Closure and Conversion
AN OPEN-MINDED APPROACH TO HOSPITAL CLOSURE

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Hospital closure is a subject that takes a certain amount of courage to tackle before a hospital audience. It differs from all the other role options; they involve new services, new organizational arrangements, facility re-orientation, and more effective use of facilities. These options all reflect rebirth and revitalization, a new lease on life. Closure is closer to suicide and death. It is in a class by itself. No self-respecting hospital executive wants to be seen at a conference session on how to close his hospital. Therefore, the temptation exists to avoid the subject of hospital closure by limiting this presentation to related topics, such as closure of a hospital building or a specific service or unit or the question of merger. These are all important subjects about which there is much to say. But such an approach would be avoiding the issue. Buildings are not hospitals, nor are service units or beds. A hospital is something different; it is a community institution, an integral part of the community. Hospital closure is an important subject and must be discussed openly as a community problem, as well as an issue in institutional management.

Many health policy analysts anticipate that 1,000 hospitals or more will lose their identity during the next decade. Almost all hospitals or their programs will be affected by pressures to close or by the impact of closure of neighboring institutions. Hospital closures and pressures to close can represent a challenge to hospital management to initiate new approaches to the community and its health problems.

Why do the experts expect so many hospitals to lose their identity in the decade ahead? Why are so many hospitals endangered? It is a matter of simple arithmetic, combined with obsession about hospital beds. The United States is overcommitted to acute hospital beds compared to other modalities of health service. Hospital occu-

pancy rates have been decreasing both because the denominator—beds—has been continuing to increase slowly and because the numerator—patient days—is starting to decrease.

Blue Cross data show a 20 percent decline in hospital days per 1,000 subscribers during the past decade, and the trend is likely to continue. In just about every category of patient, except Medicare recipients, the number of patient days per 1,000 persons has been decreasing. With continued emphasis on alternatives to inpatient care, these trends can be expected to continue and eventually even to affect Medicare patients despite the aging of this segment of the population. New approaches to aging, chronic illness, and terminal illness, including hospice care, will effect Medicare utilization.

The fact is that every type of hospital bed has decreased drastically, except acute medical-surgical and long-term beds. The evidence suggests that the same thing is about to happen to these bed types, as well.

In the 1940s, tuberculosis beds were in short supply. Most tuberculosis was in the cities, and most tuberculosis hospitals were on the top of mountains in the country. This problem of access was solved by developing effective treatment for tuberculosis patients on an ambulatory basis. Now tuberculosis beds are almost nonexistent, and the tuberculosis hospitals—a major classification during most of hospital history in the United States—are now all gone.

New approaches to psychiatric care have resulted in major reductions in psychiatric hospital beds and the closure of many so-called mental hospitals. The number of pediatric and obstetric beds is also low. In general, the thrust of American medicine during the past quarter century has been to take care of patients to the maximum extent while they were ambulatory, sleeping in their own beds instead of in hospital beds. Thus, hospital stays are becoming shorter and shorter and fewer and fewer in almost all categories. Some observers expect that at least 10 percent of surgery that is performed on an inpatient basis will shift to an outpatient basis within the next 10 to 15 years.

There is national concern that what happened to obstetrics in the 1960s will happen to medical-surgical beds in the 1980s. When the obstetrics census dropped in the 1960s, hospitals allocated their capital expenditures to this area. This happened because administrators called in their obstetricians to discuss the low-occupancy problem and possible solutions. The obstetricians naturally recommended modernizing the facilities. The hospitals modernized the facilities, but the census still decreased. Obstetricians then recommended adding more obstetricians to the staff. Of course, none of those approaches did anything to increase birth rate! Unfortunately, there is a perverse tendency in the hospital field to put capital investment in areas where demand is dropping.

Almost all health policy specialists visualize hospitals almost exclusively in terms of hospital beds! As they see it, if beds are decreasing, then the number of hospitals also should decrease. That concept seems to be simple common sense to anyone obsessed with the bed. Much confusion exists both among hospital officials and others, about what a hospital really is. Many persons do not realize that the vast bulk of hospital patients do not stay as overnight guests. Economists are more obsessed with the bed than hospital executives, but the obsession is pervasive in both groups. Of course, there are issues of economy of scale and quality. As inpatient use declines, many hospitals will not be able to maintain the minimum critical mass of inpatients required to ensure quality and effectiveness, unless different options are explored.

Thus, there will be pressures to close, and there will be closures. Whether these closure developments will be crushing problems or exciting opportunities for indi-

vidual hospitals will depend on the applicability of a relatively little known concept that I call the Basic Closure Rule. This rule is based on more than 30 years of study and direct involvement in closures. It is a general rule that should provide useful insights in most situations.

The Basic Closure Rule states that a hospital that has the following four basic commitments will not—as a matter of fact, *cannot*—close. The four basic commitments are a committed governing board, a committed medical staff, a commitment to the community, and a commitment to a decent institutional standard for ethical conduct and relationships. With these four commitments, a hospital is totally immune to closure. These four commitments do not include such things as cash flow, bottom lines, dollars, or capital funds. They do not even mention anything about good management. All these things are important, but they will not guarantee a hospital against closure. But if a hospital has a committed board, a committed medical staff, a commitment to its community, and a commitment to a set of ethics, those other factors will be taken care of somehow, by hook or by crook!

A committed governing board means a board with members who really believe in the institution and who are willing to work to produce the needed results, not board members who just go along. The board members, at least four or five of them, must be hooked.

With respect to medical staff, something is lacking if there are no physicians in a hospital! Some hospital administrators might like to think otherwise sometimes, but they all know that a hospital must have a committed medical staff. Again, every member of the medical staff does not have to be committed, but a minimum who are building their professional practice around the institution is essential.

In addition, a commitment to the community is extremely important because, in the final analysis, the community will be the hospital's real protector. To have a commitment to a community, the hospital first must identify its community. It must outline a geographic area with inhabitants who have some kind of identity. The hospital might take care of persons outside of that community; it might not take care of all the persons in it. But it must have a sense of commitment to that community, and the inhabitants should know it and, therefore, be committed to the hospital in return.

The fourth commitment—ethical standards and ethical institutional relationships—is essential. The best known statement of institutional ethics is the American Hospital Association's guidelines on *Ethical Conduct and Relationships for Health Care Institutions*, approved by the AHA Board of Trustees in 1974. These guidelines are included at the end of this chapter. Every hospital governing board should spend at least one board meeting each year reviewing these guidelines in relation to the past year's performance. These guidelines reflect a minimum decent set of ethical standards. And communities, trustees, medical staffs, and administrators do not want to be associated with an institution that does not have decent ethical standards.

Again, if a hospital has these four commitments, everything else will take care of itself. They provide almost absolute immunity to closure. They are even better than the polio vaccine.

If a hospital is missing one or more of the four basic commitments, the situation becomes complex. If the hospital is missing any one commitment, the situation gets risky. The more commitments that are lacking, the more risk! The situation is analogous to the risk factors related to heart attacks. If persons avoid the seven risks related to heart attacks, they minimize their chances of heart attack, although they are not totally immune. The more of the seven factors that are disregarded, the more likely the persons are to have a heart attack. However, despite violation of all seven rules, they may not have one at all. So, too, with the Basic Closure Rule. Hospitals

may be able to disregard all four commitments and survive. But they are putting themselves in a very risky position. Adherence to the Basic Closure Rule does guarantee against closure, but its disregard does not guarantee that the hospital will close, only that it will be at great risk.

At this point, a word or two is in order about *hit-lists*, an increasingly popular term used by health systems agencies. Hit-list refers to an always secret, but always leaked list of hospitals scheduled for closure. If a hospital has all four basic commitments, it will be strengthened by being on a hit-list. In fact, being placed on a hit-list may help strengthen hospitals that have at least two of the four basic commitments. In other words, a hit-list can substitute for two commitments! But do not count on it; someone may forget to put the hospital on the hit-list.

An exception to the Basic Closure Rule may occur some day, but it is doubtful. For years, Brooklyn (NY) Jewish Hospital has seemed on the brink of closure. If it ever closes, it will be an exception, because it has all four commitments. So far, an exception to prove the rule does not exist. The Brooklyn Jewish Hospital continues to operate. It is bankrupt, just like Penn Central, but as with the railroads, the federal government won't let the hospital close.

Carrying the Basic Closure Rule a step further, if a hospital lacks any one of the four essential elements, it still probably won't close or, at least, certainly not in a hurry. In every instance of closure that I have studied, the hospital had lost one or more of the essential elements three or more years before closure. That is, the hospital lost its vitality and viability *years* before it closed. And in each instance, they were like the boxer who fights until he is no longer able to protect himself, but won't fall down.

A hospital closes only when it is dead on its feet. Closing a hospital is difficult to do, although some studies of hospital closures seem to indicate otherwise. That is because such studies usually analyze events immediately preceding closure. By that stage, the persons associated with the hospital, as with the punch-drunk boxer have lost all sense of reality and do not provide an accurate perspective. Those with good judgment and insight about the situation left years before because they knew what eventually would happen with the absence of the four basic commitments.

A thorough understanding of the Basic Closure Rule permits a less tense, more open-minded—if not lighthearted—approach to closure.

It is good to know that a hospital with the basic commitments (board, medical staff, community, and ethical institutional standards and relationships) is virtually immune to closure. If your hospital lacks one of the four basic commitments, deal with it promptly, because sooner or later this absence may destroy the hospital.

Conversely, to help a hospital close, work as hard as possible to undermine or divert the basic commitments. Get the trustees, the medical staff, and the community interested in other institutions.

Actually, diverting trustee and medical staff interest to other hospitals may lead to merger rather than to closure. Although some persons think of closure and merger as being essentially the same thing, they are very different options. That concept reminds me of my mother, who thought that my impending marriage was a fate worse than death for me, considering who I was marrying, but she got over it. Most other persons are able to distinguish between death and marriage. And, in this day and age, most persons are even able to distinguish between death and just living with somebody. As death is to marriage, closure is to merger. They have nothing to do with each other. Merger has to do with new life, not death.

To ensure that a hospital will not close, close attention to each of the four basic commitments is necessary. The American Hospital Association provides guidance on how to maintain a strong, committed board. With respect to a committed medical staff, the concern may be numbers, commitment, or both. A shortage of physicians is a key factor in most closures, but finding physicians frequently is a difficult problem, both urban or rural. Hospital officials must recognize that they cannot solve the problem alone. They must focus on the mission of the institution, relationships with other hospitals, and the health of the community, rather than filling beds. If it is a serious problem of numbers, the solution probably will require innovative medical staffing arrangements with other hospitals in the region.

With respect to community commitment, it can be the hospital's biggest hindrance or its best protection. For example, during the 1960s, an effort was made to close hospitals in London, England. Although the government owned the hospitals and the hospital received all operating money and capital funds from the government, the head of a London hospital district believed that the government could not just close the hospitals. Why not? Because the communities would not allow it; they would have complained to the House of Commons, and the Prime Minister would not have approved of their dissatisfaction. If a hospital wants to rely on community support as insurance against closure, it must identify this community, relate to it, and know what its health problems are. The hospital also must get the community to identify with it, and that takes time. But it is worth the time to find new roles that represent cost-effective public service.

With respect to ethical standards and relationships, no one—trustees, medical staff, nor others—likes to be associated with an institution that does not live up to generally accepted standards of ethical conduct and relationships. An unethical institution will have weak and unstable support in a crunch.

A possible closure can create an opportunity or a problem for another hospital, but the behavior is the same. The closing hospital's identity must be respected, no matter how much trouble it is in. The stronger hospital should assess the closing hospital in terms of the four commitments and, then, in a low-key way, help in any way possible. Being helpful is important. If the stronger hospital helps, it will improve its own position.

It is not in the interest of this country for any of its 7,000 hospitals to close, especially those with small sparks of the basic commitments to service and caring. Every hospital must fan the flame and adapt to new community patterns; to new patterns of hospital organization, medical practice, technology, government regulation, and financing; and to new missions in terms of promoting health and community service and conserving resources required for many human services. A better time for fanning the flame never existed. Administrators, trustees, and medical staff together can facilitate this process by adopting new role options. As to those hospitals in which that flame seems to have gone out irretrievably—their services will not be missed, only the memories of them before they lost their way.

In the final analysis, modern hospitals are community institutions concerned about the health and well-being of the residents in their communities. If they all play that role in one way or another, 7,000 such institutions is not too many. This country can make good use of each one. Let's hope that all 7,000 can retain their basic commitments—board, medical staff, community, and ethics—and continue to serve the public interest in a variety of cost-effective roles.

American Hospital Association
Guidelines on Ethical Conduct and Relationships for Health Care Institutions

Approved by the Board of Trustees
of the American Hospital Association, April 1, 1974

Health care institutions are service organizations that provide patient care and a varying range of education, research, public health, and social services for their communities. These institutions carry public responsibilities for their own conduct, the well-being of their patients, and the health of their communities. This role places special obligations upon health care institutions and their representatives to adhere to ethical principles of conduct. The following guidelines are intended to assist members of the American Hospital Association in defining their institutional policies, ethical relationships, and practices.

1. Good health is of utmost importance to the nation, to the community, and to every individual. Health care institutions should be interested in the overall health status of people in addition to providing direct patient care services.
2. The public has accorded high priority to the availability of services to the sick and injured, but there are limits to the individual and collective resources available for this purpose. Recognizing this, health care institutions should:
   a. Support the most effective use of economic and other resources to ensure access to comprehensive services of high quality.
   b. Deliver services efficiently.
3. The community's health objectives are advanced when all health care providers and social, welfare, educational, and other agencies work together in planning and offering improved services. Health care insitutions should promote and support cooperation among each other, all providers, and community agencies in efforts to increase the results they could achieve separately.
4. Patient care services are inherently personal in nature. Health care institutions should maintain organizational relationships, policies, and systems that produce an environment that is conducive to humane and individualized care for those being served.
5. Individual religious and social beliefs and customs are important to each person. Health care institutions should, wherever possible and consistent with ethical commitments of the institution, ensure respect and consideration for the dignity and individuality of patients, employees, physicians, and others.
6. Health care institutions should establish and maintain internal policies, practices, standards of performance, and systematic methods of evaluation that emphasize high quality, safety, and effectiveness of care.
7. Health care institutions, being dependent upon community confidence and support, should accept an ethical sense of public accountability; reflect fairness, honesty, and impartiality in all activities and relationships; manage their resources prudently; and ensure that reports to the public are factual and clear in interpreting institutional goals, status, and accomplishments.
8. Health care institutions should relate to their communities and to each other constructively and in ways that merit and preserve public confidence in them, both individually and collectively.