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Causes of Rural Hospital Closure

In this issue of the *JABFP*, Pirani, Hart, and Rosenblatt¹ have provided the rural health research, policy, and practice communities with a valuable addition to a growing literature on rural hospital closures. Until their study no national research of which I am aware has surveyed the attitudes and opinions of rural physicians about the causes of rural hospital closure. Thus, the authors add another piece to a puzzle that has caused, and continues to cause, acrimonious debate among the parties of interest: residents and practitioners in communities that have lost or are about to lose their facility; academics and policy analysts who try to put the closure issue into wider, often cost-benefit, perspectives; and rural health care advocacy groups that regard closure as evidence of decreasing commitment by state and federal government to assure access to health services for rural populations.

The results of the Pirani, et al. study are revealing: the majority of physicians in the study

cited, in descending order of importance, government reimbursement policies (such as the Medicare prospective payment system [PPS]), poor hospital management, and general financial problems as the principal reasons leading to closure. At the same time, nearly three-fourths of the respondents agreed that "physician actions were not a significant cause of hospital closure." The authors, comparing these results with those obtained from a similar study they completed that surveyed the mayors of communities with closed hospitals, noted that ". . . both physician and community leaders implicated one another more often than themselves as causes of . . . hospital closure . . ." In short, their study is testimony to a blame-the-other-person mentality. In another study of rural hospitals, my colleagues and I found a similar situation but in reverse; rural administrators, the category of person with whom many of the physicians in the Pirani, et al. study found fault, themselves blamed other groups as contributing to the problems of rural hospitals, including physicians and nurses, especially in respect to recruitment and retention.²

Perhaps the most important conclusion from the Pirani, et al. study is not so much the content of the specific attitudes and perceptions of the rural physician sample, but that the direction of their findings is consistent with a tendency documented among other survey groups to assign blame, first, on either large-scale socioeco-

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conomic forces beyond the control of any particular person or community group or, second, on a specific person other than oneself or on some group other than one's own. In our own study, "other" forces, agencies, and programs were cited as making life hard for rural hospitals. For example in 1988, 93 percent of the administrators of 797 rural hospitals surveyed almost uniformly castigated PPS and agreed that the Health Care Financing Administration (HCFA) needed to equalize the rural-urban differential.

To blame others is not really surprising. For persons caught in the day-to-day struggle to keep a rural hospital afloat, it might be impossible to comprehend the myriad converging causal forces. The predictable tendency is to simplify, to clarify, and usually, to blame a reasonably visible target. The factory shutdown literature of the 1970s presaged the very same phenomenon: when a company closes or threatens to close its doors, panic, fear, rigidity, and a search for a culprit ensue. The potential disintegration of community bonds accompanying the weakening and the demise of a major employer and social institution (like a rural hospital) helps force to the surface fears, scapegoating, recriminations, and an incapacity to deal with change.³ The phenomenon was aptly described by Friedman in her accounts of rural hospital closure: "In New Mexico, the hospital was killed by community rigidity; in Maine, it was killed by community feuding; in Texas, it was killed by community ignorance; and in Wyoming, it was killed by community apathy."⁴

The reality of a hospital closure, however, belies the simplistic ranking of PPS or any other factor as first among causes of rural hospital financial difficulties, even if the exercise helps affected persons to organize their understanding of events. In the Pirani, et al. study, the physicians surveyed pointed their collective finger most often at PPS, but most rural hospital experts regard PPS as only one of several historically and structurally important reasons for rural hospital financial difficulty, a conclusion supported by most multivariable studies.⁵ Another way this complexity can be appreciated is by reading case studies of rural hospitals and their fight to survive.^{6,7} To illustrate this point, I refer to a small follow-up of six rural hospitals in our study. We found a hospital in a midwestern state

that had closed since the original 1988 study. By piecing together interviews conducted with the former administrator, governing board members, the mayor, a physician, and others, we recreated the series of events that led to closure.

Members of the governing board of a hospital in weak financial condition, without the knowledge of the administrator, had been approached by a physician practicing in another community who said that if he were offered admitting privileges at the hospital, he could bring in many more patients to the facility than the physician who then practiced there. The administrator heard of this idea and argued against it, but he was ineffectual with the governing board and could not dissuade them. The physician who was then currently admitting patients to the facility was angered at the decision of the board to proceed with negotiations with the other physician and, in retaliation, made plans to move his practice to another community and its local hospital. While he was proceeding with these plans, the negotiations between the board and the physician it was recruiting broke down and the physician did not make the move after all. The other physician, still angered by the entire affair, did complete his move, however. Thus, the hospital not only did not gain the new physician and his promised patients, but it also lost the physician who was there in the first place. Recriminations followed rapidly, the administrator quit, and the hospital quickly closed its doors.

This incident shows how, in fact, it is often impossible to assign simple and well-defined blame for closure. Who should shoulder the blame? The federal government and its decision to effect payment reform in Medicare? The state government and its spending restrictions on Medicaid? Urban hospitals and their aggressive marketing services in the affected rural hospital market? The governing board for wanting to bring in a new physician and his patients? The administrator for opposing the decision? The out-of-town physician for considering the idea to move? The already established physician for pulling his practice out? The community's leaders for not staving off the problem? All are to blame, of course, and the lesson is that an overarching causal theory or model is required to make sense of the numerous forces, some proximate, others remote, that are relevant. In the Pirani, et al.

study, rural physicians' perceptions provided a glimpse of a particular piece or angle of the truth; put another way, these respondents remarked on but one of the layers of the onion, but did not give a glimpse of its entirety.

What the entirety or theory should look like is not yet known, but in addition to the objects of "blame" mentioned in the previous paragraph, it would contain other forces. Many have been in the making for years, such as the Hill-Burton Act of 1946 that led to the building of hundreds of small rural hospitals that today operate with difficulty and that some have argued have become obsolete in the organizational and technological sense.⁸ Another example is the enduring shortage of physicians in rural areas, one that has been bemoaned since at least the time of the Committee on the Costs of Medical Care in 1932.⁹

In the end this focus might be on the wrong side of the phenomenon, for although closure has been widespread and continues to be a threat, most rural hospitals remain open despite heavy odds against them. This fact should make us consider the other side of this contemporary issue: (1) How are rural hospitals able to remain resilient under the circumstances? (2) In which activities are these organizations engaged that provide needed relief and garner community support? (3) What adaptations and reconfigurations are rural hospitals undertaking that equip them to thrive in weak operating environments? (4) What is it about a rural community that brings it together to defend its own local institutions? I do not mean to diminish the problem of rural hospital closure; the facts are clear as Pirani, et al. have discussed. I do wish to em-

phasize, however, that there is much to be learned from rural hospitals' struggles in the 1980s and 1990s, and their stories could provide insight into how the United States might solve not only its rural health delivery problems, but broader health delivery problems as well.

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