has influenced the drive to obtain more accurate diagnostic information more quickly.

"People don't have the luxury of staying in the hospital for five days for a work-up," Dr. Lee said. "The emphasis today is to get the patient in, pinpoint the problem, and take care of it without subjecting the patient to unnecessary tests. Radiology is playing a larger role in the process because physicians rely more on diagnostic imaging. That's one of the reasons imaging has evolved to such a precise science."

NEW DRUGS FOR A NEW AGE

Recent pharmacologic advances have given physicians powerful new weapons to treat many major diseases. Among the recent breakthroughs are clot-busting drugs which can be administered to heart attack victims as soon as they enter the emergency room. By acting instantly to dissolve the clot that is causing the patient's heart attack, these drugs save the heart muscle from more extensive damage and debilitation.

"There is a huge improvement in the sophistication of medications today," agreed pharmacy director Jack Schick. "The new medications target a disease or symptom much more precisely with fewer side effects."

The hospital pharmacy today is a far cry from the dispensing station Jack Shick encountered when he joined Community in 1960:

"The pharmacy was quite a bit different in the old days. Instead of individual patient orders, the medications were distributed to the floor as stock and the nurses were responsible for picking the medicines. They'd have a bulk bottle and dispense one pill at a time to various patients. The control was very loose and as medications became more potent, the nursing staff really wasn't prepared to handle it. Nowadays, each and every dose is individually packaged, labeled and delivered to the patient. It's completely computerized with failsafes built into the system against duplication of therapy and drug and food interactions."

With so many complex new drugs coming on the market, Community's physicians, nurses and pharmacists work collaboratively to provide patients with the most effective drug therapy.

"Of course, the physician is still the one who decides on the medication," Mr. Schick continued. "But the pharmacist will sometimes consult with the physician if we think there might be a better approach. The nurse's role is to monitor the patient's response and alert the physician if any problems occur."

Pharmacology is expected to continue to yield even more promising new drugs in the years ahead, particularly in the area of biotherapeutics. One example is tricking micro organisms into producing human hormones such as insulin.

"The pharmacist of today understands the body's physiology and biochemistry better than we did when I started out," Mr. Schick added. "When I see a new drug, my orientation is: what other drugs, in my experience, does this drug look like? The newer pharmacists have all of that plus they understand the microbiology that's going on underneath. They know what's happening on a cellular level and which enzyme systems are being affected. They are highly educated and can talk to physicians on a one-to-one level."

HEALING, TEACHING, TOUCHING THE COMMUNITY

The hospital's mission to serve the community does not stop at diagnosing and treating disease. Long Beach Community Medical Center is actively engaged in community education, health screenings, flu clinics, parent and caregiver support, and women's welfare.

During the Gulf War of 1991, Community sponsored "Operation Homefront," a free support group for concerned relatives and friends of service people called to fight in the Persian Gulf. The hospital has a strong diabetic education and support service helping these individuals control their disease with diet, exercise, and medication. Other free community education and support activities include **Moms Helping Moms,** cancer and bereavement support groups, and regular classes on parenting, poison prevention, safe sitter babysitting education, CPR and infant CPR, stopping smoking and other health topics.

Every Christmas, Community's employees collect food for dozens of needy area families. The hospital's Christmas spirit comes alive again in April when employees volunteer their time to paint, repair, and spruce up community service agencies such as Traveler's Aid and the Boys and Girls Clubs.

Long Beach Community is also committed to helping female victims of violence, a growing threat in our society. In 1994, the hospital teamed up with the Long Beach Health and Police Departments to create the **Sexual Assault Response Team.** In a compassionate and calm setting, the rape victim receives a medical examination that includes collecting evidence required for legal prosecution and counseling.

"It's a wonderful program," Dr. William Hurst said. "If a woman has been traumatized by rape, she shouldn't have to wait in a hospital ER for a doctor who's busy treating a heart attack victim or a baby with a seizure. The sexual assault crisis facility is staffed by a forensic nurse who is trained and has the time and understanding to do a thorough assessment without creating further distress for the victim."

LOOKING AHEAD

Community's Emergency Department introduced an urgent care service in 1995 to provide walk-in non-emergency care for individuals. The service is an alternative to using more intensive emergency medicine resources for non-threatening medical problems such as respiratory infections and minor injuries. As a result, the emergency department's census tripled and is projected to grow to 4,000 patients per month. To prepare for the increase in emergency visits, the hospital embarked on a $1.3 million expansion of the emergency service including two triage stations and an enlarged waiting room.

A HOSPITAL FOR ALL SEASONS

For nearly a century, Long Beach Community has cared for, and been supported by, the people it serves. Whenever a health need was identified, Community responded with skill and caring. Today it is a full-service medical center with every technological advantage. It competes successfully against much larger institutions and enjoys a reputation as the most caring hospital in the area.

"As someone once said to me, probably 95 percent of any medical care we would ever need can be done at Community Hospital," concludes Jean Bixby Smith. "For the kinds of illnesses most people will face over a lifetime, they can be given care and cared for with kindness at Community."

FOUNDATION LEADERSHIP

Early in the development of the LBCMC Foundation, **Stewart "Bus" Bachtelle** came to the hospital as part of an evaluation team with **Jim Nagle** to see if we were ready to launch a capital campaign in the city to benefit the hospital. He was well received by all the leaders of the hospital and was offered the job as executive for the Foundation. He was well qualified for the job since he was raised in Long Beach, he was well liked and he knew so many people. Immediately he became familiar with the physicians, Board members and employees, encouraging them to raise money by giving themselves. He organized many fund raising events and told everyone that we would be "fund raisers and friend raisers" as well. Events would be fun and first class in quality. Bus was a retired Colonel in the U.S. Air Force, completing his military career on the faculty of the Air Force Academy in Colorado Springs.

The **Community Classic golf tournament** became one of the most prestigious events in the community. It was scheduled every June and fulfilled his prediction of raising funds and friends. He was particularly impressive in following up with potential and past donors so that they maintained their interest and connection with the Foundation. Whenever any of them would need the hospital services for any reason, he made sure that the service was superb. He had a policy of never asking donors for contributions when they were in the hospital. Bus and his capable staff made many home visits to patients after they were discharged from the hospital.

Much of his success was due to the organization of fund raising teams. Potential donors were evaluated by the most knowledgeable of their contemporaries, and solicitations were encouraged to be conducted face to face and after the solicitor had made a personal commitment. Names of potential donors were distributed on a voluntary basis. All fundraisers were instructed as to what the "case statement" for the donation was. Bus made sure that experts in estate, property and taxes were available as needed. Under his direction the **Fillmore Condit Club** became a potent resource for fundraising for the hospital. The annual formal Condit dinner was mainly a "thank you" and recognition of all new members as well as those achieving a higher level of membership. He was truly a charismatic guy with a quick and easy smile and laugh that added to the fun and festivity of all Foundation events. The Condit dinners were held in the International City Club until participants became too numerous for that club to accommodate. The event was moved to one of several hotels in Long Beach.

The Foundation prospered during the late seventies and eighties. They were the good times when it was feasible and appropriate to conduct weekend retreats away from the city so that physician and Board members could achieve relationships on a first name basis. Inspirational leaders from outside the hospital were effective in providing motivation and knowledge. Mr. Bachtelle was a real social catalyst in those settings.

Stewart "Bus" Bachtelle

AN EFFECTIVE FOUNDATION

The Long Beach Community Foundation has always supported the hospital's mission with the funds necessary to turn dreams into reality. The Foundation's spirited response to the hospital's needs has funded every major expansion, renovation, and capital equipment purchase at Community for the past twenty years.

"The purpose of the Foundation, which is a true charitable organization, is to benefit the hospital," according to Foundation board member Bill Williams. "In my opinion, the only way to do that is to answer the call when the hospital says 'we need this.'"

Bill Williams has been a chairman of the Foundation board and the hospital board for a combined total of eight years. From 1977 to 1994, Mr. Williams served as the chairman of every major fund-raising campaign for Long Beach Community. Why does a busy attorney contribute so much time and energy to the hospital?

Chairmen of the Board of Directors 1975-2000; Back row: Gregg Whelan, Bill Williams. Middle row: Myrna Wigod, Mason Kight, Ken Davis, Jim Lockington. Front row: Betty Keller, Jess Grundy, Suzanne Nosworthy, Richard Bechler.

"It's a way I can contribute back to the community," Mr. Williams explained. I think a lot of Community, and that's why I've put so much of my time into the hospital. There's personal satisfaction helping the hospital and interacting with the medical community."

According to Bus Bachtelle, "Bill Williams is the ultimate board chairman, a true leader. He belongs to many civic organizations and has been instrumental in getting several people to donate land and money to the hospital."

Dr. Guy Lemire pointed out, "We're not endowed with a lot of money like some hospitals. At Community we rely on the community. It's a way for people to feel involved in their community and in their medical center."

"There's no way a hospital can be competitive in the industry without community help," said Jess Grundy, a founding member of the Foundation. "Without fund-raising, the hospital would have to charge such high fees it wouldn't be able to serve all the people in need."

And without dedicated and effective community leaders taking responsibility for the hospital's future, the Foundation could never have succeeded.

In Bus Bachtelle's mind, two names stand out, "Bill Williams and Jess Grundy were the two strongest Foundation members the hospital ever had."

One of the Foundation's most successful fund-raising events is the annual Golf Classic, which Jess Grundy helped start. The Golf Classic, now held each June, includes a car raffle, auction, golf tournament, and banquet. The popular one-day event typically draws a crowd of community supporters, physicians, and hospital employees.

When asked who he felt had contributed the most to the Foundation in its twenty year history, Jess Grundy replied, "Dr. Schumacher, Myrna Wigod and her husband Dr. Dick Wigod, Harry Kayajanian, Bill Williams, and all the past chairmen of the Foundation."

The Wigods have both played an important part in Long Beach Community's history. Dr. Dick Wigod has been influential as the chief of the medical staff and as an activist in medical politics in the state of California. Myrna Wigod has sparked the Foundation with her wit and creativity.

"Myrna Wigod is very active and makes a great master of ceremonies," Bus Bachtelle revealed. "She has a great sense of humor and always made every event a lot of fun. She was behind the roller skating marathon, which generated a lot of publicity for Long Beach Community."

The next generation is poised to continue the Foundation's long tradition of support.

"The greatest contribution Bix Bixby and I have made to the hospital is that we gave them our daughters, Suzanne Nosworthy and Jean Bixby Smith," Jess Grundy said. "My daughter Suzanne joined the Foundation board to replace me and is on the hospital board as well. Jean Bixby Smith has been the hospital's Joan of Arc."

AN EDUCATED AND VISIONARY BOARD

Jean Bixby Smith joined the hospital Board in 1976 and later served on the UniHealth corporate board. A well-known civic leader and former chair of the hospital board, Mrs. Smith helped guide Long Beach Community through its most challenging period.

"It's been a fascinating involvement because I had the unique opportunity to be in a leadership position at the point at which we affiliated," Mrs. Smith said. "UniHealth exposed me to a much broader health care arena From a personal and educational standpoint, it's been very interesting."

SERVING A HOSPITAL THAT SERVES THE COMMUNITY

I'm honored to be affiliated with an organization that has a heart as well as a head. I've volunteered in various things over the years and I like the idea of Community being a place where there's more than just a lot of technology. They make a real effort for patients and their families who are going through difficult times and treat them with respect. They make them comfortable and help them understand what's going on. I'm sure we miss the boat sometimes, I mean we all do, but there's a real effort to keep it personal and to treat people as individual human beings instead of just patients.

Jean Bixby Smith

A FAMILY TRADITION

Like Jean Bixby Smith's, Richard Bechler's family instilled in him a sense of civic philanthropy. Mr. Bechler has served both on the Foundation board and as chair of the Long Beach Community Medical Center Board of Directors.

"My Dad and Mother and Grandfather were always in charitable organizations since the family moved here in 1921," Mr. Bechler related. "I got involved with Community around 1980 when Myrna Wigod was the chair of the Foundation and started the roller-skating marathon down Ocean Boulevard. It seemed like a hare-brained idea at first but we had a lot of fun. It was a regular marathon, except we did it on roller skates. We raised money for the hospital that way for three years and drew a lot of public attention to the hospital."

As the chair of the hospital board, Richard Bechler applied business principles to health care decision-making:

"We were very selective about investing in new technology," Mr. Bechler explained. "When we considered building the new Cancer Center, we evaluated it in terms of what the rate of return would be. We decided that the return would be very high because it's state-of-the-art, very efficient, and could achieve good outcomes. Those are all very important factors when you're negotiating an HMO contract."

Karolyn Morrison talked about the teamwork that guides the capital budget planning process:

"People bring the information in and say 'this is what's happening in my department and for us to maintain our service level, this is what we have to do." We haven't had the money to buy everything every year, so people have collaborated and said, 'Okay, if the people in that department need that now, I can wait another year for what I want.' To maintain a service, we find a way to get it, whether through our capital budget or through the Foundation. The Foundation is excellent about supporting the hospital."

Richard Bechler continues to believe the hospital's goal should be "to become low cost, a very good provider, and still keep the friendliness Community is known for." He sees serving on the hospital's board of directors as a way to serve the community.

"Board members watch out for the good of the community and the good of the hospital," Mr. Bechler explained. "We have nothing financial to gain from it. The Dalai Lama was right when he said that the purpose of life is to give pleasure, which you get by doing things for people and making the entire community better. If everyone acted selfishly in their own interest, then the good of the whole is very much lower."

PEOPLE WHO GIVE FROM THE HEART

Bill Williams not only contributed a lot of financial support to the hospital, but he also gave up the potential income of doing legal work in the medical malpractice area so he would be able to sit on the board and remain totally at arm's length. Jess Grundy spent hours and hours when he was chairman of the foundation for some eight years. He's always been a positive guy who raised a lot of money for the hospital. Of course Jean Smith, who has served so capably on the hospital board, different hospital committees, the UniHealth board, and as chair of the UniHealth strategic planning committee. Her contributions go on and on, along with all the other things she does for the city.

Richard Bechler

A DEDICATED AUXILIARY

Long Beach Community has also been blessed with a resourceful and loyal Auxiliary. **Alice Brown** is a registered nurse who came to Community in 1957 and retired in 1985. Today she is a volunteer member of the Auxiliary. Alice Brown explained why she volunteers at Community:

"After I retired, I took a few years to sit back and put my feet up, and then I felt I was wasting my time. I missed Community because it's part of me, of what I am, of who I am. I wanted to be able to see patients and help people again. I wanted to give something back to the hospital. I joined the Auxiliary because I remembered seeing how much the "pink ladies" contributed when I was a nurse.

The volunteers deliver flowers to patient rooms, staff the cuddler program for the NICU, and some are assigned to actual units like surgery or oncology. We do lots of things for the hospital to spare the staff's time. We read to patients, wheel discharged patients to the curb, sit at the information desk, and update families who have someone in surgery. We go wherever we're needed. If you put our hours into money, we save the hospital a lot. The volunteers who can't come in anymore stay home and knit the baby caps the babies wear home."

Former administrator Bruce Sanderson credited the Auxiliary as one of the hospital's best resources.

"The Auxiliary at Community Hospital has always been wonderful to work with," Mr. Sanderson noted. "They would give whatever financial support they could, which complemented what the Foundation raised. They came through with services and the kind of love that was an extension of the hospital into the community. You just can't put a price on that."

In 1996, 400 volunteers including 250 Auxiliary members, contributed more than 70,000 hours of time in 75 departments. Such community support is the lifeblood of Long Beach Community Medical Center.

"The volunteers deserve special recognition," affirmed Bus Bachtelle. "The hospital couldn't have operated without them. The money they have raised and the hours they have given are beyond price."

LBCMC Auxiliary

LOYAL EMPLOYEES

One hallmark of Community's strength is the support of the Employee Foundation. They give back to the hospital not only their time, but also their money. Employees raised $180,000 to build the Neonatal Intensive Care Unit, an amount matched by the Auxiliary. They raised more than $200,000 for the Community Heart Center and continue to answer the call with enthusiasm whenever they're asked to raise funds for Community.

"Every time we have had any kind of capital campaign, the employee Foundation has pledged a significant amount," according to Karolyn Morrison. "The employees have always met or exceeded the goal they set for themselves. It's amazing when you think that a couple of years ago we had a freeze on raises at the hospital, and even during those years the employees at this hospital kept their pledges to the foundation."

Dr. Eugene Temkin believed such employee loyalty is unique to Community saying, "I don't know of any other place where the employees support the hospital financially and give to the hospital as much as the employees do at Long Beach Community."

THEN AND NOW: A COVENANT WITH THE COMMUNITY

The story of Long Beach Community Medical Center is the story of people who united to serve the community's health needs. From the beginning, the humble community hospital relied on the generosity of citizens with vision, original ideas, daring, and civic spirit. Endowed with strong community support, the hospital was able to attract talented nurses, brilliant physicians, and creative administrators.

Throughout its history, Long Beach Community has been guided by a commitment to setting the highest standard of medical care without losing the warmth of the human touch. The task has not always been easy, particularly in the current era of cost-consciousness. But with the continued support of the community it serves, Community will succeed in fulfilling its covenant with the people of Long Beach.

A LIVING LEGACY

Many of Long Beach Community's legendary doctors, dedicated nurses, far-sighted administrators, and dynamic board and Foundation members are gone now.

But their legacy lives on in the picture-perfect image of a spiral CT scan, in the non-surgical removal of a previously inoperable brain tumor with stereotactic radiosurgery, in a life-saving heart bypass operation that restores a father to his family. It is the noble legacy of the hospital's original mission that is heard in the soft voice of an NICU nurse comforting a sick baby, and the words of gentle encouragement a new mother hears from her LDR nurse.

This same spirit exists in the strategic planning process and vigorous fundraising programs that allows Community to anticipate and respond to rapidly changing health care needs and regulations. Because of the continued commitment of all who believe that it takes good health care to keep a community healthy, Long Beach Community Medical Center's graceful arches remain open and ready to meet the challenges of the 21st century.

Appendix

Community Leaders and Professional Staff that have contributed to the success of Long Beach Community Medical Center and the Foundation

Hospital Presidents/CEO/Administrators:

Blanche Stair, R.N.
Mary Fraser, R.N.
Sarah Ruddy, R.N.
Howard Hatfield
Walter Oliver
Bruce Sanderson
Michael Jenike
Steve Yerxa
Bob Barkley
Howard LeVant
Paul Viviano
Earl Simendinger
Janet Parodi
Makoto Nakayama
Tom Hennessy

Hospital Chairman of the Board:

Fillmore Condit	1924-26	Guy S. Balser	1972-75
Paul Graham	1926-28	Marvin W. Davis	1975-77
Charles Henderson	1928-29	Gordon W. Dougherty	1977-79
B. F. Tucker	1929-49	G. E. Wilcox	1979-82
Archie Jones, M.D.	1949-51	Thomas A. Ramsey	1982-86
George Brown	1951-52	Jean B. Smith	1986-89
George Richards	1953-56	William Williams	1990-93
Hale Young	1956-57	Richard Bechler	1994-97
Lloyd Leedom	1957-60	Betty Keller	1998-
William T. J. Harris	1960-63		
Herbert Murphy	1963-65		
Walter Groshong	1965-67		
Clarence Scott	1967-69		
C. Duane Mooney	1969-72		

Foundation Presidents:

Roland Bach	1973-75
Richard Codd	1974-79
Stewart "Bus" Bachtelle	1979-93
RoMa Johnson	1993-96
Annette Kashiwabara	1996-97
Edward N. Lewis	1997-

Chiefs of Medical Staff:

Dr. Plane	1928-31	Dr. William Turner	1962
Dr. Dwight Sigworth	1932	Dr. Charles Morrell	1963
Dr. Sosnowski	1933-35	Dr. Edward Platz	1964
Dr. Raymond Swinney	1936	Dr. William Carnes	1965
Dr. Will Boyd	1937	Dr. Harry Jacob	1966
Dr. Lynn Vaughn	1938-39	Dr. Melvin Casberg	1967-68
Dr. Theodore Strang	1940	Dr. Robert Schumacher	1969-70
Dr. Archie Jones	1941	Dr. Robert Griffiths	1971-72
Dr. William Garrison	1942-43	Dr. Walter Stegeman	1973-74
Dr. Clement Counter	1944	Dr. Carl Natter	1975-76
Dr. Dorothy Hewitt	1945	Dr. Richard Wigod	1977-78
Dr. Lorin Nelson	1946-47	Dr. James Reitz	1979-80
Dr. George Verbryck	1948	Dr. Edward Platz	1981-82
Dr. Harry Jacob	1949-50	Dr. Joseph Dahlquist	1983-84
Dr. Earl Ray	1951	Dr. William Olson	1985-86
Dr. William Durnin	1952	Dr. Charles Durnin	1987-88
Dr. John Rowe	1953-54	Dr. Stanley Goldberg	1989-90
Dr. Roger Graham	1955	Dr. Thomas Norum	1991-92
Dr. Geneva Beatty	1956-57	Dr. Robert Pugach	1993-94
Dr. William Stanton, Sr.	1958	Dr. George Hancock	1995-96
Dr. Walter Welton	1959	Dr. William Hurst	1997-99
Dr. Gustavus Bock	1960	Dr. Lawrence Waldrop	1999-
Dr. Kenneth Berkaw	1961		

Foundation Chairmen of the Board:

Valle "Bud" Young	1974-75	Betty Keller	1989-90
Jess Grundy	1975-78	Jim Lockington	1991
Myrna Wigod	1979-81	Ken Davis	1992-95
Bill Williams	1982-83	Gregg Whelan	1996-98
Richard Bechler	1984-85	Suzanne Nosworthy	1999-
Mason Kight	1986-88		

Auxiliary Presidents:

Carmelita Penrose	1957-58	Peggie Widetick	1974-75
Lee Clarke	1958-59	Edith Armstrong	1975-76
Florence Neumaier	1959-60	Beverly Cook	1976-78
Clare Atwater	1960-61	Binnie Berro	1978-80
Aileen Wetmore	1961-62	Maxine Pierce	1980-81
Bonnie Orme	1962-63	Ruth Marshak	1981-83
Olda Doherty	1963-64	Edith Armstrong	1983-84
Mary Jane Moore	1964-65	Georgia Ewald	1984-85
Mary Sleet	1967-68	Mollie Patchen	1985-87
Virginia Dobbins	1968-69	Beverly Cook	1987-89
Jimmie Burke	1969-70	Mary Lou Carnes	1989-91
Ruth Fuerth	1970-71	Hazel Testa	1991-94
Betty Brown	1971-72	Cleo Clark	1994-96
Olivia Casberg	1972-73	Allene Tumelty	1996-99
Betty Jones	1973-74		

Las Damas de la Plaza Presidents:

Anne Cramer	Inception	Kathleen Costello-Pitts	1993-95
Marni Stegeman	Inception	Therese Hancock	1995-97
Clara Andrews	1985-87	Anna Walsh	1997-98
Eleanor Williams	1987-89	Beverly Cook	1998-99
Georgia Bechler	1989-90	Eleanor Williams	1998-99
Suzanne Nosworthy	1990-93		