



Elegy for a Teaching Hospital

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(Fam Med. 2022;54(3):232-3.)

doi: 10.22454/FamMed.2022.223917

I stare out my office window at the shuttered hospital bereft even of the bronzed letters on its portico that proudly spelled out its name: *Memorial Hospital of Rhode Island*. This hospital was the home and sponsor for the Brown Family Medicine Residency since 1975. Nearly two-thirds of the family doctors in the state were trained there and it had a long and storied history as a community-academic hospital caring for the underserved. It had also been my professional home for nearly two decades as a clinician, educator, researcher, residency director, and chair. During those many years at Memorial I had been engaged in full-spectrum family medicine “cradle to grave” care and I knew every service and most of the 1,500 employees. The hospital’s last patient, a man born nearly a century earlier on its labor and delivery ward, left on the final day of operation. As he walked out, the last entry in the electronic health record was signed, the terminal was turned off, and the whiteboard with his name was erased. The few remaining staff gathered their belongings and unceremoniously headed out as the final remaining inpatient unit went dark. After 116 years this community institution serving all who might pass through its portals closed its doors.

The demise of this hospital in an already underserved community is not an isolated event. It has played

out again and again across the United States over the past decade as more than 100 hospitals have closed and many more, particularly in rural areas, are on the brink of bankruptcy.¹ A significant number of these hospitals provided training and practice opportunities to family physicians. What do these closures mean for us as family medicine educators and clinicians, and what do they feel like?

It is strange how you experience the dissolution of a place. For me, the process of observing and participating in the closure was viscerally painful. This was particularly the case as I watched colleagues and coworkers so dedicated to the mission and the community suffer as each part of the shutting down took hold. Some steps, like the closure of the maternity ward, were met with anger and protests. The reaction to other steps were more subtle and sometimes unexpected. For example, the looks of defeat and the tears shed by everyone, including me, in the cafeteria on its last day of operation were unanticipated. It wasn’t just a food service that was ending; it was the termination of sustenance that powered healers and healing. There were no celebrations as units and services were shut down, and nothing left to do but go home. People, context, service, purpose. It all gets jumbled up as the doors close and the parking lot empties.

What did the closure mean for the community? This medically underserved area became even more underserved with the family medicine residency clinic and nearby federally qualified health center now becoming the nearly sole safety net providers. Once the largest employer in the city, employees of the hospital lost their jobs, adding to the already tantamount local poverty and despair.

An elegy is a lament often for the dead and it would be permissible to end this story with the hospital’s closure. However, much as I wanted to personally surrender to the sadness, I realized, as did the faculty, residents, and staff, that we had a larger responsibility. We are all the heirs of general practice, the keepers of the flame of family medicine, and the caregivers to the vulnerable and underserved. We could not allow those central tenets of belief to be diminished by the demise of a single hospital. I acknowledged that we had to let go of our grief, accept the inevitable, and move on. As is sometimes said, “when one door closes, another may open,” and the unfolding events caused us to seek new opportunities, act boldly and collectively.

Although the shutting down of the hospital was a heart-wrenching experience, it has led to an energizing

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revitalization and expansion of the Brown Department of Family Medicine across the state to a greater extent than was thought possible. Prior to the closure, as it became evident that we were in a hospital death spiral, we moved our residency institutional affiliation and established new adult medicine, newborn, and maternal and child health teaching services at neighboring hospitals. We acquired a nearby struggling osteopathic family medicine residency, got it ACGME accreditation, and merged the two residencies under the Brown insignia. This united residency, now with 48 residents, is engaged in care across the state in both of the major Brown-affiliated health systems. We dramatically increased the recruitment and retention of our residency and fellowship graduates in the state, adding a new generation to the family medicine landscape who exhibit remarkable skill, dedication, and professional vigor. With the backing of our sponsoring health system we also established more family medicine practices, with attendings having the option to teach and precept. Finally, our highly-regarded Maternal and Child Health (MCH) Fellowship found a new home, making three sites in Rhode Island where we now provide family medicine-obstetric services. In the midst of all of this, our original

Memorial Family Medicine continuity site has thrived even without the adjoining hospital (part of which is now housing for homeless families and is going to be turned into veterans' housing), and we have taken on more of a safety net and urgent care role than ever before. The criticism that we were "just in Pawtucket" has waned as residents, fellows, faculty, and community attendings crisscross "Little Rhody" as part of the new Brown Family Med reality.

As I sit in my office staring across at the darkened shell of the hospital, I think of all the lives that passed into the world and passed out from inside its walls, and the noble contributions of generations of doctors, nurses, staff, and patients. I reflect on the first patient and the last patient and the enormous changes in health care that came in between. Then I turn my back to the hospital and attend to the business at hand: providing care for our local communities that have some of the most vulnerable and underserved populations in the region, training the next generation of family medicine providers, and producing the new knowledge needed for both. As we consider the challenges that will come in the decades ahead, we really cannot imagine what will be; nor could we have imagined what has occurred.

Rhode Island is often the canary in the coal mine: a small and relatively poor state stuck between larger and richer neighbors. Family medicine residencies and departments across the United States must be certain to maintain a viable Plan B as systems of care radically and rapidly change. As we plan the future of our discipline, we should always remember that we are the heirs of general practice and the providers of care to the underserved and the vulnerable. These populations need us more than ever. Their health and the health of the country depend on it, as does the future of family medicine itself.

PRESENTATIONS: This narrative won the STFM Annual Poetry and Prose Contest (runner-up) with a public reading at the STFM 2019 Annual Spring Conference, April 27, 2019, in Toronto, Canada.

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