The Death Throes of Mercy — Our Shared Responsibility When Hospitals Close

Austin S. Kilaru, M.D., M.S.H.P., and Kevin B. Mahoney, D.B.A.

Hospital closures disrupt communities. They also demand that we clarify our goals: Do we come together to support endangered hospitals, or do we support the patients and communities relying on them? Sometimes the second requires the first, but not always.

For 245 years, the Philadelphia General Hospital served the city as a public institution. It closed in 1977, when the city could no longer afford escalating operating costs and capital expenses. The creation of Medicare and Medicaid also made it easier for private hospitals to care for the poor and the elderly. Together, private hospitals assumed responsibility for vulnerable patients and crafted a new safety net.

Many of those hospitals have since closed. Last year, the bankruptcy of Hahnemann University Hospital drew national attention and was portrayed by some observers as a tale of corporate greed endangering the health of vulnerable patients.[1] The closure complicated access to care for Hahnemann's patients, nearly all of whom had public insurance or were uninsured. More than 2500 people lost their jobs, including 575 physicians-in-training.

Less than a year later, another Philadelphia institution, Mercy Philadelphia Hospital, has announced that it will close. Although Mercy has made noble efforts to remain open, including expanding its emergency department (ED), the hospital is in its death throes.

Hospitals are failing in communities throughout the United States. The reasons for these failures are complex but can be glimpsed in the Philadelphia market, which has previously maintained a high number of hospital beds per capita. Health care has increasingly shifted to outpatient settings, reducing demand for the inpatient care that supports higher financial margins than ambulatory care. For safety-net hospitals serving communities that rely on Medicaid, even margins for inpatient care are often negative. A loss for each patient cannot be made up by increasing volume. Distressed hospitals may provide lower-quality care with limited innovation, further reducing demand. Rural hospitals experience even greater challenges, since they need to maintain essential access to services without the volume — or clinicians — to make ends meet.[2]

Calls for government action have followed each new hospital closure. Yet it is uncertain whether investments to keep hospitals open can be sustained. Market forces may make closure necessary and ultimately inescapable. However, government intervention, whether through funding or regulation, is needed to facilitate soft landings for patients after closures.

To ensure that patients are not forgotten, communities as well as private health care institutions often step in to help them. When Hahnemann shut down, nearby hospitals came to the rescue, absorbing patients requiring emergency and inpatient care and saving some jobs. But the costs of caring for these displaced patients can be high, and public reimbursement is low. Hospitals that have managed to stay viable also need to maintain their strength to prevent future losses to their communities.

Our remaining hospitals are indispensable, as the Covid-19 pandemic has shown. The current crisis has exposed declining hospital capacity in the United States. Hospitals that have weathered years of diminishing volume had to suddenly prepare for an overwhelming public health emergency. Critical care beds, in particular, are in short supply. In the coming weeks, hospitals must overcome sharp declines in revenue due to overall reduced patient volume and suspension of services, including elective surgeries. Even more hospitals are likely to close. After the pandemic, the United States will be challenged to bear the cost of maintaining sufficient hospital capacity to be prepared for future public health emergencies.

Effective responses may require us to think beyond traditional hospitals. For all the disruption they cause, hospital closures represent opportunities to develop new and robust ways to support patients. All strategies should be informed and driven by community needs, but a few strategies are evident in Philadelphia and could be applied more broadly.

One key strategy is to strengthen the outpatient safety net. A network of Federally Qualified Health Centers (FQHCs) and city-operated health centers accounts for the bulk of Philadelphia's safety net. These facilities provide essential primary and preventive care

and support services. It is imperative that they have adequate resources to care for patients and to address population health. In addition, many services, including surgeries and diagnostic procedures, have shifted from inpatient to outpatient settings. Timely access to providers performing those services is essential, as is tight coordination between primary care and specialists. All patients, but particularly those with complex medical needs, will benefit from expanded options for specialty care, which may in turn require changes in reimbursement structures or development of new care delivery models.

It is also essential to develop and provide alternatives for acute care. Mercy Philadelphia has provided 48,000 ED visits each year. Many alternative options can serve patients who previously sought emergency care. Some patients could receive treatment at an urgent care center or an FQHC based in the former hospital. A free-standing ED might also treat patients with low-acuity conditions while transferring patients who require admission to nearby hospitals. Currently, Pennsylvania law does not permit free-standing EDs, although such facilities have expanded access to acute care in many other states. Finally, telemedicine services are likely to gain further traction given their widespread use during the Covid-19 pandemic. Health systems, clinicians, and patients may find increasing comfort and utility in telemedicine both for triaging acute problems and for managing chronic illness.

Behavioral health services should also be expanded. Until this year, Mercy Philadelphia operated a crisis center for mental health emergencies, including substance use disorder. Regardless of whether they have excess acute care hospital beds, few cities have sufficient psychiatric inpatient capacity or adequate community-based services to prevent hospitalization. As many as half of medical inpatients have behavioral health diagnoses, and identification and early attention to these needs could improve clinical outcomes and reduce costs.[3]

On the financial front, Medicaid subsidies should be allocated in proportion to where patients receive care. Philadelphia hospitals rely on a complex system of state and matching federal subsidies for their financial health, including supplemental funding allocated by Medicaid.[4] Subsidies for "disproportionate share hospitals" are threatened even as closures reveal their value. After hospitals close, these funds need to remain in communities affected by closures. Furthermore, city, state, and federal matching funds should be fairly and transparently distributed to the hospitals and community organizations that assume the care of displaced patients, rather than being diverted for other needs.

A longer-term, preventive strategy is to address the social determinants of health in affected communities. Hospitals are not, in and of themselves, solutions for housing and food insecurity, violence and injury prevention, prejudice and residential segregation, or education and health literacy, among a host of health-related social needs. But hospitals and health systems can be advocates and help to coordinate services that address these structural problems.

Finally, new strategies are required to prepare for public health emergencies. The Covid-19 pandemic has demanded far greater acute care capabilities than many U.S. communities have in place.[5] Surging rates of hospitalizations have compelled hospitals to convert waiting rooms into critical care wards, cities to build hospitals in convention centers, and the hospital ship *USNS Comfort* to dock in New York Harbor. The crisis precipitated a sudden and dire need for hospital beds, but when the pandemic abates, it will not be possible to sustain this expanded capacity in order to be prepared for the next crisis — particularly if the pandemic accelerates hospital closures. A coordinated and flexible system may prove to be a better solution for mitigating surges during emergencies. Such a system would require collaboration among government, health systems, and industry to rapidly deploy hospital beds, ramp up production of necessary medical equipment, and rapidly mobilize an expanded health care workforce.

The closure of Mercy Philadelphia, like the closure of Hahnemann, will leave its mark on patients, employees, and the city. To alleviate these harms, we should ensure that remaining hospitals maintain their financial health so that they can share responsibility for treating displaced patients. At the same time, these closures offer an opportunity to reconsider the services that our city, and communities throughout the country, need most.

The views expressed in this article are those of the authors and do not necessarily reflect those of the U.S. Department of Veteran Affairs or the U.S. government.

Disclosure forms provided by the authors are available at NEJM.org.

From the National Clinician Scholars Program (A.S.K.), the Department of Emergency Medicine (A.S.K.), and Office of the Chief Executive Officer, University of Pennsylvania Health System (K.B.M.), Perelman School of Medicine, University of Pennsylvania, and the Corporal Michael J. Crescenz Veterans Affairs Medical Center (A.S.K.) — both in Philadelphia.

This article was published on May 27, 2020, at NEJM.org.

1. Rosenbaum L. Losing Hahnemann — real-life lessons in "value-based" medicine. N Engl J Med 2019;381:1193-5.
2. Frakt AB. The rural hospital problem. JAMA 2019;321:2271-2.
3. Laderman M, Mate KS. Behavioral health integration in acute medical settings: an opportunity to improve outcomes and reduce costs. Jt Comm J Qual Patient Saf 2016;42:331-6.
4. Brubaker H. Hahnemann closure puts $51 million in Medicaid funds in play. Will the money stay in Philly? Philadelphia Inquirer. November 21, 2019 (https://www.inquirer.com/business/health/hahnemann-medicaid-funds-philadelphia-public-hospital-20191121.html).
5. Tsai TC, Jacobson BH, Jha AK. American hospital capacity and projected need for COVID-19 patient care. Health Affairs Blog. March 17, 2020 (https://www.healthaffairs.org/do/10.1377/hblog20200317.457910/full/).

DOI: 10.1056/NEJMp2002953

When the EMR Stole My Pen

Ranjana Srivastava, F.R.A.C.P.

"Lost something, Doctor?"

"I think my nice pen slipped under your sheets," I explain.

Groaning at the thought of moving his diabetic legs, the patient says, "Maybe you should keep your nice pens at home."

People have been telling me that for years.

My first nice pen was a Sheaffer, a medical school graduation present from a friend. Silver trimmed in gold, it was the first item engraved with my new title of doctor. After everything it took me to get there, I couldn't leave the pen at home. From my first day of internship, it became my companion and cheerleader. On dull night duty, as I filled out warfarin orders or wrote blood slips, a glance at the gold lettering would remind me that my role mattered. If a patient needed a pen, I'd exhaust all options before reluctantly handing over mine. Australian doctors don't wear white coats, and my clothes seldom had functional pockets, but protected in my palm, my dutiful Sheaffer lasted 2 years before I lost it during a code. I felt simultaneously annoyed, guilty, and bereft. A voice in my head said it was only a matter of time before a nice pen went missing, but I loved to write, and in those days — with paper records, paper scripts, paper everything — there was a lot to write. So after some searching, I bought myself an elegant Waterman.

If an engraved pen could be lost, an unengraved one stood no chance, but I managed to hold on to my Waterman for a few years, until a friend upgraded it to a sleek Cross. By then, I was a fellow whose credibility rested on writing meaningful notes on the 30 or 40 patients I saw each day. With a nice pen, work never felt like a chore. I loved the swish of pen on paper, the gel technology that felt like ink without the mess. The act of writing parsed my thinking and made me more deliberate. Why would anyone leave a nice pen at home with all this writing to be done at work?

When I passed my fellowship exam, my husband surprised me with a black and gold Montblanc — and unexpected responsibility. Should I leave it in its silk cocoon, designated as a "milestone" pen? If I lost it, would my husband be more annoyed than I'd be devastated? But mere admiration couldn't do it justice, so I began taking it on rounds — and writing effusively.

When I became an attending, my brother bought me a congratulatory Montblanc, crimson with gold accents. I assumed that an attending wouldn't need to write much, but in the era of subspecialization, I'd routinely arrive to find my residents involved in testy exchanges with other units over a hapless patient who'd been subdivided into organ systems — situations demanding thoughtfully composed notes from me.

An elderly smoker with a large lung mass was bedbound and cachectic. The home team wanted a biopsy to exclude "something else." Emergency had already called cardiology about his bradycardia. Endocrinology wanted to chart his labile sugars. The man just wanted to be left alone.

A woman with newly diagnosed breast cancer had fractured her hip and was confused. Two teams argued over pain management. Orthopedics was questioning her prognosis before taking her for surgery. Nephrology was annoyed that she was dry. Neurology wouldn't see her without an MRI.

Such fragmented care was damaging to patients. I saw my job as cutting through the confusion, setting a direction, and taking responsibility for the whole person. And often, the best way to do so was by writing an opinion labeled "Consultant Note." I'd gather some files, find a quiet corner, and write a considered argument as to why instituting end-of-life care for one patient was the best way forward but