

# The human costs to staff from closure of a general hospital: an example of the effects of the threat of unemployment and fragmentation of a valued work structure

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**Objectives:** To describe the stressors and stress responses in medical (and to some extent other) staff as a result of the process of closure of a major general hospital. This is the first such clinical description in the literature.

**Method:** Semistructured individual interviews were conducted with 50 senior medical staff and with administrators at a time of imminent closure of the hospital. Information was also pooled from medical unit and other hospital meetings. Impressions regarding the effects on other staff were also noted.

**Results:** The perceived threat of loss of work, meaninglessness of the closure and erosion of medical values caused manifestations of demoralization and stress, as well as overt medical symptoms and illnesses. Methods of coping included denial and other defences. Treatment included stress counselling at individual and group levels, which provided staff relief through being able to verbalize, label and connect their feelings and distress to valid stressors. However, the overall impact of counselling was limited.

**Conclusions:** There must be an understanding of the human costs on staff and patients when hospital closures are contemplated.

**Key words:** hospital closures, psychological effects, stress, unemployment.

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In the last decade, many hospitals worldwide have been closed at least in part on the basis of economic rationalism. However, to a lesser extent, wards and hospitals are closed or relocated all the time. While to administrators such activity may be quite rational, it may involve human costs, which should also come into their calculations.

Very little has been written on human costs of hospital closures in regard to either patients or staff. Indeed, an *Index Medicus/MEDLINE*, *HealthGate* and Internet search

revealed only a handful of papers dealing with the topic. One study mentioned increased incontinence and mortality among relocated chronic disease patients [1], and another noted a slight increase in mortality rates when a psychiatric hospital closed [2]. Only one study referred to staff responses and cautioned against underestimation of the varied griefs of staff and patients following closure of a psychiatric hospital [3].

To the author's knowledge, no prior study has addressed the effects on staff of closure of a major general hospital. The aim of this study is to explore and describe such effects, especially on medical staff.

## Method

Prince Henry's Hospital (PHH) was one of four major teaching hospitals in Melbourne. After years of rumour, the final two years saw a

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planned contraction in its services and its ultimate closure in 1991. In the last three years of its operation, the hospital formed a Hospital Stress Committee, which included senior psychiatrists and physicians, with the author (PV) as chairman.

The bulk of the information in this paper was gathered from personal interviews by PV with 50 senior medical staff, including surgeons and physicians as well as administrators. The interviews were conducted in a three-month period ending 5 months before the final closure. This was the beginning of the period of staff attrition and relocation of some staff to another hospital 20 km away.

Interviews were individual and semistructured. They started with a general question about how things were going. They then covered the process that the hospital was undergoing, and how it affected the individual and his or her group. The responses were totally undirected in the initial part of the interview. In the second part, potential stressors and their consequences were followed up in greater detail. Specific questions were asked regarding morale, adaptation, coping and symptoms. In the third part, the interviewer gave feedback as required by subjects.

Because PV was on the staff himself and Chairman of the Hospital Stress Committee, there was an obvious possibility of bias toward eliciting negative interviewee responses. This was consciously taken into account and was countered in interviews by attempting to make no a priori assumptions that the process of closure was negative. For instance, questions searched for positive as well as negative responses.

Subjects were assured of confidentiality, although all subjects knew that general information from the research would be made public. Indeed, most subjects desired that their responses be given public voice, as many had felt constricted by silence up to this point. Minor disguises are used in this study to retain anonymity.

As well as individual interviews, information was also pooled from participation in medical unit and other group meetings, which included non-medical staff, many personal contacts with medical and non-medical staff and regular meetings of the Hospital Stress Committee.

## Results

Nobody refused to be interviewed. In fact, staff were generally keen to talk, and many were grateful for the opportunity to gain words and labels for the first time, which enabled them to think cogently about what had been bothering them for a long time. Many then led their own staff through the same process, often engaging a stress committee member to facilitate such meetings.

In the initial phase of the interviews, most subjects expressed surprisingly intense distress. The themes could be categorized as pained confusion at the meaninglessness of their world collapsing and their values being eroded. In the next phase, specific stressors such as unemployment and stress responses such as anxiety were mentioned. Overt symptoms and illnesses were often mentioned only as a seeming afterthought.

### Meaninglessness of the hospital closure

Very few subjects accepted the official rationale for the hospital closure, which was that amalgamation with another hospital would service a needy geographical area. Because they felt that the hospital was unable to cater even for local needs due to a chronic shortage of

beds and growing waiting lists, staff theorized that actually the hospital must be a victim of political animosities and misguided ideologies including a general antimicrobial feeling of the times.

Typically, interviewees expressed their bewildered frustration and sense of meaninglessness through historical comparisons. In the past, saving lives and providing the best possible care were seen as the meaning and purpose of staff. Rewards included success, peer respect and status. Financial rewards were secondary. Most worked many extra hours for little money and many had even worked in honorary capacities. The hospital administration or the 'hospital' had nurtured staff and took pride in its achievements and reputation.

In contrast, staff now felt that the meaning and purpose of their work was undermined and that the 'hospital' (that is its administrators) had turned against them. They felt that they were coerced into participating in what to them seemed to be a deeply meaningless process.

### Erosion of values

Overlapping the themes of lost meaning and purpose, medical and nursing staff felt that their values regarding patient care were being eroded. They felt cajoled into taking on the bureaucratic values of the 'new breed of administrators' who seemed to staff to 'cherish budgetary goals, deadlines, paperwork and meetings – none for patient benefit'.

A new language of euphemisms had been imposed. For instance, costly machines were called 'supply fuelled demand'. Highly skilled and specialized staff felt they were treated as lowest common denominator impersonal commodities, which could be shuffled around like pins on a board. Staff, including heads of units, had to reapply for positions, and those not reappointed felt especially betrayed.

Indeed, previously valued loyalty and teamwork were also eroded. The hospital no longer nurtured staff or patients. It felt perverse to doctors that they were responsible for patient care, even as they were forced to compromise it and devolve it. For instance, services had to be prioritized, and referrals had to be made to services that staff knew were already stretched. Staff said that their complaints were not listened to and lines of upward communication were blocked. Those in power were not accountable, yet if anything went wrong, staff were to blame.

### View from the other side

The new administrators saw their goals as bringing political decisions to fruition. These decisions were based on ideologies of cost-saving, rationalizing, amalgamating and regionalizing. The new merged hospitals would serve basic community needs rather than the elite, expensive needs of doctors. Certainly some people were bound to be hurt in the process, but closure and takeovers occurred in the corporate world all the time. A good administrator must see the broader view, be tough in taking hard decisions and even be a bastard if necessary. Ten years hence the means to achieve ends would be forgotten.

The staff were cynical of such views. They saw 'amalgamation' as a euphemism for cutting services, 'basic needs' meant cheapness, 'involving community services' meant passing State hospital costs to Federal Medicare costs. And if cost-cutting was so imperative, they said, why were the administrators increasing in numbers and building better facilities for themselves in a hospital with fewer beds?

## Stressors, stresses, distress and illnesses

Stresses were not the same for everyone, and some subjects even looked forward to the changes. Heads of units, especially the older ones, seemed among the most stressed. Younger consultants and those who had not had an intense engagement with the hospital were among the least stressed.

### Stressors

In addition to meaninglessness and erosion of values, stressors included feelings of being devalued and expendable. For doctors used to power and control, their loss felt stressful.

Loss of employment and threats to survival, identity, status, specialist skills, work satisfaction and loss of bonds and loyalties were other stressors. Loss of the hospital itself included small but cherished things, such as walking up the stairs each morning. More and more long-term colleagues were disappearing without ceremony as they simply walked out of the hospital for the last time, and the same was going to happen to those still remaining.

However, perhaps the biggest loss was the ability to care for patients. One doctor described with much pain and bewilderment how he had to say goodbye to patients in a clinic in which they had received help for 20 years.

### Stress responses

Anger from frustration and perceived injustice was the commonest emotional response. It was expressed indirectly because of the fear of retaliation. For instance, staying away from the hospital expressed 'let the hospital suffer through my absence'. Some turned anger at themselves, saying 'yes, doctors *had* been prima donnas in the past and now they are getting what they deserve'. Other emotional responses were anxiety, a sense of being oppressed and feeling 'down'.

### Demoralization and distress

Staff felt a kind of despair, alienation and apathy. Increased worries alternated with forced complacency and even detachment, which could be mistaken for callousness. Demoralization manifested in decreased punctuality and increased sick leave days, unofficial leave and resignations. Symptoms of burn-out such as poor sleep, fatigue, lack of concentration, decreased functioning and irritability were common.

### Coping with stresses

Many used denial: 'I don't care. One day I'll just point the car in the wrong direction'. A few kept fighting, achieving minor victories. Some found work in other hospitals, many concentrated on their private practices, some upgraded their skills and others diverted energies to pursuits outside medicine. Some cooperated and sought opportunities in the new system. Few allowed themselves open grief. What clinical work remained in the hospital was a great boon, because the patients were still the same.

## Symptoms and illnesses

The staff clinic reported massive increases in attendances, with stress-related illnesses such as headaches, migraines, chest pains, back pains and other pains, asthma and ulcers. Instead of obtaining extra help, the staff clinic was advised to 'put a lid on' its work and 'not allow a can of worms to be opened'.

Medical staff did not attend the staff clinic. As usual for them, they tended to deny their illnesses, including during the interviews. However, when the formal questioning was over, many interviewees casually confided their symptoms. These included emotional blunting, mood swings, irritability, loss of enjoyment of life, fears of becoming old, withdrawal from relationships, increased alcohol consumption and marital difficulties. Illnesses included disabling back pains, a goitre, a perforated ulcer, and a presumptive stroke at a time of particular stress that was eventually diagnosed as fatigue. Mental disorders included subclinical depressions and a flare up of an obsessional disorder. These illnesses seemed to be related specifically to closure stress and often reached a crescendo at times of particularly acute distress. For instance, the doctor with a perforated ulcer had lesser ulcer symptoms while stressed at work, and these lesser symptoms reached their climax as his department was closing down. The Hospital Stress Committee had the impression that doctors underreported their symptoms.

It also seemed to the Hospital Stress Committee that nurses and paramedical staff suffered more. The following is a typical story: a nurse was greatly distressed because she had no memory of having defibrillated a patient. Three of her long-term colleagues had left her department in the previous week, and her childhood asthma flared up for the first time that week after many years. An extreme case was a paramedic who regarded the hospital as his home killed himself as his department was preparing to close. Although staff commonly had other problems too, it appeared that without the hospital stresses, most of the above illnesses would not have occurred.

## Hospital Stress Committee contributions

Hospital Stress Committee members met with staff in individual, and small and large group settings. A hospital grand round (clinical meetings open to all staff caring for patients, and administrators) on the subject was very well attended. All these settings were used to educate staff on stress generally and on the specific effects of stress found within the hospital. Staff were very relieved to learn that their symptoms were common and normal under the circumstances, and that they made sense when traced to their origins. The fact that distress could now be talked about and shared offered further relief. These measures did not remove the stresses of hospital closure, but at least the secondary worries and shame due to the symptoms were ameliorated, and some sense of control and self-esteem were regained. These measures were consistent with stress and trauma treatment in other situations [4,5].

The Hospital Stress Committee also liaised with the administrators. For instance, it raised issues of proper endings and grieving. The administration hired the services of an outside stress team for a short time, but many staff felt them to be unsatisfactory. This was because they often followed the simplistic administration view that what was happening was positive. On the other hand, the psychiatric unit hired a sympathetic and experienced mental health team with some positive

results. The Hospital Stress Committee met regularly and debriefed itself in order to help its own members.

Although the Hospital Stress Committee felt that its efforts helped many individuals and groups, it also felt that a greater and more sustained effort would have reaped much greater benefits.

## Discussion

This paper is an initial clinical study exploring and describing the effects of stress on medical staff during a process of hospital closure. More empirical controlled studies are needed to replicate and extend this study. Future studies may follow up current indications that the amount and intensity of stress and symptoms can be quite marked.

This study concentrated on senior medical staff. However, there were indications that those of a lower socioeconomic status in the hospital perhaps suffered more. Future studies should include nurses and other hospital staff.

A further caveat on this study is its phase specificity. Anecdotal evidence indicates that staff continued to experience stresses after the hospital closure. For instance, a number of senior staff sought help for stress symptoms associated with their relocation. Some units were emptied of relocated staff after a short time. However, such impressions need to be verified by controlled studies of possible long-term harm.

Although comparable hospital closure studies are not available, the effects described in this paper are concordant with stress responses in comparable situations. Thus, Stein [6] describes similar effects to those in this study in a smaller medical organization threatened with extinction for reasons of failure at a higher administrative level.

Short and long-term morbidity and mortality as a result of closures of industrial enterprises and of unemployment have been repeatedly documented [7,8]. More specifically, Mathers and Schofield [9] in their thorough review, which included Australian studies, showed that factory closures and unemployment led to increased morbidity and mortality from a range of illnesses such as cardiovascular disease. Interestingly, middle aged men who were not used to unemployment (like many medical staff in this study), as well as members of lower socioeconomic and otherwise less advantaged status, were shown to be most vulnerable.

It may be said that closures and mergers, disrupted ways of working and changes in values are part of normal life these days, and the distress accompanying them do not warrant special attention. However, they warrant special attention for at least three reasons. First, because of the very reason that they are common, an

understanding and amelioration of widespread stress effects may be beneficial for a wide section of the community. Second, 'normal distress', such as anger, outrage, losses, demoralization, and a sense of corroded bonds and values, may cause at least as much suffering and anguish as illness. Third, stress responses and demoralization are in the buffer zone between distress and formal symptoms and illnesses [5], hence treating them not only saves much suffering but is also good preventive medicine.

The treatment and prevention of ill effects from unemployment is still in its infancy [10]. However, some principles employed by the Hospital Stress Committee, such as listening and feedback, education about stress and its effects and advocacy for the human needs of staff may be usefully applied more widely.

Finally, if perceived meaninglessness and erosion of values contribute to the stressfulness of change, this feedback may be used to reassess future proposed changes. If indeed the changes are still deemed to be necessary for the greater good, it is possible that a 'slash and burn and don't tell me about the pain of it' attitude could be beneficially replaced by the 'generals' of change regarding displaced medical staff akin to honoured casualties in a war, that is, deserving of special status, acknowledgement and extra help in redeployment. Much research, the search for correct paradigms and education are needed in the wider area of medical economics and politics.

## Conclusion

This paper draws attention to potential human costs for staff involved in hospital closures. It is suggested that managers should take these costs into account when considering closures of wards and hospitals, and relocation of staff.

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