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Responses by Chinese Physicians to Changes in Health Care Delivery

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Abstract

The current relationship between the Chinese patient and the Chinese physician offers a critical component in the delivery of health care which cannot be readily replicated by a non-Chinese physician. This paper will profile the Chinese physician and patient, analyze the changes in health care delivery from the physician's perspective, and suggest possible strategies for the Chinese physician to preserve his or her relationship with the Chinese patient community.

By practicing primary care, many Chinese specialists provide the access to care otherwise unavailable to limited English-speaking Chinese patients. Along with providers of traditional medicine, they are often the only source of primary care to their communities because of their language skills and their knowledge about cultural health practices. In the United States, it is inevitable that solo practitioners and small group practices will give way to larger partially or fully integrated groups in association with integrated delivery systems and specialists become subordinate to primary care physicians in defining the overall management of a patient's care. As a result, many Chinese specialty physicians who currently serve the unique cultural and linguistic needs of their patients may be isolated from their patients.

The evolution of managed care can be described in four phases; all are driven by efforts to control costs and assure quality. In the third phase, utilization control is taken away from the physician by the integrated delivery system channeling patients to preferred, contracted providers through the use of economic incentives and disincentives. In the fourth phase, the specialty physician can no longer negotiate directly with the integrated delivery system, but can only subcontract their services through primary care physicians. The option for the Chinese American specialist include competing with their fellow specialists for the limited openings in that specialty in large multispecialty physician groups with access to the favorable contracts serving populations including the Chinese; or forming a multispecialty physician group and integrated delivery system directed at the unique needs of the Chinese or Asian patients in communities with sufficient concentrations.

To assimilated non-Chinese patients, the disadvantages of severing direct access to the specialist may be offset by universal coverage, the economic benefit of lower premiums and improved continuity of care. To Chinese patients, the change could supplant Chinese specialists with primary care physicians who are unfamiliar with cultural practices and unable to communicate satisfactorily. The economics of managed care would sever the physician-patient relationship that may be the patients' only access to bilingual and

bicultural primary care services. To the limited English-speaking Chinese, the advantages of coverage, savings, and continuity will be secondary if there is first no meaningful exchange in the physician-patient encounter.