Appendix D - **UNIVERSITY HONORS PROGRAM**
SENIOR PROJECT - APPROVAL

Name: Sunaina Dowray

College: Arts and Sciences Department: BCMB

Faculty Mentor: DR. HANDEL WRIGHT

PROJECT TITLE: Service Learning for Social Justice at Fort Sanders Regional Medical Center: Studying Social Issues at a hospital

---

I have reviewed this completed senior honors thesis with this student and certify that it is a project commensurate with honors level undergraduate research in this field.

Signed: Handel Wright EACS, Faculty Mentor

Date: 10th May 2001

Comments (Optional):

Sunaina has done an excellent study here blending service and volunteerism with research skills and keen observation. Her discussion of the role universities do and ought to play in communities is strikingly important. On the whole her thesis epitomizes the kind of reflection, activism and community minded consideration and incisive analysis I was hoping to foster when I first offered the honors course in service learning. The thesis is a mature piece of work and it was a genuine pleasure working with Sunaina as she developed it.

HW

Service Learning for Social Justice at Fort Sanders Regional Medical Center
Studying Social Issues at a Hospital

SENIOR HONORS THESIS
UNIVERSITY OF TENNESSEE HONORS PROGRAM

Sunaina Dowray
Spring 2001

TABLE OF CONTENTS

CHAPTER1 *Service Learning*.....1

CHAPTER 2 *The Hospital: Fort Sanders Regional Medical Center*.....16

CHAPTER 3 *Issues of social justice at Fort Sanders Medical Center*.....25

REFERENCES.....45

BIBLIOGRAPHY.....47

CHAPTER 1

SERVICE LEARNING

Introduction

Service learning is a discipline combining learning and volunteerism (and in some cases, active research). Although currently gaining more attention and acceptance, service learning does have a long history. Service learning was the culmination of many ideas and events. John Dewey's community based educational curriculum could be regarded as one of its roots. Dewey's curriculum merged with a spirit of community and campus cooperation, that evolved in the civil rights struggles of the 1960s, and combined with the idea of university responsibilities in the community (as represented in the 1860 land grant movement) (Stanton, Giles, & Cruz, xii-xiii, 1999). This combination of developments could be regarded as the comprehensive roots of service learning.

Robert Sigmon, a leading member of the Southern Regional Education Board, defined service learning by three criteria. First, the services provided should be dictated by the people who are being served. Second, the people being served should gain the ability to improve their own situations. Third, the people who are serving should gain something from the experience (in Stanton, Giles, and Cruz, 3-4). Reciprocity is central to service learning and this is often lacking in many community service projects. There are multiple types of service learning. Some educators support service learning as a means of developing moral citizens, some as a method of producing active citizens, and still others as a means of enacting social change. Service learning inherently challenges many of the principles that have become part of the foundation of the current educational system. Traditionally educators have steered clear of value-based education. Education has become the study of only facts and objective truths. Many question whether this principle should be overridden.

Universities and their views on service

Universities traditionally have included three components in their mission statements – research, teaching, and service. Different types of universities emphasize one component over the other two. Liberal Arts Colleges have become known for emphasizing the development of thinking skills and reason. Their focus remains the pursuit of Truth. The education provided is rather different from the service learning ideal of practical education. Liberal Arts universities do believe they are fulfilling their mission of service by developing the character of their students. Research universities, as the name implies, focus on research. Service is seen as being achieved through the products of faculty research. Research universities focus on applied science, which is science that can be applied to some practical use. Many research universities were created by the land grant movement, including my university The University of Tennessee, which was started to promote research for the agricultural sector. Professional schools prepare students for valuable positions in society and service, to them, is inherent in their purpose. Community colleges were originally created to allow all people access to higher education. The very presence of a community college is a service to its community. Although all universities see themselves as fulfilling their duty to service, service learning defines a university's' duty to service in broader terms. The service provided by each institution does not fulfill the requirements of service learning (Stanton, Giles, & Cruz, 14-16, 1999). Different universities have different perspectives on how they are fulfilling their duty to service however true service will be achieved when a solid bridge has been formed between the university and the community. University research is often seen as a form of service but it fails to serve because of the distance between these two

communities. Due to university isolation, which has lead to their public image as "ivory towers," faculty research often fails to be or is not perceived as being socially relevant. Research that is done is usually not accessible to the community as professors publish and present their work in forms accessible and designed for their peers (Checkoway, 308, 1997). Professional schools and community colleges do provide an important service in the community and by integrating service learning into the curriculum this service can be maximized.

The Debate over the Town-Gown Relationship

Lee Benson and Ira Harkavy coined the term "town-gown collaboration." The "town-gown collaboration" refers to the connection between the town/community and the gown/ the university. Many debate what connection, if any, should exist between the community and the university. On May 31, 1996 Time magazine published an article entitled "Old Friends, New Foes; President and a Preacher; one activist runs Columbia; One Fights it." The conflict centered around two old college friends, Father Castle and George Rupp, who differed in their views on a university and its responsibility to the community. Father Castle, a preacher in Harlem, publicly criticized George Rupp, then president of Columbia, for failing to fulfill his responsibility to help improve Harlem. Castle felt that a powerful and influential university like Columbia had an obligation to use its resources to uplift the surrounding community. Rupp countered that Columbia does not have any responsibility to the community and further by helping Harlem Rupp felt he would be remiss in his duties as president (Benson & Harkavy, 5-7, 1996). Rupp is representative of the traditional educational philosophy, which perceives a dichotomy between the university and the community. This conception of the university has isolated

universities from their surrounding communities. However service learning, through its many pioneers, has shown that the goals of the university and the goals of the community can be successfully accomplished together.

The Pioneers

Service learning connects three fragmented areas- the world of service, the community, and education (Stanton, Giles, & Cruz, 19, 1999). The community and education are connected when students participate in service learning and study issues of importance in their communities. The service and community are connected because service learning is a step toward improving our nation by creating educated and active citizens and channeling the knowledge and skills of our educated toward our communities' most pressing social concerns.

The history of the development of service learning can be divided into three parts. First was the development of community- development focused internships. The first 'service-learning' program was the work of Bill Ramsay and Bob Sigmon in 1965. Both worked at the Oak Ridge Institute of Nuclear Studies in Tennessee. Ramsay worked closely with the Clinch-Powell Rivers Development Agency and with the TVA began research on development in the area. An internship was created which allowed students to aid in this research (Stanton, Giles, & Cruz, 24-25, 1999).

Helen Lewis and Mel King were responsible for another development by creating curriculum based experiential learning. Lewis began the first Appalachian studies program in Clinch Valley College in Wise, VA. Most of her students were from coal mining families and were being affected by recent developments in the coal industry such as the mechanization of coal mining and the increase in strip mining. Lewis held weekly

seminars that were open to the public. Students researched community issues and brought community members to support their programs. King also felt that the community was a valuable source for education. King started a Community Fellows Program, service learning program, at MIT for students to participate in the civil rights movement (Stanton, Giles, & Cruz, 28-29, 1999).

An important development in East Tennessee was the 1932 creation of the Highlander Research and Education Center in Monteagle, TN by Myles Horton. Created as a training institution for union labor leaders, the Highlander center soon became a training center for civil rights leaders. Highlander has become the leading adult education center for the poor of Appalachia. Institutions like Highlander are based in the ideals of service learning. Their belief is that education provides the poor and disenfranchised with the tools they need to work on solving their own economic and social problems. Service Learning is clearly not a field of charity. Rather it is a field of empowerment both for those being served and those serving (Stanton, Giles, & Cruz, 77, 1999).

Ira Harkavy is another leading figure in the field of Service learning. Harkavy has advocated and worked towards bridging education and the community. Harkavy has worked to build a strong community-university partnership between the University of Pennsylvania and the West Philadelphia community. (Stanton, Cruz, & Giles, 31, 1999).

Nick Royal and Mary Tillman further developed an important component of service learning. An important part of the service learning course is student reflection on their volunteering experience. Royal and Tillman were the first to emphasize the need for structured student reflection (Stanton, Giles, & Cruz, 30-31, 1999).

Early Columbia professors and professors at the University of Chicago, such as

John Dewey were the first to combine education and community action in the late 1800s (Benson & Harkavy, 8, 1997). The theory behind service learning comes from the work of John Dewey and his counterparts at the University of Chicago. Dewey judged the quality of education and research on their real world relevance and applications. Dewey's views on education contrasted with those of the traditionalists who reflected Plato's ideas on knowledge. To Plato education, the pursuit of Truth, was an inherently valuable pursuit. There was no need for education to be socially useful/ relevant (Benson & Harkavy, 9-10, 1996). With this view education serves as a divisive force within the community. The community people, represent ignorant 'lay' people absorbed in daily, mundane tasks while the university people were those who had risen above the common and sought the pursuit of higher knowledge. The traditional view corresponds to a separation between the university and the community as two distinct entities, much as George Rupp believed.

Why Should Universities Change?

There are many reasons for the call for higher educational reform and an integration of service learning. Some educators feel that it is a highly needed reform in education. Higher education and research have become increasingly isolated and socially unimportant. Service learning calls for pragmatic education. Many feel that classroom learning fails to provide students with real world experience, which leaves them at a disadvantage after graduation. Practical experience can be gained through service right in the local community. Still others feel that service learning is the key to countering the widespread passiveness and apathy of youth. Service learning could promote the development of a socially conscious and politically active generation.

Why should universities change when they have survived with their traditions? Ultimately every university needs to have a strong connection to its community because they are interdependent. The condition of the community surrounding a university affects the university. When selecting a university, faculty, students, and parents take the condition and appearance of the surrounding community into their decision. Currently universities are facing pressure to be accountable to their communities. The community no longer reveres the university as an "ivory tower" of knowledge. Rather, they want to know what their tax money is going toward. A local example is the recent funding crisis that the University of Tennessee has been facing for the past two years. It has been an uphill struggle for the university to get the state legislature to fight for their cause in Nashville. The reluctance of the legislature to take on the university's funding crisis shows that members of the legislature did not feel that the fate of the university was an important issue to the majority of their constituencies. The community did not necessarily consider the university to be a valuable and contributing entity in their community. Universities, whether private or public, do obtain some public funding and therefore have a responsibility to meeting public needs. Universities such as the University of TN were created by federal land grant legislation in the late 19th century and early 20th centuries. These grants were created for research in the agricultural and engineering fields to stimulate outreach service. Universities such as UT have a responsibility to aid the community by actively pursuing agricultural research (Harkavy, 333-335, 1997).

Ideas for Reform

The current system in higher education punishes those faculty members who believe in seriously incorporating service into the curriculum. Research, in terms of

publications, tends to play a highly influential role in professors gaining tenure. University presidents and administrators need to place an emphasis on service and reward faculty members who successfully integrate it in their courses and research.

To bridge the gap between university and community university professors need to practice what Henry Louis Taylor, Jr. terms "public service." Public service refers to using one's academic expertise to help solve community problems (Taylor, 329-330, 1997). David Matthews argues that a fourth element needs to be added to the university tripartite mission of research, teaching, and service. Universities need to create a place on campus where the community and university have a forum for communication. The Community Partnership Center (CPC), at UT, is precisely such a place. The CPC was created as a place where community organizations could come and access university resources-faculty and students. One of the CPC's duties is to ensure the university fulfills the intent with which it was created- mainly to provide service to the agricultural sector. The CPC works with matching community organizations with students. The CPC works to provide student participants with a fruitful and educational experience at the community organization, which will better prepare them for their career and educational goals (Gregg, memo, March 30, 1998). When professors and students begin communicating with community leaders education will inevitably gain social relevance.

Reform in action

Universities in Eastern TN are working towards the integration of service in higher education. The East Tennessee Consortium for Service Learning has an annual newsletter describing the steps participating universities are taking to change in this direction. Universities are working to divert resources to service learning projects (East

Tennessee Consortium for Service Learning, annual newsletter, 1998-1999). One example of a service learning project is offered at the East Tennessee State University. ETSU offers a paid summer internship in rural community health for premedical students. Students will aid in collecting health-related information in one of several locations in East TN or Southern VA. This program is an ideal example of service learning in that it allows students to gain valuable skills, which will be needed when they are doctors, mainly interpersonal skills as they will be interviewing people. In addition they will be making a significant contribution to the community, as their research is an assessment of healthcare problems among these ignored communities. Research can be used by community leaders to fight for better healthcare. Community members gain an opportunity to have their complaints and concerns heard and voiced in the national arena.

The SICK(Solutions to Issues of Concern to Knoxvillians) Speaker is a publication of a community action group in Knoxville which focuses on supporting the poor and improving their conditions. In the newsletter one SICK leader, Sarah Scott, expressed a need for more support, particularly youth support, but was unsure how to effectively recruit young members. Universities' moves to integrate service learning would be beneficial to groups like SICK and participating students. Although the University of TN has taken positive steps towards service integration, such as the formation of the CPC, the CPC needs to work on publicity on campus. I did not know such an organization existed on campus until I was introduced to service learning in an honors seminar. In the East Tennessee Consortium for Service Learning UT has described the achievements of the CPC, which include creating a database of community organizations students can work with (East Tennessee Consortium for Service Learning,

annual newsletter, 1998-1999).

Among service learning programs international service learning programs are extremely valuable educational experiences. The International Partnership for Service Learning offers programs focusing on social justice in countries like South Africa and India. Students have the option of taking a three-week course or a nine-week course. The program involves extensive education in the history and culture of the country lead by local scholars. Students gain the opportunity to work with community organizations such as Mother Theresa's Home for the Dying in Calcutta. These programs appear to be highly enriching and educational experiences (http://www.ipsl.org).

Disadvantages to Service Learning

An article on service learning courses at the San Francisco State University provides a more complete picture of service learning by analyzing both its strengths and weaknesses. Since I have already discussed the many benefits of service learning let us discuss some disadvantages. One is that planning effective service learning projects requires time which teachers do not have (Gose, 1997). In UT I did a project in service learning through an honors seminar. In the seminar we were each allowed to choose an organization to work with that suited our interests. In the seminar we contacted the organization of choice and effectively planned it ourselves. Our instructor, Dr. Handel Wright, was a valuable guide helping us reflect on our experiences and observations and showing us the 'big picture.' Another disadvantage is that organizations may get burdened with excess volunteers (Gose, 1997). This is a valid point which I have noticed in my work at Fort Sanders Regional Medical Center, the site of my project. Often there is barely enough work for one volunteer. During orientation the volunteer coordinator

made it a point to avoid any overlaps in volunteers' shifts. Another drawback is the limited time most students can devote to the organization, on average 4hrs/week (Gose, 1997). With such a limited time will the experience be beneficial to both parties? If students do not plan to continue at the organization past one semester it may not be a worthwhile investment for the organization to train these students.

The debate on integrating service learning underlies the broader question of what the purpose of education should be. Should it be to prepare active citizens and/or moral citizens who will work for social change? Does our educational system have the right to promote such values? These questions are difficult to answer. Finn and Vanourek argue that service learning politicizes the educational system (Claus, J., & Ogden, C., 1-5, 1999). The American government has tried to make the educational system relatively morally neutral for fear of offending those with varying moral ideals. In many ways it does promote values like actively discouraging the use of alcohol, drugs, and tobacco in middle and junior high schools. Issues of social change deal with issues of race, power, gender, sexual orientation, class, privilege etc. Thus the issues raised in these learning experiences are issues which society still struggles with. Do faculty, as representatives of the public educational system, have a right to teach their students their own views on these issues? In higher education these issues can be left unresolved and students can voice their opinions in class debate. Finn and Vanourek also feel that service learning degrades service by making it a requirement (Claus, J., & Ogden, C., 1-5, 1999).

Service Learning in Campus Life

Although it will take a while for service learning to become an accepted part of the educational curriculum, service does have a central role in education. All activities I

have participated in, in this regard, have focused on community involvement but not reciprocity with the community(although this happens as a result). In honors societies, such as Gamma Beta Phi, students become highly active members of the community. Gamma Beta Phi has continuous activities planned with children from the Boys and Girls Club. I feel this is an example of service learning although it is not being complemented by structured in-class reflection. College students gain an opportunity to mentor children while they learn about the problems underprivileged children in America face. Every year at Christmas time Gamma Beta Phi participates in the Angel Tree Program where each member can take the Christmas wishes of needy children and buy them gifts.

The University of Tennessee's environmental group SPEAK (Students Promoting Environmental Action in Knoxville) is an ideal example of service learning promoted by student driven organizations that work on campus and in the community. This student run organization is an active member of the Knoxville community and works to help in solving environmental problems. The group has adopted a polluted Creek in the area and members volunteer their time to clean. SPEAK sponsors local and national environmental leaders to educate members on important environmental issues. These speakers are bridging the gap between the local community, national community and the university community. SPEAK works in conjunction with the Knoxville Sierra Club. They inform members of national political issues and how they can make their voice heard. In this manner SPEAK represents service-learning in action.

Volunteering has not only become a significant part of campus life but it has become a determining factor in future career goals. Employers and graduate school admissions' committees look for applicants who have done service in their communities.

Medical schools recognize volunteering at a hospital as a crucial premed requirement. Premedical students' community involvement shows that they see volunteering as a valuable educational experience. Working in a hospital and getting involved in it reflects a commitment to the medical field based on an educated decision informed by hands-on experience. Personally I feel volunteering will help me decide whether I want to pursue medicine. Medicine is a big commitment and sacrifice and I have been volunteering at two hospitals, Fort Sanders and the East Tennessee Children's Hospital, to absorb myself in the medical field and gain experience.

My Interest in Service Learning

I first learned about service learning in general and the model of service learning for social justice in particular through an honors seminar I took my sophomore year with Dr. Wright. As a student in the university honors program we are required to take honors seminars offered in a wide range of fields every semester during our first three years. In the course each student was allowed to choose an organization of interest and volunteered at the organization a minimum of 4hrs/wks. Since I have been considering medicine as a future career choice I decided to volunteer at a local hospital, Fort Sanders Regional Medical Center with a fellow classmate. We both volunteered in the ER of the hospital every Saturday for four hours and through careful observation and talking to patients and staff uncovered many social issues. The experience was valuable in exposing both of us to the inner world of medicine. Service learning for social justice allows a student to volunteer at a community organization and focus on identifying social issues within the organization. Identified issues are representative of societal problems thus the service experience is not only a study of the organization but is a broader study

of society, its problems, and this organization's efforts to handle the consequences of these problems. In class we shared our volunteering experiences and our observations on issues of social justice at our various organizations. Dr. Wright, supplemented our volunteering with readings on town-gown relationships, service learning, and social justice as well as Stephen Fisher's book, *Fighting Back in Appalachia: traditions of resistance and change,* on community organizing and social justice issues in Appalachia (Fisher, 1993). This senior honors thesis is an expansion of my original project conducted in that course. All honors students are required to complete a research project under the supervision of a faculty mentor. I chose to continue with my project and working with Dr. Wright have continued volunteering at Fort Sanders Regional Medical Center.

CHAPTER 2

THE HOSPITAL

FORT SANDERS REGIONAL MEDICAL CENTER

Introduction

I chose Fort Sanders Regional Medical Center as the site for my service learning project. I would like to provide some background information on the hospital before I describe social issues at the hospital. Laying this foundation, with the structure and organization of the hospital and the emergency room, the social issues I observed within the hospital can be better understood. To conceptualize the problems faced by current healthcare professionals I have also described the recent structural changes that managed care has created in the healthcare industry. Finally I have discussed a relevant study of the hospital culture at one hospital to provide a perspective on social problems observed at hospitals.

Fort Sanders: History

Fort Sanders Regional Medical Center was founded on May 29, 1919 in downtown Knoxville. The hospital was built on the Civil War site of the Battle of Fort Sanders. The Knoxville Presbyterian Church began to manage the hospital in 1954 and the hospital changed its name to Fort Sanders Presbyterian hospital. In 1979 the name was changed to Fort Sanders Regional Medical Center which consisted of the hospital, clinical specialty programs, the school of nursing, and the Patricia Neal Rehabilitation Center. As Fort Sanders developed it improved health care services to the area. The 1920s were marked by the development of the first ambulatory service. The hospital was the first to have penicillin in the 1940s and in the 1970s it was the first to provide hospice care and to provide linear accelerator treatment, used in cancer treatment.

During the 80s and the 90s Fort Sanders created a network with other hospitals and organizations including Sevier County Medical Center and a nursing home in 1981.

In 1984 the company Fort Sanders Alliance was created and this company formed Preferred Health Partnership, a managed care company. PHP is the largest regional managed care company. Fort Sanders created other managed care organizations such as Tennessee Behavioral Health (statewide behavioral health network) and Tennessee Health Partnership(a managed care group jointly run with UT Medical Center). Fort Sanders ParkWest was founded in 1990 and included physician's offices, stores, fitness center, and a child care facility. A branch was also created in Loudon county in 1989. In 1992 Peninsula Health took over Fort Sanders behavioral services. A maternity center was created in 1993. In 1994 Fort Sanders began the Community Health Initiative (CHII), which helps concerned citizens address local health concerns. The CHII deals with issues of drug abuse and teen pregnancy. Fort Sanders Health System and MMC Healthcare System joined together to form Covenant Health, which focuses on "building healthy communities and delivering quality health care to the people of East Tennessee."

Fort Sanders currently has 541 hospital beds and is a regional center for neurology, orthopedics, oncology, cardiology, obstetrics, and rehabilitation medicine. The hospital also offers special services such as one-day surgery, electrodiagnosis, a 24-hour chest pain center, a diabetes center, a sleep disorder center, prenatal education and sports medicine department. Fort Sanders Regional Medical Center and Fort Sanders ParkWest describe their mission as providing medical care to all patients that enter their doors (http://www.covenanthealth.com/aboutus/fsrmc/fsrmc-history.html).

Hospital Organization

Hospital structures vary from defined hierarchies to the modern trend of horizontal organization where the emphasis is on collaboration between all levels in the

hospital and people are grouped together based on the type of patient care provided. Most hospitals have three influential groups- the professionals, the management, and the board of trustees. Power is the organizing principle of the hospital hierarchy. However with increasing power comes increasing responsibility. The board of trustees is a group of citizens, usually influential community members or citizens with valuable skills, who take ultimate responsibility for the hospital. Board members are not compensated financially. The board's function is to represent the community and ensure the hospital is meeting the needs of its people. The board chooses the CEO (Snook, 25-32, 1992).

The CEO is the manager of the hospital. The CEO shares the responsibility for the hospital with the board. The CEO must allocate the hospitals resources to fulfill the hospital's mission. The CEO chooses the CAO (Snook, 37, 1992).

Fort Sanders Regional Medical Center is a non-profit community hospital, which is owned by a parent company under Covenant Health. Covenant Health owns various hospitals and an insurance company, PHP-Cariten. Since Fort Sanders is a non-profit hospital, and tax exempt, it must provide charity care and treat all patients regardless of their ability to pay. Although Covenant usually does not make money from Fort Sanders Regional, it does from services at Fort Sanders ParkWest. The fitness center, daycare services, and other services at Fort Sanders ParkWest provide the corporation with profit. Covenant Health has a board of directors similar to the board of trustees at most hospitals.

The fact that Covenant Health owns an insurance company should provide for better communication between the insurance company and the hospital; however, I was told the hospital still has trouble getting payments from the insurance companies. A chief

executive officer, CEO, manages Covenant Health. Fort Sanders Regional has a team of administrators including a CAO, chief administrative officer, CNO, a chief nursing officer who manages clerical duties, CFO, a chief finance officer, and the CSSO, the chief support services officer. In addition Fort Sanders has a corporate vice president and president. The V.P. of the medical staff serves as the physicians' representative to the administration. The V.P. of clinical effectiveness maintains the quality of care for management. The hospital thus has a complex structure that is hierarchical but contains a lot of communication between levels.

The Emergency Room

The structure of the emergency room could be defined as a hierarchy with a long chain of command from the ER director, a representative of management in the department, to the medical director, then the doctors, the physician's assistants, the nurse shift leader, the nurses, the nurses' assistants and then the technicians. Although there is a chain of command the ER in action operates as a horizontal organization.

The ER provides the hospital with 50% of its revenue (Snook, 48, 1992). The ER at Fort Sanders is a standard Level 1 emergency department. Characteristics of a level 1 emergency department are a ground floor location for accessibility to sick/injured patients. In addition the emergency department should be physically separated from the hospital's main entrance. The ER has basic facilities for friends and families of ER patients. Within the ER there should be a method of getting samples to the lab and back fast and there should be an X-Ray machine in the ER. ER patients are usually treated and sent home, but in cases where observation is needed they may stay in the ER (heart patients). Some patients will be admitted if more treatment is needed (Snook, 48-49).

ERs in urban areas tend to provide primary care to their patients, as there is a shortage of available physicians for people on welfare and Medicaid and tend to have problems collecting money for the provided medical services. In urban areas there is a shortage of available physicians, so patients on welfare and Medicaid use the ER as their primary care provider. In some states Medicaid fails to meet the hospital costs of its patients leaving the hospital in debt (Snook, 48, 1992).

Managed Care

During the late 1980s and early 1990s America faced a healthcare crisis with per capita spending in the private sector rising more quickly than spending in Medicaid and Medicare (Scott, 2000). Although the US was the global, industrialized leader in healthcare spending, the quality of its healthcare was poor. Compared to other industrialized nations the US had the highest infant mortality rate. A large percentage of American children were still not immunized. And a large segment of the population, 15%, still failed to receive their basic health care needs since they lacked insurance coverage (Cassens, 413, 1992).

Managed care sought to lower health care costs and allowed patients, under particular HMOs, access to health care providers that were covered. Healthcare providers are chosen on the basis of the discounts they will provide. Managed care organizations also decrease costs by peer reviews, pre-approval procedures before visits to costly specialists or for procedures (Cassens, 389-390, 1992). Managed care was a solution to the increasing costs of healthcare in America. The transition to managed care was facilitated by the recession during the late 1980s and early 1990s. Companies were forced to restructure in the face of the losses caused by the recession. Employees feared losing

their jobs and the insurance their employers provided so they gave up their freedom of choice and accepted managed care. Insurance carriers found managed care advantageous as they could contract physicians and hospitals and decrease their costs. Managed care decreased healthcare spending by the discounts they obtained from healthcare providers. Managed care organizations have medical practice guidelines and preauthorization requirements (Scott, 2000). Managed care also adds an administrative burden on healthcare providers. Managed care has been beneficial in taking the responsibility of providing healthcare to the poor on Medicaid. Before people on Medicaid found it difficult to find healthcare providers. Now managed care organizations are responsible for Medicaid coverage although they don't always fulfill this theoretical duty (Levi, 2000).

Fort Sanders in the community

To develop a better understanding of the structure of Fort Sanders I talked with a marketing administrator. After my first project at Fort Sanders I had wondered what exact role the CHII had in the hospital. The group was described as a means for the community to work with the hospital to resolve their community health concerns by leading community health programs. From the marketing administrator I learned of one example of the work of the CHII. In Loudon county teen pregnancy was a community concern. The hospital provided the community with financial support so the community could educate teens on the realities of parenthood and pregnancy. The program had a significant effect on the community reducing teen pregnancies.

The marketing administrator described how Fort Sanders works in getting payments from insurance companies for its patients. The hospital agreed to capitation

with insurance providers, which entails caring for patients in return for a per member/per month payment. The amount of this payment is fixed regardless of how much the patient has used the hospital/ how little they have used the hospital. The marketing administrator informed me that at Fort Sanders Regional, which services many low-income people, often this deal is advantageous to the insurance companies. The patients at Fort Sanders Regional often exceed their monthly costs reimbursed by the insurance providers. Fort Sanders ParkWest services patients from middle class to affluent economic levels and tend to make money from this arrangement. However, since these are non-profit hospitals any profit is re-invested in the hospital.

Hospital Culture

Before exploring the hospital culture at Fort Sanders I read an article, which was a comprehensive study of one particular hospital in Western England. After intensive research and interviews Bate identified three cultural problems within the hospital. One was a "culture of tribalism." Tribalism refers to each department working for its own benefit with little interdepartmental communications. Tribalism was identified between management and professionals, and between professionals of different specialties (Bate, 405, 2000). Second, was a "culture of individualism." This referred to the attitude of the healthcare professionals of the hospital who saw no need to justify their actions to management. Professionals refused to be accountable to the budget. Management was seen as an illegitimate force of occupation, which could be legitimately resisted (Bate, 495-495, 2000). The third cultural problem was a "culture of conservatism." The hospital is a bureaucracy and therefore is designed for stability not flexibility. The healthcare professionals of the bureaucracy refused to adapt and incorporate management into their

organization (Bate, 506, 2000).

Through group discussions Bate and fellow researchers helped hospital staff define a new vision for their culture. This new vision was a networked community defined by a "culture of sharing," culture of "accommodation," and a culture of "flexibility" (Bate, 502, 2000). The two rival hierarchies, management and the professionals, were combined into a partnership of hierarchies.

The hospital culture described in this study gave me ideas of social issues that hospitals in general might face. I used this study as a source for some issues to focus on when exploring social issues at Fort Sanders. This study made me realize that power can be a dominant force in the hospital culture. It showed me that power could be a divisive force between management and healthcare professionals at a hospital. Power could also be a divisive force between professionals. This study made me recognize the need to explore power dynamics at Fort Sanders.

CHAPTER 3

ISSUES OF SOCIAL JUSTICE AT FORT SANDERS MEDICAL CENTER

Introduction

My senior thesis for the University of Tennessee's honors program is a service learning for social justice project where I focused on exploring social issues within a hospital, Fort Sanders Regional Medical Center by volunteering in the ER. There are two aspects to the exploration of social issues within a hospital- the patients' side and the hospital's internal community. Patient cases represent community social issues that the hospital as a community organization faces. The hospital's internal culture describes the social issues within the hospital. A service learning project at a hospital is an educational experience that allows students to gain an understanding of the social issues affecting their community. The hospital is a representative microcosm of the community.

Orientation

My first volunteering experience was in the fall of 1999, for my service learning class, and then I continued volunteering this semester, spring of 2001, for my senior honors project.

Before starting to work in the hospital environment all volunteers are required to attend an orientation session at the hospital. The first orientation I attended was held on Tuesday Oct 5, 1999. This session began with a demonstration of how to use a wheelchair and transport patients safely. The key to transporting patients safely is to wheel them slowly, watch ahead and maneuver corners carefully. When a patient is taken on an elevator they should be backed onto the elevator so they are not facing the back wall during the ride. In addition if a patient is to get out of a wheelchair or onto one, the lock should be in place. To protect our backs during patient transport we should get into the proper position, which was outlined. We were taught how to use a fire extinguisher

and to report a fire if we observed one. We were also shown the various code signals, which are used to identify various emergency situations. There are police on the hospital grounds at all times and volunteers who come late at night were advised to take an escort policeman/woman with them for protection in the parking garage. The third section was infection control and the primary point stressed was hand washing and how it can reduce the spread of germs significantly. In addition protective wear such as gloves and a protective mask can be worn to prevent the transmission of disease. We were told that during our first day volunteering we would be assigned a mentor who would train us in needed skills. Another important aspect of volunteering is accepting the rules of confidentiality. There are many legalities involved in the field of health care and patients have the right to withhold information. Therefore as volunteers we should not talk about incidents in the ER. Even when notifying family members of the situation it is up to the patient how much information we can provide.

The head of the ER nursing department also spoke to us about the ER volunteer program. There were two volunteering positions created to facilitate patient care in the ER. One position is the Care Partner whose job description included stocking patient's rooms and cleaning after examinations, providing the "human" aspect of the patient care with emotional support and comfort, serve as a liaison to the family, help in minor procedures, deliver specimens to the lab, transport patients, and assist with any other needed tasks. The Service Partner would be involved in more clerical duties. They would greet patients, serve as a liaison to the family, direct patients, care for pediatric patients by providing coloring books and toys, answer the telephone, and file records. During

most shifts there were going to be at least two volunteers in the ER so they could decide which position they would like to take; either at the front or in the back of the ER.

The orientation session held for this semester was much shorter than the first one I attended. The same background and safety information was provided. However, the volunteer coordinator said this semester volunteers could only work in the ER. Also the coordinator made it a point to avoid having more than one volunteer scheduled in the ER at a time. Also no volunteer positions were described. On the whole the volunteer program has become a little less formal than it was the first time I volunteered.

Volunteering

During my first volunteering experience I volunteered a total of 23 hours for the semester and worked 4hr shifts on Saturday mornings from 9am-12am. I had a friend in the class who was also a pre-med student and we both volunteered at Fort Sanders. My friend and I worked the same shift and so worked together and were able to compare notes and observations. On the first day I went in and followed a medical technician around. He showed me how he draws blood and takes an echocardiogram (ECG) on patients. The first day I basically walked around the ER and helped wherever I could. When I began volunteering the ER was still under renovation and there was no receptionist working since the receptionist's desk was inaccessible. The triage nurse was alone in the waiting room and had to do her job and that of the receptionist, getting people signed in, so I helped her. I would greet people who came in and also help people with directions within the hospital. If a patient came in I would ask them to sign in and fill out a slip with their name and SS# which the triage nurse took from them when she saw them. My major responsibility, which kept me on my toes, was to serve as a liaison

between the patients' families and the patients. For example, when people came in looking for a particular friend or relative I would hurry to the back and look at the board to see if the patient was in a room. Then I would ask a nurse if the patient could get visitors, if they could I would bring the person to the patient's room. After the first three volunteering days; however, there was not a lot of work for us volunteers to do. We were left cleaning beds and changing the sheets on beds once patients had been discharged. We also went around to the various rooms and refilled glove boxes. The Care Partners, a paid position with the duties described during orientation, and the medical technicians however shared these jobs with us.

This semester I worked on Friday afternoons from 1230-430pm. On the first day of volunteering I had one other volunteer working with me. A patient care advocate gave us an ER orientation. She showed us around and even showed how to take a patient's temperature and blood pressure. Under the supervision of this PCA we got to check the vitals on a patient. Our job included cleaning beds once patients had been discharged. We also put in new glove boxes in rooms that were running low and replaced full linen bags. Twice this semester I went to the medical records office to bring a particular patients' chart to the ER. Most of the time we followed the PCAs on duty and tried to help them transporting patients or restocking supplies.

The ER at Fort Sanders

During my first volunteering experience at Fort Sanders the ER had just been remodeled and a new system was being implemented. Originally when a patient entered the ER they would go to a receptionist at the front desk and provide personal and insurance information. Then they would be called in by the triage nurse and examined in

a separate room. In the new system the triage nurse had a desk right near the entrance and examined patients as they came in. The waiting room also had a desk behind which the receptionist sits. The receptionist makes sure that each patient signs in and fills out a slip with their name and social security number. This slip would be given to the triage nurse when they saw her and the triage nurse would give this to a secretary to begin the registration process. Later the patient, or their family, could provide a secretary with personal and insurance information.

This was an important change, as with the triage nurse right in the waiting room she would know what cases need to handled first. The triage nurse has an important responsibility to separate patients according to the level of their need. The Fort Sanders ER consists of an area for non-emergency care, an intensive care unit and 10 rooms for emergency care. One of these rooms has a camera in it and is kept for psychiatric patients or violent patients. The camera is connected to a TV screen on the nurse's station. The nurse's station is a central area with computers and desk space. Doctors and nurses fill out charts here and secretaries' work on inputting information into the computer and doing paper work on patients. The nurse's station also serves as a place where nurses and doctors and other medical staff can interact. In addition to the 10 emergency rooms there are two additional rooms, which are isolation rooms with special circulatory systems. The positive isolation room is for patients with breathing problems while the negative isolation room is for patients with infectious diseases and ensures that the air from the room is not recirculated so other ER patients are not exposed.

Another change being implemented at that time was the computerization of the ER. New large televisions were installed throughout the ER, which were connected to the

computer terminals on the central desk (nurse's station), which the doctors and nurses could use to track patients. Previously a dry erase board was used to mark which room patients are in and which doctors and nurses are in charge of which patients. In addition the movement of patients was recorded. For example, if they are taken for an X-Ray the person who takes them puts the time he/she left, his/her initials, and the time they returned. At that time the staff were adjusting to the new system. At the time both the dry erase board and computers were used together. The ER keeps a goal of getting ER patients discharged within 2hrs and this has been built into the computer system. Once a patient has been in the ER for an hour their names are highlighted in yellow and once they have stayed past 2hrs their names become highlighted in red.

This semester I noticed a few changes to the ER system. First the computer system has become fully integrated in the ER and even us volunteers can input information regarding our jobs into the ER. The computer indicates which rooms need to be cleaned and once we have cleaned then we can input this information into the computer. The board is not really used anymore. A corridor has been added between the waiting room and the inside of the ER. The corridor can be entered through a door that the receptionist can open for people. The triage room is the first room in the corridor. The next room is the office of the Care Coordinator. For the first time the hospital has hired a social worker for this position. The Care Coordinator is responsible for supplementing the medical care patients receive in the ER. The social worker helps patient receive the appropriate follow up care and gets them in touch with appropriate community organizations for problems they may be facing. The triage nurse brings patients back to her room and examines them and then takes them to the appropriate section of the ER.

Method for exploring social issues

I collected data by observation, informal interviews and discussions, taking field notes, and distributing a survey. I will be providing thick descriptions of my observations and experiences in the ER. There are two sides to explore when identifying social issues at a hospital. One is the patients' side, as the social issues affecting them are brought with them to the hospital. The second is the hospital culture, which defines social issues within the structure of the organization. I used my observations in the emergency room as a volunteer and surveys completed by healthcare professionals in the emergency department to gain a holistic perspective of social issues in the hospital culture. I distributed my surveys in the mailboxes of emergency room staff members. From the surveys returned I gained an internal perspective on social issues within the hospital culture.

Patients' cases

The patients coming into the emergency room are from the South Knoxville area and the Fort Sanders neighboring community. The registration department informed me that 50% of emergency room patients are on TNCare, 40% are on Medicare, and 10% have private insurance providers. TNCare, Tennessee's version of Medicaid, and Medicare are government-sponsored insurance for the poor and the elderly. This shows that most emergency room patients are either poor or elderly.

During my first volunteering experience I focused my attention on patient cases to understand the social issues encountered by emergency room staff. One social issue that the emergency department handles is the isolation of the elderly in our society. One particular elderly woman was a common patient who all staff recognized. The woman

would come in repeatedly throughout the year complaining of illness apparently because she wanted attention and companionship rather than because she was genuinely ill. The hospital staff were understandably somewhat annoyed with the woman because they need to devote their time and energy to real emergency cases. One day when I was working at the front desk an elderly woman came up to us and said she was feeling faint. I immediately helped her into a wheelchair and rolled her into the waiting room. Within about five seconds the woman got up, went outside, had a smoke and came back and sat down in the wheelchair. Another elderly gentleman entered the emergency room asking for directions to a particular floor. Walking him to the area I noticed his vision was impaired and he told me that he was almost blind as a result of an illness. The next day the same man entered the emergency room and basically asked for someone to help him to the floor. I told him I could take him to the same place. This case is reflective of a serious problem in our society where elderly people, like this man, have no family to support them and must rely on the help of strangers. I asked the emergency room social worker what is usually done with elderly patients who frequent the emergency room for some attention or in cases of neglect? If neglect is suspected she usually speaks with the person to find out what the family situation is like. She could also call a relative and talk to them. If they are being neglected and need to be cared for the social worker serves as a liaison between patients and appropriate community agencies. The ER social worker also described other patient cases that bring social issues into the emergency department such as abuse and rape.

Another social issue is handling drug addicts who come to the hospital for drugs or come when they have overdosed. One day when I was helping in the non-emergency

area a man came in who said he had broken his hand an hour earlier. The physician's assistant checked him and told me that it was obvious the man had come here for a pain medication, which he was addicted to. The X-Ray of his hand indicated the injury was an old one that was already healing. Another clear sign was the fact that he claimed he was allergic to all pain medications except for the most powerful one. The P.A. told him that she could not prescribe such a strong medication for an injury which had almost healed. The man claimed he desperately needed it for the pain and finally got mad and left. In the emergency room medical dispensing is done through a computerized machine in which staff enter a security code, patient information, and the dosage of the drug they need. This machine makes drug dispensing safe from abuse by both ER staff and patients.

Another issue I felt was important was that of patient privacy. During orientation volunteers were told to maintain patient confidentiality by not discussing individual's medical cases. However within the ER often patients have little privacy. Hospital staff encourage us volunteers to go into rooms and watch procedures. Often technicians or patient care advocates allow us to follow them around and observe procedures they perform on patients. I can't help putting myself in the position of the patient who could not be comfortable with observers. When we go into a room with a staff member they usually introduce us as premed or pre-nursing students, depending on what the volunteers are, however the patients are not asked whether they would feel comfortable having observers. I feel people should be asked first and then if they are comfortable we can come and observe. Often when they are told that we are premed students they feel obligated to let us watch. Sometimes after talking to them some more we realized they thought we were actually medical students.

Hospital Culture

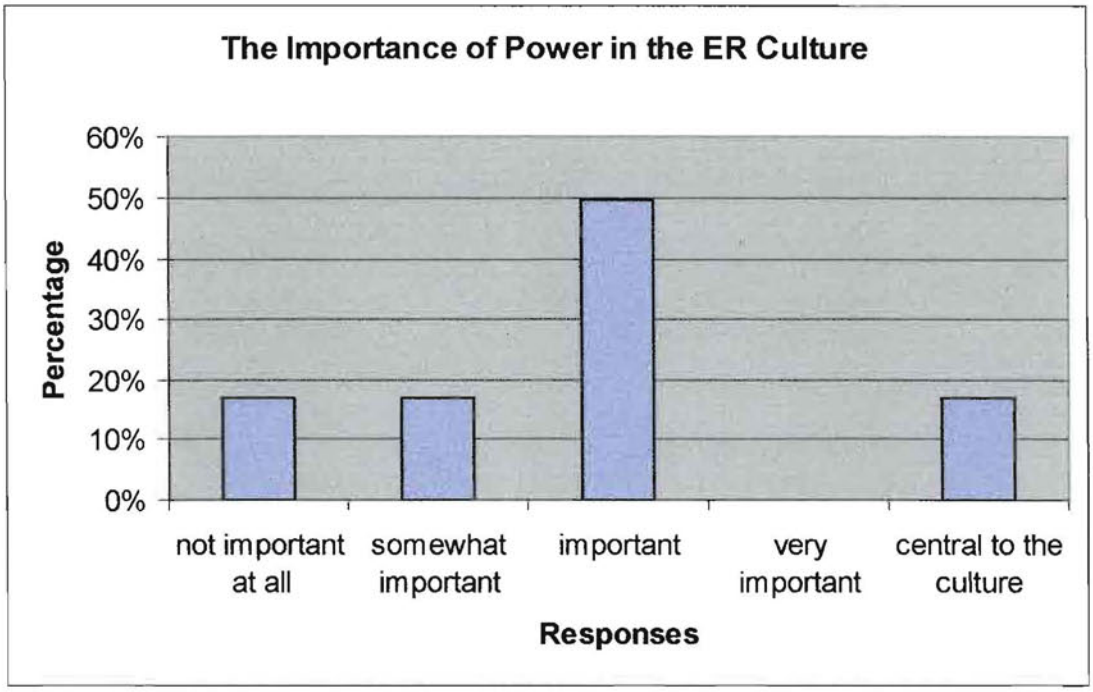
To explore the hospital culture in general and issues that sometimes arose at Fort Sanders I observed the situation during both of my volunteering experiences. There is a clearly defined hierarchy within the ER. However staff collaborate together as a cohesive unit working towards their mutual objective- providing patients with quality care. Conflicts I observed between staff members were minor and due to personality differences rather than representative of cultural problems.

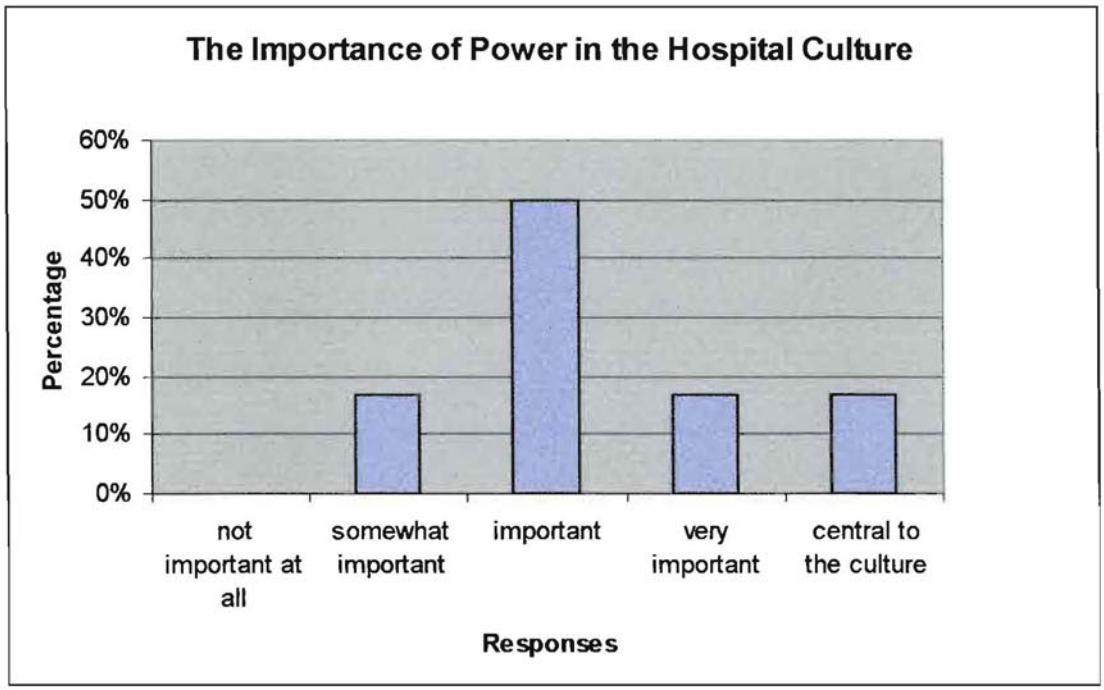
Before discussing the hospital culture let me describe the gender and ethnic variation among ER staff as it relates to positions. All the doctors in the emergency department are males. There are both male and female nurses in the department. The only ethnic minorities I have seen are one African American doctor and two African American receptionists. Although the emergency department is not diverse, when the hospital is taken as a whole, it does have diversity. During the period I first volunteered at Fort Sanders the medical technicians were mostly males. Most of the medical technicians were premed students who were spending a year gaining medical experience while they waited on getting medical school admission. This semester the patient care advocates have duties similar to those of the technicians and there are an equal number of males and females.

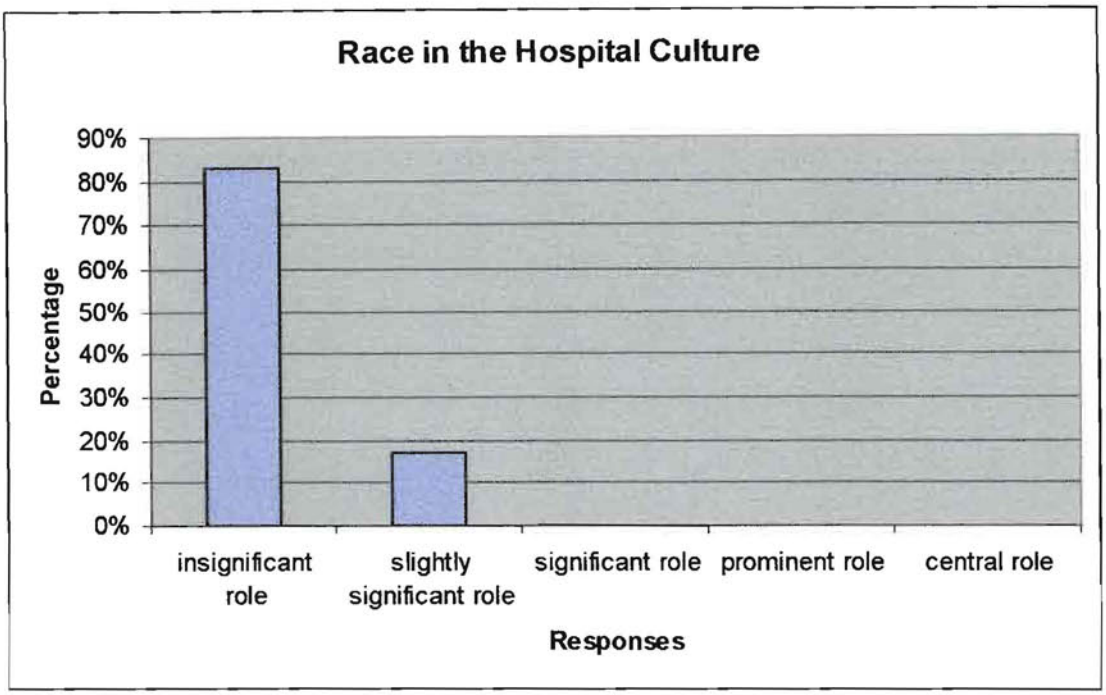
The survey I gave ER employees is provided in Figure 1. My survey was designed to explore social issues of power (including its expression as departmental territorialism and its role in management's relationship with the healthcare staff), gender, and race. The survey also addressed the social issues the hospital faced as a result of managed care in the healthcare industry. The responses are graphically represented in

Figure 2. All of the responses I received were from nurses in the emergency department. 50% of the respondents felt that power was important to the culture of the emergency room. 50% of the respondents also agreed that power was important in the hospital's culture. One nurse said, "we have to be authoritative at times and feel comfortable handling it." This response helped me understand the complexity of power in the hospital culture. Commonly identified power dynamics are usually those between doctors and nurses; however, healthcare professionals have a power dynamic with their patients. Often healthcare professionals are not completely comfortable with telling others what to do. One nurse responded that, "power gets in the way. Many of those assisting our manager don't understand the responsibility that comes with power." This shows that the culture does have a division between healthcare providers and management.

FIGURE 1


The Importance of Power in the ER Culture
60%
50%
40%
30%
20%
10%
0%
Percentage
not important at all
somewhat important
important
very important
central to the culture
Responses


The Importance of Power in the Hospital Culture
60%
50%
40%
30%
20%
10%
0%
Percentage
not important at all
somewhat important
important
very important
central to the culture
Responses


Race in the Hospital Culture
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Percentage
insignificant role
slightly significant role
significant role
prominent role
central role
Responses

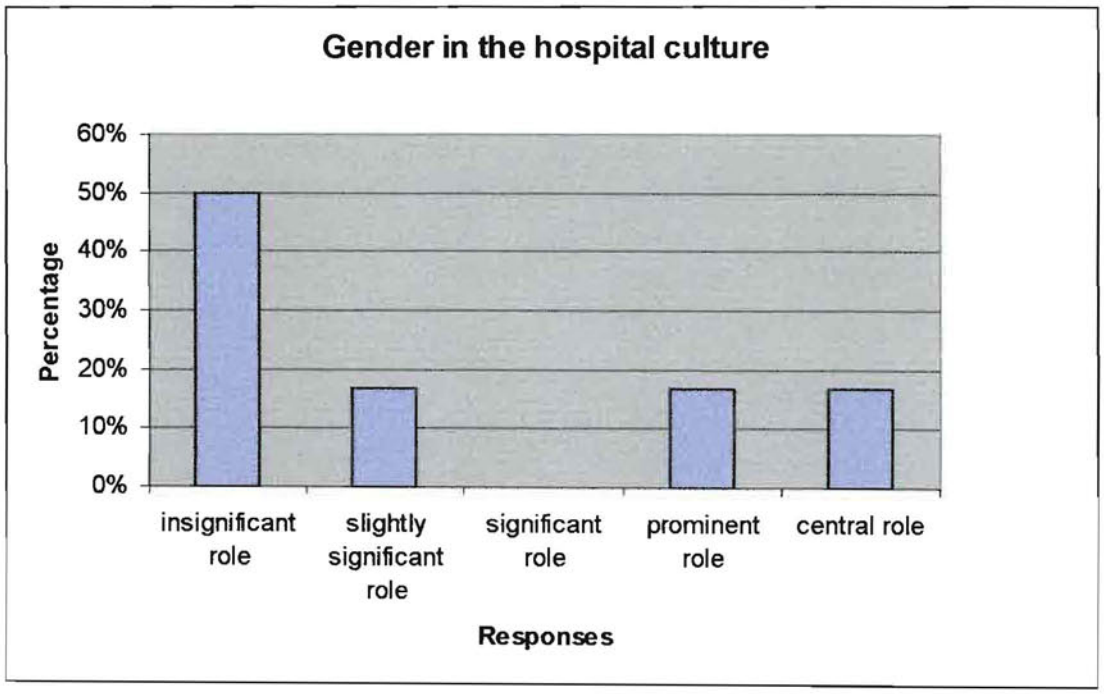

Gender in the hospital culture
60%
50%
40%
30%
20%
10%
0%
Percentage
insignificant role
slightly significant role
significant role
prominent role
central role
Responses

FIGURE 2

Hi my name is Sunaina Dowray and I am a volunteer at the hospital. I am doing a service learning project on social issues within the hospital. This questionnaire deals with the hospital culture here at Fort Sander's. I would really appreciate your input.

Thank you, Sunaina

Position within the hospital_____

1. How important do you feel power is in the culture of the ER?

1	2	3	4	5
not important at all	somewhat important	important	very important	central to the culture

How important do you feel power is in the culture of the hospital as a whole?

1	2	3	4	5

If you answered 2 or higher could you briefly explain the role you feel power has?

2. How much of a role do you feel race has in the hospital culture?

1	2	3	4	5
insignificant role	slightly significant role	significant role	prominent role	central role

If you answered 2 or higher could you explain the role you feel race has?

3. How much of a role do you feel gender has in the hospital culture?

1	2	3	4	5

If you answered 2 or higher could you briefly explain the role you feel gender has?

4. Do you feel that there is territorialism between departments in the hospital culture or do you feel the hospital works as a unified team to a common purpose?

5. How would you describe management's relationship with the healthcare staff?

6. Do you feel managed care has an overall +/- role on the healthcare industry? Working in the ER have you seen these effects?

83% of respondents felt that race had an insignificant role in the hospital culture. One nurse felt that race was slightly significant in the culture as, "Most races other than Caucasian usually have minimum wage jobs." It would be hard to determine the exact role of race. Although the survey shows a majority agreed it was not important it should be noted that a majority of the staff are not ethnic minorities.

50% of respondents felt that gender had an insignificant role in the hospital culture. One nurse who felt the role of gender in the hospital culture was significant said, "Males still dominant." Another nurse who felt gender had a central role in the culture responded, "Males have more power."

All respondents agreed that there was territorialism in the hospital culture. Some departments were identified as being particularly territorial and refusing to share resources when needed. I observed this territorialism when I went with a PCA to find some wheelchairs. The nurses in one particular department were quite rude about assisting us in finding a wheelchair. One nurse commented, " Some departments are definitely territorial and refuse to bend to meet any need." At Fort Sanders there is clear territorialism between certain departments for resources.

Concerning management's relationship with the healthcare staff one nurse felt there was a positive relationship. All other respondents characterized it as needing improvement from management's side. I did hear from one nurse that management was taking some efforts to involve healthcare staff in their decisions. One nurse said, "Higher management seems unaware of what they ask in order to get the job done. Sometimes they don't have a clue about what is really going on. They are beginning to learn that power needs to be with the people because they have good ideas and once they see us as

mature adults able to make decisions, and act as such, things will improve." Other responses characterized managements as "negative," "distant," and "patronizing."

All respondents described managed care as having a negative impact on the healthcare industry. The ED seems to face the brunt of these negative consequences. Many patients use the emergency room as a primary care provider. As one nurse said, "Yes many people have no one to manage them so they come here or they have a PCP who is totally overworked and tells them to come to the ED." Another nurse responded, "A negative impact. We provide primary non-emergent care for a great number of patients who have no PCP assigned or can't get a follow up."

Social Work

Since its inception social work has been involved in healthcare by working to improve environmental conditions. The social worker complements the medical care the hospital provides by helping patients with environmental and psychological problems (Fort Cowles, 129-130, 2000). Since the purpose of my service learning project was to explore social issues at a hospital I talked with the emergency room Care Coordinator. The social worker's main responsibility is to help ER patients get the follow up care they need such as getting appointments with appropriate specialists. The social worker also has a duty to help patients with their social problems by guiding them to the appropriate community organizations. The social worker maintains close ties with organizations in the community so they can get the patients the best support.

At Fort Sanders patient cases can be referred to the social worker by doctors/nurses. This is considered an "open referral system." Jackie Pray conducted research on physicians' views on what cases need to be referred. Pray found that

physicians were more likely to refer cases where the patent had problems like a need for follow up care, transportation, or financial help. However, Pray found that physicians were often unaware of "affective-expressive problems revolving around attitudes, feelings, or behaviors related to health" (Fort Cowles, 142, 2000). This could be representative of Fort Sanders but I was not in a position to ascertain this.

The ER social worker feels her job is not to solve people's problems but to educate patients so they can help themselves. Empowering patients can often be a matter of educating them about their rights under TNCare, a state sponsored insurance program for the poor. By educating patients of their healthcare rights the ER social worker helps people take control of their own healthcare. The social worker feels that TNCare abuse cases are a social problem in the emergency room. She has worked with patients who had to wait for needed medical procedures.

TNCare

January 1, 1994 marked the beginning of TNCare, a statewide managed healthcare reform program. The old Medicare program was replaced with TNCare, which consisted of nine health maintenance organizations under a contract to the state (http://www.state.tn.us.commerce/tncardiv.htm). The healthcare professionals in the emergency department and the emergency room social worker share the opinion that TNCare needs reform.

SICK (Solutions to Issues of Concern to Knoxvillians) is a local organization that focuses on helping the poor and fighting for causes that affect them. Their summer 1996 newsletter described a workshop they held on educating people of their rights under TNCare. During the workshop a general discussion on healthcare issues took place. SICK

gave people surveys to assess how well their health care needs were being met. The survey showed that 85% of pregnant women had not seen a doctor for prenatal care. The newsletter contained a section outlining the procedure for people to communicate grievances to TNCare. TNCare rules on premiums, experimental services, and grievance procedures were up for public comment at the TNCare Bureau in Nashville in March 1996. SICK members and TNCare enrollees went to Nashville to testify. Tony Gar, director of TN Health Campaign, feels that the term "experimental services" is used by TNCare to describe anything they do not cover. He says that TNCare is making more decisions on what treatment is medically necessary rather than letting physicians determine this (SICK Newsletter, Summer 1996). SICK is an important community organization in its direct approach to empowering the poor. Information is a powerful tool. The poor are learning what they can demand of TNCare to ensure their needs are met.

Conclusion

For my service learning for social justice project I volunteered at a hospital. This service learning experience was valuable allowing me to gain practical skills in assisting in the ER and gain an understanding of the structure and organization of a hospital and an ER. I focused on actively exploring social issues in a hospital through observation and investigation. Social issues observed through patient cases included the isolation of the elderly and drug abuse in our community. Another social issue is providing healthcare to the poor. Most healthcare professionals agree that TNCare fails to meet the healthcare needs of the poor. In exploring the hospital culture I observed staff and their interactions. I gave staff surveys and used the representative sample of completed responses I received

to gain an internal perspective on the culture. I found that a majority of ER staff felt that power was an important part of the ER culture and that of the hospital as a whole. In a hospital, which operates on a hierarchy, it is not surprising that power was identified as a dominant force in the culture. One hospital department was recognized as being highly territorial with its resources. Most felt that management had a lot of progress to make in involving healthcare professionals in its decisions rather than commanding them. Most ER staff also felt that managed care had hurt the healthcare industry and that working in the ER they faced the brunt of these negative effects as patients come to them for primary care. Interviewing the ER social worker I learned of the importance of a social worker in the hospital in helping the organization help patients with social problems.

The hospital is an organization highly involved in the community. Patient cases involve hospital staff in community social problems. The hospital's culture is separate from the community but its internal social issues of power, race, and gender are issues present in the cultures of most communities.

Service learning has been a beneficial experience in allowing me to gain practical experience in the medical field, which I can use to make an educated decision about becoming a physician. I was able to view the internal structure of the hospital in its day-to-day practice. Service learning for social justice is an effective method for students to gain a realistic perception of the organization they are working with and gain a realistic perception of the social issues in their communities.

REFERENCES

Bate, P. (2000). Changing the Culture of a Hospital: From Hierarchy to a Networked Community. *Public Administration*, 78(3), 485-512.

Benson, L., & Harkavy, I. (1996). Universities, Colleges, and their Neighboring Communities. *Universities and Community Schools*, 5(1-2), 5-7.

Cassens, B.J. (1992). Preventive medicine and public health (2nd ed.). Baltimore: Williams & Wilkins.

Claus, J., & Ogden, C. (Eds.). (1999). Service Learning for youth empowerment and social change. New York: P. Lang.

Fisher, S. (1993). Fighting back in Appalachia: Traditions of resistance and change. Philadelphia: Temple University Press.

Fort Cowles, L.A. (2000). Social Work in the Health Field. New York: The Haworth Press.

Harkavy, I. (1997). The Demands of the Times and the American Research University. *Journal of Planning Literature*, 11(3), 333-335.

Levi, J. (2000). Managed Care and Public Health. *American Journal of Public Health*, 90(12), 1823-1824.

Matthews, D. (1997). The Public and the Academy. *Higher Education Exchange*, 71-78.

Scott, J.S. (2000). Thank you, managed care? *Healthcare Financial Management*, 54(12), 26-27.

Snook, D.I.Jr. (1992). Hospitals What They Are and How they Work (2nd ed.). Gaithersburg: Aspen Publishers, Inc.

Stanton, T.K., Giles, D.E.Jr., & Cruz N.I. (1999). Service Learning. San Francisco : Jossey-Bass Publishers, xii-xiii.

Taylor, H.L.T.Jr. (1997). No More Ivory Towers: Connecting the Research University to the Community. *Journal of Planning Literature*, 11(3), 329-330.

BIBLIOGRAPHY

Bate, P. (2000). Changing the Culture of a Hospital: From Hierarchy to a Networked Community. *Public Administration*, 78(3), 485-512.

Benson, L., & Harkavy, I. (1996). Universities, Colleges, and their Neighboring Communities. *Universities and Community Schools*, 5(1-2), 5-7.

Bringle, R.G., Games, R., & Malloy, E.A. (1999). Colleges and Universities as Citizens. Boston: Allyn and Bacon.

Brown, N.C. (1997). Reinventing the Research University for Public Service: Comments and Observations. *Journal of Planning Literature*, 11(3), 320-322.

Cassens, B.J. (1992). Preventive medicine and public health (2nd ed.). Baltimore: Williams & Wilkins.

Checkoway, B. (1997). Reinventing the Research University for Public Service. *Journal of Planning Literature*, 11(3), 307-319.

Claus, J., & Ogden, C. (Eds.). (1999). Service Learning for youth empowerment and social change. New York: P. Lang.

Eyler, J., & Giles, D.E.Jr. (1999). Where's the Learning in Service-Learning. San Francisco: Jossey-Bass Publishers.

Feld, M.M. (1997). One Invention-HUD's Office of University Partnerships-And One Pervasive Problem. *Journal of Planning Literature*, 11(3), 323-326.

Fisher, S. (1993). Fighting back in Appalachia: Traditions of resistance and change. Philadelphia: Temple University Press.

Fort Cowles, L.A. (2000). Social Work in the Health Field. New York: The Haworth Press.

Harkavy, I. (1997). The Demands of the Times and the American Research University. *Journal of Planning Literature*, 11(3), 333-335.

Levi, J. (2000). Managed Care and Public Health. *American Journal of Public Health*, 90(12), 1823-1824.

Matthews, D. (1997). The Public and the Academy. *Higher Education Exchange*, 71-78.

Reardon, K.M. (1999). A Sustainable Community/University Partnership. *Literal Education*, Summer, 20-25.

Scott, J.S. (2000). Thank you, managed care? *Healthcare Financial Management*, 54(12), 26-27.

Snook, D.I.Jr. (1992). Hospitals What They Are and How they Work (2nd ed.). Gaithersburg: Aspen Publishers, Inc.

Stanton, T.K., Giles, D.E.Jr., & Cruz N.I. (1999). Service Learning. San Francisco : Jossey-Bass Publishers, xii-xiii.

Taylor, H.L.T.Jr. (1997). No More Ivory Towers: Connecting the Research University to the Community. *Journal of Planning Literature*, 11(3), 329-330.

Wade, R.C. (Eds.). (1997). Community Service Learning. New York: State University of New York Press.