Internship Report for the Central Texas Medical Center in San Marcos

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Spring 2012
Introduction

During Spring 2012, I pursued an internship at the Central Texas Medical Center (CTMC) based on my recent choice to apply eventually to medical school and become a physician. I would recommend working at CTMC as a volunteer, extern, or intern to any person who is interested in employment within the medical field; most of the student workforce present in the hospital is comprised of individuals dedicated to a future career in medicine, nutrition, or health administration.

This report will begin with a background section on CTMC and its affiliated medical clinics, followed by an outline of the duties I had while working in the hospital. Next I will proceed by referencing inequality and health care and explaining how unequal access to health care relates to emergency room crowding and preventative medicine. Following that will be a section devoted to the analysis of hospital space and physician listening with respect to patient attitude and comfort. Lastly I will illustrate CTMC’s quality assurance protocol before finally reflecting on my stay at CTMC and expounding on my future goals.

Background

CTMC is a member of the Adventist Health System (AHS), an organization that umbrellas forty-three Seventh-Day Adventist hospitals and more than fifty nursing homes and home health agencies in North America. The AHS is administrated by the General Conference of Seventh-Day Adventists, an international, non-profit governing body that oversees operations for the entire Seventh-Day Adventist Church. Although the Church is affiliated with only one medical school in the United States (Loma Linda University’s School of Medicine), its presence
in both national and international hospitals, universities, and secondary schools is extensive. The AHS remains the largest non-profit Protestant health care provider in the United States.

CTMC is a 178-bed hospital providing a wide range of health services managed by more than 220 active and consulting physicians. The hospital includes a basic Level IV Emergency and Trauma Center and a Level II Neonatal Intensive Care Unit, both of which are partnered with the hospital’s Air Evac Lifeteam. Ambulatory services and the Air Evac Lifeteam work separately to transfer patients who are in need of an increased level of care to other hospitals along the Austin-San Antonio corridor. Along with an established Emergency Department and Women’s Center, the hospital is also equipped with an Intensive Care Unit (ICU), a Progressive Care Unit (PCU), a Surgery Department, a Medical/Surgical floor, a cardiopulmonary unit, and a Medical Imaging Department.

Various neighboring medical buildings and specialty clinics are affiliated with CTMC and provide even more health services, most of which have various opportunities for interns and volunteers seeking experience in the medical field. These CTMC health establishments include the Sleep Improvement Center, the Institute for Advanced Wound Care Healing, the Physical Therapy and Rehabilitation Institute, CTMC’s Hospice, the CTMC Home Health program, Central Texas Medical Associates, and the Institute for Healthy Living.

CTMC’s Institute for Healthy Living offers a number of programs and activity groups that provide support for diseases and conditions such as breast cancer, grief, autism, diabetes, and brain injury. Other programs include nutrition counseling, support for parenting, and weight management. Best Food for Families, Infants, and Toddlers (Best Food FITS), a nutrition research project managed by Texas State University, is also affiliated with the Institute for
Healthy Living. CTMC also administers HealthCheck, an annual health fair and screening event within Hays County. HealthCheck conducts various tests at reduced costs and sponsors several physician presentations regarding various health conditions. HealthCheck is an especially useful event for student volunteers attempting to acquire experience with patients or for potential interns seeking a Bachelor of Science degree in health administration.

My duties at CTMC were limited yet appropriate for a first-time anthropology and pre-medical extern. I worked my hospital shifts in three different areas: the volunteer desk, the information desk, and the emergency room (ER).

The information desk is the first thing anyone will see when entering the hospital, and it is the main area accessed by guests and patients who require general assistance. Volunteers occupying the information desk are responsible for directing hospital visitors, providing general information, making sure guests find the hospital staff member they are looking for, and managing paperwork for the hospital. Because the desk for the Institute of Healthy Living is near the information counter, volunteers are often asked by their staff to help sort and manage paperwork, especially during HealthCheck.

Transferring patients for admissions and discharges is the principle job responsibility for individuals at the volunteer desk. Volunteers work together with registration staff to transfer patients to the PCU, the cardiopulmonary unit, the radiology center, the outpatient surgery floor, or the med/surg floor. More often than not, patients who require assistance are in need of a wheelchair, and occasionally the transfer process is made slightly more difficult by the presence of an oxygen tank or other support device that must accompany the patient at all times. In rare instances a volunteer will be called upon to transfer a patient directly to the ER if an emergency
comes up before the patient is processed by registration. Volunteers are responsible for making sure that the patient’s paperwork is turned in to their receiving nurse or the desk clerk. For discharges, volunteers are called by the nursing staff in their respective area of the hospital to collect a patient and wheel them to the front of the hospital to be picked up. Patients are often weak, clumsy, or disoriented after their stay in the hospital, so it is imperative that the volunteer physically assist them into their wheelchair if necessary. It is the volunteer’s responsibility to keep the patient company throughout the transfer process until they are picked up, meaning that a volunteer might spend an extended amount of time with a patient if they are required to visit the pharmacy before they leave or if they have a voucher from the hospital to be picked up by a taxi.

In the ER, volunteer responsibilities include transporting patients for admissions and discharges, organizing and disinfecting patient rooms, conducting patient rounds, delivering patient samples to the lab, transporting patients to other sections in the hospital, and assisting techs and nursing staff with any requests they might make. Most of the ER volunteer’s time is spent helping the techs and nurses by cleaning up rooms and preparing them for new patients. Volunteers also spend a significant amount of time meeting every available patient to make sure they are comfortable. Patients will often ask for things like pillows, blankets, water, or a snack. It is the volunteer’s responsibility to always ask the attending physician if their patient is allowed to consume anything that they request.

**Inequality and Access to Health Care**

Considering my involvement at CTMC I feel it is necessary to expound on one of the most pressing issues faced by health care providers and consumers in the United States today, not only because it is relevant to working at a health-providing institution, but because these are
the issues any individual who enters the medical field will eventually have to become familiar with.

There is an inverse relationship between socioeconomic status and health (Dressler 2010:549), indicating that those with the means to afford health care benefit from it, and those without the means to afford health care suffer from a lack of medical attention. Options for the uninsured remain few; if there are no free clinics or volunteer doctors in a local area, the ER often remains one of the only possible places for an uninsured individual to turn to. Emergency rooms often deal with patient crowding because they cannot turn away a patient based on their insurance status.

Crowding in the ER is an issue faced by many hospitals throughout the United States (Schafermeyer 2003:22). Medicaid patients and the uninsured alike often substitute the ER for a primary care physician because they have nowhere else to go. Because doctors are poorly compensated for admitting patients with Medicaid, fewer and fewer primary care physicians allow it as an insurance option (Harrison 2011:474). Unfortunately for Medicaid patients and the uninsured, emergency room care is a dismal substitute for continuous primary care. Patients who substitute the ER for primary care do not actually get healed, but rather they get temporarily mended.

ER patients who often come in for comparatively minor conditions—including stomach pains, headaches, and nausea—often revisit the ER multiple times and are known as “ER regulars” at CTMC. During my internship, I witnessed an example of such an ER regular—a man who came to the ER two times for two different ailments. On the first occasion the man was admitted with a headache, and on the second occasion he was admitted with a cold. I happened
to be eavesdropping when the physician assigned to treat the man expressed his disdain with respect to the situation: “He’s in for a cold? You’ve got to be f***ing kidding me….” The nurse who was assigned to him had a less hostile attitude, but still believed that the man should “get his act together” and “find a normal doctor.”

Emergency room physicians are typically able to treat a health problem and then refer the patient to an appropriate specialty physician, but the uninsured and some Medicaid patients are not given that option because the receiving physician will not accept them. Though priority will always be given to patients who actually exhibit an emergency condition, patient crowding in the ER wastes the resources of the hospital and wastes the physician’s time. McCabe (2011:673) suggests that three policies could be implemented at the national level to help ease ER overcrowding issues. The first policy must aim to decrease the number of uninsured and underinsured patients; the second policy should create new incentives for individuals seeking a career in nursing or health professions to stay in the hospital environment; and the third policy must improve Medicaid reimbursement rates so as to motivate more physicians to accept it as an insurance option, which will then lower the total number of Medicaid patients who turn to the ER as a last resort.

It is worth mentioning that the number of primary care physicians is shrinking due to a lack of interest based on wage disparities for graduating medical doctors. Compared to other physician specialties, primary care doctors have among the lowest salaries (Bodenheimer 2006:861). After graduating from medical school, the average M.D. or D.O. will have a debt of several hundreds of thousands of dollars, so new graduates are likely to continue their disinterest in lower-paying physician specialties. This ultimately means that there will be fewer primary care physicians who accept Medicaid insurance for patients to choose from, resulting in
continued emergency room crowding and a greater expense paid towards health issues that could otherwise be prevented and treated with focused care.

Unequal access to health care has tremendous implications with respect to preventative services. Health insurance is not just important because it protects families against the high and unexpected costs of medical care, but because it connects individuals to networks and systems of health care providers (Hoffman and Paradise 2008:149). Those without insurance are less likely to have routine checkups, less likely to receive dental care, less likely to seek prenatal care, and less likely to receive screenings for conditions such as breast cancer or hypertension.

The goal of preventative medicine is to treat an illness early, before it gets worse, in order to protect the patient’s health and wallet, and the hospital’s or clinicians’ resources. Dr. Xavier, an orthopedic surgeon I interviewed, provided an example regarding the consequences of abstaining from dealing with an illness early on:

I got a guy right now who’s…in the intensive care unit over at Seton and has a seizure disorder. [He was] probably previously diagnosed, ignored his medication, [and] is an active alcoholic. He was getting out of a car, had a seizure, and broke his leg when he fell on the ground because he is osteoporotic through vitamin D deficiency…there is no vitamin D in beer.

Universal health care is presently one of the only available solutions which would ensure that every U.S. citizen has access to health care, and which in turn would allow individuals to routinely visit their primary care physician. It is unlikely that issues surrounding preventative medicine and ER crowding will be fixed with the implementation of a single, overarching health care policy, but ensuring that every person has the ability to control and manage their own health seems to be a step in the right direction. Dr. Xavier conveyed a similar sentiment:
[Health care] should be run as a quasi-government non-profit entity, almost like the post office. As a health care provider I’m going to hate [it], but as a consumer [and] taxpayer I think it’s the only option.

The Hospital Environment and Patient Comfort

In their analysis of patient attitudes and perceptions as they relate to medical clinic spatial arrangements, Strathmann and Hay concluded that “spatial arrangements of the clinic seemed to exacerbate patient reactions; the more removed the clinic was from the waiting area the more irate the patients seemed to get with staff” (2008:58). Strathmann and Hay continue to suggest that clinical space is an important factor with respect to the “overall patient experience and organization of medical care.” Based on my participant observation involvements at CTMC, I also believe the spatial arrangement within the hospital contributes greatly to general patient satisfaction and comfort; however, I include the welcoming religious atmosphere into the equation as well.

The hospital has many different sections, but the guest areas and hospital staff areas are relatively well integrated. Within the various hospital sections (PCU, the outpatient surgery floor, and the med/surg floor), each respective nursing station is located at the center of the floor, with individual patient rooms aligned to the left and right sides. For surveillance purposes, the only barrier that separates a patient from being in view of the nursing station and its staff is the patient’s own private door, which opens and closes at the patient’s own discretion during non-procedural moments. In more public areas like the general waiting room and the registration waiting room, the space is even more open—by “open” I simply mean that guests and patients are not totally separated from hospital staff members.
Several physical and religious variables contribute to the hospital’s pleasant atmosphere. Throughout the guest areas of the hospital there are religious decorations that range from metal representations of angels to scripture quotes embedded into paintings of natural landscapes. Behind the information desk and in large letters the AHS motto—“extending the healing ministry of Christ”—is imprinted on the wall. In the general waiting room there is a painting of Jesus Christ and several glass prints lined together that depict homes on rolling hills. Conversations that are brought up between two strangers will often be religious in nature, patients will sometimes make an inquiry about the Seventh-Day Adventist Church, and the hospital’s 700 employees all wear badges with the AHS motto on them.

CTMC is generally a comfortable environment. The hospital’s first-floor front wall is essentially comprised of large windows that let in a large amount of natural light and give hospital guests a view of CTMC’s well-manicured lawns. Hospital staff members who walk along the halls frequently make eye contact and smile to people who pass by. And the lighting throughout the hospital makes the entire setting seem more cheery. I think all of these attributes explain why I have never witnessed a patient outside of the ER express disdain towards the hospital or its staff.

I should mention that although CTMC is a privately run hospital owned by the AHS, I have never observed Seventh-Day Adventism, Christianity, or any religion being incorporated into clinical practice. Religious matters might come up during small talk, but among the clinical staff, religion is essentially irrelevant with respect to patient care. It is the hospital chaplain, not the patient’s practitioners, who is called to participate if a patient inquires about prayer services or things of that nature. The physicians and nurses who are employed by CTMC receive the
same training as clinicians employed by other hospitals and are not required to sign a statement of faith or religious code of ethics.

The physical hospital layout is not the only thing that contributes to the hospital’s overall environment. Nurse and physician care, as well as treatment from other hospital staff members, directly influences how patients and guests view the hospital setting. The clinician-patient relationship is ultimately what most influences a patient’s perspective regarding their treatment.

During my stay at CTMC I had many conversations with an elderly gentleman who had cerebral palsy, and in one of those conversations he expressed his admiration for one of CTMC’s orthopedic physicians. The reason he liked this doctor so much was simply because the doctor seemed to take the time to listen to him and understand what his problems were. Jagosh et al. express their ideas regarding the importance of physician listening (2011:373):

> Listening fosters a deeper connection between physician and patient—one that is bound up with an interpretive activity. In this sense, it contributes to a richer interpersonal dialogue, generosity of spirit, and awareness of preconceptions and an active suspension of bias.

Listening seemed to matter so much to the individual I spoke with that he claimed the aforementioned orthopedic physician was the best doctor he had been treated by during his entire life. It makes sense that a hospital environment generally radiates a feeling of comfort if the physicians who work there can be perceived as being of superior quality.

A good physician is not only required to play the role of healer and medical expert, but to be a mediator between the patient and modern, scientific medicine. Arthur Kleinman provides an
in-depth elaboration on the distinction between a physician treating the patient’s illness and treating the disease as professionally recognized by the physician (1988:5):

Illness complaints are what patients and their families bring to the practitioner. Indeed, locally shared illness idioms create a common ground for patient and practitioner to understand each other in their initial encounter. For the practitioner, too, has been socialized into a particular collective experience of illness. Disease, however, is what the practitioner creates in the recasting of illness in terms of theories of disorder. Disease is what practitioners have been trained to see through the theoretical lenses of their particular form of practice. That is to say, the practitioner reconfigures the patient’s and family’s illness problems as narrow technical issues, disease problems.

A good physician is someone who can go beyond the “theoretical lens of their particular form of practice” by treating the patient, not just the disease. As per the previously mentioned example, taking the time to listen to a patient and contextualizing the disease to specifically fit the patient’s circumstances leads to a happier patient and an increase in the quality of medical practice.

Arthur Kleinman makes the point that there is an obvious disconnect between the meaning of illness as a physician considers it and the meaning of illness as it should be considered with the patient’s context in mind. In other words, the biomedical model and the clinical sciences divorce a patient from his or her context as a person. This fault in the diagnostic and treating process has drastic implications, which Kleinman expands upon (1988:9):

Social reality is so organized that we do not routinely inquire into the meanings of illness any more than we regularly analyze the structure of our social world.
Indeed, the everyday priority structure of medical training and of health care delivery, with its radically materialist pursuit of the biological mechanism of disease, precludes such inquiry. It turns the gaze of the clinician, along with the attention of patients and families, away from decoding the salient meanings of illness for them, which interferes with recognition of disturbing but potentially treatable problems in their life world. The biomedical system replaces this allegedly “soft,” therefore devalued, psychosocial concern with meanings with the scientifically “hard,” therefore overvalued, technical quest for the control of symptoms. This pernicious value transformation is a serious failing of modern medicine: it disables the healer and disempowers the chronically ill.

### Quality Assurance

Risk management and quality assurance are a part of a single department at CTMC called Performance Improvement. This department tracks incident reports, measures patient satisfaction, assesses employee risks, and uses focused studies to analyze and improve hospital performance. I sat down for a short and informal interview with CTMC’s Director of Patient Experience and Quality to learn more.

Performance Improvement at CTMC follows a 5-step guideline labeled DMAIC—define, measure, analyze, improve, and control—and is part of a managing strategy called six sigma. Six sigma is a process improvement methodology that was initially employed by several manufacturing industries to remove waste and variation from a process while eliminating defects. DMAIC is a procedure used by health administrators that incorporates the use of statistics into a focused study to solve a known problem.
An example given to me of DMAIC in action consisted of an easily fixable hospital issue concerning a problem with turn-around time on medication orders; customers and patients were complaining that the pharmacy took too long to put medication orders into the computers. It was later found out that pharmacy staff actually put orders in as soon as they received them from a physician. Data was collected by the performance improvement team to see exactly when the physician wrote the order, when the order was faxed to the pharmacy, when the pharmacy received that order, and when that order finally became available to the patient. It was discovered that physicians would often write out an order and proceed to leave the patient chart containing that order in a random section of their hospital unit. Over a period of time somebody would find the chart and place it onto a rack to eventually get faxed, but the patient chart seemed to stay on that rack for quite a while. When the issue was brought up the common excuse was that the unit clerk was the only person who knew how to fax an order—nobody else thought it was their job to do the faxing. Data suggested that there was an average time delay of an hour and a half between an order being placed and an order being faxed; the pharmacy itself only took thirty minutes to dispense the medication. To solve the confusion the performance improvement team implemented a new rack system and trained physicians to use it: the top rack would indicate something that still needed to be faxed and the bottom rack would indicate an order that was already sent to the pharmacy. Instructions on how to fax were prepared and taped to the fax machine, and a preset dial was created that would send any order to the pharmacy with the push of a single button. The performance improvement team trained every hospital staff member who might walk by the top rack (including physical therapy consultants, dietary staff, and housekeeping staff) to fax any order that might be there. By the end of the investigation the hour-and-a-half process was reduced to a twenty-minute process.
CTMC also uses a hospital administration philosophy as outlined by Quint Studer, a nationally recognized leader in healthcare development and improvement. Quint Studer has acted as CEO at several hospitals and is famous for turning around hospitals with low performance. In accordance with Quint Studer’s hospital administration philosophy, all CTMC leaders conduct patient rounds.

Rounding is what doctors in hospitals have traditionally done to check on patients. The same idea can be used in business, with a CEO, VP, or department manager—‘making the rounds’ to check on the status of his or her employees. Rounding is all about gathering information in a structured way. It’s proactive, not reactive. It’s a way to get a handle on problems before they occur and also to reinforce positive and profitable behaviors. Best of all, it’s an efficient system that yields maximum return on [an] investment. – Quint Studer

Every hospital employee in a leadership position at CTMC is assigned to a certain day and unit every week or every other week for rounding. Leaders will talk to patients and ask them whether they need anything, get to know the nurses, ask patients how their nurses have been, and help out with anything that needs to be done.

As part of the Obama healthcare reform law, hospitals are mandated to participate in the new Centers for Medicare and Medicaid Services (CMS) value-based purchasing program, an incentive that requires hospitals to measure patient experiences through standardized surveys. These surveys ask questions such as “How often were you satisfied with your nurse?” and use a likert scale with answers ranging from “never” to “always.” In the past CTMC received money from the CMS program for simply administering the survey, but with the new healthcare law hospitals are compensated for each individual survey only if the patient responds with an
“always” for at least some of the questions. CTMC’s goal is to increase patient satisfaction so that they may acquire a maximum of $2 million a year from the program. My interviewee expressed several thoughts regarding the new CMS standard:

I think it is good. This holds nurses and physicians accountable and curbs their emotions into what is right for the patient. Patients have no perception of quality—they do not know if they have received evidence-based practice. But they do know if people are nice to them and the hospital is clean. [The CMS survey] helps patients judge what they think is quality.

With respect to anthropological entrée in the hospital setting, Irwin Press surmises that “hospital administration is interested in results of immediate, mainstream relevance, not theory, ‘studies,’ or exotica” (1985:68). This begs the question as to how anthropological aid could presently be of any use to hospital administrators whatsoever. When, for example, could anthropology have been put to use in the previously mentioned medication order scenario? How could anthropology help hospital administrators figure out why Alzheimer’s and dementia patients fall out of bed at night? According to CTMC’s Director of Patient Experience and Quality, patients with these conditions fall out of bed at night because they have to get up and go to the bathroom while in a confused mental state. The working solution is to give these patients company, somebody to talk to, and somebody to help them if they need it. I remain skeptical that an anthropologist could come up with a better solution unless they were given the time to conduct an in-depth ethnographic study.

Irwin Press (1985:67) mentions several issues that no longer exist today, such as the decline of the patient population, the ambiguity behind quality assurance roles, and the idea that the hospital administration professions are seeking a “methodological repertoire.” These issues
seem to have been weeded out over time, perhaps due to the successful efforts of Quint Studer or Press’s own Ganey Associates, Inc., a patient satisfaction research company. Studer and Press have employed very similar performance solution designs and have implemented them with tremendous success, leading to the improving performance of many of the nation’s hospitals. According to the Press Ganey website (Wolosin 2010), “Press applied the tools of cultural anthropology (interviews, participant observation, analysis of documents, etc.) to the contemporary practice of medicine and found that, like other ‘tribes,’ it possessed a distinct culture, with its own language, customs and worldview.” Indeed, participant observation is comparable to Studer’s concept of patient rounding, and the analysis of documents is likewise comparable to Press’s own method of collecting and analyzing data while also using information stored in databases and case studies (Press Ganey n.d).

Conclusion

Working at CTMC was a great experience, and I would strongly recommend interning there to any anthropology student, especially if they have an interest in medicine. My goal for this internship was to gain knowledge of the medical universe, secure a general idea of what it would be like to work in a hospital, and obtain some kind of notion as to what it might be like working as a physician. My advice for anyone hoping to work at the hospital or its affiliated clinics is to inquire about a position early and broadly. Speak with the volunteer coordinator, but also make sure to poke and prod individual departments.

This internship was the first step I needed to gather clinical experience, and it is one of the extracurricular activities that I will note on my medical school application. The road to becoming a physician is long and arduous, but completing this internship helped make that road
a little less rutted. The next steps towards my career will include taking two extra years of post-baccalaureate classes in order to complete the necessary math and science pre-requisites for medical school, establishing a research background in the sciences, completing both clinical and non-clinical volunteering activities, and obtaining a competitive Medical College Admission Test score. After that I merely need to get accepted into medical school and complete eight or so years of coursework and training until I can consider myself a full-fledged doctor.

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