BURRITO

Join Luh, MD

The burrito is a core breakfast staple in Galveston, Texas. While I was growing up, there were several competing families with their own take on the breakfast burrito. *La Estacion* (still in business and serving the city/county employees across the street from the courthouse) had, and still has, the "Surprise Burrito." At the former *Tacqueria Juarez*, it was the "Special Burrito." At The *Donut Shop* (donuts are not their forte), it is was, and still is, the "Bronco Burrito." At *El Nopalito*, it was the "Nopalito Burrito." And these were available in Galveston before I moved to San Antonio for medical school.

It was in San Antonio that there was a change in culinary culture. The folks in San Antonio didn't do breakfast burritos. San Antonians eat breakfast tacos. Burritos are considered a lunch item. I was introduced to *Taco Cabana* [1], a casual Mexican food franchise, that started as a family business in San Antonio, and is now a major multi-state franchise. Although *Taco Cabana* went public with its first stock offering in 1992, it still had that mom- and- pop feel when I started med school in 1994. Chris, a San Antonio native who I befriended early on, introduced me to *Taco Cabana's* 99 cent bean and cheese burrito--a large filling burrito with refried beans, shredded cheese, shredded lettuce, and chopped tomatoes. It was very nourishing, and I would make it a practice to purchase at least five on a Sunday. In between cold cereal and ramen noodles, I would be adequately nourished for the week. If I wanted to splurge, there was the *Burrito Ultimo*, that for three bucks more, would include beef or chicken fajitas, sour cream and guacamole. When dining in, Chris advised me to always ask for an extra tortilla, so that I could use some of the contents of the first burrito to make another one--giving me the feeling that I was actually eating TWO burritos.

In 1996, the year I started my 3rd year of med school, corporate decisions by *Taco Cabana* were made that affected the bean and cheese burrito and other items on their menu. I experienced the effects of this one evening when I was getting two bean and cheese burritos to go. My plan was to

enjoy one burrito on site (where I had unlimited access to four varieties of salsa and two varieties of pico de gallo), and take the other with me to enjoy later when I got hungry. To my chagrin, the burrito literally contained only beans and cheese. The cheese was melted processed cheese, not the fresh grated cheddar cheese I was used to. The lettuce and tomatoes were obviously missing. Interestingly, *Taco Cabana* didn't do anything to the Burrito Ultimo, with the exception of the use of processed cheese. The end result was that I gave up on the bean and cheese burrito (I was too cheap to get the Burrito Ultimo on a weekly basis) and started using my slow cooker more.

Consolidation, corporatization, regionalization, centralization, and private equity are all terms that we've been hearing a lot more of. We saw it happen to K-mart and Sears when they got into financial trouble. Customer service tanked as everything got centralized – including local scheduling. If I bought an appliance, I had to go through the national scheduling system to book an appointment for a service person to show up at my house within a six-hour window. Even the managers at the stores complained about lack of support, lack of adequate inventory, and lack of authority to fix issues locally. Customers stopped shopping there. Profits dropped and ultimately they no longer exist in Humboldt. In and of itself though, corporatization/consolidation of struggling businesses is not necessarily a bad thing. It allowed Sears and K-mart to stay in business for a bit longer. It would have been ideal if those at the top of the vertical integration ensured that there was adequate inventory, and that local managers were given the authority to fix infrastructure issues instead of having to get everything approved by layers of bureaucracy.

You know this is going to lead to a healthcare parallel. The ability to call a doctor's (or ahem, radiology) office, getting a live person to answer the phone, and being able to schedule an appointment, seems to be a patient experience from a bygone era. Instead, we are now forced to listen to automated messages with that all too familiar, "...if this is a medical emergency, please hang up and dial 911," followed by the need to navigate through a complex phone tree. And then when you

finally reach someone, you may only be able to leave your name a phone number, and told that someone will call you back. Then you may never hear back. And we know why. There are not enough front office staff, scheduling staff, technologists, medical assistants, unit clerks, and yes, even cafeteria cashiers. With this barrier to entry, many patients just go without healthcare – kind of how I just gave up the bean and cheese burrito. However, the consequences of giving up healthcare is much more serious than giving up weekly bean and cheese burritos.

The fact that *Taco Cabana* didn't mess with the more expensive Burrito Ultimo means they wanted to retain this product, and they certainly didn't want to upset the customers with more cash who could afford the Burrito Ultimo. *Taco Cabana* didn't care about the bean and cheese burrito crowd, of which I was a member – we had less money to spend. But bean and cheese burrito customers will occasionally splurge on a Burrito Ultimo. And so it goes with medical specialties. Our country's health system protects and funds the resources afforded to those departments that perform high revenue-generating procedures, not the ones that are involved with long term, chronic care that are heavy on coordination and counseling (without realizing primary care feeds the specialties – both can thrive). Because of this, many patients get a lot of specialty care, but very little primary care – leaving the patient responsible for synthesizing all the specialty care they get. With patients having difficulty figuring out the labyrinthine scheduling process, prescription refills, and high medical bills from insurance denials and high deductibles, it's no wonder why we need patient navigators – something I never heard of until the 21st century.

But it doesn't have to be that way.

The tumultuous changes taking place within the Providence system may offer a glimmer of hope that the system is changing its tune. Over the past month, our physician community received multiple organizational announcements. Providence St. Joseph Hospital Eureka lost its CEO, CMO, CFO and CNO. The Providence Northern California Region lost its COO, CMO, CQO (Chief Quality Officer),

director of cardiac and vascular care, and senior manager for urgent care centers. An announcement from Providence's Northern California Region's CEO Laureen Driscoll stated, "the changes we are announcing at this time mostly affect administrative regional functions, and will reduce redundancy, move accountability and decision-making closer to patient care..."

Providence's CEO Rod Hochman, MD, said that the new model of operation, "... will simplify our administrative and shared services leadership structure and concentrate resources on patient care."

Could this mean that support staff, clerks, medical assistants, lab techs, etc will be recruited, retained, and treated well so that they can support the physicians who depend on them, thereby increasing productivity and timely patient care? Could this mean that when patients need to schedule an imaging study, they can do so locally without playing phone tag with our current dysfunctional regional scheduling system? Would this mean that a clinic manager would be able to replace a broken fax machine without having to seek approval from multiple levels? Could this mean that local recruitment of physicians and staff can be done by people who know our community and not by someone in Seattle who has a conflict of interest in trying to recruit for ministries in the Seattle area? Would it mean that clinics in Humboldt can have the flexibility of offering better salaries (instead of being stuck with lower Southern California salary standards) to front desk staff, scheduling staff, and scribes so they don't run off to become bank tellers for a few more bucks per hour?

In other words, would the *Taco Cabana* at the corner of Fredericksberg and Wurzbach Rd, be able to put the lettuce, tomatoes and real shredded cheese back into their bean and cheese burritos?

In the end, it's the doctors, nurses, and patient-facing technologists/staff who care for and save the lives of patients. They are also the ones generating revenue for the hospital, unlike the C-suite who consume revenue and have developed the reputation of cutting the resources of the very people who help pay their salaries. You want a doctor to see more patients? Make the doctor's

documentation and ordering requirements highly efficient with as little clerical burden as possible (that's what the unit clerks and MA's are for). There is absolutely no reason why a physician should have to devote two extra hours in front of a computer for every hour spent in front of a patient [2]. You want to stop out-migration of radiology services? Restore local scheduling with enough staff to actually answer the phone. Invest in the MRI and PET/CT technologies that will pay for themselves in just a couple years.

The lettuce, tomatoes, and real shredded cheese are the unit clerks, techs, and MA's. Taco Cabana was generous with their lettuce and tomatoes (much to my enjoyment and nourishment) before corporate interests took over. The ancillary staff are critical to a hospital's operations and we need a lot of them. Only until we restore them, treat them well so that they can be retained, and abandon the mindset of always cutting resources, will we be able to rebuild our local health system to actually serve the needs of our community.

NOTES:

1. https://en.wikipedia.org/wiki/Taco_Cabana, retrieved August 21, 2022.

2. Sinsky C, Colligan L, Li L, Prgomet M, Reynolds S, Goeders L, Westbrook J, Tutty M, Blike G. Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. Ann Intern Med. 2016 Dec 6;165(11):753-760. doi: 10.7326/M16-0961. Epub 2016 Sep 6. PMID: 27595430.