Physicians' Cultural Norms and Health Care Intensity

Abstract

Importance The role that physicians' cultural norms play in differential regional patterns of health care intensity is unclear.

Objective To assess and operationalize relevant cultural norms and constructs that vary in regions with different health care intensity patterns, and to develop a testable theoretical framework to explain the relationship between physician culture and health care intensity.

Design, Setting, and Participants Prospective data collection of primary care physicians' perceptions of cultural norms in practice areas with high and low health care intensity rates (determined by Dartmouth Atlas's Hospital Care Intensity Index), as well as retrospective analysis of ethnographic and interview data from a previous study of physician norms at two intensive care units with differing Hospital Care Intensity scores. 72 field note transcripts and 59 interview transcripts from the secondary data set using thematic content analysis, guided by the principles of grounded theory analysis, and 16 high and 17 low intensity interviews were conducted and analyzed also using thematic content analysis.

Main Outcomes and Measures Cultural norms, including values, premises, and problematics, were identified within each region, and analyzed according to principles of grounded theory. Regional variations in cultural constructs were identified, and a testable theoretical framework was created to explain the relationship between these cultural constructs and differential treatment decisions that lead to higher or lower health care intensity.

Results While the problematic concerns that framed decision making were largely similar for physicians in high and low intensity regions, physicians in these distinct regions tended to respond to these problematics using diverse strategies which were associated with different values held in the regions. Primary care physicians in the lower intensity region tended to share strong values that favored more "conservative" practice styles and acknowledged that these styles could reduce overuse. In the higher intensity region, physicians shared values that tended toward emphasizing certainty in their practices, and tended to conceptualize overuse as a problem in other areas of medicine but did not identify examples from primary care. For example, physicians in the lower intensity region tended to prioritize risks resulting from medical treatment, while physicians in the higher intensity region tended to prioritize risks due to uncertainty, and valued the "definitive" quality of testing. In the ICUs, physicians in the higher intensity region held premises that made aggressive therapies a top priority, and which emphasized "saving" patients and not "giving up." In the lower intensity region, physicians espoused premises that prioritized delivering care that was a "bridge" to a better health outcome, and also valued helping patients to achieve a "good death." Physicians in both regions valued avoiding delivering futile care, but this value conflicted with other values held in the higher intensity region. In the higher intensity region, physicians tended to perceive that they were not empowered to direct end of life decision making toward palliative care goals, while physicians in the lower intensity region expressed that they were able to help guide families through end of life decision making and could encourage p[illegible]