FROM THE EDITORS' DESK

Cultural Influences on Primary Care Delivery

Malathi Srinivasan, MD

Department of Medicine, University of California, Davis School of Medicine, Sacramento, CA, USA.

J Gen Intern Med 31(11):1265–6

DOI: 10.1007/s11606-016-3852-6

© Society of General Internal Medicine 2016

The elderly patient and her son walked together into primary care clinic, scoliosis obvious and painful with each step. I sat in a corner, quietly observing. In just 5 min, the patient's doctor listened carefully, performed a focused physical, reviewed her films with her, empathized, and clarified. Smiling, he reviewed expected improvement, and prescribed physical therapy and non-opiate pain medications. She nodded, asked a question, and expressed relief. All were satisfied with the outcome. For 2 min, the physician charted a brief note, including his exam findings. He was done. The next patient entered the room, brought in by the nurse.

This Japanese patient was seen in a primary care clinic in a rural outreach area on the southern edge of Kyushu Island, over an hour from the nearest hospital. Her doctor this day was an emergency medicine physician who now practices primary care at the clinic three times a week.

Dr. Paul Batalden famously stated, “*Every system is perfectly designed to get the result it gets.*” Cultural expectations for clinical care and population needs have created dramatically different primary care systems in many parts of the world.

Unlike the North American 15–30 min clinical encounter, Japanese physicians and patients have brief, focused and frequent encounters that typically last 3–6 min. These visits have minimal preamble, with both parties expecting the other to focus on the major point at hand. In that context, a major university hospital may see 3000 outpatients in a single day. The majority are walk-in appointments, managed with a ticketing system, like a national museum timed entry. Home visit reimbursement has led to better primary care for the chronically ill and homebound, as physician and nurse teams visit vulnerable patients in their living rooms and kitchens. Japanese physicians may routinely switch specialties—driven by curiosity, population needs or economics—moving from surgery to critical care to primary care or another specialty, often without additional specialty-specific training.

Similar scenes unfold in other parts of Asia. In Shanghai, hundreds of patients wait patiently in an open area for a same day appointment at a tertiary hospital, with a vendor selling

water and juice to expectant crowds. They know that they might not be seen for hours, and have brought snacks and reading material. A Shanghai physician, in a day, will comfortably see 40–50 patients, while reviewing their charts and making quick thoughtful decisions. Patients are expected to engage in the recommended treatment plan.

Special problems arise in rural primary care sites in many developing nations. In Thailand, patients are happy to see new physicians practicing for a 2-year service internship in rural areas—mainly without supervision—as an alternative to no care at all. When the intern gets stuck, he might “crowd source” decision-making on physician chat sites, uploading films, EKGs and case scenarios for rapid second opinions. Core care is universally covered by government insurance, but diagnostic testing and expensive therapies are limited, so the wealthy take on private insurance as well. The comprehensiveness of care depends on an individual's insurance coverage.

In India, patients seek care from multiple types of primary providers, who are all valued. In a Southern Indian clinic, a homeopathic physician uses both allopathic and homeopathic remedies to treat her expanding patient panel. In the eight-bed outpatient/inpatient clinic that she built, she performs her own radiology and core lab testing. Nearby, a pediatrician turned family physician treats a fragile geriatric patient who speaks another language, translated by her family into English. People feel that disability is a normal part of aging, and many conditions go untreated—with underutilization of rehabilitation. Patients generally express that they feel deep bonds with their primary providers, defend them in conversations, and get to know them over time.

Certainly, these examples from observed clinical encounters don't represent the full spectrum of primary care services (or their unique challenges) within each country, but they do highlight some unique aspects of primary care in Asia. Developing an understanding of the values and choices that drive their care delivery puts our North American systems into sharp relief.

In North America, we value patient engagement and patient safety as core principles of patient-centered care. As such, North American systems are perfectly designed for longer, more detail-oriented visits, filled with deeper discussions, team-based care, and much more paperwork. Over the past several decades, the North American power balance has shifted between primary care physicians, patients, and health care teams/organizations. These shifts have empowered

patients, improved quality reporting, and have lead to new conflicts during some patient–physician interactions.

This month in JGIM, several authors explore issues related to care delivery in North America. Rhodes et al.¹ remind us that comprehensive primary care matters, and the case of the Pennsylvania Chronic Care Initiative (CCI), can lead to reduced inpatient admissions and cost savings. In this study, Rhodes explored outcomes of the 5-year CCI to provide coordinated, centralized primary care for high-risk Medicaid patients in the state of Pennsylvania. In their comparison of 96 CCI practices and 60 non-CCI practices, they found average cost savings of over \$4000 per patient, driven by emergency department (ED) visits reduced by 15 %, and psychiatric hospitalizations reduced by 41 %. Goodwin et al.² highlight the value of sound clinical judgment in cancer screening. Generally, patients with life expectancies of less than 10 years may not benefit from screening for sporadic age-related cancers. Goodwin demonstrated that older patients who were screened for cancer lived longer than those not screened—even when life expectancy tables based claims data considered them inappropriate for screening. Schonberg's³ capsule commentary on Goodwin's work convincingly argues that the relationship between the physician and patient has lead the physician to a deeper intuitive sense of the patient's true longevity.

In many cultures, patients are reluctant to share their problems in sticking with a chronic disease management plan with their physician. As such, when diseases are uncontrolled, physicians escalate treatment, as opposed to providing adherence-related counseling. In a randomized controlled trial, Kronish et al.⁴ illustrate how good data can help. Patients with hypertension above goals used a four-compartment pill box that recorded (and transmitted) lid opening when they took their medications. Only 59 % of patients were adherent to their medication regimen over 80 % of the time. Physicians who received adherence-related information were more likely to appropriately escalate therapy or counsel (69 % vs. 34 %). Similarly, Herzig et al.⁵ show that when patients are readmitted to the hospital after discharge within 30 days, their inpatient and outpatient physicians were able to identify mainly patient-related factors that impacted their health (such as adherence and understanding of their condition). For any individual patient, these physicians disagreed on the exact cause of health deterioration, pointing to opportunities in

knowing patients lives more deeply, especially in a health care system that values patient engagement.

Even within different regions of the United States, care delivery varies dramatically. This month in JGIM, Clough et al.⁶ show that Medicare patients access specialty care quite differently across the nation, with a 1.5–3.9-fold difference in specialty utilization, especially high for endocrinology and gastroenterology. These differences, Clough found, were in part driven by how much the specialist was paid—the more the reimbursement, the higher the utilization. And, interestingly, patients reported least satisfaction with access to providers who were paid the least, without any differences in health status or care satisfaction.

Understanding the health care culture of other countries can help us to see our own health care culture more clearly. Understanding our own culture can help unveil new solutions in improving the health of our patients, and the health care of populations.

Corresponding Author: Malathi Srinivasan, MD; Department of Medicine/University of California, Davis School of Medicine, 4150 V. Street, Suite 2400, Sacramento, CA 95833, USA (e-mail: malathi@ucdavis.edu).

REFERENCES

1. Rhodes KV, Bassey S, Gallop R, Noll E, Rothbard A, Crits-Christoph P. Pennsylvania's medical home initiative: reductions in healthcare utilization and cost among medicaid patients with medical and psychiatric comorbidities. *J Gen Intern Med*. 2016. doi:10.1007/s11606-016-3734-y.
2. Goodwin JS, Sheffield K, Li S, Tan A. Receipt of cancer screening is a predictor of life expectancy. *J Gen Intern Med*. 2016. doi:10.1007/s11606-016-3787-y.
3. Schonberg MA. Capsule commentary on Goodwin et al., Receipt of cancer screening is a predictor of life expectancy. *J Gen Intern Med*. 2016. doi:10.1007/s11606-016-3824-x.
4. Kronish IM, Moise N, McGinn T, Guan Y, Chaplin W, Gallagher BD, Davidson KW. An electronic adherence measurement intervention to reduce clinical inertia in the treatment of uncontrolled hypertension: the MATCH cluster randomized clinical trial. *J Gen Intern Med*. 2016. doi:10.1007/s11606-016-3757-4.
5. Herzig SJ, Schnipper JL, Doctoroff L, et al. Physician perspectives on factors contributing to readmissions and potential prevention strategies: a multicenter survey. *J Gen Intern Med*. 2016. doi:10.1007/s11606-016-3764-5.
6. Clough JD, Patel K, Shrank WH. Variation in specialty outpatient care patterns in the medicare population. *J Gen Intern Med*. 2016. doi:10.1007/s11606-016-3745-8.