2024, Volume 56, Issue 8, 468-470, e-ISSN 1938-3800

Family Medicine

EDITORIAL

I Wish It Need Not Have Happened in My Time

William E. Cayley Jr, MD, MDiv

AUTHOR AFFILIATION:

School of Medicine and Public Health, University of Wisconsin, Eau Claire, WI

CORRESPONDING AUTHOR:

William E. Cayley Jr, School of Medicine and Public Health, University of Wisconsin, Eau Claire, WI, bcayley@yahoo.com

HOW TO CITE: Cayley Jr WE. I Wish It Need Not Have Happened in My Time. *Fam Med.* 2024;56(8):468-470.
doi: 10.22454/FamMed.2024.197560

PUBLISHED: 4 September 2024

Last year, I had the opportunity to reflect in an editorial on uncertainty in medicine and education.[1] If only I had known....

In January of this year, my colleagues and I learned that the entire local system sponsoring our residency would close by the end of the academic year (June 2024). Uncertainty became a palpable daily reality as we plunged into all five stages of grief at once. Over ensuing days, the local impact became evident. Our area would lose two hospitals, a long-standing chemical dependency treatment program, local clinics, regional rural clinics, and nearly 1,400 jobs.[2]

In our community the news was met with shock and grief, and it catalyzed an outpouring of emotion, expressions of support, and task forces across the community. Legal actions were threatened and filed. Our legislators and the governor weighed in. Other regional health care systems have publicized their efforts to fill the looming gaps in care. The local chambers of commerce have banded together to address the economic impact. Amidst all of this, it has become even more painfully clear how much a hospital (indeed, a health system) is not just a business and not just a source of clinical care, but an integral part of an entire community.

Hospitals range in size from small, isolated rural institutions to large medical centers facing competitive market environments. Hospitals of all sizes typically include education either centrally or peripherally in their mission, serving as clinical sites for students and interns in occupational and physical therapy, nursing, social work, pastoral care, as well as medicine. The closure of our hospital has directly affected health professions students from adjacent college campuses, has eliminated rotations for students from our regional medical school, and has led to closure of our residency, which has trained 246 family physicians since 1975. Ironically, we learned this news in the same month that our governor created a task force to address the impending shortage in our health care workforce.[2]

Hospital closures leave patients feeling hopeless and powerless, confused over where to seek care, and facing delays in care and treatment.[3] Rural hospital closures are associated with decreased local per capita income, increased local unemployment rates by up to 3% (including loss of jobs in non-health care sectors such as construction, education, and real estate), and possibly increased mortality.[4] In rural and urban settings, hospital closure can lead to increased difficulty obtaining primary and specialty care, increased travel times for routine and emergency care, longer waits for care, increased use of emergency services for chronic health conditions, disruption and fragmentation of care, and adverse outcomes for patients who do not understand the changes in the local system.[4–7]

Nearly 100 years ago, the reciprocal relationship between hospital and community was articulated by Edward Lewisnki-Corwin:

> A hospital's responsibilities are as numerous as are its social ramifications, and they imply not only the obligations of the hospital to the community, but also the reciprocal relation of the community to the hospital.[8]

In recent years, elements of this relationship have been codified for nonprofit hospitals, which now under the Affordable Care Act (ACA) are required to routinely document community benefit activities. The last 2 decades have also seen increased appreciation for the role of hospitals as "anchor institutions" within communities, "responsible for improving the social determinants of health and community well-being through targeted hiring practices, selection of local vendors, career laddering, real estate development, and financial investment."[9] To that end, Howard Koh and colleagues identified four key elements important to the success of anchor medical institutions

within their community:

1. A strong anchor mission and narrative,
2. Robust partnerships with community institutions,
3. Willingness to commit years of time engaging key internal and external audiences, and
4. Identifying collaborative projects attractive enough to gain private and public funding.[10]

An atomistic view of hospitals focusing on the financial bottom line might seem to imply that financial efficiency is both the primary business goal for a hospital and the primary driver of clinical success. Counter-intuitively, the evidence demonstrates that hospital resilience is associated with taking care of patients with higher clinical complexity employing more highly trained staff,[11–13] and with increased provision of outpatient services,[12,13] and with taking a higher percentage of patients on Medicare and providing higher levels of charity care.[14] All these endeavors imply higher levels of clinical, educational, and financial investment in the local community, exemplified at the institutional level by the "anchor" institution concept with reciprocal obligations between the hospital and community to work for mutual stability and growth.

In her final president's column last spring, Dr Renee Crichlow proposed three strategies to actualize a "primary care moonshot" of joyful practice: payment reform, practice redesign, and educational pipeline development.[15] While these articulate areas for focused effort to develop family medicine education and clinical practice, none of these are attainable in an environment that leaves education and clinical care dependent on the whims of sponsoring institutions' responses market competition.

A survivor of the Hahnemann University hospital closure in 2019 called for a rethink of the market-oriented drive towards the financial bottom line in hospital operations:

> Highly competitive health systems should rethink noncollaborative strategies before allowing struggling institutions to succumb to market forces.[16]

Hospital care at the individual and organizational level must focus on the health and well-being of the patients and community served. As Guenter Risse observed 25 years ago:

> Business values can easily jeopardize the technical quality and humanitarianism inextricably linked to hospital services.[17]

Prioritizing business undermines care of the patient and care for the community. Prioritizing community collaboration, community investment, and high-level quality care is essential to building the resilience needed to face institutional and societal challenges and to providing the education and care that our society needs. Within family medicine, focusing aspirationally on the development of our specialty is useful. However, it is even more important for our patients and our society that we work collaboratively toward, and hold our partners accountable to the development of clinically and financially robust systems that will foster the type of primary care to which we aspire.

> *"I wish it need not have happened in my time," said Frodo.*
> *"So do I," said Gandalf, "and so do all who live to see such times. But that is not for them to decide. All we have to decide is what to do with the time that is given us."*[18]

REFERENCES

1. Cayley WE. Expecting Uncertainty. *Fam Med.* 2023;55(5):286-288.
2. Health Care Shutdown. *WEAU 13 News.* 2024. https://www.weau.com/news/healthcare-shutdown/.
3. Countouris M, Gilmore S, Yonas M. Exploring the impact of a community hospital closure on older adults: a focus group study. *Health Place.* 2014;26:143-148.
4. Mills CA, Yeager VA, Unroe KT, Holmes A, Blackburn J. The impact of rural general hospital closures on communities-A systematic review of the literature. *J Rural Health.* 2023. https://onlinelibrary.wiley.com/doi/10.1111/jrh.12810.
5. Romero D, Kwan A, Nestler S, Cohen N. Impact of the closure of a large urban medical center: a quantitative assessment (part II). *J Community Health.* 2012;37(5):995-1005.
6. Romero D, Kwan A, Swearingen J, Nestler S, Cohen N. Impact of the closure of a large urban medical center: a qualitative assessment (part I). *J Community Health.* 2012;37(5):982-994.
7. Walker KO, Clarke R, Ryan G, Brown AF. Effect of closure of a local safety-net hospital on primary care physicians' perceptions of their role in patient care. *Ann Fam Med.* 2011;9(6):496-503.
8. Lewinski-Corwin EH. Community Responsibility of Hospitals. *Public Health Reports.* 1926;41(14):605-617.
9. Cronin CE, Singh SR, Turner JS, Evashwick CJ. Hospitals' contributions to their communities: should they be regulated? . *Front Public Health.* 2022;10:1064210.
10. Koh HK, Bantham A, Geller AC. Anchor institutions: best practices to address social needs and social determinants of health. *Am J Public Health.* 2020;110(3):309-316.
11. Pai DR, Hosseini H, Brown RS. Does efficiency and quality of care affect hospital closures? . *Health Syst (Basingstoke).* 2017;8:17.
12. Langabeer JR, Ii, Lalani KH, Champagne-Langabeer T, Helton JR. Predicting financial distress in acute care hospitals. *Hosp Top.* 2018;96(3):75-79.
13. Enumah SJ, Chang DC. predictors of financial distress among private U.S. hospitals. *J Surg Res.* 2021;267:251-259.
14. Beauvais B, Ramamonjiarivelo Z, Betancourt J, Cruz J, Fulton L. The predictive factors of hospital bankruptcy-an exploratory study. *Healthcare (Basel).* 2023;11:165.
15. Crichlow R. Primary care moonshot-a joyful practice. *Fam Med.* 2024;56(5):342-343.
16. Hamilton RJ. The Hahnemann University Hospital closure and what matters: a department chair's perspective. *Acad Med.* 2020;95(4):494-498.
17. Risse GB. *Mending Bodies, Saving Souls.* Oxford University Press; 1999.

18. Tolkien JRR. *The Fellowship of the Ring*. Allan & Unwin; 1954.