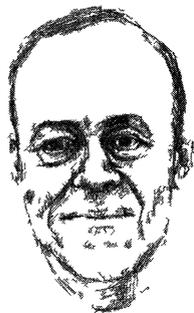


## Letter from Chicago: Closing the hospitals



In many respects closing a hospital is tantamount to wiping out an entire community. It scatters people who have worked together for many years and who may never meet again. The nurses, always in high demand, are the first ones to move on,

often at the first rumour of closure and even some time before the final word is out. Never again will nurse X call from intensive care at 2 am to tell you that Mr Jones in bed 2 has just vomited a pint of coffee grounds and that his vital signs are unstable. Then the doctors start admitting their patients to other hospitals and eventually stop coming. Later they may meet again at medical society functions, but lost for ever is the unique chemistry of a doctors' lounge where colleagues drank coffee and chatted about patients and many other things. Gone likewise will be the other workers, the librarians, the clerks, the guards, and there will be no more Christmas parties. Gone also is the silent majority, the patients, the other members of the family, some of whom had

actually been born there. They too must now go to different hospitals, often to different doctors.

So far, 15 hospitals have closed in the Chicago area and several more are expected to follow suit. Located in the inner city and serving mostly the poor, they could not survive the present reimbursement policies and at last ran out of money. Even the survivors face an uncertain future, too strapped for funds to make improvements or replace obsolete equipment. They too may eventually close, perhaps because somewhere some higher power has decided that larger hospitals are more efficient or possibly more easily policed.

Judging from David Widgery's article (24 August, p 473) Chicago and London have the doubtful distinction of being sister cities in this respect, so that the Metropolitan Hospital where I worked some 30 years ago has also been closed. There it was, in the east end of London, small though not necessarily beautiful, but friendly, where people all knew one another. It had two medical wards, one for men and one for women. Everything was within easy reach, and it did not take 30 minutes and two elevator rides to get from one ward to another.

The hospital had five visiting attending physicians, each of whom made rounds on different days. There was a busy casualty

department, a daily outpatients clinic, and also a considerable tradition. Parkes Weber was said to have visited there and observed many of the rare syndromes he described in his book, some of which still bear his name. There were so many tabetics at outpatients that it sufficed for diagnosis to look at their pupils, test the ankle jerks and deep pain sensation, and stand them up for a Romberg's test. Curiosities included a large family with coexisting polycystic kidney disease and peroneal muscular atrophy. Two Turkish sisters unaccountably both had carpal tunnel syndrome, and several Iranian nurses perpetually complained of lower abdominal pain. In the summer there was an outbreak of rubella with arthritis of the small joints of the hand and carpal tunnel syndrome, an entity that apparently had not yet been widely recognised at the time.

Now all that is gone. Yet could it be that these closures are a big mistake? Are little hospitals really that inefficient? Are these large monsters with their high costs, bloated bureaucracies, and a post office atmosphere truly more cost effective? Is it not perhaps a grave evil and a disturbance of the right order of things, as Professor E F Schumacher once suggested, to assign to greater organisations functions that a smaller entity can do just as well?—GEORGE DUNEA, *attending physician, Cook County Hospital, Chicago, USA*