Great (cultural) expectations

I consider myself to be quite fortunate. I enjoy being able to travel and observe different cultures. This has been the case since early in my professional career and doesn't apply to international travel alone. I recall excursions to various locations within the US—rural and urban—where interacting with other physicians enabled me to understand why some chose to live in particular environs for family, leisure or professional reasons. In some ways my Midwest upbringing (and contentment) has allowed me to appreciate the balance between preferring the extremes of 7.6 m (25 ft) of snow (driving an SUV, snowmobiling and enjoying winter sports) and the heat and humidity of our Southern states (going to the beach, playing golf and fishing). Mountains, beaches and deserts each have their own unique enticements, as do the arts and entertainment available in large cities. I have, however, noticed less divergence in the 'quality of care' provided by physicians in each locale than in the preferences related to their nonprofessional and lifestyle choices. As our world becomes more homogenized, I am also getting the same impression at an international level.

Over the past year I have traveled to Asia, the Middle-East and Africa. Given the affluence of the US, the expense of it's health-care system and the poor cost-effectiveness achieved in many health arenas, I had erroneously concluded that standards in the US would be higher than elsewhere. As in the US, however, I was impressed by the educational standards and quality of care provided by physicians, although the level of care is dependent upon the local resources available.

During my recent visit to Seoul, I had the opportunity to address the Korean Association of the Study of Intestinal Disease and also to visit a university hospital. The presentations were indistinguishable from our own society meetings. The hospital was 'state-of-the-art' and had more modern facilities, equipment and information systems than my own medical center provides. The cost of care for patients was remarkable. The charge for a colonoscopy or CT scan approximated US$50 each compared with the thousands of US dollars charged by my hospital, although I do recognize the comparison is artificial and that I'm unable to identify the true costs to whoever is paying for them. But what really struck me was the difference in how the Korean gastroenterologists practiced. They also tended to work 12 h days in their clinics and hospitals, but the difference in patient numbers was incredible. Most of the gastroenterologists I met were seeing more than 60 outpatients a day (usually during a 6–8 h clinic) and performing 30 procedures per 4–6 h session. I consider myself to be a busy academic clinician who, without administrative responsibilities, sees 60–100 patients during a 6-day week. These clinicians were able to provide clinical care, monitoring and perform clinical research using data from their IBD patients—each patient had either a Crohn's Disease Activity Index or Simple Colitis Clinical Index score documented in their electronic medical record for each encounter. The time taken by their trainees to perform 200 upper and lower endoscopies was just a few months.

I'm not an expert in assessing cross-cultural quality outcomes, but my assumption, based upon comparable standards of clinical research presentations, is that there is less divergence globally in quality of care than might be anticipated. On the other hand, it is difficult for me to imagine US patients accepting an encounter with their clinician that lasts less than 5 min or (typically, unsedated) endoscopies performed in under 10 min. Similarly, with US health standards necessitating preprocedural and postprocedural documentation and an average colonoscope withdrawal time of no less than 6 min, there must be a gap between physicians' ability to perform these evaluations and to communicate with patients in the way they expect.

One of my surgical colleagues commented to me that he didn't need to see his inpatients every day, but they needed to see him. Indeed, it is my impression that the perceived quality of patient encounters in my culture is more dependent on face time with a physician than the documented elements of examinations and procedures. Perhaps this view is a result of our historically competition-driven, fee-for-service health care compared with that provided in more socialized, publicly funded health-care settings. As we attempt to evolve the US health-care system, it makes me wonder whether we will be able to modify the cultural expectations of our patients sufficiently to adjust to the reduced amount of physician face time that a more cost-effective system would require (if drastic reductions in physician incomes are to be avoided). Being from the Midwest allows me to speculate that the most workable solution will lie somewhere in the middle.

P. S. Anyone concerned after reading in last month's Editorial that my diastolic pressure was 130 mmHg needn't worry—it was my systolic!

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> "...it is difficult ... to imagine US patients accepting [a clinician] encounter ... that lasts less than 5 min"

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Competing interests
S. B. Hanauer declares no competing interests.