The Closure of Hahnemann University Hospital and the Experience of Moral Injury in Academic Medicine

Hahnemann University Hospital closed last summer. A very large medical training institution with more than 150 years of service to the public, the loss was felt by patients, learners, faculty, staff, and neighboring communities. Other academic hospitals have folded before and a number have shut down since, but Hahnemann’s is the first closure of a major urban teaching hospital in the United States.1 Few observers would argue that the process was handled well: communication was inadequate, transition planning insufficient, and the timing unthoughtful at best. The integrity of academic medicine itself was deeply affected; many hundreds of resident physicians, fellows, and health professions students who had placed their faith and their futures in the hands of the academic hospital found their needs and expectations subordinated to other interests.

The Hahnemann closure followed a well-recognized, apparently legal path in the business world: long-standing deficit leading to acquisition and merger (in 1993), unsustainable losses followed by bankruptcy (in 1998), another sale (in 2018), continuing deficit, and then the decision to close (in 2019).2 Ethically, though, the rapid closure of the academic hospital was difficult to accept because Hahnemann had cared for the ill of Philadelphia for more than a century and a half and was considered a critical safety net hospital for decades.2 Moreover, the hospital was owned by a resource-intensive company with a problematic history,3 and the company separated the hospital from its land while declaring bankruptcy to attain real estate profits. Furthermore, Judge Kevin Ross of the U.S. Bankruptcy Court for the District of Delaware ruled that residency slots may be sold as assets without the consent of the Centers for Medicare and Medicaid Services.2,4 Tangibly, the abrupt and insensitive manner of the closure displaced and hurt vulnerable and voiceless people—people who deeply matter to us in the field of academic medicine.

Whether resident and fellow positions can be sold, as if physicians-in-training were mere objects rather than our cherished mentees and early-career colleagues, is now a matter for the courts. The Centers for Medicaid and Medicare Services, along with professional societies across the country, have thus far blocked the unprecedented sale by Hahnemann of their allocation of graduate medical education positions for $55 million.5 Congressional leaders have stated that such a sale "sets a dangerous precedent and sends a signal to Wall Street that there is money to be made off the downfall of community hospitals."6

Additionally, residents, fellows, and their teaching attending physicians employed from January 2018 through August 2019 and then terminated by Hahnemann because of the closure very belatedly received the news that their malpractice insurance “tail” was not paid by the hospital, despite the hospital’s obligation to do so.2,7 Unremedied, such a gap in insurance coverage, by state regulations, places these physicians’ licensures and livelihoods at risk. The many international residents and fellows in training at Hahnemann were also left in an extremely difficult situation, given the challenges surrounding employment-dependent visas in the United States.7 The effects of the Hahnemann University Hospital closure thus extend far beyond the walls of the institution and neighborhoods of Philadelphia and will reach well into the future.

In this issue of our journal, we have assembled 5 Invited Commentaries reflecting upon the Hahnemann closure, written by leaders of academic and stakeholder professional organizations. The essays by Hamilton,8 Aizenberg and Logio,9 and Berns et al10 provide exceptionally thoughtful, often humbling insights of faculty leaders who were on the front line of the crisis. These authors communicate well the overwhelming and unprecedented issues faced in the earliest days after the announcement that the hospital’s doors would close. Nasca et al11 describe the role and actions of the Accreditation Council for Graduate Medical Education in addressing the concerns of affected residents and fellows and in following up on the many systems-level implications of the shutdown of such a large urban hospital serving as an accredited sponsor of graduate medical education. Orlowski and Thompson12 of the Association of American Medical Colleges also speak to these issues, emphasizing the importance of supporting the displaced trainees and of advocating graduate medical education more broadly.

These commentaries seek to elevate crucial initial observations and prepare the way for a future collection of essays that will help document the enduring consequences of the Hahnemann closure from a wide number of perspectives. The repercussions are already being felt by health professions students, residents and fellows, patients, and hospitals affiliated with Hahnemann. Affiliated medical schools in Philadelphia have lost significant numbers of faculty physicians, resulting in reduced capacity to care for patients and teach health professionals, both short term and long term.13 The decisions of courts, Congress, organized medicine, and health care leaders will either reaffirm or redefine foundational aspects of academic medicine, such as our current system of graduate medical education and the role of academic medical centers in providing care for underserved populations and communities.

Hundreds of rural and urban hospitals have closed in the United States in the past decade.1 Like Hahnemann, many of

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these hospitals experienced deficits that were simply relentless and unsustainable. The data on patient outcomes after local hospital closures are both predictably bad (e.g., for some instances of trauma-related injury) and sometimes better (e.g., for some illnesses requiring tertiary care and subspecialty expertise), depending on the availability of other nearby services. Reports in Philadelphia newspapers document the perceived consequences of the closure of Hahnemann’s emergency room, warning that local community members may be adversely affected.14 Hahnemann is thus just one example of a hospital transition in a nation whose health system is continuously being reconfigured, but without adequate safeguards to protect patient needs. Nevertheless, Hahnemann’s status as an academic medical center, its history and mission, its size with 496 inpatient beds and a large number of diverse and high-need subspecialty services, and, very importantly, the manner of its closure draw our collective attention.

The loss of Hahnemann strikes me as especially difficult because the experience resembles what is referred to as moral injury. Moral injury is defined as a betrayal of what is right, by agents in a position of trust, in a situation of consequence.17 Moral injury is an ancient concept recognized for its value in understanding and caring for traumatized veterans, soldiers, and refugees whose fundamental expectations of life have been broken.18 Hahnemann is thus just one example of a hospital transition in a nation whose health system is continuously being reconfigured, but without adequate safeguards to protect patient needs. Nevertheless, Hahnemann’s status as an academic medical center, its history and mission, its size with 496 inpatient beds and a large number of diverse and high-need subspecialty services, and, very importantly, the manner of its closure draw our collective attention.

Thankfully, the field of academic medicine has not turned a “blind eye” to the plight of the Hahnemann trainees and patients. As with past catastrophes such as Hurricane Katrina, programs locally and nationally have stepped forward to offer positions and support to residents and fellows, many of whom had only recently matched to Hahnemann programs. Medical schools have opened up spots to provide rotations for students affected by the closure. Administrative leaders at local hospitals have worked tirelessly to help place and care for patients in need. Federal entities, professional societies, and accrediting bodies have moved quickly to intervene and bring stability on individual and system levels, including, for example, a proposed solution to the malpractice tail problem. Such efforts are invaluable in helping to foster resilience, deploy necessary resources, and restore trust, each so important in repairing moral injury and redressing the system fragilities so clearly displayed in the Hahnemann closure.

And, yet, the hospital closure, even if it was inevitable, should not have happened in the way it did. The sequence of decisions leading to the closure prompts questions about the social mission of medicine and about sustainability and accountability in present-day health care organizations. The abrupt and disjointed process of the closure raises concerns about the adequacy of structures that exist for the benefit and security of our trainees and training institutions. And the consequences of the closure leave us, Dear Reader, with the imperative to safeguard the people and values that matter to our profession and thus to demonstrate the integrity of academic medicine.

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Editor’s Note: The opinions expressed in this editorial do not necessarily reflect the opinions of the AAMC or its members.

References


15 Snyder S. For Drexel, Hahnemann closure was “a crisis thrown on our doorstep.”

