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**GOVERNING THE CHINESE MEDICAL PROFESSION:
A SOCIO-LEGAL ANALYSIS**

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A thesis presented for the degree of Doctor of Philosophy

School of Law

The University of Edinburgh

2011

I hereby declare that this thesis is my own work.

Wei Ouyang

ACKNOWLEDGEMENTS

I am deeply indebted to my supervisors, Professor Graeme Laurie and Dr Sharon Cowan, for their help, guidance and supervision throughout the work. I would like to express my gratitude and countless thanks to them for keeping me focused, maintaining my confidence and for being great mentors. I would also like to express my sincere thanks with deepest respect to Professor J. Kenyon Mason for his scholarly inspiration, intellectual support and constant encouragement.

I would like to express my profound gratitude to the University of Edinburgh College of Humanities and Social Sciences for providing scholarships for making this thesis possible, and the French Centre for Research on Contemporary China for being the fieldwork sponsor. My deepest gratitude goes to the 223 Chinese medical practitioners who took part in my field studies and showed me generous support.

I own special thanks to Wendy Wales, for her meticulous proofreading of this thesis and giving me years of tremendous support and unremitting kindness. I also would like to express my sincere appreciation to Sarah Gallagher and John Gallagher for proofreading Chapter 8 and their kind support at all times.

Finally, I would like to express my heartfelt gratitude to my parents and my husband for giving me unfailing love, encouragement and support. This thesis is dedicated to you.

ABSTRACT

As the first systematic and in-depth study in any language on the subject, this thesis makes original contributions by unravelling the relationship between Chinese healthcare state governance, health law and medical practitioners, and casting a spotlight on the ethically problematic medical practices raised by cases of SARS and others. More specifically, this thesis examines the role of state governance and regulation in China's healthcare system and their impact on professional practices and ethics. The thesis addresses the issues from a social-legal perspective. It provides evidence from an integration of historical, empirical and theoretical approaches to explore the role of Chinese medics in their relations with healthcare state governance and law. It explores the character of power relations and the consequences of imbalance of power in these relations. Diagrammatic models are used throughout this work to illustrate the findings from the above approaches and to represent the changing nature of the author's thinking about the dynamics at work in the relationships under scrutiny.

The basic principle advocated in this thesis is that the effective formation and delivery of healthcare is facilitated by ethically-based systems of policy, rules and regulation. More particularly, it is argued that the roles of medical professionalism and patient control are central to good governance of healthcare in China. Set within this context, the thesis has three main goals. First, it aims to contribute to the development of theories about the relationship between the medical profession and the Communist state of China, examining the relatively powerless position of medical professionals in China as demonstrated by both historical and original empirical evidence generated by the research undertaken for this thesis. Secondly, the thesis examines the nature and extent of de-professionalisation among Chinese medical professionals. More particularly, it considers the consequences of challenges to Chinese medics' professional autonomy which have occurred as a result of the Chinese healthcare power structure. Ultimately, it is argued that a re-structured model which places Chinese medical practitioners in a more professional and responsible role is urgently required.

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CHAPTER 1 INTRODUCTION

1. Introduction

In recent years, health provision has become a central social concern in China. A combination of underpaid local healthcare professionals, a government unable to uphold its healthcare obligation to the public,¹ profit-chasing motivations among healthcare institutions,² and increasing numbers of medics taking kickbacks from pharmaceutical companies have all seriously damaged public trust in China's healthcare system and its service provision.³ Corruption has eroded public confidence in China's medical community; whenever malpractice happens, patients tend to use extreme methods, such as attacks on healthcare practitioners and hospitals, to express their anger.⁴ It is commented by scholars that "the system was almost made to be abused."⁵ In 2001, the Chinese government declared that its healthcare system was in crisis, and the ministries responsible for healthcare have been tasked with making major reforms to the entire system.⁶

Besides a failed health system, the cover-up by Chinese officials of the SARS crisis in 2003 also put China's medical community under the spotlight. At that time, hundreds of thousands of Chinese medical practitioners knew that government officials were

¹ A. Browne, 'In China, Doctors tell Patients to Pay Upfront', (Dec 7th, 2005) *the Wall Street Journal*.

² Q. Meng, 'New Directions in China's Health Sector Reform', 9 (2009) *China Brief* 5; WHO report, *China, Health, Poverty and Economic Development* (Office of WHO representative in China, Beijing, 2005); M. Wang, *WTO, Globalization and China's Health Care System* (Palgrave, New York, 2006).

³ S. Finder, 'Insider Analysis: Pharmaceutical Outsourcing to China – Some Legal Issues', (2007) *FDC Reports*; J. Tao (ed) *China: Bioethics, Trust, and the Challenge of the Market* (Hong Kong, Springer, 2008); P. Zheng, et al., 'Public Hospitals in China: Privatization, the Demise of Universal Health Care and the Rise of Patient-Doctor Violence', 4 (2006) *Journal of Law & Medicine* 465-70; Y, Yang, 'Netizen Accuses Zhejiang Doctors in New Kickback Scandal', (Feb 28th, 2011) *China Daily*.

⁴ See e.g., 'Worsening Patient-Doctor Relationship: Different Opinions from Media, Patients and Medical Professionals' (in Chinese), (Aug 29th, 2006) *Yunnan Information Daily*; 'Doctor/ Patient Conflicts Become More Common' (in Chinese), (Aug 8th, 2001) *China Daily*; and 'Patient-Doctor Disputes: Wearing Helmets to Work' (in Chinese), (Jan 10th, 2007) *Asian Times*.

⁵ The Economist Intelligence Unit, *Research Report: Healthcare in China into the 21st Century* (London, EIU, 1998), 123.

⁶ The International Trade Administration, *Health Industries Report: Medical Device Reimbursement in China*, US Department of Commerce.

risking lives by denying the scope of the SARS epidemics.⁷ (In this thesis, the term “medical/healthcare practitioners”, “medical/healthcare professionals”, or “medics” refers generally to a group of healthcare providers, including doctors, nurses, hospital pharmacists and allied qualified health personnel.) In effect, medical practitioners in China were asked to, and did, participate in the SARS cover-up in order to avoid social panic and maintain the stability of Chinese society and its economic environment.⁸ When recalling that history, one of the physicians admitted, that when WHO inspectors visited his hospital, they were instructed by local officers to remove dozens of SARS patients from their isolation wards and transfer them to locations where they could not be observed by the inspectors.⁹ Physicians even had to change SARS patients’ medical records to hide the truth.¹⁰

Chinese medical practitioners – who appeared to put state interests above medical ethics – could be said to come within the provision of *the 1998 PRC Medical Practitioners Act* which states, “In the event of a natural disaster, the spreading of an infectious disease, an unexpected heavy casualty or other emergencies seriously threatening the people's lives and health, doctors should accept assignments by order of the administrative department of health under the people's government at or above the county level.”¹¹ Clearly, Chinese medical practitioners fulfilled their legal obligations by giving in to the demands of the state. However, their conduct broke *the Hippocratic Oath* - the guiding ethical code for Western physicians. The question is whether Chinese medical practitioners take or work according to the Hippocratic Oath or at least its spirit?

Chinese medical practitioners do take an ethical oath when they become medical students. *The Oath of a Medical Student*, which has been adopted by most Chinese medical schools, was enacted by the Ministry of Education in 1991.¹² However, the

⁷ See e.g., T. S. Jost, *Readings in Comparative Health Law and Bioethics* (Durham, Carolina Academic Press, 2007), 358; M. Forney, ‘Heal Thyself?’ (June 9th, 2003) *Time Magazine*; S. Jakes, ‘Beijing’s SARS Attack’, (April 8th, 2003) *Time Magazine*.

⁸ Ibid.

⁹ X. Wang, ‘Memory of SARS at Di Tan Hospital’ (in Chinese), (Dec 24th, 2003) *People’s Daily*; S. Jakes, ‘Beijing Hoodwinks WHO Inspectors’, (April 18th, 2003) *Time Magazine*.

¹⁰ Ibid.

¹¹ The 1998 PRC Medical Practitioners Act, Article 28.

¹² The Higher Education Office of the PRC Ministry of Education, ‘The Oath of A Medical Student’ (in Chinese), Document No. 106, File 4.

Chinese Oath is different from the Hippocratic Oath (whether the ancient or modern version).¹³ *The Oath of a Medical Student* emphasises loyalty, dedication and self-development, without giving any specific reference to bioethics (more detailed discussions about the Oath appear in Part III).¹⁴

All of the above discussion, including the SARS experience, reflects a need for clarification of medical ethics and its role for medical practitioners in China. It also suggests a need to review the way in which healthcare is practised and organised in China's social and economic reform era. In this thesis, it is argued that there is a broad systemic weakness in and between China's healthcare institutions, laws and state governance, that is – there is a missing role of responsible medical professionalism.

As Lubman points out, “the current scene is marked by a partially marketized economy, a dilution of the control over society by the central Party-state, and expanded personal freedoms.... Reform has also generated a crisis of values: Communist ideology is hollow, while corruption and disorder are increasing.”¹⁵ The trends of marketisation and political decentralisation in China have affected not only the healthcare system and general welfare, but also the manner of medical practice and healthcare delivery. This thesis considers how Chinese medical practitioners respond to such challenges. It focuses on how Chinese medics talk about, explain, circumvent or even resist these threats.

On the basis of the analysis presented in forthcoming chapters, it is argued that medical deprofessionalisation in China presents considerable challenges for medical ethics and patient care, necessitating careful and sympathetic adjustments. These arguments are underpinned by historical and empirical research in areas which have received little attention from academics. Indeed, perhaps because of the lack of attention given to the study of Chinese medical deprofessionalisation and to issues raised by a decline of medical ethics in China, this thesis and its conclusions have

¹³ E. A. Yolly and R. N. Gamutan, ‘The Hippocratic Oath’, available at: http://www.acim-asia.com/The_Hippocratic_Oath.htm (Last visited on May 25th, 2010)

¹⁴ Q. Liu and L. Xu, ‘The Oath of a Medical Student’, 29 (1999) *Chinese Journal of Medical History* 4.

¹⁵ S. Lubman, *Bird in the Cage: Legal Reform in China after Mao* (Berkeley, Stanford University Press, 1999), abstract; Y. Ji, *China's Enterprise Reform: Changing State/Society Relations after Mao* (London, Routledge, 1998).

resonance across a range of contemporary debates relating to the question of health system reform,¹⁶ the dynamics of the doctor-patient relationship,¹⁷ and the impact of law or ethics on improving the quality of care in China.¹⁸

2. The Aims of this Thesis

With regard to China's healthcare problems, previous commentaries have placed emphasis on reforms of the healthcare system or healthcare legislation.¹⁹ Such an approach provides an important context for the present study, but in this thesis it is argued that attention to these factors alone could not solve the inner problem of de-professionalisation. Focusing on medical practitioners, their views, frustration and powerlessness, this thesis offers a deep consideration of an indispensable but hitherto neglected feature of China's healthcare governance: the lack of professionalism among China's medics.

This thesis is written from a socio-legal perspective. Its concern is not with solving legal disputes or moral dilemmas about power, or helping others to do so; it is rather concerned with identifying the current role of Chinese medics, the character of power relations to which they are subject and the consequences of the imbalance of power in these relations. The approach of this thesis is primarily exploratory and explanatory. It aims to cast a spotlight on the problematic medical practice that were brought to light by the case of SARS; more specifically, it is concerned with the role of regulation and state governance in China's healthcare, and the impact of these systems on professional practice and bioethics.

¹⁶ See note 2.

¹⁷ See notes 3 and 4.

¹⁸ See e.g., J. Fang, 'The Chinese Health Care Regulatory Institutions in an Era of Transition', 66 (2008) *Social Science and Medicine* 952-962; R. Peng, 'How Professional Values are Developed and Applied in Medical Practice in China', 30 (2000) *The Hastings Center Report* 4, 23-26; M. Harris and C. Wu, 'Medical malpractice in the People's Republic of China: The 2002 Regulation on the Handling of Medical Accidents' 33 (2005) *Medicine & Ethics Journal of Law* 456; J. Nie, 'The Plurality of Chinese and American Medical Moralities: Toward an Interpretive Cross-Cultural Bioethics', 10 (2000) *Kennedy Institute of Ethics Journal* 3, 239-260; R. Qiu, 'Confucianism, Traditional and Contemporary China', in R. M. Veatch (ed) *Cross-Cultural Perspectives in Medical Ethics* (London, Jones and Bartlett Publishers, 2000).

¹⁹ Ibid, also see D. Jiang, 'Thoughts on the Practice of Regulation on the handling of Medical Accidents', 11 (2002) *National Judges College Law Journal*, 53-56; L. Pei, 'Hospital Management in China in a Time of Change', 11 (2002) *Chinese Medical Journal* 115, 1716- 1726.

The basic principle advocated in this thesis is that the effective formation of the healthcare service is facilitated by ethically-based systems of policy, rules and regulation. The roles of a well-functioning medical profession and patient control are central to good governance of healthcare in China. Set within this context, this thesis has three main goals. First, it aims to contribute to the development of theories and understanding about the relationship between medical professionals and the Communist state of China; it does so by examining the relatively powerless position of medical professionals in China from both a historical perspective and by providing up-to-date empirical evidence. Secondly, the thesis examines the nature and extent of de-professionalisation among Chinese medical professionals. It is especially concerned with the consequences of challenges to the Chinese medics' professional autonomy in the healthcare power structure. Thirdly, it is argued that a re-structured model which places Chinese medical practitioners in a more professional and responsible role is urgently needed.

3. A Socio-Legal Methodology

Socio-legal research uses “various empirical methods to study what is legal about legal processes, legal institutions and legal behaviour”.²⁰ The sociology of law receives its intellectual impetus mainly from mainstream sociology and aims to transcend the lawyers' focus on legal rules and legal doctrine by remaining “exogenous to the existing legal system”, in order to “construct a theoretical understanding of that legal system in terms of the wider social structure”.²¹

The ‘socio’ in socio-legal studies does not refer to sociology or social science, but represents “an interface with a context within which law exists”.²² In this thesis, the socio-legal method offers a way to explain empirical data in the light of theoretical materials that draw attention to the relationship between health care state governance, medical law and bioethics as linked to medics' practices.

²⁰ R. Banakar and M. Travers, *Theory and Method in Socio-Legal Research* (Oxford, Hart Publishing, 2005), Introduction.

²¹ *Ibid.*

²² S. Wheeler and P. A. Thomas, ‘Socio-Legal Studies’ in D. J. Hayton (ed), *Law's Future(s)* (Oxford, Hart Publishing, 2002), 271; P. A. Thomas (ed), *Socio-Legal Studies* (Aldershot, Dartmouth, 1997).

It has been claimed that, “medicine is so central to modern society, doctors have emerged as perhaps the key profession”.²³ Yet it is argued in this work that in an authoritarian state like China, healthcare practitioners may have difficulties in remaining true to their moral views and ethical responsibilities, particularly when facing conflicting guidance from bureaucratic and administrative rules. Therefore, this thesis uses the socio-legal method to hear the hidden voices from Chinese medics about their opinions concerning their perceptions of and interactions with law, state governance, their understandings of bioethics and even ethical dilemmas (if they exist) over conflicting interests.

4. Research Questions

Surveys about legal awareness in the health sector have been found in a few Asian studies.²⁴ In 2001, Zhou conducted fieldwork on the nurses’ legal knowledge within a hospital in Beijing.²⁵ However, Zhou’s research object was confined only to nurses and their legal education. So far, there is still no survey which has been done in China to study what impact state governance, law and bioethics have on medical practice, professional behaviour, medical costs, and healthcare service outcomes. Although several research groups have conducted long-term or short-term studies related to healthcare and ethics in mainland China, their research topics concentrate mainly on the One-Child Policy,²⁶ women’s rights,²⁷ historical bioethics in China,²⁸ healthcare legislation,²⁹ the healthcare system,³⁰ Chinese medicine,³¹ and there are even two

²³ M. Moran and B. Wood, *States, Regulations and the Medical Profession* (Buckingham, Open University Press, 1993), preface.

²⁴ K. Kim, et al., ‘Perception of Legal Liability by Registered Nurses in Korea’, 27 (2007) *Nurse Education Today* 6, 617; Z. Ueki, ‘Legal Awareness in Dentists’ Medical Practice’, *Medical Law* (Tokyo, Yuhikaku Publishing, 2003, 2nd edn), Chapter Three.

²⁵ R. Zhou, ‘A Study of Nurses’ Legal Education’, 36 (2001) *Chinese Journal of Nursing* 761.

²⁶ See e.g., S. Greenhalgh and E. A. Winckler, *Governing China’s Population: from Leninist to Neoliberal Biopolitics* (Stanford, Stanford University Press, 2005); P. Lofstedt, et al., ‘Abortion Patterns and Reported Sex Ratios at Birth in Rural Yunnan, China’, 12 (2004) *Reproductive Health Matter* 24, 86.

²⁷ See e.g., C. N. Milwertz, *Accepting Population Control: Urban Chinese Women and the One-Child Family Policy* (Surrey, Curzon Press, 1997).

²⁸ See e.g., P. U. Unschuld, *Medical Ethics in Imperial China: A Study in Historical Anthropology* (Berkeley, University of California Press, 1979) and P. U. Unschuld, *Medicine in China: A History of Ideas* (Berkeley, University of California Press, 1985).

²⁹ See e.g., J. Fang, ‘The Chinese Health Care Regulatory Institutions in an Era of Transition’, 66 (2008) *Social Science and Medicine* 952-962.

³⁰ See e.g., Y. Liu, ‘China’s Public Health-care System: Facing the Challenges’, 82 (2004) *Bulletin of the World Health Organization* 7, 532-538.

extensive field studies about the political abuse of psychiatric units³² and the trade in organ transplantation in China.³³ The role and position of Chinese medics within the healthcare system and against the backdrop of medical legislation remains a relatively unexplored landscape awaiting discovery and understanding.

As the first systematic and in-depth study on this subject, the thesis traces voices from the Chinese medical practitioners who usually hide behind a veil of silence; it provides compelling evidence that they have clear and even active views about professional power. It also explores the complex political, legal, socio-cultural, and historical terrain that shapes their silences, and their diverse understandings of professional ethics.

The research questions which this study addresses are:

- (1) How do Chinese medical practitioners react to state governance and law?
- (2) Whether, how and why do law or political ideology take priority over medical ethics and professional knowledge, or vice versa?
- (3) Do Chinese medics feel frustration over their role within the healthcare system and think that their current position in the healthcare arena is problematic?
- (4) If so, what are the causes, effects and solutions?

The main purpose of this study is to explore the ways in which the medical practices of health personnel are affected by guiding principles, such as law, political guidance and ethics, and any dilemmas they may face in choosing guiding principles in practice. What is more, this thesis foresees professionalism as a crucial missing element in China's healthcare power structure that must be brought into being.

³¹ See e.g., S. Dharmananda, 'Understanding Chinese Medicine', available at: <http://www.itmonline.org/arts/understand.htm> (Last visited on April, 11th, 2010).

³² See e.g., R. Munro, *China's Psychiatric Inquisition: Dissent, Psychiatry and the Law in Post-1949 China* (London, Wildy, Simmonds and Hills, 2006); R. Munro, 'Political Psychiatry in Post-Mao China and Its Origins in Cultural Revolution', 30 (2002) *Journal of American Academic Psychiatry Law*, 97-106; J. Birley, 'Political Abuse of Psychiatry in the Soviet Union and China: A Rough Guide for Bystanders', 30 (2002) *Journal of American Academic Psychiatry Law*, 145-147, and R. Munro, 'Judicial psychiatry in China and Its Political Abuses', 14 (2000) *Columbia Journal of Asian Law* 1-125; Human Rights Watch and Geneva Initiative on Psychiatry, *Dangerous Minds: Political Psychiatry in China Today and its Origin in the Mao Era* (New York, Human Rights Watch, 2002).

³³ See e.g., D. Matas and D. Kilgour, *Report into Allegations of Organ Harvesting of Falun Gong Practitioners in China* (6 July 2006); and hereafter *Revised Report into Allegations of Organ Harvesting of Falun Gong Practitioners in China* (31 January 2007).

5. The Structure of this Thesis

In order to answer the research questions, this thesis has 10 chapters which are divided into three main parts:

Part One - Literature Review

Following on from the introduction, Part One (consisting of Chapters 2 and 3) seeks to examine the overall conceptual framework of the relationship between the Chinese state, law and medical practitioners, by firstly in Chapter 2 analysing and dissecting the Western model of healthcare governance, followed by a working model of healthcare governance in China today. Chapter 3 then traces the framework, from a historical perspective, of the development of Chinese medical practitioners, bioethics and state governance up to the present day.

Part Two - Empirical Studies

Part Two of this thesis consists of Chapters 4, 5 and 6. The fourth chapter describes the methods adopted in the empirical study. The fifth and sixth chapters present the findings from the questionnaire and interview studies respectively.

In this section, I examine the views of Chinese medical practitioners, as collected through my empirical studies. The empirical studies provide up-to-date views of 223 Chinese medical practitioners who are working on the frontline of China's healthcare services. The data include quantitative and qualitative studies conducted from six cities in China, during the period from November 2008 to March 2009.

Part Three - Problem and Suggestions

Having examined the problem from both a historical perspective and an empirical basis, Part Three then provides a theoretical analysis of the problem and proposes a new long-term and multi-level model for future development.

The data presented in Part Two make clear that the vast majority of Chinese medics feel that they lack control over their practices. Part Three consists of three chapters. Chapter 7 contains an analysis of the problem of deprofessionalisation in China and the need to tackle this phenomenon. Chapters 8 and 9 introduce ideas of professionalisation and professionalism. By suggesting the establishment of a new model which emphasises an increase of professional power to Chinese medical professions while ensuring scrutiny mechanisms, I argue for accountable medical professionalism in China.

This thesis proposes a process of re-modelling the healthcare power structure from the actual situation to a suggested ideal one. At each stage of my research, I offer diagrammatic representations of my evolving thinking about the nature of the power structure, more specifically, the position of Chinese medics in the power dynamic of healthcare state governance, medical law and bioethics. Five models are offered in this thesis, including two hypothetical models, one model developed from empirical findings, and two new models proposed in Part Three. These models reflect different stages in my intellectual journey through the process of writing this thesis. They are representations of my assumptions about the nature of the relationship between the state and its medical professionals, which I then tested by different research methods as the research progressed. Each stage of the model was refined in light of my findings. The final version of the model represents what I consider to be the optimal balance of considerations and power in the state/professional relationship.

The final Chapter (Chapter 10) reflects on the data, discussion and models presented. It concludes that the need for a balance of power in China's healthcare necessitates in turn a call for medical professionalism. This is not only for the benefit of patients or the meaning of medicine, but ultimately, for Chinese society's benefit, in becoming more democratic and liberal.

PART ONE LITERATURE REVIEW:

**CONCEPTUAL FRAMEWORK AND
HISTORICAL BACKGROUND**

CHAPTER 2 CONCEPTUAL FRAMEWORK

1. Introduction

A healthcare system is viewed by Frenk as “the vehicle for the organized social response to the health conditions of the population.”³⁴ In Frenk’s understanding, the concept of a healthcare system involves three components: “vehicle”- method; “organization”- system; and an aim to respond to the needs of the population. In particular, “a shared aim” is key to developing an integrated health system. In practice, a healthcare system consists of a set of building blocks, which are, in Rapoport’s words, “a bundle of relations”.³⁵ The method for achieving the shared aim therefore varies among different “actors” in a system and between systems.

The purpose of this chapter is not to describe the detail of the political-economic contexts and variations of healthcare governance in different countries, but rather to review briefly what these experiences tell us about the relationship between medical professions, state and law in such healthcare systems. I suggest that it is possible to identify a common pattern of relationship-model and that this can provide a conceptual framework for this thesis. This provides a starting point from which to address the distinctiveness of the governing infrastructure and institutional organisation of Chinese medical practitioners.

To this end, this chapter focuses on conceptualising the role of the state, law and healthcare profession in healthcare systems and the relationship between them. The conceptual model will then be used to help us better interpret the multilateral relationships between Chinese medical practitioners and China’s state-led healthcare governing mechanisms. The ultimate goal of this chapter is to develop a preliminary model or framework to represent how Chinese health practitioners are governed, so that it can be tested, modified and developed through further analyses encompassing historical, empirical and theoretical approaches.

³⁴ J. Frenk, ‘Dimensions of Health System Reform’, 27 (1994) *Health Policy* 19-34, 25.

³⁵ A. Rapoport, ‘System Analysis: General Systems Theory’, 15 (1968) *International Encyclopaedia of the Social Science* 458.

2. The Nature of the Medical Profession, State and Law in Most Developed Countries

In the area of healthcare, particularly in most developed countries – and many middle income countries – governments have become central to social policy and healthcare. The state normally participates in healthcare through three major mechanisms: regulation, financing, and direct delivery of services. Their involvement is justified on the grounds of both equity and efficiency. The medical professionals of these countries, on the other hand, may not necessarily be completely under the rule of the state, but can probably exert different degrees of influences on state-led control mechanisms.

2.1 The State-led Control Mechanisms over the Medical Profession

This section concentrates on relationship in a broad sense between the state and medical profession. It first examines briefly the major effects of state healthcare financing and delivery policies on the practice of medicine. It then sketches the influence of professional regulation on medical practice.

(1) Healthcare Financing and Delivery Policies: the Healthcare System

Frenk says, “States are central to the working lives of doctors.”³⁶ The challenge of professional development cannot be fully understood without reference to the role of the state in our society. The state is perceived narrowly by Frenk as the institutions of government which provide the administrative, legislative, and judicial vehicles for the actual exercise of public authority and power.³⁷ The way in which healthcare is organised and delivered is influenced by a state’s social, organisational, economic, political and cultural background. Comparativists, such as Terris, rightly note that

³⁶ See J. Frenk and L. Durán-Arenas, ‘The Medical Profession and the State’, in F. W. Hafferty and J. B. McKinlay (ed), *The Changing Medical Profession: An International Perspective* (New York, Oxford University Press, 1993); also cited by Moran, see note 23, at 4.

³⁷ J. Frenk, ‘Dimensions of Health System Reform’, 27 (1994) *Health Policy* 19-34, 25; J. Frenk, ‘The Political Economy of Medical Underemployment in Mexico: Corporatism, Economic Crisis and Reform’, 15 (1990) *Health Policy* 143-62.

there is great variety in the degree to which states and their agencies exercise centralised control over social and economic institutions.³⁸ With respect to the role of the state, different types of healthcare system vary mainly in terms of their prevalent founding values or principles, and corresponding ways of financing, service provision and regulation.³⁹

Contemporary medicine is, in general, practised within healthcare systems, namely: a state-funded health service; a social insurance-type health system funded by a comprehensive planning model; and private insurance. The way a country's healthcare system is structured determines the nature of its healthcare institutions and scope of service delivery, and simultaneously affects the character of healthcare practice. This was well expressed by Shipler when he said that the system of medical care expressed the full range of strengths and weaknesses in society: "It is a model of the country's hierarchy, reflecting the instincts of authoritarianism, conservatism and elitism that pervade all areas of life."⁴⁰ In the case of China, we have witnessed large scale market forces becoming involved in the state-funded healthcare system, which in the end transformed the nature of healthcare delivery as well as the "guiding values" of professional practice (the transition of the Chinese healthcare system will be discussed in more detail later in this chapter).

Having briefly discussed the relationship between the state and medical profession, the next section explores the regulatory structure of the medical profession, and the broad influences that professional regulation has on medical practice.

(2) Regulation on Healthcare Practice

It is understandable that the objective of any system of regulation should advocate and ensure standards, accountability and efficiency in practice; thus most states play a role

³⁸ M. Terris, 'The Three World Systems of Medical Care: Trends and Prospects', 68 (1978) *American Journal of Public Health* 11, 1125-1131.

³⁹ H. Rothgang, et al., 'The Changing Role of State in Healthcare Systems', 13 (2005) *European Review Supp* 1, 187, 191.

⁴⁰ D. K. Shipler, *Russia: Broken Idols, Silent Dreams* (New York, New York Times Books, 1983), 216.

in the regulation of medical practitioners.⁴¹ The medical arena, on the other hand, has its own particular interests, values and power structure. In practice, these features have a distinctive influence on the way a country regulates its medical profession.

Before discussing the role of law in regulating medical practice, it must be recognised that knowledge, experience and values have been built up and developed within the medical community and that the state has its role in steering or controlling professional regulation, from its formulation to its implementation. Medical practice is governed by technical, generational values and ethical standards. The ethical standards, as “collegiate values independent of individual choices made by doctors”,⁴² evolve as a normative standard to guide or control professional behaviour. This does not mean that governments lose legitimacy in the enforcement of law concerning morality or propriety of medical practice. Instead, law, as a system of rules, helps to “ensure predictability through their normative or prescriptive force; they impose obligations and create corresponding entitlements, which are publicly acknowledged and collectively enforced”.⁴³

The extent to which judicial “intervention” in medicine is appropriate emerges as a paradox. Lord Woolf’s statement sheds some light on this: “Although it will never be a substitute for proper standards of professional ethics, the law can provide a base below which standards should not fall and guidance as to what actions are lawful. If an action is unlawful, then it will certainly be unethical.”⁴⁴ In fact, an increasing role of law in regulating healthcare professionals, has been pointed out by many scholars, such as Montgomery: “the discipline of healthcare law is at risk of being transformed – moving from a discipline in which the moral values of medical ethics (and those of the non-medical health professions) are a central concern, to one in which they are being supplanted by an amoral commitment to choice and consumerism.”⁴⁵ Jacobs

⁴¹ J. Frenk and L. Durán-Arenas, ‘The Medical Profession and the State’, in F. W. Hafferty and J. B. McKinlay (ed), *The Changing Medical Profession: An International Perspective* (New York, Oxford University Press, 1993), 33.

⁴² J. Montgomery, ‘Review: Medical Law in the Shadow of Hippocrates’, 52 (1989) *Medical Law Review* 4, 570; R. S. Downie, ‘Collective Responsibility in Health Care’, 7 (1982) *Journal of Medical Philosophy* 1, 43-56.

⁴³ D. Beetham, *The Legitimation of Power* (London, Macmillan, 1991), 65.

⁴⁴ The Rt Hon Lord Woolf, ‘The Judiciary, Medicine and Ethics’, in J. Carrier et al. (ed), *Law, Medicine and Ethics: Essays in Honour of Lord Jakobovits* (London, Cancerkin, 2007).

⁴⁵ J. Montgomery, ‘Law and the Demoralisation of Medicine’, 26 (2006) *Legal Studies* 2, 185-210, 186.

also argues that: “law has no substantial place in regulating medicine because although some rules establish structure, the law’s prime concern is with the untoward.”⁴⁶ Harvard expresses similar frustration with legal threats to medicine.⁴⁷

In short, medical practice identifies strongly with morality through medical ethics. Yet, debates over the relationship between law and medical practice are becoming more difficult, since moral and ethical debates are increasingly accommodated into the discourse of law. In McKinlay’s opinion, law is a system of rules that “enables capitalist modes of production in medicine to exist through infusing capital into the medical industry and by maintaining the whole structure through legitimatizing the activities of powerful players in the medical game.”⁴⁸ The role that medics play in this “medical game”, however, remains ambiguous; even though medics are “often presented from the outside as powerful, while it nevertheless remains subject to the underlying logic of the game.”⁴⁹

The involvement of the state in professional regulation implies that politics lies at the heart of regulation. A political process involves “the exercise of power and authority in struggles between competing interests; and it is a process in which the struggle for control of state power”.⁵⁰ As Dingwall put it, “The fundamental challenge to medicine is not from law but from the governmentality that favours law as its operative strategy.”⁵¹ Professional regulation is, by nature, political, albeit that – traditionally at least – ethics has been more the preserve of the medics, while law has been the tool of the state; thus the realities are that political power is a strong shaping force with respect to the regulation of the medical profession. This, at least, has been true of Western states (I will explore the situation in China shortly).

⁴⁶ J. M. Jacobs, *Doctors and Rules: A Sociology of Professional Values* (London, Routledge, 1988), 166.

⁴⁷ J. D. Harvard, ‘The Legal Threat to Medicine’, 284 (1982) *British Medical Journal* 612.

⁴⁸ D. M. Frankford, ‘Professions and the Law’, in F. W. Hafferty and J.B. McKinlay (ed), *The Changing Medical Profession: An International Perspective* (New York, Oxford University Press, 1993), 44.

⁴⁹ *Ibid.*

⁵⁰ See note 23, at 26.

⁵¹ R. Dingwall et al., ‘Litigation and the Threat to Medicine’, in D. Kelleher, et al. (ed), *Challenging Medicine* (London, Routledge, 2006), 57.

To sum up, I agree with what Montgomery suggests - law should be facilitative (stressing the importance of ethics and values of the healthcare profession) rather than proactive (taking over the determination of ethical issues and promoting patient rights).⁵² When professional ethics provides only guiding but not binding principles, there is still a necessity for law with respect to accountability.

Having briefly examined the major effects of state healthcare policies and regulation on the practice of medicine, the next section will discuss the impact of medical profession on state policies and regulation.

2.2 The Medical Profession's Impacts on State Governance and Law

It is said in *Understanding Doctors* that, “There is a tendency in our over-centralised and largely state-controlled health system to blame government and politicians for all the ills facing the profession. Yet it is clear that many of the pressures and challenges on the medical profession are not confined to the United Kingdom or to this profession and instead reflect wider social and technological change.”⁵³ This section aims to examine how the healthcare profession responds to state governance and legal controls.

(1) Medics' Reducing Influence on Healthcare Governance

The Western medical profession generally tends to represent a “privileged and satisfied stratum” in society.⁵⁴ In the West, various nouns such as, healers, scientists, professionals, entrepreneurs and politicians, have been used to describe doctors.⁵⁵ The use of the term ‘politicians’ indicates that Western doctors, both individually and collectively, access and possess many political resources. The profession can intervene positively in public policy debates about healthcare, by using its positive public image, its expertise and reputation to function as an influential lobbyist. The American Medical Association (AMA) is an example. “With growing public

⁵² J. Montgomery, ‘Law and Demoralisation of Medicine’, 26 (2006) *Legal Studies* 2, 185-210.

⁵³ R. Levenson, et al., *Understanding Doctors: Harassing Professionalism* (London, Royal College of Physicians and King's Fund, 2008), foreword.

⁵⁴ H. M. Vollmer and D. L. Mills (ed), ‘The Politics of Professionals’, *Professionalization* (New Jersey, Prince-Hall, 1966), 321.

⁵⁵ See note 23, at 3.

acknowledgment of governmental responsibilities in furnishing medical care, the political activities of the AMA have expanded enormously.”⁵⁶

The political influence of the medical profession is not unique to the AMA. Medics are widely recognised by societies as the experts in the field. They are also the exemplary expression of professional authority and autonomy, especially for controlling the technical content of work and the process of service provision, as described in much of the social science literature.⁵⁷ Western medical professionals are collectively organised in order to negotiate their interests with the state for, wages, working conditions and other terms of employment.⁵⁸ Self-evidently, the degree to which the medical profession is able to influence politics and, vice versa, depends upon local social and political context. In the case of the British National Health Service (NHS), in Klein’s words, it is a situation of “mutual dependency”.⁵⁹

“On the one hand the state became a monopoly employer: effectively members of the medical profession became dependent on it not only for their own incomes but also for the resources at their command. On the other hand the state became dependent on the medical profession to run the NHS and to cope with the problems of rationing scarce resources in patient care.”⁶⁰

Indeed, in the past, the British medical profession seemed to operate as partners with the state, rather than as a pressure group in the policy-making process.⁶¹ The establishment of the NHS in 1948 indicated a willingness and capacity of British medics to adapt to a political settlement, while still being able to maintain accountability in response to their privileged status granted by society. For the previous government, the contract with the profession entailed a stewardship of the NHS and the development of a regulatory regime that gave confidence to the public

⁵⁶ D. R. Hyde, et al, ‘The American Medical Association: Power, Purpose, and Politics in Organized Medicine – The Political Basis of Power’, 63 (1954) *The Yale Law Journal* 937-1022, 955.

⁵⁷ E. Freidson, *Professional Dominance: The Social Structure of Medical Care* (Chicago, Aldine, 1970), 45; M. S. Larson, *The Rise of Professionalism: A Sociological Analysis* (Berkeley, University of California Press, 1977); J. Frenk and L. Durán-Arenas, ‘The Medical Profession and the State’, in F. W. Hafferty and J.B. McKinlay (ed), *The Changing Medical Profession: An International Perspective* (New York, Oxford University Press, 1993), 27.

⁵⁸ American College of Physicians – American Society of Internal Medicine, ‘Physicians and Joint Negotiations’, 134 (2001) *Annals of Internal Medicine* 787-782.

⁵⁹ R. Klein, ‘The State and the Profession: the Politics of the Double bed’, 301 (1990) *British Medical Journal*, 700-702.

⁶⁰ Ibid.

⁶¹ C. Webster, ‘Conflicts and Consensus: Explaining the British Health Service’, 1 (1990) *Twentieth Century British History* 2, 115-151.

and ensured effective professional accountability.⁶² However, many things have changed since the establishment of the NHS. There have been sweeping reforms to further regulate the medical profession as a result, for example, of the Shipman scandals.⁶³ Many critics saw the medical profession as having too much power. The medics' self-regulation institutions, such as the General Medical Council (GMC), have undergone radical reform as a result.⁶⁴

The trend of decreasing power of the medical profession, is not confined merely to their roles in affecting the direction of healthcare governance, but also reflects massive changes in the statutory control of the medical profession. The following section will focus on the medical profession's eroding influence on regulation.

(2) The Influence of the Medical Profession on Healthcare Regulations

There are vast variations between different countries in how far the medical profession is regulated. Each country has to make decisions based upon the following factors: how medical students are selected and trained; how much commercial competition is allowed; what ethical standards will govern their practices; what institutional settings should be provided; and how professionals are going to be paid.⁶⁵ The content of healthcare regulation is important, but what matters more is the determination(s) of regulation. This raises questions, such as: what is the ultimate source of healthcare law and rules; how influential or dominant is the medical profession or state in determining the regulations in the first place? Getting to the bottom of these questions, is a polemic about the power of the medical profession.

⁶² C. Ham et al., 'The Medical Profession, the Public, and the Government', 324 (2002) *British Medical Journal* 838-841.

⁶³ These healthcare scandals have included the suspension from the medical register of pediatric cardiac surgeons from Bristol following an inquiry into poor standards of care, the revelation that children's organs had been removed and retained without their parents' consent during post mortem examinations at Alder Hey Hospital in Liverpool, and the murder by Dr Harold Shipman of more than 200 of his patients. See e.g., M. Redfern, *The Report of Royal Liverpool Children's Inquiry*, available at: <http://www.rlcinquiry.org.uk/>; D. J. Smith DBE, *The Shipman Inquiry: Independent Public Inquire into the Issues raised from the Case of Harold Fredrick Shipman*, available at: <http://www.shipman-inquiry.org.uk/reports.asp> (Last visited on Jan 21st, 2011)

⁶⁴ Recent reforms in the UK post-Shipman period have been discussed by, for example, J. K. Mason and G. T. Laurie, *Mason and McCall Smith's Law and Medical Ethics* (Oxford, Oxford University Press, 2010, 8th edn), 14-23.

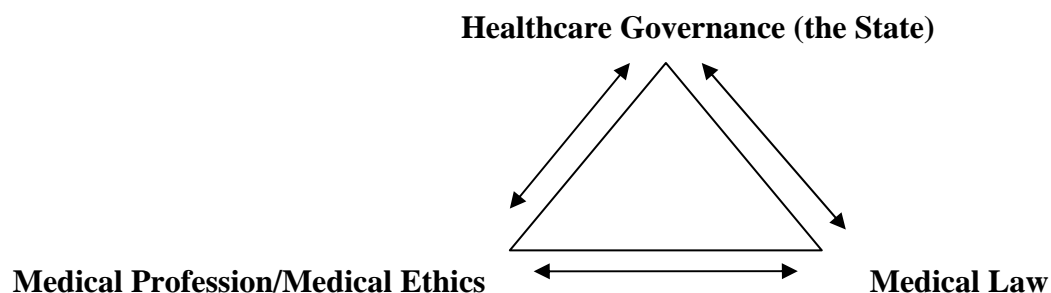
⁶⁵ See note 23, at 19.

Although, as discussed earlier, the nature of professional regulation is political, one should not ignore that the profession, as an agent, also shapes the political and social process. The prestige of science may act as an authoritative source for rules of social organisation, providing its own quality control or self-management. But does this mean that the medical profession is powerful, and/or that this power is legitimate? Legislation in a contemporary democratic society is often expected to represent the will of the majority; the degree of professional dominance over healthcare regulation, so to speak, is decided through negotiations between the public, government, and medics. Therefore, the legitimacy of professional-influenced health legislation depends greatly on its local context.

2.3 Summarising the Bilateral Relations and Setting up a Working Model

This section has discussed the bilateral relationships between the medical profession and its control mechanisms (state governance and law). Though the role of the state in healthcare delivery and financing varies across countries, the state occupies a key position in this network of bilateral relationships. The medical profession's role could be lobbyist or partner in state governance; and whether medics could be one determinant of law or not depends on the local political and socio-economic contexts. This ultimately lies in the legitimacy of professional power. Generally speaking, there has been a decrease in the Western medics' influence over healthcare governance and law, but they still to a varying degree exert influence on healthcare policies or even voice their resistance towards medical law and reforms.

Based on the above analysis, the hypothetical working model of the Western healthcare governance emerged as a triangular shape:



This triangular shaped model suggests that, in the area of healthcare governance, the state is based at the top deciding the nature of the healthcare system and supervising the direction of healthcare legislation. Under the state's healthcare governance, the medical profession remains amongst the most trusted of professions and most likely to exert an influence over government and legislators, though the nature of these relationships has been changing.

The nature of the relationship between state healthcare control mechanisms (financing, delivery policies and regulation) and the medical profession as generated above will provide a broad and symbolic method/model of shedding some light on the examination of healthcare governance in the Chinese context. The following section will look into the position of Chinese medics in relation to state governance and law under this structure: (1) state healthcare governance and Chinese medics; (2) the regulatory control mechanisms (in which the political nature of law will be examined) and Chinese medics.

3. The Chinese Medical Practitioners, State Governance and Law

In the previous section, I have proposed a conceptual framework that described the multilateral relationships between state, medical profession and law in the West. This section focuses on the nature of the relationship of Chinese medics with the state, and the ways in which healthcare regulation and practice are influenced by political, social and cultural norms. It also explores the role that the Communist Party doctrines play in shaping the ethics of Chinese medics and their professional practice by distinctive control mechanisms.

3.1 Healthcare State Governance and Chinese Medical Practitioners

One major question to be answered in this section is how the Chinese healthcare governmentality is formed. In order to trace the bilateral relationships between the state, law and medical practitioners in China, this section starts by discussing that relationship by looking briefly into the Chinese healthcare system and three-level

healthcare delivery service. It then examines the impact of the healthcare regulatory framework on Chinese medics: more specifically, the nature of the law in China; the healthcare regulatory framework and legislation trends. Finally, this section explores the engagement of political control mechanisms in healthcare.

(1) The Under-Resourced Healthcare System

The healthcare system during Mao's period placed emphasis on prevention. It made health services affordable by charging below cost for visits and hospital stays.⁶⁶ With easy access to basic curative care, and affordable services tailored to meet local needs, Mao's government earned solid support from its political base – the rural and urban working populations – and was regarded internationally as “a success”.⁶⁷

The market-orientated economic reform in China that began in the late 1970s significantly shaped Chinese health policies toward the development of the country's health sector.⁶⁸ As part of that transition to a market economy, near-universal access to basic healthcare has dismantled. By decentralising healthcare provision and management, reforms aimed to improve productivity and efficiency and encouraged privatisation. The Chinese central government reduced its role in universal healthcare provision and let the private sector take part in healthcare provision and financing.

In 1988, with the introduction of fiscal contracts, the government formally expressed the notion that local authorities should minimize dependence on support from higher levels.⁶⁹ With tax autonomy, local governments were expected to generate revenues by their own efforts to cover public service costs. Healthcare institutions were allowed more financial independence and given decision-making power from local

⁶⁶ W. C. Yip and W. C. Hsiao, 'Medical Savings Accounts: Lessons from China', 16 (1997) *Health Affairs* 6.

⁶⁷ See e.g., D. M. Lampton, 'Changing Health Policy in the Post-Mao Era', 54 (1981) *The Yale Journal of Biology and Medicine*, 21-26; W. C. Hsiao, 'Transformation of Health Care in China', 310 (1984) *The New England Journal of Medicine* 392-396.

⁶⁸ Q. Meng, 'New Directions in China's Health Sector Reform', 9 (2009) *China Brief* 5.

⁶⁹ J. Ma and J. Norregaard, *China's Fiscal Decentralization*, Internal Monetary Fund Research Report (Oct 1998).

authorities.⁷⁰ As a result of economic reform, the government subsidy was significantly reduced to cover only 10-20% of hospital expenditure.⁷¹

Healthcare decentralisation without sufficient funding allocation has led to vast inequalities in access to healthcare, especially in impoverished areas.⁷² Healthcare facilities and even some government health programs depended on patient revenues to meet their operating expenses and needed to charge user fees for services rendered.⁷³ The devastating result was that the richer one was, the better the healthcare one received; while those whose income was low and who could not afford medical treatment were deprived of their right to access healthcare.⁷⁴

In 2000, a report published by World Health Organisation, ranked China 144th amongst 191 member states with regard to public health infrastructure.⁷⁵ In terms of equity in healthcare, China was ranked 118th – the fourth from the bottom amongst all countries surveyed. Research conducted by the Chinese government found that, due to financial difficulties, in 2007, 59.3% of rural population in China tended not to go to hospital when sick.⁷⁶ It was shown in the official report that, in 2009, the health inequality problem was still serious; the average rural population's yearly healthcare spend was 455 RMB (equivalent to 44 GBP), which was much less than their urban counterparts (21862 RMB, equivalent to 2000 GBP).⁷⁷ Poverty and inequality are major challenges to China's healthcare system.

⁷⁰ See e.g., J. Tao (ed), *China: Bioethics, Trust, and the Challenge of the Market* (Hong Kong, Springer, 2008), 137-142; W. C. L. Hsiao, 'The Chinese Health Care System: Lessons for Other Nations', 41 (1995) *Social Science and Medicine* 8, 1047.

⁷¹ W. C. Yip and W. C. Hsiao, 'Medical Savings Accounts: Lessons from China', 16 (1997) *Health Affairs* 6.

⁷² WHO, *China, Health, Poverty and Economic Development* (Beijing, WHO's Representative Office in China, 2005), 27.

⁷³ Ibid, 1052; also see, The World Bank, *China 2000: Financing Health Care: Issues and Options for China* (Washington, World Bank, 1997).

⁷⁴ L. Lim, 'The High Price of Illness in China', (March 2nd, 2006) *BBC News Beijing*.

⁷⁵ A. Tandom, et al., *Measuring Overall Healthcare System Performance for 191 Countries*, (2000) WHO GPE Discussion Paper Series: No 30.

⁷⁶ Research Centre of PRC Ministry of Civil Affairs, 'Problems faced Urbanisation and Urban Migrant Peasants' (in Chinese), available at:

<http://zyzx.mca.gov.cn/article/mjzl/lq/200712/20071200009107.shtml> (Last visited on Nov 20th, 2010).

⁷⁷ Ministry of Health of PRC, *The 2009 Public Health Report: Date Interpretation* (in Chinese), available at: http://www.gov.cn/gzdt/2010-04/09/content_1576976.htm (Last visited on April 13th, 2010).

China is currently at the crossroads of transforming its healthcare system, since the Chinese government is committed to increasing government funding for healthcare by as much as 850 billion RMB (equivalent to 78 billion GBP) over the next several years, aiming to provide universal basic healthcare by 2020.⁷⁸ (The latest developments on China's healthcare system reforms will be discussed in Chapter 9).

(2) Healthcare Delivery in China

In China there are three tiers of healthcare institutions which include hospitals, health centres, health clinics or units, etc – Levels I, II and III – representing increasing degrees of specialisation and sophistication. The Level III hospitals refer mainly to provincial hospitals or municipal/city hospitals. Their affiliated physicians are most likely to be specialists, providing specialised care, such as mental health, maternal and child health, paediatrics and oral or thoracic surgeries, etc. The Level II healthcare services are mainly provided by district level hospitals in urban areas or towns, providing emergency, outpatient and inpatient care. The Level I healthcare institutions cover community health centres, township health centres and village clinics, which provide basic, primary and preventative care.

Under this organisational structure, institutions at each level are evaluated and ranked, based on quality and quantity of care, as Grade A (highest), B or C (lowest). The higher the grade, the more skilled the medical staff and the more advanced techniques an institution has. By the end of 2009, the number of health institutions in China had reached 916,571, within which, the number of Level III hospitals was 1,233 (within which there were 765 Level III Grade A hospitals), and, the number of Level II and Level I hospitals was 6,523 and 5,110 respectively.⁷⁹

The provision and distribution of healthcare delivery institutions is shown as below:

⁷⁸ F. Wang, 'Medical Reforms have led to a New Way of Thinking: Ministry of Finance' New Investment in Healthcare' (in Chinese), (October 29th, 2006) *Sohu News*; '200 Billion Yuan for Universal Basic Healthcare' (in Chinese), (September 18th, 2006) *Xinhua TV News*.

⁷⁹ Ministry of Health of PRC, *The 2009 Public Health Report* (in Chinese), available at: http://www.gov.cn/gzdt/2010-04/09/content_1576944.htm (Last visited on April 13th, 2010).

Healthcare Institutions in China 2009⁸⁰

Hospital	20,291
<i>(within which) General Hospitals</i>	<i>13,364</i>
<i>Chinese Medicine Hospitals</i>	<i>2,728</i>
<i>Specialist Hospitals</i>	<i>3,716</i>
Community Health Centres	27,308
Health Units	39,627
<i>(within which) Country Health Units</i>	<i>38,475</i>
Outpatient Clinics	7,639
Clinics (health centres, clinics, nursing clinics)	174,809
Country Clinics	632,770
Blood Collection and Supply Centres	526
Maternal & Child Health Centres	3,020
Disease Control & Prevention Specialist Centres	1,291
Preventive Care Units	3,536
Health Inspection Centres	2,809
In total	916,571

At the same time, the total number of healthcare practitioners in China reached 7,844,000:

Health Workers in China 2009⁸¹

Urban Healthcare Staff	5,397,000
<i>(within which) Licensed (including assistant) doctors</i>	<i>2,205,000</i>
<i>(within which) Licensed doctors</i>	<i>1,825,000</i>
<i>Licensed nurses</i>	<i>1,841,000</i>
<i>Pharmacists</i>	<i>342,000</i>
<i>Medical device technicians</i>	<i>323,000</i>
Other skilled workers	275,000
Management staffs	363,000
Technical support workers	558,000
Medical Staffs in Rural Areas	1,251,000
<i>(within which) Licensed (assistant) doctors</i>	<i>124,000</i>
<i>Licensed nurses</i>	<i>14,000</i>
<i>Country doctors</i>	<i>1,042,000</i>
<i>Clinicians</i>	<i>71,000</i>
In total	7,844,000

Although the number of healthcare workers has seen an increase, the official report revealed that the average workload of each Chinese resident physician had risen to 7.5 patient appointments per day.⁸² Due to the under-resourced healthcare system, their income, however, did not follow at the same pace as their increasing workload. The

⁸⁰ Ibid, I realise that the report shows an incorrect total number which should be 913,626, based on the number provided above. In this thesis, I quote it as exactly as it appears.

⁸¹ See note 79.

⁸² Ibid.

PRC deputy Health Minister stated that, in 2008, only 5% of government funding was used for healthcare workers' incomes.⁸³ Based on a survey conducted in 2010 by an independent educational statistical consulting firm, in terms of the average salary of college graduates from different majors six months after graduation, the bottom two incomes ranked are graduates from: dentistry (the lowest income, 1740 RMB per month, equivalent to 160 GBP) and clinical medicine (the second lowest income, 1747 RMB per month, equivalent to 162 GBP).⁸⁴

“An effective regulatory framework is key to delivering system reform and to creating a well-functioning healthcare market.”⁸⁵ The under-resourced healthcare system in China has deprived patients of equal access to healthcare. It also places medics' wages on a relatively low level. These have led to enormous, compounded social problems (which have been briefly discussed in the Introduction and will be given more detailed discussion in Chapter 3) and further eroded the effectiveness of the healthcare environment.

Having explored the Chinese healthcare delivery system, the next two sections will address medical practice under the supervision of the healthcare regulatory framework and the Chinese Communist Party (CCP) respectively.

3.2 The Healthcare Regulatory Framework and Its Impact on Chinese Medics

Chinese medical practitioners are subjected to one main source of control – medical laws and regulations. This section starts by discussing the nature of law in China, before examining its healthcare regulatory framework and patterns of medical law development.

⁸³ Interviews with Deputy Health Minister Huang Jiefu, S. Wang, ‘Don’t Expect the Healthcare Reform will Increase Health Workers’ Incomes’ (in Chinese), (Mar 6th, 2008) *China Economic Daily*.

⁸⁴ The survey report was based on 500,000 random samples and 245, 000 returned filled questionnaires. See, MyCos HR Digital Information, *College Graduates Careers and Jobs Report 2010* (in Chinese), June 2nd, 2010, (Beijing, Social Science and Academic Press China, 2010).

⁸⁵ Monitor, *Discussion Paper: Developing an Effective Market Regulatory Framework in Healthcare*, (Oct 18th, 2005) Independent Regulator of NHS Foundation Trust.

(1) The Nature of Law in China: Relationship between the State and Laws

Laws are the finalization of the Party's principles and policies; they are fixed general lines and specific policies of the Party put in a legal form.

Peng Zhen, speech to the Central Party School, 1979⁸⁶

The law of China is defined by Chinese officers as legislation with “Chinese characteristics”.⁸⁷ It is a product of policy decided by the Party/state to build an institutional framework to support Chinese economic growth.⁸⁸ According to Peng Zhen, the top political legal officer of the 1980s, the legal rules in China exist not only to identify the thrust of CCP policy, but also to provide an organisational framework for the enforcement of that policy.⁸⁹ Chinese law, in his opinion, is an expression of Party policy manifested through command rules enacted by the state apparatus.

Indeed, some political ideologies are reflected explicitly in law. For example, the *Four Basic Principles* – “insisting on the socialist road; on people’s democratic dictatorship; on the leadership of the CCP; and on Marxism-Leninism, Mao Zedong thoughts and Deng Xiaoping’s theory”, appear in *the PRC Law of Legislation*.⁹⁰ Similar political ideologies, such as, the Chinese Communist Party’s “Three Represents” posted by the former PRC President and CCP Secretary General Jiang Zemin,⁹¹ has also been incorporated in *the PRC Constitution*.⁹²

⁸⁶ P. B. Potter, ‘Peng Zhen: Evolving Views on Party Organization and Law’, in D. Merwin (ed.), *China’s Establishment Intellectuals* (London, M.E. Sharp, 1986), 21.

⁸⁷ The PRC State Council, ‘II: Legislation and Legal System with Chinese Characteristics’, *White Paper: China’s Efforts and Achievements in Promoting the Rule of Law*, Feb 28th, 2008.

⁸⁸ The decision to pursue legal reform, first articulated at the Third Plenum of the 11th Central Committee Congress in late 1978, was the result of a tentative commitment to introducing market mechanisms to the state-planned economy. See Communiqué of the 3rd Plenum of the 11th CCP Central Committee (in Chinese), 1 (1979) *Red Flag* 14-21.

⁸⁹ See note 86.

⁹⁰ The Article 3 of the PRC Law of Legislation states: “Legislation shall follow the principles of the Constitution, taking economic construction as a core, insisting on the socialist road, on people’s democratic dictatorship, on the leadership of the Chinese Communist Party, and on Marxism-Leninism, Mao Zedong thoughts and Deng Xiaoping’s theory and insisting on reform and openness.”

⁹¹ The “Three Represents” was promoted in China as the nucleus of Jiang Zemin’s political theory. The theory focuses on the future role of the CCP as “a faithful representative of the requirements in the development of advanced productive forces in China, the orientation of the advanced culture in China, and the fundamental interests of the broadest masses of the people in China.” See e.g., J. Fewsmith, ‘Studying the Three Represents’, (Fall 2003) *China Leadership Monitor*, No. 8, Hoover Institution of Stanford University; ‘Three Represents’, *News of the Communist Party of China*, available at: <http://english.cpc.people.com.cn/66739/4521344.html> (Last visited on Oct 29th, 2010).

During the Cultural Revolution, all the universities including the law schools were shut down (more detailed discussion about the Cultural Revolution will be in Chapter 3). China went through a lawless period when professions such as the police, prosecutors, and judges were smashed in the social movement of the Cultural Revolution.⁹³ At that time, the rules of the CCP replaced law to control or oversee society. The well-known Chinese idiom “Communist Party rules and law” which literally puts ‘party rule’ ahead of ‘law’ in its wording, indicates party rules are superior to law. I agree how Chen summarises the nature of justice in this lawless period – the “Marxist concept of law was used to restructure society, to suppress class enemies, and to enforce party policies rather than protecting individual rights”.⁹⁴ This means that the idea of justice was politicised from the start of the PRC.

After the death of Mao, the CCP started its series of social and economic reforms. Besides the healthcare system reform, restoration of the legal system was also on the political agenda. Ruling the state by law rather than by people became a political slogan.⁹⁵ This is reflected in *the PRC Legislation Law*, that China is “promoting the government of the country according to law and building a socialist country under the rule of law.”⁹⁶ But this does not mean that the CCP handed over its power to Chinese legislators. Indeed, the legislative, executive and judiciary powers are still centralised by the CCP-led government. “The Communist Party wields ideological control, making sure that law in China serves Party policies.”⁹⁷ More recently, the Chairman of the PRC National People’s Congress, Wu Bangguo stated that, “China will never simply copy the system of Western countries or introduce a system of multiple parties

⁹² Preamble of the 2004 PRC Constitution states, “Under the leadership of the Communist Party of China and the guidance of Marxism-Leninism, Mao Zedong Thought, Deng Xiaoping Theory and the important thought of ‘Three Represents’, the Chinese people of all nationalities will continue to adhere to the people’s democratic dictatorship and the socialist road...”

⁹³ B. Liang, *The Changing Chinese Legal System, 1978-Present: Centralisation of Power and Rationalisation of the Legal System* (New York, Routledge, 2008), 20.

⁹⁴ Ibid; also see, J. Chen, *Chinese Law: Towards an understanding of Chinese Law, Its Nature and Development* (Cambridge, Kluwer Law International, 1999), 36-40.

⁹⁵ See e.g., S. Yuan, ‘Significant Theoretical and Practical Problems concerning the Party’s Rule by Law’ (in Chinese), available at:

<http://www.chinalaw.gov.cn/article/jgz/bld/ysh/xgwz/200905/20090500133118.shtml> (Last visited on Dec 5th, 2010).

⁹⁶ The PRC Legislation Law, Article 1.

⁹⁷ C. L. Baraban, ‘Inspiring Global Professionalism: Challenges and Opportunities for American Lawyers in China’, 73 (1998) *Indiana Law Journal* 1247; J. Wang, *The Role of Law in Contemporary China: Theory and Practice*, doctoral dissertation, Cornell University, 1988, 352.

holding office by democratic voting system. Although China's state organisations have different responsibilities, they all adhere to the same Party line, principles and policies."⁹⁸ Wu's speech further confirms that the political ideologies of the CCP are still reflected in the law.

Therefore, one should bear in mind that the Chinese conception of justice and "rule of law" differ greatly from the Western democratic understanding of these concepts. In the Chinese conception, "law is a body or system of rules imposed on the society by the current political leadership regulating how people should conduct themselves in order to achieve modernization of the state in accordance with Marxist/socialist ideology."⁹⁹ It seems that, irrespective of issue and level, the Party/state is the only authority that is in firm control of healthcare legislation and policy making. With regard to healthcare, the approach undertaken by the Chinese government in implementing the 'rule of law' is to "create new or use existing administrative structures to supervise the compliance with relevant laws by actors, including the health facilities."¹⁰⁰ The Western-based hypothetical working model (which I offered earlier in this chapter) does not therefore fit the Chinese context.

To sum up, law in China presents and serves the will of the Party/state. The following section will investigate how this authoritarian model is reflected in the healthcare context. What is more, it aims to identify a representation of the relationship between state governance, law and medical practitioners in China.

(2) The Legal and Regulatory Framework for Healthcare in China

This section seeks to examine the legal and regulatory framework for healthcare practice in China. Attention will be placed primarily on an overview of the organisational structure, as well as the system of administration of health laws. This approach is taken with a view to analysing the practical implication of the legislative

⁹⁸ 'Bangguo Wu: China will never start Multi-party System or "Separation of Powers"' (in Chinese), (April 16th, 2009) *China.com News*; 'China "will not have democracy"' (in Chinese), (March 9th, 2009) *BBC News*.

⁹⁹ R. A. Herman, 'The Education of China's Lawyers', 46 (1981-1982) *Albany Law Review* 789.

¹⁰⁰ See note 29.

developments in the regulation of health rather than ascertaining the letter of certain laws.

The PRC Constitution has the highest legal authority in the Chinese legal framework. In China, legal documents with lower authority than *the Constitution* (in decreasing order of legal authority) are as follows: national law enacted and amended by National People's Congress (NPC) or amended by Standing Committee;¹⁰¹ administrative regulations enacted by the State Council (SC);¹⁰² local decrees, autonomous decrees and special decrees enacted by the local People's Congresses and the local people's governments at various levels, organs of self-government in national autonomous regions;¹⁰³ and administrative or local rules enacted by relevant departments or ministries, such as the Ministry of Health (MOH).¹⁰⁴ This legal and regulatory framework which applies in the healthcare sector presents a remarkably complex network.

One must also note that, this regulatory network exists within the government administrative structure. The health administration system, comprising the MOH at the national level and the Health Bureaux (HB) at the local level, is the main government institution responsible for the regulation of healthcare. The MOH, as a regulator, also concurrently serves as the top administrative and regulatory institution in governing public healthcare facilities.

More specifically, at the national level, the major roles of the MOH in China are to “draft health laws, regulations and policies; propose health development programs and strategic goals; formulate technical protocols, health standards and supervise their enforcement”.¹⁰⁵ At the local level, the MOH is responsible for guiding “the reform of medical institutions; to formulate criteria for medical practitioners, medical quality and service delivery, and to supervise their enforcement”, as well as formulating “national development programs on health professionals and professional ethics

¹⁰¹ The PRC Legislation Law 2000, Article 7.

¹⁰² Ibid, Article 56.

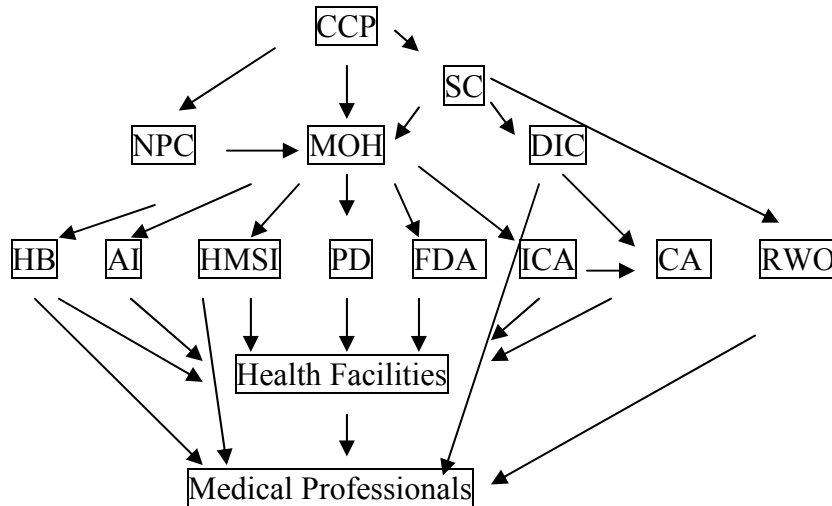
¹⁰³ Ibid, Article 69.

¹⁰⁴ Ibid, Article 71.

¹⁰⁵ Mandates I, II and VIII of the Ministry of Health, available at: http://www.gov.cn/english/2005-10/09/content_75326.htm (Last visited on Dec 9th, 2010).

protocols for health personnel; to draft and implement staffing standards for health institutions and accreditation criteria for health personnel.”¹⁰⁶

Inspired by Fang’s figure,¹⁰⁷ below is my graphic representation of the vertical regulatory framework of medical professions, which illustrates the position and relationship of regulatory institutions in China:



Abbreviations: The Chinese Communist Party (CCP); The State Council (SC); The National People's Congress (NPC); The Ministry of Health (MOH); The Discipline Inspection Committee of CCP (DIC); Health Bureaux (HB); The Auditing Institute (AI); The Hygiene Monitoring and Supervisory Institute (HMSI); The Price Division (PD); The Food and Drug Administration (FDA); The Industry and Commerce Administration (ICA); The Consumer Association (CA); The Rectifying Wrongdoing Office (RWO).

The above network of government agencies is in charge of governing the healthcare industry that is dedicated to providing healthcare services for 1.3 billion Chinese people. This network also shows that the healthcare administrative regulatory agencies are functioning under the control of the CCP disciplinary organisations, for both legislation and political discipline.

Under the supervision of the MOH, the Hygiene Monitoring and Supervisory Institute (HMSI) was established within the health administration system to be responsible for monitoring and supervising food and environmental hygiene, health facilities, etc.

¹⁰⁶ Ibid, Mandates V and IX.

¹⁰⁷ J. Fang, ‘The Chinese Health Care Regulatory Institutions in an Era of Transition’, 66 (2008) *Social Science and Medicine* 959.

The HMSI's role has been legitimised by a number of laws, including *the Food Hygiene Law*, *the Ordinance of Medical Institution Management*, *the Medical Practitioner Act*, *the Law for Professional Nurses* and *the Law concerning Infectious Disease Prevention and Treatment*. The HMSI is a law-enforcing institution. Besides, other parts of the health facilities are also regulated by the following governmental institutions: the Price Division (PD); the Auditing Institute (AI); the Food and Drug Administration (FDA); the Industry and Commerce Administration (ICA); and the Consumer Association (CA).

However, the above functional agencies do not have control over the PRC healthcare regulatory framework. The Chinese Communist Party (CCP) has power to oversee and supervise all political, judicial, administrative, and state-owned enterprises or organisations (to be discussed shortly).¹⁰⁸ Its Discipline Inspection Committee (DIC) with its monitoring and supervisory unit, has the power to oversee CCP members (so called cadres).¹⁰⁹ A large number of Chinese medical practitioners (who are also registered as CCP cadres) are under the DIC's supervision. The Rectifying Wrongdoing Office (RWO) serves directly under the leadership of the State Council (SC). Its role is to guide, facilitate, check and prevent wrong-doings (such as corruption), within the public sector.

Having briefly discussed the nature and framework of China's healthcare legislation, the next section analyses in general the content of medical legalisation; in particular, two pieces of legislation formulated during the last decade, in response to the healthcare system transition: *the 1998 PRC Medical Practitioner Act* and *the 2002 Regulation on the Handling of Medical Accidents*.

(3) Healthcare Legislation

There are a growing number of regulations pertaining to the standardisation of licensing doctors,¹¹⁰ nurses,¹¹¹ and pharmacists,¹¹² etc, and to procedures of particular

¹⁰⁸ See note 29.

¹⁰⁹ Ibid.

¹¹⁰ The 1998 PRC Medical Practitioner Act.

¹¹¹ The 1994 PRC Licensed Nurse Act; The 2008 Administrative Measures for the Registration of Practicing Nurses.

departments or general medical practice. This section will not examine in detail healthcare regulations relevant to particular medical departments, but trace the pattern of legislation in order to understand how these regulations affect the Chinese medics' role and their ability (or not) to change things in general.

In June 1998, China's legislature passed its first statute for licensed practitioners – *the 1998 PRC Medical Practitioners Act*. The Act was designed for “the purpose of strengthening a contingent of doctors, improving occupational morals and professional skills of doctors, safeguarding [the] legitimate rights and interests of doctors, and protecting the people's health”.¹¹³ It emphasises the need for Chinese medical practitioners to practise ethically for their patients' best interest, and to avoid any fraud or wrongdoings. It was praised as being able to “greatly assist the development of professional morals in medicine”.¹¹⁴

For example, doctors who engage in unethical conduct in healthcare settings – such as receiving a ‘reward’ (or ‘grey income’) from patients, recommending unnecessary medical tests, procedures, and services, using excessive amounts of medicine, and engaging in illegal surgery – breach Article 27 of the Act which reads: “Doctors shall not take advantage of their positions to extort or illegally accept the patients' property or seek other illegitimate gains”. It states that hospitals and doctors have obligations to accept and treat critically ill patients rapidly, irrespective of whether or not they have enough money to pay for treatment.¹¹⁵

It is clear that the 1998 Act tries to establish a legal basis for the Chinese medics' ethical duty – that is to save life and to practice professionally without fraud. Apart from disciplining medics, the Act also aims to safeguard the legitimate rights and interests of doctors. It states “the whole society should respect doctors”;¹¹⁶ and “anyone who obstructs a doctor from his medical practice according to law, insults, slanders, threatens or strikes a doctor, or encroaches on one's personal freedom, or

¹¹² Legislating pharmacists is still under discussion, so far, pharmacists in China were subject to PRC Drug Administration Law, starts its enforcement since Dec 1st, 2001.

¹¹³ The 1998 Act, preface.

¹¹⁴ R. Peng, ‘How Professional Values are Developed and Applied in Medical Practice in China’, 30 (2000) *The Hastings Center Report* 4, 23-26, 25.

¹¹⁵ The 1998 Act, Article 24.

¹¹⁶ The 1998 Act, Article 3.

interferes in one's normal work and life shall be penalized according to the provisions of *the Regulations on Administrative Penalties for Public Security*; if a crime has been constituted, criminal liability shall be investigated according to law."¹¹⁷ In this regard, the 1998 Act was trying to balance the rights and obligations of Chinese doctors and even extend its influence to the doctor-patient relationship (the breakdown of trust in this relationship, including hospital violence will be discussed in Chapters 3).

With the desire to establish a credible system of medical liability, and to reduce the incidence of hospital violence against medical professionals, Chinese legislators perceived that hospital violence was a serious social problem for which a legal solution was required. *The 2002 Regulation on the Handling of Medical Accidents* was thus drafted to "increase the adequacy and fairness of compensation, make improvements to the procedure for resolving medical disputes, and overall, to reduce medical errors and improve the quality of care".¹¹⁸ As set forth in Articles 1 and 59 of this Regulation, one of the purposes of the regulation is to maintain an orderly and safe environment for medical practice; by providing criminal penalties or other punishments for anyone who picks a quarrel and stirs up trouble. This corresponds to Article 40 of the 1998 Act as discussed earlier.

Another controversial issue from the 2002 Regulation is that it assigns the burden of proof to healthcare practitioners in liability cases. It also imposes liability on medical institutions to supervise their medical staff, which includes provisions for civil remedies, administrative punishment, and even criminal punishment in very serious cases. This shows the ambition of the Chinese government in trying to deal with complex doctor-patient relationships. Harris and Wu have suggested that "The 2002 Regulation is not merely a mechanism for handling individual cases of medical malpractice...Chinese lawmakers have combined reform of the liability system with efforts to improve the quality of care. Thus, this Regulation describes a comprehensive system of quality assurance, reporting requirements, regulatory supervision, administrative discipline, and compensation for injuries to patients."¹¹⁹

¹¹⁷ The 1998 Act, Article 40.

¹¹⁸ The 2002 Regulation on the Handling of Medical Accidents, Article 1.

¹¹⁹ M. Harris and C. Wu, 'Symposium Article: Medical malpractice in the People's Republic of China: the 2002 Regulation on the Handling of Medical Accidents' 33 (2005) *Medicine & Ethics Journal of Law* 456.

It should be recognised that the 2002 Regulation which puts the burden of proof on medical professionals is a sign of improvement. Patients are given more protection and power because of the better regulation of patient care and healthcare institutions. But the side-effect of this is that, to some extent, such patient empowerment seems to encourage patients to make claims, and potentially, it disempowers and de-motivates Chinese medics. Findings in my empirical studies support this notion (more discussions will be given in Chapter 6). Empirical data also show that most of the claims are solved by monetary compensation at the pre-trial level, as hospitals try to avoid litigation in order to minimise the damage to their reputation.¹²⁰ Since patients are increasingly critical of the medical profession and sceptical of their knowledge, medical professionals who are afraid of being sued are widely practising defensive medicine.¹²¹

It seems necessary for both pieces of law to recognise the existing problems in China's healthcare arena. In the past ten years, with an increasing number of healthcare laws, they begin to play an increasingly important role in governing Chinese medics and healthcare institutions. Although it is unclear how much effect it has made on encouraging or potentially de-motivating Chinese medics; healthcare legislation can, at best, set practice standards in this profit-driven healthcare environment. From a macro point of view, this is an improvement. But I recognise that law has its limitations, and these health laws cannot meet their ends (i.e. solving the crisis of trust or restoring doctor/patient relationship) without fundamentally reforming the healthcare financing system (more discussion in Part Three).

Having discussed the healthcare regulatory mechanism (its nature, framework and pattern), in the next section, I will assess the Chinese Communist Party (CCP)'s disciplinary controls in healthcare practice.

3.3 Disciplinary Controls of the CCP

¹²⁰ J. Yang, 'The Side-Effect of China's Patient-Centred Healthcare Reform', paper presented at the *Social Policy Association Conference 2010*; also see my own empirical findings in Chapter 6.

¹²¹ Defensive medicine means medical decisions are undertaken by medics primarily to avoid liability rather than to benefit the patient. Chinese medics are widely practising defensive medicine has been discussed by X. Chen, 'Defensive Medicine or Economically Motivated Corruption? A Confucian Reflection on Physician Care in China Today', 32 (2007) *Journal of Medicine and Philosophy* 635-648.

“All levels of political leadership should put healthcare as a priority on the party’s agenda.”

The State Council of PRC¹²²

This section aims to discuss how disciplinary control by the CCP works in China. It begins with an overview of the role of the CCP in general, followed by an assessment of the potential effect of the CCP disciplinary controls on healthcare practice.

Although no law specifies to what extent the CCP has authority to oversee healthcare governance, as the sole political party stipulated by *the PRC Constitution*, it has power to oversee and supervise all political, judicial, administrative and service institutions.¹²³ Clearly, there is no exception for China’s healthcare facilities. Indeed, the CCP has penetrated into every level of Chinese society by appointing cadres to government and other departments and by setting up party committees and branches from the central government down to village committees. There were 77.99 million party members nationwide by the end of 2009 (about 6 percent of the Chinese population).¹²⁴

To qualify as party members, applicants must be at least eighteen years old and go through a one-year probationary period.¹²⁵ During this period, the Party organisation makes serious efforts to educate and observe these probationary members. The selection process emphasises applicants’ technical and educational qualifications rather than ideological criteria. Members are expected to be “vanguard fighters of the Chinese working class imbued with communist consciousness” for the purpose of making the party apparatus “more responsive to the demands and wishes of the masses of the people”. *The Party Constitution* stresses that,

¹²² The State Council of PRC, ‘Guideline for Further reforming Medical and Pharmaceutical System’, available at: http://www.gov.cn/jrzq/2009-04/06/content_1278721.htm (Last visited on Sep 29th, 2009).

¹²³ The Preamble of the PRC Constitution states, “Under the leadership of the Communist Party of China..., the Chinese people of all nationalities will continue to adhere to the people’s democratic dictatorship and follow the socialist road, steadily improve socialist institutions, develop socialist democracy, improve the socialist legal system...”.

¹²⁴ PRC Government, ‘Until the end of 2009, the Number of Chinese Communist Party Member Reaches 77, 995, 000’ (in Chinese), (Jun 28th, 2010) *PRC Government news*; Chinese Communist Youth League, ‘The Number of Chinese Communist Party Members Rose 16 times since the Birth of PRC’, available at: http://www.ccy1.org.cn/newscenter/news/200907/t20090701_264266.htm (Last visited on Nov 15th, 2009).

¹²⁵ The 2002 Chinese Communist Party Constitution, Chapter 1 ‘Membership’.

“It is essential to inspire the Party members and the people with the Party’s basic line, patriotism, community spirit and socialist ideology, enhance their sense of national dignity, self-confidence and self-reliance, imbue the Party members with lofty ideals of communism, resist corrosion by capitalist and feudal decadent ideas and wipe out all social evils so that our people will have lofty ideals, moral integrity, a good education and a strong sense of discipline.”¹²⁶

Once qualified, all Party members are required to have regular training. Such training is done principally through the nationwide networks which combine senior officer management schools and administrative management schools administered by local and provincial governments, the Party school system, and other specialised vocational training programmes.¹²⁷

The governors at each level of government and the heads of various government departments, such as the Health Bureaux and public hospitals, are usually Party members; while the offices of deputy governors and directors can be taken by non-Party members. The CCP therefore can be considered to have absolute influence on these regulatory institutions, although it still retains many of its traditions such as political campaigns and exhortation as part of Party discipline.

As previously noted, Chinese medical practitioners who are Communist Party members are under scrutiny from the monitoring and supervisory unit – the Discipline Inspection Committee (DIC) within the CCP. This falls under *the CCP Constitution*: “Party discipline refers to the rules of conduct that must be observed by Party organizations at all levels and by all Party members... Party organizations must strictly observe and maintain Party discipline. A Communist Party member must act conscientiously within the bounds of Party discipline.”¹²⁸ The DIC’s role in thought education and disciplinary sanctions for every level of Party members indicates the CCP’s hierarchical structure and control in Chinese society.

¹²⁶ Ibid, ‘General program’.

¹²⁷ See note 125; also see, R. L. Worden, et al. (ed), ‘CCP Membership’, *China: A Country of Study* (Washington, GPO for the Library of Congress, 1987), 106; D.L. Shambaugh, *China’s Communist Party: Atrophy and Adaptation* (California, University of California Press, 2008), 143.

¹²⁸ See note 125, ‘Chapter VII: Party’, Article 37.

Greenhalgh comments that, ideology is fundamental to the legitimacy of the PRC regime and its leaders.¹²⁹ According to Wang, such political ideological education aims to raise the population's "political consciousness" and "intellectual level".¹³⁰ Nevertheless, political disciplinary control adds another dimension to the relationship between state governance, regulatory control and medical practitioners. This, in my opinion, may directly or indirectly affect the nature or function of the triplicate relationship or elements of its relationship in between. Under such multi-dimensional control, there are a lot of complexities surrounding the position and role of China's healthcare practitioners.

Chinese medics' collective silence during the SARS scandal indicates that political propaganda and ideology have transformed the values of Chinese medics, whose first loyalty was no longer to the patients, but to the Party/state and to its development under the Marxist/socialist ideology. "The Party is like God. He is everywhere. You just can't see him".¹³¹ This expression given by a Chinese professor indicates that we should never underestimate the influence of the CCP, though its effects on every aspect of Chinese society may not seem obvious. Indeed, it is difficult to assess how much impact the CCP and its political disciplines have had on medical practice in China, from merely reading documents issued by the Party. The following Chapters 3, 5 and 6 will therefore explore this as one of the research questions using historical and empirical approaches.

4. Conclusion

This chapter has firstly discussed the nature of the bilateral relationship between the medical profession and its control mechanisms (state governance and law). Following the discussion, a hypothetical triangular-shaped working model of Western healthcare governance was suggested. This chapter then shifted its attention to the Chinese context, examining the healthcare state governance, as well as the control mechanisms

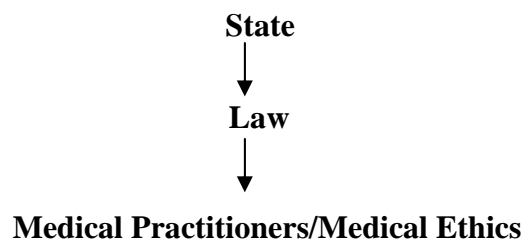
¹²⁹ S. Greenhalgh et al., *Governing China's Population: from Leninist to Neoliberal Biopolitics* (Stanford, Stanford University Press, 2005).

¹³⁰ J. Wang, *People's Republic of China: Politics and Government* (Beijing, Central Party School, 1995), 29-30.

¹³¹ Interview with a Chinese professor from Renmin University, cited by R. McGregor, *The Party: the Secret World of China's Communist Rulers* (London, Allan Lane, 2010).

(including law and political discipline) and their impact on Chinese medics. It seems that, there is no clear boundary between law and politics in China, where law and political discipline are treated equally, as both are, by nature, political. The supreme status of Party/state in China not only presents itself in legal terms, but can also be seen from its governmental structure, influence and complete control in overseeing every level of institutions and social lives. The healthcare institutions and their affiliated medical practitioners are no exception. Therefore I conclude that the triangular-shape working model that I offer earlier does not fit the Chinese context.

Since Chinese law is an expression of the will of the state, there is no clear divide between the respective roles of state and law. State, law and the medical profession can no longer form in a balanced way – a triangular model, but more as a top-down model as below:



This model can also be understood as a simplified Chinese healthcare regulatory framework (as suggested earlier), where the Chinese medical practitioners are based at the bottom.

Having discussed both the conceptual framework and contents of administrative, regulatory and political controls relevant to the Chinese medics, the next chapter serves to orientate an analysis of the historical development of Chinese medical practitioners and their interactions with the state.

I recognise that, though medicine is a type of applied knowledge that exists across the world, medical practice “is the product of the culture, the tradition, the history, and the personal life course of the social setting in which he or she applies that knowledge”.¹³² Indeed, in Chapter 3, we will see that, in China, the relationship

¹³² M. G. Field, ‘The Position of the Soviet Physician: the Bureaucratic Professional’, 66 (1988) *Milbank Quarterly* 182-201, 199.

between state bureaucracy, regulation and the medical profession is precisely a power struggle between state authority and Chinese medical practitioners. The historical development of the Chinese medical practitioners is actually a showcase of how state power has been used to bring professional activities under its control.

CHAPTER 3 THE HISTORICAL DEVELOPMENT OF CHINESE MEDICAL PRACTITIONERS

1. Introduction

This chapter reviews the political, economic and social background of Chinese medical practitioners. It aims to trace influences from the changes of traditional philosophies, political ideologies and social structures on medical practice, and the dynamic interaction between state governance and Chinese medics. This historical development can be divided into three chronological periods: the era of imperial and the Republican China; Maoist China; and lastly the Socialist market era. Finally, this chapter develops a preliminary hypothesis concerning state governance and law, and their influences on Chinese medical practice. This hypothesis, together with the working model (that I developed earlier) will be further tested by the empirical studies in the later part of this thesis.

2. Chinese Health Professional Development from the Imperial to the Republican Era

2.1 Medical Practice in Ancient China: Confucianism, State Governance and Bioethics

Chinese medicine was based on a profound philosophy and also on a particularly rich empirical tradition that evolved over the last 3000 years. It took a holistic approach to understand the human body by its unique interventions, through diet, exercise, awareness of environmental influences on health, and the use of herbal remedies.¹³³ This section provides an overview of the professional background and its bioethical development in Imperial China.

¹³³ J. Gawne, 'What is Traditional Chinese Medicine', (Jan 28th 2010) *Ezine Articles*, available at: <http://ezinearticles.com/?What-is-Traditional-Chinese-Medicine?&id=3653981> (Last visited on April 10th, 2011).

(1) Medical Administrative Management in Imperial China

Traditional Chinese Medicine (TCM) began to develop in the Zhou Dynasty (1045–256 B.C.).¹³⁴ It involved many different practices employed by practitioners who had inherited the experience and skills from their predecessors.¹³⁵ TCM gradually formed and grew into a more systematic ideology and practice in the Tang (618–907 A.D.) and Song Dynasties (960–1279 A.D.) when there was growing demand for skilful medics from the increasingly centralised and civilised monarchy.¹³⁶ Organised medical education, examinations, supervision and administrative management began to develop.

Apart from the influence of the strengthening state administration, Chinese ancient philosophies, such as Confucianism¹³⁷ and Daoism,¹³⁸ also had far-reaching impacts on the invention and evolution of TCM. TCM allows for a tremendous amount of diversity via the personalisation of medical practice. Medical care was delivered by a variety of classes of practitioners, ranging from official Confucian physicians to Taoist priests and itinerant drug peddlers.¹³⁹ “All these maxims, exhortations, admonitions, and warnings are personal advice or suggestions of then famous and prestigious physicians based on their personal experience of practicing medicine, but not professional codes in any sense.”¹⁴⁰ In other words, there was no unified school or code for TCM practitioners. Unschuld explains that,

“The common underlying conceptual basis of all these practitioners [those who were well-educated in the tradition] was exceedingly narrow, being limited to the acknowledgement of certain surviving works as classic texts and a belief in the fundamental truth of the central theories of the five phases and the all-encompassing dualism of yin-yang. But, even the

¹³⁴ Ibid.

¹³⁵ S. Dharmananda, ‘Understanding Chinese Medicine’, Institute for Traditional Medicine, available at: <http://www.itmonline.org/arts/understand.htm> (Last visited on Dec 13th, 2009).

¹³⁶ G. Henderson, ‘Physicians in China: Assessing the Impact of Ideology and Organization’, in F.W. Hafferty and J.B. McKinlay (ed), *The Changing Medical Profession: An International Perspective* (Oxford, Oxford University Press, 1993), 184 -194.

¹³⁷ Confucian emphasised spiritual harmony and well-being. See, P. Lo, ‘A Confucian Philosophy of Medicine and Some Implications’, (2010) *Journal of Medicine and Philosophy* 1-11.

¹³⁸ Taoism emphasises that following principles of the nature for the ideal life or even achieve immortality. See, Z. Liu, *The Mystery of Longevity* (Beijing, Foreign Languages Press, 1990), 2-3.

¹³⁹ See Note 136.

¹⁴⁰ R. Qiu, ‘Confucianism, Traditional and Contemporary China’, *Cross-cultural Perspectives in Medical Ethics* (London, Jones and Bartlett Publishers, 2000), 293.

interpretation of the universally revered classics, as well as the application of these theories to the concrete realities of daily life, gave rise to numerous contradictions, fragmenting the large community of private scholars and professional medical practitioners seeking solutions to health-related problems into countless individuals, groups, and traditions.”¹⁴¹

However, the absence of a unified professional code did not mean that there were no rules governing TCM in imperial China. The *Tang Code* (created in 624 A.D.) was the first comprehensive criminal code in Chinese history.¹⁴² It issued rules to cover medical malpractice disputes. For example, “if a pharmacist sold a poison instead of a drug, in order to poison others, and there were consequential results, the pharmacist would be sent to the gallows; if the above behavior existed but with no consequential result, the pharmacist was subject to banishment two thousand miles away; if a pharmacist sold a drug which could cure disease but had potential to poison, the pharmacist’s unknowing action of selling the drug would be not subject to scrutiny”¹⁴³; “If a false disease was made up by a doctor in order to obtain property from his patient, the doctor would be charged with theft”¹⁴⁴, or “if medical malpractice was caused by a doctor’s wrong prescription, the doctor was subject to two years in jail”¹⁴⁵ etc.

With a detailed malpractice instrument such as the *Tang Code* in place, governors in the Tang Dynasty also held yearly examinations for gentry physicians (who served the royal families and the upper class).¹⁴⁶ But Unschuld is right that “no comprehensive government regulation of the vocational practice of healthcare and, almost no supervision of the qualifications of the physicians and pharmacists as a whole were introduced during the imperial age”.¹⁴⁷ Both the governance and legislation of the TCM in the Imperial period were predominantly for the benefit of the throne and the upper class rather than for the benefit of the general public. But this does not necessarily mean that ordinary people in Imperial China had less trust or respect for

¹⁴¹ P. U. Unschuld, *Medicine in China: A History of Ideas* (Berkeley, University of California Press, 1985).

¹⁴² See e.g., J. Wallace, trans., *The Tang Code* (Princeton, Princeton University Press, 1979).

¹⁴³ *The Tang Code*, named Tang Lv Su Yi (in Chinese) edited by Zhang Shun Wu Ji and other 18 scholars of Tang Dynastic. Citations are originally in ancient Chinese, translated by author, Article 263.

¹⁴⁴ Ibid, Article 383.

¹⁴⁵ Ibid, Article 395.

¹⁴⁶ P. U. Unschuld, *Medicine in China: A History of Ideas* (Berkeley, University of California Press, 1985).

¹⁴⁷ P. U. Unschuld, *Medicine in China: A History of Pharmaceutics* (Berkeley, University of California Press, 1986), 4.

medical practitioners. On the contrary, ancient Chinese medics were held in high esteem. Ancient Chinese medical ethics, which placed an emphasis on humanity and love, had to strike a balance between serving the Empire and the public. In the next section, I will review ancient Chinese medical ethics in more detail.

(2) Ancient Philosophies and Traditional Chinese Medical Ethics

Although the history of TCM spans more than two thousand years, the first explicit literature on medical ethics did not appear until the 7th century, when Sun Simiao (581-682 A.D.) wrote a famous treatise “On the Absolute Sincerity of Great Physicians”.¹⁴⁸ Sun requires a physician to develop “the sense of compassion and pity, to commit himself to save every living creature, to treat every patient on equal grounds, and not to seek wealth by his expertise”.¹⁴⁹ He also pointed out the necessity of a thorough education and rigorous conscientiousness.¹⁵⁰ This treatise was thought to be the Chinese Hippocratic Oath.¹⁵¹

As a physician, Sun’s theory reflected the social concepts inherent in Confucianism. Confucianism dominated China since it was founded by Kong Qiu (551-479 B.C.). Confucianism sought to nurture a spirit of selflessness.¹⁵² It described medicine as the “art of *Ren* (humaneness), and one was required to master the “art of *Ren*” to become a physician.¹⁵³ Specifically, the “art of *Ren*” required: (1) to have humanity and compassion at heart; (2) to practice for the benefit of patients but not oneself; and (3) to treat patients equally. Moreover, *Ren* was the fundamental human virtue that bound

¹⁴⁸ S. Sun, ‘Prescriptions for Emergency worth a Thousand Pieces of Gold’ (in Chinese), in Chinese Medical Association (ed), *A Hundred Must Read Chinese Medicine Classics* (in Chinese) (Beijing, Hua Xia Press, 2008), 9-11; also see, P.U. Unschuld, *Medical Ethics in Imperial China: A Study in Historical Anthropology* (Berkeley, University of California Press, 1979), 24-27.

¹⁴⁹ Ibid; also see R. Qiu, ‘Medicine- the Art of Humaneness: on Ethics of Traditional Chinese Medicine’, 13 (1988) *the Journal of Medicine and Philosophy* 277-300, 278.

¹⁵⁰ Ibid.

¹⁵¹ Ibid.

¹⁵² See e.g., D. C. Lau, ‘Confucius’, *The Analects* (Hong Kong, Chinese University, 1984); M. Elvin, *The Pattern of the Chinese Past* (Stanford, Stanford University, 1973), 180.

¹⁵³ R. Qiu, ‘Medical Ethics in China: Status Quo and Main Issues’, at O. Döring (ed) *Chinese Scientists and Responsibility: Ethical Issues of Human Genetics in Chinese and International Contexts* (Hamburg, Mitteilungen, 1999), 24.

people together, first by appropriate family relationships and then directs other wider social relations, such as the doctor-patient relationship.¹⁵⁴

Sun's bioethical doctrine had many followers. For example, three centuries later, Dr Gong Xin wrote "Warnings to Enlightened Physicians" and "Warnings to Mediocre Physicians" in his *Medical Lessons in Ancient and Modern Times*.¹⁵⁵ He emphasised that physicians should have a sense of humaneness and justice in their hearts and not strive for their own benefit.¹⁵⁶ But there was also disagreement, such as, from Dr Lu Xi (754-805 A.D.) who pointed out that medicine was both a means to treat patients and to allow the group who practised medicine independently to earn money.¹⁵⁷ In Unschuld's summary, "the 'professional' physician, selling his medical knowledge and skills for money, was not socially respected in pre-modern China".¹⁵⁸ Under Confucianism, medics are kind and skilful masters practising medicine with the virtue of *Ren*. The motivation for practicing TCM was to pursue the Confucian moral ideals – of self-cultivation, loyalty to the family and the state, and spiritual harmony – rather than material gain.¹⁵⁹

However, generally speaking, I agree with Summers that "medicine in Imperial China was in a peculiar position".¹⁶⁰ Although there were government-sponsored schools for training physicians and taking medical examinations, "the physician was generally regarded as a member of the artisan class"¹⁶¹ which was lower than the class of government officials, i.e., a gentleman-scholar, who got his job by virtue of a competitive civil service examination which covered classical poetry, philosophy and literature.¹⁶² The fact that the social status of medics was relatively low can also be

¹⁵⁴ R. Fan and B. Li, 'Truth Telling in Medicine: The Confucian View', 29 (2004) *Journal of Medicine and Philosophy* 2, 179-193.

¹⁵⁵ R. Qiu, 'Medicine – the Art of Humaneness: On Ethics of Traditional Chinese Medicine', in R.M. Veatch (ed) *Cross-cultural Perspectives in Medical Ethics* (London, Jones and Bartlett Publishers, 2000), 293.

¹⁵⁶ Ibid.

¹⁵⁷ P. U. Unschuld, *Medical Ethics in Imperial China: A Study in Historical Anthropology* (Berkeley, University of California Press, 1979), 24-27.

¹⁵⁸ See note 147, at 4.

¹⁵⁹ J. Legge, *Confucian Analects, the Great Learning, and the Doctrine of the Mean* (New York, Dover Books, 1971); also cited by R. Fan and B. Li, 'Truth Telling in Medicine: The Confucian View', (2004) 29 *Journal of Medicine and Philosophy* 2, 179-193.

¹⁶⁰ W. C. Summers, 'The Chinese Nail Murders: Forensic Medicine in Imperial China', 72 (1999) *Yale Journal of Biology and Medicine* 409- 419.

¹⁶¹ Ibid.

¹⁶² See note 147.

seen from the historical record. Most young people preferred to prepare themselves for the Imperial exams to become government officials; while becoming a medic was a second choice.¹⁶³

Unschuld explains that “the hesitation of traditional Chinese society to advance the medical and pharmaceutical ranks was probably grounded in a general characteristic of Confucian policy not to allow any experts with a specialized expert knowledge to rise in society as a group, because this might have led to social tensions, crises, and even restrictions.”¹⁶⁴ Indeed, every gentleman-scholar was expected to know sufficient medicine to care for his family, especially his parents.¹⁶⁵ Medical knowledge that was not exclusive to medical practitioners who were granted less power and privilege.

2.2 The Practice of Medicine at the End of the Imperial Period: Western Medical Influence on the TCM

Not only did Empire governance and ancient Chinese philosophies play roles in TCM development, foreign medical developments, techniques and ideas also exerted considerable influence on TCM. Islamic medicine had been introduced to China by the Arab and Persian immigrants from the Yuan Dynastic (the 8th Century) through the Sink Road and other overseas routes. In 923 A.D., a Chinese botanist Li Xun wrote *Medical Matters from the Countries beyond the Sea* describing 121 medicinal drugs imported from the Western regions, which generally referred to Central Asia, the Indian subcontinent, and the Middle East.¹⁶⁶ The Islamic medical influence had been recorded by a Chinese scholar Zhao Rushi who wrote that more than ten Islamic herbs had been imported to China and been incorporated into Chinese medical practice.¹⁶⁷ Despite this, the large scale of TCM and Western medicine integration did

¹⁶³ P. Lo, ‘A Confucian Philosophy of Medicine and Some Implications’, (2010) *Journal of Medicine and Philosophy* 1-11.

¹⁶⁴ See note 147, at 4.

¹⁶⁵ Ibid.

¹⁶⁶ X. Li, *Medical Matters from the Countries beyond the Sea* (in Chinese), J. Sang (ed.) (Beijing, People’s Medical Publishing House, 1997); also cited by O. Kahl, ‘Scientific Transfer and Scholarship in Medieval Arabic Pharmacology’, paper presented at the conference *1001 Inventions: Discover the Muslim Heritage in our World*, Manchester, March 2006, available at:

<http://www.muslimheritage.com/topics/default.cfm?articleID=692> (Last visited on Nov 30th, 2010).

¹⁶⁷ R. Zhao, *The Foreign Land*, written in 1125, (Beijing, Zhonghua Book Company, 2000).

not start until the last Empire of Imperial China – the Qing Dynasty, when Western medical text books started to be introduced to China.¹⁶⁸

In the late 1800s, more American and European missionaries brought Western medicine to a number of coastal cities of China.¹⁶⁹ The Jennerian vaccination introduced to China by surgeon Alexander Pearson, had made a wide social impact.¹⁷⁰ Although, in general, Chinese medics still remained sceptical about Western medicine; a number of medical and nursing training schools, along with small hospitals, were established by Western missionaries.¹⁷¹ The following figures indicate the extent to which Western medicine influenced Chinese society: “By 1887, 150 missionary physicians had come to China, including 27 females, most of them Americans. Thirty-three had degrees in theology or medicine. At that point, there were still no medical schools sponsored by foreigners.”¹⁷² By 1915, influences from Western medicine further increased. There were 23 missionary medical schools, with 67 female and 238 male students; and 36 nursing schools, with 272 students.¹⁷³ At the same time, there were 383 missionary physicians practising in China and 330 hospitals had been built.¹⁷⁴

During the 1920s and 1930s, the development of Western medicine in China was guided by foreign advisers.¹⁷⁵ The Chinese Medical Board was set up in 1913 by the Rockefeller Foundation to help develop a modern Chinese medical system, and in

¹⁶⁸ Such as, *Introduction to the Human Body* written by Jean Terrenz and *Illustrated Introduction to the Human Body* written by Giacomo Rho and Nicolaus Longobardi. See, Z. Xu, *Abstracts from Translations of Missionaries during the Ming-Qing Dynastic* (in Chinese), (Hong Kong, Chung Hwa Book, 1940).

¹⁶⁹ S. M. Hillier and J. A. Jewell, *Health Care and Traditional Medicine in China: 1800-1982* (London, Routledge & Kegan Paul, 1983).

¹⁷⁰ X. Zhang, *The History of Westernized East* (in Chinese), (Beijing, The Commercial Press, 1934), 71; Z. Ma, *A History of Translation in China Volume 1* (in Chinese), (Wuhan, Hubei Educational Press, 1999), 509; S. S. Brook, ‘China Curiosi: 19 century examples of the east-west titration’, (1985) 75 *Journal of the Royal Society Medicine* 945-948. Also see, G.T. Staunton, *Memoirs of the Chief Incidents of the Public Life of Sir George Thomas Staunton* (Cambridge, Cambridge University Press, 2010).

¹⁷¹ See note 169.

¹⁷² J. Wang and L. Wu, *History of Chinese Medicine* (Shanghai, Tientsin Press, 1936), 467; also cited by J. Cai, ‘Integration of Traditional Chinese Medicine with Western Medicine: Right or Wrong’, 27 (1988) *Social Science and Medicine* 5, 521-529.

¹⁷³ *Ibid.*

¹⁷⁴ *Ibid.*

¹⁷⁵ See note 136, at 184.

1917, the same Foundation founded the Peking Union Medical College (PUMC).¹⁷⁶ According to Bullock, this transplantation of the American medical education model, was based on the new Flexner model developed at Johns Hopkins University.¹⁷⁷ Under an eight-year curriculum, PUMC graduated 140 students each year. These graduates, along with graduates from other foreign-sponsored medical schools, exerted considerable influence over the evolution of Western medicine in China. Some of them became heads of medical schools, and leaders in the Ministry of Health of the Republican Nationalist Government (1925-1949). However, critics noted that the financial and intellectual dependencies created by the Rockefeller program meant a Western and capitalist-dominated medical agenda only focused on teaching students about diseases prevalent in the West rather than improving the health of Chinese people.¹⁷⁸

It should also be taken into account that, at the end of the Imperial period, China became a semi-feudal and semi-colonial society. Western medical institutions were resisted by TCM practitioners who regarded these foreign aids as economic and political weapons intended to further colonise Chinese society.¹⁷⁹ Chinese bioethics during that time had two characteristics: First, nationalism. One echo that was popular at that time was “transmitting one’s love for the people to one’s love of the nation”. During the Japanese invasion in the early 19th century, many physicians devoted themselves to the reform of Chinese society. Sun Yat-sen (Former president of the Republic of China, Taiwan), Lu Xun (a famous critic), and Guo Moruo (a writer) are notable figures amongst them.

Secondly, “Bethune’s spirit”, meant practising medicine selflessly. Dr Norman Bethune was a Canadian surgeon who worked in guerrilla-based China during the Anti-Japanese War. He died from septicaemia caught by an infected cut whilst providing emergency services to Chinese patients. His heroic spirit had been praised by Chairman Mao and widely broadcast. Chairman Mao appealed to all Chinese

¹⁷⁶ M. B. Bullock, *A American Transplant: The Rockefeller Foundation and Peking Union Medical College* (Berkeley, University of California Press, 1980).

¹⁷⁷ Ibid.

¹⁷⁸ E. R. Brown, ‘Public Health in Imperialism: Early Rockefeller programs at Home and Abroad’, 66 (1976) *American Journal of Public Health* 9, 897-903.

¹⁷⁹ J. Cai, ‘Integration of Traditional Chinese Medicine with Western Medicine: Right or Wrong’, 27 (1988) *Social Science and Medicine* 5, 521-529.

people to learn from him. The “Bethune’s Spirit” – selfless love is regarded as a moral code by Chinese medical practitioners even now (more discussions in contemporary Chinese medical ethics will be given shortly).

To sum up, the end of Imperial China can be regarded as a period of “combat and survival” of Chinese medicine. It was also an important period of adjustment and transition for TCM practitioners who learned to practice medicine alongside Western medicine practitioners. Such integration brought opportunities as well as challenges to them; this was witnessed particularly in Maoist China. The ups and downs of medical practice in the Maoist China will be discussed in the next section.

3. Medical Practitioners in Maoist China

In 1949, the People’s Republic of China (PRC) was founded by Mao Zedong after the end of the Civil War when the Chinese Communist Party (CCP) replaced the Nationalist Party and set up a CCP government. Between 1949 and 1978, the Maoist socialist PRC was based on the Communist ideology advocated by Karl Marx, Friedrich Engels, and Joseph Stalin.¹⁸⁰

By the time the Communists took power in China, there was a real dilemma regarding how best to deal with the apparent dichotomy between Western-based medical practice and that followed by TCM practitioners.¹⁸¹ It was uncertain how many of these Western and TCM doctors had moved to Taiwan after the end of the Civil War, statistics showed there were 38,000 Western medicine doctors and 276,000 TCM doctors in China.¹⁸² Although the number of Western-trained physicians was much less than that of the TCM doctors, they were a group of people who supported the scientific bases of Western medicine and held more financial resources than TCM

¹⁸⁰ See e.g., K. A. Wittfogel, et al., “‘Maoism’—‘Legend’ or ‘Legend of a ‘Legend’ ”, (1960) *The China Quarterly* 4, 88-101.

¹⁸¹ T. Williams, *Complete Chinese Medicine: A Comprehensive System for Health and Fitness* (Bath, Mustard, 1999), 15; M. Chan, ‘Keynote Address at the International Seminar on Primary Health Care in Rural China’, (1 November, 2007) WHO Speeches in Beijing.

¹⁸² Note 136, 188.

doctors for research and training opportunities; the TCM medics however were “oppressed, ruled and powerless.”¹⁸³ In 1949, Western medicine dominated the Chinese Medical Association who even called for a complete abolition of TCM.¹⁸⁴ Mao rejected this proposal and urged recognition and support of TCM. By 1954, the government officially recognised TCM practitioners as representing a “medical legacy of the motherland” and thus began a parallel development between Western and TCM practice.¹⁸⁵

This section discusses Chinese medics’ experiences in Mao’s China. Chronologically, it is divided into three parts: (1) Ministry of Health (MOH) and Chinese Communist Party (CCP); (2) doctors under attack: the Great Proletarian Cultural Revolution; and (3) the shifting power of the MOH and the status of medical practitioners.

3.1 Medicine under the CCP

In the initial years of the PRC, the prestige of Western medicine remained high in society, and the CCP relied on the cohort of Western-trained physicians for advice and leadership.¹⁸⁶ The PRC Ministry of Health (MOH) was staffed with Western medical practitioners who were both CCP members and had army experience. These practitioners set up the curriculum at the newly established, state-owned medical schools that were similar to the Western sponsored schools.

The CCP-led government, at that time, drew heavily upon the Yugoslav experience, which stressed rural medical modernisation, particularly, in training local peasants in rural health work. In the CCP-led government’s opinion, the MOH represented the urban and Western professional bias which conflicted with its country-based health delivery policies. The MOH, on the other hand, thought that the quality of health workers should not be compromised by quantity. What is more, it believed that the most important problems facing China were the lack of the resources to expand the training of medical personnel and the cost-effectiveness issues raised by the

¹⁸³ J. Cai, ‘Integration of Traditional Chinese Medicine with Western Medicine: Right or Wrong’, 27 (1988) *Social Science and Medicine* 5, 521-529, 526.

¹⁸⁴ *Ibid.*

¹⁸⁵ See note 181.

¹⁸⁶ See note 176.

increasing demand of urban hospitals.¹⁸⁷ Lampton argues that the professional and military backgrounds of staff in MOH “reinforced in these individuals a desire to resist complete Party political domination of ‘professional’ work”.¹⁸⁸

To give legitimacy to the CCP policy, four basic guidelines for the organisation of healthcare were high on the agenda for the first National Health Congress of the PRC in August 1950:

- “1. Medicine should serve the workers, peasants and soldiers;
2. Preventive medicine should take precedence over therapeutic medicine;
3. Chinese traditional medicine should be integrated with Western scientific medicine;
4. Health work should be combined with mass movement”.¹⁸⁹

The guidelines confirmed that the focus of healthcare in this period was typified by an emphasis on prevention, and easily affordable access to basic curative care. Gradually political healthcare policies began to win over professional wishes, and Western medical practitioners in China became controlled by CCP bureaucrats.

To achieve this national agenda set out by the National Health Congress, Western-trained healthcare practitioners were losing support for learning and development of new diagnostic methods for treating rarer and more complicated illnesses. Instead, they had to take time from research to be more frequently involved in training peasants in the basic knowledge of medicine, while these rural barefoot doctors were given much more opportunity to be trained and to participate in the basic prevention of disease in rural areas.¹⁹⁰

By the mid-1950s, the battle between Western medics of the MOH and the CCP became really serious. The CCP actively campaigned to undermine the MOH’s

¹⁸⁷ D. M. Lampton, *Health, Conflict, and the Chinese Political System* (Michigan, Center for Chinese Studies, 1974), 67.

¹⁸⁸ Ibid, 66; D. M. Lampton, *The Politics of Medicine in China: The Policy Process 1949-1977* (Kent, Westview Press, 1977), 76.

¹⁸⁹ China National People’s Congress, available at: <http://www.china.org.cn/english/archiveen/27702.htm> (Last visited on Oct 23rd, 2007).

¹⁹⁰ Barefoot doctors are farmers who received minimal basic medical and paramedical training and worked in rural villages in China. Their purpose was to bring healthcare to rural areas where urban-trained doctors would not settle. They promoted basic hygiene, preventive healthcare, and family planning and treated common illnesses. The name comes from the fact that rice field workers do not wear shoes in the wet paddies. Hence being “barefoot” symbolizes a paramedic who also engages in agricultural work. See e.g., W. Dong, ‘Health Care Reform in Urban China’, *Working Paper 2001/2*, Munk Center for International Studies, University of Toronto; V. H. Li, ‘Politics and Health Care in China: The Barefoot Doctors’, 27 (1975) *Stanford Law Review* 3, 827-840.

authority. It even formed a national committee – the Nine Man Sub-Committee (NMSC) to promote its public health agenda without involvement of the MOH. The NMSC, which consisted of CCP members from departments of agriculture, health and water conservancy, effectively established their own health apparatus by promoting mass campaigns guided by Mao’s socialist equity values;¹⁹¹ as a result of which, finances and human resources were diverted towards rural areas and away from the cities and basic research, and “the most detached” middle levels of the Party structure was tied to “both professional and local (peasant) pressures”.¹⁹²

Beside the establishment of institutions (such as, the NMSC) and rural health delivery policies, conventional bureaucratic strategies were also applied by the CCP, to increase its control over healthcare governance. Since the 1950s, physicians with CCP membership not only staffed the MOH, but were positioned as leaders of medical schools and hospitals.¹⁹³ Indeed, when more loyal CCP individuals were placed in strategic positions and more mainstream CCP ideologies were institutionalised in the healthcare system, the medical community gradually lost its power to oversee medical education, research, or even control orthodox medical knowledge.

In 1955, Mao called for a re-evaluation of TCM and incorporated it into the formal structure of medical education.¹⁹⁴ Various TCM schools were encouraged to establish their own academies with courses based on TCM added to all medical schools.¹⁹⁵ This formal integration of Chinese and Western medicine forced the assimilation of TCM knowledge into the Western medicine framework, such as case recodes and institutionalised trainings.¹⁹⁶ More importantly, it seemed to increase the status of TCM and gave its practitioners access to more resources.

¹⁹¹ D. M. Lampton, *The Politics of Medicine in China: The Policy Process 1949-1977* (Kent, Westview Press, 1977).

¹⁹² D. M. Lampton, ‘Health Policy during the Great Leap Forward’, 60 (1974) *the China Quarterly* 668-698, 692.

¹⁹³ See note 191.

¹⁹⁴ T. Schroeder, ‘Chinese Regulation of Traditional Chinese Medicine in the Modern World: Can the Chinese Effectively Profit from one of Their Most Valuable Culture Resources’, 11 (2002) *Pacific Rim Law and Policy Journal* 3, 687-716.

¹⁹⁵ Ibid.

¹⁹⁶ See note 191, 63; also see, E. Hsu, *The Transmission of Chinese Medicine* (Cambridge, Cambridge University Press, 1999).

However, Henderson reminds us that such empowerment “was accomplished on party terms rather than those of the various leaders of traditional medicine.”¹⁹⁷ Indeed, Departments of TCM and of combined Western and TCM were set up in most hospitals, bringing many private practitioners into the state-run organisations under the planned economic framework.¹⁹⁸ By 1966 virtually all clinics and hospitals in PRC were owned by either the government or by labour unions.¹⁹⁹ Mao’s calling for TCM empowerment eventually brought all TCM practitioners under institutional control.

3.2 Doctors under Attack: The Great Proletarian Cultural Revolution

The economic setbacks suffered after the disastrous Great Leap Forward in 1961 temporarily weakened the CCP and reinforced the MOH.²⁰⁰ However, the conflict between the CCP and MOH continued until 1965, when Mao expressed his anger in a public message towards the “elite clique” of bureaucrats running the MOH:

“Tell the Ministry of Health that it only works for 15% of the total population and that this 15% is mainly composed of lords, while the broad masses of peasants do not get any treatment. The Ministry of Health is not Ministry of Health for the People, so why not change its name to the Ministry of Urban Health, the Ministry of Lord’s Health, or even the Ministry of Urban Lord’s Health?”²⁰¹

It is noted that, under Mao’s rule, public health made most progress in rural areas. The creation of the paramedics by Mao in 1965, so called ‘barefoot doctors’, were assisted by midwives and community health workers affiliated to health clinics in rural areas.²⁰² Around 1.3 million peasants were trained for 3 to 6 months and qualified as

¹⁹⁷ Note 136, at 189.

¹⁹⁸ See note 191.

¹⁹⁹ Y. Cong and L. Hu, ‘Case Study: the VIP Floor’, (2005) *Hasting Center Report*, January –February, 16-17.

²⁰⁰ The Great Leap Forward was an economic and social plan used from 1958 to 1961 which aimed to use China’s vast population to rapidly transform China from a primarily agrarian economy by peasant farmers into a modern communist society through the process of agriculturalization and industrialization. It ended in catastrophe as it triggered a widespread famine that resulted in tens of millions of deaths. See, D. T. Yang, ‘China’s Agricultural Crisis and Famine of 1959 -1961: A Survey and Comparison to Soviet Famines’, 50 (2008) *Comparative Economic Studies* 1–29.

²⁰¹ See note 191.

²⁰² See note 190.

healthcare workers to provide basic prevention and intervention services in rural areas.²⁰³

The health policy led by Mao was credited with bringing almost universal healthcare to the population. However, the Cultural Revolution, which was set in motion by Mao, brought chaos to medical practice, and long-term suffering to Chinese medical practitioners and academics. In 1966, the CCP passed its *Decision Concerning the Great Proletarian Cultural Revolution*.²⁰⁴ The decision suggested,

“At present, our objective is to struggle against and crush those persons in authority who are taking the capitalist road, to criticize and repudiate the reactionary bourgeois academic ‘authorities’ and the ideology of the bourgeoisie and all other exploiting classes and to transform education, literature and art, and all other parts of the superstructure that do not correspond to the socialist economic base, so as to facilitate the consolidation and development of the socialist system.”²⁰⁵

In 1949, there were 22 medical schools with 152,000 students enrolled in China.²⁰⁶ From the 1960s onwards, most medical schools were shut, as medical academics were dispatched to the countryside for up to ten years, to “learn from the peasants”.²⁰⁷ Others were beaten, imprisoned and publicly humiliated.²⁰⁸ During that period, biomedical scientists were criticised for conducting research divorced from the needs of the masses; medical academics and practitioners were accused of arrogance and promoting their own interests above patients’ interests. In Mao’s 1965 directive, he stated the following ideas concerning medical education:

²⁰³ Ibid; also see C. Leslie, *Asian Medical System: a Comparative Study* (Berkeley: University of California Press, 1976); A. Lucas, *Chinese Medical Modernization: Comparative Policy Continuities, 1930s-1980s* (New York, Praeger, 1982); R. Sidel and V. Sidel, *The Health of China: Current Conflicts in Medical and Human Services for One Billion People* (London, Zed Press, 1982).

²⁰⁴ ‘Decision of the Central Committee of the Chinese Communist Party concerning the Great Proletarian Cultural Revolution’, (Aug 12th, 1966) *Peking Review*, 6-11; M. Schoenhals (ed), *China's Cultural Revolution, 1966-1969: Not a Dinner Party* (Armonk, Sharpe, 1996); R. Macfarquhar and M. Schoenhals, *Mao's Last Revolution* (Harvard, Harvard University Press, 2006).

²⁰⁵ Ibid.

²⁰⁶ H. Shen, ‘Regional Difference in Distribution of Chinese’s College and Universities and Its Impact on the Equality in Access to Higher Education’, 3 (2007) *Canadian Social Science* 1, 74-86; J. Zhang, *Educational Year Book of China 1949-1981* (in Chinese) (Beijing: The Encyclopaedia of China Publishing House, 1984).

²⁰⁷ K. K. Jain, ‘Glimpses of Chinese Medicine, 1971: Changes after the Cultural Revolution’, 106 (1972) *Canadian Medical Association Journal* 46; The Economist Intelligence Unit, *Research Report: Healthcare in China into the 21st Century* (London, EIU, 1998), 37.

²⁰⁸ Ibid.

“Medical education should be reformed. There is no need to read so many books. In medical education there is no need to accept only middle school graduates. It will be enough to give three years to graduates from primary schools. They would then study and raise their standards mainly through practice. If this kind of doctor is sent down to the countryside, even if they do not have much talent, they would be better than quacks and witchdoctors and the villages would be better able to afford to keep them. The more books one reads, the more stupid one gets. We should leave behind in the city a few of the less able doctors who graduated one or two years ago and others should go to the countryside, if medical and health work put emphasis on the countryside.”²⁰⁹

It was recorded that, within health administration offices, medically qualified experts were replaced by those who were judged politically reliable.²¹⁰ Medical organisations were taken over by CCP leaders who could demonstrate any revolutionary health work experiences, no matter how remote.²¹¹ Professional associations were curtailed. Academic journals stopped publishing. Anyone suspected of having a foreign connection or being a Western supporter was rounded up for criticism and punishment.²¹² Under such great oppression, the MOH was actually closed down. “In the 1967-1969 period, not a single major health directive originated with the MOH. All directives were, instead, given the imprimatur of Chairman Mao, the Central Committee, the Cultural Revolution Group, or the Standing Committee of the State Council.”²¹³

In short, the Cultural Revolution, which involved countless anti-professional, anti-technological, anti-urban, anti-foreign campaigns lasted almost a decade in China.²¹⁴ No group, not even the Communist Party members, was free from suspicion. It was in particular a living history of deprofessionalisation (by which I mean a way of losing occupational control. I will explain this in more depth in Chapter 7). Ranks, salaries, and other signs of professional prestige were abolished in all medical institutions at that time. The status of the profession was reversed; for example, doctors were ordered to sweep floors and were forced to make self-criticism of their elitist behaviours and attitudes; many nurses or medical students replaced surgeons who

²⁰⁹ Ibid, 38.

²¹⁰ See note 136, at 190.

²¹¹ Ibid.

²¹² Ibid.

²¹³ D. M. Lampton, *Health, Conflict, and the Chinese Political System* (Michigan, Center for Chinese Studies, 1974), 106.

²¹⁴ See note 136, at 190.

performed tasks which should have been done by physicians or their teachers.²¹⁵ Patients were encouraged to join in medical decision-making, while doctors were reluctant to offer unsolicited advice or supervise patient care. Medical record-keeping was discontinued as few were willing to take responsibility for decision-making.²¹⁶

In 1971, a few medical schools reopened, but they offered a largely political curriculum; medical disciplines were relegated to secondary importance. It is reported that the medical training curriculum was reduced to three years and did not resume a standard five-year curriculum until 1977.²¹⁷ Policies and research protocols were given to TCM and grass-roots facilities.

The Cultural Revolution illustrated Michel Foucault's observation that "medicine is politics".²¹⁸ Foucault's analysis of power is helpful in understanding the functions (or loss of function) of the medical profession (which will be discussed in detail in Chapter 7). The devastating mass campaign brought about the destruction of physicians' and of other health workers' ability to control medical knowledge and regulate their work. Though TCM practitioners gained legitimacy during the process, medicine under Mao, in essence was not a battle between Western medical practitioners and those who practiced TCM. It was a battle between politics and the medical profession.

The loss of control of Chinese medical practitioners over their practice in the last century is still seen today. The CCP and its ruling committees emerged in charge of every workplace; and this remains so even now.²¹⁹ The change of the MOH's organisational pattern and its political agenda from resisting to fully supporting the CCP reflects the CCP's dominant position in healthcare governance. Healthcare delivery strategy became more bureaucratic than professional. And "because of the

²¹⁵ V. W. Sidel and R. Sidel, *Serve the People: Observations on Medicine in the People's Republic of China* (Boulder, Westview Press, 1973); J. Horn, *Away with All Pests: An English Surgeon in People's Republic of China* (New York, Josiah Macy Foundation, 1969).

²¹⁶ Ibid.

²¹⁷ K. K. Jain, 'Glimpses of Chinese Medicine, 1971: Changes after the Cultural Revolution', 106 (1972) *Canadian Medical Association Journal*, 46.

²¹⁸ M. Foucault, 'Part Five: Right of Death and Power over Life', *History of Sexuality, Vol. I: the Will to Knowledge* (Paris, Gallimard, 1976); A. Petersen and R. Bunton, *Foucault: Health and Medicine* (London, Routledge, 1997).

²¹⁹ R. McGregor, *The Party: the Secret World of China's Communist Rulers* (London, Allan Lane, 2010).

extraordinary extent of organisational dependency to which all medics in state-run health institutions were subject, there were few countervailing forces available to break the authority of the party.”²²⁰ Importantly, the Cultural Revolution had completely destroyed the confidence of Chinese medics, and it will take a long time, both for their confidence and their ability to say “No”, to be restored.

4. Chinese Medics in the Profit-Driven Period

After reviewing briefly a long history of development of Chinese medical practitioners under the context of continuing political, social and economic transitions, this section will discuss contemporary Chinese medical practitioners’ position in relation to the transitional healthcare system, and healthcare regulation as well as political disciplinary controls. It starts by giving an overview of Chinese medical practitioners’ experience during the healthcare transition and post-Mao economic reforms. It then ponders what impacts the healthcare system and economic transformations have had on Chinese medical ethics and the doctor-patient relationship. Finally, this section maps the power structure of Chinese healthcare and puts forward a graphic model representing the relationship between state, law and medics in contemporary China.

4.1 Chinese Medical Practitioners in the Healthcare Transition Period

After the death of Mao in 1976, and with the end of his political campaigns, daunting challenges lay ahead for Chinese medical practitioners. From 1978 onwards, China under Deng Xiaoping, initiated market reforms to improve China’s economy. He labelled this as “socialism with unique Chinese characteristics”.²²¹ Under the reform, economics was once again in command and law was formalised.²²² Market reform has been the driving force of China’s social development until today, although, politically,

²²⁰ See note 136, at 191; also see G. Henderson and M. S. Cohen, *The Chinese Hospital: A Socialist Work Unit* (New Haven, Yale University Press, 1984); A. G. Walder, *Communist Neo-Traditionalism: Work Authority in Chinese Industry* (Berkeley, University of California Press, 1986).

²²¹ M. Wang, *WTO, Globalization and China’s Health Care System* (Palgrave, New York, 2006), 11; M. M. Rosenthal, *Health Care in the People’s Republic of China: Moving towards Modernization* (London, Westview Press, 1987), 177-192.

²²² X. Deng, *Selected Works of Deng Xiaoping: Volume II* (Beijing, the People’s Press, 1994), 48; Y. Bian, ‘Chinese Social Stratification and Social Mobility’, 28 (2001) *Annual Review of Sociology* 1, 91.

the CCP and its ideology still provide the leadership to the government and its legislative, executive and judicial branches.

Under this trend of economic reform, university entrance examinations were reinstated in 1977.²²³ Doctors at all levels who had received training during the Cultural Revolution were offered special review courses and subjected to qualifying examinations in order to continue practice.²²⁴ Scientists, educators, and scholars were permitted contact with international colleagues and to study abroad.²²⁵ For the first time in many years, foreign technology was imported. International agencies and foundations started to offer advice, staff training, loans and grants. Western medical equipment and pharmaceutical companies began to flood the Chinese health market.²²⁶ Although the health policies of the 1980s have been criticised for ignoring patient interests, the decade was devoted to restoration and modernization, and to some extent, Chinese medics were given back authority.²²⁷ Expertise became a criterion for leadership. Ranks were reintroduced and salaries were increased.

However, the Chinese medical education system and public health institutions have been detrimentally affected in the aftermath of Maoist policies. China was short of experienced senior healthcare professionals, epidemiologists, medical technicians and other specialists required to make and implement public health policy.²²⁸ In the late 1970s and early 1980s, China was desperate to re-establish normal governmental health functions. However, because of the lack of educated labour from which to recruit, a large number of people who received little or no formal training have been placed in government health agencies, especially in the poorer provinces.²²⁹

²²³ See e.g., S. L. Shirk, 'Educational Reform and Political Backlash: Recent Changes in Chinese Educational Policy', 23 (1979) *Comparative Education Review* 2, 183-217.

²²⁴ C. Gu and J. An, 'Introduction of Medical Education System and Postgraduate Cardiovascular Surgeon Training Program in China', 53 (2005) *the Japanese Journal of Thoracic and Cardiovascular Surgery* 6, 330-331.

²²⁵ D. Zweig, *Internationalizing China: Domestic Interests and Global Linkages* (New York, Cornell University Press, 2002), 161-210.

²²⁶ G. Henderson, 'Issues in the Modernization of Medicine in China', in D.F. Simon and M. Goldman (ed) *Science and Technology in Post-Mao China* (Cambridge, Harvard University Press, 1988), 199-221.

²²⁷ See note 136, at 193.

²²⁸ The Economist Intelligence Unit, *Research Report: Healthcare in China into the 21st Century* (London, EIU, 1998), 38.

²²⁹ *Ibid.*

As salaried employees of state-run healthcare institutions, Chinese medics have been bound closer to institutions during this period. After graduating from medical school, Chinese medical students were assigned to jobs that gave them housing and child-care benefits, healthcare subsidies and other welfare benefits making it almost impossible for them to leave. The terms of their medical practice (salary, type, and number of patients seen) were set by the state. Workplace leaders had considerable authority in evaluating any professional matters, to which political rather than economic criteria were applied. Joining the CCP therefore, became a great opportunity to show their commitment to the state and be promoted.

Health delivery was also highly bureaucratic. For example, the decision to purchase a new drug was subject to many layers of committee review and to competing budgetary constraints of under-funded organisations.²³⁰ The state's close relation with hospitals presents not only involves monetary control, but also represents a command-and-control system – “a bureaucratic-managerial system whereby the government can exercise more direct control over what healthcare providers actually do”.²³¹ Chinese public hospitals are subject to personnel control, political surveillance and bureaucratic regulation. For example, local government can exercise direct control over the number of posts or personnel appointments in hospitals, and over the extent of investment in high-tech equipment.²³²

In short, reforms since the 1980s have restored the normal working life for physicians from the chaos of the Cultural Revolution, but medical practitioners are still bureaucratized and it is difficult to determine the degree to which medics are empowered individually or collectively. The next two sections seek to trace the impact of the healthcare system transition on medical ethics and the healthcare delivery environment.

4.2 Medical Ethics in the New Era

²³⁰ G. Henderson et al, ‘High Technology Medicine in China’, 318 (1988) *New England Journal of Medicine* 1000-1004.

²³¹ R. Klein, ‘China’s Health Policy: A Comparative Footnote’, in C. J. Finer (ed), *Social Policy Reform in China: Views from Home and Abroad* (Hants, Ashgate, 2002), 174.

²³² *Ibid.*

Heal the wounded, rescue the dying, practice revolutionary humanitarianism.

The Motto of Chinese socialist medical ethics²³³

In 1979, the Kennedy Institute of Ethics organised the first group of American bioethicists, along with lawyers, philosophers, theologians, and physicians, to travel throughout China for two weeks to explore Chinese bioethics.²³⁴ However, reflection on their discoveries seemed intellectually disappointing. Far from what they expected, “a number of very sincere, [and] interested individuals deal with issues that we in the United States would unquestionably see as bioethical. These issues in China, however, have not evoked the same intellectual scrutiny; they lack a tradition of criticism and debate about the intellectual bases of social and moral policies.”²³⁵

In Engelhardt’s report, he frankly stated that, for many Chinese intellectuals including physicians, “ethics was a mode of moral indoctrination or of exegesis of a single moral viewpoint, in this case Maoist-Leninist-Marxism.”²³⁶ The Chinese “failed to distinguish principles” they held from “grounds” or “conceptual foundations” that justified those principles for the reason that:

“(1) Their lack of extended experience with a variety of moral viewpoints; (2) unfamiliarity with discussions focused primarily on discovering the comparative intellectual merits of varying moral viewpoints apart from any immediate concern to establish or maintain a single one; and (3) their overriding tendency, because of dialectical materialism, to hold that all ethical reflections are reducible to economic forces.”²³⁷

And he concluded that, in China, “there is no well-developed philosophical tradition of questioning basic assumptions and of seeking the underlying justifications for claims in ethics and sciences.”²³⁸ And though “there was a well-developed set of moral views”, Chinese intellectuals (including physicians) “had not attended with a

²³³ Translated by J. Nie, *Behind the Silence: Chinese Voices on Abortion* (Lanham, Rowman & Littlefield, 2005), 163.

²³⁴ J. Nie, ‘The Plurality of Chinese and American Medical Moralities: Toward an Interpretive Cross-Cultural Bioethics’, 10 (2000) *Kennedy Institute of Ethics Journal* 3, 239-260; H. T. Engelhardt, ‘Bioethics in People’s Republic of China’, 10 (1980) *Hastings Centre Report* 2, 7-10.

²³⁵ *Ibid*, 10.

²³⁶ *Ibid*, 8.

²³⁷ *Ibid*, 8.

²³⁸ *Ibid*, 10.

conceptual, analytical interest” to the nature of bioethics and had “no systematic regard for the justification of their presuppositions”.²³⁹

In 1981, sociologists Fox and Swazey conducted six-weeks of fieldwork at a Western medical hospital in Tianjin, a Northern industrial city of China.²⁴⁰ Chinese medics’ “medical morality” was described by them as “a spirit of self-sacrifice and self-cultivation, a high sense of responsibility, modesty, self-control, devotion, and other virtues.”²⁴¹ Their observation, analysis, interpretation and evaluation as sociologists of China’s medical ethics was different from that of the scholars sent by the Kennedy Institute of Ethics; they not only saw the existence of Chinese medical ethics, but also pointed out the difference between Chinese and Western medical ethics. They argued that, many aspects of Chinese medical morality, such as, the emphasis on personal virtues, holism, mutual dualism (which involved a chain of dualities: Yin-Yang, self and others, the individual and society, preventive and curative medicine, and so forth), and the principles of pragmatism and collectivism, could provide an “antidote” to many problems in Western bioethics.²⁴²

At the same time, Fox and Swazey criticised the “American-ness” of bioethics and “its intellectual assumptions with a series of observations about its narrowly gauged individualism..., scientism, absolutism, secularism” and so forth.²⁴³ They states that “Bioethics is not just bioethics, and is more than medical.”²⁴⁴ For Fox and Swazey, their appreciation of Chinese medical morality came from the perspective of cultural comparison. They thought outside the box and had a broader view of bioethics.

Referring to traditional Chinese medical ethics, one key Confucian principle that still strongly influences contemporary Chinese medics is – that “the practice of medicine as a benevolent cause to do good” has been emphasised by Engelhardt and

²³⁹ Ibid, 8.

²⁴⁰ R. C. Fox and J. P. Swazey, ‘Medical Morality is not Bioethics – Medical Ethics in China and United States’, 27 (1984) *Perspectives in Biology and Medicine* 336, 360.

²⁴¹ Ibid.

²⁴² Ibid.

²⁴³ Ibid.

²⁴⁴ Ibid.

Hinkley.²⁴⁵ It means that physicians should try their best even when there is little hope of success. They must act with little regard for their own personal safety, and sometimes even be willing to give up their own life in order to save the patient. This moral duty carries a strong sense of selflessness. *The Maxims for Medical Workers*, addressed by the Chinese Academy of Medical Sciences, sheds some light on the selflessness emphasising medical ethics:

“Heal the wounded, rescue the dying; Treat people equally, without discrimination; Have a sense of responsibility; Constantly improve one’s skill; Be honest and upright; Seek no personal gain; Words cordial and kind; Be dignified and sedate; Put patient’s interest first; Unite with one’s colleagues.”²⁴⁶

Medical ethics must be set within the context of the healthcare system in order to be understood properly. In February 1982, the PRC Ministry of Health (MOH) published *Maxims for Medical Workers in Hospitals*:

- “1. Ardently love the motherland, the Communist Party, socialism, and the thought of Marxism-Leninism and Mao Zedong;
2. Try hard to study politics and endeavour to gain professional proficiency...;
3. Display the spirit of healing the wounded, rescuing the dying, and ...serve the people whole-heartedly;
4. Take the lead in observing the laws and decrees of the state...;
5. Submit oneself to organizations, be concerned with the collective...;
6. Have a boundless sense of responsibility in one’s work; rigorously enforce rules and regulations and operating instructions;
7. Be honest in performing one's duties; stand fast at one’s post...;
8. Pay attention to politeness; actively take part in the patriotic health campaign...”²⁴⁷

The official publication of medical practice disciplines which emphasised “the motherland, the Communist Party, socialism, and the thought of Marxism-Leninism and Mao Zedong” indicated that merely being selfless to serve patients is not enough for Chinese medics. They are required to be loyal supporters of the CCP-led government and be willing to submit themselves to the organisations. They need to be both technically accountable and politically obedient.

²⁴⁵ H. T. Engelhardt and A. E. Hinkley, ‘Chinese Health Policy: An Introduction to the Moral Challenges’, in J. Tao (ed) *China: Bioethics, Trust, and the Challenge of the Market* (Hong Kong, Springer, 2008), 12.

²⁴⁶ ‘Medical Ethics in Chinese Law’, in Documents related to Medical Ethics, 14 (1989) *Journal of Medicine and Philosophy* 3, 361-362.

²⁴⁷ Ibid.

One question to be raised is whether such selflessness and loyalty emphasising bioethics is still relevant to Chinese medical practitioners today. More recent research found that Chinese medics were less familiar with the contemporary presentation of bioethics and more likely to be confused about their ethical responsibilities in this new era. After two decades of healthcare and economic reforms, more recent research showed that Chinese medical practitioners were confused about the meaning of bioethics. According to an investigation of the medical school of Zhejiang University, about 91.5% of 687 surveyed students were unable to define professional ethics.²⁴⁸ At Jinzhou Medical University, 230 freshmen participated in a quantitative study. Only 19.57% of the students believed it was a professional ideal to rescue the dying and heal the wounded, or to practice humanitarianism. About 73.04% students responded that their idea of being a medical professional was one with high medical skills; and this was also the foundation for one to gain respect and future career promotion. 7.39% of students responded that their professional ideals were driven by personal or financial interests.²⁴⁹

Indeed, under rapid socio-economic transitions, the ways that Chinese medical students view bioethics, its conceptions and applications, and how much these ethical norms are mandatory may have changed. Chapters 5 and 6 will revisit this issue and present empirically-based answers, where I am going to explore contemporary Chinese medics' understanding of medical ethics; and how they would prioritise bioethics with other control mechanisms (such as, law and political disciplines) when they come into conflict in practice.

To sum up, in the new economic reform era, the actual influence of Chinese medics over the healthcare system transition has been limited; what is more, they might have become more passive than their predecessors in the early decades of the PRC. Chinese medical ethics which had been influenced largely by Chinese ancient philosophies, such as Confucius, have moved into an undefined transitional era.

4.3 A Breakdown of the Doctor-Patient Relationship

²⁴⁸ B. Zhang, 'The Important Role of Case Studies in Ethical Teaching in Medical Education', in O. Döring (ed) *Ethics in Medical Education in China: Distinguishing Education of Ethics in Medicine from Moral Preaching* (IFA, Hamburg, 2000), 113.

²⁴⁹ Ibid.

Under health reforms, cost recovery and expansion of revenue-earning services were the main strategies adopted by hospitals in China.²⁵⁰ Health providers were inclined to respond to the financial incentives embedded in fee-for-service payments by providing more services, thereby earning more for themselves and their institutions.²⁵¹ They pursued their own ‘survival’ agenda by increasing user charges and favouring expensive prescriptions and new medical technologies and pharmaceuticals.²⁵² The distorted financial arrangements led to so-called ‘Public identity, private behaviours’, with revenue maximization overshadowing traditional Confucian ethical standards.²⁵³ This eventually caused a breakdown of the doctor-patient relationship in China.

With limited regulatory activities and the absence of a pricing policy, according to data from the Chinese Ministry of Health, drug prices increased dramatically, by up to 68% in 2007 and 74% in 2008.²⁵⁴ Consumer dissatisfaction around such issues as reduced benefits of previously publicly-funded insurance schemes, the poor attitudes of doctors, and poor quality of hospitals and physician services have been frequently reported.²⁵⁵ When the relationship between patients and the medical profession became increasingly tense, healthcare violence emerged when conflicts escalated.²⁵⁶ There have been alarming reports that Chinese medical practitioners have been attacked by patients or members of patients’ families.²⁵⁷ From 2000 to 2003, there were 502 reports of violence against the medical practitioners in Beijing, in which medics were wounded or disabled.²⁵⁸ From January 1991 to July 2001, in Hubei

²⁵⁰ A. P. den Exter (ed) *International Health Law: Solidarity and Justice in Health Care* (Apeldorn, Maklu, 2008), 203.

²⁵¹ *Ibid.*

²⁵² *Ibid.*

²⁵³ H. Zhao, *Governing the Health Care Market: Regulatory Challenges and Options in the Transitional China*, PhD thesis, La Trobe University, School of Public Health, 2005, 37.

²⁵⁴ Ministry of Health, *PRC Healthcare Service Data Report 2008* (in Chinese), available at: <http://www.moh.gov.cn/publicfiles/business/htmlfiles/mohwsbwstjxxzx/s8208/200904/40250.htm> (Last visited on Dec 1st, 2010).

²⁵⁵ *Ibid.*, 30.

²⁵⁶ See e.g., P. Zheng, et al., ‘Public hospitals in China: Privatization, the Demise of Universal Health Care and the Rise of Patient-Doctor Violence’, 4 (2006) *Journal of Law & Medicine* 465-70; E.G. Hui, ‘The Contemporary Healthcare Crisis in China and the Role of Medical Professionalism’, 35 (2010) *Journal of Medicine and Philosophy* 477- 492.

²⁵⁷ See note 4.

²⁵⁸ *Ibid.*

province, 568 attacks on healthcare facilities and medics were reported, and some medical practitioners were even killed.²⁵⁹

It has been noted that medical disputes raised by medical malpractice have increased. According to the Chinese Medical Doctor Association's *the 2004 Research Report of the patient-doctor relationship in China*, on average, there are 66 medical disputes raised with each hospital a year. And there are 5.42 attacks on healthcare facilities and 5 on medical professionals in each hospital each year.²⁶⁰ In the city of Shenzhen, medical practitioners at one hospital even have to wear helmets to work.²⁶¹ Those acts of hospital violence have been attributed, in part, to the tremendous surge in healthcare costs and public grievances, but, mainly, to a decline of trust in and respect for medical practitioners (more discussion about this problem will be given in Chapter 9).

The healthcare reforms after Mao have been mainly driven by market forces. During this process, medics have been perceived by the Chinese public as more like shareholders of a profit-driven healthcare market, rather than public-interest guardians. Hospital violence reflects conflicting interests between patients and the system Chinese medics are serving.

5. Conclusion

Thousands of years of Chinese history suggest that it is the state that decides whether it confers authority on medical practitioners or not. China demonstrates a remarkable system of state power. This state power is ruled by a single Communist party system. Until today, Chinese medics have continuously met with daunting challenges. Fifty years ago, the Cultural Revolution condemned thousands of Chinese practitioners to labour camps. Today, medics play an important role in China's drive to modernise its healthcare system. The number of medical practitioners has increased dramatically, yet the public remains unsure of them and reports of corruption surround them.

²⁵⁹ D. Jiang, 'Thoughts on the Practice of Regulation on the Handling of Medical Accidents' 11 (2002) *National Judges College Law Journal* 53-56, 55.

²⁶⁰ See note 4.

²⁶¹ *Ibid.*

The evidence-based nature of Western medicine does not necessarily grant its practitioners the status of being held in high regard in the political arena. Henderson says,

“Much like the controversy between Confucian and independent practitioners in imperial China, the conflict between Western and traditional medicine can be understood on several levels. It reflects debate over the virtue of two different worldviews in China, identifying themselves through different responses to the models of state medicine, and it signifies the struggle between two warring factors within the leadership of the country.”²⁶²

In China, both TCM and Western medics are subjected to political ideological surveillance and to the organisational dependency forced on them by the Soviet-style bureaucracy established in 1949.

Today, under a different economic system, questions raised are, how have these historic and contemporary, political and economic factors, contributed to professional authority? How do Chinese medical practitioners react to state governance and law? In Chinese medics’ daily practice, whether, how and why do laws or political ideologies take priority over medical ethics and professional knowledge?

In order to find answers to these questions, Part Two of this thesis (Chapters 4, 5 and 6) presents first-hand responses from medics about their interactions with law, state bureaucracy and Communist Party. In short, the main purpose of the empirical studies is to explore the ways in which the medical practices of health workers are affected by guiding principles, such as law, political ideologies and bioethics, whether they have experienced and how they resolve any ethical dilemmas caused by conflicting principles and moral duties in practice.

²⁶² See note 136, at 193.

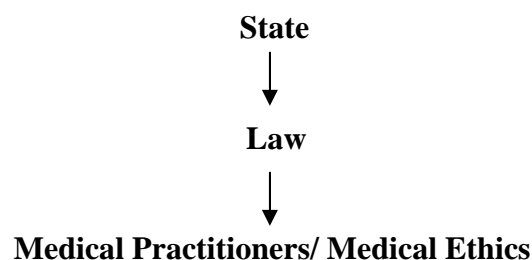
SUMMARY OF PART ONE AND HYPOTHESIS FORMULATION FOR EMPIRICAL STUDIES

1. Summary of Part One: Mapping the Power Structure of Healthcare Governance in China

After outlining the general healthcare governance model from the Western experiences, Part I of this thesis has explored the historical development of China's healthcare practitioners from the ancient Imperial era to the contemporary Socialist economic age. The power structure of China's healthcare governance shows that the determinants of China's healthcare regulation are mainly political. Though some individual medical practitioners were invited to participate in the National People's Congress meetings, without a regime of transparent elections with democratic voting, it is unclear how representative their views will be. The influence of Chinese medics as a group is still too small to be able to challenge state dominance.

In China, the state engages actively in deciding what is morally right or wrong in medical practice. It is known that not all Chinese medics are CCP members and not all of them are subject to the internal party disciplinary sanction. However, political ideological education has been given to all Chinese through the media as a way of propaganda. Medical ethics, under this circumstance, can hardly be regarded as the medics' own business.

As argued previously in Chapter 2, the Western triangular-shape working model was found unfit in the Chinese context. Generalised from the above conceptual discussion and historical observations, the triangular model was replaced by a re-formulated Chinese top-down model as below:



In this model, the state remains at the top of the power structure determining the healthcare law and overseeing the law-ruled Chinese medics.

However, such a top-down model fails to provide enough details about how Chinese medical practitioners perceive their position in this governing structure. It is also uncertain whether the hypothetical model generated from literature reflects “the real world” in terms of medical practice. And therein lies the need for further testing and re-evaluation. Indeed, this objective informed the methodology adopted in this thesis: to listen to the voices of the Chinese medical practitioners who have been hidden behind a veil of silence about their views on law, political ideology and bioethics. At the end of Part One, the last section aims to bridge the literature review with the following empirical studies in Part Two. Drawing from what has been discussed in Part One, I will develop an empirically testable hypothesis to be examined in the fieldwork.

2. Hypothesis Formulation for the Empirical Studies

In this section, several ethically distorted cases, that originally drew my attention to this research project, will be reviewed and used to generate hypotheses to be examined in the quantitative and qualitative studies in Part Two.

The empirical studies aim to lift the veil of silence from Chinese medical practitioners who are incompetent through their lack of professional ethical judgement, or even actively involved in immoral governmental actions that might endanger the health and lives of their patients. The hypothetical top-down relationship of China’s healthcare power structure will also be examined. In short, the empirical studies seek to explore the Chinese medics’ perceptions of the extent of control they have over the regulation and governance of their profession. More specifically, research questions to be addressed in the empirical study are:

(1) How dynamic are Chinese medical practitioners’ views on hospital rules, law, political order and medical ethics and how do they shape their views?

(2) Do ethical dilemmas exist in the Chinese medics' daily practice? If so, how do they resolve them?

And (3) what is or are perceived by Chinese medics as problematic? What changes do they expect to happen?

Before seeking answers to these questions, I attempt to probe preliminary answers concerning the Chinese medics' legal consciousness from the following two case studies.

Case One happened in Beijing where it was reported that the hospital had the capability to save a pregnant woman and her unborn child's life by giving her an emergency operation.²⁶³ When the pregnant woman lost consciousness, and her husband who was sceptical of the doctors' diagnosis refused to sign the consent form authorising a C-section to be performed on his pregnant wife, doctors tried unsuccessfully to contact the patient's other relatives through the police. They asked for permission to perform the operation from the local administrator overseeing the hospital. But the response was that "the operation cannot proceed without the patient or her families' consent." Consequently, none of the thirty doctors dared to take the risk of providing the emergency surgery for her without valid consent. In the end, the woman and her unborn child died in the hospital.

Case Two concerns organ transplantation. Two patients were in need of kidney transplants, but neither of their families were compatible organ donors.²⁶⁴ Yet, coincidentally, their organ donors' kidneys were suitable for transplant to the counterpart patients. They proposed to the hospital that they exchange their organ donors in this manner. But their proposal was refused by that hospital's ethical committee by referring to *the PRC Organ Transplant Law* that says living organ donation cannot be approved between non-relatives.

These two cases suggest that, in the face of ethical-legal dilemmas, while authoritative bureaucracy was not involved in the medical decision-making, Chinese medics did

²⁶³ X. Zhao et al., 'Husband Refused to Sign, His Pregnant Wife Died' (in Chinese), (Nov 23rd, 2007) *Xinhua News*.

²⁶⁴ Y. Wang, 'The Law Needed to be Clarified for Protecting Life Better' (in Chinese), (January 18, 2008) *Legal Daily*.

prioritise law over ethics. My speculation on the underlying causes or motives is that, in today's China, the media and public would attack medics for their "callousness". Under such pressures, Chinese medical practitioners have learned to be cautious. They put "free from responsibility" ahead of patient safety; that is why they wait for authorisation before starting an operation, rather than taking their own professional decisions. When the patients' trust in doctors and hospitals has been severely damaged, Chinese medics frequently practice defensive medicine so as to justify their treatment and protect themselves from being sued or even physically attacked.

Besides a high level of legal consciousness, Chinese medics also have great political sensitivity. After the *Sanlu dairy scandal* broke out in China – a food safety incident in 2008 with an estimated 300,000 victims, with 6 infants dying from kidney stones and other kidney damage, and a further 860 babies hospitalised,²⁶⁵ several families who were victims of the scandal sought legal advice. The Chinese government put pressure on the lawyers who were in touch with victims' families.²⁶⁶ Based on an interview with a doctor's wife, the media reported that, her husband (the doctor) had reminded her never to tell any journalist that the hospital he worked for had received an internal order from a government department to "close their mouths and make no comment on the milk scandal".²⁶⁷

As is shown by the problematic and ethically-distorted SARS case, a whole nation of physicians, except one, had participated in the cover-up (more discussion will be given in Chapter 7). This, to some extent, indicates that Chinese medics lack power in the healthcare system as a group. In the course of studying the case of dairy scandal, and especially the doctor's reaction to the state's internal order, many new questions are also raised:

(1) How does a Chinese medical practitioner prioritise between medical ethics, law and political ideology when these are in conflict?

²⁶⁵ PRC Ministry of Health, 'Latest Update about Conditions of Sick Children Who Consumed Contaminated Baby Formula San Lu Milk Powder' (in Chinese), Oct 15th, 2008, available at: <http://www.moh.gov.cn/publicfiles/business/htmlfiles/mohbgt/s3582/200810/38069.htm>; W. Lam, 'Milk Powder Scandal Exposes China's Worsening Administrative Malaise', (Oct 7th, 2008) 8 *China Brief* 19; J. Yardley and D. Barboza, 'Milk Scandal Shows Holes in China's System', (Sep 28th, 2008) *International Herald Tribune (The Global Edition of New York Times)*.

²⁶⁶ W. Wong, 'Courts Compound Pain of China's Tainted Milk', (Oct 16th, 2008) *New York Times*.

²⁶⁷ J. Chen, 'Internal Order Asked Doctors to Close Their Months' (in Chinese), (Sep 20th, 2008) *Secret China*.

(2) Does a medical practitioner exercise his or her own professional judgement, but feel disempowered and dare not speak or act?

(3) Does a medic simply agree with the authority and believe that no criticism or resistance is the best way to contribute to a “harmonious” society?

Based on the literature review, and my own observation and pilot interviews conducted in China in August 2007, my hypothesis is, that Chinese medical practitioners may have a relatively high legal consciousness. They would use law to protect themselves but not as a vehicle for protecting the best interests of patients. The Party/state still remains as a supreme power in supervising healthcare practice. When there is a legal or policy gap (which also means neither state governance nor the law is in place to supervise behaviours), a commercial interest would become the main motive for their behaviour. Medical ethics may play the least important role in the Chinese medics’ prioritisation in decision-making.

PART TWO EMPIRICAL STUDIES:

**LISTENING TO THE HIDDEN
VOICES OF CHINESE MEDICAL
PRACTITIONERS**

CHAPTER 4 METHODOLOGY

It is much easier to recognise error than to find truth; the former lies on the surface, this is quite manageable; the latter resides in the depth, and this quest is not everyone's business.

Johann Wolfgang von Goethe²⁶⁸

1. Introduction

Part Two of this thesis (Chapters 4, 5 and 6) aims to present empirical evidence of the degree to which medical practitioners think seriously about law, political norms and bioethics, and how these pluralist guidelines impact on or are impacted by Chinese medical practitioners. Specifically, I will report the findings of empirical studies designed to explore the extent to which my initial question – how do medics prioritise laws, political ideology and medical ethics – is supported by empirical data. This chapter seeks to highlight the dilemmas and problems experienced when designing, conducting and analysing the empirical research.

2. Sampling

2.1 Choice of Venues and Respondents

A representative sample “reflects the population accurately so that it is a microcosm of the population.”²⁶⁹ It is generally assumed that a representative sample is more likely to be the outcome of random selection, though random selection of a sample cannot guarantee an absence of bias. By the end of 2009, the number of Chinese healthcare workers reached 7,844,000.²⁷⁰ The need to sample was inevitable, and the first question raised in the field was how to select representative samples for my qualitative and quantitative studies.

²⁶⁸ J. W. Goethe, *Maxims and Reflections: An English Translation of Meximen und Reflexionen*, translated by E. Stopp (London, Penguin Books, 1998), No.166; also cited by R. Naylor, *Medication Errors: Lessons for Education and Healthcare* (London, Radcliff Medical Press, 2002), 41.

²⁶⁹ A. Bryman, *Social Research Methods* (Oxford, Oxford University Press, 2004), 87.

²⁷⁰ See note 79.

Bryman says, “it is incredibly difficult to remove any bias and deliver a truly representative sample, what needs to be done is to ensure that steps are taken to keep bias to an absolute minimum.”²⁷¹ Considering the probability of using a randomly selected sample of Chinese health professionals, I realised that to do this, I would have to seek governmental support. In other words, only by seeking governmental cooperation and permission for such a top-down approach, would I be able to access those randomly chosen healthcare workers.

When conducting large-scale social research in China, authorisation – getting approval from relevant authorities – is unavoidable. Though authorisation might allow me to access a large pool of respondents, it would bring more uncertainty to the fieldwork management. Not only would my research questions be scrutinised, but also the way I planned to conduct the research would be subject to political guidance. The frequent need to obtain authorization from the relevant authorities when undertaking survey research would make it difficult for me to retain direct control over the data collection activities.

What is more, I worried that, once I finally received the governmental permission, my academic research might be tainted by this top-down approach, at least in the eyes of potential participants who might confuse this fieldwork with a governmental survey. Informed-consent to participation might be misunderstood by research subjects as a forced duty. This problem was compounded by a lack of guarantee that subsequent studies would not be disrupted or challenged, especially since my research was supported by a foreign university. There is a lack of transparency about what is permissible in a social survey in China.²⁷²

Manion has noted that “sampling is not the only serious obstacle to survey research in the People’s Republic of China. Many other problems challenge the ingenuity of social scientists in adapting standard methods to distinctively non-standard conditions.”²⁷³ Given the considerations outlined above, I decided against nationwide

²⁷¹ Ibid, 89.

²⁷² R. L. Jacobson, ‘Universities in China are Told not to Cooperate in Social Research Projects with Hostile West’, (June 19th, 1991) *The Chronicle Higher Education* A1-A27.

²⁷³ M. Manion, ‘Survey Research in the Study of Contemporary Culture China: Learning from Local Samples’, (1994) *China Quarterly* 139, 741.

random sampling using a top-down approach, but decided to use snowball sampling in order to access different hospitals and healthcare institutions by means of existing relationships. Though the limitations of this survey method meant that this fieldwork could not provide a full picture that represented all Chinese medics, my hope was that these small-scale “local” survey samples, could serve as a “snapshot” of the thoughts of a number of contemporary Chinese healthcare practitioners and get at least a few medics’ voices heard, so as to end this group’s long-term silence.

Snowball sampling means sampling through a process of reference from one person to the next.²⁷⁴ I used this method to help me gain access to the largest possible number of healthcare institutions. The survey ultimately covered 18 hospitals in 6 cities of two provinces. However, I realised that snowball sampling could cause problems in generalisation. Once I became familiar with a particular institution, I conducted simple random sampling of healthcare workers in order to keep sampling biases to a minimum. Therefore every healthcare practitioner in that institution had an equal chance of being selected.

Within a research process, gate-keepers are persons who are in charge of allowing or denying researchers access to the respondents’ institutions or settings. “In the ‘real world’ in which we conduct our research, researchers remain dependent on the goodwill of gatekeepers to a very large extent.”²⁷⁵ I selected the gatekeepers in my fieldwork more or less through personal relationships (so-called “*Guanxi*” in Chinese), which I will explain more in the next section.

Using a snowball sampling technique, I made initial contact with 6 gate-keepers in China who either worked at or knew people who were working at 10 different hospitals in 3 cities of one province (which I named Province A). When talking to these 6 gate-keepers, I first asked them which level of hospital they were working in or could approach. Then I asked them to introduce me to their hospital colleagues, who happened to be on duty and were available at the time when I was disseminating

²⁷⁴ M. Denscombe, *The Good Research Guide: for Small-Scale Social Research Projects* (Philadelphia, Open University Press, 2003), 16.

²⁷⁵ S. Heath, et al., ‘Informed Consent, Gatekeepers and Go-betweens’, Paper presented at the Sixth International Conference on Social Science Methodology 2004, available at: www.sociology.soton.ac.uk/Proj/Informed_Consent/ISA.rtf (Last visited on April 30th, 2010).

questionnaires. I started my research in Province A, a southeastern province in China where the general population are relatively well-off.

In order to further eliminate sampling bias, I increased the sample size from one province to two. At the same time, another 6 gate-keepers from a central southern province (named Province B) were contacted. Province B is less developed and its general population is less well-off than that of Province A. As provinces in China are not developing equally, these two provinces at different stages of socio-economic development might affect medical practitioners' working experiences, and that might be reflected in the medics' views about their interactions with law, bioethics and healthcare governance.

In the end, the fieldwork covered 18 hospitals in 6 cities of 2 provinces (with three cities in each province). My research subjects were, medical practitioners including doctors, nurses, and a few pharmacists and laboratory staff, of different ages, who currently work at three different levels of hospital, in two provinces of China. Below is the summary of the questionnaire samples that I collected from the different classifications of hospitals:

Hospital Classification ²⁷⁶	Province A		Province B		Total	
	Hospitals	Questionnaires	Hospitals	Questionnaires	Hospitals	Questionnaires
III A	4	27	4	48	8	75
III B	0	0	1	38	1	38
II A	5	57	1	26	6	83
II B	1	6	0	0	1	6
I	1	10	1	11	2	21
Total	11	100	7	123	18	223

This thesis focuses on the general pattern of findings from a macro perspective, without digging into the data to analyse them from a micro-comparative point of view. Most of the data analyses have not been broken down by province except in one key question – the causes of ethical dilemmas. The data analysis would benefit more from a larger scale comparison of the data on provinces, gender, professional basis etc. Due

²⁷⁶ Hospital classification in China has been discussed in Chapter 2.

to the research scale of this thesis, I have left this micro-comparative data analysis for future study.

I was also aware that there should be an even spread across the levels of hospitals so that data bias could be better eliminated. However, the fact was that those gatekeepers whom I was able to approach were mainly based in urban areas, as a result of which provincial and municipal/city hospitals (in other words, hospitals of the Level II and Level III) were overrepresented in my data.

A choice was given to the questionnaire participants as to whether or not they would agree to take part in future interviews. Therefore, interviewees were sampled from questionnaire respondents who consented to participate and left their contact details. To preserve the confidentiality of each informant and his or her serving hospital, no name, signature or any identifiable information about their work place was presented in this thesis (issues of confidentiality will be explored further shortly).

2.2 Access

There are many restrictions when studying a social phenomenon in China in its real-life context, especially when data collection is based on surveys and interviews conducted by members of foreign academic institutions and research institutes. Therefore, flexibility was built into the basic research design. Due to the difficulties in collecting data in China, Croll has recommended that empirical data be limited to the “icing on the cake” with the main study being based on documentary studies.²⁷⁷ However, based on personal contacts and connections (*guanxi*) in China, individual scholars have been able to carry out their own research.

Guanxi is conventionally translated into English as “relationship”. China is an example of “a society resting on networks [which] contains no sharp boundary lines, but only ambiguous zones of more or less dense and more or less institutionalized

²⁷⁷ E. Croll, ‘Short-term Field Investigation in China: A Personal View’, 1 (1987) *China Information* 2, 17-26.

network configurations”.²⁷⁸ Traditional relationships or networks (with relatives, friends, colleagues and former classmates) are still dominant in daily, personal or social life.

With the help of personal *Guanxi*, I could easily access some of the medical practitioners who were working at the sampled hospitals in one city from each province. Because of the trust relationship built previously when I was in the field, respondents emerged through a process of reference from one person to the next, and the sample snowballed into three cities from each province. I realised that such snowball sampling might result in potentially biased findings. So I tried to extend the informant pool from my own social network of *Guanxi* to the widely extended social networks of friends’, families’, relatives’, and former-classmates’. This ripple-effect helped me to reach medics with a range of different lengths of practitioner experience, specialism, affiliations to different levels of health institutions from various classifications and locations.

In this respect, the fieldwork was not a personal effort; it reflects a range of different *Guanxi* that have made possible the project results. *Guanxi* is important in conducting research in China. Besides its snowballing effects, it is extremely helpful for building trust between researchers and research participants. Trust is a key factor in influencing people’s willingness to collaborate and supply honest and full answers, especially in China where public speech is sometimes under scrutiny.

There were several occasions when I myself did not know the gate-keeper personally, as he or she may have been introduced by friends or relatives. I started by introducing myself and the purpose of my research, by saying “I am a doctoral research student who is interested in understanding medics’ dilemmas at work. I hope my research might help to improve your and your colleagues’ working environment.” Then, I gave the gate-keeper one questionnaire with its covering letter to read and fill in. Once the gate-keeper had finished the questionnaire, I then asked whether he or she was willing

²⁷⁸ G. G. Hamilton and W. Zheng, *From the Soil: The Foundation of Chinese Society* (A Translation of Fei Xiaotong’s *Xiangtu Zhongguo*) (Berkeley, University of California, 1992), 23. For detailed analysis of the re-emergence of traditional social networks and of *Guanxi* ties in post-Mao China, see T. Gold, ‘After Comradeship’, 12 (1985) *China Quarterly* 104, 657-675.

to introduce me to his or her colleagues. Most of the time, I managed to build a relationship with this gate-keeper and successfully gained their help.

Though gate-keepers played an important role in my research, I did not entirely rely on their introductions in order to disseminate these questionnaires. Once I became familiar with a hospital environment, I tried as much as I could to introduce myself to medical practitioners who were at that time seeing no patients but were on duty. As a young female, I found middle-aged and young female medics were more likely to accept my request than elderly females. I also found male medics to be generally accessible, yet on three occasions I was refused by elderly male physicians from three different hospitals. So in general, senior physicians were cautious and more likely to be sceptical or distrustful of the purpose of my research.

Without the help from gate-keepers, I found that medics were more distrustful of my self-introduction approach, even though they might accept a questionnaire. Of the 42 completed questionnaires that I received without the help of a gatekeeper, only 2 respondents expressed willingness to participate in the follow-up interview. By comparison, 42 out of the 181 I approached with the help of gatekeepers agreed to participate in the follow-up interview.

3. Methods

Statistical survey data are often used to provide a summary of major patterns whilst interview data support these patterns by providing depth, detail and meaning.²⁷⁹ This study is based on a combination of questionnaire surveys followed by in-depth interviews. Considering the difficulty of approaching potential interviewees in China, I employed a survey as a method of helping me reach those whom I had no acquaintance but who were willing to share their feelings and experiences. Every questionnaire informant was given an option to choose whether or not to participate in a follow-up interview. I anticipated that those who chose to tick the box were ready to be open and honest; otherwise it would be a waste of their precious time. In short, the empirical study was conducted in two main stages. At a preliminary stage,

²⁷⁹ A. Bryman, *Social Research Methods* (Oxford, Oxford University Press, 2004), 443-446.

questionnaires were pilot tested (details of the pilot test will be given shortly), and then delivered either by post or in person. At the second stage, research questions were further explored in in-depth interviews.

3.1 Planning the Quantitative Research – Survey

The research started with a questionnaire in order to obtain a general idea of the medics' consciousness and attitude towards laws, bioethics, and political ideology. The initial hypothesis that – “Chinese medical practitioners may have a relatively high legal consciousness for practising preventively. The state/party has supreme influence over medical practice, while commercial interests may also affect medical judgements.” – was converted into testable survey questions (details of survey design will be given shortly).

Once the questionnaire had been designed, the first question that arose was how to conduct the survey. In quantitative research, researchers are uninvolved with their subjects and in some cases may have no connection with them, such as in research based on postal questionnaires or on hired interviewers doing market research.²⁸⁰ This lack of relationship with the subject of an investigation is regarded as desirable by Bryman and Bell, as investigators may feel their objectivity will be compromised if they become too involved with the people they study.²⁸¹ I considered this methodological approach, and it would have been possible to collect the quantitative data without having any interactions with any participants in order to achieve objectivity. But in China, it would have required me to gain admission and cooperation from the hospital management team or local health administrative officers. The advantage of using this method was that the potential sample size would be much larger and I could remain more objective.

In the first hospital piloted in Province A, the gate-keeper, Pharmacist A, did approach his hospital management team on my behalf. He gave a copy of my questionnaire plus its covering letter to the hospital director and the secretary of hospital Communist Party branch for them to look at. Both read my questionnaire and

²⁸⁰ Ibid, 287.

²⁸¹ A. Bryman and E. Bell, *Business Research Methods* (Oxford, Oxford University Press, 2007), 425.

finally agreed to ask the hospital's medical administration department to disseminate it to 160 medical practitioners based at that hospital. I refused their suggestion. Feedback from some doctors who participated in the questionnaire pilot test had indicated a negative attitude towards this method of top-down questionnaire dissemination. One doctor told me, getting a questionnaire from the hospital administration department would be more like an "external examination", rather than social research. Depending on who is organising the research, doctors like him who are too busy with their jobs would either complete it casually or give "correct" answers rather than honest ones.

I decided later not to approach either hospitals' management team or local health administrative officers when I conducted my quantitative study in China. My reasons were as follows: first, it would be unethical if academic research was to be coloured by the political or administrative order, and medics could not opt in or out as they wished, but would be forced to participate. Second, if their answers were uniformly "correct", the research would lose its purpose. In the field, I insisted on going to different hospitals to disseminate the questionnaire myself for as long as time and finance permitted. During this process, I began to genuinely understand their working environment. Such observations could be used to supplement the quantitative data by giving it a context. At the same time, I also tried to have a dialogue and foster a relationship of trust with medics.

3.2 Planning the Qualitative Research – Semi-structured Interviews

Although the survey research method is able to help researchers to collect information from a relatively large number of respondents (in this case over 220), a major drawback of this survey research method is that one loses the clarity of detail and the supplementary, interpretative information that one obtains in a qualitative study. Based on information given by questionnaire respondents who agreed to participate in a follow-up interview, I contacted these potential interviewees. This process can be described as triangulation, which refers to a process of cross-checking findings

deriving from both quantitative and qualitative research.²⁸² The combined method of survey plus interviews meant that I could start seeking “close involvement with the people being investigated”.²⁸³

The interviews were carried out using qualitative research interview methods as described by Kvale.²⁸⁴ This method attempts to grasp opinions, feelings, attitudes and the meanings that are implicit in medics’ actions from their own viewpoints. Technically, my qualitative research interview was semi-structured and carried out following an interview guide, which contained certain themes such as the interviewees’ interpretation and prioritisation of law, bioethics or political ideology, personal experience of ethical dilemmas, ways of resolving dilemmas, etc.²⁸⁵ The object of the qualitative research was not only to clarify the responses in the questionnaires, but to understand how the respondents had prioritised different forms of guidance in work, and the meanings they ascribed to such guidance. It sought to elicit descriptions of specific situations, as opposed to general opinions, and to obtain concrete descriptions of what the informant had experienced and how she/he had reacted in a situation where ethics, law, or political ideology are in conflict.

Interviews provided me with rich information about how the respondents felt, why they prioritised one set of guidelines over another, the dilemmas they faced and their causes, how they solved the dilemmas and what expectation they had of their working environment. However, I also realised that there were potential problems in conducting in-depth interviews in China:

First was Chinese culture. Chinese scholar Chen has pointed out the problem of trying to apply Western research methods to China, as Chinese people do not like to express their personal opinion in this way and tend to convey opinions in accordance with

²⁸² D. Deacon, et al., ‘Collision or Collusion? A Discussion of the Unplanned Triangulation of Quantitative and Qualitative Research Methods’, 1 (1998) *International Journal of Social Research Methodology* 47 – 63; also cited by A. Bryman, *Social Research Methods* (Oxford, Oxford University Press, 2004), 275.

²⁸³ A. Bryman, *Social Research Methods* (Oxford, Oxford University Press, 2004), 286.

²⁸⁴ S. Kvale, *InterViews: An Introduction to Qualitative Research Interviewing* (London, SAGE Publications, 1996).

²⁸⁵ The guide sheet for this semi-structured interview is available in the appendices.

social norms.²⁸⁶ Before conducting interviews, I was cautious about the validity of their responses to politically sensitive issues and the possibility therefore of reluctance to respond to some of my questions.

My second concern was that patriotism or nationalism might affect Chinese medics' expressions and feelings. Though the Chinese people in their own ways may be pressing for their rights and improved lives, they have simultaneously exhibited unmistakable signs of nationalism that make them less receptive to the virtues of democratization. My worry was that participants would feel embarrassed to say anything bad about the system in which they were working, and especially when they realised that my report would be open to foreign investigators. Their loyalty to the state might mean that nationalism would bias them against telling the truth and speaking their minds.

Thirdly, I was concerned about the influence of state propaganda or political thought education. The recent political agenda has broadly focused on building a "harmonious society".²⁸⁷ Through its media, textbooks, and propaganda machinery, the Chinese government emphasises that democratisation, political liberalisation, a free press, and anti-government protests will only bring about the collapse of the current regime and hence are dangerous and destabilising for Chinese society. Chinese medical practitioners might feel hesitant to criticize the government and might even treat their problems in work as a necessity for China's economic modernisation. Therefore, it would be difficult to know the extent to which they face dilemmas and problems in the system.

²⁸⁶ Y. Chen, 'Out of Traditional Halls of Academe: Exploring New Avenues for Research on Women', in C. K. Gilmartin, et al. (ed), *Engendering China* (Cambridge, Harvard University Press, 1994), 70-71; also cited by C. N. Milwertz, *Accepting Population Control: Urban Chinese Women and the One-Child Family Policy* (Surrey, Curzon Press, 1997), 207.

²⁸⁷ 'Harmonious society', a theory was originally derived from Confucian thinking. It has been adopted by the current president Hu Jintao as the latest political slogan. The objective of the harmonious society envisioned by Confucius was to bind individuals and groups to preciously defend social roles and to regulate permanently the relationships between these roles by means of a hierarchical, tightly-knit nexus of mutual obligations. China published a resolution on building a harmonious society in 2006. The resolution was adopted at the conclusion of the Sixth Plenary Session of the 16th Central Committee of the PRC Communist Party. The resolution stresses the harmonious socialist society is to be built and shared by all Chinese along the road of socialism with Chinese characteristics and under the CPC leadership by 2020, available at: <http://www.china.org.cn/english/2006/Oct/184810.htm> (Last visited on Nov, 13th 2009).

The above concerns were taken into account when I designed this research. First, I decided to approach potential interviewees by asking questionnaire respondents whether they would like to take part in follow-up interviews, on the assumption that those medics who expressed their willingness would be likely to be more open and honest in the interview. Second, I kept a fieldwork diary to record my everyday field observations, including short and long conversations with the medics whom I met, their facial expressions after I introduced myself, my research purposes, their reasons for refusing to participate and messages written on the bulletin boards hanging on the walls of hospital halls, corridors and offices. Third, I paid more attention to the wording I used in both questionnaires and the interview questions. I eliminated sensitive expressions and tried to ask respondents more open questions rather than closed ones. And finally, in the field, I reassured them of their anonymity and that confidentiality would be protected. They were told that no signature was required in the questionnaire, and their interview transcripts would not be recorded without their permission.

4. Data Collection Procedure

4.1 Pilot Testing and Modification

The first task in the field was to get the English version of the questionnaire translated into Chinese and for it to be pilot tested. I pilot tested the preliminary questionnaire with Pharmacist A who also served as a gate-keeper to his hospital. He was initially conscious about the sensitivity of my questionnaire, but I received positive feedback. He pointed out a few unclear expressions used in my questionnaire and said that he was especially interested in questions with regard to the functions of hospital party branch to medical practices. He said he had never come across such questions before. He also discussed the time taken to complete the questionnaire. It took him 20 minutes to finish it, yet he doubted whether busy professionals such as physicians would be willing to take 20 minutes out of their working day. He recommended, therefore, that I simplify some of the time-consuming questions (especially the ones requiring them to rank answers in order).

After pilot testing with him, I made changes to a few words and expressions, and started to think about the ways I could keep the time-consuming questions as close to the original as possible, while also reducing the time needed to complete the questionnaire. I added an additional column and changed the format of choices from letters to numbers. I was not sure whether these changes would help or not.

Pharmacist A later introduced me to six of his colleagues working at the same hospital. Four of them were doctors, one a nurse, and one another pharmacist. The questions on the original questionnaire were modified, based on feedback from these 7 participants in the small pilot study. Most of them responded that several questions, which required them to rank answers in order according to level of importance (starting from the most important one), were time-consuming. If the survey was not introduced by gate-keepers, they said, they would not have bothered to take part.

To simplify the survey, I reduced the number of this type of question from 6 to 3. With fewer significant questions, participants were asked to choose only the answer they considered to be most relevant. In three important questions, I asked them to rank the answers in order of preference (from the most important to the least). To make the questionnaire appear less sensitive, I also made changes to the sequencing and section titles. In the modified Chinese version, I put law at the beginning instead of state governance. I changed the original title “state governance and healthcare professionals” to “the healthcare system and healthcare professionals” (copies of the questionnaire in both the English and Chinese version are available in the appendix).

4.2 Questionnaires, Interviews and Informal Discussions

Interestingly, I found it was easy to talk to medics when they returned their completed questionnaires, even though they had not indicated a willingness to be interviewed in response to the last question of my questionnaire. So I decided not to wait until I finished collecting all the questionnaires before conducting follow-up interviews. Rather, I tried as much as possible to talk to medics in the field, especially after they completed the questionnaires. Questions asked in these more informal interviews followed the same structure as the more formal organised ones. I managed to make

notes during and after the talks, as I noticed that Chinese medics are uncomfortable talking openly to researchers while having their answers tape-recorded.

There were three focus group discussions which were not pre-organised and happened at the end of the doctors' work period. When I went to one of the offices to collect completed questionnaires, a few physicians happened to be gathering to have a break. I tried to start an informal talk with one physician, asking him, "What do you think about the questionnaire?" The other physicians started joining in the conversation. It was interesting as I found they were intrigued to hear about my experience in the West and my understanding of their working conditions. Then they started to complain about their situation.

However, informal talks can never replace formal ones. The locations of our informal talks were mostly in public areas where both I and medics were very careful with what we said. In this situation, sensitive questions are hard to ask, develop and answer. To some extent, their careful attitudes demonstrated the medical practitioners' ethical dilemma between telling the truth, and their need to balance them with other considerations (details of their ethical dilemmas will be explored later).

In the last question of my questionnaire, respondents who agreed to take part in a follow-up interview were asked to fill in their email address or telephone number. However, I found that contacting 44 potential interviewees who gave their consent in the questionnaires was a much harder process than I was expecting. There were 3 medics who said "yes" without leaving contact details. Some email addresses were mistakenly written or unidentifiable, and 15 medics who left me their office number where 5-10 doctors were sharing the same room and using the same telephone. I could not approach all these medics who had indicated willingness to participate in the follow-up interviews. I managed to contact the remaining 26 interviewees and asked them to choose how and when they felt comfortable participating. Two medics changed their minds, which left 24 formal interviews in total which were conducted through face to face interviews or by phone. Below is a brief summary of the sample sizes of both the survey and interview data:

Sample Size/ Gender Breakdown

Questionnaire Respondents	Female	Male	TOTAL
Doctor	52	77	129
Nurse ²⁸⁸	54	0	54
Pharmacist	8	2	10
Laboratory worker	5	3	8
Others	3	8	11
Occupation unknown	4	2	6
Subtotal	126	92	218
Refused to provide any personal information			5
Total			223

Interview Respondents	Female	Male	TOTAL
Doctor	5	6	11
Nurse	6	0	6
Pharmacist	0	2	2
Laboratory worker	0	2	2
Administrator	1	2	3
Total	12	12	24

Informal Talks	Female	Male	TOTAL
Doctor	2	2	4
Nurse	2	0	2
Laboratory worker	1	0	1
Total	5	2	7

Group Discussions	Female	Male	TOTAL
Group 1 from Ophthalmology	2	2	4
Group 2 from Radiotherapy	1	1	2
Group 3 from Department of Medicine	0	4	4
Total	3	7	10

4.3 Response Rates

“A response rate is the number of completed surveys with reporting units divided by the number of eligible reporting units in the sample.”²⁸⁹ Groves and Lyberg suggested, “there are so many ways of calculating response rates that comparisons across

²⁸⁸ Nurses in China are mostly female; it is rare to find male nurses in China.

²⁸⁹ A response rate is the number of complete surveys with reporting units divided by the number of eligible reporting units in the sample. Definition given by the American Association for Public Opinion Research, ‘Standard Definitions: Final Dispositions of Case Codes and Outcome Rates for Surveys’, Revised 2008.

surveys are fraught with misinterpretations.”²⁹⁰ Response rates, cooperation rates,²⁹¹ refusal rates²⁹² and contact rates²⁹³ are commonly utilised in survey reports and in research literature. In this thesis, I used response rates to report the degree to which my empirical research was accepted by those Chinese medics I approached.

In this empirical research, the 223 completed questionnaires were distributed in three different ways – solely by gate-keepers (49 cases), by me in the presence of gate-keepers (132 cases), and by me alone (42 cases). In total, 174 questionnaires were disseminated by me directly to medical practitioners and all returned to me directly in the field. The 49 questionnaires distributed by gate-keepers were those whom I could not approach due to the difficulties of time and cost to me in travelling. I gave these gate-keepers large envelopes and repeatedly emphasised to them that all questionnaires were to be anonymous and unidentifiable. I trusted them to tell the respondents that they could answer truthfully and in confidence. All of those 49 questionnaires were returned to me by post.

As Cornish notes, potential respondents who have been contacted may refuse to cooperate for a variety of reasons including inconvenience, the sensitive subject matter, or lack of trust in the researcher.²⁹⁴ In this research, I found that, when approaching respondents, the degree of reliance on gate-keepers might affect the respondents’ attitude to participation, and possibly yield variable response rates. In order to have a clearer picture of whether and how response rates changed, these were calculated separately. Moreover, since it was impossible to calculate the response rate when questionnaires were distributed solely by gate-keepers, the calculation in this survey disregards this method of questionnaire distribution, but considers responses to

²⁹⁰ R. M. Groves, and L. E. Lyberg, ‘An Overview of Nonresponse Issues in Telephone Surveys’ in R. M. Groves, *Telephone Survey Methodology* (New York, John Wiley & Sons, 1988).

²⁹¹ Ibid. A cooperation rate is the proportion of all cases interviewed of all eligible units ever contacted.

²⁹² Ibid. A refusal rate is the proportion of all potentially eligible cases in which a respondent refuses to do a survey, or breaks-off a survey. See e.g., R. Kent, *Data Construction and Data Analysis for Survey Research* (New York, Palgrave, 2001), 57.

²⁹³ Ibid. A contact rate measures the proportion of all cases in which some responsible member of the eligible reporting unit, such as, housing unit, was reached by the survey.

²⁹⁴ J. Cornish, ‘Response Problems in Surveys: Improving Responses & Minimising the Load’, available from:

http://unstats.un.org/unsd/methods/statorg/Workshops/Yangon/Session4_Surveys_Cornish_Paper.pdf (Last visited on May 1st, 2010); M. Denscombe, *The Good Research Guide: for Small-scale Social Research Projects* (Philadelphia, Open University Press, 2003), 20.

the questionnaires that were distributed by myself alone or in the presence of gatekeepers.

When questionnaires were distributed by me with introductions from the gate-keepers, almost every informant whom I encountered (except 3) agreed to participate. This included cases of refusal before or after reading questionnaires. So the response rate where there was an introduction from a gate-keeper was: $129/132 = 97.7\%$. This indicated that, when the gate-keepers were introducing me to participants or disseminated the questionnaires on my behalf, the chances of receiving all or almost all of the questionnaires was very high.

In comparison with this, the response rate dropped when questionnaires were disseminated by me without any introduction from gate-keepers. During the time I disseminated these questionnaires, I recorded in my fieldwork diary that, when I introduced myself alone and requested their participation, there were 34 medics who refused to participate, and 42 who agreed. So the response rate for self-introduction was calculated as follows: $42/(34+42) = 55.3\%$.

Within the total number of 223 returned questionnaires, 44 respondents (19%) agreed to participate in interviews having left their email addresses or telephone numbers. However, only 24 of these respondents (11%) were successfully contacted and agreed to be my interviewees. Within the 44 potential interviewees, the contact success rate was 54%. Below is a brief summary of the response rate of the survey and interviews:

- Questionnaire distribution and collection (including pilot tests) ran from 30th November 2008 to 7th January 2009, during which time face to face interviews and informal talks were conducted.
- Follow-up face to face or telephone interviews (including interview pilot tests) ran from 22nd January 2009 to 28th February, 2009.
- 223 questionnaires were collected, 218 were fully completed.²⁹⁵

²⁹⁵ Due to various reasons, such as, not applicable, refused to answer, don't know, forgot to answer, not all respondents answered all the questions. I entered all 223 questionnaires into the data matrix, including the 5 cases, of which values are missing, for whatever reasons. Those partially answered questions were counted individually.

- 24 semi-structured interviews were conducted (13 were face-to-face interviews, 11 were telephone interviews); there were 7 informal individual talks; and 3 informal group discussions, making a total of 34 conversations.
- 19.7% of questionnaire respondents expressed interest in participating in follow-up interviews, and 70.8% of interviewees agreed to be re-contacted for future studies.

5. Question Format and Data Analysis

When creating the questionnaire and interview guide, emerging themes from Part One (Literature Review: Conceptual Framework and Historical Background) were converted into several main groups of research questions. These research questions were formulated into closed and open-ended questions for the questionnaire and interview.

In the questionnaire, a number of closed questions were used in order to minimise the amount of time that respondents would have to spend completing them. Space was given at the end of each closed question to enable the respondents to add additional comments. This type of question was formulated as a single or multiple choice question and mainly asked for the respondents' attitudes towards, and knowledge of law, state and bioethics. Before analysing the questionnaire data, completed questionnaires were given unique identifiers so that apparent inconsistencies generated in the data could be located and checked. Data were then typed into Microsoft Excel's spreadsheet, analysed by cumulative frequency distribution, and presented in the report as ratios.

The open-ended comments in the questionnaires and interviews were used for generating detailed, descriptive data mainly for explaining the impact on professional work of law, state and bioethics. Such data were textual, and so were transcribed into a raw data spreadsheet and further categorised in terms of their common themes. Data collected from open-ended comments were interpreted on both cumulative and individual bases.

6. Ethical Considerations

The empirical research focused on getting medical practitioners' perceptions. The hypothesis did not require research with patients, and there was no need for analysis of their medical files or their use of hospital equipment, so there was no difficulty in gaining ethical approval for this research from the ethics committee of the University of Edinburgh. However, the fact that ethical approval had been sought at a British university did not mean that ethical issues would not be raised in a local Chinese environment. Also, it should not be taken for granted that Chinese medics are less vulnerable than patients. Ethical considerations therefore underlie virtually all the decisions made about the research, particularly when the positions of medical practitioners within Chinese hospitals were unknown.

A number of scholars have expressed concerns that empirical research could be exploitative and oppressive. They argue that it consists of research in which there is an uneven distribution of power between researchers and research participants.²⁹⁶ The power wielded either by gate-keepers or researchers can be seen in terms of their ability to determine what needs researching, the ways of approaching the questions, timing of the questions and the power to interpret respondents' answers. In this sense, researchers have considerable autonomy whilst those who are researched have little.

In my attempts to tackle ethical issues in this research, I was guided by the provisions of *the College of Humanities and Social Science Code of Research Ethics* and *the Ethical Code of ESRC (Economic and Social Research Council) 2005*.²⁹⁷ All research participants were assured that I considered myself bound by these ethical codes. It meant that "the research was designed and conducted in such a way that meets certain ethical principles; and the research subjected to proper professional and institutional

²⁹⁶ R. Sapsford and P. Abbot, *Research Methods for Nurses and Caring Professionals* (Buckingham, Open University Press, 1992); M. Miles, 'Towards a methodology for feminist research', in M. Hammersley (ed) *Social Research: Philosophy, Politics and Practice* (London, Sage, 1993).

²⁹⁷ ESRC, *Research Ethics Framework*, the 2005 version has been recently amended. The ESRC Research Ethics Framework 2010 is available from: http://www.esrc.ac.uk/esrcinfocentre/images/esrc_re_ethics_frame_tcm6-11291.pdf (Last visited on May 2nd, 2010).

oversight in terms of research governance.”²⁹⁸ This ethical statement was also stated clearly in the cover letter of each questionnaire.

It was recognised that the issue of the function of the hospital Communist Party branch and the medical practitioners’ ethical dilemmas could be sensitive topics for medics to talk about. The first principle of all ethical codes was that research subjects should not be harmed by the research. It was uncertain whether or not criticism of the system would have a negative impact on medics and their affiliated hospitals.

Assurances as to the confidentiality of their participation were clearly stated. There was no question in the questionnaire asking the participant to provide details of his or her name, the hospital at which he or she worked or the district in which they were based, so even I myself could not tell the identity of the particular individuals involved (except the identities of gate-keepers). In order to minimise disturbance to respondents and their hospitals, the identities of individuals, their affiliated hospitals, and the location of cities and provinces were kept confidential in this thesis. Return envelopes, with names and addresses, distributed by gate-keepers were destroyed after they were received. Questionnaires were not given unique identifiers until they were coded for analysis.

With regard to coding, I coded the questionnaire and interview participants separately. Every questionnaire participant was given a number “1, 2, 3 or 4 etc”, with an initial “A or B” standing for the province in which the participant is based, such as A1, A2 or B1 etc. Each of the 24 interview respondents was identified by a letter “A, B, C or D etc”, with an initial “D (for doctors), N (for nurses), P (for pharmacists), L (for laboratory), and A (for hospital administrative staff).

Because of concerns about confidentiality, I ignored several opportunities to start informal talks with medics, when a gate-keeper was standing besides me. Gate-keepers normally introduced me to colleagues they knew quite well; so my concern was that some medics might have agreed to participate because they felt pressure from friendship, colleague-ship, or otherwise, and therefore had not freely chosen to

²⁹⁸ Ibid.

participate. In the field I tried to make sure medics were not required to complete the questionnaire, but instead were asked to ‘opt in’ to the study. In an effort to ensure that their decisions were informed, the aims of the research project, the methods employed, the funding body and possible uses of the data were all outlined in the covering letter accompanying each questionnaire.

I was aware that there would be a possible response bias to consider. “Correct” responses might exist in questionnaires. On one occasion, when collecting completed questionnaires from doctors, one female middle-aged doctor came forward to ask for reassurance that I would not put her name onto her complete questionnaire. I worried that there might be other respondents who also believed their anonymity would not be well protected. Their previous experience of surveys had probably been related to official Party or governmental investigations, so a concern about giving a “politically incorrect” answer might well have overshadowed their honesty and openness in my survey.

I was also concerned about the method of questionnaire collection. At hospitals, I was walking around, especially when collecting questionnaires; I would stand outside some of the physicians’ offices waiting for them to complete them. My presence might have put additional pressures on the physicians who might have felt forced to complete and return the questionnaire to me quickly. Once I realised that one participant had noticed my presence, I tried to ease their pressure by saying “Thank you very much for your time. I understand that you have been very busy. Please take your time”. Though my presence in collecting the questionnaire was unavoidable, I worried that other hospital staff would know who was completing it because of my presence. Identification of respondents in this way was therefore another issue that I had to take into account.

One thing I did not anticipate was that some physicians would ask me for a little incentive. They thought I should have prepared some little gift for those who had participated. What I could give was my name card, with which they could contact me whenever they had questions. Some of them asked whether my research report would be available in the future, and said that they would like to have a copy of it, as a favour in return for their participation. The response I gave was that I would love to

let them have a copy, but this depended on whether the Chinese version of my thesis would be available, and if it was, whether they would be approachable at that time.

At the end of the questionnaire, so as to preserve medics' autonomy, they could opt out of the second stage of the project – the interview – and most did, since only 44 out of 223 questionnaire respondents agreed to participate. Where they gave their telephone number or email addresses, without requiring names, such details were copied and coded into an interview note book which was kept locked in a cabinet at my home.

Research subjects can be harmed by research in a psychological way, which was not an impact I had anticipated, though I was aware of its possibility. There was a physician who was suspicious that I would record our telephone interview without getting his consent, on the basis that I was using a landline rather than a mobile phone. I assured him that I would not record his responses without his permission. With medics who had agreed to have the interview recorded, I would use an internet phone to call, and made it was clear that only I would listen to it for note-checking purposes. There were several physicians who asked me to be friends at the end of the interviews, saying they would like to keep in touch with me. This was beyond my expectation. I did not reject their requests directly, but as a researcher, in order to preserve my objectivity within the project, I have not communicated with them since the interviews.

7. Conclusion

This chapter has outlined issues faced during my research design and given reasons for any methodological choices: the sampling approach, the access to research participants, the research procedure for conducting the questionnaires and interviews, and how I proceeded with the data analysis. Problems that arose before and during the fieldwork have also been given recognition and solutions found if those were available. The limitations of this research have been acknowledged, though they do not undermine the integrity and strength of my findings.

The research allowed me to hear the voices of a particular group of Chinese medical practitioners, namely, doctors, nurses and other healthcare staff, at a significant and unique moment in their history. The findings allow us (1) to assess the impact of healthcare law, state governance and bioethics on Chinese medical practitioners, (2) to explore the ways in which medics understand these controlling mechanisms as relevant to them, and how physicians react to these different mechanisms when they are in conflict with each other. In Chapters 5 and 6 that follow, I will present the research findings from the questionnaires and interviews respectively.

CHAPTER 5 QUESTIONNAIRE FINDINGS

1. Introduction

This chapter presents the questionnaire findings. It was designed to gather evidence, from the perspectives of the Chinese medical practitioners, to show how, and to what extent their medical practice is affected by medical law, political ideology and bioethics. The chapter is divided into four parts according to different themes: attitudes, motivations, interactions, and prospects for the future. First, it will assess the Chinese medics' attitudes towards law, governance and bioethics, followed by an analysis of the motivations for their attitudes. Their interactions with the healthcare system, medical law and political ideology will be the third part of this chapter. The final aim is to explore Chinese medical practitioners' views on the prospects for the development of "professionalism".

2. Medics' Attitudes towards Law, State Governance and Bioethics

2.1 Attitudes

(1) Levels of Importance

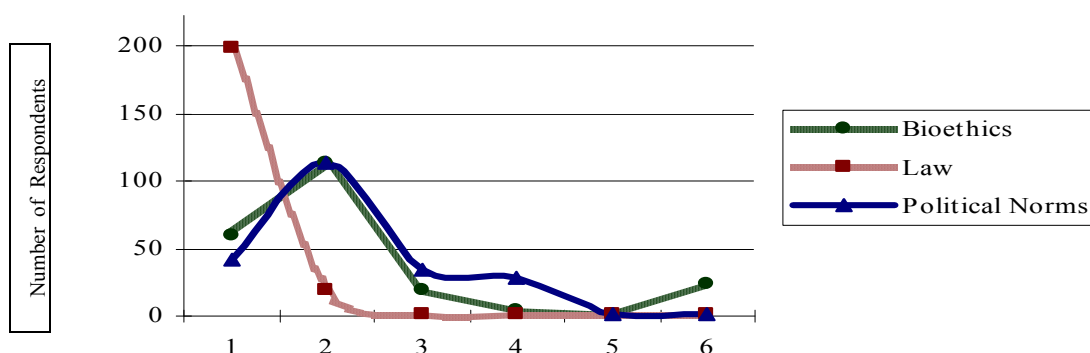
At the broadest level of abstraction, three main questions were asked in the questionnaire – "how important is it to apply bioethics, medical law or political thoughts in medical practices" in order to understand whether there is a discrepancy between medics' attitudes towards these pluralist control mechanisms. Responses to the questions were as follows:

Of the 223 medical practitioners surveyed, 199 practitioners stated that it was very important to apply law to their practice, especially laws that regulated their area of practice. Only 42 practitioners thought it was very important to apply political ideology to their practice; and 60 medics stated that bioethics very important to their

work. In addition, 114 practitioners stated it was only relatively important to apply bioethics or political norms to their practices (see Figure 1).

Comparing the medical practitioners’ legal, political and ethical consciousness, 218 of them (99%) thought applying law to their practice was either “very important” (199 medics, 90%) or “relatively important” (19 medics, 9%); while their attention to medical ethics and political ideology was significantly less. Over half of them (114 medics) commonly classified political ideology or medical ethics as “relatively important” governing norms; and less than one third of medics perceived political ideology (42 medics, 19%) or medical ethics (60 medics, 30%) as “very important” (see Figure 1).

Figure 1: The importance of bioethics, law and political norms (based on answers to questions ‘In your opinion, do you think medical ethics are important to your practice?’, ‘Do you think it is important to apply the law regulating your area of practice to your work?’ and ‘Do you think you should connect the latest political thought with your practice?’).



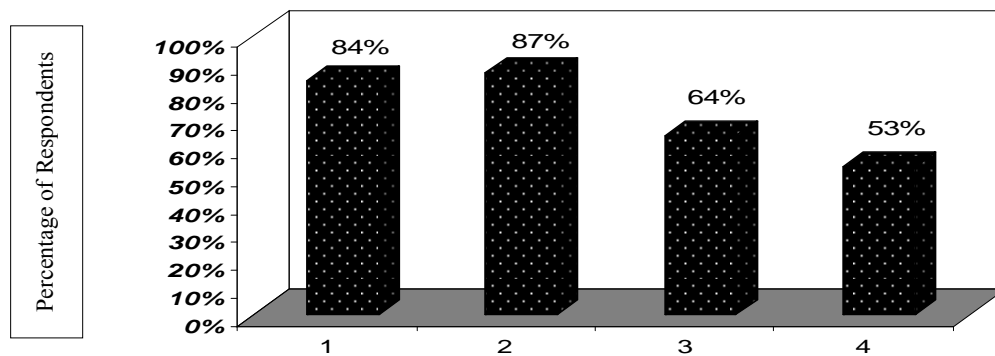
1. Yes, it is very important.
2. Yes, it is relatively important.
3. No, it is not.
4. I am not sure.
5. No comment.
6. Missing data.

Number of practitioners responding to this question: 223.

Almost one third of the medics (63) stated that either political thought was “not important” (35 medics) or that they were not sure about its importance (28 medics). The percentage of negative or tentative attitudes towards medical ethics was slightly lower, yet, there were still 19 medical practitioners who thought bioethics was “not important” to their practice, plus 4 medics who were not sure about the importance of bioethics at all (see Figure 1).

These figures show the high degree of legal consciousness of Chinese medics, who perceived law as the most important guideline, followed by bioethics, with political thought to be the least important. This finding has been replicated through another survey question asking each practitioner to rank the most important practice guideline to him/her (see Figure 2).

Figure 2: Guidelines classified by levels of importance (based on answers to the question, ‘Could you please classify what is the most important practice guideline to you? Please choose whatever is relevant to you, and then put them into order according to their level of importance (start from the most important one)’).



1 Practice guidelines of the hospital to which you belong. 2 Medical law. 3 Medical ethics. 4 Political norms.
 Number of practitioners responding to this question: 218.

Before discussing findings from this question, it should be noted there might be a discrepancy between how I had asked this question and how the question had been answered. In this question and two others (see Figures 7 and 15) of a similar format, I required respondents to choose and rank them based on one specific criterion. However, when coding responses to this type of question, I found it difficult to judge from the many answers formulated as “1234”, “123” or “34”, whether the respondents were choosing and ranking in order, or simply making multiple choices without the ranking. Such concern had been raised in my pilot studies when the medics pointed out that these types of “choose-and-rank” questions were time-consuming and so potential respondents would not bother to answer in the way I had asked. But amongst these doubts, I also found some answers were ranked correctly, like “2134”, “3412”, etc. Because of this discrepancy, I decided to analyse the data in terms of the percentage of respondents, rather than calculating the ranking order (or not). Although this is not ideal, to analyse by percentage still provides us with valuable information.

Of the medics surveyed, 87% agreed “medical law” was the most important guideline, whereas 84% agreed that the “practice guidelines of his/her affiliated hospital” came second most. Medical ethics was third and political norms were rated as the least important (see Figure 2). These responses support Griffiths’s argument that legal reality anywhere is a collage of obligatory practices and norms emanating both from governmental and non-governmental sources alike, rather than law being “an exclusive, systematic and unified hierarchical ordering of normative propositions’ emanating from the state.”²⁹⁹ The question of whether Chinese medical practitioners see the “practice guidelines of his/her affiliated hospital” as part of the “legal reality” will be addressed in Chapter 6 (interview findings).

(2) Norm-Behaviour Discrepancies

As Selznick writes, “a legal order is known by the existence of authoritative rules.”³⁰⁰ Rules issued by hospital authorities are directly authoritative and assert control over medics by sanctioning those who are believed to have broken the rules. “When an institution possesses authority and issues rules, it is, according to this foundation, a legal order.”³⁰¹ The hospital rules are seen, therefore, by medical practitioners as almost equally important as laws.

The survey results further illustrated that, law seemed to be the key element that affects medical practice in China. In second place came bioethics, leaving political norms as the least effective element. This raised a question about whether medical practitioners’ stated attitudes necessarily correlate with their behaviours. In order to assess this, a supplementary question was added on the application of law: “If you think law is important, how often do you apply law to your professional practice?”

The survey showed that while 90% of medical practitioners said law was very important to their practice, only 64% followed the law carefully. One reason accounting for this lower rate may be a lack of understanding — 14% of medics

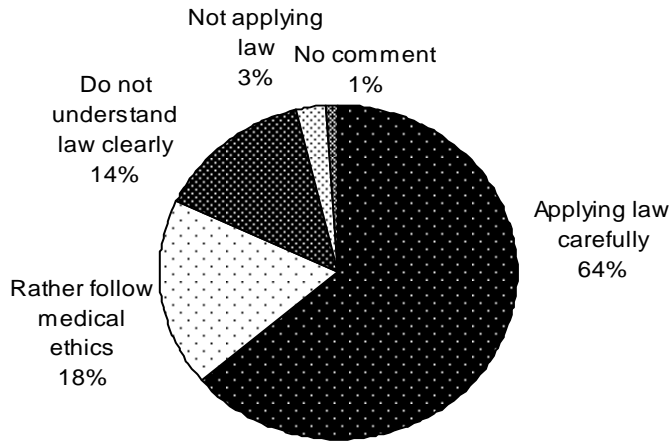
²⁹⁹ J. Griffiths, ‘What is Legal Pluralism?’ 24 (1986) *Journal of Legal Pluralism and Unofficial Law*, 3.

³⁰⁰ P. Selznick, *Law, Society, and Industrial Justice* (New York, Russell Sage Foundation, 1969), 5.

³⁰¹ M. M. Feeley, ‘The Concept of Law in Social Science: A Critique and Notes on Expanded View’, 10 (1976) *Law & Society Review* 4, 501.

belonged to this category. Another 18% of respondents said that they would rather apply medical ethics than law to their professional work (see Figure 3).

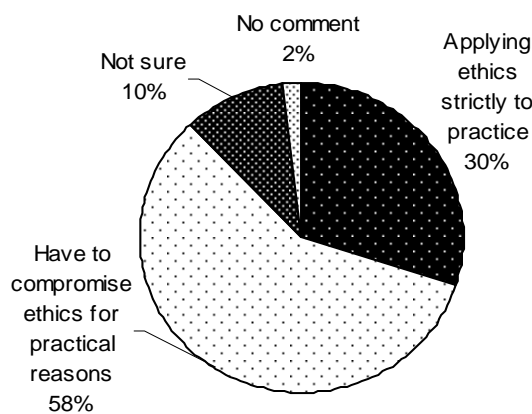
Figure 3: Norm-behaviour relationship in terms of applying laws (based on answers to the question, ‘If you think law is important, how often do you apply it to your work?’).



Number of practitioners responding to this question: 221.

The norm-behaviour discrepancy regarding the application of law to medical work, to some extent also corresponds to a gap between attachment to ethical norms and actual behaviour (see Figure 4).

Figure 4: Norm-behaviour relationship in terms of applying medical ethics (based on answers to the question, ‘If you think medical ethics is important, how important it is to your practice?’).



Number of practitioners responding to this question: 198.

As discussed before, more than half of the medics thought medical ethics were at least “relatively important” in response to the question asking them about the importance of

ethics (see Figure 1). However, only 30% of them admitted that they would stick to it in practice (see Figure 4). The remaining 58% said that they sometimes had to balance it for practical reasons. The question of whether this answer equated with these 58% of medics acting “unethically” is hard to discern within a survey, but it will be addressed in interviews.

2.2 Concept Comprehension

The discrepancy between knowing the importance of law and not really applying it in practice disclosed a discernible gap between norm and behaviour. According to Anderson and Whitman, law is a rule of conduct that “specifies the consequence of certain actions, and the knowledge of these consequences can be assumed to futuristically ‘rule’ or control behaviour”.³⁰² Thøgersen points out that the general problem of norm versus behaviour is particularly important in China, “where there seems to exist a set of ready-made, socially acceptable value judgements about almost everything”.³⁰³ The norm-behaviour discrepancy among Chinese medical practitioners may be caused by a lack of clear comprehension regarding the interplay between ethics and law.

In the realm of professional practice, it was necessary to clarify whether Chinese medical practitioners understood the meaning of law and bioethics, and whether they saw either of them as socially acceptable values. In other words, with respect to concepts like “law” and “bioethics”, which I used in questionnaires and interviews, a Chinese medic might mean what he/she said, but they might not know or even agree exactly what those “abstract” concepts meant. Reflecting on the difficulty of how to elicit a more personal level of reality, precise and concrete questions related to behaviour would be a solution to break through this problem.³⁰⁴

Medics’ responses to questions – how active their awareness and comprehension of laws regulating medical practice, seemed to show that, although law seemed very

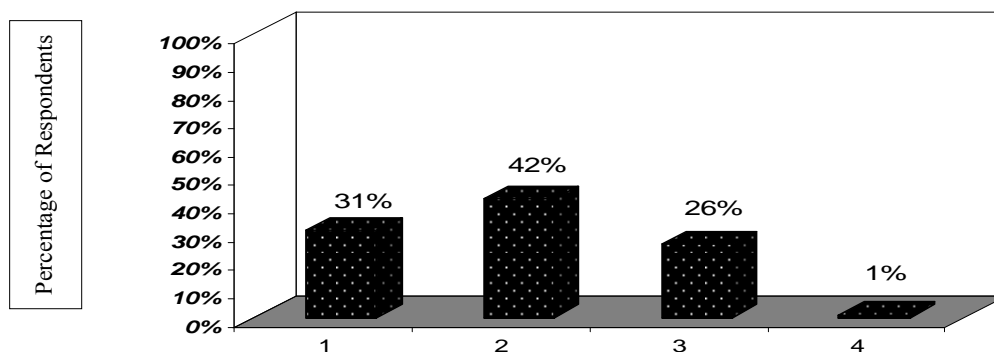
³⁰² D. C. Anderson and T. L. Whitman, ‘The Control of Behaviour Through Law: Theory and Practice’, 47 (1972) *Notre Dame Lawyer* 831.

³⁰³ S. Thøgersen, ‘Official Interviewing in China – Notes from Four Trips’, in O. Bruun, et al., (ed), *Modern China Research: Danish Experience* (Copenhagen, University of Copenhagen Press, 1991), 37.

³⁰⁴ *Ibid.*

important to them, the majority of medical practitioners were aware of a few of them (see Figure 5). Even then, the majority admitted they only understood what the law meant occasionally (see Figure 6).

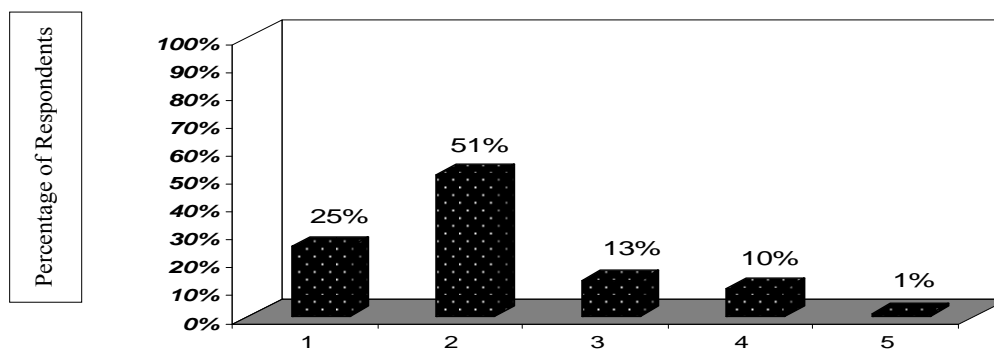
Figure 5: Legal awareness (based on answers to the question, ‘Are you aware of any law regulating medical practice?’).



- 1 Study laws and regulations relevant to my practice closely;
- 2 Aware of a few medical laws;
- 3 Don't know much detail about medical laws;
- 4 Don't know any medical laws.

Number of practitioners responding to this question: 222.

Figure 6: Comprehension of laws and regulations relevant to medical practice (based on answers to the question, ‘Do you understand laws and regulations that are relevant to your practice clearly?’).



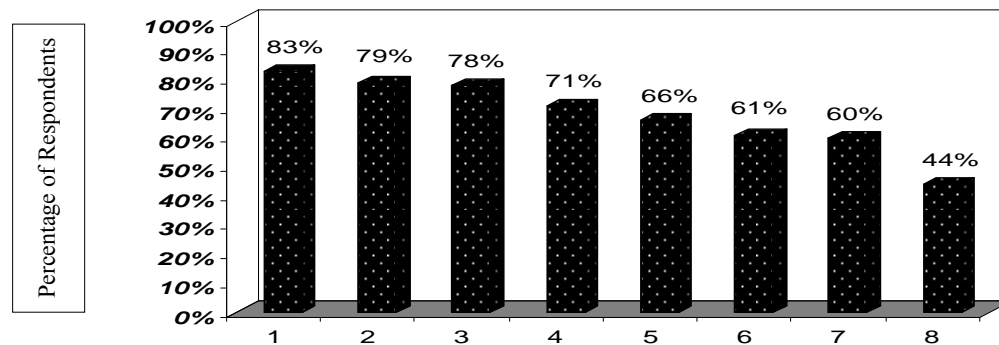
- 1 Understand what the law requires me to do in any situation;
- 2 Understood law occasionally;
- 3 Often not sure what the law requires;
- 4 Never sure what the law requires;
- 5 No comment.

Number of practitioners responding to this question: 223.

Similar responses to two of my questions on the comprehension of medical ethics also supported my interpretation of a possible confusion between the Western conception of “bioethics” and the Chinese interpretation. In response to the question “what is your understanding of modern medical ethics?”, the top three preferences according

to the Chinese medics, were firstly “improve the quality of patient care” (83%), secondly “no disclosure of patients’ medical records” (79%), and thirdly “team work between colleagues” (78%). The three options ranked least relevant were: “non-maleficence” (61%), “ethical aspects of biotechnological development” (60%) and “combining professionalism with patriotism” (44%) (see Figure 7).

Figure 7: Medics’ understanding of medical ethics and their levels of importance (based on answers to the question, ‘What is your understanding of modern medical ethics? Please choose whatever is or are relevant to you, then to put them into order according to level of importance (start from the most important one)’).



1. Improve the quality of patient care;
2. No disclosure of patients’ medical records;
3. Team work between colleagues;
4. Respect patients’ autonomy;
5. Safeguard public health;
6. Non-maleficence;
7. Ethical aspects of biotechnological development;
8. Combining professionalism and patriotism.

Number of practitioners responding to this question: 223.

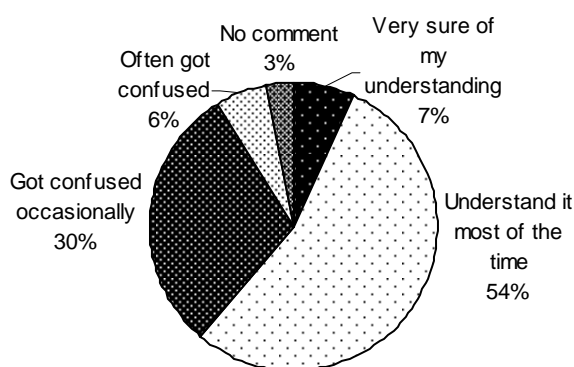
Medical ethics has a broad application in all cultures due to its potential to affect the moral dimension of medical practice. Between Western and Chinese medics, differing understandings of bioethics are worthy of investigation (Chapter 3 has discussed this, but a later chapter will elaborate further). The options given by this question to Chinese medics were based on the ethical principles and values set out in the World Medical Association’s *International Code of Medical Ethics*³⁰⁵ and the officially issued *Oath of Medical Students*³⁰⁶ set out by the PRC Ministry of Education in 1991 (further discussion is in Part III). These choices were set out in random order.

³⁰⁵ World Medical Association, *International Code of Medical Ethics*, available at: <http://www.wma.net/en/30publications/10policies/c8/index.html> (Last visited on Dec 14th, 2010).

³⁰⁶ Q. Liu and L. Xu, ‘The Oath of Medical Students’, 29 (1999) *Chinese Journal of Medical History* 4, 214.

However, the last option, “combining professionalism with patriotism”, does not belong in modern bioethics. It was deliberately put into the questionnaire in order to identify whether medics answered this question from a patriotic perspective. The result indicated that the majority of medical practitioners did agree that it was not part of modern bioethics and was therefore ranked as the least important consideration. But there were still 44% of respondents who agreed it was part of modern bioethics (see Figure 7).

Figure 8: Confidence in their understanding of medical ethics (based on answers to the question ‘Do you find modern medical ethics guidelines understandable?’).



Number of practitioners responding to this question: 219

Compared with their comprehension of medical law, many Chinese medical practitioners were unsure about their understanding of bioethics. When asked whether they were confident in their understanding of bioethical guidelines, 54% of them agreed they understood in general, while only 7% were confident of their understandings. Some 30% of medics declared that they were occasionally confused about medical ethics and 6% admitted they were often confused (see Figure 8). This result suggested that, when resolving ethical dilemmas, medics were more likely to refer to a set of principles or laws than use medical ethics.

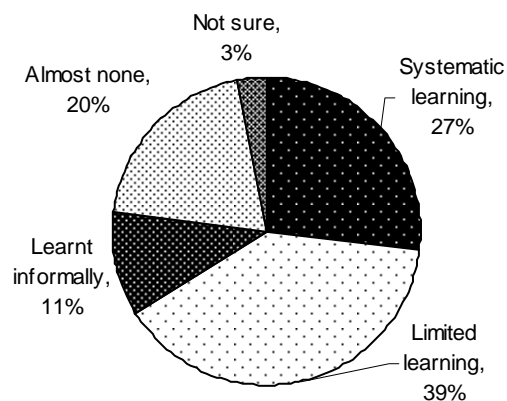
Having analysed the findings concerning the medics’ prioritisation of law over either ethics or political ideologies, this section presented data showing their comprehension of legal and ethical concepts. This data showed that, where there was a conflict between law and ethics, Chinese medics were more likely to apply law, even though they had slightly more confidence in understanding ethics than law. An optional answer (the choice 8, see Figure 7), deliberately placed within the multiple choices,

identifies that less than half of those surveyed did not reply from a purely personal point of view. To some extent, a nationalistic perspective was involved which affected or coloured their answers.

2.3 Education of Law and Bioethics

By comparison, Chinese medical schools did not seem to pay as much attention as hospitals to the education of their students in medical law. In response to a question concerning whether medics learnt about medical law in medical school, as few as 11% agreed. In response to a question concerning the teaching of bioethics, 77% of medical practitioners stated that they were taught this at medical school. Their learning experience can be divided into three categories: systematic learning of medical ethics, limited learning of medical ethics, and informal learning (Figure 9).

Figure 9: Bioethical education (based on answers to the question ‘have medical ethics lessons been given when you were in medical school?’).



Number of practitioners responding to this question: 219.

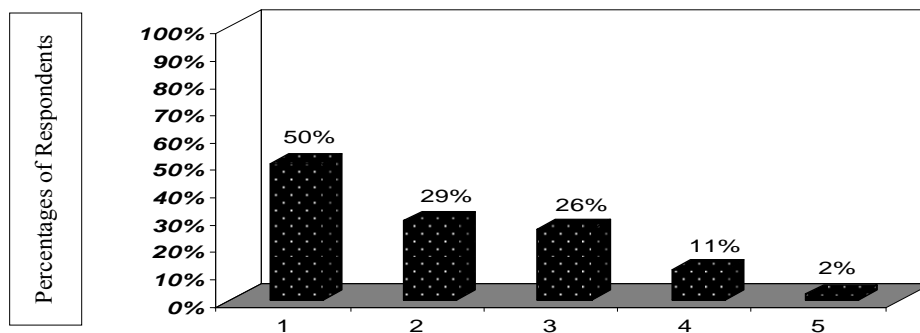
Responses indicated that, although bioethics was taught at medical school, only around one third of them (27%) had studied it systematically; 39% of medics responded that they had limited study of bioethics and 11% of them had learned bioethics from optional courses rather than compulsory ones at medical school. The statement “almost no bioethics was taught when at medical school” was selected by 20% of the medical practitioners (see Figure 9). Traditional Chinese bioethics which used to be learned through apprenticeship seems to have lost its tradition.³⁰⁷ Survey

³⁰⁷ See discussion in Chapter 3.

data indicated that Chinese medical schools have not paid much attention to the professional ethics courses either. A further question therefore was identified for the follow-up interview, that is: where do Chinese medics get their understanding of medical ethics from?

In terms of legal education, survey responses showed that legal promotion campaigns were widely undertaken in hospitals. In response to the question “how do you know about medical law?” half of the medics admitted that they learned about it mainly from the hospitals’ legal promotion campaigns. Almost a third of medics (29%) surveyed stated that they learned medical law from hospital on-the-job training. And only 26% of medical practitioners stated that they learned about law through self-learning via libraries, the internet or the media (see Figure 10). This also meant that a relatively small number of Chinese medics learned medical law spontaneously or independently.

Figure 10: Legal education resources (based on the question ‘How do you know about the laws that regulate your area of practice?’).



1. Through law promotion campaigns;
2. Through hospitals on-the-job training;
3. Self-learning from libraries, internet, or media;
4. At school;
5. From colleagues.

Number of practitioners responding to this question: 222.

This section has explored the findings of surveyed Chinese medics’ different degrees of prioritisation, understanding, and sources of education in law, state governance and ethics. Having presented these findings concerning their attitudes and knowledge, the next section will look into the reasons why medics prioritise one set of guidelines over another, and at the motives of Chinese hospitals that were actively engaged in

legal promotion campaigns, and will moreover, probe into their experiences of and, at the moral dilemmas caused by conflicts between law, state governance and ethics.

3. Motivations and Moral Dilemmas

3.1 Motivations

As discussed when formulating the initial hypothesis for this empirical study, it was disclosed by a doctor's wife that an internal order had been given to medical practitioners to "close their mouths and make no comments on the milk scandal".³⁰⁸ This raised questions of whether Chinese medics believed that political interest outweighed public interest; and whether they thought that refraining from criticism was the best way to contribute to a "harmonious society",³⁰⁹ or whether Chinese medics simply just felt powerless to express their views.

When asked whether they agreed or not with the statement that "good medical practice is important to secure a politically-advocated 'harmonious society'", 96% of medics agreed, while only 4% disagreed or were unsure. The results showed that the value they accorded to their profession was, at least in part, politically motivated. However, in a complementary question, medics were asked why they thought healthcare services were important in contributing to a "harmonious society". Significantly more than half of the medics (69%) believed that medical services benefited public interest, while 8% thought good medical services mattered to the society was because it was emphasised by Chinese politicians (see Figure 11, below). If most medical practitioners thought the purpose of medicine was to protect public interest rather than political interests, it raises a question about whether they have experienced dilemmas when political interests conflicted with their professional ethics (safeguarding public interests).

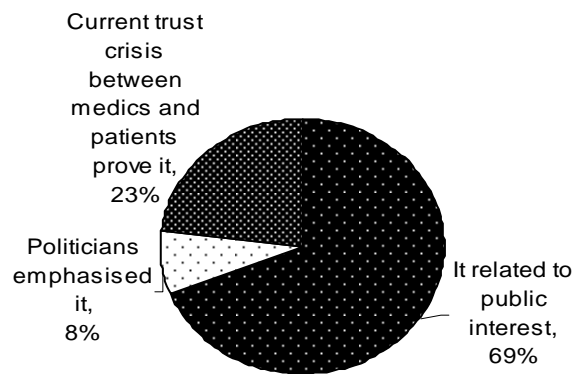
As *the World Health Report 2008* notes, conditions of "inequitable access, impoverishing costs, and erosion of trust in healthcare constitute a threat to social

³⁰⁸ See notes 267.

³⁰⁹ See note 287.

stability.”³¹⁰ The remaining 23% of medics stated that the current trust crisis between doctors and patients had showed that the unequal healthcare system had affected Chinese social stability (see Figure 11). The struggles of medical practitioners to cope with public disappointment about the healthcare system which they are servicing are implicitly revealed by this answer too (I will further explore this issue in the interview findings).

Figure 11: The benefits of medical service (based on the question ‘Why do you think good medical practice is important to secure a ‘Harmonious Society’?’).



Number of practitioners responding to this question: 223.

3.2 Moral Dilemmas

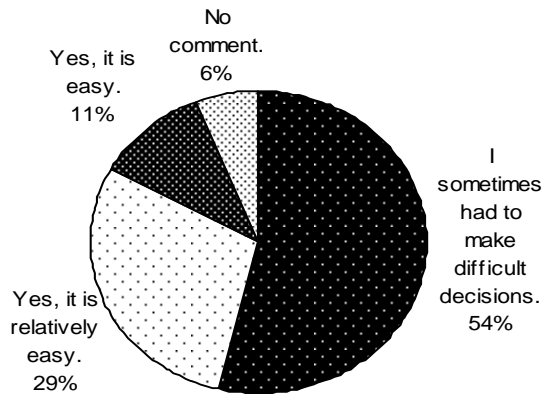
When designing this questionnaire, I realised that it would be very sensitive to ask medics directly whether they had ever experienced a work-related moral dilemma. This kind of question seemed to presume that Chinese medics had been put into difficult positions in making decisions that they would not want to make. To eliminate sensitivity, while still providing a chance for respondents to express their feelings towards the job, I asked whether respondents found it easy in practice to apply bioethics and furthermore, whether they had experienced feelings of depression during or after work and the frequency of this.

The result of this first question was that, 11% of those surveyed medics totally agreed, 29% partly agreed, while 54% did not agree and indicated that ‘I had to make difficult

³¹⁰ World Health Organization, *The World Health Report 2008: Primary Health Care (Now more than ever)*, available from: <http://www.who.int/whr/2008/en/index.html> (Last visited on Nov 13th, 2009)

decisions in some situations.’ (see Figure 12) These responses implicitly referred to the existence of ethical dilemmas, though the question did not allow for them to indicate directly the reasons why it was difficult to apply bioethics in practice.

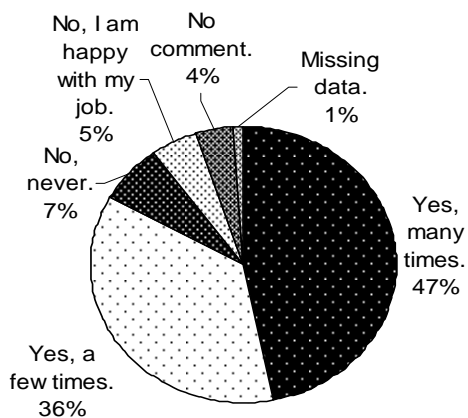
Figure 12: Existence of ethical dilemmas (based on answers to the question ‘In the current situation, do you think it is easy for you to apply your understanding of medical ethics to your practice?’).



Number of practitioners responding to this question: 220.

On the question of whether they experienced any feelings of depression and the frequency of these feelings, the responses revealed a high degree of depressive experience: 47% of medical practitioners had felt depressed many times, while, 36% of them had experienced depression a few times. In total, 83% of those surveyed medics had experienced depression a few or many times. Only 7% of respondents had never experienced any depression and as few as 5% of medics responded that they were pleased with their jobs (see Figure 13).

Figure 13: Feeling depression (based on answers to the question ‘Have you ever had a feeling of depression during or after your work?’).



Number of practitioners responding to this question: 221.

These survey findings corresponded to one recent piece of government sponsored research – *the 2009 Chinese Doctor Career Survey*, conducted by the Chinese Medical Doctor’s Association.³¹¹ Based on 3182 returned questionnaires, researchers found that 63.61% of Chinese doctors were dissatisfied with their practice environment, 63% of physicians would not encourage their children to choose medicine as their future career, and 44.82% of medics had even considered giving up their medical careers.³¹²

Besides this government sponsored research, in 2008, a nation-wide joint survey was conducted by one Chinese newspaper *Life Times*, together with two health-focused websites “Sohu Health” and “Ding Xiang Yuan” on Chinese doctors’ living and working conditions.³¹³ This on-line survey collected views from 2067 internet-user medics. It also showed that a majority of those surveyed were worried about their jobs. In response to the question “Do you enjoy your medical career?”, only 6% of medics said that they liked it very much. The remaining 94% held either negative views (21% admitted practicing merely to make ends meet; 23% felt medicine was a meaningless and a disappointing career; while, 6% worked for money) or partly positive views (44% liked it but were scared of being confronted by angry patients).³¹⁴ What is more, as many as 95% of those surveyed medics felt tired with the job, both physically and mentally (39% felt very tired and 56% felt a bit tired).³¹⁵

The research cited above found that a majority of medics had feelings of depression, dissatisfaction, and tiredness with their medical careers. However, the question remains as to why Chinese medics were dissatisfied and discouraged with their careers. In my empirical study, a multiple choice question was given in order to further understand, where depression existed, what caused it. As shown in Figure 14,

³¹¹ Chinese Medical Doctor Association, *The 2009 Chinese Doctor Career Survey*, available at: <http://www.cmda.gov.cn/News/huodongzhuanti/yishifashizhounian/diaoyan.html> (Last visited on Dec 15th, 2010).

³¹² Ibid.

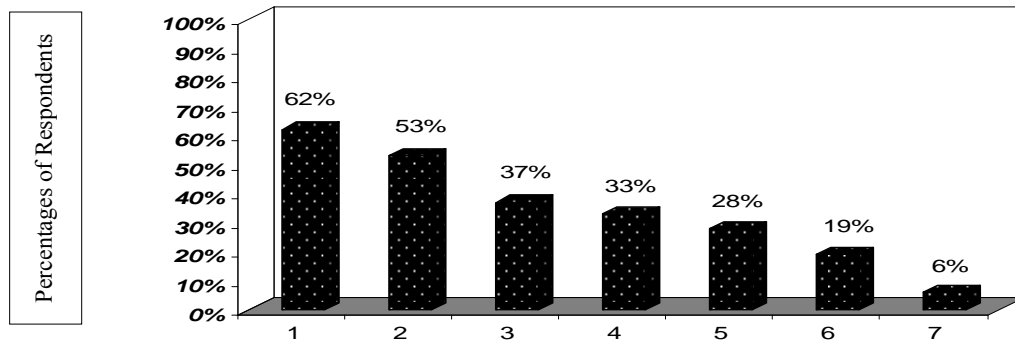
³¹³ N. Jiang, L. Yang and J. Liu, ‘Chinese Doctors’ Living and Working Conditions Survey Report 2008’ (in Chinese), available at: <http://health.sohu.com/s2008/yisheng/> (Last visited on Dec 15th, 2010).

³¹⁴ Ibid.

³¹⁵ Ibid.

Income (reason 1), Reputation (reason 2) and Commercial interest conflicting with bioethics (reason 3) are three of the most commonly stated causes of depression.

Figure 14: Reasons for different levels of depression (based on answers to the question ‘Why did you get depressed?’).



1. Income is too low;
2. Medics’ reputation has been damaged. We were misunderstood by the public;
3. Sometimes commercial interests conflict with my medical ethics;
4. Lack of Professional independence;
5. Sometimes law conflicts with my medical ethics;
6. Guidelines and requirements are much too confusing;
7. Others.

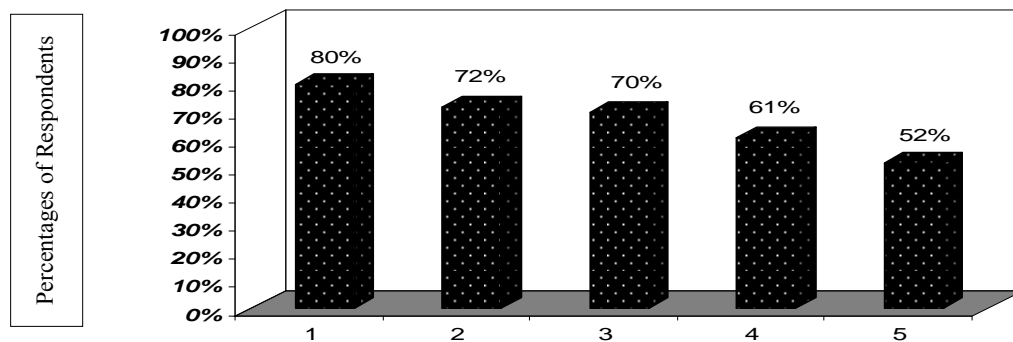
Number of practitioners responding to this question: 223.

The three most-commonly selected answers indicate that Chinese medics felt they were under-paid, under-valued, and were even forced to face dilemmas of the possibility of using corruption or other unethical behaviour to gain financially. The role of commercial treatment in China has been discussed in Part One of this thesis. Although the majority of Chinese medical practitioners intended to retain their integrity, the profit-driven behaviour of some Chinese medics has seriously damaged the medics’ public reputation. The trust-crisis between Chinese medics and patients has also been mentioned in an earlier chapter.

In the above Figure 14, other causes of depression were: lack of professional independence (reason 4); law conflicting with bioethics (reason 5); and confusing guidelines (reason 6). These three reasons seemed not to stem from Chinese medics’ financial concerns. Instead they were related more to an underlying issue – that of a lack of professional autonomy and control. Dilemmas caused by conflicting and confusing control mechanisms were essentially due to a lack of professional power. This problem among Chinese medics will be elaborated in Part Three of this thesis.

Both government-sponsored research and the media-led online survey have also traced reasons for professional depression. Both surveys found that low-paid careers, decline of public esteem, highly-stressful work loads and the increasing demands of regulatory requirements were the main causes of dismay among Chinese medics. These survey results corresponded with my questionnaire findings. However, I realised that the multiple-choice survey questions on depression (both mine and others) tended to be generalised or even oversimplified, and thereby may not give sufficient, and systematic explanation for why neither service providers nor recipients found China's healthcare delivery system desirable. I have attended to this question in more detail in the follow-up interviews.

Figure 15: Areas that need improvement (based on answers to the question 'which area that relates to you work needs most improvement? Please choose whatever you think is or are relevant, then to put them into order according to level of importance (start from the most important one)').



1. Healthcare system; 2. Legislation in healthcare; 3. Income; 4. Medical ethics; 5. Public opinions.
Number of practitioners responding to this question: 217.

To further understand the extent to which medical practitioners are affected by their working environment, one of my survey questions asked the medics "which area relating to your work needs most improvement (start from the most important one)".³¹⁶ As shown in Figure 15, as many as 80% of medics indicated that the healthcare system needed to be changed. In other words, a majority of practitioners thought that healthcare governance should be tackled as a priority task. The second common choice was medical law legislation. The response showed that 72% of those surveyed were dissatisfied with the current legislation in healthcare. The remainder

³¹⁶ As stated earlier, this ranking type of question has been analysed by the percentage choosing the option rather than ranking orders.

hoped for changes in income (70%), medical ethics (61%) and public perceptions (52%). The least commonly mentioned hope was change to public perceptions.

This section has presented findings about Chinese medics' motivations for prioritising law, political guidelines or ethics and their moral dilemmas, as well as feelings of depression caused by low income, low social status, and lack of occupational control. The following section will present further survey findings exploring the interactions between Chinese physicians and pluralist forms of control from law, state and ethics.

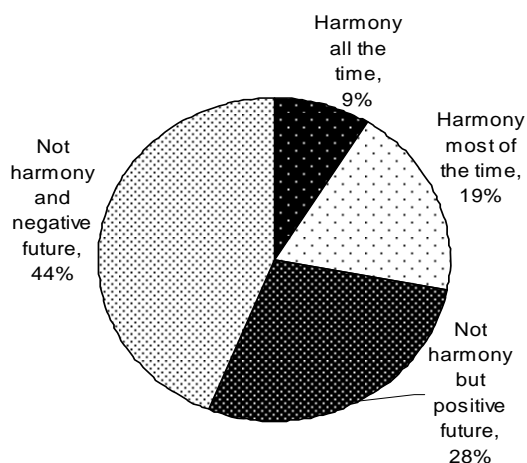
4. Interactions between Medics and Pluralist Governance

Previous sections have discussed findings about Chinese medics' attitudes to pluralist governance, and their motivation and dilemmas in prioritising one form of guidance over another. This section shows their perceptions of the effects of the healthcare system, medical law and political ideology on their practices.

4.1 Effects of the Healthcare System on Medical Practice

To start with, when asked whether they agreed or not with the statement that "China's health service is currently in harmony with the public", 44% of medics disagreed, and they commonly chose the optional answer "Conflicts can't be solved in the short term; the situation is too complicated". Disagreement was also expressed by another 28% of medics who chose the answer "there are often conflicts, but I believe things will be better in the future". Only 9% of medical practitioners agreed with the statement "yes, China's health service is always in harmony with the public", but 19% stated that "most of the time, the health service is in harmony with the public" (see Figure 16, below).

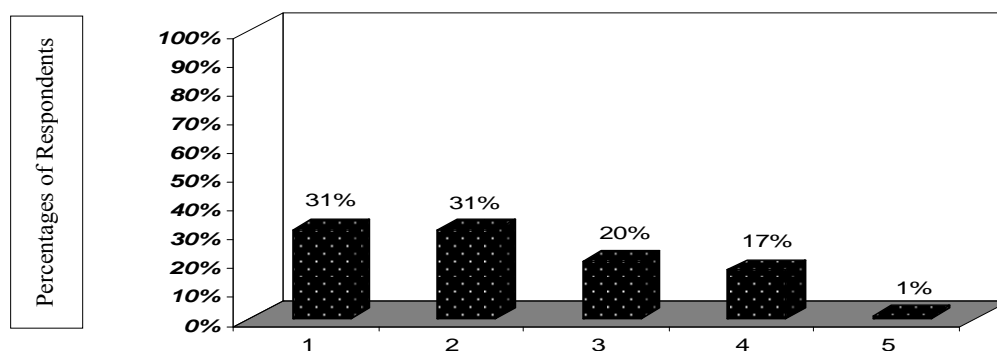
Figure 16: The relationship between the health service and the public (based on answers to the question ‘In terms of China’s current health service, do you think it is in harmony with the public?’).



Number of practitioners responding to this question: 223.

When they were asked how their practice had been affected by China’s health sector reform, 31% of medical practitioners stated that the reform had affected their practice in a negative way, while 31% stated they were not sure. On the other hand, only a minority of medics (20%) reported either a positive or a neutral effect. Medics who answered that their practice hadn’t been affected at all made up 17% of the respondents (see Figure 17, below).

Figure 17: Effect of China’s health sector reform (based on answers to the question ‘Has your practice been affected by China’s health sector reform?’).



1. Affected in a bad way; 2. Not sure; 3. Affected in a good way; 4. Not affected at all; 5. No comment.

Number of practitioners responding to this question: 218.

Due to the sensitivity of the question which can be interpreted as a potential criticism of the central government, underlying dissatisfaction can arguably be presumed to exist, even if unspoken. An unusually high rate of surveyed medics (31%) stated “I am not sure about the effect”. This was the only question in the survey where as high

as a third of medics commonly responded “I am not sure”. It is not clear to me whether they were simply unsure or whether some of them were hesitant to judge. Hypothetically, if some of them simply hesitated to criticise the state governance by choosing this “third way”, their answers may foreshadow some of their ethical dilemmas between “one’s ethical belief system and what one feels compelled to do or is told to do by someone in a position of power”.³¹⁷

This assumption was supported by answers to the subsequent open question in the survey, by asking how their medical practice had been affected by the health sector reforms. Some practitioners contradicted their initial positive answers “Medical practice has been affected in a good way” by putting negative answers in this open question, such as: (1) “Chinese medics have become more passive in medical disputes”; (2) “Medics are indeed one of the vulnerable groups in Chinese society”; (3) “Practising medicine in China bears high risks while receiving low-income”; and (4) “Patients and their families are making more unreasonable claims for compensation. It seems the obligations of paying compensation are all transferred from hospitals to us”.

Medics’ responses to the open question were informative. In my opinion, although only 51 of 223 respondents chose to answer this question, those who were willing to take the time to write down how their practices were affected can be considered to be honest in their answers. The open question, in this regard, is particularly helpful for hearing some medics’ hidden dissatisfaction.

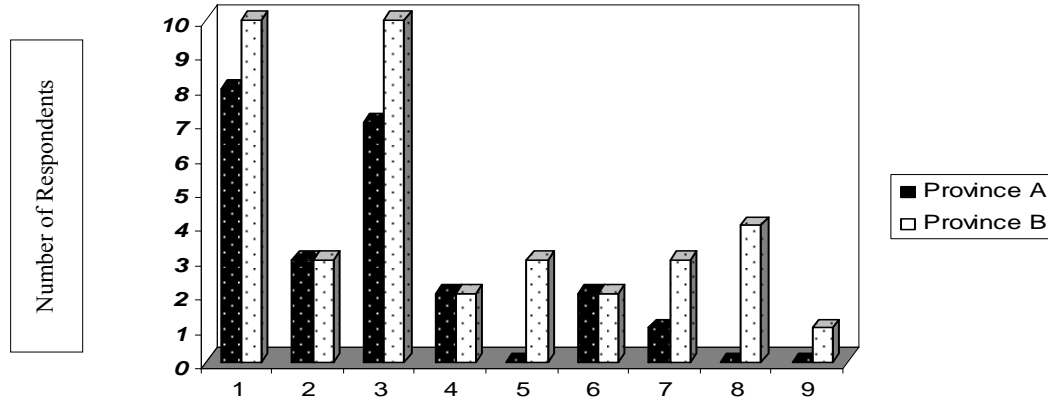
In their answers to the open-ended question, shown in Figure 18 below, the following aspects were mentioned by medics from Province A (the relatively developed province) and B (the relatively underdeveloped province).³¹⁸ The most commonly experienced effects reported from both provinces were that, they must use “defensive medicine” to protect themselves; followed by the second most commonly experienced effect – the worsening doctor/patient relationship. Although attention to both problems was significantly higher compared with the other effects reported; both these negatives might prove to be an even greater challenge to those from a less

³¹⁷ K. E. Des Jardin, ‘Political Involvement in Nursing-Politics, Ethics, and Strategic Action’, 74 (2001) *AORN Journal* 5, 613-622.

³¹⁸ I have ‘grouped’ medics’ responses to this open-end question together for ease of showing it in a table.

developed province where less financial support had been given from its local health service department

Figure 18: The effect of China’s health sector reform (based on answers to the question ‘Has your practice been affected by China’s health sector reform? If you answer “yes”, could you explain how it was affected?’).



Effects of health sector reform: answers to the open question

1. Have to practice defensive medicine;
2. Low income, high risk & low social status;
3. Disturbing working environment, conflicting doctor-patient relationships, trust crisis;
4. Dilemma in choosing between profits and ethics;
5. Work overtime, increasing work pressure;
6. Will be less commercialised and more accessible to poor people, community service in the future;
7. Long-term treatments are unaffordable to patients;
8. Practices tend to be more standardised;
9. Poor working conditions.

Number of practitioners responding to this open question: 51.

Figure 18 showed that medics from Province A and B varied in the extent to which they answered negatively. Some from Province B mentioned that, because of the new health legislation, healthcare services had become more standardised, though no respondents in Province A referred to this point. Speculation may be that unequal economic development might affect the medics’ perception of local health regulations. In Province B they were subjected to more serious doctor-patient conflicts, thus they welcomed law to bring standardisation to their practice, so that they could provide better services and increased patient satisfaction.

It is understandable that medics from a less developed province would be more likely to suffer from poor working conditions, facing patients who can not afford to pay for medical services, and working overtime as, the overall workload is shared by fewer

staff. Such negative effects caused by financial strain have been reflected by the answers of medics from Province B (see Figure 18).

Beyond these differences, medics in both provinces commonly reported that they had experienced “low income and low social status” and had “dilemmas in choosing profits or ethics”. What is more, they also expressed similar positive beliefs in the latest healthcare reforms. They thought the future trend of the Chinese healthcare system would be “less commercialised, more community based, and more accessible to poor people”, even though the frequency of mentioning positive effects was much less than for the negative ones (also see Figure 18).

This section has presented the survey findings concerning the Chinese medics’ views on the healthcare system. In their answers to the open question about the effects of health sector reforms, few of them mentioned medical law. This, however, does not mean the effect of medical law on their practice was less than the effect of the state’s healthcare infrastructure. The following section presents findings specifically on their perceptions of medical law.

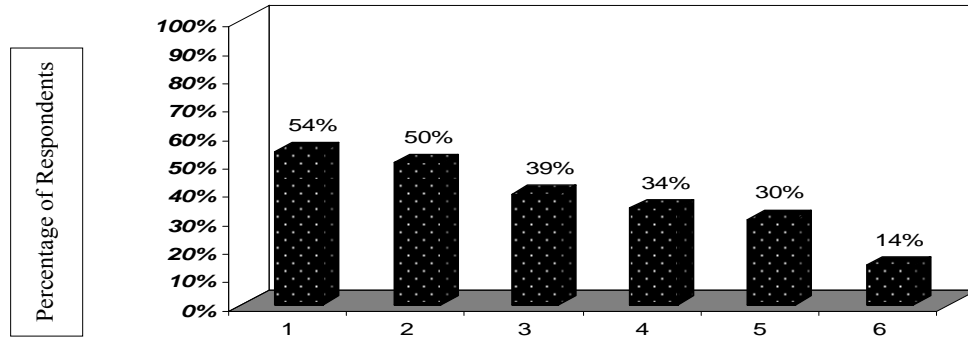
4.2 Effects of Medical Laws on Medical Practice

In response to my main research question – “what influences medics’ decision-making?”, the questionnaire found that medics in China have a high legal awareness. As discussed earlier, 99% of surveyed medics stated that they thought law was very important to their practice (see Figure 1). Their preference raises questions about why law is their most important guideline, which laws practitioners are paying most attention to and where they are getting their required legal knowledge from.

Answers to the multiple-choice question “why is it important to apply law to your practice?” illustrated a strong tendency towards self-protection from medical practitioners in China, as 54% of those surveyed agreed “law can be a tool for self-protection against a possible suit”, and 34% regarded law as “my guide to a better understanding of patients’ rights”. At the same time, as many as 39% of medics agreed that they would hold on to law even when legal requirements conflicted with

bioethics, as this would be the least risky way to practice medicine in China; and 30% who said they did so for fear of punishment (see Figure 19).

Figure 19: Motivations for medical law application (based on question ‘If you think it is important to apply the law regulating your area of practice to your work, why do you think so?’).



- 1 Self-protection;
- 2 Obligation as a citizen;
- 3 It is the safest way to practise medicine;
- 4 To better understand patients’ rights;
- 5 Fear of punishment;
- 6 Political education encourages me to obey law.

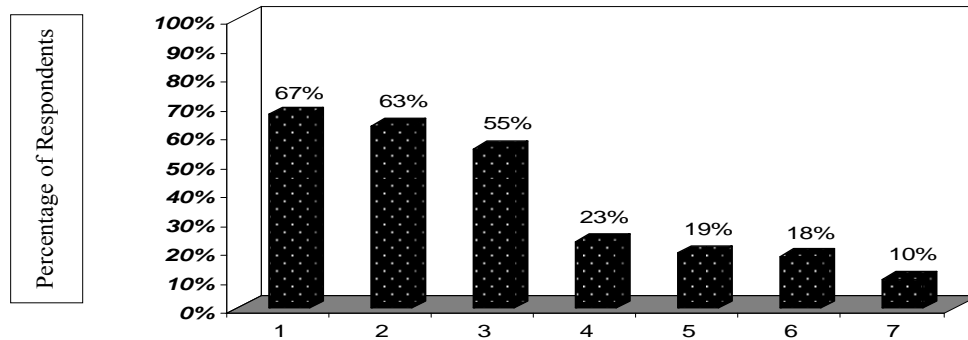
Number of practitioners responding to this question: 221

A further 50% explained that their motivation for applying law to practice was to fulfil their duties as a decent citizen. This answer expressed an elite Chinese nationalist sentiment. It was unclear whether this patriotic expression of loyalty and desire to serve one’s country was a consequence of political propaganda; for example, on-the-job legal training provided by the hospital Communist Party branches and the mass media. A relatively small number of practitioners (14%) admitted their motivation for using medical law was influenced by the state’s well-known political slogan – “rule the country by law” (also see Figure 19). Their responses suggested that the state may play an important role in motivating them to apply law to practice. Indeed, “observing laws and regulations and following the technical and operating rules” was highlighted as the first obligation of all Chinese medical practitioners by Article 22 of *the 1998 PRC Medical Practitioner Act*.

Responses to another question as to which areas of law the medics paid most attention, explained the reasons behind their high degree of legal consciousness. Of the 7 areas of medical law listed, the most “popular” area was that relating to medical and clinical malpractice, with 67% agreeing this was important. Second came general

medical practice regulations (63%), and professional codes and bioethics was rated in third place (55%) (see Figure 20).

Figure 20: Area of law to which medics paid most attention (based on the question ‘What sort of law do you pay most attention to?’).



- 1 Regulating medical and clinical malpractice;
- 2 Regulating general medical practice;
- 3 Professional codes;
- 4 Legal aspects of medical product and medical device usage;
- 5 Legal procedure of medical law making;
- 6 Legal aspects of medical research;
- 7 Legal and moral questions concerning the beginning and the end of life.

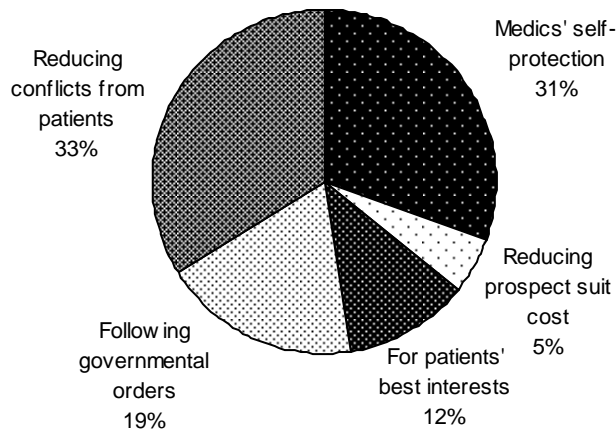
Number of practitioners responding to this question: 222.

The fear of malpractice suits accounts for a vast growth in the use of defensive medicine. As discussed in Part One, the trend towards defensive medicine has led to an enormous increase in the cost of medical care, and the compensation that Chinese medics must pay from their own incomes. This has led to a pattern of defensive medical practice. In other words, Chinese medical practitioners are constantly aware of the need to cover themselves against the possibility of an accusation of malpractice. The principle of respect for informed consent as a prerequisite to medical treatment has had a huge impact on the Chinese practitioners’ reactions to life-saving treatment in emergencies. Where law and bioethics conflict and there was fear of being sued, 10 out of 14 medics interviewed agreed that they would rather wait for consent from patients or their families, than immediately give life-saving treatment.

The drive for better knowledge of medical law does not come solely from practitioners, but also from hospitals. As noted earlier, legal promotion campaigns have been widely undertaken in hospitals. Yet the precise role these hospitals played in influencing both their attitudes and motivations for legal study is not clear from

these answers. To further understand why the hospitals promoted the study of law in workplace training, I noticed that the two main responses to this question were first, “To reduce conflict between patients and medics in order to maintain a harmonious working environment” (33% agreed) and second, “In reaction to patients’ increasing demand, legal knowledge can be used for defending medical practices and protecting medics” (31% agreed). Only 12% of medics thought that the motivation for promotion of the hospital legal campaign was to better protect patients’ interests (see Figure 21).

Figure 21: Motivations of hospital law promotion campaign (based on the question ‘What do you think is the motivation of law promotion campaigns?’).



Number of practitioners responding to this question: 222.

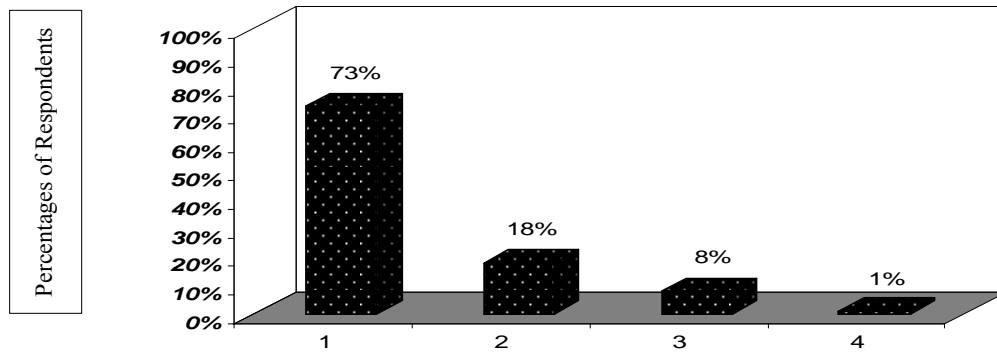
These results show that hospitals are playing an important role in enabling medics to equip themselves with an awareness of protective strategies and “tools”, thereby protecting institutions from being sued.

4.3 Effects of the Political Ideologies on Medical Practice

As is stated by the PRC State Council, “All levels of political leadership should put healthcare as a priority on the party’s agenda.”³¹⁹ The CCP retains much of its long tradition of control mechanisms, i.e. political campaigns and exhortations, which extend to hospitals. Figure 22 shows that education about political ideology was accessible to most surveyed medics at their affiliate hospitals (73%).

³¹⁹ The State Council of PRC, ‘Guideline for Further reforming Medical and Pharmaceutical System’, available at: http://www.gov.cn/jrzq/2009-04/06/content_1278721.htm (Last visited on Sep 29th, 2009).

Figure 22: Accessibility of political ideology education (based on answers to the question, ‘Besides the law promotion campaign, is political education accessible at your serving medical institution?’).

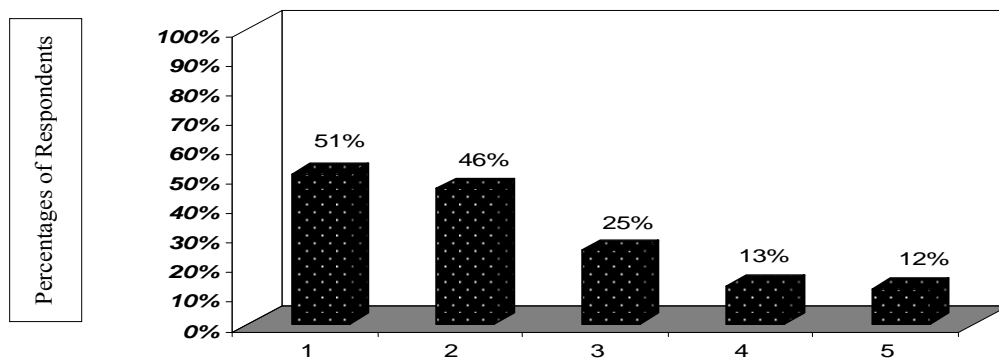


1. Yes; 2. No; 3. I don't know; 4. Missing data.

Number of practitioners responding to this question: 222.

The medics mostly received guidance on political ideology via hospital staff meetings (51%) and the media (46%). Since not every medical practitioner was a member of the CCP, and there were different percentages of communists in each hospital, only 25% of medics learnt political ideology from CCP branch discussion groups within the hospitals (see Figure 23).

Figure 23: Political ideologies education sources (based on answers to the question, ‘where do you usually get your political thought updated?’).



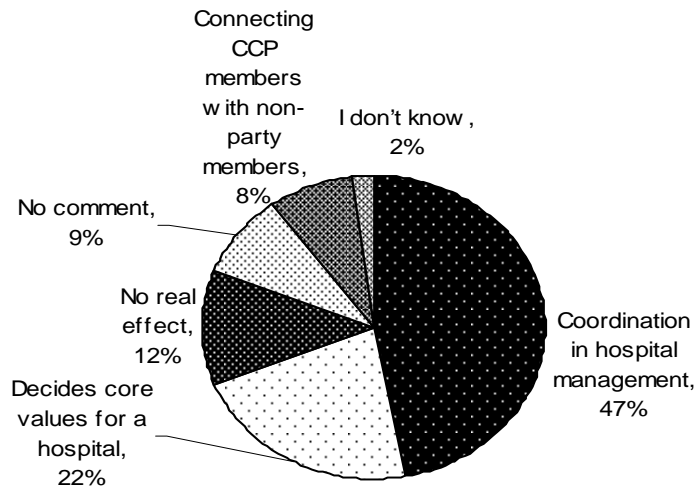
1. Hospital staff meetings; 2. Media; 3. Hospital Party branches; 4. Not relevant; 5. No comment.

Number of practitioners responding to this question: 222.

The function of a CCP branch in hospital management will be explained in the discussion of interview findings. Here in the questionnaires, most medical practitioners stated that the party branch coordinated hospital management team

(47%). (see Figure 24). Hospital party branches often organised after-work socialising activities within the hospitals, involving both party members and non-members.

Figure 24: The main function of the hospital’s party branch (based on answers to the question, ‘What functions does the hospital’s party branch play in hospital management?’).



Number of practitioners responding to this question: 220.

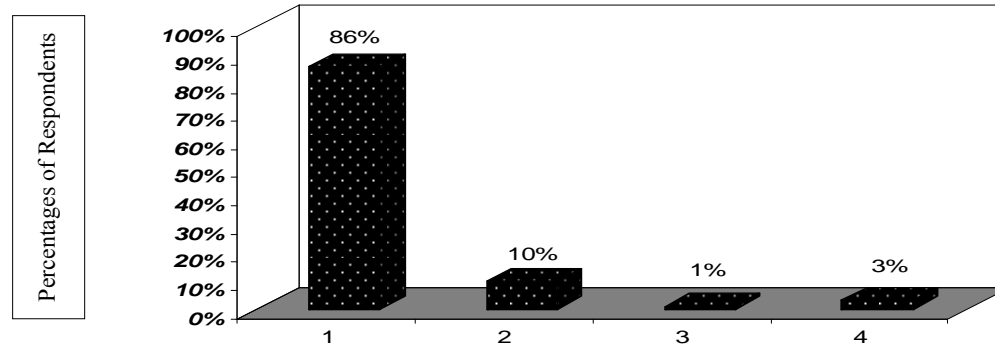
5. Prospects for Change

5.1 Interest in Health Legislation

Due to the sensitivity of the issues, in this survey, I did not ask medical practitioners directly about their considerations of, or thoughts on, challenging either the structure of their healthcare system or any official or unofficial rules guiding that system. In my view, a response which indicated an awareness of de-professionalisation, was implied by signs of demand for change in the present system. Several questions in the survey refer to the central questions, either explicitly or implicitly – How do practitioners see their own capacity to exercise power within the tripartite relationship of law, ethics and state regulation? Do medical practitioners perceive a need for self-regulation?

Of those surveyed, 86% (190 out of 222) of medical practitioners stated that it was very important to involve medical practitioners in healthcare legislation (see Figure 25).

Figure 25: The importance of involving professionals in law-making (based on answers to the question, 'Do you think there should be more involvement of medical professionals in medical law making in China?').



1. Very important; 2. Relatively important; 3. Not important; 4. Not sure.

Number of practitioners responding to this question: 222.

As Lord Horder puts it, “only the doctor knows what good doctoring is”.³²⁰ Chinese medics expressed similar concern in interviews. As one doctor from Province A said, “Medical work is so technical that only medical professionals can understand, assess and regulate it.” This answer further confirmed the Chinese medics’ expectation for self-regulation.

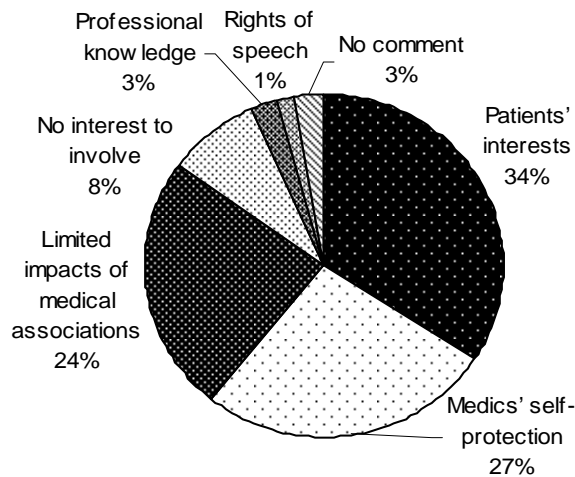
In terms of what drove their expectations for self-regulation, a subsequent multiple-choice question showed that the Chinese medics’ desire and hope to be involved in medical law-making comes from the following reasons: one third (34%) thought that a professional review of medical law could provide better protection of patients’ interests; just over a quarter (27%) would like to be involved in arguing for the medics’ own interests, and just under a quarter (24%) of medics stated that their involvement might make an impact on changing the Chinese Medical Association’s inactive role in defending their interests. A small percentage of practitioners (8%) thought that more medics should be involved in medical law making, though they personally had no interest in being involved in this (see Figure 26).

In addition to the above reasons, a few medics added two more when answering this question. They were: “professional knowledge” (3%) and “rights of speech” (1%).

³²⁰ K. Barnard and K. Lee, *Conflicts in National Health Service* (New York, Neale Watson Academic Publications, 1977), 74.

Although such comments were given by a relatively small number of those surveyed, they indicated a slight sign of professional awareness in wanting to take control over these areas.

Figure 26: Reasons for involving professionals in health legislation (based on answers to the question ‘If you think it is important to involve medical professionals in medical law making, could you please give a reason?’).



Number of practitioners responding to this question: 222.

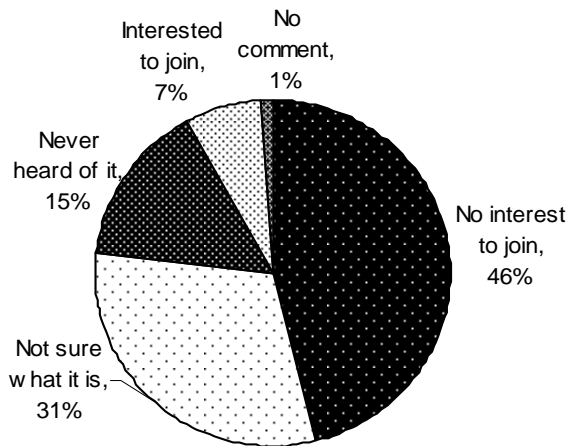
Generally speaking, these findings suggest that, either individually or collectively, more than half (51%) of the surveyed medics suggested engaging in legislation for their own interests, although 34% were interested in legislation for the benefit of patients. It showed that patients' interests seemed a less significant reason for motivating the Chinese medics in a willingness to be involved in law-making. But how much of this can be interpreted as their indifference towards patient care is unclear. On different occasions during interviews, the medics did express their concern about patients. But they also told me they felt that the law had empowered patients while disempowering them. To be involved in health legislation was for balancing power, rather than going against patients' interests.

The Chinese Health Law Society (CHLS) was set up by the Chinese Ministry of Justice, as an organisation for the education of medics in medical laws.³²¹ However, the survey finding showed that its impact on medics' self-regulation awareness seemed rather limited. Although as many as 86% medical practitioners thought that

³²¹ China Health Law Society, available at: <http://www.chls.net/> (Last visited on Nov 9th, 2009).

more involvement in medical law making was “very important” (see Figure 25), only 7% of those surveyed expressed an interest in joining in the CHLS, while 46% of them showed ignorance or uncertainty regarding this organisation (see Figure 27).

Figure 27: Current awareness of self-regulation (based on answers to the question ‘Have you ever heard of “Chinese Health Law Society?”’).



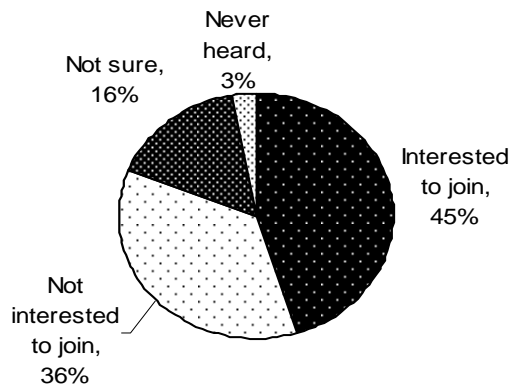
Number of practitioners responding to this question: 222.

To sum up, a majority of those surveyed expressed an interest in being involved in health legislation. Although their motivations varied, almost half of them referred to using law to better protect their own interests; a slightly lower percentage was motivated by a wish to improve patients’ interests. Despite a wish to be involved in legislation, there was a lack of awareness as to how to achieve this end and so make their voices heard, not to mention exploring the possibilities for self regulation.

5.2 Membership of Professional Associations

Figure 28 showed that the Chinese Medical Association (CMA) is well-known to medics. 81% of the medics had heard of it, yet slightly below half of respondents intended to become a member or were members already. Due to a fault in the question design, it is unclear how many of those who expressed interest in joining were in fact already members of CMA.

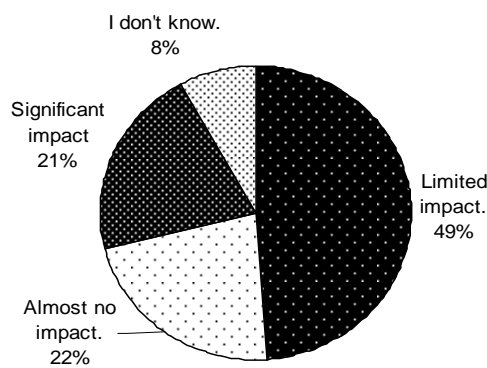
Figure 28: Interested in joining professional association (based on the question ‘Have you heard of and been interested in joining the Chinese Medical Association?’).



Number of practitioners responding to this question: 216.

One potential reason for their lack of interest in joining professional associations is that, from a socio-cultural point of view, Chinese society is not group orientated. Instead, Chinese society is centred on the individual and is built on networks of ties that link the individual with discrete categories of other individuals (more discussion will be given in Chapter 7).³²² More importantly, the limited impact that professional associations had on professional practice could be another reason for their lack of popularity.

Figure 29: Impact of professional association (based on the question ‘Has the “Chinese Medical Association” had any impact on your work so far?’).



Number of practitioners responding to this question: 218.

³²² See A. Y.C. King, ‘The individual and Group in Confucianism: A Relational Perspective’, in D. Munro (ed), *Individualism and Holism* (Ann Arbor, University of Michigan, 1985), 57-70; H. Nakamura, *Ways of thinking of Eastern Peoples* (Honolulu, University of Hawaii Press, 1971), 247-258.

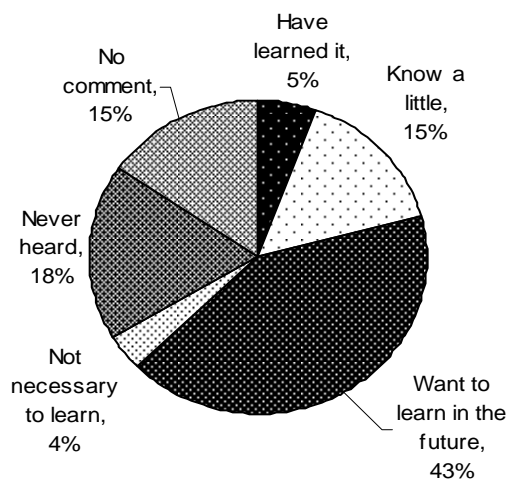
When asking whether the CMA had had any impact on their work, 22% of the respondents thought the Association had made almost no impact and 8% were ignorant of its impact; 49% stated that the CMA had limited impact, leaving as little as 21% who thought that the CMA had a significant impact on their jobs (see Figure 29, above).

Having discussed the survey findings with regards to the Chinese medics' interest in involvement in healthcare legislation and professional associations, the next section seeks to examine the surveyed medics' interest in learning about international bioethical guidelines.

5.3 Interest in International Bioethical Guidelines

Chinese medics expressed a great interest in learning about international bioethical guidelines and the Western experience of dealing with conflicts between law and ethics. Of those surveyed, although 18% of medics have never heard about international bioethical guidelines, and 15% of them made no comment or considered learning about them as unnecessary (4%); 43% were interested in learning about them, 15% already had some knowledge and 5% stated they already knew about them (see Figure 30). This meant that a majority of the surveyed medics had an interest in accessing more information about medical ethics.

Figure 30: Interest in international bioethical guidelines (based on the question 'Have you ever consulted international bioethics guidelines, particularly those relating to your field?').



Number of practitioners responding to this question: 218.

However, only a small percentage of those had learned about them. This indicated that in both medical schools and/or Chinese hospitals, bioethics was taught from a domestic perspective. Those who expressed no interest in international bioethical guidelines might argue that they seemed irrelevant to their work, and that it did no harm if they learned nothing about them. However, I argue that this can be seen as one aspect of deprofessionalisation.³²³ Information is powerful and can be used for good; but if it comes from one sole source, it could be confusing and even misleading. Most surveyed medics' expectation for broadening their bioethical knowledge, in this regard, could be seen as a sign of willingness to open up their ethical dilemmas for wider discussion.

6. Summing up Questionnaire Findings

This chapter has presented the questionnaire findings from 223 Chinese medical practitioners. It has examined their different levels of awareness and concept comprehension of medical law, governance and bioethics. Having examined the motivations behind their principle prioritisations and moral dilemmas; it has analysed and discussed the effects that medical law, state governance and political ideologies have had on medical practices. It has demonstrated the medics' current status and their future expectations of gaining more professional control, such as self-regulation, memberships of more effective professional associations and a broader knowledge in bioethics.

The questionnaire findings inform us that Chinese medical practitioners tended to prioritise law and hospital rules over ethics or political slogans in making medical decisions. Potential political-ethical tensions and power struggles amongst medics exist, especially when their priorities clash with the allocation of limited resources or ethics. What is more, differences in personal and professional understanding of ethics, conflicting loyalties, and a negative public image, create ethical tensions for Chinese medics. A large percentage of them expected changes to allow them to gain more professional control in work, i.e. involvement in healthcare legislation and a more

³²³ More exploration of deprofessionalisation will be provided in Chapter 7. Briefly speaking, it means a loss of control and power.

active participation in their professional associations. However, among these wishes, fewer of them wanted to become active advocates for either their colleagues or their patients.

Nevertheless, the questionnaire findings have their limits, as they tend to lead respondents to answer according to preconceived responses that could be unclear, and/or lacking nuance and detail. In the next chapter I discuss the findings from the interviews. These offer more in-depth, qualitative and subjective perspectives about Chinese medics' understanding of pluralist guidance, their experiences of and resolutions to ethical dilemmas, and their expectations for empowerment. Specifically, the following three themes were highlighted in interviews, and the findings presented in the next chapter are organised around them:

- (1) Medics' understandings and relevant educational experiences of professional ethics, health law and Chinese Communist Party discipline, and their reasons for prioritising one over the other when facing ethical dilemmas.
- (2) Chinese medics' perceptions of their position in China's healthcare power dynamics and
- (3) Their expectations for future change.

CHAPTER 6 INTERVIEW FINDINGS

Q: What do you interpret as professional power?

A: I don't think we have a consciousness of the need to change anything actively, though we are well educated. No one wants to be the first to show signs of resistance, including hospitals. We are all passive in controlling our own rights, in affecting other medics' unethical behaviours. The only thing that I and my colleagues care about is that our professional work is done carefully, without leading us open to question.

A male doctor, January 2009

1. Introduction

Scholars suggest that in-depth interviews help a researcher to gain insights into people's attitudes, behaviours, value systems, motivations, etc, and how these elements contribute to their decision-making.³²⁴ Such a qualitative method provides an opportunity to get people to talk about their personal feelings, opinions, and experiences, it is thus more likely to achieve a fuller and more coherent picture than other methods (for example, questionnaires) of ascertaining what happened and why.³²⁵ In-depth interviews are also appropriate for addressing sensitive topics that people might be reluctant to discuss in a group setting, and allow questions that are difficult to assess through multiple-choice survey questions.

In this study, the interviews were conducted after the questionnaires with a small sample of surveyed medics, in a semi-structured, open-ended format. The interviews probed into medics' understanding of different guiding norms, letting them exemplify their experiences of and resolutions of ethical dilemmas. Finally I led medics to discuss more complex issues, such as, how ethical, legal and political issues underpinned medical practice and professional power.

Having discussed survey responses in Chapter 5, this chapter analyses findings from interviews. The analysis of interview findings is divided into three main sections, each

³²⁴ C. Boyce and P. Neale, 'Conducting In-Depth Interview: A Guide for Designing and Conducting In-Depth Interviews for Evaluation Input', (May 2006) *Pathfinder International Tool Series: Monitor and Evaluation -II*, 3; N. Mack, et al, *Qualitative Research Methods: A Data Collector's Field Guide* (North Carolina, Family Health International, 2005), 29-30.

³²⁵ Ibid.

of which addresses the following themes: guidance comprehension and prioritisation; ethical dilemmas and resolutions; and expectations for power and control.

2. Comprehension and Prioritisation of Guidance

2.1 Chinese Medics' Understanding of Bioethics

Beauchamp and Childress suggest that professional morality “specifies general moral norms for the institutions and practices of medicine” and is “generally acknowledged by those in the profession who are serious about their moral responsibilities”.³²⁶ By codifying professional morality, informal morality is then formulated into formal instructions recognised by the profession. In China, besides the government’s version of medical ethics, there is no commonly recognised code adopted by any medical body. When asked questions, “Are general moral standards informally transmitted in the profession?” and “What are the Chinese medics’ understanding of professional ethics?” I found that the medics’ views concerning their experiential knowledge and understanding of medical ethics varied with their seniority.³²⁷ Interviewees’ responses to the above questions can be divided into three categories:

(1) The first type of answer came from relatively senior medics. They said that they did not know much about medical ethics. Typical answers were “I graduated from a medical school in 1988. I had not learned law or ethics in classes, so I don’t really understand them.”³²⁸ Or “I am over 50 now. At the time when I was at medical school, medical morality was not a compulsory course, so we learned it only at a most general and superficial level.”³²⁹ Or “I did not learn much about it at [medical] school. The school paid more attention to our technical and practical skills than to ethics.”³³⁰ This first type of response showed that Chinese medical institutions in the early years did

³²⁶ T. L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics* (Oxford, Oxford University Press, 2009, 6th edn), 6.

³²⁷ Demographic information was collected in questionnaires, in which respondents were asked to take the box in order to indicate their belonging age groups: under 25; 26-35; 36-45; 46-55; 56-65, and over 65. At the same time, technical titles (primary; intermediate; associate senior; or senior) and length of one’s professional serving time were also asked.

³²⁸ A male doctor from a Level IIA hospital, length of service: 20 years.

³²⁹ A female doctor from an outpatient clinic, length of service: 34 years.

³³⁰ A male laboratory technician from a Level IIB hospital, length of service: 16 years.

not pay much attention to teaching medical ethics. Thus the concept of medical ethics was not commonly known to these senior medics.

(2) The second type of answer was mainly from less senior medics, who believed that professional medical ethics was equivalent to social morality or social values. For example, interviewees said, “Bioethics is changing in the process of social morality and cultural development. The era of dedication to becoming a noble, self-sacrificing hero has gone. Now social values are accommodating both the public interest and self-interests and this is the same in medicine.”³³¹; and “medical ethics are essential to us medics. In my opinion, it is a socially and culturally related standard for being a decent person.”³³² Responses from the younger generation of Chinese medics showed that they may have more awareness concerning medical ethics than their predecessors. The reason for this could be partly because of changes in medical school curricula, or the increasing emphasis on ethics in healthcare institutions (more discussion of this will follow shortly).

(3) The third type of response was given by the rest of interviewed medics of various ages. They commonly mentioned “a hospital requirement” instead of giving me a description of their understanding of bioethics. For example, one answer was “Medical ethics are important. It has been emphasised by my hospital that we must abide by medical morality which forbids us to accept commission fees from patients.”³³³ Or they referred to “hospital-based medical ethical assessment” – a reward system which has been widely set up by different hospitals in order to motivate professional moral behaviour. Medics seemed to think that the assessment guidelines were codes of professional ethics. Healthcare institutions, in this regard, played an important role in influencing Chinese medics’ understanding of ethics.

The medical assessment guidelines, however, vary between hospitals. A male pharmacist (from a IIA hospital, length of service: 9 years) told me that his hospital ran yearly medical ethics assessments, and the assessment results related to a bonus and the chance to receive a hospital party branch good performance award. In his

³³¹ A male doctor from a Level IIA hospital, length of service: 6 years.

³³² A female nurse from a Level IIA hospital, length of service: 10 years.

³³³ A male doctor from a Level IIIA hospital, length of service: 15 years.

hospital, the staff medical ethics assessment had no link to political education or party branch activity; what was more, the most popular medics (chosen by the highest number of patients) were not necessarily registered CCP party members. The most popular medics would be regarded as the ones judged to be most ethical, and they would receive the hospital-based medical ethics assessment awards. He added that such popular medics were most likely to be those who worked overtime, otherwise it would be impossible to see so many patients in a day.

In terms of the hospital-based medical ethics assessment process, one interviewee told me, “Every one of us in the hospital had to go through an annual medical ethics assessment. According to the assessment instructions, we firstly underwent self-assessment; then we had individual department assessments; finally our practice records were assessed by the senior hospital administrator. The result of annual bioethical assessments affected our wages.”³³⁴ She further explained that the assessment guidelines included clauses like “saving life and curing pain; confidentiality; the obligation to provide treatment without considering the patients’ ability to pay; respect for patients, etc”, and added, “generally speaking, if we work carefully, that will be fine. Patients also have rights to watch our work and complain about any misbehaviour to the hospital management team.”

After listening to medical staff, I also managed to talk to a hospital administrator about his opinions of the role of an institution in training and assessing medical ethics. According to the hospital administrator, “The degree of one’s ethical understanding is related to one’s political motivation. Only those who receive high marks in their medical ethics assessment can be allowed to enrol in the party. The basic rule of my hospital’s ethical guideline is not to over-charge patients or accept commission fees from drug companies. If this rule is broken, the medics can be expected to be fined double to triple the money paid to them by the drug company. We organise meetings at different levels of administration to disseminate medical ethics and political ideology. We also have yearly medical ethics assessments. These results would affect our yearly bonus, and would act as a factor to be taken into account when assessing

³³⁴ A female nurse from a Level IIA hospital, length of service: 4 years.

those who are CCP members in their regular membership assessments.”³³⁵ This senior officer’s comments reinforced my speculation about the key role of bureaucratic institutions in moulding Chinese medics into being more institutionalised.

To sum up, these three kinds of answers showed that the notion of professional medical ethics in China has been influenced by general social values and the hospitals’ ethics examinations. Carr-Saunders and Wilson state, “Of more importance to the social control of the professional is the silent pressure of opinion and tradition...which is constantly around him throughout his professional career”³³⁶ This socially-influenced sense of bioethics will be explored further in Part III of this thesis. In terms of the medical ethics assessment, the level of hospital made no significant difference. What is more, hospitals’ medical ethics assessments seemed to play a key role in affecting the medics’ understanding of professional standards. This was supported by answers to the survey question, discussed previously, which showed limited systematic medical ethics instruction had been given to medics in medical school. Overall, interviewees’ responses to this question suggested that the Chinese medics’ understanding of bioethics varied widely with age, hospital setting and background. Hospitals in China were not only a main source of legal knowledge, but were also actively engaged in bioethical teaching and assessments.

2.2 Chinese Medics’ Understanding of Regulatory Mechanisms

As discussed in Chapter 2, Chinese medical practitioners were subjected to two main sources of surveillance control – medical law and CCP disciplines. The role of hospital guidelines and their medical ethical assessments, however, was not explored. This was partly because institutional rules varied from hospital to hospital. Technically, it was difficult for researchers to examine systematically the guidelines of all hospitals and their medical ethics assessments. However, the role of institutional rules, which might have been underestimated by researchers, was repeatedly referred to during interviews. Hospital rules are therefore included in the analysis of the medical regulatory framework, alongside discussions of medical law and CCP

³³⁵ A male hospital administration officer from a Level IIA hospital, length of service: 30 years.

³³⁶ A. M. Carr-Saunders and P. A. Wilson, *the Professions* (Oxford, Clarendon Press, 1933), 403.

disciplines. This section presents Chinese medics' perceptions of this regulatory framework: hospital rules, medical law and CCP disciplines.

(1) Views of Hospital Rules

Article 31 of the 1998 PRC Medical Practitioner Act (the 1998 Act) indicates that hospitals in China have a legal obligation to assess and evaluate medical practitioners.³³⁷ Indeed, hospital guidelines were referred to by several interviewees, as previously cited. As institutions directly managing and controlling the quality of service, hospitals are a major source of authoritative guidance to medics in their daily practice. Two thirds of interviewees referred to hospital rules when answering questions about their understanding of medical ethics and law. Why did they use hospital rules to interpret their understanding of bioethics or law? My hypothetical explanation would be that Chinese hospitals operate not only as administrative agencies, but also as the Chinese medics' workplace training programme providers for legal, ethical and political disciplines. One male doctor (from a IIIA hospital, length of service: 11 years) said, "We did not have much teaching about law in the hospital. Instead hospital guidelines and departmental technical requirements were taught."

Article 35 of the 1998 Act adds that,

"Institutions of medical treatment, prevention or health care should guarantee training and continued medical education of their own doctors according to provisions and planning.

Medical and health institutions entrusted to the administrative department of health under the people's government at or above the county level are to undertake the evaluation of doctors and should provide and create conditions for training and continued medical education of doctors."

Chinese hospitals that are "entrusted to the administrative department of health under the people's government" formulate institutional rules and staff training programmes that reflect the state's policy and regulations. The fact that so many interviewees

³³⁷Article 31 of the 1998 PRC Medical Practitioner Act states that, "Institutions or organizations entrusted by the administrative department of health under the people's government at or above the county level should make evaluation of doctors at regular intervals in respect of their professional skills, achievements in work and occupational morals in accordance with practising standards of doctors. Evaluation institutions should report evaluation results of doctors to the administrative department of health granting registration for the record".

spontaneously included hospital rules in their discussions of ethics and law suggest that hospital rules have a strong influence on their daily practice. Reflecting on this, one male doctor (from an IIA hospital, length of service: 20 years) said, “Since last year [2007], I can’t prescribe some relatively high-priced drugs to patients, even if they are the most effective ones. There are maximum prices set by the hospital. Once we prescribe over the quota, we have to pay for the outstanding amount of money ourselves. So now, I only prescribe basic drugs in order to sustain my income.”

These maximum price guidelines can be traced back to the drug administration legislation introduced in 2001, by the PRC State Price Commission, to address the problem of outrageous drug prices and drug-related corruption in Chinese hospitals. The problem has been commented on by Chinese scholars: “Driven by financial pressure, hospitals have found many ways to survive including over-charging for services, either by grossly violating the price regulation or by taking advantage of loop-holes in the system.”³³⁸ In light of the prevalent over-charging behaviour among hospitals, *the Drug Administration Law* was introduced in 2001, and its relevant implementation regulations gradually implemented.³³⁹ From this interviewee’s remarks, it is clear that the legislation was designed to stop corruption but is having an unintended effect of circumscribing treatment. Although various interviewees admitted that over-charging for drugs can not be tackled effectively without fundamentally reforming the healthcare financing structure, the effect of hospital rules on Chinese medics’ daily practice can be powerful and should not be underestimated.

One of the flaws in the interview design was that I did not realise the importance of hospital rules before conducting this fieldwork. Therefore the content of hospital rules was not a specific question in my semi-structured interviews. Consequently, very few interviewees discussed the contents of their hospital rules. Instead they either referred to them when answering questions related to the application of medical ethics or law to their practice, or as a reason for explaining why their behaviour had changed in practice. However, I noticed one phenomenon that was common to all hospitals that I visited. Hospital rules and practice guidelines were publicly posted like campaign

³³⁸ X. Liu, et al., ‘The Chinese Experience of Hospital Price Regulation’, 15 (2000) *Health Policy and Planning* 2, 157-163.

³³⁹ The 2000 PRC Drug Administration Law, its enforcement starts since Dec 1st, 2001; also see Regulation for the Implementation of the 2002 PRC Drug Administration Law.

texts in hospital hallways or corridors. I managed to record some of them (hospitals in which I conducted such observations were not deliberately chosen according to any particular criteria but depended on whether I had spare time before or after meeting respondents), such as:

“Patient’s interests are our sole concern. Patients’ interests are our service priority.”³⁴⁰

“Practice medicine following clinical guidelines and law; Understanding discipline clearly will ensure trust; Regard the hospital as home, love the colleagues; Be aware of cost-effective measures; Contribute to our medical career without considering personal interests.”³⁴¹

“To study political ideological theories and reform one’s worldview.”

“Strictly follow the Eight Medical Career Disciplines given by the Ministry of Health (June, 2005):

- (1) No commission fee is allowed to be taken in any medical treatment by any medical organisations or their departments;
- (2) Financial revenues and expenditures of all hospital departments should be managed by the financial department of that institution only. No department is allowed to distribute its income to its contracted medical staff;
- (3) Medical practitioners are not allowed to accept any kind of benefit from their patients;
- (4) Medical practitioners are not allowed to take any commission fee by issuing or prescribing any medicines, medical devices, equipment or examinations;
- (5) Medical practitioners are not allowed, any kind of financial benefits, from introducing patients to other medical institutions to receive medical examinations, treatment, drug-purchasing or use of medical equipment;
- (6) Both the medical organisation and medical practitioner can only charge patients under the categories and price standards set by the state. No over-charging, separating items in order to incur overlapping charges or increasing the price above the standard is allowed;
- (7) Medical institutions should abide by state pharmaceutical bidding and purchasing rules, in accordance with contract procurement to buy drugs;
- (8) No counterfeit and inferior drugs are allowed to be used in the hospital; hospitals are not allowed to produce, sell or use drugs or formulations made by the hospital itself without getting full official approval.”³⁴²

“Deepening our understanding of Scientific Development – current dominant political ideology urged by President Hu. This is an important political thought which should equip our Socialist theoretical system with Chinese characteristics; further strengthen the Economic Open-door Policy, promote social harmony and stability, and most importantly, increase our Party’s political administrative ability. It is one of the necessities for our Party to maintain its advanced characteristics.”³⁴³

“Promoting patriotic education, increasing patriotic sentiment for the State; Promoting legal education, increasing staff legal awareness; Calling for trustworthy and honest medical

³⁴⁰ Outside an administration office of Hospital A of Province A (Hospital Level: IIA).

³⁴¹ Corridors of Hospital A of Province A (Hospital Level: IIA).

³⁴² Hallway of Hospital B of Province A (Hospital Level: IIA).

³⁴³ Hallway of Hospital C of Province A (Hospital Level: IIA).

practice, strengthening trust; Calling for polite practice and better doctor-patient relationships.”³⁴⁴

Literally, these ‘campaign’ texts appeared like proverbs, presented in simple language with a promising and encouraging tone. In some respect, these texts gave me the impression that they were used to give public promises. It was unclear whether hospitals followed strictly these campaign texts, or whether they were intended to only be used as slogans to give patients reassurance that this hospital was under strict quality control. Possibly they were positioned to remind medics of their responsibilities and practice rules. On one occasion, I asked one interviewee, “What does ‘the viewpoint of scientific development’ mean exactly? I saw the text in your hospital hallway.” He replied, “I don’t know. The hospital managers asked us to learn this and bear it in mind. So even though I know nothing about it, I still have to remember it. I suggest you check the meaning on the internet.”³⁴⁵ His answer indicated that, though Chinese medics do not always seem to understand the substance of the rules, they understand that the rules are important.

The extent of the influence and variety of content of the hospital rules in China can hardly be examined in this “snapshot” manner. But one thing seemed clear; the impact and degree of authority that hospital rules had differs from hospital to hospital. Though hospital rules have referred to repeatedly by interviewees and the hospitals that were observed seemed to be promoting their rule-obeying culture actively, the responses below show that hospital corruption is still a problem that has not been solved:

“Giving big prescriptions is a common phenomenon in the environment in which I am working. As long as the drug does no harm, and the pharmaceutical company pays some benefits, the doctors, including senior doctors with professorships, constantly over-prescribe drugs.”³⁴⁶

“We were told each week by the hospital managers about medical ethics. But I don’t think medical ethics itself is working by merely mentioning its importance. Hospital

³⁴⁴ Corridors of Hospital D of Province B (Hospital Level: IIIA).

³⁴⁵ A male doctor from a Level IIA hospital, length of service: 9 years.

³⁴⁶ A male doctor from a Level IIIA hospital, length of service: 15 years.

corruption is still a serious problem. Good ethical behaviour is dependent on one's self-control."³⁴⁷

"I personally never accept commission from patients. I always remit it to the hospital if a patient has given me 'a red pocket' [money]. But I know my colleagues and former classmates do accept 'red pockets' or valuable gifts from patients, as our income is not high."³⁴⁸

These testimonies corresponded with my argument in Part I that, without a fundamental reform of the healthcare financing system, health rules or law could only play a limited role in regulating professional behaviour (interviewees' further discussion about their colleagues' misbehaviours in practice will follow in the ethical-financial dilemmas section).

When discussing the role of hospital rules, one interviewee added his perception about the position of Chinese medics: "Working under the supervision of both hospitals and courts, we medics need to practice very carefully; if we are careless, we could get complaints or even be sued. No one wants to find him or herself ending up either in the hospital manager's office or in the court room."³⁴⁹

Having presented the interviewees' perceptions of hospital rules, the following section turns its attention to the medics' understanding of the impact of law on medical practice. Medical law, according to the questionnaire findings, was regarded as the most influential mechanism for supervising the Chinese medics' conduct. The next section aims to explore whether interviewees' responses were consistent with this finding.

(2) Views and Understanding of Medical Law

As mentioned in Part I, Chinese medical practitioners are governed by a growing number of health laws, for example, *the 1998 Medical Practitioner Act* and by *the*

³⁴⁷ A female doctor from a Level IIA hospital, length of service: 6 years.

³⁴⁸ "Red pocket" in Chinese means a monetary gift. A male doctor from a Level IIIA hospital, length of service: 15 years.

³⁴⁹ A male doctor from a Level IIA hospital, length of service: 9 years.

2002 Regulations on the Handling of Medical Accidents. Healthcare legislation during the 21st century in China has sparked off by the unethical and profit-driven conduct of many public hospitals and medics, which has, accordingly, given rise to a crisis of trust in healthcare. After applying legal standards for almost a decade, one purpose of the empirical study is to briefly sketch the factual situation of the Chinese medics' legal awareness and their perception of legal influence (if any) on their medical practice. This section presents the interviewees' views on medical law and their motives for following (or not following) legal standards.

The survey showed that Chinese medics have a relatively high level of legal consciousness compared with their bioethical understanding and level of interest in political ideology. The survey found that nine out of ten questionnaire respondents agreed that applying law to their medical practice was "very important". Questionnaire results also showed that medics' relatively high attention to learning and applying medical law was not just because they cared about standards of patient care, but also to an increasing distrust of medics by patients who might sue or physically attack them. Because of this, preventive measures have come to be used by Chinese medical practitioners.

In answering the question about medical practitioners' legal consciousness, one interviewee told me, "I have been keeping track of the latest developments in medical legislation and practise carefully under legal instruction."³⁵⁰ A similar answer was repeated by many other interviewees. However, it should be considered that there may be a divergence between Chinese medics' own interest in learning medical law, and their interest in law (if any) that was affected by other factors, such as hospitals. One interview finding was that most interviewees stated that their knowledge of medical law was largely mediated by healthcare institutions. Six interviewees commented on their hospital which has often actively engaged in training its staff in legal knowledge. For example,

³⁵⁰ A female doctor from a Level IIA hospital, length of service: 13 years.

“The hospital I am working for emphasises the importance of law. It organised our law study (especially the regulations of medical malpractice), so that we could have more preventative awareness.”³⁵¹

“I work in a maternity department where complicated cases are more common. We study law every week as there are an increasing number of new medical malpractice guidelines.”³⁵²

“Our hospital chief has emphasised the importance of law in order to reduce the costs of lawsuits.”³⁵³

“Our hospital would organise and provide those relevant medics with medical law education for any department which was likely to handle risky cases, such as on the emergency ward. I have also learned medical regulations at medical school where it was taught as an optional course.”³⁵⁴

“Since 2006, the hospital has emphasised medical law and the doctor-patient relationship. We were told this was required by the Health Minister. Every year we get a booklet called ‘medical law’, on which we need to pass an informal test. Personally, I don’t think this is necessary. The hospital is making a big deal out of it simply because patients are becoming more aware of their rights.”³⁵⁵

“Senior managers of our hospital pay more attention to medical law. I haven’t thought and don’t know much about it.”³⁵⁶

However, one could not deduce from these responses that all medical practitioners are passively learning law because their hospitals required it. Some responses from interviewees expressed appreciation for their hospital’s legal training. Coincidentally or not, such responses were all from female nurses:

³⁵¹ A female doctor from an outpatient clinic, length of service: 34 years.

³⁵² A female nurse from a Level IIA hospital, length of service: 13 years.

³⁵³ A male pharmacist from a Level IIIA hospital, length of service: 4 years.

³⁵⁴ A male doctor from a Level IIIA hospital, length of service: 15 years.

³⁵⁵ A male pharmacist from a Level IIA hospital, length of service: 9 years.

³⁵⁶ A male doctor from a Level IIA hospital, length of service: 11 years.

“My hospital emphasises medical law everyday, in order to prevent medical disputes. Yet, medicine has not promised to cure every disease. There is so much we don’t know or can’t do. When patients are paying more attention to claiming their legal rights, we need to keep every prescription and treatment in accordance with law. Risks are unavoidable, not only to doctors but also to nurses. We need to pay attention to drug usage; we have to check and double-check, so our workload and pressure are increased.”³⁵⁷

“We learn legal standards in the hospital. It distributes a booklet to each of its staff which we need to read to pass the test. This is helpful for our jobs. I can now explain medical records to my patients more clearly.”³⁵⁸

“The hospital organises seminars on medical law for us. Medical law was an optional course when I was in medical school. Learning medical law is important, as it helps us to protect ourselves from legal disputes. Similarly, patients are also protected by more careful practice.”³⁵⁹

“We study medical law in hospital as the managers think it is necessary for us. This afternoon we were studying legal cases. We have a person responsible for giving the seminars so that we can discuss and study. It is helpful for both patients and medics.”³⁶⁰

Why did these nurses appear more cooperative with the hospital’s legal training programmes than the rest of the respondent healthcare workers? I interpret their views as representing a group of Chinese medics who take the law seriously. They were not afraid of legal sanctions and they are not being defensive. They thought law was a useful tool for better equipping them with the standard-based rules that they needed in order to give their patients the best possible healthcare service. So law they thought could be both enabling and empowering. It became a means for improving the doctor-patient relationship.

³⁵⁷ A female nurse from a Level IIA hospital, length of service: 30 years.

³⁵⁸ A female nurse from a Level IIIA hospital, length of service: 5 years.

³⁵⁹ A female nurse from a Level IIA hospital, length of service: 10 years.

³⁶⁰ A female nurse from a Level IIA hospital, length of service: 4 years.

Aside from hospital-organised legal training, responses also showed that in recent years, medical schools in China had been paying more attention to teaching medical students about medical law. The Chinese media also play an active role in raising public interest in medical law by broadcasting controversial legal and ethical cases. Some interviewees, who might not have opportunities to study law in their job, had either learned law at medical school or sought legal knowledge from other sources. The following responses illustrate these findings:

“We learned medical law at [medical] school. It was a compulsory course.”³⁶¹

“I learned it from the media. I haven’t studied it systematically in hospital. It is helpful in writing medical records. Medical malpractice cases are becoming increasingly common.”³⁶²

“We need medical law. Its importance has been repeatedly emphasised by my hospital and the local health bureau during on-the-job training. Also the Chinese Medical Association organises relevant legal study on-line.”³⁶³

In terms of the practitioners’ views of the impact of medical law, not every interviewee agreed that law was either important or helpful in their job. Some interviewees expressed their disappointment in law because they thought “the patients’ interests are better protected than the medics”. But these medics admitted that they lacked motivation to learn about law. One interviewee even said, “Law does little to protect medics. It is confusing and useless to learn law.”³⁶⁴ Other interviewees gave more detailed explanations as to why they felt disappointed with the law, such as:

“Currently I am have been training at a Level IIIA hospital, having finished training at a Level II hospital. Both these hospitals provided legal training for staff. I used to work in a township where we didn’t have many opportunities to study medical law. My knowledge of law was from disputes that happened around me. Disputes were most likely to be solved by pre-trial resolution, such as the payment of money claimed

³⁶¹ A male pharmacist from a Level IIIA hospital, length of service: 4 years.

³⁶² A male administrator from a Level IIA hospital, length of service: 30 years.

³⁶³ A female doctor from a Level IIA hospital, length of service: 6 years.

³⁶⁴ A female nurse from a Level IIIA hospital, length of service: 30 years.

by patients. Law has become the patients' tool to threaten the hospital or medics. We pay money in order to fulfil our government's calling for a 'harmonious society'. To some extent, I think law protects doctors, but in most cases, disputes have been solved before going to trial. Whether they save the patient or not, doctors are likely to face criticism anyway. Nothing backs up the medics."³⁶⁵

"Lawyers think differently from medics. There is no law adequately protecting doctors, so we have to protect ourselves. That which is legally reasonable does not necessarily mean medically acceptable. As a doctor, I am under increasing pressure to practice. The pressure not only comes from patients, but also comes from the increasing demands of legal requirements."³⁶⁶

"Law has no real function. I met a patient who miscarried and was totally unreasonable. The medics' practice was faultless, but the patient asked our hospital to pay compensation of 2000 Chinese Yuan [equivalent to 200 pounds] for her miscarriage. Otherwise she refused to leave the hospital. The hospital, concerned for its reputation, paid the amount the patient claimed. Apart from this, for example, you can also tell that the law is useless where property developers force locals to leave in order to clear the land to build new buildings, roads, railways, etc. The law in China only protects those who are financially and politically capable."³⁶⁷

In contrast to the previously discussed female nurses' supportive attitudes to legal training, these comments from male medics expressed disappointment. One might tentatively suggest that male and female medics differ in terms of their perception of the impact of medical law. This gender difference in perceptions of medical law is a subject beyond the scope of this thesis but worth pondering in the future.

To sum up, it seems clear that Chinese medics have contradictory feelings towards the study of law and the influence of law. Some of the interviewees liked it, because it provided them with tools to aim for and to achieve self-protection and better patient care. Others hated it, because law seemed not to solve the problem of loss of trust and

³⁶⁵ A male doctor from a Level IIIA hospital, length of service: 15 years.

³⁶⁶ A male doctor from a Level IIA hospital, length of service: 6 years.

³⁶⁷ A male doctor from a Level IIA hospital, length of service: 20 years.

did not fulfil medics' expectations of being better protected. Instead they felt more pressure caused by the legal demands on them. 6 out of 24 interviewees did not comment directly on the influence of law or tell me how they felt. They simply stated whether or not they knew about law, and the source of their knowledge.

One might argue that these control mechanisms provided by healthcare institutions and healthcare legislation are not unique to China. Similar systems of quality control and institutional training exist elsewhere. What makes the Chinese way of governing medical practitioners unique is the role of the Chinese Communist Party, which penetrates healthcare governance, including the management of Chinese medics. The following section reveals how medics perceive the Chinese Communist Party (CCP) disciplinary controls.

(3) Views of CCP Discipline

As discussed earlier, hospital rules, CCP discipline and medical law are employed as the three main controlling mechanisms to govern Chinese healthcare practitioners. Having reviewed interviewees' perceptions of hospital rules and medical law, this section reveals medics views on CCP discipline. As noted previously, the number of registered CCP members reached 77.99 million by the end of 2009.³⁶⁸ Although the number of Chinese medics who are also registered as CCP members has not been revealed, it is pointed out by the Chinese government that 17.72 million registered CCP members hold professional qualifications.³⁶⁹ Chinese medical practitioners who have CCP membership are under scrutiny from the CCP's monitoring and supervisory unit – the Discipline Inspection Committee (DIC).

From the highest level hospital to a small local clinic, political propaganda and professional ethics are highlighted on the bulletin boards of hospital registration halls. The CCP has never loosened its propaganda role in governing Chinese medics. However, both the questionnaire and interview findings revealed that the measures taken by the DIC, such as political campaigns and political education activities, have become less effective than they were in Mao's era. Questionnaire data show that in

³⁶⁸ See note 124-127.

³⁶⁹ Ibid.

practice, compared with medical law and medical ethics, political ideology came as a last resort for medics to consider.

Although the survey data found that there was less influence from political ideology, it also showed that half of those surveyed (52%) claimed that education given by the Party branch in bioethics and medical law was relatively important to them. Only 16% of medics stated that political norms were irrelevant to their practices. To verify these survey findings, I asked the same question again in interviews. “How do you react to political thought education in your hospital?” Surprisingly, interviewees’ opinions and attitudes differed significantly from the dominant attitude expressed in the survey. Five interviewees stated that political thought had nothing to do with medicine, three held negative views about it, while only two out of 24 interviewees said they thought political norms were important to them. The remaining 14 medics chose not to answer this question.

This discrepancy between the survey and the interview findings concerning the importance of political thought may show that medics who decided to opt into the interviews were a self-selecting group who held a rather different attitude from the rest of the respondents. Considering the political sensitivity of this question, it was not surprising that many interviewees refused to answer it. Loyalty to the CCP seems still dominate China’s healthcare arena. Apart from that, the indifferent attitude towards political guidelines was shared among the following five interviewees,

“There are 50 party members within our hospital’s 300 medics. All of us need to learn party guidelines, as is required by our senior managers. But I have no idea and no interest in knowing what the party thoughts are really about.”³⁷⁰

“I am not a communist member and I don’t think it affects our work much.”³⁷¹

“We learnt medical ethics and attended anti-corruption campaign meetings organised by our hospital party branch. Honestly, it offered little help. Because our medics are human, we still have to think about our incomes and working hours. Receiving a

³⁷⁰ A male doctor from a Level IIA hospital, length of service: 9 years.

³⁷¹ A female nurse from a Level IIIA hospital, length of service: 29 years.

commission fee from patients has become common practice among medics. Most of my colleagues are on the practical side.”³⁷²

“We have a lot of Party members in my hospital. They are people who have political motivations. But it doesn’t mean they are technically active or excellent. Political ideologies are separate from doctors’ practice.”³⁷³

“The Party branch in my hospital does not play a leading role but more of a coordinating one. The relationship between it and the hospital administration department is complicated. These political thoughts are not meaningful any more, as social values have changed. In practice, economic interest has taken over political ideology’s previous supreme status.”³⁷⁴

Negative attitudes towards the CCP rules were found among three interviewees. They suggested that the CCP political doctrines had no real meaning in practice. The following answers showed such perceptions:

“In public hospitals, we have to study the latest political ideologies, even though I am not a communist party member. I think the doctrine is hypocritical, because those thoughts or disciplines serve no practical purpose.”³⁷⁵

“I am not a communist, but I do think those heroes or model medics who were publicised by politicians were fake. Ideological education is to achieve President Hu’s so-called harmonious society.”³⁷⁶

“All the staff in my hospital have to attend meetings which disseminate political ideology. Two thirds of my colleagues including myself think technical skill is what matters in medicine. Political education has no real meaning.”³⁷⁷

³⁷² A male pharmacist from a Level IIIA hospital, length of service: 4 years.

³⁷³ A male administrator from a Level IIA hospital, length of service: 30 years.

³⁷⁴ A male doctor from a Level IIIA hospital, length of service: 15 years.

³⁷⁵ A male pharmacist from a Level IIIA hospital, length of service: 4 years.

³⁷⁶ A male doctor from a Level IIA hospital, length of service: 20 years.

³⁷⁷ A male pharmacist from a Level IIA hospital, length of service: 9 years.

These attitudes regarding the CCP rules in the healthcare environment may indicate that not all Chinese medics are subjected to the CCP rules, especially non- CCP members. Another possibility might be the supervisory unit – the Discipline Inspection Committee (DIC) – has a diminishing influence on Chinese medics. However, it does not mean that the CCP and DIC have completely lost power. The DIC still possess the power of policy making and political supervision and is becoming increasingly important to the Party’s life-or-death struggle against corruption (including hospital corruption).³⁷⁸ In contrast to the negative comments, two interviewees held positive views toward the CCP rules and its influence on medicine. They said:

“I heard that most hospitals classified as IIIA are active in training staff in political thought and Party activities. The Communist Party branches prop our professional motivations and ethics up.”³⁷⁹

“We learn political thought, so that our jobs can be done more safely. We will be less likely to make mistakes if we follow political orders. There are many Party members in my hospital. Communist Party membership gives one more opportunity for promotion. The Party branch provides our education which I think is necessary.”³⁸⁰

These comments from interviewees all confirm the existence of political education at their hospitals. However, assessment of the impact of the CCP branch and its political disciplinary training differed between interviewees. Although eight interviewees held similar views to the CCP, its political ideological campaign does not seem to have had a significant effect on their medical practice. Two interviewees’ positive attitude toward the CCP and its influence suggested that Chinese medics’ political perceptions are not black and white. There may be “grey” areas concerning their attitudes or feelings. What is more, due to the sensitivity of this subject, the inconsistent responses to this issue may pose a question of validity.

³⁷⁸ T. Gong, ‘The Party Discipline Inspection in China: Its Involving Trajectory and Embedded Dilemmas, 49 (2008) *Crime, Law and Social Change* 139-152.

³⁷⁹ A female nurse from a Level IIIA hospital, length of service: 13 years.

³⁸⁰ A female nurse from a Level IIA hospital, length of service: 30 years.

Despite some respondents holding negative or indifferent views towards the CCP in hospitals, and their explanations that political ideology is no longer spiritually inspiring as Chinese social values have become more materialistic and economically driven; we should not ignore the fact that CCP branches are engaging either directly or indirectly in hospital management. Chinese politicians are closely involved in monitoring China's healthcare delivery and its workers. As to the role of Party branches at different public hospitals, a healthcare administration officer, who holds a medical degree and then worked for a local healthcare bureau in Province A, told me:

“First of all, I need to clarify that my answer would not be representative. In my own opinion, the party branch is there to provide hospital medical ethics education and career direction. In short, it has to control thoughts and minds. In some hospitals, the secretaries of their Party branch are more powerful and authoritative than the hospital directors. They have the power and authority to decide job promotion within the hospital.”³⁸¹

This officer kept a straight face when making this comments. It was difficult to tell from her comments whether she held a positive or negative attitude towards political doctrines. But her remarks indicated that the power of the secretaries of the Party branches should not be underestimated. “As the sole political party stipulated by the Constitution of PRC, the CCP has power to oversee and supervise all political, judicial, administrative, and service organizations.”³⁸² Although some respondents said political doctrines were not so relevant any more, the CCP still keeps its grip on power of healthcare governance (as discussed in Part I).

This section has presented Chinese medics' perceptions in relation to three regulatory frameworks: hospital rules, medical law and CCP discipline. These mechanisms are being used in China in the hope of improving professional performance. Responses from most interviewees showed that they held different degrees of respect for, and interest in, learning them. Compared with the CCP disciplines, hospital rules and medical laws were held in relatively high esteem. This finding also corresponds with the survey results, discussed in Chapter 5.

³⁸¹ A female administrator from the local health bureau, length of service: 11 years.

³⁸² See note 29.

In short, there is a consistency between the survey and interview findings in terms of medics' understanding and prioritisation of medical ethics and the regulatory mechanisms. However, interview responses revealed the complexity of the medics' views. They not only presented factual findings that were similar to those of the survey, but also revealed their emotional and personal feelings with regard to these practice guidelines. The next section discusses the consequences of the relationship between legal requirements, political commands and bioethical considerations. It aims to examine how medics interact within these guidelines particularly when there are ethical dilemmas. It also explores whether there are consistencies or inconsistencies in medics' stated preference for particular guidelines.

3. Legal Requirements, Political Commands and Bioethical Considerations: Any Ethical Dilemmas?

“Law is so important. Without it, there is no order in society. However, medical legislation does not always meet medical needs, especially when it conflicts with bioethics. It could cause more harm than good. Law-makers are not medics. The standards that they set to regulate medical practice could become barriers hindering medical development. In this circumstance, no medic dares to provide medical services containing risks.”

A senior doctor³⁸³, December 2008

Questions concerning the existence of conflicting control mechanisms or medics' dilemmas were inserted into the draft before conducting the semi-structured interviews. These questions were hypothetically based, as there was no evidence from literature reviews or media reports that Chinese medics experienced any specific ethical dilemmas, even in the case of SARS (mentioned earlier). However, lack of official reports does not mean ethical dilemmas or conflicts are non-existent.

The purposes of questioning on this hypothetical theme are manifold. First, the aim was to examine whether medics' prioritisation of guidelines were consistent when raised in sample cases. Secondly, it aimed to explore whether there were any unspoken inner dilemmas that interviewees had experienced. It was presumed in that

³⁸³ A female doctor from a Level IIIA hospital, length of service: 29 years.

case they had to do something unethical, which they would not have chosen to do, had they been allowed to have more control over their work. Thirdly, this was a question one step closer to the core theme of this interview study, to unlock the Chinese medics' hidden voice so that their perception of professional power, experience of ethical dilemmas (if any) and emotional feelings could be captured when examining the relationship between state, law and medics in China.

Realising the limitation of information that can be elicited concerning this sensitive issue, I have searched and found data from a Chinese medics' online forum (assuming it to be mainly medics), their comments and discussions were posted after they read "the 2008 Chinese Doctors' Living and Working Conditions Survey Report". I have referred to this survey in the questionnaire findings. The Ding Xiang Yuan website is one of the main communication methods used by Chinese medical practitioners.³⁸⁴ According to the website introduction, it has 1.95 million registered users who are medical practitioners working in any field of medicine in China.³⁸⁵ The website posted the 2008 Survey Report online in March 2008.³⁸⁶ Up to January 2011, it has raised 820 relevant topic-discussions and debates and has generated, in total, over 66,000 comments from its registered users.³⁸⁷

Dholakia and Zhang indicate that, "The internet is much more than a communication medium—it is also an evolving nexus of cross-referenced databases."³⁸⁸ They also suggest that "A bulletin board is a medium that displays all messages that have been

³⁸⁴ Ding Xiang Yuan, available at: <http://www.dxy.cn/> (Last visited on Jan 5th, 2011).

³⁸⁵ 'About us' (in Chinese), Ding Xiang Yuan, available at: <http://www.dxy.cn/cms/upload/html/about.html> (Last visited on Jan 5th, 2011).

³⁸⁶ The report (in Chinese) was divided into four serials to be post perspective on the Ding Xiang Yuan website. Serial I 'How Chinese Public Views on Medical Practitioners', available at: <http://www.dxy.cn/bbs/topic/11206971>; Serial II 'How Tired Chinese Medical Practitioners are', available at: <http://www.dxy.cn/bbs/topic/11261320>; Serial III 'Are Chinese Medics' Incomes Relatively Low or High', available at: <http://www.dxy.cn/bbs/topic/11326004>; and Serial IV 'How Chinese Medics Judge about Themselves and Their Work', available at: <http://www.dxy.cn/bbs/topic/11388369> (Last visited on Jan 5th, 2011).

³⁸⁷ Ibid. The number of topic discussion was found from key word 'The 2008 Chinese Doctors' Living and Working Conditions Survey Report' search result of the website. Comments numbers are calculated and shown below each post. Up to Jan 5th 2011, Serial I had attracted 15242 comments; Serial II had attracted 27683 comments; Serial II had attracted 17439 comments; and Serial IV had attracted 5746 comments.

³⁸⁸ N. Dholakia and D. Zhang, 'Online Qualitative Research in the Age of E-Commerce: Data Sources and Approaches', 5 (2004) *Forum Qualitative Sozialforschung /Forum: Qualitative Social Research* 2; M. Poster, *The Mode of Information* (London, Blackwell, 1990) and M. Poster, *The Second Media Age* (London, Blackwell, 1995).

posted on it and their respective replies.”³⁸⁹ So it is one of the ways of accumulating qualitative data in cyberspace.³⁹⁰ This thesis is going to cite some online users’ comments placed on this website. They are to be used as complementary data in the following discussion of my interviewees’ perceptions of ethical dilemmas.

However, I am also aware of a possible weakness in using data from an online forum. There can be an over-representation of views or experiences from medics of a particular age group. Though more and more seniors are accessing the internet and becoming part of the online community, presumably most comments posted on Ding Xiang Yuan’s discussion forum would be from junior medics.³⁹¹ But the advantage of this medium would seem to outweigh the disadvantages. Thanks to anonymity, comments posted by forum users contributing to the discussion, can conceivably be frank and honest.

Due to the sensitivity of this issue, not every interviewee responded to the direct question – “Have you experienced any dilemma with political ideology or law conflicting with your understanding of medical ethics? Could you give me an example? If you haven’t, have you heard from a colleague who has? ” Out of the total 24 interviewees, 13 explicitly or implicitly responded to this question. Those reminding either answered, “No, neither I nor my colleagues has experienced any ethical dilemmas.” or declined to answer to the question.

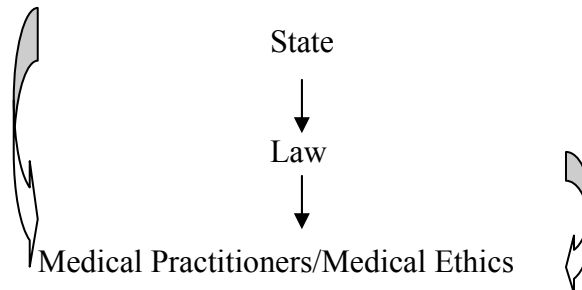
Answers from the 13 interviewees indicate that ‘hypothetical’ dilemmas do exist. Specifically, these dilemmas could be divided into two types. The first caused by conflict between professional ethics and financial stress; the second by conflict between the application of medical law and bioethics. These two types of dilemmas could also be found in comments from Ding Xiang Yuan. Putting these two kinds of

³⁸⁹ Ibid.

³⁹⁰ Ibid.

³⁹¹ We can see this from the contents of their comments which often referred to their salaries as residents and working history; second, due to the aftermath of the Cultural Revolution, elder Chinese are generally less open to express their feelings in public; and third, research shows that seniors’ use of the internet normally are more limited than those of younger people, and it is less common for people over 60 to uses online purchasing, online gaming, and online photo or idea sharing. See e.g., M. Notess and L. Lorenzen-Huber, ‘Online Learning for Seniors: Barriers and Opportunities’, 5 (2007) *eLearn Magazine* 4; J. Goodman, et al., *Older Adults’ use of Computers: A Survey*, in Proceedings of HCI 2003, Bath, UK, Sep 2003.

dilemmas into the top-down model (I suggested at the end of Part I), the medics' answers revealed that, within the relationship between state governance, medical law and bioethics in China, conflicts did occur either between state governance (lack of funding) and bioethics, or between medical law and bioethics, see graph below:



In order to distinguish these two dilemmas, the first type of dilemma concerning conflict between Chinese medics' moral understanding and financial strains, will be called "ethical-financial dilemmas"; the second type concerning conflicts between medics' moral understanding and legal rules, will be called "ethical-legal dilemmas".

3.1 Ethical-Financial Dilemmas

As discussed in Part I, most Chinese medical practitioners (apart from the medical élite) are poorly paid, not only by comparison with their colleagues in other non-Communist countries, but even within their own society. In interviews, six physicians told me, on different occasions, that some of their colleagues were looking for controversial means to supplement their income, such as gaining commission by prescribing special brands of medicine or by accepting valuable gifts from patients. This has become a well-known but publicly unspoken phenomenon inside the medical community. They also added that they were doing this as there was no choice. "The system is forcing good women to become prostitutes."³⁹² Two of them mentioned this common proverb when expressing their dismay. One interviewee added, "It is the state's healthcare financing system that should be blamed not medics". Another interviewee stated, "We are the powerless victims, not patients." I heard similar comments from several medics who expressed disappointment towards the health system during interviews and informal talks.

³⁹² A female doctor from an outpatient clinic, length of service: 34 years.

Dissatisfaction was also shown from their answers to this open-ended question – “Has your practice been affected by China’s health sector reform? If “yes”, could you explain how it is affected? ” Though the exact cause of their ethical-financial dilemmas may vary, the common theme emerging from both the interviews and questionnaires could be summarised by one interviewee’s words, “I believe all the medics do want to help, but we have no choice.”³⁹³ Three interviewees further expressed their personal experiences of ethical-financial dilemmas as listed below:

“I would love to do more research into the subject of maintaining a healthier lifestyle in order to help patients with chronic disease. But this idea was rejected by our hospital managers, simply because they thought this was not profitable. Do you know what I have gained from trying to help patients in the long term? Nothing. I haven’t received support from my colleagues. Because I am not a Communist Party member and my political awareness is low, there is no chance for me to get career promotion.”³⁹⁴

“I had a dilemma once. A woman was due to give birth at our hospital. She didn’t have any family to accompany her and had no money to pay for the deposit. We still operated. The woman left without paying anything. In the end, the whole team who participated in saving her, had to pay for the medical cost ourselves, and even got fined for doing this.”³⁹⁵

“The healthcare system needs to be changed. We have some patients who are too poor to pay for the treatments. We had to repeatedly ask the patient to pay. We have sympathy for these poor patients, but if we can’t claim back the medical bill, we medics have to pay the cost ourselves. Our incomes are not high. In a public hospital, we have a profit-making target for each department. If one department reaches the profit target, everyone in that department will get a bonus. Commercialisation has changed the ‘public’ meaning of the hospital.”³⁹⁶

³⁹³ A laboratory technician from a Level IIA hospital, length of service: 16 years.

³⁹⁴ A male doctor from a Level IIA hospital, length of service: 20 years.

³⁹⁵ A female doctor from a Level IIA hospital, length of service: 13 years.

³⁹⁶ A female nurse from a Level IIIA hospital, length of service: 5 years.

These answers feature ethical-financial dilemmas that three of my interviewees had experienced: a hospital rejection of a medic's research proposal because of its non-profitability; being fined for proceeding with life-saving surgery without considering cost; an additional role of being a nurse in China – medical bill-chasing. These ethical-financial dilemmas involved the tensions for medical practitioners between helping financially limited patients and sustaining their own or their hospital's incomes. Essentially, these were caused by the financial strains put upon Chinese hospitals.

Aside from these interviewees' stated experiences, some comments from other medics' ethical-financial dilemmas are also found on Ding Xiang Yuan. Take some of their statements for example:

“There is a serious income-inequality problem among Chinese medics. Working in the same city, physicians in some departments of a Level III Central hospital could receive a salary plus bonuses totally over 10,000 RMB [equivalent to 1000 GBP] a month; while we physicians who work at a Level II hospital are very demoralised as most of us are getting less than 2000 RMB [equivalent to 200 GBP] a month. Our workloads are similar to the others; we have to keep diagnosing, writing prescriptions, double-checking for mistakes, chasing patients for payments, earning medical security savings, and thinking how to achieve the hospital and departmental income target. If we can't achieve the target, we can't receive a fully paid salary. We feel so tired!”³⁹⁷

“Compared with the average salary of 1500RMB [equivalent to 150 GBP] for the general Chinese public, many of our resident doctors and general practitioners' incomes are at or below the average public income level. Only a very small percentage of medics can receive a relatively high income, such as 5000-6000 RMB [equivalent to 500-600 GBP] a month. Healthcare reform should have focused on encouraging medical research, motivating medics to practice to the best of their ability; so that we can be better prepared to treat patients, rather than being forced to do accounting. Only when Chinese medics' hard labour and low pay have been

³⁹⁷ Ding Xiang Yuan user qiu0628 posted a comment (in Chinese, translated by author) to a discussion thread on Serial III 'Are Chinese Medics' Incomes Relatively Low or High', available at: <http://www.dxy.cn/bbs/thread/11352248> (Last visited on Jan 3rd, 2011).

recognised, understood and respected, can we return to the focus on medicine! It is meaningless to discuss something else if the medics' normal life pay can't be secured."³⁹⁸

As discussed in Part I of this thesis, following economic reforms, public hospitals in China now receive very limited financial support from the government, as a result of which, hospitals have been forced to generate income to cover costs. Cuts to hospital subsidies have left Chinese medics reliant on finding ways to make ends meet. Moreover, it implies a financial incentive to over-investigate and over-treat. The conflict of financial interest and ethical responsibility pose a threat to the Chinese medics' ability to retain their professional integrity. In their own words – “The system is forcing the good women to become prostitutes” – sheds some light on such struggles and hardship.

The following online comment expressed in practice, not only the feeling of being a medic who has to bear financial pressures, but also thinking about the reasons for and consequences of this financial-ethical dilemma:

“Most medics' delegates to the National People's Congress are senior doctors. Those who are on high payrolls may not understand the struggles of the large number of low-paid junior medics. Some of those have started to accept financial kickbacks from drug companies; other juniors refuse to practise unethically and quit for better paid jobs outside medicine. One of my colleagues said publicly, ‘Because being a surgeon earns me so little, my main income has to come from somewhere else, such as stock trading’. Since Chinese medics cannot concentrate on their profession, I would not be surprised if medical malpractice will happen more frequently in the future. But then, whom should we blame for the adverse consequences?”³⁹⁹

The comment above is consistent with my interviewees' answers. The common ethical-financial dilemmas that they have to face are that the financial reality does not

³⁹⁸ Ding Xiang Yuan user nayucy posted a comment (in Chinese, translated by author) to a discussion thread on Serial III ‘Are Chinese Medics' Incomes Relatively Low or High’, available at: <http://www.dxy.cn/bbs/thread/11389000> (Last visited on Jan 3rd, 2011).

³⁹⁹ Ding Xiang Yuan user niguansen posted a comment (in Chinese, translated by author) to a discussion thread on Serial III ‘Are Chinese Medics' Incomes Relatively Low or High’, available at: <http://www.dxy.cn/bbs/thread/11392538> (Last visited on Jan 3rd, 2011).

allow them to practice ethically. Failure of state healthcare governance has put Chinese medics in a difficult environment which does not nurture professional development. The loss to the medical community is much more than monetary. It is the medics' confidence in moving forward that suffers the most. One of the forum users said, "We practitioners who are working at the frontline of healthcare service are really tired. We wait for changes to come in the future... if we have a future."⁴⁰⁰

3.2 Ethical-Legal Dilemmas

Changes in legislation are having a significant impact on medics' ethical-legal considerations when making medical decisions. *The 2002 Medical Malpractice Act* which assigns the burden of proof in liability cases to healthcare practitioners, as discussed in Part I, is an example. Conflicts between regulations and ethical responsibility may lead to ethical-legal dilemmas in medical practice. This section reveals Chinese medics' experiences and thoughts about ethical-legal dilemmas.

The questionnaire findings showed that the highest percentage (87%) of Chinese medical practitioners regarded medical law and regulation as the most important guideline, along with hospital rules (second), medical ethics (third) and CCP discipline as the least important. In an attempt to triangulate these findings, I asked interviewees to rank ethics, law and political ideology according to their importance to their work. Surprisingly, 8 out of 13 interviewees who responded to this question prioritised bioethics above the others. This discrepancy between questionnaire and interview findings is worth pondering, because it reveals the probability of the existence of ethical-legal dilemmas for many Chinese medics.

An ethical-legal dilemma only occurs when, on the one hand, ethics is treated with seriousness, but on the other, a doctor still has to base a decision wholly on the law. For a medic with no regard for ethics following whatever he/she was taught of law or regulation, ethical dilemmas are unlikely to happen. The 8 interviewees who ranked ethics as the highest guideline have as much awareness of law as those who ranked

⁴⁰⁰ Ding Xiang Yuan user stone32 posted a comment (in Chinese, translated by author) to a discussion thread on Serial III 'Are Chinese Medics' Incomes Relatively Low or High', available at: <http://www.dxy.cn/bbs/thread/11419594> (Last visited on Jan 3rd, 2011).

law the highest. However, they were most likely subject to ethical dilemmas because of the high regard they hold for both law and ethics. Their answers to the questions – “Have you ever experienced any ethical dilemma in your workplace or heard from a colleague who has? If you have, how did you or your colleagues resolve those dilemmas?” – proved my assumption.

Five of the eight medics who had originally said ethics was the most important guideline, contradicted themselves by saying they had or would resolve their dilemmas by following law rather than ethics (details of their own examples of ethical-legal dilemmas will be discussed shortly). On one occasion, I said to an interviewee, “You just told me ethics was the most important guideline. How is it that ultimately you used the law to resolve your dilemma?” He replied, “Oh...yes, I did not realise that.”⁴⁰¹ He then laughed, embarrassed, and added he thought it was a morally wrong decision, but had to compromise with practical realities.

This contradictory response echoes one of the survey results that 55% of respondents replied “I had to make difficult decisions in some situations.” In balancing the requirements of law and ethics, interviewees gave me contradictory answers. A conflict between what one wants to follow (such as, ethics) and what one sees as more practical (such as, law) indicates the existence of an ethical-legal dilemma.

Examples of ethical-legal dilemmas can be seen from the following statements given by my interviewees. They addressed several areas of ethical-legal dilemmas that they faced in practice:

“This is a case I heard about. Blood transfusion law requires blood to be used only after testing. One pregnant woman who had a difficult labour was in need of a blood transfusion. Yet her blood type was O negative, a rare type. The media broadcast this, and a volunteer came to the hospital, willing to donate blood. As the patient was an emergency, there was no time to do blood testing. Her family begged the hospital to transfuse the blood without testing, and were willing to sign their awareness of the

⁴⁰¹ A male pharmacist from a Level IIA hospital, length of service: 9 years.

risk, promising they wouldn't sue the hospital. The hospital refused and the patient died 20 minutes before the blood test result was released.”⁴⁰²

This legal but ethically problematic decision is a classic example of an ethical-legal dilemma. Such a defensive attitude can also be found in emergency care, where instead of taking a medical decision, medics tend to wait for legal authorisation before starting an operation. Two statements from my interviews illustrate the medics' thoughts and feelings during such dilemmas:

“I believe all medics want to help, but we have no choice. In one case, a patient was in need of emergency surgery. The whole medical team had to wait for the patient's family to sign before taking action. This delayed life-saving treatment. The patient died soon afterwards. Since the law requires medics to bear the burden of proof, we have had to become defensive. There are a lot of patients who could have been saved, but they died because no medics dared to do high-risk procedures to save them. In the end, it is the patient who bears the bad consequence, but state policy is at fault. It is so unfair that medics who have every intention of helping have to carry this bad reputation or worry all the time about being sued.”⁴⁰³

“It happened once. We couldn't save a patient in time because of our changing shifts. The patient's family was unavailable to sign the consent form during the emergency, and we dare not to go ahead. We are now cautious about accepting very sick patients. We even make notes of every conversation with the patient's family and ask them to sign that they are fully informed.”⁴⁰⁴

Other examples of ethical-legal dilemmas can be found on online Ding Xiang Yuan, on which the users had expressed their concerns and frustration over problematic tensions between healthcare law and ethics. One example is as follows:

“We have been discussing the recent case from Fujian province, where the Sanming No.2 Hospital offered patients' families high financial compensation after four

⁴⁰² A female doctor from a Level IIIA hospital, length of service: 29 years.

⁴⁰³ A laboratory technician from a Level IIA hospital, length of service: 16 years.

⁴⁰⁴ A female nurse from a Level IIA hospital, length of service: 30 years.

anaesthesia-related deaths occurred during surgery. There are doubts about the way that the hospital dealt with these medical incidents. The law assigns the burden of proof to healthcare practitioners in cases of liability. And it does not allow us to perform an autopsy without family consent. The problem is that an autopsy is barely acceptable to most Chinese; a medic cannot prove his innocence without an autopsy. Under such circumstances, the hospitals tend to offer financial compensation to ease the anger of relevant families. My question is why should we pay compensation without confirming the cause of incident? In reality, the compensation has to be paid by all the medical staff of the hospital, including those who had no involvement; the compensation sum would be deducted from our salaries. This is unfair and very demotivating. Chinese medics are trapped in a vicious circle. More good doctors are quitting their jobs, and more incidents are likely to happen.”⁴⁰⁵

Cases such as these demonstrated that medics who have a high level of consciousness of legal regulation are careful to avoid accusations. Two of these cases involved failing to provide life-saving treatment to a patient simply because the medical team could not get the informed consent in time. It also seemed that self-protection has become the main motive for medics to obey the law. This is shown especially in the blood-transfusion case. The fourth comment expressed the Chinese medics’ difficult circumstances where they have to obey the law but the law itself has deficiencies. It is a dilemma where both ethical-legal and ethical-financial conflicts are in play. Dilemmas in such cases are therefore not mutually exclusive. Instead they interplay with each other, making the Chinese medics’ practice environment even more difficult.

In the 2009 report – “the Chinese Doctor Career Survey”, conducted by the Chinese Medical Doctor Association,⁴⁰⁶ 74.79% of its 3182 doctors thought that *the 2002 Medical Malpractice Act* which assigned the burden of proof to healthcare practitioners in liability cases, had an adverse influence upon medical development as

⁴⁰⁵ Ding Xiang Yuan user xtagfn posted a comment (in Chinese, translated by author) to a discussion thread on Serial III ‘Are Chinese Medics’ Incomes Relatively Low or High’, available at: <http://www.dxy.cn/bbs/thread/13010165> (Last visited on Jan 3rd, 2011).

⁴⁰⁶ Chinese Medical Doctor Association, *The 2009 Chinese Doctor Career Survey*, available at: <http://www.cmda.gov.cn/News/huodongzhuanti/yishifashizhounian/diaoyan.html> (Last visited on Dec 15th, 2010).

no one dared to take any risks in practice.⁴⁰⁷ The report also showed that Chinese medics had little trust in Chinese legal system. In the pilot test of the same survey, as few as 12.63% of medics thought that medical malpractice was handled fairly by the courts.⁴⁰⁸ This suggests that there were many reasons for the Chinese medics' high levels of legal consciousness. The reason for this may be because their fear of legal sanctions, and not because they believed that the law has put public interest protection as its main aim.

The existence of both ethical-financial and ethical-legal dilemmas indicates conflicting interests in China's healthcare system and underlying problems in Chinese medical law. The conflicts between financial pressure, legal requirement and ethical obligations implies that, in China, healthcare governance, medical law and bioethics have not created a balanced state of power dynamics in guaranteeing that both patient and medics' best interests are secured.

4. Questioning Professional Power and Control

Having overviewed interviewees' prioritisation and experience of pluralist guidance, the last section revealed that Chinese medical practitioners felt ethically compromised and stressed when faced with ethical-financial and ethical-legal dilemmas. This section presents interviewees' views on their need or desire to gain some form of power and control over their practice.

4.1 "I am Physically and Mentally Exhausted"

(1) Mixed Feelings

As discussed in Part I, the decline of patient trust has become a major challenge to the health system in China. Pre-trial resolution and patients' claims indicated that law could be a tool for public use in order to threaten hospitals for monetary compensation. In the field, I found that Chinese medical practitioners had become a target of public anger and grievance. Some of them might have become corrupt; some

⁴⁰⁷ Ibid.

⁴⁰⁸ Ibid.

might even refuse to stay in their profession, but the majority of Chinese medics were working under great pressure in order to compromise with reality. The empirical study found that, along with a loss of trust in professionals had come a loss of influence. Chinese medical practitioners tended to feel undervalued, threatened, and, at times, exerted little authority over the structure of the healthcare system.

Talking of their feelings about their jobs in general, interviewees gave me answers that indicated dissatisfaction and frustration. One interviewee said, “I am disappointed with the job. My income is low. The patients do not respect me. I am physically and mentally exhausted. My family life has been ruined, as both my husband and I are medics, and we are both working under a lot of stress. I don’t have confidence in the healthcare environment.”⁴⁰⁹ More specifically, the medics’ frustrations were caused by two main concerns: firstly, financial problems, and secondly, the decline of public trust and respect.

Firstly, according to a doctor, the financial concern was: “Generally speaking, the whole healthcare environment has developed very slowly. There is less financial investment in our hospital as compared to other hospitals. But our hospital is applying for an upgrade to Level III, so our incomes are expected to increase and the hospital will get more investment. But this means workloads and pressures will also increase dramatically. One department is a team. Whoever makes a mistake, the team will sacrifice part of their income to pay for it.”⁴¹⁰

Secondly and more frequently, interviewees indicated that their reputation and public image were eroded. Examples of their comments are as follows:

“Most doctors feel that they have lost their reputation in society. While patients are eager to fight for their rights, doctors are learning how to evade or dodge angry patients, and to timorously consult higher level administrative officers so that the patient can be transferred to a higher level hospital.”⁴¹¹

⁴⁰⁹ A female nurse from a Level IIA hospital, length of service: 30 years.

⁴¹⁰ A female doctor from a Level IIA hospital, length of service: 30 years.

⁴¹¹ A male doctor from a Level IIA hospital, length of service: 6 years.

“We have lost the meaning of medical jobs. Although salaries are increasing, the whole environment is disappointing.”⁴¹²

“Doctor-patient relationships are getting worse. Patients’ distrust forces us to learn how to be better at self-protection. For example, we dare not operate without informed consent from patients. Even if we have patients’ consent, that doesn’t mean their families won’t protest at the hospital if anything goes wrong. Most of the patients’ families don’t want to go to the court. They just hire a group of trouble-makers to protest and show their grievance in the hospital. They also reveal their cases to the media in order to add pressures to the hospital to give in and offer them compensation.”⁴¹³

Referring to what this interviewee said, it is clear that the Chinese media play an important role in provoking tension between medics and patients. For example: the alleged greediness of Chinese medics in cheating patients; their irresponsibility exemplified by medical malpractice, and hospitals becoming profit-driven without considering public interest can be frequent topics in Chinese newspapers, on television, and on the internet.⁴¹⁴ Another interviewee expressed concern about the role of the media. He said, “I rarely feel too bad about my career, but I know that some of my colleagues do, especially after meeting a patient who called nurses ‘servants’. Nowadays, TV programmes and newspaper reports are full of medical negligence cases. These have seriously damaged our reputation and greatly changed our practice environment. When my grandfather was a doctor, no matter whether his treatment was successful or not, the patient would be thankful. Now the patient will make trouble if one cannot cure him. We are misunderstood by patients.”⁴¹⁵

I agree with this interviewee that the media in China has increased the tension between medics and patients rather than easing it. More often than not, it is hard to

⁴¹² A male laboratory technician from a Level IIIB hospital, length of service: 6 years.

⁴¹³ A male doctor from a Level IIIA hospital, length of service: 15 years.

⁴¹⁴ See e.g., different scandals of greedy healthcare workers and their for-profit hospitals have been reported (in Chinese) by *Sina News* (<http://news.sina.com.cn/c/2011-03-06/220222063570.shtml>); *Ifeng TV* (http://news.ifeng.com/society/2/detail_2010_11/16/3118544_0.shtml); *People.com* (<http://politics.people.com.cn/GB/14562/14077159.html>) or <http://society.people.com.cn/GB/41158/13233810.html>); *Beijing Newspaper* (<http://news.bjnews.com.cn/news/2010/1027/95856.shtml>), (Last visited on March 8th, 2011).

⁴¹⁵ A male doctor from a Level IIIA hospital, length of service: 15 years.

tell whether media reports reflect the truth; whether some were misreported due to the reporters' lack of medical knowledge, or motivated by a desire to catch an audience's attention with sensational stories. As a result, Chinese medics' public image and doctor-patient relationships have been damaged. It seems natural that, since patients have become increasingly sceptical and distrustful of medical community, medics have learned to be more cautious and defensive.

In Ding Xiang Yuan's online forum, users' comments about their feelings concerning the healthcare environment are also worth consideration:

“Nowadays, my hospital is employing more doctors and nurses on short-term contracts. These hospital staff are treated like cheap labour. They were given 400-500 RMB [equivalent to 40-50 GBP] a month. They have to use this little amount of money to pay rent, examination fees and their own living costs. They are discriminated against and vulnerable. I really feel sad for them. But no one seems to care about this disadvantaged group of healthcare workers.”⁴¹⁶

“We junior physicians are feeling extremely tired. One of my longest shifts was two nights and a day without any sleep. It is like fighting a war. One of my colleague has four more years working experience than me, and has a master's degree from a well-known medical school, he also said, within the four years, he had never had the time to travel a long-distance to visit his family. He told me he had never accepted any 'grey income'. After graduating from medical school, he never bought himself expensive clothes. All his income has been used to pay his living costs, and support his elderly parents, and this has left him with no savings. He couldn't even afford a decent gift for his younger sister's wedding. He cried many times and even planned to quit his medical job to work in a hotel. He said he is just fed up with this inhumane treatment.”⁴¹⁷

⁴¹⁶ Ding Xiang Yuan user wuxiangqian posted a comment (in Chinese, translated by author) to a discussion thread on Serial III 'Are Chinese Medics' Incomes Relatively Low or High', available at: <http://www.dxy.cn/bbs/thread/11514538> (Last visited on Jan 3rd, 2011).

⁴¹⁷ Ding Xiang Yuan user cyz306 posted a comment (in Chinese, translated by author) to a discussion thread on Serial III 'Are Chinese Medics' Incomes Relatively Low or High', available at: <http://www.dxy.cn/bbs/thread/11552096> (Last visited on Jan 3rd, 2011).

“We are feeling tired physically and mentally. We have to work carefully from day to night, but this does not gain us public respect. The public thinks we have no morality and we are suspects. The government does not support us. All social conflicts raised by ineffective medical investment and inadequate healthcare security have been transferred to us. It is heart-breaking.”⁴¹⁸

The above comments showed that Chinese medics have noticed a drop in public esteem towards them. Medics felt that although they were praised when they were seen as keepers of discipline, their status has been damaged, not because they deliberately wanted to destroy their own professional honour, but because they have been put into the difficult position of having to choose between public interest or self-survival strategies, neither of which they wanted to sacrifice. Their answers to questions and feelings about their job generally corresponded to the earlier discussion about dilemmas, i.e. in essence there are problems embedded in China’s healthcare financing system causing ethical-financial dilemmas.

When asking about the causes of depression in survey and interviews, the medics’ responses were consistent. Their answers indicated conflicts between state governance, medical law and bioethics, and healthcare governance was a major cause of dissatisfaction. In my opinion the trend of patient empowerment has produced a positive change in healthcare culture, but this implies that the government has responsibilities to educate the public to be more responsible and reasonable ‘power-owners’. As discussed in Part I, there have been countless incidents where Chinese medics have been physically threatened by patients’ families, and become victims of violence. A doctor asked me during the interview, “Who will protect the medics’ human dignity and safety when facing the extreme behaviours of patients’ families? I know the Medical Practitioner Act has clear regulations for this, but in practice the law is not working.”⁴¹⁹ Another interviewee concluded “Lots of my colleagues said they wouldn’t want to be a doctor, if they had a second life.”⁴²⁰

⁴¹⁸ Ding Xiang Yuan user 杏林一僧 posted a comment (in Chinese, translated by author) to a discussion thread on Serial II ‘How Tired Chinese Medical Practitioners Are’, available at: <http://www.dxy.cn/bbs/thread/11306052> (Last visited on Jan 9th, 2011).

⁴¹⁹ A male doctor from a Level IIIA hospital, length of service: 15 years.

⁴²⁰ A male doctor from a Level IIIA hospital, length of service: 15 years.

In the Ding Xiang Yuan online forum, similar angry comments were also evident. For example, “It is not the medics who are extorting money from patients; it is society that is killing medics.”⁴²¹ Or, “A physician is also a human being who needs to lead a life. How can we go and save lives when we are hungry. How come the government does not understand this simple theory? Ridiculous!! Being a physician in China is miserable!”⁴²² There was a doctor who even showed anger when refusing to take part in my fieldwork, “I don’t want to participate. Whatever we medics complain about wouldn’t lead to any change. Only those who have power can make an impact.”⁴²³

However, medics did not only express negative feelings such as depression and anger. There were also positive comments, such as:

“Although the current situation is not so good, medics should be satisfied with what they already have. They are middle class and are better off than a lot of people. We should not demand too much.”⁴²⁴

“I believe that healthcare reform will change the situation for good.”⁴²⁵

“We need to stick to this profession since we have chosen it. Years of effort have got us to this position. There is nothing wrong in being a doctor. Eventually society will recognise how much we have put into it as we became good doctors.”⁴²⁶

Speaking of political campaigns that never stop requesting that Chinese health workers must serve the people and act in the best interests of patients, there were interviewees who expressed support for patient empowerment. Some others said,

⁴²¹ Ding Xiang Yuan user gaodan posted a comment (in Chinese, translated by author) to a discussion thread on Serial III ‘Are Chinese Medics’ Incomes Relatively Low or High’, available at: <http://www.dxy.cn/bbs/thread/11466261> (Last visited on Jan 3rd, 2011).

⁴²² Ding Xiang Yuan user wuxiangqian posted a comment (in Chinese, translated by author) to a discussion thread on Serial III ‘Are Chinese Medics’ Incomes Relatively Low or High’, available at: <http://www.dxy.cn/bbs/thread/12509102> (Last visited on Jan 3rd, 2011).

⁴²³ A female doctor from a Level IIA hospital, length of service: unknown.

⁴²⁴ A male hospital administrator from a Level IIA hospital, length of service: 30 years.

⁴²⁵ A male pharmacist from a Level IIA hospital, length of service: 9 years.

⁴²⁶ Ding Xiang Yuan user 诊疗常规 posted a comment (in Chinese, translated by author) to a discussion thread on Serial III ‘Are Chinese Medics’ Incomes Relatively Low or High’, available at: <http://www.dxy.cn/bbs/thread/15368821> (Last visited on Jan 3rd, 2011).

“Chinese politicians are sacrificing Chinese medics to win over public support.”⁴²⁷ Or, “Disappointingly, the late 20th century healthcare reform hasn’t brought good changes so far. It is the government’s responsibility to secure health insurance, and we medics are paying a terrible price for its irresponsibility.”⁴²⁸

Responses from interviewees shed some light on the Chinese medics’ general views on their career. I found that medics had mixed feelings, with a strong sense of disappointment and tiredness. As a group with skills that can cure and save, Chinese medics are squeezed by the distorted healthcare system, medical liability reforms and growth of litigation culture. They need support, but they lack the confidence in getting their messages across, and in interacting with the state.

(2) Suffering in Silence

Looking at all the comments given by both my interviewees and in the on-line forum, the most prevalent feeling seems to be that of disappointment. But this disappointment and even anger has not led to large-scale resistance. In the face of insufficient government support and erosion of public trust, most Chinese medical practitioners do not act spontaneously, nor do they act responsively to call for change. In resolving dilemmas, medics would passively compromise their ethical beliefs for these practical reasons. As one of the interviewees put it, “Whenever I feel depressed after work, I will adjust my mood, or will I just get used to it.”⁴²⁹ The most common resort of interviewees when feeling depressed or disappointed was to turn to families or friends.

Interviewees either expressed indifference concerning their dilemmas, or told me they did not want to take risks which might lead to them losing their jobs. For these medics, even when they are dissatisfied with the system, they do not have the courage or confidence to voice their disagreements. For example, one senior doctor stated, “I tend to ignore political corruption and dictatorship. There is no need for us to react

⁴²⁷ Ding Xiang Yuan user zyent posted a comment (in Chinese, translated by author) to a discussion thread on Serial II ‘How Tired Chinese Medical Practitioners Are’, available at: <http://www.dxy.cn/bbs/thread/11302494> (Last visited on Jan 9th, 2011).

⁴²⁸ A male doctor from a Level IIA hospital, length of service: 11 years.

⁴²⁹ A male laboratory technician from a Level IIIB hospital, length of service: 6 years.

actively or to hope that we could change anything. The communist party is simply too strong.”⁴³⁰

But if someone is willing to speak up, even after considering the consequence, they might have to be prepared to give up their job. For example, one young pharmacist told me, “I don’t feel there is any need for resistance, even though the way I or my colleagues sometimes have had to practice goes against our medical ethics. I have grown up in a practical profit-driven world, and I myself am practical. Even though something is morally wrong, once we accept it as a common practice, it eventually will become a norm. I am planning to quit my job, so I dare to tell you this under-the-table truth. If you publish it one day, it will not affect me or my career.”⁴³¹

This young pharmacist further suggested that corrupt behaviour amongst Chinese medics could be perceived as a form of empowerment and resistance. He said, “I think Chinese medics are not so powerless. Economically, at least, they are seeking their power. Medical practitioners have to work very hard, thus I think they deserve decent incomes no matter where the money comes from”.⁴³² Though, personally I do not agree that corruption is justifiable behaviour, I argue that the financial benefits taken by a few medics could lead to greater long-term harm to the profession, their patients and society. Nevertheless, this comment represents the standpoint of some medics.

Most of the time during the interviews, I did not feel their pride in their work, but their indifference, silence or even fear. A few of my interviewees were still haunted by the terrible memories of the Cultural Revolution. One senior health administrator who used to be a physician said: “Medic’s voices are too low. Their influence is too limited. Yes, we have the knowledge to save lives, but that knowledge doesn’t mean power. We were deprecated in the Cultural Revolution, with Chairman Mao’s idea, we were – so called ‘chou lao jiu’”.⁴³³ Power has never been granted or gained by doctors since then. Chinese medics are passive about their careers. This does not mean

⁴³⁰ A male doctor from a Level IIA hospital, length of service: 20 years.

⁴³¹ A male pharmacist from a Level IIIA hospital, length of service: 4 years.

⁴³² A male pharmacist from a Level IIIA hospital, length of service: 4 years.

⁴³³ ‘Chou lao jiu’ means stinking ninth category (of class enemies next to landlords, reactionaries and even spies, etc). It was a term of abuse by ultra-leftists for teachers and other professional people in the 1966-1976 Cultural Revolution.

that they are less active towards patients or that they intend to harm patients. They have just lost their passion for making change.”⁴³⁴

Another doctor held similar views about Chinese medics’ impassivity. He said, “Being a doctor has not much social power. Corruption in the hospital management team acts like a protective umbrella. Even if a medic has enough courage to speak up for the public interest, he or she needs to prepare for being punished. No one wants to take the risk of losing their job by resisting in any form or by any means, because security of employment to feed the family is always a priority.”⁴³⁵ His statement answered one of my research questions, explaining why Chinese medics might feel indignant but dared not say a word in public. This comment tied in with another comment given by a doctor about the unspoken truth of an event that occurred in low level hospitals, including hospital corruption and distrust of patients:

“The trust crisis between patients and doctors is serious, especially at the lower level of hospital where I used to work. Patients always doubted our expertise and the hospitals’ medical facilities. Worse still, many hospital managers at the township and countryside levels are corrupt. They care about pleasure and money but not the further development of the hospital. By sustaining good relationships with the higher level authority, they keep their jobs. The complex problems at the lower level of the healthcare delivery system cannot be solved by government investment only. Although the government now regards China as a “rule-by-law” country, in reality, it is a people-ruled society. Social networks and personal background dominate the rules of the game.”⁴³⁶

This comment included a complex knot of factors bound up with the loss of professional power and control, especially for general medics who were working at lower level Chinese hospitals. It indicated that the difference between rich and poor hospitals was not only in their capacity to access resources, but also in how they managed ethical-financial conflict. It seemed that medics who work in the lower level hospitals have been pushed to the extremes of frustration by their working

⁴³⁴ A male doctor from a Level IIA hospital, length of service: 9 years.

⁴³⁵ A male doctor from a Level IIIA hospital, length of service: 15 years.

⁴³⁶ A male doctor from a Level IIIA hospital, length of service: 15 years.

environment, their relationships with patients, and hospital corruption. This interviewee also recognised that law, by itself, has a limited role in fixing the complex problems of China's healthcare governance. So my next question would be: what do Chinese medics expect to happen in order to untie this knot that intertwines legal, ethical, social and political problems in their professional practice?

4.2 Chinese Medics: Expectations of Changes

By the end of interviews, when asked what changes needed to be made in the future, it became clear that interviewees in the main cared about two issues: the healthcare financing system and its legislation. In terms of the healthcare financing system, interviewees said:

“I hope we will have investment from the state. Because patients are paying more for their medical service, consequently they expect more. But medical service development has increased at a slower pace. If patients can't see that their payment has resulted in a satisfactory treatment outcome, the medics will have to suffer their anger. I also expect a growth of incomes.”⁴³⁷

“The healthcare system needs to be changed. Our value hasn't been recognised by the public. As the public has to pay more to get their medical services, they have higher expectations of us. If the treatment outcome is disappointing, they will vent their anger on us. In the current system, we doctors are disappointed and helpless, while patients are vulnerable.”⁴³⁸

In Ding Xiang Yuan, the users also expressed their wishes for change to the healthcare system. Moreover, they discussed how to make their voices heard, so that the truth about what was happening could be heard by the Chinese healthcare authority. One comment said, “The health reform implemented by the Ministry of Health should not sacrifice Chinese physicians' rights and interests in exchange for their public support.”⁴³⁹ In general, medics hoped to receive more support from the

⁴³⁷ A female nurse from a Level IIA hospital, length of service: 30 years.

⁴³⁸ A male pharmacist from a Level IIIA hospital, length of service: 4 years.

⁴³⁹ Ding Xiang Yuan user zyent posted a comment (in Chinese, translated by author) to a discussion thread on Serial II 'How Tired Chinese Medical Practitioners Are', available at: <http://www.dxy.cn/bbs/thread/11302494> (Last visited on Jan 9th, 2011).

public and more government policies launched in order to ease the physical and mental suffering that Chinese medics are experiencing.⁴⁴⁰

Besides medics' requests for healthcare system reform and a more medic-friendly practicing environment, they think legislators should take medics' legal needs into consideration. In recent years, hospital violence has been increasingly fierce, claims for medical malpractice are increasing, and the problem of practicing defensive medical service is becoming obvious. In practice, there is no legal solution to end hospital violence, "we can only change our priority from saving patients to self-protection", a doctor said.⁴⁴¹ Twelve interviewees stated this similar view. Their views echoed one survey finding, that 86% (190 out of 222) of medical practitioners stated that it would be very important to involve more medical practitioners in change to China's legislation on healthcare so that the medics' rights could be better protected.

However, a senior medic commented on the Chinese political environment and criticised this idea, saying that, merely changing the legislation would not bring any differences to medics' lives, "We can't be an entirely democratic China. Society will become disorderly. As to my understanding, by reading your survey questions, your research is to propose changes in legislation. This is impractical. Like 'the Great Leap Forward' period, we aimed to chase British industrialisation and overcome America as the super power of the world. It turned out we were all day-dreaming. Changes to the political system should be a priority. China has a long history of being a power-controlled society. Chinese people have got used to this and are patriotic. We would rather not have democracy so as to keep our society in order."⁴⁴²

This interviewee referred to the history of Mao's Great Leap Forward⁴⁴³ to support his argument that reform should start from politics rather than legislation. I agreed with him, but I could not tell him that questions related to proposals for political reforms in China, was too sensitive for me to ask in the fieldwork. However, questions about the

⁴⁴⁰ See e.g., Ding Xiang Yuan user bwr20060515 posted a comment (in Chinese, translated by author) to a discussion thread on Serial II 'How Tired Chinese Medical Practitioners Are', available at: <http://www.dxy.cn/bbs/thread/11306052>; Ding Xiang Yuan user 寻医问药 posted a comment (in Chinese, translated by author) to a discussion thread on Serial II 'How Tired Chinese Medical Practitioners Are', available at: <http://www.dxy.cn/bbs/thread/11278986> (Last visited on Jan 9th, 2011).

⁴⁴¹ A male doctor from a Level IIA hospital, length of service: 9 years.

⁴⁴² A male hospital administrator who used to be a doctor, from a Level IIA hospital, length of service: 28 years. Also see note 200 on 'the Great Leap Forward'.

⁴⁴³ See note 200.

legitimacy of legislation are much less politically sensitive, thus they were put into the questionnaire. Apart from his criticism of the purpose of my fieldwork, one idea raised by this interviewee raised attracted my attention. He did not believe a democratic system would work in China, his reason being that the Western way of democracy would bring chaos to Chinese society.

This was not the only occasion that I encountered interviewees who stated expressly that they were against democracy. But their reasons for opposing it were similar, i.e. they believed democracy would bring chaos and disorder in China's stable society. One interviewee added, "From watching TV, we observed that Western democracy is making a mess of social stability. People can fight in parliament or even throw shoes at the president."⁴⁴⁴ Discussion concerning this comment would be outside the scope of this thesis. But it revealed the influence of political propaganda and the media had on Chinese people, including the medics.

In short, Chinese medics have expectations of the healthcare system and legislative reforms. They hoped they could be trusted by both the government and the patients, and supported by law. Despite heavy pressures put on them to follow the standardized hospital rules and regulations, no interviewee regarded them as a problem. But they would like to be treated more humanely and be given discretionary power to make decisions when they are capable of doing so.

Weber's definition of power is "the probability that one actor within a social relationship will be in a position to carry out his own will despite resistance, regardless of the basis on which this probability rests."⁴⁴⁵ Though none of the interviewees or Ding Xiang Yuan users have clearly stated that they would like to have more power in this healthcare arena, words like "powerless", "helpless" or "suffering" were used repeatedly in interviews so indicating their desperation for change. Moreover, Chinese medics expressed the view that they wished their voices could be heard and that more medics would engage in Chinese healthcare legislation so that their rights and interests could be better protected. In an obscure way, Chinese

⁴⁴⁴ A male hospital administrator, from a Level IIA hospital, length of service: 30 years.

⁴⁴⁵ M. Weber, *Economy and Society* (Berkeley, University of California Press, 1978), 53.

medics are looking for more control or power over their medical careers and the general healthcare environment in China.

5. Interview Findings: Summing up and Verification

In this chapter, I stressed that the Chinese medical practitioners' views and experiences of state, law and ethics were diverse, complicated, and intriguing. Voices from those medics in both formal interviews and informal conversations enhanced my understanding of my previous hypothetical questions as to what reactions Chinese medical practitioners would have towards these dilemmas.

Under current circumstances, Chinese medics were dissatisfied with the healthcare system and their medical careers.⁴⁴⁶ Though the “black market” serves to adjust the low salaries imposed by central authorities, medics who I approached in the hospitals, either informally or through interviews, admitted they wished that public health welfare was not only public in name, but also financed properly by government. Chinese medics also wished that the healthcare system reform could start from the state and focus on resources.

The interviews explored some of the existing questionnaire findings in greater depth, i.e. on medics' perceptions and resolutions to their ethical-legal and ethical-financial dilemmas. Medical practitioners' complex feelings about their own experiences, insights and constructive ideas about the impacts of healthcare governance, law and ethics on their practice were also explored in more detail.

What is more, when crosschecking my quantitative and qualitative data, I found that some qualitative interview data contradicted the previous questionnaire findings. In earlier questionnaires, four respondents held the opinion that political thoughts were very important' to their practice. However, they had contradicted themselves during interviews by expressing views that political ideologies were indeed separated from,

⁴⁴⁶ M. K. Lim, H. Yang, et al., 'China's evolving health care market: how doctors feel and what they think', 69 (2006) *Health Policy* 329-327.

irrelevant to or even useless in medical practice.⁴⁴⁷ Instances of contradiction could also be found in interviewees' clarification of their prioritised guidelines – law, ethics or political discipline. In answering the same question in the questionnaires, three respondents stated that law, ethics and political discipline were all very important without significant difference, but all held different views in the follow-up interviews.⁴⁴⁸ One respondent who stated in the questionnaire that she never had to make difficult decisions in practice was not short of ethical dilemmas in response to a similar question asked in the interview.⁴⁴⁹

There was also one occasion where a respondent's answers to the questionnaire and the interview were self-contradictory.⁴⁵⁰ Initially, she prioritised political guidance as the most important guideline to her practice; then contradicted herself by telling me in the interview that medical ethics was the most important guideline. When explaining her past experience of ethical dilemmas, she then admitted that she had to compromise her ethical understanding with orders from the authorities. This respondent also gave me contradictory answers in terms of her professional titles – in the questionnaire she stated she was a pharmacist, and then in the interview she turned out to be a nurse.

My speculations on the cause of these discrepancies between quantitative and qualitative findings are: the respondents' changes of view; their possible dilemmas with telling the truth to a researcher; and/or the giving of incorrect data by mistake. I recognise that the use of differing research methods can lead to different or even conflicting findings, but there is an increased potential for data validity and enrichment of our understanding for a wider variety of views.

This chapter tried to set out the Chinese medical practitioners' personal experiences by recording their voices directly, rather than making use of sweeping generalisations.

⁴⁴⁷ They are a female nurse from a Level IIA hospital, length of service: 36 years; a male pharmacist from a Level IIIA hospital, length of service: 4 years; a female nurse from a Level IIA hospital, length of service: 10 years; a male hospital administrator, from a Level IIA hospital, length of service: 30 years.

⁴⁴⁸ They are a male medical laboratory technician from a Level IIIA hospital, length of service: 6 years; a female nurse from a Level IIA hospital, length of service: 36 years; a male pharmacist from a Level IIIA hospital, length of service: 4 years.

⁴⁴⁹ A female nurse from a Level IIA hospital, length of service: 4 years.

⁴⁵⁰ A female nurse from a Level IIA hospital, length of service: 10 years.

I fear that my interpretation may fail to capture the full meanings and complexity behind interviewees' socio-cultural, political, and moral status, and even the full extent of the struggles behind those voices. Still, I tried to put myself in the professionals' shoes, moreover, to interpret medics' views as a researcher; to understand their unimaginable hardship, courage and weakness, the complexity of local social-political context, as well as the hope that their voices embody.

Lastly, the medical profession, like all social organisations, relies upon and is enacted with an interlocking set of factors which include language, cultural norms and expectations, and interpersonal relationships. The interview findings shed light on my previous historical and conceptual analyses, and I realise that the heart of the problem in China's healthcare governance and medical law is that in the fast economic development, the Chinese government has been trying to fix the health governance problems by increasing regulation in a piecemeal manner, whilst ignoring pressing problems that require action, e.g. the need to examine systematic deficiencies in governance and restoration of trust between medics and patients.

In the current failed system, a key element that has been paid little attention to is that Chinese medical practitioners lack leadership and a sense of cohesion, which would enable them to work together more effectively both for themselves and their patients. Chinese medics hold in their hands the power of life and death. The hybrid approach adopted by the Chinese Party-state combining legal and ethical campaigns to regulate and educate health providers, demonstrated institutional constraint and an authoritarian regime. Under such a regime, Chinese medics will find it even more difficult to gain the necessary voice required to enable change. Without the active participation of the Chinese medical practitioners, there is a slim chance of success for China's healthcare governance reforms.

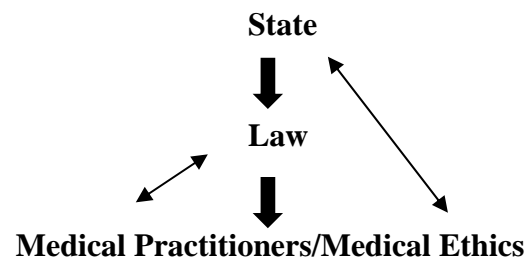
CONCLUSION TO PART TWO: HYPOTHESES EVALUATION AND DISCUSSION

1. Hypotheses Evaluation

Having discussed both the survey and interview findings, it is necessary to revisit the initial hypothesis concerning how medics prioritise law, political ideology, and medical ethics. The empirical research has not only demonstrated that law is the most important instrument for Chinese medics, but also explained their motivation, confusion and ethical dilemmas. It seemed that “right or wrong” tended to be less important to medics than the security of their jobs. They seemed not to have a clear understanding about their possible role in influencing law or law-making. Some of them did not even care. They paid most attention to instructions given either by law or by a hospital mandate. Breaking either set of instructions risked the loss of jobs. What was more, cultural acceptance contributed to their silence. The submission of the individual to the state conformed most closely to the stereotype of the captive practitioner. A large scale of resistance, therefore, would be less likely to happen amongst Chinese medical practitioners.

The state’s influence over “ethics” has been enormous. This influence was not only seen from the bulletin board information provided by Party branches, but also from medics’ own viewpoints and their understanding of medical ethics as part of a commitment to the state and its political ideology. Their unfamiliarity with varying international moral viewpoints highlighted their lack of extended experience from a variety of moral angles. Taking away other choices may not necessarily have led to an increase of faithfulness towards one prevailing ethical source, but lack of choice could be dangerous to an intellectual group of experts. The Chinese Medical Association does not function independently by representing the associational power of a professional group or corporate body, but rather like an instrument of control over health personnel. Its major function is to protect the interests of state first and its members second.

To sum up, the model below outlines the relationship between state, law and medical practitioners in China.



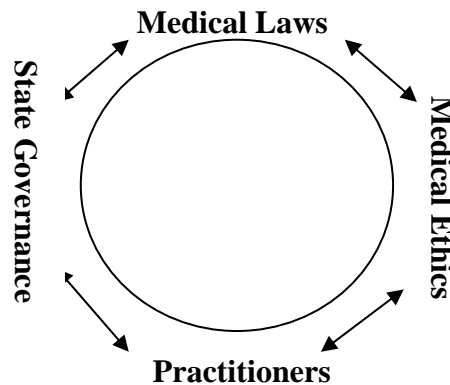
In the West, healthcare power dynamics has evolved from a model of governance which is more bottom-up democratic, humanistic, empowering, and based on decentralised decision making. In contrast, in my opinion, the Chinese healthcare power structure reflects a top-down, authoritarian model with centralised command and control. The authorisation of state intervention is obviously the strongest element within the relationship between state, law and medics (and their ethics). The empirical investigations have contributed to an enhanced understanding of the medical practitioners' position in China's healthcare power dynamic: i.e. they are based at the bottom; however this does not mean Chinese medics have absolutely no sense of resistance. The findings of this empirical study verify the top-down structured hypothesis offered at the end of Part I.

2. New Ideas

As well as supporting my hypothesis, more importantly, this empirical research has revealed new findings. One important finding that needs further attention is that different levels of medical institution and healthcare practitioners are taking law seriously. Chinese medics said bioethics (or professional morality) was very important. However, in practice, they did not follow their professional ethics, but law. As discussed in Part One, law and policy in China are essentially political. Further empirical study found that hospitals' Party branches acted as a main source for training Chinese medics about medical laws and bioethics.

In my pilot study before the survey, one of the medics who read my questionnaire told me directly she did not understand the point of my questions: "Since we have to follow whatever we are told, discussing which guidance is more important than the

other is simply meaningless.” In medics’ eyes, there seems to be no clear divide between state governance, medical laws and bioethics in China. A circle-like relationship is drawn as below to show this new finding:



This circular relationship is based on my interpretation of the Chinese medics’ perceptions of state governance, medical law and bioethics. Findings from my empirical study show the high level of legal consciousness within most Chinese medics, therefore I highlight this at the top of the circle. By disregarding ethics or morality, Chinese medical practitioners seem only to follow law in resolving ethical-legal dilemmas. At the same time, the state has never loosened its control on the medics’ ethical and legal education. Most of the respondents admitted that CCP branches were working alongside their hospital managers. Although some medics seemed to believe political discipline did not have a significant impact on their professional practice, in general, the empirical study found that political propaganda was mixed with law and bioethics in hospitals’ training sessions. The multi-functional nature of the Party branch symbolises its power and potential influence. It seems, at least, that there is no a clear divide between state governance, medical laws and bioethics at the educational level.

3. Summing up Empirical Findings

The following points constitute a summary of my research findings from both the survey and follow-up interviews. The survey found that:

- Medics prioritised the authority of law (as most important) over ethics (2nd most important) or political discipline (least important);

- Their main motive for prioritising law was to protect themselves from being sued;
- Most medics had experienced after-work depression. The main causes of their depression were low incomes and loss of trust from patients;
- Most medics thought the effect of China's market-led healthcare system caused conflict between medics and the public. They thought medical legislation affected professional autonomy and caused ethical-legal dilemmas.
- The CCP has easy accessibility to most medics and it coordinates with hospital management teams;
- Medics expected or hoped that more of them could be involved in medical law-making.

The interviews found that:

- In terms of comprehension of guidance, the Chinese medics' bioethical understanding has either been influenced by social values or hospital ethics examinations. Medical law, party disciplines and hospital moral norms are mainly taught through on-the-job trainings;
- In practice, priority was given to legal guidance even though for some of them ethics was their stated priority in the beginning;
- Both legal-ethical and financial-ethical dilemmas existed in their practices;
- Medics hoped for more change in the healthcare financing system and legislation.

After discussing the position of Chinese medical practitioners from a historical (literature review) and a contemporary perspective (empirical study), the next three chapters, which form Part III of this thesis, turn to a closer examination of what I argue is the root problem – deprofessionalisation. Questions to be answered in Part III are, how could a powerful elite like the medical practitioners in China, seldom question but most of time accept any state intervention in their practice? Is it problematic for medics to have lost control over their professional practice? If this is a problem, what should be done to tackle it?

PART THREE

DISCUSSION AND SUGGESTIONS:

FACING UP TO THE PROBLEM AND

LOOKING TO THE FUTURE

CHAPTER 7 DEPROFESSIONALISATION

1. Introduction

The empirical studies in Chapters 5 and 6 presented the view of Chinese medical practitioners of state governance, law and ethical guidelines. Within the present social and economic situation in China, evidence has shown that not only do most Chinese medics accept the state's control over medical practice through healthcare governance, regulation, political and ethical education, but they also have experienced the dilemmas caused by ethical-financial and ethical-legal conflicts. After discussing the position of Chinese medical practitioners from both a historical and contemporary perspective, Part Three of this thesis seeks an answer to the question – how could a powerful elite like the medical profession in China, seldom question, and mostly accept passively, any state intervention in their practice?

The purpose of this chapter is to contextualise the analysis in Part One (Theoretical and Historical Background) and the findings in Part Two (Empirical Studies). In particular, it undertakes a closer examination of political motives and the context of medical deprofessionalisation in China. From the perspective of the top-down power of state, it starts by analysing theories of bio-politics, bio-power, medicalisation and instrumentalisation. It concludes from the analysis that there is a trend towards deprofessionalisation amongst China's medical practitioners.

This chapter is divided into three sections: First, a discussion is framed in terms of Foucault's bio-politics and bio-power theories, and their developing theory – medicalisation. Secondly, it ponders relationships between the state and medical professionals in the context of medicalisation and biopolitics; and considers political instrumentalisation as their adverse consequence. Thirdly, this chapter maps this view from the Chinese medical practitioners' perspectives, and includes two case studies, in order to offer more insight and to assess the context of medical deprofessionalisation in China. The central argument of this chapter is that, in the face of the challenges posed by the state, Chinese medical practitioners have lost their professional power

and autonomy in safeguarding the public interests. Therein lies their need to be relocated into a more professional and responsible role.

2. State: Bio-politics and Medicalisation

Michel Foucault's analyses offer a methodological direction and a perspective that links medicine and politics. He recognises that "society's control over individuals was accomplished not only through consciousness or ideology but also in the body and with the body. For capitalist society, it was biopolitics, the biological, the corporal, that mattered more than anything else".⁴⁵¹ Even though Foucault's theories refer to a capitalist society, Foucauldian approaches are helpful in understanding the politics of life at the collective level in China. They shed some light on the bio-political situation and its effects on Chinese medics that have rarely been explored.

I begin this section by clarifying how I use key Foucauldian terms such as "bio-politics" and "bio-power". Being careful to note that there might be incompatibilities and differences between Foucault's concepts and the situation in China, I address the question of what relevance Foucault could possibly have to the Chinese context and indicate how his theories might inform a macro level understanding of medical deprofessionalisation in China.

2.1 Bio-politics and Bio-power

Bio-politics was first introduced by Roberts to stress a notion that life appears as the object of political strategies during a historical process.⁴⁵² Foucault reinterprets the notion "bio-politics" in his work. Since *Birth of the Clinic*,⁴⁵³ then the lectures given at the Collège de France,⁴⁵⁴ and lastly with *the History of Sexuality*,⁴⁵⁵ he argues that

⁴⁵¹ M. Foucault, 'The Birth of Social Medicine', *Power: Essential Works III 1954-1984* (New York, New Press, 2001), 137.

⁴⁵² M. Roberts, *Bio-Politics: An Essay in the Physiology, Pathology, and Politics of the Social and Somatic Organism* (London, Dent, 1938).

⁴⁵³ M. Foucault, *The Birth of the Clinic*, first published by Naissance de la in 1963 (London, Routledge, 2003).

⁴⁵⁴ M. Foucault, *Society must be Defended: Lectures at the College de France, 1975-1976*, translated by D. Macey (New York, Picador, 2003).

⁴⁵⁵ M. Foucault, *History of Sexuality, Vol. I: the Will to Knowledge* (Paris, Gallimard, 1976), 'Part Five: Right of Death and Power over Life'.

bio-politics represents the emergence of new forms of power-knowledge primarily concerned with life.

The attempt to understand how medical questions came to be articulated as social problems led Foucault to examine the tension between bio-politics and populations. Since “population” in the West arose as a central domain of modern power, bio-politics emerges around the processes of administration and optimisation of the health of the population.⁴⁵⁶ He explained “the interest of governmental power in the life of the governed in terms of a *politics of health*.”⁴⁵⁷ Bio-politics, understood as a government-population-political economy relationship, refers to the power dynamics which “coordinates, institutionalizes, stratifies and targets” the population.⁴⁵⁸ In other words, it could be understood as the political mission of a government to take control of anything related to the reproductive capacity of bodies, and related to the population’s health, birth, and morality.⁴⁵⁹ In a more specific sense, regulation of customs (e.g. drinking/smoking/even eating habits), of “well-being”, of disease and epidemics, of the policing of water, sewage, foodstuffs, graveyards, and of reproductive practices are examples of bio-politics – “administering life”.⁴⁶⁰

Politics has long been concerned with the interests and lives of those whom it governed. According to Fehér and Heller, hygienic prescriptions and health regulations were closely intertwined with religious ritual in every pre-modern arena.⁴⁶¹ In Aristotle’s view, human beings must be subject to the authority of the city-state in order to attain the good life.⁴⁶² Foucault writes: “The way in which a rationalization was attempted, dating from the eighteenth century, for the problems posed to governmental practice by the phenomena specific to an ensemble of living

⁴⁵⁶ M. Foucault, *History of Sexuality, Vol. I: An Introduction* (London, Penguin, 1979).

⁴⁵⁷ N. Rose, *The Politics of Life Itself: Biomedicine, Power, and the Subjectivity in the Twenty-First Century* (Oxford, Princeton University Press, 2007), supra n.3; also cited by R. Ciccarelli, ‘Reframing Political Freedom in the Analytics of Governmentality’, 19 (2008) *Law and Critique* 307-327.

⁴⁵⁸ Ibid.

⁴⁵⁹ See note 456, at 139.

⁴⁶⁰ Ibid, 138.

⁴⁶¹ F. Fehér and A. Heller, *Biopolitics* (Aldershot, Avebury, 1994), 63.

⁴⁶² Stanford Encyclopedia of Philosophy (SEP), ‘Aristotle’s Political Theory: Presuppositions of Aristotle’s Politics’, (July 2002), available at: <http://plato.stanford.edu/entries/aristotle-politics/supplement2.html> (Last visited on Sep 17th, 2008).

beings: health, hygiene, birth rate, longevity, races...”⁴⁶³ In short, according to Foucault, what was central to the politics of health in the 18th century was the emergence of governance in health and population well-being.

From the nineteenth to mid-twentieth century, bio-politics tried to manage the quality of the population. It turned to regulation of customs, habits, reproductive practices, family, blood, etc. Indeed, the Nazi regime, in its attempts to racially “purify” the population, brought bio-politics to a point that had never been reached before. China’s One-Child Policy is another controversial example of population control (which I will address in detail shortly). The last half-century has witnessed the dynamics of biotechnical development, and bio-political strategies have been modified along with these changes.⁴⁶⁴ As some scholars predicted, we are entering “a biotech century – an age of marvellous yet troubling new medical possibilities.”⁴⁶⁵ The rapid advance of biotechnology, genetic screening, reproductive technologies, organ transplantation, genetic modification of organisms, new drugs, even the possibility of the medical use of stem cell research, etc, have sparked heated ethical debates amongst politicians, regulators, theologians, ethicists, philosophers, and others.

In the field of bio-politics, bio-power is not a single power which is confined to the territory of medicine alone, but a power-field comprised of interacting, agonistic powers in strategic relation to each other. This power-field can be interpreted as a power that involves increasing organisation of human life by bureaucratic, legal, and administrative means. Though bio-power is not a true source of power that has capacity to legislate or legitimate, it is the characteristic form of power in modern society where life itself becomes the central object. “It was life more than the law that became the issue of political struggles, even if the latter were formulated through affirmations concerning rights.”⁴⁶⁶

⁴⁶³ M. Foucault, ‘History of Systems of Thoughts, 1979’, 8 (1981) *Philosophy and Social Criticism* 3, 352-360, 353.

⁴⁶⁴ See note 457.

⁴⁶⁵ See note 457, introduction.

⁴⁶⁶ M. Foucault, ‘Part Five: Right of Death and Power over Life’, *History of Sexuality, Vol. I: An Introduction* (London, Penguin, 1979), 145.

Foucault uses the term bio-power to describe 20th century “political strategies” which “lay further stress on the proliferation of political technologies that ensued, investing the body, health, modes of subsistence and habitation, living conditions, the whole space of existence.”⁴⁶⁷ Rose further defines contemporary bio-power as “a sum of policies of life in which the state devolves its power to near-autonomous legislative organs (for example, bioethical commissions; private companies like fertility clinics; biotechnological multinationals, which sell products like genetic tests direct to consumers; and professional groups such medical associations, regulated at a distance by complex mechanisms of certification, standards, bench-marketing and balances).”⁴⁶⁸ (It should be noted that this is not what has happened in China. The relevant issues will be dealt with shortly).

Although Foucault’s writings on bio-power were fragmentary, his concepts have inspired the development of studies on the politics of life in the modern era.⁴⁶⁹ The Foucauldian approach allows us to think about shifting social movements and the struggles of the governed. They are also helpful for our understanding of the phenomenon of resistance that occurs in Western societies. However, there are limits on the Foucauldian notion of bio-power. Calhoun argues that Foucault’s theories cannot achieve historical specificity or grasp the particular traits of different cultures.⁴⁷⁰ Applying Foucault’s approaches to China poses challenging questions of political contextual relevance.

As regards political structures, power is more centralised in China than in many modern Western countries. Foucault’s claim in 1976 – “power would no longer be dealing simply with legal subjects whom the ultimate domination was death, but with living beings, and the mastery it would be able to exercise over them would have to be

⁴⁶⁷ Ibid, 143-144.

⁴⁶⁸ See note 457.

⁴⁶⁹ The terms ‘biopower’ and ‘biopolitics’ have been used by two of our leading contemporary philosophers – Giorgio Agamben and Antonio Negri who have made these terms central to their critical analyses of politics. See e.g., G. Agamben, *Homo Sacer* (Stanford, Stanford University Press, 1998); G. Agamben, ‘Form-of-Life’, in P. Virno and M. Hardt (ed), *Radical Thought in Italy* (Minneapolis, University of Minnesota Press, 1996), 151-156; M. Hardt and A. Negri, *Empire* (Cambridge, Harvard University Press, 2000); M. Hardt and A. Negri, *Multitude: War and Democracy in the age of Empire* (London, Penguin, 2004).

⁴⁷⁰ C. Calhoun, *Structure of Power and Constraint* (Cambridge, Cambridge University Press, 1990); C. Calhoun, *Critical Social Theory* (Oxford, Blackwell, 1995); S. Verma and A.K. Pandey, ‘Knowledge, Power and Culture: Towards a Critical Perspective’, 11 (2009) *Journal of Social Science* 1, 159-166.

applied at the level of life itself; it was the taking charge of life, more than the threat of death, that gave power its access even to body.”⁴⁷¹ – directs no attention to the Chinese government’s direct special control of its population. The same is true of his notion of bio-politics, which was developed mainly as a critique of liberal governance and the consequence of modern power. China is not yet a liberal state, but far from making Foucault’s ideas irrelevant, this thesis embraces Foucauldian notions calling for liberal modes of governance and acknowledges that power needs to be balanced. I propose ways of dispensing power and a mechanism for realising the professionals’ self-ownership of power and responsibility (more discussions in Chapter 9).

Another concern of relevance arises from the level of analysis. Foucault critiques medical discourse and bio-politics at the macro-level of state, the regulation of the population, or social body; I am interested in examining Chinese medics’ perceptions and causes of medical deprofessionalisation in China, which is more at the micro level of an individual professional group, and at its self-disciplinary and institutional control. But different analyses can be complementary rather than contradictory. Applying a top-down approach – by showing how state power is exercised and internalised in medicine, as well as how the control of the medical profession in China is achieved through the production of various disciplines from political, social, cultural, legal and institutional channels – I aim to create an overall account of the evolution of state-achieved bio-political power over Chinese medical practitioners at both *macro* and *micro* levels.

Therefore despite these apparent incompatibilities, the Foucauldian bio-political approach and the mechanisms used by the Chinese government to govern its population, do converge in some respects. Foucault’s ideas provide insights for analysing power relations in health governance. Taking a bio-political approach broadens our appreciation of the role of the Chinese government in governing its population and its effect on medical practitioners. The concept of bio-power that emerges from Foucault’s investigation of bio-politics indicates that power arose from modern techniques to create “a new bio-politics around the administration and

⁴⁷¹ See note 466, at 143.

optimization of the process of life.”⁴⁷² As I will argue later, these elements also exist in the discourse of China’s bio-politics, especially in governing China’s population. Adopting Foucault’s analytical approach thus offers a wider and deeper perspective which allows us to probe more generally central questions related to professional governance in Chinese healthcare politics and of medical deprofessionalisation.

In short, Foucauldian bio-politics and bio-power refer to a broad range of relations between the forces that extend throughout the social body, governing “the management of towns and routes, the conditions of life (habits, diet, etc), the number of inhabitants, their life span, their ability and fitness for work”.⁴⁷³ To narrow down the concepts of bio-politics and bio-power, the next section discusses a more medically focused theory developed from Foucault’s – medicalisation.

2.2 Medicalisation

Having discussed the concepts of bio-politics and bio-power – the political strategies of the power field, this section directs attentions to medical jurisdiction, which has expanded in recent years and now encompasses many problems which hitherto were not defined as medical issues. The increasing use of medicine as a channel to understand social problems represents medicalisation as – “a process whereby more and more of everyday life has come under medical dominion, influence and supervision.”⁴⁷⁴ Alcoholism, obesity and mental disorders are examples of medicalising social problems.

This section begins by briefly reviewing the development of medicalisation in Western society, followed by an exploration of its causes and effects. It then focuses on the relevance of the term ‘medicalisation’ to the Chinese context, especially on how this conception links the previous discussions of bio-power and bio-politics to

⁴⁷² S. Greenhalgh et al., *Governing China’s Population: from Leninist to Neoliberal Biopolitics* (Stanford, Stanford University Press, 2005), 6.

⁴⁷³ M. Lazzarato, ‘From Biopower to Biopolitics’, 2 (2002) *Tailoring Biotechnologies* 2, 11-20.

⁴⁷⁴ P. Conrad, ‘The Discovery of Hyperkinesis: Notes on the Medicalization of deviant Behavior’, 23 (1975) *Social Problems* 12-21, 12; P. Conrad, ‘Medicalization and Social Control’, 18 (1992) *Annual Review of Sociology* 209-232.

the next section – the examination of political instrumentalisation of medicine in China.

Pasquino suggested that, in the 20th century, a great campaign of medicalisation was launched across Europe.⁴⁷⁵ The commentary given by the Dean of a Catholic University in 1969 on the revival of witchery on a college campus indicates the shift in handling social problems,

“We’ve really become progressive around here. A couple of hundred years ago we would have burned them. Twenty-five years ago I would have expelled them. Now we simply send them all to psychiatrists.”⁴⁷⁶

Indeed, although Foucault may not use the term ‘medicalisation’, he has analysed changes from non-medical to medical definitions and their treatment in *the Birth of the Clinic*⁴⁷⁷, *Madness and Civilization*⁴⁷⁸, and *Discipline and Punish*⁴⁷⁹. Foucault shows that people who incarcerate others for “madness” gain power and control.⁴⁸⁰ One of Foucault’s followers’ central contentions is that “society is medicalised in a profound way, serving to monitor and administer the bodies of citizens in an effort to regulate and maintain social order as well as promoting good health and productivity.”⁴⁸¹ Medical interventions in dealing with social problems exist in many countries, including China (I will explain this in detail shortly). Critics argue that we are experiencing a medicalisation of social problems, arguing that medics are intruding into moral and political matters.⁴⁸²

⁴⁷⁵ P. Pasquino, ‘Theatrum Politicum’: the Genealogy of Capital – Police and the State of Prosperity, in G. Burchell, et al. (ed), *The Foucault Effect: Studies in Governmentality* (England, Harvester Wheatsheaf, 1991), 116.

⁴⁷⁶ Reported in the *New York Times*, 1969, cited by I. K. Zola, ‘In the Name of Health and Illness: on some Socio-political Consequences of Medical Influence’, 9 (1975) *Social Science Medicine* 83.

⁴⁷⁷ M. Foucault, *The Birth of the Clinic*, first published by Naissance de la in 1963 (London, Routledge, 2003).

⁴⁷⁸ M. Foucault, *Madness and Civilization* (New York, Random, 1965), 239.

⁴⁷⁹ M. Foucault, *Discipline and Punish: The Birth of the Prison* (London, Allen Lane, 1977).

⁴⁸⁰ See note 478.

⁴⁸¹ D. Lupton, ‘Foucault and the Medicalisation Critique’, in A. Peterson and R. Bunton (eds) *Foucault Health and Medicine* (London, Routledge, 1997), 100.

⁴⁸² I. K. Zola, ‘Medicine as an Institution of Social Control’, 20 (1972) *Sociological Review* 487; I. K. Zola, ‘In the Name of Health and Illness: on some Socio-political Consequences of Medical Influence’, 9 (1975) *Social Science Medicine* 83; also cited by S. J. Williams and M. Calnan, ‘The ‘Limits’ of Medicalization?: Modern Medicine and the Lay Populace in ‘Late’ Modernity’, 12 (1996) *Social Science Medicine* 1609-1620.

With regard to the causes of medicalisation, one side of the argument considers medicalisation to be the result of broader social processes to which medical professionals are merely passively responding. Take Illich for example. He developed his original critique of medicalisation in the mid-1970s, in which he highlighted that as part of the wider process of industrialisation and bureaucratisation, medical professionals have taken away the public's right of self determination, especially in the situations of death and dying.⁴⁸³

The other side of the argument perceives that the tendencies of medicalisation to offer many aspects of life are mainly due to medical professionals' quest for power and control.⁴⁸⁴ Freidson notes that professional dominance and monopolisation have had a significant role in giving medicine jurisdiction over virtually anything to which the label "health" or "illness" could be attached.⁴⁸⁵ Pawluch agrees with this by giving a well-researched historical example to provide an insight – the changing focus of paediatrics in a changing social environment.⁴⁸⁶ His research shows that paediatricians were able to adapt their orientations to maintain their practices when there were fewer sick children by becoming "baby-feeders" and new "behavioural paediatricians" "treating" children's troubled behaviours.⁴⁸⁷ Pawluch's accounts echo what Clark says,

"We have grown used to speaking of medicalisation as a byword for all things negative about the influence of modern medicine on life and society. The term has become synonymous with the sense of a profession reaching too far: into the body, the mind, and even the soul itself."⁴⁸⁸

⁴⁸³ I. Illich, *Limits to Medicine – Medical Nemesis: The Expropriation of Health* (Penguin, Harmondsworth, 1976); also cited by S. J. Williams and M. Calnan, 'The 'Limits' of Medicalization?: Modern Medicine and The Lay Populace in 'Late Modernity'', 42 (1996) *Social Science and Medicine* 12, 1609-1620; D. Clark, 'Between Hope and Acceptance: the Medicalisation of Dying', 324 (2002) *British Medical Journal* 7342, 905-907.

⁴⁸⁴ E. Freidson, *Professional Dominance: The Social Structure of Medical Care* (New York, Atherton Press, 1970).

⁴⁸⁵ E. Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (New York, Dodd, 1970).

⁴⁸⁶ D. Pawluch, 'Transition in Paediatrics: a Segmental Analysis', 30 (1983) *Social Problems* 449-65; also cited by P. Conrad, 'Medicalization and Social Control', 18 (1992) *Annual Review of Sociology* 209-222.

⁴⁸⁷ Ibid.

⁴⁸⁸ D. Clark, 'Between Hope and Acceptance: the Medicalisation of Dying', 324 (2002) *British Medical Journal* 7342, 905-907.

Looking at both sides of the argument in terms of the causes and nature of medicalisation, I argue that medicalisation would move into the jurisdiction of the medical profession whether medics themselves were directly involved or not. And I agree with Conrad who says that medicalisation “consists of defining a (non-medical) problem in medical terms, using medical language to describe a (non-medical) problem, or using a medical intervention to ‘treat’ it ... This is a socio-cultural process that may or may not involve the medical profession, lead[ing] to medical social control or medical treatment, or be the result of intentional expansion by the medical profession.”⁴⁸⁹ Osborne further suggests that we “replace the negative language of ‘medical monopoly’, ‘medicalisation’ or ‘medicine as an instrument of social control’ with a more positive form of explanation that would be concerned, not with a critique of medical power, but ... with the ways that such programmes are tied or seek to tie themselves to wider rationalities of government”.⁴⁹⁰ This is the position I hold in this thesis. What is more, I will argue that medical deprofessionalisation and medicalisation could happen at the same time.

There is a substantial literature about debates on, or critiques of, medicalisation, concerning the relationship between medicine and lay people and the expansionist tendencies of medicine in the West.⁴⁹¹ However, one seldom finds the term ‘medicalisation’ used in the literature relating to underdeveloped countries, partly because, it is a concept introduced by Western scholars who assume that medicalisation benefits medical professionals who are mainly based in the West. It might also be because, if one views medicalisation narrowly as “what doctors actually control and do”, then for medical professionals from underdeveloped countries whose

⁴⁸⁹ P. Conrad, ‘Medicalization and Social Control’, 18 (1992) *Annual Review of Sociology* 209-232.

⁴⁹⁰ T. Osborne, ‘Security and Vitality: Drains, Liberalism and Power in the Nineteenth Century’, in A. Barry, et al. (ed), *Foucault and Political Reason* (London, University College London, 1996), 99.

⁴⁹¹ See note 489; also see P. Conrad, ‘The Discovery of Hyperkinesis: Notes on the Medicalization of deviant Behavior’, 23 (1975) *Social Problems* 12-21; A. T. Scull, ‘From Madness to Mental Illness: Medical Men as Moral Entrepreneurs’, 16 (1975) *European Journal of Sociology* 218-61; S. J. Pfohl, ‘The Discovery of Child Abuse’, 24 (1977) *Social Problems* 310-323; J. W. Schbeide, ‘Deviant Drinking as a Disease: Deviant Drinking as a Social Accomplishment’, 25 (1978) *Social Problems* 361-372; I. Illich, *Medical Nemesis* (New York, Pantheon, 1976), 294; P. Conrad and J. Schneider, ‘Looking at Levels of Medicalization: A Comment on Strong’s Critique of the Thesis of Medical Imperialism’, 14 (1980) *Social Science and Medicine* 75-79; I. K. Zola, ‘The Medicalization of Aging and Disability’, in *Advances in Medical Sociology* (Greenwich, JAI, 1991), 299-315; S. J. Williams and M. Calnan, ‘The ‘Limits’ of Medicalization?: Modern Medicine and The Lay Populace in ‘Late Modernity’’, 42 (1996) *Social Science and Medicine* 12, 1609-1620; J. E. Davis, ‘How Medicalization Lost Its Way’, 43 (2006) *Society* 6, 51-56.

medical power has not yet reached maturity, medicalisation simply would not be a problem.

The reason why this thesis applies the term ‘medicalisation’ to the Chinese context is because I see this as a complex phenomenon. It encompasses more than the doctor-patient interaction. Medicalisation could also happen merely because the state wants to use medicine as one of its social control mechanisms. But if medical practitioners have to do what they are asked to do in the state’s interest, then in these circumstances, medical professionals would be disempowered rather than empowered. But this would, nonetheless, still be an example of medicalisation. This thesis views medicalisation in a broad sense and argues that the use of medicine is not only for medical professionals’ benefit or patients’ interest; it can also serve other purposes, such as the state’s interests.

According to Zola, in war time, physicians were put in the position of choosing between the best goals of treatment and rehabilitation and the “war effort”, and all too often, medical practitioners had to sacrifice the long term health of their patients to the short term goal of the army commander.⁴⁹² When the roles which medical professionals play in medicalisation are passive, it is the state interest behind the medicalisation movement which prevails. In this case, medical practitioners no longer take the lead to extend their jurisdiction but serve as the state’s instruments of social or political control. This is how medicalisation happens in China. My argument is that, in the name of health and the control of illness, medicalisation – potential uses and abuses of medical techniques and discoveries by the state through the medical profession – would unavoidably cause moral dilemmas for physicians. It thus raises the obvious question as to how these dilemmas are to be resolved. Indeed whether the medical profession is sufficiently empowered to resolve them in ways other than quietly following the will of the state.

Instrumentalisation and deprofessionalisation will be discussed in the next section, followed by analyses of two cases – both reflect issues of medicalisation, instrumentalisation and deprofessionalisation in China. The case studies to be

⁴⁹² I. K. Zola, ‘In the Name of Health and Illness: on Some Socio-political Consequences of Medical Influence’, 9 (1975) *Social Science Medicine* 83.

discussed shortly provide examples of the Chinese government's bio-political strategies as well as Chinese medics' instrumentalisation and deprofessionalisation, where technology and knowledge are serving as a means for political ends.

3. State and Profession: Instrumentalisation

Previous discussions of bio-politics and medicalisation have shown the lack of separation between politics and medicine. When a professional group is politically integrated and not independent, biomedical techniques are even more likely to be used to solve the state's social and political problems. The aim of this section is to provide a critical appraisal of the political instrumentalisation of medicine in China. In particular, I will address two questions: firstly, how are medical professionals entangled in the state's political activities and secondly, how does the state's medicalisation strategy affect their professional judgement and ethics?

3.1 The Political Instrumentalisation of Chinese Medical Practitioners

According to Hivon, the concept of instrumentalisation is “a process through which the user places the artefact in his/her hand and personalises it. Often seen as a *misuse* of the functions for which it is designed.”⁴⁹³ In my opinion, instrumentalisation means a process in which one subject is used for serving purposes other than those for which it was originally intended. The prohibition of the “instrumentalisation” of human subjects is widely referred to in bioethical debates. Conceptions of instrumentalisation in the bioethical context borrow heavily from the Kantian imperative – “never treat people merely as a means to an end”.⁴⁹⁴ In contrast to the non-instrumentalisation principle in bioethics, the meaning of instrumentalisation in this thesis is the control of medics by outside actors, e.g. parties, politicians, social groups or movements, or

⁴⁹³ L. Hivon, et al., ‘From network of Calculators to Collaborative Knowledge Construction in the Class’, (2008) *Repères - IREM*, 72(1), 79-102, 13.

⁴⁹⁴ In contrast with instrumentalisation, Western conceptions of respect and, specially, the principle of respect for persons is influenced heavily by the 18th century philosopher, Immanuel Kant. In his celebrated work *Fundamental Principles of the Metaphysic of Ethics*, Kant prescribes the practical imperative: “So act as to treat humanity, whether in thine own person or in that of any other, in any cases of as an end withal, never as means only.” This practical imperative has been translated to mean that people should always be treated as ends to themselves, and never as mere means (for instance, as objects) to the ends of others. See, I. Kant, translated by. L. W. Beck, *Foundations of the Metaphysics of Morals* (New York, Macmillan, 1959 [1785]), 56.

economic actors seeking political influence, who use them to intervene in the world of politics.⁴⁹⁵ I use the term instrumentalisation to refer specifically to political instrumentalisation in this thesis.

Both the population management strategy and the control of psychiatric practices show the power of the political regime in China, which decides its forms of intervention differently to its contemporary Western counterparts. Weak consensus on medical ethics and limited development of professional self-regulation reflect the fact that healthcare workers in China have, to a significant extent, not been members of autonomous institutions, but have been ruled by politicians. Within the conflicts over medical professional autonomy and “instrumentalisation” of medicine, there is a strong sense of deprofessionalisation.

We witness that, from both historical and empirical studies, Chinese medical practitioners have a relatively high tendency to cooperate with the Chinese government’s bio-politics. As Beetham says,

“If power is one person’s ability to achieve their purposes through others, then it cannot be a matter of capacities and resources alone, but all depends on the degree of the others’ willingness to cooperate. And that willingness cannot be sufficiently created by incentives and sanctions on their own; it depends on the normative status of the power holder; and on normative considerations that engage us as moral agents.”⁴⁹⁶

However, there appears to be a general understanding that the medical profession should not to be the subject of political instrumentalisation. We would expect medical professionals, not merely to accept the consequence of governmental desire, but rather that they would show possible conflict “between the aims and desires of government and the norms of the domain to be governed”.⁴⁹⁷ Possible conflict does exist. In the empirical studies, I discovered there is a high percentage of dissatisfaction from medical practitioners toward their working conditions, either due to the financial stress, to doctor-patient relationships, bureaucracy or simply the stress of the work

⁴⁹⁵ See e.g., D. C. Hallin and P. Mancini, *Comparing Media Systems: Three Models of Media and Politics* (New York, Cambridge University Press, 2004).

⁴⁹⁶ D. Beetham, *The Legitimation of Power* (New York, Palgrave, 2003), 38.

⁴⁹⁷ P. M. Strong, *The Alcoholic, the Sick Role and Bourgeois Medicine*, paper given at the Medical Sociology Conference, Warwick; also cited by D. C. Hallin and P. Mancini, *Comparing Media Systems: Three Models of Media and Politics* (New York, Cambridge University Press, 2004).

load. The fieldwork findings indicate that there is not an absolute acceptance of bio-politics among Chinese medics, though there is a strong political influence and a lack of autonomy in their practice. This finding affirms Foucault's notion of power and resistance: "Where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power."⁴⁹⁸ (More detail discussions about the notion of resistance will be given in Chapter 8)

3.2 Examples of Medicalisation and Political Instrumentalisation in China

I want to continue the current argument – political instrumentalisation is likely to happen when medical professions are too powerless to follow their professional ethics – with two case studies, which I hope will illuminate part of the Chinese bio-political realities and their "side-effect" on medical professionals: medicalisation and instrumentalisation. Of the two cases below, the first example is about the One-Child Policy and family planning legislation; the other is about the politically-controlled psychiatric units.

(1) Case Study I: The One-Child Policy and the Population and Family Planning Law

China's population policy has been implemented very effectively since the late 1970s.⁴⁹⁹ Chinese population policies were unique in two crucial ways. Firstly, China approached limiting population growth as a matter of state planning of births. Secondly, in the early stages of the policy, Chinese politicians attempted direct state intervention, not only in the number of children allowed to each couple, but also by the timing of marriage, the initiation of childbearing, and the spacing between children (where the couple was allowed to have more than one child).⁵⁰⁰

⁴⁹⁸ M. Foucault, *The History of Sexuality, Vol. 1: An Introduction* (New York, Vintage, 1980), 95.

⁴⁹⁹ Compared with 1970, in 1994 China's birth rate dropped from 33.43 per thousand to 17.7 per thousand; the natural growth rate, from 25.83 per thousand to 11.21 per thousand; and the total fertility rate of women, from 5.81 to around 2. See e.g., Permanent Mission of P.R. China to the United Nations Office at Geneva and Other International Organisations in Switzerland, *Family Planning in China*, available at: <http://www.china-un.ch/eng/bjzl/t176938.htm> (Last visited on May 1st, 2008).

⁵⁰⁰ S. Greenhalgh et al., *Governing China's Population: from Leninist to Neoliberal Biopolitics* (Stanford, Stanford University Press, 2005), 38-42.

“Despite its indigenous political philosophies, its long history of imperial bureaucracy, and its more recent revolutionary history of Maoist socialism”,⁵⁰¹ bio-politics has seldom been discussed in Chinese studies until the advent of modern medical developments. In China, with the well-known One-Child Policy and its subsequent legislation *the 2001 Population and Family Planning Law*, medical decisions went beyond a private contract between the doctors and individual patients. The distinctive quality of the political power embodied in the One-Child policy and in subsequent legislation can be regarded as an attempt by a government to control its entire population in all aspects of human life. In Foucault’s words, it is “an exploration of numerous and diverse techniques for achieving the subjugations of bodies and the control of populations”.⁵⁰²

The controversial One-Child Policy was implemented by the Chinese government to control “birth according to plan”.⁵⁰³ Greenhalgh and Winckler’s indicate that, “with population as their object, Chinese political leaders constructed an enormous edifice of knowledge and state bureaucratic power that sought, and largely managed, to take charge of the production and, to a lesser extent, the “quality” of life itself.”⁵⁰⁴ Since the One-Child Policy became central to the state, *the PRC Marriage Law* was revised in 1980 in order to align itself more closely with the family planning policy.⁵⁰⁵

Though the One-Child Policy was one that has been successful in statistical terms, it was controversial in terms of its implementation.⁵⁰⁶ Reports are available of forced abortions, forced sterilisation, infanticide and strict penalties.⁵⁰⁷ To regulate its policy implementation, in 2000 and 2001, China issued two major legal documents on

⁵⁰¹ J. Farquhar and Q. Zhang, ‘Biopolitical Beijing: Pleasure, Sovereignty, and Self-Cultivation in China’s Capital’, 20 (2005) *Cultural Anthropology* 3, 303-327.

⁵⁰² M. Foucault, ‘Part Five: Right of Death and Power over Life’, *History of Sexuality, Vol. I: the Will to Knowledge* (Paris, Gallimard, 1976), 140.

⁵⁰³ A. Jenkins, ‘Defining and Defending the Chinese State: Geopolitical Perspective’, in T. Cannon and A. Jenkins (ed), *The Geography of Contemporary China: The Impact of Deng Xiaoping’s Decade* (London, Routledge, 1990), 117-123.

⁵⁰⁴ See note 500, at 286.

⁵⁰⁵ Article 2 of the 1981 PRC Marriage Law states “Family planning shall be practised”.

⁵⁰⁶ See note 500, at 38.

⁵⁰⁷ R. Knapp, ‘China’s populations: Readings and Maps’, available at: <http://afe.easia.columbia.edu/china/geog/population.htm> (Last visited on April 20th, 2008); M. Weisskopf, ‘One Couple One Child: Abortion Policy Tears at China’s Society’, (January 7th, 1985) *Washington Post*, A1 20.

reproductive policy, *the 2000 Decision*⁵⁰⁸ and *the 2001 Population and Family Planning Law*. They finally brought the One-Child Policy, which has been operating in China for almost twenty-five years, into line with legal norms – an overall post-Mao regime shift from party fiat towards “a state ruled by law” (as noted in Chapter 2). This major transition also reflects how the concept of the birth programme was granted legal authority and legitimate enforcement.⁵⁰⁹

Instead of relying on coercive measures, Article 2 of *the Population and Family Planning Law* states that, “the State adopts comprehensive measures to control the population and to improve the quality of life. The State relies on publicity and education, advancement of science and technology, and comprehensive services to establish and perfect the systems of healthcare and social security, and to carry out the tasks involved with population and family planning.” The law also aims to set high demands on government administrative procedures, especially on local family planning administrative departments, to reduce corruption and coercion.⁵¹⁰

However, I argue that the reform of family planning administration is far from complete, both in principle and practice, by merely implementing a new piece of regulation. It is reported that from late 2004 to early 2005, in three districts and nine counties in Linyi city, Shandong province, there were family planning officers engaged in a large-scale population planning campaign, which included coercive and forceful actions such as imprisonment and assault, in order to force 22 women to have late-term abortions and sterilisations.⁵¹¹ To make matters worse, activist lawyer Chen Guangcheng who provided legal advice to these pregnant women, exposed this issue and consequently was sent to prison in 2006.⁵¹² According to his defence lawyers⁵¹³:

⁵⁰⁸ Chinese Communist Party Central Committee, *Decision of the Central Committee of the Communist Party of China and the State Council on Enhancing Work of Population and Ensuring Stable and Low Level of Birth*, Document No. 8, March 2, 2000.

⁵⁰⁹ Note 500, 158-160.

⁵¹⁰ See, in particular, the Article 4 and Article 39 of the PRC Population and Family Planning Law 2001.

⁵¹¹ ‘Has China’s One-Child Policy worked?’ (September 20th, 2007) *BBC News*; ‘Chen Guangcheng, who uncovered abuses of family planning policies, will be behind bars for more than four years’, *Los Angeles Times*, (August 25, 2006); W. Yuan, ‘China Vs. My Husband: A Dissident's Ordeal’, *Washington Post* A 27 (October 12, 2006).

⁵¹² *Ibid.*

⁵¹³ Their names are Li Jinsong, Zhang Lihui, Li Fangping, Teng Biao, and Xu Zhiyong.

“Chen Guangcheng, a blind advocate for the rights of Chinese villagers, recently made headlines around the world when he was sentenced to four years and three months in prison. But, as his chosen lawyers, we were prevented from presenting a fair defence by obstacles erected by Chinese authorities. A local court imposed unacceptable terms on us defending our client at his August 18 trial. Before the trial, we had been detained by police, intimidated, and one lawyer was not freed until the trial was over... Chinese officials punished Mr. Chen for disclosing their own criminal activities-forcing villagers to undergo sterilizations and forced abortions, even though these are officially illegal under Chinese law.”⁵¹⁴

In Chen’s case, *the Population and Family Planning Law* was disregarded by family planning officers, government officials and even judges who made legal judgments in Chen’s case. Local authorities and the legal system did not provide justice and punish those who infringed the law. Instead they provided a protection umbrella over the family planning officers, who forced women to undergo unwanted abortions or sterilizations in order to meet birth-control quotas.

There are no medical practitioners reported to have been involved in Chen’s case and, currently there is scant evidence about how Chinese medics reacted in the face of enforced abortions and sterilizations ordered by family planning officers. In Nie’s understanding, Chinese medics who work for a department of obstetrics and gynaecology (OB/GYN) carry a strong sense of social responsibility and patriotic nationalism.⁵¹⁵

In Nie’s fieldwork, one doctor from a department of obstetrics and gynaecology told him that she saw delivering babies and performing terminations as two totally different matters. Performing abortions was a task she undertook to help implement the national birth control policy and she strongly supported it. The doctor considered abortion as “a remedial measure when contraception fails”. She also said,

“Westerners just don’t understand the Chinese family planning program. It isn’t the women who are forced to have abortions as they [foreigners] say. I never encountered a case in which the woman wasn’t willing to have an abortion – very rarely. As far as my experience is concerned, no one was ever forced. No one grumbled... The actual situations of the two countries [China and the United States] are different. If everyone just carried on having children, how will China develop industry, agriculture, and advanced technology?”⁵¹⁶

⁵¹⁴ J. Li, et al., ‘Blind Injustice’, (September 13th, 2006) *Asian Wall Street Journal*, 200.

⁵¹⁵ J. Nie, *Behind the Silence: Chinese Voices on Abortion* (Lanham, Rowman & Littlefield, 2005), 1.

⁵¹⁶ *Ibid*, 2.

What is more, the interviewee suggested to Nie that it was Nie's duty to help the world, especially the West, to understand the "national reality" of China and the truth about China's population program. His interviewee's reaction reminds me of my own personal experience. I encountered one young Chinese doctor in Edinburgh in 2008 at a seminar where I presented a poster about Chinese Doctors' Ethical Dilemmas. This Chinese doctor was angry with my criticism that Chinese medical practitioners were forced to follow state orders rather than their professional ethics. He said, "You are misleading the foreigners who have been misled a lot by foreign media." Both Nie's and my own experience show a strong sense of nationalism and patriotic pride amongst Chinese medics. Nie's small-scale study even suggests that, under the One-Child Policy, most of the OB/GYN doctors were proud of their contributions to the important cause of slowing population growth and accepted birth-control surgeries as part of their routine medical practice. With reference to comments from Greenhalgh and Winckler, "as employees of the state, China's medical practitioners were sometimes required to violate both professional and human ethics by conducting mass surgeries in substandard conditions, aborting fully developed fetuses, and administering lethal injections to unauthorized newborns."⁵¹⁷

Yet there have also been occasions when professional calm was disturbed. In 2000, McElroy reported a case in Hubei province where a retired female doctor saved the life of a newborn baby who was scheduled for late-term abortion as a fourth child.⁵¹⁸ When local family planning officials heard of this, they demanded that the doctor hand over the baby to them to be drowned in a nearby rice field.⁵¹⁹ According to the news report, the elderly doctor was devastated. She said "How could they be so cruel? Yes, the child was born outside the family planning system, but it could have been looked after in a children's welfare home. How could they do this?" A week after the event, it was reported that the doctor was still too traumatised to talk in detail about the killing. She said the incident had made her ill. "I've lost weight with the worry. My blood pressure is very high. I can't talk about this again."⁵²⁰

⁵¹⁷ See note 500, at 252-253.

⁵¹⁸ D. McElroy, 'Anger Sweeps China over Baby-killers', (August 27th, 2000) *Sunday Telegraph*.

⁵¹⁹ Ibid.

⁵²⁰ Ibid.

China's One-Child Policy encourages families to raise the best offspring they can. Infanticide (especially when children are born with birth defects) is another ethical compromise forced upon Chinese doctors.⁵²¹ "Discrimination against, maltreatment, and abandonment of baby girls are prohibited"⁵²² – *the Population and Family Planning Law* also explicitly acknowledges the problem of maltreatment of female infants.

The case study of China's One-Child Policy has shown a complex dimension in bio-politics. It not only shows how the state's bio-political strategy has placed people's lives under its control; it also shows the state can lose power in incidents of resistance. More discussion and reflection will come after the second case study – the political involvement in psychiatric practice.

(2) Case Study II: Psychiatric Units and the Political Definition of "Mad"

There is a reason for the general deterioration as regards liberty. This reason is the increased power of organizations and the increasing degree to which men's actions are controlled by this or that large body.

Bertrand Russell⁵²³

Psychiatry was the area that first called attention to critics of medicalisation.⁵²⁴ Szasz argues that the principle of the rule of law is threatened by many contemporary psychiatric practices, which he defines as "psychiatric abuses of power".⁵²⁵ Controversy continues, and the continual question is what methods are justified and which are not, in promoting so-called mental health?

⁵²¹ Infanticide in China has not been legally defined as it is in English law, where the killing of a baby is by its mother after birth. E. K. Kim, 'Neonatal Euthanasia in Modern China', Vol III-1 *the Lantern* 23. Also see the Parliament of the United Kingdom, has declared that China's family planning programs contribute to incidences of infanticide, available at:

<http://www.publications.parliament.uk/pa/ld199697/ldhansrd/vo961218/text/61218-08.htm> (Last visited on May 1st, 2008). Infanticide, especially female infanticide, in this context refers to the crime of killing child, either by the child's parents, medical staffs or family planning officers.

⁵²² The 2001 PRC Population and Family Planning Law, Article 22.

⁵²³ B. Russell, *Portrait from Memory: and Other Essays* (London, George Allen & Unwin, 1956), 205.

⁵²⁴ T. Szasz, *Law, Liberty and Psychiatry* (New York, Macmillan, 1963), 281.

⁵²⁵ *Ibid*, 6-7.

Documentary evidence shows that the political use of psychiatry existed in China during the Cultural Revolution, when virtually all forms of mental illness in officials' perception were caused by politically deviant thoughts.⁵²⁶ What is more, it is reported by various Western researchers that such political use of psychiatry still exists in contemporary China, through which involuntary "treatments" are applied to dissidents and nonconformists including Falun Gong members, independent labour organisers, and whistle blowers.⁵²⁷ According to Munro, there are uncountable numbers of people held in institutions for mental illnesses, based solely on a politically motivated diagnosis.⁵²⁸ The Human Rights Watch report *Dangerous Minds* states that during the 1980s, the percentage of people held in asylums who were being punished for committing political offences was as high as 15 percent of the total criminal psychiatric caseload.⁵²⁹

Munro claims that "political criminals", the subset that includes Falun Gong practitioners, are those who evince "a perplexing absence of any normal instinct for self-preservation [and], wind up in mental institutions."⁵³⁰ As to reasons for confining Falun Gong practitioners in mental facilities, judgments of the appropriateness of the detentions do not seem to be made on the basis of generally accepted psychiatric criteria. Several pragmatic reasons have been suggested, such as, practitioners are sent to mental hospitals when they have been held in traditional detention facilities longer than the law allows, or when overcrowding becomes too severe, or when the authorities at detention centres are trying to reduce their own costs.⁵³¹ Human rights organisations estimate that, since July 20, 1999, over 1000 healthy Falun Gong

⁵²⁶ See e.g., R. Munro, 'Political Psychiatry in Post-Mao China and Its Origins in Cultural Revolution', 30 (2002) *Journal of American Academic Psychiatry Law* 97-106; J. Birley, 'Political Abuse of Psychiatry in the Soviet Union and China: A Rough Guide for Bystanders', 30 (2002) *Journal of American Academic Psychiatry Law* 145-147.

⁵²⁷ Ibid, also see Human Rights Watch and Geneva Initiative on Psychiatry, *Dangerous Minds: Political Psychiatry in China Today and Its Origin in the Mao Era* (New York, Human Rights Watch, 2002); R. Munro, *China's Psychiatric Inquisition: Dissent, Psychiatry and the Law in Post-1949 China* (London, Wildy, Simmonds and Hills, 2006); A. A. Stone, 'The China Psychiatry Crisis: Following Up on the Plight of the Falun Gong', 6 (May 1st, 2005) *Psychiatry Times* XIII; M. Muminovic, 'Psychiatric Association to investigate abuse in China', 325 (2002) *BMJ* 513; and E. Eckholm, 'Psychiatric Abuse by China Reported in Repressing Sect', (February 18th, 2001) *New York Times*.

⁵²⁸ Ibid.

⁵²⁹ Ibid

⁵³⁰ R. Munro, *China's Psychiatric Inquisition: Dissent, Psychiatry and the Law in Post-1949 China* (London, Wildy, Simmonds and Hills, 2006), 300.

⁵³¹ D. Matas and D. Kilgour, 'Report into Allegations of Organ Harvesting of Falun Gong Practitioners in China' (6 July 2006), available at: <http://www.david-kilgour.com/2006/Kilgour-Matas-organ-harvesting-rpt-July6-eng.pdf> (Last visited on September 2nd, 2008).

practitioners have been imprisoned in mental hospitals and drug rehabilitation centres, where they have been injected with toxic, nerve-damaging drugs, tortured with electric shocks, tied down for extended periods and force-fed etc. It was learned that over 100 Chinese mental hospitals at provincial, city, county and district level participated in the persecution.⁵³²

During May to August 2001, different international psychiatric communities, including the World Psychiatry Association (WPA), the [British] Royal College of Psychiatrists, Global Initiative and the American Psychiatric Association have responded to the problem of politically abusive psychiatry in China and voted to urge the WPA to send an investigative team to China to assess the validity of the charges of psychiatric mistreatment of Falun Gong members.⁵³³

In response to this, China Mental Health Watch (CMHW) agreed that in April 2004, the WPA and the Society of Psychology (SP) would conduct a collaborative investigation in Beijing. However, this investigation was indefinitely postponed at the Chinese government's insistence.⁵³⁴ Instead of a collaborative investigation, in November 2004, the Chinese Society of Psychiatrists (CSP)'s investigation identified "instances in which some Chinese psychiatrists failed to distinguish between spiritual-cultural beliefs and delusions, as a result of which persons were misdiagnosed and mistreated."⁵³⁵ The statement attributed these acts to "the lack of training and professional skills of some psychiatrists rather than [to] systematic abuse of psychiatry." In addition, the CSP agreed to take steps to "educate [its] members" about the issues that led to misdiagnosis and mistreatment and said it welcomed the WPA's "assistance in correcting this situation" so that there could be an improvement in psychiatric diagnosis and treatment throughout China.⁵³⁶

⁵³² R. Munro, *China's Psychiatric Inquisition: Dissent, Psychiatry and the Law in Post-1949 China* (London, Wildy, Simmonds and Hills, 2006).

⁵³³ Human Rights Watch, 'China: No Medical Reason to Hold Dissident', available at: <http://www.hrw.org/english/docs/2006/03/17/china13010.htm>; F. Charatan, 'World Psychiatric Association asked to take up case of Chinese dissidents', 32 (2001) *British Medical Journal* 817.

⁵³⁴ K. Hausman, 'WPA, Chinese Psychiatrists Agree On Psychiatry Abuse Charges', 39 (2004) *American Psychiatric Association: Psychiatric News* 15.

⁵³⁵ Ibid.

⁵³⁶ Ibid.

The CSP's investigation can be seen as progress in that, the Chinese government has admitted that there are problems in China's psychiatric diagnosis and treatment. However, it is not ideal as it overlooks systemic problems. On the one hand, it lacks the transparency of the country's existing national and local-level legislation and administrative regulations in governing psychiatric assessment; on the other hand, there are potentially biased influences from police and prosecution agencies who have close interactions with psychiatrists or the dual-role of psychiatrists serving at army or armed force hospitals. Last but not least, the CSP did not provide clear guidelines concerning the medical or legal basis for psychiatric custody. It blamed individual doctors' "misdiagnoses and mistreatment", but did not point out that the country's prevailing political or ideological orthodoxies should not be used to "educate" doctors in order to provide a medical or legal basis for the diagnosis of mental illness. Most importantly, Chinese legislation should promptly formulate and enact its long-delayed *Mental Health Law* by referring to internationally accepted provisions. Though the law itself cannot be seen as a once-for-all solution (as discussed in the case of the One-Child Policy), it would at least show a first-step attitude change from the state, so that in the future misbehaviours of mental health clinicians could be judged by a transparent standard.

Human Rights Watch and the Geneva Initiative urged the U.N. "Special Reporter on Torture and Ill-Treatment" to address the issue of political psychiatric abuse in China.⁵³⁷ They also called on the Chinese government to conduct a systematic review of China's legislation and administrative regulations governing forensic psychiatric assessment, and of the interactions between police and psychiatrists, and to remove all provisions stating or implying that dissident or nonconformist beliefs provide a justifiable basis for the diagnosis of mental illness.⁵³⁸ Acknowledging that most Chinese psychiatrists are not involved or complicit in the abuses, the recommendations given by Human Rights Watch to the Chinese psychiatric and mental healthcare community are:

⁵³⁷ Human Rights Watch, 'China: End Political Abuse of Psychiatry, World Psychiatric Association Should Act in Yokohama', available at <http://www.hrw.org/press/2002/08/china081302.htm> (Last visited on Sep 17th, 2008).

⁵³⁸ Ibid.

“China’s mental healthcare professionals should resist any pressure or inducement from the country’s law-enforcement and judicial agencies to become personally involved in the legal handling or psychiatric assessment of persons detained by the police solely or mainly on account of their peaceful and non-violent political or religious views or activities...Where direct conflicts of interests are encountered between their ethical obligations and their professional duty to examine police detainees, they should refuse to participate.”⁵³⁹

It is significant that Human Rights Watch points out that pressure or inducement from the country’s law-enforcement and judicial agencies would influence psychiatrists’ decision-making. However, it overlooked the historical institutionalisation of the bio-political power structure in China, through which Chinese medical practitioners have little power or capacity to refuse participation. My criticism is that this recommendation would lose its practical impact unless Chinese psychiatrists were sufficiently empowered with the capacity to resist such pressures. Without professional autonomy, psychiatrists are only tools for fulfilling the state’s bio-political social control mechanisms.

3.3 State and Medics: Case Reflection

The two case studies have shown how bio-political power comes from a central authority in China, and medical power is likely to be abused in the name of the quality of the population and welfare of society, especially when professionals themselves have no autonomy. The two cases exemplify the existences of medicalisation and instrumentalisation in China. Lord Acton says, “Power tends to corrupt; absolute power corrupts absolutely.”⁵⁴⁰ It is hard to find abuse cases (except the German Nazi one) in Foucault and his followers’ biopolitics arguments. I assume that one important reason is that the contexts of their bio-political arguments are generally based within liberal societies. In a liberal society, power is no longer in a central and symbolic place.

Bearing in mind that Foucault’s work was completed against the background of Western liberalism, I did not attempt to find in Foucault’s work an answer to the question – what causes medical instrumentalisation in China? But I found Foucault’s

⁵³⁹ Human Rights Watch and Geneva Initiative on Psychiatry, *Dangerous Minds: Political Psychiatry in China Today and Its Origin in the Mao Era* (New York, Human Rights Watch, 2002), 27-28.

⁵⁴⁰ Biography of Lord Acton, available at: <http://www.mcadamreport.org/Acton.html> (Last visited on Dec 10th, 2009).

reconfiguration of “the concept of power” to be particularly helpful to illuminate the complex power relation for analysing the causes of medicalisation and instrumentalisation in China. Foucault’s understanding of power is productive and it does not operate through any form of strong force. Instead it controls the subject through successive discipline.⁵⁴¹ “The succession of disciplinary forces results in a dominating form which both constructs the subject and subjects him to subtle forms of control.”⁵⁴² “The successive disciplinary forces” exist at different levels of China’s party-state institutions and have instructed medics to be bureaucratic technocrats. In this bureaucratic structure, they submit to hierarchical control, and are subject to rigid hospital rules and regulations; if a physician is a communist party member, one is also subject to the Party’s disciplinary surveillance; consequentially, they are likely to experience a loss of autonomy within their medical practice.

To understand how the “disciplinary forces” work in China’s healthcare bureaucracy, it is important to examine, not only the power of the state over physicians but also of political parties. In search of the résumés of all previous Chinese Health Ministers since Mao, I found that with the exception of the current Health Minister – Dr Chu Chen, who was appointed in July 2007, as the first medically qualified Health Minister without CCP membership – his predecessors, who were appointed to lead the Ministry of Health, did not necessarily have a medical background, rather they had strong politically reliability records. It is difficult to tell whether this signals a significant change to the power dynamic of China’s healthcare or whether it simply reflects the flexibility of the CCP in response to increasing demands from the public. Nevertheless, the conventional bureaucratic strategies used by CCP (at least previously) could be regarded as bio-political attempts – by placing politically reliable individuals in key positions of healthcare administration, the Party’s mainstream ideology would be institutionalized within the system, and the state’s exercise of bio-power would instrumentalise the professionals.⁵⁴³

⁵⁴¹ M. Foucault, *Discipline and Punishment: the Birth of the Prison* (Harmondsworth, Penguin, 1979).

⁵⁴² V. Tadros, ‘Between Governance and Discipline: The Law and Michel Foucault’, 18 (1998) *Oxford Journal of Legal Studies* 1, 75-103.

⁵⁴³ *Ibid*, 49.

China lacks the flourishing professions and self-governing subjects of the liberal societies that Foucault studied; and more generally, power is more centralised in China than in modern Western states.⁵⁴⁴ As one Chinese political analyst has stressed:

“As China is a socialist country in which the working people are the masters, we employ the system of the National People’s Congress rather than the system of “separation of powers.” Some people regard the separate organizational setup of the state organs as a kind of separation of state power. This is a misunderstanding of China’s situation. The separate organizational setup of the state organs is for the convenience of management and the division of responsibility for state affairs does not mean the separation of state powers.”⁵⁴⁵

In a trend of increasing state-led medicalisation, one of the adverse consequences – medical instrumentalisation - highlights the serious underlying problem of state-professional conflict, providing little room for individual professional autonomy under such centralised power.⁵⁴⁶ In a Communist society, professional power is, according to Lo and Shape, “state-centred” in nature.⁵⁴⁷ In a “state-centred” country like China, the state has authoritarian regimes and maintains considerable administrative control over the medical profession. The psychiatric case indicates that a medical term could be used to “order”, define or even “treat” a political or social problem. Political ideology is likely to influence scientific understanding and affect medical decisions. For example, dissidents would likely be ‘diagnosed’ as insane. A “state-centred” medical form of social control is achieved via this complex interplay between processes of medicalisation and instrumentalisation.⁵⁴⁸

In contrast to Chinese bureaucratic technocrats, the Western conception of doctors is profession-centred, based on notions of complexity and procedural technicality.⁵⁴⁹ This profession-centred conception coincides with the democratic notion of “a new citizenship based on the techniques of self-esteem, self-empowerment, self-

⁵⁴⁴ See note 500, at 31.

⁵⁴⁵ Xiang, ‘Compares Separation of Powers, NPC System’, *Jie Fang Jun Bao*, Beijing, May 21, 1987. Translation by US Congressional Research Service, cited by A. Mayer, ‘The Rocky Road to Democracy: A Few Comments on Legal Development in China since the Cultural Revolution’, 6 (1989-1991) *China Law Reporter* 3.

⁵⁴⁶ H. W. Babb and A. Y. Yshinsky, *The Law of the Soviet State* (New York, Macmillan Co, 1948); I. Lapenna, *State and law: Soviet and Yugoslav Theory* (London, Athlone, 1964); R. R. Ludwikowski, ‘Socialist Legal Theory in the Post- Pashukanis Era’, 10 (1987) *International Comparative Law Review* 323.

⁵⁴⁷ C. W. Lo and E. Shape, ‘Lawyers in the People’s Republic of China: A Study of Commitment and Professionalization’, 53 (2005) *The American Journal of Comparative Law* 2, 433.

⁵⁴⁸ See note 489.

⁵⁴⁹ See note 547.

entrepreneurship and individual well-being.”⁵⁵⁰ Such a phenomenon does not exist in China. Instead, China’s bio-political strategy has disempowered its medics, transforming them from knowledge-based medical practitioners into bureaucratic technocrats.

I have argued in this section that influences from institutional and political “successive disciplinary forces” instrumentalise Chinese medical practitioners. Both case studies also show that China’s bio-political strategies, not only control the life and birth of populations, but also deeply affect the medical practitioners’ professional autonomy. Medicalisation and instrumentalisation, as two contributing factors, lead to the trend of deprofessionalisation which I will discuss in the following section.

4. Medical Practitioners: Deprofessionalisation in China

Against the background of the state’s bio-politics, the use of bio-political power and its medicalisation strategy, I have introduced the concept of instrumentalisation to discuss the relationship between the state and medics and those relevant cases that represent political instrumentalisation of Chinese medical practitioners. Although I realise that political instrumentation of healthcare is not always the consequence of the existence of biopower, biopower does play a role in affecting professional judgements, especially in China.

In this section, I argue that Chinese medical practitioners have become deprofessionalised as a means to a political end; serving the country as a bio-political instrument rather than a real profession. Moving from the state’s bio-politics, and state driven medical instrumentalisation, this section focuses on the deprofessionalised status of Chinese medical practitioners, examining intrinsic reasons that might prevent Chinese medics from behaving more professionally (the concept of a profession and its characteristics will be explored in the following chapter).

4.1 Definition of Deprofessionalisation

⁵⁵⁰ R. Ciccarelli, ‘Reframing Political Freedom in the Analytics of Governmentality’, 19 (2008) *Law Critique* 307-327, 319.

The term deprofessionalisation has been used by Haug to explain the phenomenon whereby the traditional autonomy of the profession of medicine has been eroded and medicine has become subject to hierarchical controls outside the profession.⁵⁵¹ According to Haug, professions lose control and status through a commoditisation and loss of ownership over the professional body of knowledge.⁵⁵² Qualities such as professional ethics, a monopoly of knowledge, authority over clients, and autonomy over work are seen to decline in the face of public questioning concerning their general professional status. This can be called the phenomenon of deprofessionalisation.⁵⁵³

Krause indicates that the trend towards “welfare states” after World War II shows examples of “the state challenges [to] professional group power”.⁵⁵⁴ As a greater percentage of medical graduates work for the state or under contract to it, the state begins to exert leverage over professional group power, and the profession may be progressively losing its position of supremacy”.⁵⁵⁵ As distinct from Haug’s deprofessionalisation argument, some scholars argue that medicine is becoming “proletarianized”.⁵⁵⁶ Certain aspects of bureaucratisation and government control over medicine, such as, increase to government regulation, changes in provider-patient relationships as a result of consumerism, the demystification of medical knowledge through the Internet, increasing use of corporations for healthcare delivery, and the increasing number of physicians working as salaried employees, were regarded as causes of proletarianization, especially in the United States. The bureaucratic

⁵⁵¹ See e.g., M. R. Haug and M. B. Sussman, ‘Professional Autonomy and the Revolt of the Client’, 17 (1969) *Social Problems* 153-160; M. R. Haug, ‘Deprofessionalization: An Alternate Hypothesis for the Future’, 20 (1973) *Sociological Review Monograph* 195-211; M. R. Haug, ‘The Deprofessionalization of Everyone’, 3 (1975) *Sociological Focus* 197-213; M. R. Haug, ‘The Erosion of Professional Authority: A Cross-Cultural Inquiry in the Case of the Physician’, 54 (1976) *Milbank Memorial Fund Quarterly* 83-106; M. R. Haug, ‘A Re-Examination of the Hypothesis of Physician Deprofessionalization’, 66 (1988) *Milbank Quarterly* 48-56; M. R. Haug and B. Lavin, ‘Practitioner or Patient: Who is in Charge?’, 22 (1981) *Journal of Health and Social Behaviour* 212-229; M. R. Haug and B. Lavin, *Consumerism in Medicine: Challenging Physician Authority* (Beverly Hill, Sage, 1983).

⁵⁵² Ibid.

⁵⁵³ Ibid.

⁵⁵⁴ E. A. Krause, ‘Doctors, Partitocrazia, and the Italian State’, 66 (1988) *Milbank Quarterly* (suppl.2), 162.

⁵⁵⁵ Ibid.

⁵⁵⁶ J. B. McKinlay, ‘Towards the Proletarianization of Physicians’, 15 (1985) *International Journal of Health Services* 2, 161-93; T. J. Hoff, ‘Physicians as Workers, Whether We Like it or not’, 26 (2001) *Health Care Management Review* 4, 82-87;

requirements of the modern state that are linked to cost-control and profit measures are viewed as possibly challenging medical power and authority.⁵⁵⁷

In essence, both deprofessionalisation and proletarianisation suggest that there has been a loss of professional power. Although neither deprofessionalisation nor proletarianisation introduced by Western scholars has been applied to the Chinese context, I will argue in the following section that elements raised in these theories are nonetheless relevant to China, for example, in the decline of medical ethics, and the increasingly high levels of governmental control and bureaucratisation. Although the loss of the once valued ethics is obviously different from the non-existence of power/autonomy, and there is no unified terminology in the theories, I will still use the term “deprofessionalisation” in this thesis to describe Chinese medical practitioners’ relatively powerless professional status and its reduced influence on professional ethics.

4.2 Is Knowledge Power?

There is a great social need for knowledge to explain illness and physical health and to help us to cope with difficult and painful situations. The medical profession, with its control of knowledge, is a source of power. Szasz observes a parallel between the role of doctors in modern society and the role of priests or religious men in earlier times.⁵⁵⁸ In Brazier and Cave’s words, “the doctor deals with the individual’s most precious commodity, life and health...He(sic) is the man with the skill and experience. In his hands, as the patient sees it, rests the power to cure.”⁵⁵⁹ Likewise, the monopoly that the medical profession enjoys gives them considerable political power. In Western sociologists’ opinions, medics are naturally powerful as they control knowledge about health.

Power, in Foucault’s view, is inseparable from knowledge. The issues of professional knowledge, power and the power struggle over state control, resonate with Foucault’s notion of power:

⁵⁵⁷ Ibid.

⁵⁵⁸ See e.g., T. Szasz, *The Theology of Medicine* (London, Open University Press, 1979).

⁵⁵⁹ M. Brazier and E. Cave, *Medicine, Patients and the Law* (London, Penguin, 2007, 4th edn), 6.

“No body of knowledge can be formed without a system of communications, records, accumulation and displacement which is in itself a form of power and which is linked, in its existence and functioning, to the other forms of power. Conversely, no power can be exercised without the extraction, appropriation, distribution or retention of knowledge. On this level, there is not knowledge on one side and society on the other, or science and the state, but only the fundamental forms of knowledge/power.”⁵⁶⁰

Foucault thinks power is based on knowledge and its usage.⁵⁶¹ However Foucault does not see having knowledge itself as a means to generate and gain power, but it is the “use of knowledge” that decides the place of power.

In Western society, politicians have been more apt to allow professional encroachment to transform political power into professional power, while in China, the government asserts and defends the sphere of politics as opposed to the authority of the professionals. The relationship between state and medical professional bodies in the West is akin to a partnership, where the government determines priorities, guidelines and standards, and at the same time, professionals decide how they should be applied in individual situations on the basis of their expertise.⁵⁶² Power, according to Foucault, is ubiquitous:

“The omnipresence of power: not because it has the privilege of consolidating everything under its invincible unity, but because it is produced from one moment to the next, at every point, or rather in every relation from one point to another. Power is everywhere; not because it embraces everything, but because it comes from everywhere... One needs to be nominalistic, no doubt: power is not an institution, and not a structure; neither is it a certain strength we are endowed with; it is the name that one attributes to a complex strategical situation in a particular society.”⁵⁶³

There is a limitation in trying to apply Foucault’s power theory to China. Foucault’s view on “power” theories is based on Western liberal societies, where power is diffuse rather than concentrated; is embodied and enacted rather than possessed; is discursive rather than purely coercive; and constitutes agents rather than being simply

⁵⁶⁰ M. Foucault, in C. Gordon (ed), *Power and Knowledge: Selected Interviews and other writings 1972-1977* (London, The Harvester Press, 1980), 131.

⁵⁶¹ M. Foucault, *The History of Sexuality, Vol.1: An Introduction* (Harmondsworth, Penguin, 1981), 92-102.

⁵⁶² See e.g., R. Klein, ‘The state and the profession: the politics of the double bed’, 301 (1990) *British Medical Journal* 700-702; T. Milewa, et al., ‘Partnership, Power and the ‘New’ Politics of Community Participation in British Health Care’, 36 (2002) *Social Policy and Administration* 7, 796-809.

⁵⁶³ M. Foucault, *The History of Sexuality, Vol. 1: An Introduction* (New York, Vintage Books, 1978), 93.

deployed by them. In an authoritarian country like China, the relationship between the state and the body of medical practitioners is one of control and being controlled. Though power may not be a straight-forward top down approach, it is not diffused to the extent that Foucault describes.

Henderson says about China that, “This was a world in which physicians were not only employees in large bureaucratic organisations, but they and their organizations were subject to vertical as well as horizontal rule by Chinese Communist Party cadres”.⁵⁶⁴ Indeed, in China, the power of bureaucratic organisations lends authority to a small number of people who are in responsible positions in healthcare organisations and their attached Party branches; while the autonomy of a large number of medical staff and Party members have been limited, especially when their career prospects are greatly dependent on reviews from bureaucratic leaders. But I agree with Foucault’s notion that power may not take the same shape all the time. Power has ‘life’, it is dynamic and productive. Thus Chinese medical practitioners will not necessarily remain short of power in the future. It is their bio-ethical consciousness that will decide their future.

4.3 Intrinsic Reasons for Being Deprofessionalised

This chapter has argued that bio-politics and political instrumentalisation have affected professional autonomy. These are external forces contributing to the deprofessionalised intellectual. Besides these external forces, in my opinion, intrinsic factors – cultural factors and medics’ missing bioethics – may play an essential role in bringing about medical deprofessionalisation in China.

(1) Cultural Dimensions of Deprofessionalisation

The US *Country Studies* note that “historically, Chinese intellectuals rarely formed groups to oppose the established government. Rather, individual intellectuals or groups of intellectuals allied themselves with cliques within the government to lend

⁵⁶⁴ See note 136, at 185.

support to the policies of that clique.”⁵⁶⁵ This section argues that the culturally influenced character amongst the majority of Chinese people, such as thoughtless obedience to leaders and lack of group identity, makes Chinese medics less likely to challenge a dominant power.

In the interviews, many interviewees, may indeed, have called themselves Communists, as they may have been influenced by Marx or Lenin and been registered members of the Chinese Communist Party. But they also admitted that they were not likely to be acting at the behest of Khrushchev or Communists of a former generation. So in this sense they were not traditional Communists any more. Their responses raise a question: why do these Chinese medics who themselves are not believers in communism pretend that they are? I could not find an answer from my empirical study, nor from any body of published literature.

I began to question myself, and I wonder whether the Chinese character produces these Chinese medics' contradictory responses. Rooted in Chinese culture, Chinese people can suppress their feelings, whether of love or hatred, for long periods. The submission of the individual to the state inhibits the development of a sense of social responsibility. Yinhe Li, a professor of sociology, pointed out that there are three kinds of people in China, just like the subjects in Hans Christian Andersen's *Allegory the Emperor's New Clothes*: Audience crowd; the little child; two weavers and courtiers.⁵⁶⁶

According to Li, in contemporary China,

(1) The first group of people resembles the “audience crowd”. In their hearts, they know what has happened, but they choose to be silent. The majority of Chinese people belong to this category; within which some are playing safe; some experience *schadenfreude* for dissidents; a few are heartless or unfeeling.

(2) A small number of people in the second category behave like “the naive little child”. Yet, their dissidence does not necessarily bring them to a happy ending. They are either in custody, have become political asylum seekers, discovered their websites

⁵⁶⁵ Library of Congress: Federal Research Division, ‘China: Policy towards Intellectuals’, in *Country Study Program: China*, July 1987.

⁵⁶⁶ Y. Li, ‘The Emperor's New Clothes’ (in Chinese), Yinhe Li's Blog, available from: http://blog.sina.com.cn/s/blog_473d533601009q9c.html (Last visited on Nov 25th, 2009).

have been closed, or are even sent to psychiatric units. The Nobel Peace Prize 2010 winner Liu Xiaobo belongs to this category.

(3) The third group of people behaves like “the two weavers”. They lie as if “the new suit is real”, or even behave like those *courtiers* who said “I have seen the new cloth. How magnificent, beautiful and excellent the new suit is.” The third group of people staff different levels of the Communist Party schools.⁵⁶⁷ Most of them have been promoted to key positions.⁵⁶⁸

Foucault says, “Governing people is not a way to force people to do what the governor wants, it is always a versatile equilibrium, with complementarity and conflicts between techniques which assure coercion and processes through which the self is constructed or modified by oneself”.⁵⁶⁹ Within these three kinds of people, *the naive little child* has called on the world to notice that the Chinese government “fool[s] public opinion through propaganda”,⁵⁷⁰

“We clearly realize that you may use your confirmed trick of interclass struggle to attach a label of “unwitting masses” at first to delimit[delineate] us from the ordinary people, then to attach another label of “lawbreaker fewness” to cast in a bone between ourselves which intends to destroy all of us one by one at last. We know it—in fact, we encourage it. The more you look on the people in this way, the more beautiful the emperor’s new suit speaks for itself.”⁵⁷¹

It is difficult to find evidence about how many Chinese medical practitioners belong to the first category “the audience crowd”, or the second one “the naive little child”. One thing for sure is that the voices from the “naive children” are not strong enough. (To illustrate this assertion, a section of Chapter 8 focuses on whistle-blowing by contemporary Chinese medical practitioners.) Very possibly, there are a large number of medics who belong to this first category. Dr Unschuld, director of the institute of medical history at the University of Munich says “Chinese physicians developed no

⁵⁶⁷ See notes 124-127; also see, D. L. Shambaugh, *China’s Communist Party: Atrophy and Adaptation* (California, University of California Press, 2008), 143.

⁵⁶⁸ See note 566.

⁵⁶⁹ M. Foucault, ‘About the Beginning of the Hermeneutics of Self’, 21 (1993) *Political Theory* 2, 204.

⁵⁷⁰ Anonymous, ‘Declaration of the Anonymous Netizens, 2009’, available at: <http://truthinchina.wordpress.com/2009/06/28/declaration-of-the-anonymous-netizens-2009/> (Last visited on May 22nd, 2010)

⁵⁷¹ Ibid.

group identity of safeguarding the entire population or, if the government goes in the wrong direction, of voicing criticism.”⁵⁷²

One Chinese sociologist Fei Xiaotong’s theories also support the notion that Chinese people develop no group identity. His sociological analysis offers a possible reason why a large number of Chinese medics prefer to remain silent rather than speak up for patients and their own interests. Fei uses the following two extended metaphors to convey the contrast forcefully to his readers.⁵⁷³ He thinks Western society is represented by straws collected from a haystack (i.e. organisations), and Chinese society is represented by the ripples flowing out from the splash of a rock thrown into water (i.e. discrete categories of social relationships).⁵⁷⁴ These two metaphors do not share any common ground.

In Fei’s view, Chinese people create their society by applying the logic of *cha xu ge ju* – the “differential mode of association, society is composed not of discrete organizations but of overlapping networks of people linked together through differentially categorized social relationship.”⁵⁷⁵ In other words, the Chinese society is centred on the individual and is built from networks created from rational ties linking the self with discrete categories of other individuals.⁵⁷⁶ Under such separate mode of organisation, Chinese society can hardly become group-oriented.

What is more, according to Fei, power in the sense of how people control and are controlled by others, is configured in a very different way in Chinese society from the West.⁵⁷⁷ In the West, where individuals are presumed to be autonomous with the ability to exercise the will and authority (the right to exercise power), is based on the rule of law. Individual rights, as identified in and secured through a constitution,

⁵⁷² Quote cited by M. Forney, ‘Heal Thyself’, (June 19, 2003) *Time Magazine*; See P. U. Unschuld, ‘Introduction: Medical System, Resources, Professionalization’, in *Medical Ethics in Imperial China: A Study in Historical Anthropology* (Berkeley, University of California Press, 1979).

⁵⁷³ See note 278.

⁵⁷⁴ Ibid.

⁵⁷⁵ Ibid, 20.

⁵⁷⁶ Ibid; also see D. Munro (ed) *Individualism and Holism: Studies in Confucian and Taoist Values* (Centre for Chinese Studies, University of Michigan, 1985), 57-70; H. Nakamura, *Ways of thinking of Eastern Peoples* (Honolulu, University of Hawaii Press, 1971), 247-258.

⁵⁷⁷ S. R. Schram (ed), *The Scope of State Power in China* (Hong Kong, Chinese University Press, 1985); L. W. Pye, *Asian Power and Politics: The Cultural Dimensions of Authority* (Cambridge, Harvard University Press, 1985); R. Taylor, ‘Chinese Hierarchy in Comparative Perspective’, 3 (1989) *Journal of Asian Studies* 48, 490-511.

specify the basis of autonomy. In contrast, Chinese society is ruled through rituals.⁵⁷⁸ Order in this type of society depends primarily on people's obedience to their principal moral obligations to their network.

Ladany supports this view by saying, "Taoism, the most typical Chinese religion and the Taoist mentality have created an individualist society. The traditional Chinese society has no in-built defence against dictatorial central power, no cohesive intermediate infrastructure between individual families and the state."⁵⁷⁹ Therefore, in China, there are no professional guilds which formed cohesive forces and structural society, no self-governing city units as in medieval Europe, and no balancing forces that could assert their own opinions in the face of central power.

He further points out that China could only be kept together only by a powerful central organisation or ruler – "China might break into pieces in separate kingdoms, but each local ruler would assume the title of Emperor in his part of the country. There was never an organic social infrastructure capable of asserting its own views."⁵⁸⁰ His theories to some extent explain why professional groups and civil societies have never prospered enough to become changing forces in China. It is in this respect that there is an absence of power; instead, power is centralised and institutionalised.

(2) Missing Bioethics in China

Apart from cultural dimensions, missing bioethics also contributes to medical deprofessionalisation. Case studies show how Chinese medical practitioners have been complicit in the state's bio-political control in ways that we would not expect of healthcare professionals; and in doing so they did not act according to biomedical ethics – that is, as medical professionals who seek first to avoid harm to patients and always put patients' best interests above every other consideration.

⁵⁷⁸ See e.g., S. R. Schram (ed), *The Scope of State Power in China* (Hong Kong, Chinese University Press, 1985), 3-25.

⁵⁷⁹ L. Ladany et al. (ed), *Law and Legality in China: The Testament of a China-watcher* (London, Hurst & Company, 1992), 29-30.

⁵⁸⁰ Ibid.

Freidson noted, “As applied work it [medicine] is either deliberately amoral – which is to say, guided by someone else’s morality—or it is actively moral by its selective intervention.”⁵⁸¹ Medical ethics cannot be an isolated discipline; professional morality is deeply influenced by the social moral and values that permeate the whole society. In my empirical findings, I have demonstrated that many Chinese medics take political ideology plus their own interpretation of social morality as a professional guide. As Freidson put it, they are “guided by someone else’s morality”. In my opinion, they are confused about bioethics, which is one of the reasons contribute to their inability to challenge state power (apart from political ideological influences, bureaucratic controls and the Chinese cultural environment).

A study which analysed textbooks on medical ethics, adopted by nine key Chinese medical schools, showed that these text books were either organised or published by the Ministry of Health or municipal or provincial governments.⁵⁸² The text books commonly included three sections: theoretical, practical and operational aspects of medical ethics,⁵⁸³ in which latter two formed a majority of the text.

Nie states that the topics covered in Chinese medical schools’ ethics courses are usually the morality of the physician-patient relationship, morality in preventive medicine, clinical diagnosis and treatment, for different clinical branches, e.g. nursing, scientific research, hospital administration, and so on.⁵⁸⁴ It seems that the way that ethical courses are usually taught in Chinese medical school, is more similar to moral preaching, rather than professional ethics.⁵⁸⁵ The researchers who conducted the text book study even claimed that “medical ethics involves doctors and everyone in society. The development of medical ethics is an important component in the building

⁵⁸¹ See note 485, at 346.

⁵⁸² R. Chen and X. Qiu, ‘The Present Status of Medical Ethics Education in the Key Medical Universities in China’, in O. Döring (ed) *Chinese Scientists and Responsibility: Ethical Issues of Human Genetics in Chinese and International Context* (Hamburg, Mitteilungen, 1999), 45-55.

⁵⁸³ Ibid.

⁵⁸⁴ J. Nie, ‘Bringing Ethics to Life: A Personal Statement on Teaching Medical Ethics’, in O. Döring (ed) *Ethics in Medical Education in China: Distinguishing Education of Ethics in Medicine from Moral Preaching* (IFA, Hamburg, 2000), 63-73.

⁵⁸⁵ The Cambridge Dictionary draws a distinction between morality and ethics: morality means “a personal or social set of standards for good or bad behaviour and character, or the quality of being right, honest or acceptable”; while ethics means “a system of accepted beliefs which control behaviour, especially such a system based on morals”.

of the spiritual civilization of our society.”⁵⁸⁶ Therefore, they concluded that Chinese medics should strictly obey the principles of socially recognised medical ethics.⁵⁸⁷

Although it is fair to say that culture, philosophy, religion, and even political ideology can influence people’s interpretation of social morality; and it is conceivable that some notions of medical ethics are embedded in every country’s culture and national traditions. I argue that socially recognised medical ethics could be an obscure concept; the use of it can be part of the problem rather than the solution. In China, the purpose of medicine seems to have become entangled with monetary terms. The medics’ low incomes have become a source of demoralisation rather than a symbol of loyal sacrifice, as it was during the Mao’s era. With changing social values, and in the absence of any obvious professional code of ethics, Chinese medical practitioners are very likely to be confused as to their roles in this increasingly capitalist society which is still rooted in socialist ideology.

The confusion in medical ethics may not just come from a change of social values, but from the influence of political slogans. The officially published Chinese medical ethics, are to some extent, educating Chinese medics to be passive – e.g. one should love one’s country, obey the CCP rules, and learn the latest political thoughts, etc. Such politically attached bioethical understanding might affect medics’ professional lives, their decision-making or even their interaction experience with the healthcare system (my interviews have attempted to illustrate this idea).

Farquhar concluded that, at least during the early 1980s, Chinese medical practitioners’ attitudes towards conflicting morality have been “relativistic”:

“Doctors must act, and they must have an ethics and a politics. But they must intervene in illness while knowing that there is ...no single objective standpoint, no absolute truth. One key to their efficacy lies in their willingness to accept teaching from the past and from elsewhere, their understanding that slowly embodies virtuosity cannot be finally verbalized, and their politics that can function in a world of multiple biases and bodies.”⁵⁸⁸

⁵⁸⁶ See note 584, at 55.

⁵⁸⁷ See note 584, at 45-55.

⁵⁸⁸ J. Farquhar, ‘Multiplicity, Point of View, and Responsibility in Traditional Chinese Healing’, in A. Zito and T. E. Barlow (ed), *Body, Subject and Power in China* (Chicago, University of Chicago Press, 1994), 93.

Fraquhar's conclusion addresses the relationship between medical practitioners, politics and ideology in the use of medicine in China. In the face of state power, Chinese medical practitioners are, for the most part, the passive instruments of the state and they "exercise little or no influence of their own over the substance and direction of institutional policy and everyday affairs."⁵⁸⁹ The state's top-down management, and the intertwining influences of Chinese culture and social history have produced an environment unfriendly to medical professionalisation, where the decline of medical professionals' own sense of ethics determines their inability to gain control. (The next chapter includes a detailed discussion of the concept of medical professionalisation) These three factors postulate "a trend towards powerlessness – a steady decline of professional power that is described as deprofessionalization or proletarianisation."⁵⁹⁰ This is also supported by my own empirical findings.

Colton warns us,

"I think that one of the most serious things that one can say about the scientific community, and by extension the research community and academic community in Germany, is not that it didn't throw itself into some kind of political effort to stop Nazism, but it did not even protest when the government itself began to interfere with universities and tell them what to do. The scientists accepted this; and then step by step some of them went down the path to very active cooperation."⁵⁹¹

If similar patterns can be detected in China, this suggests an increasing need for medical practitioners themselves to establish their own ethical guidelines. Those guidelines should be based on their ethical and clinical judgements rather than mainstream political ideology.

5. Conclusion: The Question of Professional Power

The thesis has moved the discussion from the hypothetical tripartite relationship (between state, law and bioethics) to a top-down model. Based on empirical studies, I modified the top-down model that I developed from the literature review into a

⁵⁸⁹ E. Freidson, 'How dominant are the Professions?', in F. W. Hafferty and J. B. McKinlay (ed), *The Changing Medical Profession: An International Perspective* (Oxford, Oxford University Press, 1993), 54.

⁵⁹⁰ Ibid.

⁵⁹¹ J. Colton, et al., 'Special Supplement: Biomedical Ethics and the Shadow of Nazism', 6 (1976) *The Hastings Center Report* 9.

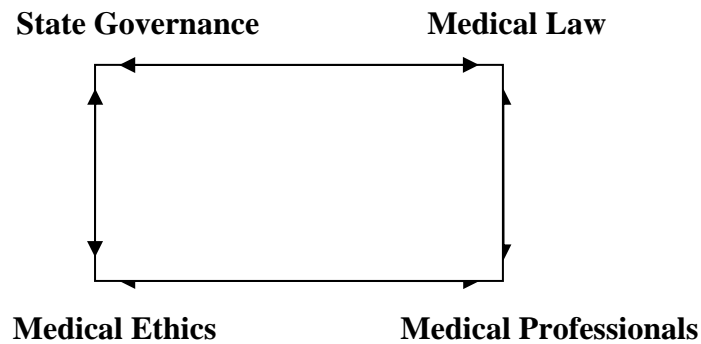
circular model of the medics' understanding of their position (among state, law and bioethics) and thus identified a problem that has never previously received sufficient attention – medical deprofessionalisation in China.

This chapter focused on discussing the problem of deprofessionalisation in China. Following an initial analysis of the state (bio-politics, bio-power and medicalisation), I explored the relationship between the state and the medical profession (instrumentalisation), and the profession itself (deprofessionalisation, cases studies). I reflected upon the relationship between knowledge and power, and moreover, on the Chinese medical practitioners' inability to obtain professional status due to the influence of cultural character and a lack of bioethics.

Rudolf Virchow made a famous statement, “Medicine is a social science, and politics nothing but medicine at a larger scale.”⁵⁹² In the golden age of medical developments, the politicians' bio-politics and bio-power strategies can be understood as using medicine as a means to serve the end of a political super-power. Chinese political authorities embrace the management of life in the name of the well-being of the population. It should also be clear that medicine is likely to be used to achieve certain political aims, especially when medical practitioners are in the position of deprofessionalisation. With life becoming a political object, Chinese medical practitioners, whose expertise does not offer them power and authority over issues beyond curing illness, have played a passive role in the field of bio-politics.

Drawn from the analysis above, I recognise that none of the triangular, top-down or circular models is sufficient to maintain balanced and effective healthcare governance. The consequence of deprofessionalisation in China not only undermines development of the medical community and advances in technique, but is also harmful to patient care and the long-term physician-patient-public relationship. A square model below demonstrates this need for professionalism (the meaning of this model is discussed in the following chapter):

⁵⁹² E. Ackerknecht, *Rudolf Virchow: Doctor, Statesman, Anthropologist* (Madison, University of Wisconsin Press, 1953); also cited by J. P. Mackenbach, ‘Politics is Nothing but Medicine at a Large Scale: Reflections on Public Health’s Biggest Idea’, 63 (2009) *Journal of Epidemiology Community Health* 181-184.



Biopower is power over life. “For capitalist society’, wrote Foucault, “it is the bio-political which is of first importance, the biological, the somatic, the bodily. The body is above all a bio-political reality; medicine is a bio-political strategy.”⁵⁹³ I do not oppose a “bio-political strategy”. Rather, I argue for the importance of professional autonomy and a more active role for professionals in the state’s bio-politics. Neither do I assert that there is nothing good in biopower. Instead, I argue that a top-down approach to biopower is likely to be abused, especially when medical professionals are deprofessionalised and instrumentalised, to be merely political tools.

Bioethics is key to medical practitioners. But it is not enough for a society that medics should merely understand ethics. Professionals must be placed in the position of power, so that they can act according to their ethics. As Adam Smith wrote in *The Wealth of Nations*, “the law ought always to trust people with the care of their own interest, as in their local situations they must generally be able to judge better of it than the legislator can do”.⁵⁹⁴ The liberal idea of good governance depends on the active participation of the governed in their own government, even their resistance which can be seen as a first sign of power-seeking. This idea should not be treated as alien to Chinese medical governance. The participation of medical professionals in the formulation of medical law, and in the political system, may constitute an effective force in China’s current health reform. The question is how to transform Chinese medical practitioners’ status from deprofessionalisation to a position of power and responsibility?

⁵⁹³ M. Foucault, ‘La naissance de la médecine sociale’, in *Dits et écrits, 1954-1988* (Paris, Gallimard, 1994), 207-228; also cited by B. Curtis, ‘Foucault on Governmentality and Population: the Impossible Discovery’, 27 (2002) *Canadian Journal of Sociology* 4.

⁵⁹⁴ A. Smith, in E. Cannan (ed), *An Inquiry into the Nature and Causes of the Wealth of Nations* (London, Methuen, 1904, 4th edn), 32.

Professionalism is an indispensable element that has been neglected in the power structure of China's healthcare service.⁵⁹⁵ While state governance interacts with law and bioethics, medical professionals perceive themselves as a passive and powerless group, according to my empirical research. To achieve a balance of power in the healthcare arena, the system needs not only a structural realignment between (decentralized) communities, professional experts and the state, but also to encourage change in the practitioners' values, attitudes and behaviours.

In this chapter, I have argued that:

- Bio-power in China represents a complex dimension of political sovereignty. After exemplifying medicalisation and political instrumentalisation in China, I have provided insights into how political, cultural and bioethical environments can undertake roles in China's medical deprofessionalisation.
- Law is important. Regulations give a first step of political determination to tackle the problem. But we should look beyond law if it merely plays a symbolic role. I still have faith in the law, but I also realise law does not give a complete answer to the problem of medical deprofessionalisation in China. In this case, professionals play a more important role in leading the fight for autonomy.

In short, I have examined the underlying issues which lead to medical deprofessionalisation. Professionalism is an indispensable element that has been neglected in the power structure of China's healthcare arena. Looking into the future, I suggest that a new professional ethics for medicine in China needs to be rebuilt. Chinese medical practitioners should play a more proactive role. The process of professionalisation increases professional autonomy and limits instrumentalisation.⁵⁹⁶

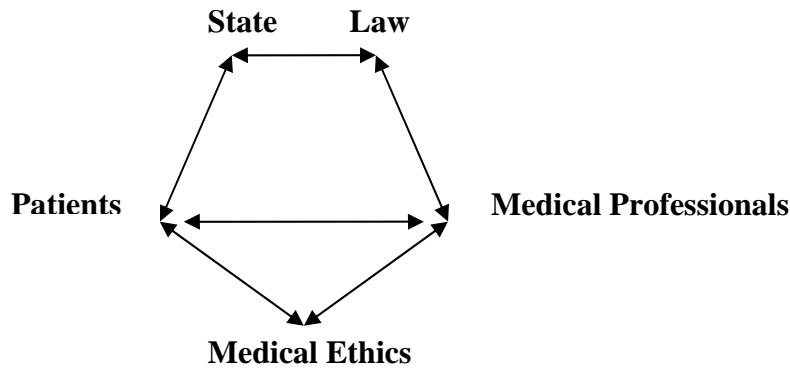
The next two chapters will elaborate on the possibilities of how to exercise professional power in China and the mechanisms for achieving professionalism. However, I also realise there are limitations and pitfalls in the model of medical professionalism. Professionalism is a controversial notion to Western societies where

⁵⁹⁵ Concepts of professionalisation and professionalism will be explicated respectively in Chapters 8 and 9. Briefly speaking, professionalism is to be achieved through the process of professionalisation.

⁵⁹⁶ Ibid.

it is sometimes said that too much power has been vested in professions. How to hold medical professionalism accountable is a question to be answered in Chapter 9.

Thus I will complete this thesis with a suggestion – a pentagon model of accountable professionalism (as below):



The pentagon model suggests the involvement of patients in the discussion of medical professionalisation in China. This helps us to find a balance between a necessary freedom for medical professionals and a sufficient measure of accountability to ensure their responsiveness to social needs and agreed social purposes.

The following Chapters 8 and 9 will discuss how to change the current “deprofessionalisation” model to a new “professionalism” model by means of professionalisation in China. And it will elaborate on the possibility of exercising professional power in China and mechanisms to hold professionalism accountable in empowerment.

CHAPTER 8 OUT OF THE SHADOWS: A PROPHECY OF PROFESSIONALISATION IN CHINA

1. Introduction

The conceptual and historical background of interactions between Chinese medical practitioners and the state has been provided in Part I. The problem of medical deprofessionalisation in China has been also examined from both theoretical and empirical perspectives. Chapter 7 pointed out that, in a deprofessionalised healthcare system, the state's power can be easily abused without surveillance. To address the problems associated with medical deprofessionalisation and respond to the Chinese medics' frustration, this chapter argues for the empowerment of Chinese healthcare practitioners. By doing so, the top-down power structure of China's healthcare arena will leave more room for professional ethical discussions and the development of a Chinese medical profession that is both fit for its members and best suited to attend the needs of its patients.

Chapter 8 attempts to justify a model of empowering the Chinese medical practitioners. An understanding of the professionalisation process and what it is that constitutes a profession is helpful in clarifying the future development of Chinese medical practitioners. It begins by looking at what is meant by "profession" and the characteristics of being a professional, followed by a discussion of whether Chinese medics want to achieve a professional status and why this ought to take place. It then considers the process of becoming a profession – "professionalisation". Ultimately this chapter ponders whether it is practical or realistic to propose medical professionalisation in China.

2. The Characteristics of A Profession

The *Oxford English Dictionary* defines a profession as “the occupation which one professes to be skilled in and to follow.”⁵⁹⁷ This definition, however, does not distinguish a professional from other skilled occupations. The characteristics of a profession have been addressed by numerous scholars. For example, Last and Ghavunduka see a profession as consisting of the following elements: autonomy; monopoly; an ideology of service (codes of ethics); and a body of esoteric knowledge.⁵⁹⁸ Greenwood summarises: systematic theory, community sanction, authority, an ethical code and a professional culture as “constituting the distinguishing attributes of a profession”.⁵⁹⁹ In general, professional behaviour is defined in terms of three essential and somewhat independent variables: its role in a society;⁶⁰⁰ the control of its knowledge;⁶⁰¹ or the powerful knowledge itself.⁶⁰²

Taking these definitions together we can posit that the central themes surrounding the meaning of the word “profession” refer to “knowledge”, “role” and “value in the society”. It also means that merely possessing the knowledge itself does not qualify a person to be a professional. A person with knowledge and skills is a technician, and it is only when the technician acquires a role to serve in the society then he/she would be perceived as a professional. Durkheim values professional ethics. He views it as the fount of a new model order which would provide the model for *corps-*

⁵⁹⁷ *Oxford English Dictionary* (Oxford, Clarendon Press, 1989).

⁵⁹⁸ M. Last and G. L. Ghavunduka (ed), *The Professionalisation of African Medicine* (Manchester, Manchester University Press, 1986), 6.

⁵⁹⁹ E. Greenwood, ‘Attributes of a Profession’, in M. Zald (ed) *Social Welfare Institutions: A Sociological Reader* (London, Wiley, 1965), 509- 523.

⁶⁰⁰ Parsons defines a profession as “a cluster of occupational roles, that is, roles in which the incumbents perform certain functions valued in the society in general, and, by these activities, typically earn a living at a full-time job.” See, T. Parson, *Essays in Sociological Theory* (Glencoe, Free Press, 1954), 372.

⁶⁰¹ On the theory of the professions, see e.g., E. Durkheim, *Professional Ethics and Civic Morals* (London, Routledge & Kegan Paul, 1957); T. Parsons, ‘The Professions and Social Structure’ 17 (1939) *Social Forces*, 457-467; B. Barber, ‘Is American Business Becoming Professionalized? Analysis of a Social Ideology’ in E.A. Tiryakian (ed), *Sociocultural Theory, Values, and Sociocultural Change: Essays in Honor of P.A. Sorokin* (Glencoe, Ill.: the Free Press, 1963); B. Barber, ‘Some Problems in the Sociology of the Professions’ (Fall 1963) *Daedalus* 669-688; H. Wilensky, ‘The Professionalization of Everyone?’, 70 (1964) *American Journal of Sociology* 137-158; B. Barber, ‘Compassion in Medicine: Toward New Definitions and New Institutions’ 295 (1976) *New England Journal of Medicine* 939-943; W. E. Moore, *The Professions: Roles and Rules* (New York, Russell Sage, 1970); N. Reingold, ‘Definitions and Speculations: The Professionalization of Science in America in the Nineteenth Century’ in A. C. Oleson and S. Brown (ed), *Knowledge in the Early American Republic* (Baltimore, Johns Hopkins University Press, 1976); P. Wilding, *Professional Power and Social Welfare* (London, Routledge and Kegan Paul, 1982); J. B. Morrell, ‘Professionalisation’, in R. C. Ollby, et al. (ed), *Companion to the History of Modern Science* (London, Routledge, 1990), 980; and, F. W. Hafferty and J. B. Mckinlay, *The Changing Medical Profession* (Oxford, Oxford University Press, 1993).

⁶⁰² *Ibid.*

intermediaires, that is, a level between the individual and the state.⁶⁰³ He suggests that, for example, professions are to be distinguished from any other occupation by their altruism which is expressed in the “service” orientation of professional people.⁶⁰⁴ The view that professions are activated by the common good was restated by Parsons,⁶⁰⁵ Halmos,⁶⁰⁶ and Marshall⁶⁰⁷. And this holds especially true in “medicine” (I provide a more detailed account in Chapter 9).

Goode points out that, at the heart of every profession is a legally sanctioned control over a specialised body of knowledge, and a commitment to service.⁶⁰⁸ I agree that a professional should be both technically qualified and ethically capable. Where either of these is missing, one cannot be called a “professional”. Professions must be distinguished from mere occupations. An occupation may require no specialised skill; by contrast, a profession may require skilled labour or craft knowledge but, if one assesses it in a rough and ready way, it is privilege, power and prestige that designate a professional. So “profession” is also a symbol of esteem. Its esteem can only be earned according to the quality of service, specifically, how well it compares with the standards or codes developed by and associated with the profession, rather than sought or bought. For these reasons, professional reliability is a key element of a profession, though technical knowledge is also indispensable.

The meanings and definitions of profession can be varied according to different contexts, but the general features of profession – being both technically and ethically capable – should be applicable to different cultures. As one of the traditional professions, “medicine” has a long history of emphasising professional ethics to ensure that persons who enter the medical world are competent and trustworthy. Medical professionals’ collective service orientation – the avowed promise of the medical profession – which have enjoyed a remarkable degree of continuity from the days of Hippocrates until the twentieth century – grants them public trust and

⁶⁰³ E. Durkheim, *Professional Ethics and Civil Morals* (New York, The Tree Press, 1957).

⁶⁰⁴ Ibid.

⁶⁰⁵ T. Parsons, *Essays in Sociological Theory* (New York, Free Press, 1954).

⁶⁰⁶ P. Halmos, *The Personal Service Society* (Cardiff, University College, 1970), 5.

⁶⁰⁷ T. H. Marshall, ‘The Recent History of Professionalism in relation to Social Structure and Social Policy’, 5 (1939) *Canadian Journal of Economics and Political Science* 32, 325-334.

⁶⁰⁸ W. J. Goode, ‘Encroachment, Charlatanism and the Emerging Professions: Psychology, Sociology and Medicine’, 25 (1960) *American Sociological Review* 6, 902.

support for their desire for autonomy.⁶⁰⁹ What I am going to argue in the following sections is that there is a need for Chinese medical practitioners to become more professionalised. Not only does Chinese society need to see the value of professions, but Chinese medical practitioners themselves need to appreciate their value and make use of it to contribute to their society.

3. Needs for Chinese Medics to become a Profession

3.1 A Calling from Society

Professionalisation and professionalism are elements that have been left out of the power structure of China's healthcare arena. The consequence of this is that medical practitioners are too powerless to take control of themselves, not to mention to serve patients' best interests. The two examples of abuse of state power discussed previously are extreme consequences of this. Without professional independence, it is the state that controls law and bioethics, whilst medical professionals passively accept state control, and neglect their professional ethics and/or their professional judgement.

The common recognition of the failures of the healthcare system from the 1980s offers an opportunity to redefine the role of the Chinese medical practitioners. However, the latest Chinese healthcare reform initiative, which includes the setting up of broad health insurance plans to cover a greater number of citizens, especially rural citizens, did not mention medical professionalisation or professionalism.⁶¹⁰ What is more, the lack of literature dealing with the subject of professionalism available to the average Chinese medic is striking. Moreover, the absence of relevant ethical material in the curriculum of most medical schools⁶¹¹ explains why, in a rapidly changing world, Chinese medics may not have a clear understanding of what the public expects from them.

⁶⁰⁹ J. C. d'Oronzio, 'Practicing Accountability in Professional Ethics', 13 (2002) *The Journal of Clinical Ethics* 4, 361-362.

⁶¹⁰ 'State Council Passes the Proposal of Health Reform' (in Chinese), (January 21st, 2009) *Xinhua News*; PRC Council of State, 'Healthcare Reform Initiative' (in Chinese), http://www.gov.cn/jrzq/2009-04/08/content_1280732.htm (Last visited on Oct 10th, 2010).

⁶¹¹ B. Zhang, 'The Important Role of Case Studies in Ethical Teaching in Medical Education', in O. Döring (ed), *Ethics in Medical Education in China: Distinguishing Education of Ethics in Medicine from Moral Preaching* (IFA, Hamburg, 2000), 113.

Professionalism is a concept new to general Chinese medics. In my field studies, most Chinese medics did not fully understand the obligations they must fulfil to satisfy public expectations and maintain professional status. Promoting medical professionalism will firstly help to train Chinese medics in the value of ethical codes, self-regulation, and interaction with colleagues; and secondly, promote cross-cultural bio-ethical debates on conflicting positions and visions, such as professional ethics and commercialisation; patient autonomy and paternalism.

In *Profession of Medicine*, Freidson focuses on medicine's achievement of autonomy and social control. In Macdonald's words, one of the important elements in Freidson's analysis is that "professions have to strive to gain autonomy and, having once done so they can begin to establish a position of social prestige independent of their original sponsoring elite and with its own distinctive niche in the system of social stratification."⁶¹² If Chinese medical practitioners can begin to consider themselves as independent from the government and the Party, they may start to see medicine from a more professional point of view. If they understand the broader goal of practising medicine within its ethical codes, they will be better placed to meet their obligations for patients. In addition, they will be able to better resist political forces given their growing ability to understand and articulate to the public their accountability and reliability.

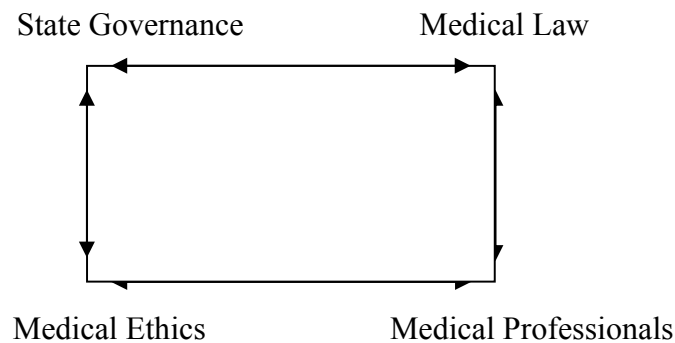
In light of the above considerations, it is suggested that we require a reconceptualisation of the imbalances of power dynamics between state power and medical professionals. I recognise that this reconceptualisation would not be a complete solution to fix all the problems in China's healthcare system. Ultimately, the system needs to find an answer to the question of how to balance power and responsibility. However, it would be a good start to relocate the role of Chinese medics from the relative powerlessness in the original power structure to a position in which they are actually involved in healthcare governance. Even though medical

⁶¹² E. Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (New York, Dodd, 1970); also cited by K.M. Macdonald, *The Sociology of the Professions* (London, Sage Publications, 1995), 8.

practitioners would still be under the surveillance of the state, they might be able to play a more active role in the healthcare arena under professionalism.

Moving from the top-down relationship, and the “circular” understanding that Chinese medics expressed, I suggest that a new professionalism model is needed in which medical professionals (note: not merely practitioners) are involved in healthcare governance. By including medical professionals as key players in healthcare governance, this square-like model also suggests a change to the original triangular model where medical professionals together with their codes of professional ethics can work hand in hand more actively in healthcare.

Building a Square-like Model



The square-like model also indicates that, along with professional empowerment, bioethics should be emphasised as another important element. In this model, medical professionals are more directly in control of their codes of ethics, rather than just being passively taught by the state. This model still recognises the function of the state and its control over medical legislation and influence in bioethics, but medics would no longer be disempowered in the healthcare system. In this model, the role of medical law also implies that medical professionals will no longer be perceived merely as the subject of medical legislation, but rather have more influence on legislative changes.

Getting a more balanced system might eventually enable health workers’ voices to be heard. When facing orders from the authorities, Chinese medics who are used to being accepting or passive may start questioning their legitimacy. This change in the system may also encourage more effective dialogues and cross-party engagement, which

could have a wider impact on the development of China's civil society and, eventually, might encourage society to embrace the notion of democracy.

3.2 Do Chinese Medical Practitioners want to become Professionals?

Before considering whether Chinese medical practitioners want to be professionals, the first question that needs to be answered is whether the Chinese medics are considered to be professionals. I would like to consider this question from two angles. On the one hand, from the standpoint of the Chinese medical practitioners where, in interviews, they saw themselves as skilled labour with specific knowledge; but at the same time did not consider themselves a group with privilege, power and political influence. On the other hand, from documentary and theoretical analyses, Chinese medics could hardly be considered as members of a profession under the Western criteria of a profession, the main reason being that they lack a binding code of conduct. Case studies in Chapter 7 showed that, in some situations, they even became like political instruments and were deprofessionalised.

While Chinese medics are not yet a profession, their expectation of becoming a profession exists. Referring to my survey findings, 86% of the 223 Chinese healthcare workers agreed that they would wish to be involved more actively in healthcare legislation. I also found a high degree of dissatisfaction with the health system and a great desire for changes among medics. Chinese medical practitioners are requesting less profit-driven hospital policies, a more trusted patient-doctor relationship, and a more secure working environment, both financially and physically. Although the Chinese medical practitioners I encountered in the field did not expressly state that they would like to become professionals (my interpretation is that they may not have realised that they do not actually meet the Western criteria for “a profession”), medics' voices, asking for more power over control their careers, have been heard clearly.

Previous chapters, from both the historical, empirical and theoretical perspectives, have pointed to the problem of the Chinese medics' relative powerlessness in China's healthcare governance. To tackle the problem of deprofessionalisation, one might argue that the solution does not only lie in professionalisation. One could also argue

for a change of government policy, a reform of particular legislation, or better management of healthcare institutions. In other words, in the top-down approach, one could hope that Chinese bio-political strategy and biopower could be more professional-friendly from the top level. But power, including biopower, needs to be balanced. As indicated before, absolute power is more likely to corrupt. Empowering medics is not only a way to solve deprofessionalisation, but also a step towards a much more open and democratic society, in which the interests of the vulnerable are better protected. Professionalisation, or the route towards professionalism, is part of the answer. Let us consider its role before asking what else might be required.

4. Achieving Professional Status: Professionalisation

To distinguish the terms “profession” and “professionalisation”, Freidson points out: “professionalisation is the process of an occupation attempting to obtain the status and recognition of a profession.”⁶¹³ In other words, Freidson thinks that, a profession is an identity, while professionalisation is a process, “working towards the acquisition of a number of defining characteristics, namely codes of ethics, professional associations, specialised skills and governance.”⁶¹⁴ However, there is much ambiguity in the definition of professionalisation. Professionalisation – in the context of health related professionals or services – is defined by Unschuld as the process by which “one group (or a number of them) endeavours to expand its possession of medically-related resources available in culture, until it exercises exclusive control over those resources”.⁶¹⁵ But I do not fully agree with the process of professionalisation asserted by Unschuld. Professionalisation, in my opinion, goes beyond the concept of a “trade union”.

Unschuld’s understanding of professionalisation is an example of deductive reasoning based on Western concept of professionalisation. In seeking a professionalised model that I can adapt to China, the Western standard of professionalisation, as Unschuld

⁶¹³ E. Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (New York, Dodd, 1970), at 13.

⁶¹⁴ B. Willians, et al., ‘From stretcher-bearer to paramedic: the Australian paramedics’ move towards professionalisation’, 7 (2009) *Journal of Emergency Primary Health Care* 4.

⁶¹⁵ P. U. Unschuld, *Medical Ethics in Imperial China: A Study in Historical Anthropology* (Berkeley, University of California Press, 1979), Introduction: Medical System, Resources, Professionalization.

describes, raises the question of whether this definition of professionalisation applies only in the West or as a universal model. Obviously, these dimensions of professionalisation implicate different aspects of professional development in Western biomedicine. The relative development of these dimensions in a group indicates the degree of professionalisation compared to other groups.

In terms of the developmental process of professionalisation, Wilensky emphasises that occupations pass through four sequential stages:

- (1) creation of a full-time occupation;
- (2) the formation of training schools;
- (3) creation of professional associations, and
- (4) the development and creation of a code of ethics.⁶¹⁶

Professionalisation, therefore, can be defined as a process involving the pursuit of various forms of occupational control and by taking control, professionals are able to enforce their codes of professional conduct. This process is gradual and it may go through several stages. For Chinese medical practitioners, Wilensky's insight is very helpful, as it indicates that in becoming a 'profession', Chinese medics need to obtain two crucial missing characteristics – "creation of professional associations, and the development and creation of code of ethics" (Chapter 9 will offer a detailed suggestion for the possible process of professionalisation in China).

5. Medical Professionalisation in China: Mission Impossible?

Before pondering how to promote medical professionalism in China (in Chapter 9), we need to consider the following three questions: How did Western professionalisation, especially medical professionalisation, develop from its early stages? And if we can hypothesise the development of medical professionalisation in China, will it adopt the same model as that of the West? How far can this development overcome possible challenges and gain momentum?

⁶¹⁶ H. Wilensky, 'The Professionalization of Everyone?', 70 (1964) *American Journal of Sociology* 2, 137-87.

5.1 The Development of Professionalisation

(1) Western Experiences

Hallin and Mancini summarise three main dimensions in professional journalism: autonomy, distinct professional norms and public service orientation of the profession.⁶¹⁷ Autonomy has always been a central element for being a profession, whether as a professional journalist, a lawyer or a doctor. Medicine is one of the classic occupations that has tried to “professionalise” itself, to justify greater control over its work processes. Krause says, “the degree of professional group power and the autonomy of individual workers in the work place are the result of complex social, historical, and economic process.”⁶¹⁸

Professionalisation is also part of social development. Certain professions such as law, medicine and ministry, have emerged since the Middle Ages and these “were used as referents for the traits and occupational characteristics of professional status”.⁶¹⁹ By the mid-twentieth century, sociologists revealed that professionalisation was a major feature of industrial societies, as well as bureaucracy and industrialism.⁶²⁰ Vollmer and Mills state that an “increasing[ly] complex division of labour and specialisation of occupational function is not only induced by industrialisation, it also appears to be required by it”.⁶²¹

⁶¹⁷ D. C. Hallin and P. Mancini, *Comparing Media Systems: Three Models of Media and Politics* (New York, Cambridge University Press, 2004), 34-37.

⁶¹⁸ E. A. Krause, ‘Doctors, Partitocrazia, and the Italian State’, 66 (1988) *Milbank Quarterly* (suppl.2), 165.

⁶¹⁹ M. M. Moloney, *Professionalization of Nursing: Current Issues and Trends* (Philadelphia, J.B. Lippincott Company, 1986); also cited by B. Williams et al., ‘From Stretcher-Bearer to Paramedic: the Australian Paramedics’ move towards Professionalisation’, 7 (2009) *Journal of Emergency Primary Health Care* 4.

⁶²⁰ See e.g., B. Barber, ‘Is American Business Becoming Professionalized? Analysis of a Social Ideology’ in E. A. Tiryakian (ed), *Sociocultural Theory, Values, and Sociocultural Change: Essays in Honor of P.A. Sorokin* (Glencoe, Ill.: Free Press, 1963); B. Barber, ‘Some Problems in the Sociology of the Professions’, (Fall 1963) *Daedalus* 669-688; H. Wilensky, ‘The Professionalization of Everyone?’, 70 (1964) *American Journal of Sociology* 137-158; B. Barber, ‘Compassion in Medicine: Toward New Definitions and New Institutions’ 295 (1976) *New England Journal of Medicine* 939-943; W. E. Moore, *The Professions: Roles and Rules* (New York, Russell Sage Foundation, 1970); N. Reingold, ‘Definitions and Speculations: The Professionalization of Science in America in the Nineteenth Century’ in A. C. Oleson and S. Brown (ed), *Knowledge in the Early American Republic* (Baltimore, Johns Hopkins University Press, 1976).

⁶²¹ H. M. Vollmer and D. L. Mills (ed), *Professionalization* (New Jersey, Prince-Hall, 1966), 46.

According to Strand, since the Industrial Revolution in the West, many occupations have become professionalised, increasing in status and prestige, often in association with increasing specialisation.⁶²² Wilding supports this view by saying “An increase in the number of professional workers has long been recognised as one of the characteristics of industrial society.”⁶²³ Although “an industrialising society is a professionalizing society”,⁶²⁴ the process of professionalisation has differed among Western countries.

Medical professionalisation is the process of historically specific socio-political processes. Medical professionalisation began in societies where the control and possession of the resources still remained in family-run practices. At present, in the US and in other industrial countries, medical professionalisation has culminated in a concentration of resources in the hands of physicians, pharmacists, nurses, and others including the pharmaceutical industry, health insurance and hospitals.⁶²⁵

Take the UK's experience of medical professional development for example. Ham and Alberti illustrate that, before the late 19th century British physicians were private practitioners and functioned independently.⁶²⁶ There was a strong moral and ethical background to medicine and a tradition of voluntary work in the poor areas as well as in the community. Self-regulation began in the 16th century with the foundation of the Royal College of Physicians which “functioned both as a setter of standards and as a closed shop”.⁶²⁷ The Royal College of Surgeons followed two centuries later.

In the 18th century, medical education was based in a few medical schools and an apprenticeship system. Self-regulation and a more uniform educational approach were strengthened in the 19th century with the establishment of the General Medical Council (GMC) and the introduction of Royal College examinations. Throughout this

⁶²² J. Strand, ‘Chapter 3: Professions Theory and Physician Acceptance of PAS’ in *Enabling Legislation for Physicians Assistants in Puerto Rico: A Socialcultural Policy Analysis*, PhD thesis of the University of North Carolina (2008), 29.

⁶²³ P. Wilding, *Professional Power and Social Welfare* (London, Routledge and Kegan Paul, 1982), 1.

⁶²⁴ W. J. Goode, ‘Encroachment, Charlatanism and the Emerging Professions: Psychology, Sociology and Medicine’, 25 (1960) *American Sociological Review* 6, 902.

⁶²⁵ P. U. Unschuld, *Medical Ethics in Imperial China: A Study in Historical Anthropology* (Berkeley, University of California Press, 1979), Introduction: Medical System, Resources, Professionalization, 4.

⁶²⁶ C. Ham and K. G. M. Alberti, ‘The Medical Profession, the Public and the Government’, 234 (2002) *British Medical Journal* 838-842.

⁶²⁷ *Ibid*, 838.

period, standards and quality were implicit rather than explicit, with government and society trusting the medical profession to protect the public and in the process granting the profession considerable autonomy. The creation of the British Medical Association (BMA) in the 18th century was intended to “promote the medical and allied sciences and to maintain the honour and interests of the medical profession”⁶²⁸ These aims remain the same today. The BMA’s political agenda which seeks to influence government policy and legislation, reflects Freidson’s belief that the “foundation of medicine’s control over work is thus clearly political in character, involving the aid of the state in establishing and maintaining the profession’s pre-eminence”.⁶²⁹

Similar development has taken place in the US, where medicine did not enjoy high status and prestige when medical education began to be formalised in the 1800s. Since medicine increasingly relied on science and resulting specialisation, medical licensing was reinstated: “the American Medical Association (AMA) became a major political force, waging a campaign against patents for medicine and establishing the physicians contract, and physicians gained in income and prestige.”⁶³⁰ As Starr argues, the basis of medical professions’ high income and status is its authority which “arises from lay deference and institutionalized forms of dependence.”⁶³¹ The lay deference to trust professional knowledge and the institutionalised form of dependence both conferred power on medical professionals.

The cross-national variations in the pattern of professional development have been attributed to differences in basic constitutional structures, regime types, cultures, and social traditions.⁶³² However, generally speaking, science and knowledge alone do not account for medicine’s rise to power. The process of professionalisation was achieved through “control of entry, education and regulation”.⁶³³ Furthermore,

⁶²⁸ The BMA, ‘An Outline History of British Medical Association’, available at: http://www.bma.org.uk/about_bma/BMAOutlineHistory.jsp (Last visited on Oct 7th, 2010).

⁶²⁹ See note 485, at 23.

⁶³⁰ See note 622.

⁶³¹ P. Starr, *The Social Transformation of American Medicine* (New York, Basic Books, 1982).

⁶³² See note 136, at 184; G. V. Larkin, ‘Medical Dominance in Britain: Image on Historical Reality’, 66 (1988) *Milbank Quarterly* (suppl.2), 120; E.A. Krause, ‘Doctors, Partitocrazia, and the Italian State’, 66 (1988) *Milbank Quarterly* (suppl.2), 148-66.

⁶³³ See note 622; A. M. Carr-Saunders and P.A. Wilson, *The Professions* (Oxford, The Clarendon Press, 1933).

professionalisation is an ethical and political process, involving the exercise of power and authority in the struggle between competing interests, retention of codes of ethics for credibility and trust. It is a process in which the struggle for control of professional power is central.

In short, medical professionalisation is one of the basic processes of industrialisation in the West. During the process of industrialisation, intellectuals, such as medical professionals, played an important role in developing the ideology of liberalism. Compared with the analyses of Western medical professionalisation, there is little research on professionalisation in developing countries.⁶³⁴ Kautsky notes the role of the intellectuals in the nationalist movements of underdeveloped countries.⁶³⁵ That these intellectuals with advanced standing in the humanities, sciences, and social sciences have played a key role in the politics of underdeveloped countries “is largely due to their paradoxical position of being a product of modernisation before modernisation has reached and become widespread in their countries.”⁶³⁶ Seton-Watson also stresses the leading role of intellectuals in the development of Russia, South-eastern Europe and other developing countries.⁶³⁷

The following section will trace the experiences of Chinese intellectuals’ empowerment - if it exists - and examines whether there is any difference between Western professionalisation and the movement in favour of Chinese intellectual empowerment.

(2) The Past Experience of Intellectual Empowerment in China

According to Barlow, in China, since the late 19th century, intellectuals have “empowered themselves through a moralist discourse of hyper-nationalism.”⁶³⁸

⁶³⁴ See e.g., M. Last and G.L. Chavunduka (ed), *The Professionalisation of African Medicine*, (Manchester, Manchester University Press, 1986); D. D. O. Oyebola, ‘Professional Associations, Ethics and Discipline among Yoruba Traditional Healers of Nigeria’, 15 (1981) *Social Science and Medicine* 87-92.

⁶³⁵ J. H. Kautsky, *Communism and the Politics of Development: Persistent Myths and Changing Behaviour* (London, John Wiley and Sons, 1968), 62-92.

⁶³⁶ *Ibid*, 63.

⁶³⁷ H. Seton-Watson, ‘Twentieth Century Revolution’, 22 (1951) *the Political Quarterly* 3, 251-165.

⁶³⁸ T. Barlow, ‘ZHISHIFENZI [Chinese Intellectuals] and Power’, 16 (1991) *Dialectical Anthropology* 209-232.

Hyper-nationalism, in his understanding, is “an ideology and politics of nation building that transforms its agent or subject into an imaginary equivalent of the nation.”⁶³⁹ Nationalist discourses empowered intellectuals to speak and write as the nation’s representatives. Sun Yatsen, a former medical doctor and later so-called “father of the Republic of China” offers an obvious example of nationalism and the intellectual in the early 20th century. Sun promoted nationalism and stressed to the Chinese public that:

“The Chinese people have shown the greatest loyalty to family and clan but not the nation...Nationalism is that precious possession which enables a state to aspire to progress and a nation to perpetuate its existence.”⁶⁴⁰

Under the conditions of “semi-colonialism”, Japanese occupation, general lawlessness, and political and economic chaos, Chinese intellectuals tried to empower themselves with reference to “National Salvation”. However, after years of discord between the Nationalist and Communist Parties, this nationalism, according to Barlow, has been translated into Party loyalty.⁶⁴¹

The intellectual empowerment evolution in the early 20th century failed “because for the most part zhishifenzi [intellectuals] appeared not as the saviour of the people-nation, but rather as a ranked position in the system of ‘class status’.”⁶⁴² They [the Nationalist Party] were criticised by the Chinese Communist Party that their professional class status was closely related with power, social status, privilege and political wealth. Along with rich landowners, capitalists, etc, their class status put them into the hated position of “old stinking nine” (*chou lao jiu*) during the Cultural Revolution.⁶⁴³

It is interesting to find that Chinese intellectuals empowered themselves through neither the state nor market specialisation, but through appeals to nationalism or

⁶³⁹ Ibid.

⁶⁴⁰ Y. Sen, *The Principle of Democracy* (in Chinese) (Taipei, China Cultural Service, 1972) Volume 2, 2, 20.

⁶⁴¹ See note 638.

⁶⁴² Ibid, 216.

⁶⁴³ See note 433 on definition of ‘Chou lao jiu’.

modernisation.⁶⁴⁴ Although the intellectual empowerment evolution did not succeed, this history implies that Chinese professions are likely to gain power if they are motivated by the benefits of society and patriotism. Undeniably, given the reactions to power struggles in the past, it also suggests that any future struggle will face barriers and challenges.

Another example of Chinese professionalisation is concerned with the Barefoot Doctors. As a political creation to meet Mao's need for better serving the rural masses in the 1960s, certain agricultural workers were trained to be health-workers. The policy was not intended to create physicians, although the label "doctor" was used. The Barefoot Doctor was chosen, trained, paid, and functioned differently from conventional medical practitioners based in urban areas and towns. However, Rosenthal and Greiner notice that these Chinese Barefoot Doctors were empowered, with the central government standing behind them.⁶⁴⁵ The policy for upgrading the Barefoot Doctors in order to improve their quality of care included increased technical education, broadening higher educational opportunities, and incentivising greater motivation. "It is part of the commitment to modernisation of the current leadership and an example of the professionalisation process It also reflects the general return to power and dominance of professionals and experts."⁶⁴⁶

The above two cases of Chinese professionalisation in recent history illustrate these things. First, Chinese professionalisation started either with reference to the state interest or being backed up by state policy. Secondly, the process of professionalisation was temporary and did not turn into a social movement where professionalisation took place in other segments of the occupation. And thirdly, even within the same nature of the occupation, hints of professionalisation developed at an uneven pace. For example, the promotion of the Barefoot Doctor programme could only be implemented where professional doctors were relatively weak and lacked the

⁶⁴⁴ More than that, the Chinese Communist Party/state also empowered themselves with reference to the nation. Partha Chatterjee states the CCP claimed power to act as the "state-representing-the-nation", therefore "any movement which questions this presumed identity between the people-nation, and the state-representing-the-nation is denied the status of legitimate politics." See e.g., P. Chatterjee, *Nationalist Thought and the Colonial World: a Derivative Discourse* (London, Zed, 1986), 168.

⁶⁴⁵ See note 190; also see, M.M. Rosenthal and J.R. Greiner, 'The Barefoot Doctors of China: From Political Creation to Professionalization', 41 (1982) *Human Organization*, 4 Winter, 330-341.

⁶⁴⁶ *Ibid*, 339.

political power to resist such a threat to their control of medical knowledge and healthcare delivery. Looking to the future, we must ask, whether the road to professionalisation has been opened for contemporary Chinese medical practitioners. If so, where does it lead, and how well will it be paved? Answers to all these questions remain unclear.

5.2 Whistle-Blowing within Chinese Medics: Attempted Professionalisation?

“Of course it's an ethical problem. We wanted to be honest, but if we didn't go along, we wouldn't exist.”

A doctor who participated in Beijing's SARS cover-up⁶⁴⁷

Even if Chinese medics were to subscribe to the Hippocratic Oath, the ancient moral dictum that guides Western medical workers, medical practitioners in China are facing moral dilemmas regarding either turning against orders or protecting themselves. Chinese medics serve the all-powerful state: whenever a professional code of conduct conflicts with Party fiat or government protocol, the latter often holds sway. But this is not always the case. Reports suggest that there were Chinese medics who refused to engage in unethical practices when other medics in the same environment did. They were the whistle-blowers whose interest lay in serving their patients or in the advancement of science. This section examines the implications of several whistle-blowing cases for the process of professionalisation in China.

Foucault says: “Where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power.”⁶⁴⁸ In other words, there is no absolute power, as therein always exists resisting forces. Such forces are present as resistance everywhere in the power network.

Within the Chinese healthcare power structure, resistance to authorities and voices asking for change have been witnessed in hospitals. A number of doctors and nurses were reported as refusing to continue working under the pressure of profit-orientated

⁶⁴⁷ M. Forney, ‘Heal Thyself’, (June 19, 2003) *Time Magazine*.

⁶⁴⁸ M. Foucault, *the History of Sexuality, Vol. 1: An Introduction* (New York, Vintage, 1980), 95.

unethical practice.⁶⁴⁹ There were an estimated 40% of registered medical graduates who chose other careers rather than become medics.⁶⁵⁰ Most of them blamed the unfunded national healthcare system and the disappointing social environment which did not give medics enough respect either in terms of material rewards or reputation. Above all these disappointments, patients for whom they are providing services, are turning against them or even physically threatening them. Some individual doctors even took off their white uniforms to launch campaigns against unethical practices in their working institutions, greedy pharmaceutical companies, and even government departments (examples will be given shortly). They operated on the maxim – “never harm”. A physician whistle-blower during the SARS epidemic is one of the premier examples and it is valuable to explore this here.

Dr. Jiang Yanyong, a retired surgeon, finally broke the silence about SARS.⁶⁵¹ After his best friend contracted SARS at a military hospital, Dr. Jiang conducted a preliminary investigation and discovered 146 SARS cases in three military hospitals alone. This was more than 10 times the figure former Minister of Health Zhang Wenkang had released at a news conference.⁶⁵² Dr. Jiang subsequently wrote to two main television stations in Beijing and Hong Kong. In his letter, Dr. Jiang called on the Minister to resign for covering up the SARS information in Beijing.⁶⁵³ After the stations refused to publish the letters, *Time Magazine* released Dr. Jiang’s findings on the internet in Susan Jakes’s article, entitled *Beijing’s SARS Attack*.⁶⁵⁴ Many doctors, experts, and health officials were also aware of the severe situation in China at the time when Dr. Jiang challenged the government’s underreported figures. However, Dr. Jiang was the only one who had the courage to speak out.

This is not the only ‘whistle-blower’ case in China. Other examples include, Doctor Chen Xiaolan, who had experienced frustration and setbacks during her 9-year-campaign against the use of fake medical instruments by hospitals in Shanghai. Her

⁶⁴⁹ Private conversation with a Chinese nurse who admitted that it is happening in her former servicing hospital, and this is also the main reason she decided to leave her hospital, personal communication, on Oct 5th, 2008, Edinburgh.

⁶⁵⁰ China Economic Information, ‘Why 400,000 Medical Graduates Give Up Becoming Doctors?’ (in Chinese), available at: www.cei.gov.cn (Last visited on Sep 1st, 2008).

⁶⁵¹ T. S. Jost, *Readings in Comparative Health Law and Bioethics* (Durham, Carolina Academic Press, 2007), 358.

⁶⁵² Ibid.

⁶⁵³ Ibid.

⁶⁵⁴ S. Jakes, ‘Beijing’s SARS Attack’, (April 8th, 2003) *Time magazine*.

whistle-blowing actions occurred against great pressure from the hospitals and her peers who thought she would cut their source of income. Because of her persistence in revealing hospital malpractice, Doctor Chen finally gained support from the central government and such malpractice was banned in 2005. In 2007, Doctor Chen was awarded the “Annual Award for Inspiring People in China”. At the award ceremony, Doctor Chen said: “Because I was a doctor, I had to be responsible for my conscience as well as the life of my patients.”⁶⁵⁵ These whistle-blowing actions show an encouraging revival of professionalism in China’s deprofessionalised healthcare environment and resistance to a top-down exercise of power by the state or hospital management.

However, Doctor Chen lost her job during her campaign and none of the Shanghai hospitals wanted to offer her a job after she disclosed the case. In an interview after the award, she told the media that she felt honoured but also sad. She wished she could wear her white uniform to receive the award, but she was no longer a doctor and had no right to wear it any more. Such a sad ending for whistle-blowers in China is not rare.

In Hainan province, more than ten doctors and nurses disclosed that, within their hospitals, their colleagues had prescribed unnecessary and potentially harmful medication to patients, in return for a commission, for six years.⁶⁵⁶ Soon after this scandal had been published by local journalists, the doctors and nurses who reported the incident lost their jobs. The explanation given by the hospital was that the hospital’s reputation had been damaged by those whistleblowers. Similar whistle-blowing cases have been reported in Anhui,⁶⁵⁷ Hunan⁶⁵⁸ and Shandong provinces⁶⁵⁹ where healthcare workers blew the whistle on their colleagues taking “kickbacks” from pharmaceutical companies by prescribing expensive and unnecessary drugs to

⁶⁵⁵ China Central Television, ‘A Doctor Persistent in Combating Fake Medical Instruments’, (Feb 17th 2008) *CCTV news*.

⁶⁵⁶ ‘Doctors who Reported Scandal Lost Their Jobs’ (in Chinese), (Aug 24th 2005) *Xin Hua News*.

⁶⁵⁷ Z. Zeng, ‘Drug Kickbacks’ (in Chinese), *Transparent Place: Visibility of the Society* (Beijing, China Youth Publishing, 2008), 1-12; ‘10 year Whistle-Blowing’ (in Chinese), (July 5th, 2006) *Sohu News*.

⁶⁵⁸ Z. Zeng, ‘Bonus for Doctors’, *Transparent Place: Visibility of the Society* (Beijing, China Youth Publishing, 2008), 13-23; ‘Doctors who Refuse to Take Kickbacks are Paid Less than a Security Guard’ (in Chinese), (July 26th, 2006) *Xinhua News*.

⁶⁵⁹ ‘Luckily There are still Stubborn Doctors: Dr Yang Guoliang’ (in Chinese), *Yahoo Editorial Report*, available at: <http://news.cn.yahoo.com/yaopinheimu.html> (Last visited on Oct 4th, 2010).

patients. They all lost their jobs, except Dr Zhang Shu. But even Dr Zhang admitted he would have remained silent and practised ethically himself if he had known about the complexity and difficulty of whistle-blowing.⁶⁶⁰ He said that he had brought great troubles to himself during the 10-year-campaign and had been isolated by his colleagues.⁶⁶¹

Referring back to the SARS whistleblower Dr Jiang, despite the fact that his whistle-blowing behaviour has saved thousands of Chinese people's lives and he has received rewards internationally,⁶⁶² he has not been given recognition in China. It is even reported that Dr Jiang was detained and held for weeks at an army guest house where he was forced to undergo "study sessions" after he wrote a letter to officials asking for a re-examination of the responsibility borne by the Chinese government for the Tiananmen Square Massacre in 2004.⁶⁶³ Though he was released later, it was reported that, in 2007, Dr. Jiang was not permitted by his army affiliated work unit Beijing Hospital 301 to travel to New York to receive the Heinz R. Pagels Human Rights of Scientists Award.⁶⁶⁴

It is worth emphasising the fact that the motivation of whistleblowers was a sense of professional ethics and responsibility. However, the sad story in China is that the whistle-blowing doctors' good intentions were not only discouraged by the hospital management team, but also discouraged by the state authority which adopted a "harmonious" society as its political slogan (as discussed before). Whistle-blowers often need credible protection against the various sorts of punishment to which they may be exposed. The UK introduced the Public Interest Disclosure Act in 1998 to protect UK employees who blow the whistle on wrong-doing or malpractice. In China, so far, there is no law in place to protect whistle-blowers' interests which to some

⁶⁶⁰ See note 657.

⁶⁶¹ Ibid.

⁶⁶² In August 2004, Dr. Jiang Yanyong was awarded a *Ramon Magsaysay Award for Public Service*. According to RMAF, the board of trustees of the Ramon Magsaysay Award Foundation "recognizes his brave stand for truth in China, spurring life-saving measures to confront and contain the deadly threat of SARS", available at: <http://www.rmaf.org.ph/Awardees/Citation/CitationJiangYan.htm> (Last visited on Oct 1st, 2010).

⁶⁶³ See e.g., E. Graham-Harrison, 'China's SRAS Whistle-blower Demands Apology', (March 13th, 2009) *China Post Taiwan*; J. Kahn, 'China Release the SARS Whistle-blower', (2004, July 21st) *New York Times*.

⁶⁶⁴ New York Academy of Sciences, '2007 Heinz R. Pagels Human Rights of Scientists Award', available at: 'http://www.nyas.org/AboutUs/MediaRelations/Detail.aspx?cid=e05795c8-2d64-4e14-927d-0744e8811308 (Last visited on Oct 1st, 2010).

extent de-motivates whistle-blowing behaviour and hinders the development of professionalisation.

Striking evidence shown in different media reports has illustrated that whistle-blowing medics in China were treated as betraying their work place – they lost their jobs, and some of them even faced threats and were placed under tremendous pressure. However, professionals' whistle-blowing actions have been welcomed by the public. In return for the loss of their jobs in the short term, whistle-blowers like these doctors, gain back the public trust for their profession in the long term. Dr Chen Xiaolan lost her title of doctor as a result of her exposure, yet her whistle-blowing has successfully stopped unethical practices at her former hospital. Her behaviour has not only been well received by the public, but also motivated a lot of colleagues. She upheld her professional beliefs, primary among which is the fundamental ethical principle “First, do no harm”. The Shanghai government's Food and Drug Administration has hired her as a Food and Drug Safety Inspector.

There may be other brave whistle-blowing medical practitioners in China. They are publicly unknown due to China's media control. One thing is for sure: there must be huge amount of pressure that these whistle-blowers have to bear. One purpose of this thesis is to argue for support for China's slow but awakening professional consciousness. As the Washington-based director of Human Rights Watch, Jendrzeczyk says, “The world medical community should speak out on this important issue. The Chinese psychiatrists who bravely refuse to participate in state repression need to feel they have support from abroad.”⁶⁶⁵ With regard to China's psychiatry abuse cases (discussed in Chapter 7), Baker and Latham say,

“Physicians need more than codes that proscribe putting their skills in the service of non-medical goals of governments, military establishments and cooperation. They also need supports for upholding medical ethics and human rights in medicine, and mechanisms to punish those who violate basic medical ethics and human rights in medicine.”⁶⁶⁶

⁶⁶⁵ Human Right Watch, ‘China: End Political Abuse of Psychiatry’, *Human Right News*, available at: <http://www.hrw.org/press/2002/08/china081302.htm> (Last visited on Sep 10th, 2009).

⁶⁶⁶ R. Baker and S. R. Latham, *the American Medical Ethics Revolution: How the AMA's code of ethics has transformed Physicians' Relationships to Patients, Professionals, and Society* (Baltimore: Johns Hopkins University Press, 1999), 308.

Hints of resistance from Chinese medical practitioners embody hopes of future professionalisation. Although barriers and obstacles might cast a shadow over success during the process, whistle-blowing, as “socially responsible dissent”⁶⁶⁷ should be encouraged and incentivised. Carr-Saunders and Wilson’s argument reflects my belief. The professions, they claim,

“inherit, preserve and pass on a tradition... they engender modes of life, habits of thought and standards of judgement which render them centres of resistance to crude forces which threaten steady and peaceful evolution...the great professions, stand like rocks against which the waves raised by these forces beat in vain.”⁶⁶⁸

China needs more representative “great professionals” like, Dr. Jiang Yanyong, Dr Chen Xiaolan, Dr Zhang Shu and many other unknown medical whistle-blowers who have steadfast loyalty to the basic principle of medical ethics: protecting patients’ best interests above all others.

5.3 Cultural and Political Barriers to Professionalisation

Freidson argues that professionalisation is designed to achieve status in the public perception,⁶⁶⁹ which means that an occupation becomes a profession when enough people agree that it is. “Professionalization does not occur in a vacuum”,⁶⁷⁰ it requires active support and involvement from individuals at the state level, institutional level (such as, professional development providers), and educational level. While the character of Chinese society may not be a direct cause of deprofessionalisation, social behaviour is “constructed through a diffuse network of apparatuses that produce and regulate customs, habits, and productive practices”,⁶⁷¹ and social and cultural elements exert diffuse impacts on professional development. It is likely therefore that any progress towards professionalisation will inevitably involve obstacles and setbacks. The following offers some general considerations of cultural and political barriers to medical professionalisation in China.

⁶⁶⁷ W. De Maria, ‘Whistleblowing’, 20 (1995) *Alternative Law Journal* 6, 270-281, 280.

⁶⁶⁸ P. A. Wilson and A.M. Carr-Saunders, *the Profession* (Oxford, Clarendon Press, 1933), 497.

⁶⁶⁹ See note 485, at 7.

⁶⁷⁰ H. M. Vollmer and D. L. Mills (ed), *Professionalization* (New Jersey, Prince-Hall, 1966), 46; also cited by B. Williams, et al., ‘From stretcher-bearer to paramedic: the Australian paramedics’ move towards professionalisation’, 7 (2009) *Journal of Emergency Primary Health Care* 4.

⁶⁷¹ M. Hardt and A. Negri, ‘Biopolitical Production’, in *Empire* (Cambridge, Harvard University Press, 2000), 21.

(1) Culturally Emphasis on Harmony

*“Social conflicts are emerging in great numbers and in more varied forms, which are inevitable for China at the present stage. But they must be properly handled in case they pose risks to the overall development of the country.”*⁶⁷²

Hu Jintao (President of PRC)

Both the documentary and empirical data show there is a phenomenon of non-resistance to control, even though there are a considerable number of professional resistance cases. These resisters are not central; they constitute a marginal movement and are not typical of a whole professional community. It is important to press the question about the attitudes towards powerful authority amongst Chinese medics, alongside the question of why there has not been more outright opposition to professional control.

I found that in my fieldwork and library research, most Chinese medical practitioners chose not to be whistle-blowers even though they might realise wrong-doing exists in their hospitals.⁶⁷³ These medics care about their patients and practice in accordance with their morals. They dare not confront conflicts, either with their colleagues or their hospital managers, but chose silent ethical practice. If they felt unable to adapt to the environment in which they were working, they would choose to change career. Reading through documents and findings from my own empirical study, it seems that, with the exception of a few whistle-blowers, researchers have not been able to get Chinese medics to come forward to discuss their resentment towards the system (if such exists). This not only includes medical practitioners, but also other intellectuals, such as lawyers.⁶⁷⁴

⁶⁷² See note 287; and Hu Jintao, ‘Building a Harmonious Society is critical for China’s Progress’ (in Chinese), (June 27th 2005) *People’s Daily*.

⁶⁷³ From my interviews and reading Chinese doctors’ blogs from Haodf website (Good Doctor Website in Chinese), one female doctor wrote her feeling after hearing Dr Chen Xiaolan’s story on her blog, available from: <http://xulingmin.haodf.com/wenzhang/39852.htm> (Last visited on Oct 1st, 2010).

⁶⁷⁴ It is argued that neither Chinese attorney nor the Chinese Government are accustomed to an independent legal profession, this is most poignantly shown by a defence attorney’s lack of any real ability to assert a client’s innocence. See e.g., C. L. Baraban, ‘Inspiring Global Professionalism: Challenges and Opportunities for American Lawyers in China’, 73 (1998) *Indiana Law Journal* 1247; D. C. Clarke and J. V. Feinerman, ‘Antagonistic Contradictions: Criminal Law and Human Rights in China’, 141 (1995) *China Quarterly* 135, 140; T. A. Gelatt, ‘Lawyers in China: the Past Decade and

The phenomenon of non-resistance can find its roots in Confucianism which emphasises harmony. Confucianism has dominated Chinese culture and demonstrated a significant influence on Chinese values for thousands of years. A central concern of Confucian principles is ‘*Doctrine of the Mean*’ which teaches that individuals who are excessive in any area disrupt social order and are therefore to be avoided.⁶⁷⁵ According to Confucius, people should avoid competition and conflict, and maintain inner harmony.⁶⁷⁶ This has influenced the Chinese people to preserve overt harmony by avoiding confrontation and to adopt a non-assertive approach to conflict-resolution.⁶⁷⁷

In Confucian social doctrine, social relationships amongst those fulfilling these roles were bound by customs and rites. As Franke and Trauzettel emphasise, “the great achievement of Confucius [was] the transformation of traditional rites, which contain no individual elements, but which were practiced in a strictly collective manner as a communal cult, into an individualized, personalized ethic.”⁶⁷⁸ Unschuld writes, “Confucius concluded that the real cause of social unrest was the discrepancy between the expectations associated with a social role and the actual conduct of members of society...The objective of the harmonious society envisioned by Confucius was therefore to bind individuals and groups to previously defined social roles and to

Beyond’, 23 (1991) *Journal of International Law and Politics* 751, 762, 781-82; C. W. Lo and E. Snape, Lawyers in the People’s Republic of China: A Study of Commitment and Professionalization’, 35 (2005) *American Journal of Comparative Law* 2; And it is argued that a lack of professional ethics is a serious detriment to Chinese legal development. See W. P. Alford, ‘Tasselled Loafers for Barefoot Lawyers: Transformation and Tension in the World of Chinese Legal Workers’, 141 (1995) *China Quarterly* 22, 30.

⁶⁷⁵ See e.g., A. Chin, *The Authentic Confucius: A Life of Thought and Politics* (New York, Scribner, 2007); D. Pierre, translated by C. L. Markmann, *Confucius and Chinese Humanism* (New York, Funk & Wagnalls, 1969); R. Wilhelm, *Confucius and Confucianism* (New York, Harcourt Brace Jovanovitch, 1931).

⁶⁷⁶ Ibid.

⁶⁷⁷ A. T. Lee, ‘Cultural Barriers to the Learning Organisation in Chinese Society’, Conference paper for the Fourth International Conference for Organizational Learning and Knowledge Management (2001); W. T. De Bary, *Sources of Chinese Tradition*, Vol.1 (New York, Columbia University Press, 1960, revised 1999).

⁶⁷⁸ H. Franke and R. Trauzettel, *Das Chinesische Kaiserreich* (Frankfurt, Fischer, 1968), 51; quote is cited by P. U. Unschuld, *Medicine in China: A History of Ideas* (Berkeley, University of California, 1985), 62.

regulate permanently the relationships between these roles by means of a hierarchical, tightly-knit nexus of mutual obligations.”⁶⁷⁹

To achieve a harmonious state, one should follow tight social rules and acknowledge social positions without breaking boundaries. “The king must act as a king; the subordinates must act as subordinates; A father as a father; a son as a son. Any confusion and break of the social levels will lead to social destruction”.⁶⁸⁰ Obedience serves as the crucial means for maintaining social hierarchy. In contrast, behaviours, such as, argument, defensive reasoning and conflicts with one’s seniors, are considered a threat to Chinese social stability. Such behaviour and attitude will not be allowed.

Marx says, “Men make their own history, but they do not make it just as they please; they do not make it under circumstances chosen by themselves, but under circumstances directly encountered, given, and transmitted from the past.”⁶⁸¹ Thus, from the cultural point of view, resistance is neither welcomed nor encouraged in Chinese society.

(2) Nationalism and Patriotism

The pressure of state propaganda and censorship upon Chinese intellectuals has never decreased. In my empirical study, one finding is that almost every medic in different ways is subject to political ideological teaching, whether they are Communist party members or not. Such political education comes from different sources, such as group meetings, on-job ethical and legal training, hospital announcement boards and media, etc. The existence of widely-used propaganda has led to a group of medics with more accepting attitudes towards authority, which explains why there is little evidence of medics who resisted to the implementation of the One-Child Policy. What is more, Chinese medics tend to balance a patient’s interest with the state’s interests when they are forced to make a difficult ethical decision. As discussed previously, a senior doctor in an interview said that procedures such as abortion and sterilisation are

⁶⁷⁹ P. U. Unschuld, *Medicine in China: A History of Ideas* (Berkeley, University of California, 1985), 61-62.

⁶⁸⁰ Ibid.

⁶⁸¹ K. Marx, in S. K. Padover (ed) *The Karl Marx Library* (New York, McGraw Hill, 1972), 245-246.

contributing to the state's family planning. They are therefore helping the patients and their families in the long run.

Nationalism or patriotism has played a part in Chinese medics' decision-making. With regard to medical professionalisation, the impact of nationalism is two-fold. As discussed before, nationalism inspired Chinese intellectuals to embrace power when the state was at risk, such as with the Japanese invasion. It has had a positive influence in reminding intellectuals of their social responsibility towards their country. However, the negative impact is that nationalism will occasionally conflict with professional ethics, especially when the nationalism itself is coloured by politicians.

The Chinese Communist Party (CCP)'s political ideology promotes the state's interest, especially after the Tiananmen Square Massacre of June 1989, which exhibited the internal legitimacy problem faced by the CCP leadership. The CCP started to feel the rise of political liberalism among intellectuals and students which was supposedly caused by a lack of patriotic education in the 1980s⁶⁸², along with trends partly resulting from the political instability at the end of the 1980s.⁶⁸³ The CCP strengthened its propaganda strategy by strengthening patriotic education for Chinese youth. It also urged the Chinese people to unite under its leadership; otherwise the country would descend into chaos.⁶⁸⁴ Later, the CCP's Propaganda Department issued the "Fundamental Principles on Implementing Patriotic Education". The aim of this new campaign was to "take concerted effort in various quarters to create a strong atmosphere in which the entire Chinese people will be influenced by the patriotic ideas and spirit".⁶⁸⁵

⁶⁸² See e.g., H.Y. Lee, 'From Revolutionary Cadres to Bureaucratic Technocrats', in B. Womack (ed), *Contemporary Chinese Politics in Historical Perspective* (Cambridge, University of Cambridge, 1991), 200-201; T. Tang, 'The Tiananmen Tragedy: the State-Society Relationship, Choices, and Mechanisms in Historical Perspective', in B. Womack (ed), *Contemporary Chinese Politics in Historical Perspective* (Cambridge, University of Cambridge, 1991), 265-327.

⁶⁸³ Ibid.

⁶⁸⁴ Ibid.

⁶⁸⁵ Beijing Review (26 September–2 October 1994), 4. For a more detailed study, see S. Zhao, 'A State-led Nationalism: the Patriotic Education Campaign in Post-Tiananmen China', 31 (1998) *Communist and Post-Communist Studies* 3, 287–302.

Kissinger argues that China's policy is driven by growing nationalism rather than communist ideology.⁶⁸⁶ I do not fully agree. Instead, I think nationalism and communist ideology are interwoven and have been promoted at the same time, since the Chinese communist party claims itself to be a "state-representing-the-nation".⁶⁸⁷ These top-down patriotic campaigns justify state policies and party rules by aligning them with nationalist or patriotic principles to encourage responsible citizens to take more accepting attitudes. In the healthcare arena, being a patriotic Chinese citizen as well as a responsible medic leads the individual medic to confront conflicting values. For example, a doctor revealed the fact that the truth had been hidden from both patients and the general public when SARS became public. How would a responsible doctor have felt about this? Would one stand up to proclaim professional opinions which went against the authority of the state? All Chinese medical practitioners except one chose not to disclose it to the public. The reason was either the belief that the benefits of revealing it were outweighed by the potential harm of doing so or that the state was putting pressure on them, or rather that they believed the state's silence must be respected as a mark of national duty or obligation.

(3) Fidelity

Another issue which can produce a barrier to professionalization is faithfulness towards Chinese culture. In China, people have been taught for centuries to respect the right of the community to dictate to the individual. With respect to medical professions, such dedication to the group can outweigh their individual professional decisions.

"Philosophically, China lacks not only a Kant but the moral machinery that produced Kant. Central to Kant's view and most (but not all) western ethical theory is the view that humans are autonomous moral agents who through a rational faculty are able to make the correct moral choices. Respect for the moral capacity of every individual implies the egalitarianism of democratic liberalism, wherein the legitimate authority of the state is dependent on the consent of the individual members of society. . . Citizens, through autonomous democratic

⁶⁸⁶ H. A. Kissinger, 'A world we have not known', (Jan 27th, 1997) *Newsweek* 74, 77.

⁶⁸⁷ Partha Chatterjee states the CCP claimed power to act as the "state-representing-the-nation", therefore "any movement which questions this presumed identity between the people-nation, and the state-representing-the-nation is denied the status of legitimate politics." See e.g., P. Chatterjee, *Nationalist Thought and the Colonial World: a Derivative Discourse* (London, Zed, 1986), 168.

choice, determine the goals for the society... This moral psychology is absent in China... Doing what was right was more important than the capacity to choose.”⁶⁸⁸

One certain characteristic of professionalisation is autonomy through self-regulation. Baraban says, “Liberalism is fundamentally concerned with individual liberty, self-determination, and self-control.”⁶⁸⁹ While individual rights are “universal” and “natural” in the West, fidelity to the community is a widely accepted norm in Chinese culture. While the liberal democracies view their constitutions as supreme laws that protect individuals from government abuses, self-determination of individuals in China has not yet infused itself into the legal soul and social norms.

5.4 Barriers to Professionalisation: Summary and Discussion

As previously discussed, the concepts of professionalism and professional autonomy are not supported by Chinese historical practice or ideological traditions. Yet cultures are different in light of historical records, and the influence of globalisation is beyond the control of a few politicians. Looking to the future, it is not the case that Chinese cultures are authoritarian and thus will remain fundamentally different from individualistic Western ones, nor the case that individual freedom and professionalism are alien or inapplicable to China.

Despite the culturalist objection, the politico-economic rejections remain. Whenever there is a proposed change, struggles and conflicts occur. Professionalisation is part of the progress for an authoritarian state to become more liberal. Such values of liberalism require first and simultaneously broader political changes in China. I also doubt that without general legal reform or broader political change, in an undemocratic country like China, it is practical to place a great deal of emphasis on empowering Chinese medical practitioners. Will Chinese politicians perceive the idea of medical professionalism as a political threat? It is not difficult to imagine that this will be so once Chinese medics demand the right to practise their professional power without political interference. The Communist Party may regard medics’ demands as

⁶⁸⁸ R. P. Peerenboom, ‘Rights, Interests, and the Interest in Rights in China’, 31 (1995) *Stanford Journal of International Law* 359, 378-379.

⁶⁸⁹ C. L. Baraban, ‘Inspiring Global Professionalism: Challenges and Opportunities for American Lawyers in China’, 73 (1998) *Indiana Law Journal* 1247.

an implicit challenge to its own competence and treat it as a political threat. Evidence can be found from the 1989 Tiananmen Square tragedy, in which Chinese university students and intellectuals confronted the government asking for democracy.⁶⁹⁰ This student protest sadly resulted in a massacre.

However, medical professionalism is not a totally impossible mission. This is not only because Chinese Communist Party ideology has long endorsed the concept that government action should reflect the will of the people, manifested in the “mass line” principle of “from the people, to the people”; but also because we are seeing changes happen. The government might (or at least is trying to) be more open to different voices. Chinese President Hu Jintao (also General Secretary of the Central Committee of China’s Communist Party) says,

“A harmonious society should feature democracy, the rule of law, equity, justice, sincerity, amity and vitality... By developing socialist democracy, the people’s opinions may be further let out, their intelligence be fully absorbed, and a democratic policy-making mechanism will help balance different social interests and avoid social conflicts.”⁶⁹¹

It is noted that Chinese leaders are aware of the importance of building up democracy in Chinese society. The question is how they balance freedom of speech/intelligence with avoidance of social conflicts. China is undergoing fast socio-economic changes and relatively slower political reform, so it is hard to predict what will happen to the medical profession in China.

The status and role of medical practitioners will be shaped by the nature of society. Professional status is not an inherent right, but is granted by society. If Chinese social evolution is in the direction of a democratic society, the emergence of professionalisation with the establishment of independent associations, increases in income and political power are likely to follow. If the evolution does not change state authoritarianism completely, professional independence without a reasonable ethical standing will be curbed and their association will remain under the control of the state.

⁶⁹⁰ See e.g., H. Y. Lee, ‘From Revolutionary Cadres to Bureaucratic Technocrats’, in B. Womack (ed), *Contemporary Chinese Politics in Historical Perspective* (Cambridge, University of Cambridge, 1991), 200-201.

⁶⁹¹ See note 287.

Admittedly it would be a long and gradual process to achieve Chinese medical professionalisation. But it is not impossible. The key element for success requires Chinese medics to win the trust from the public, learning from their ancestors who empowered themselves through nationalism (further discussion of which in Chapter 9). If it brings social benefits, the evolution of medical professionalisation will be welcomed by the Chinese people. And it will be hard for the Chinese government, which has always claimed that it represents the Chinese people's best interests, to counter this move. This is also why the square model presented in the beginning of this chapter is important.

6. Conclusion: Looking to the Future

After looking closely at China's medical deprofessionalisation in Chapter 7, this chapter has discussed the need for the empowerment of Chinese medical practitioners. Starting with an analysis of what constitutes a profession in the Western conception, I have analysed these characteristics that distinguish professions from other occupations and the means by which a technician or skilled worker is granted the status of a professional. I then examined the need for and prophecy of developing professionalisation in China. This includes questioning general processes of medical professionalisation in the West and briefly reviewing China's past experience of intellectual empowerment. I then attended to the question of whether early-stage attempted professionalisation exists in China and considered, what are, or would be cultural and political barriers for preventing Chinese medical practitioners from becoming more professional.

Recognising that the state - which uses various means such as the law, courts, and the administration and financing of services – could be the most powerful constraint or incentive to influence professionalisation, the Chinese Communist Party has indeed never withdrawn its ideological control in order to ensure that the law in China serves Party policies. I argue that, on balance, professionalism is a preferable model of organising the work of medical professionals in a highly authoritarian country like China. Foucault has traced the influence of professional knowledge on both social policy and everyday life. Although he did not use the terminology of professionalism,

he was in fact concerned with professionalism, for the professions are the agents who create and advance knowledge inherent in their disciplines, and the impact of their knowledge has an influence on social and state affairs.

Given the complex and changing context of the Chinese healthcare system, it is the right time for Chinese medics to reposition themselves as a profession. The whistle-blowing cases have shown that a few Chinese medical practitioners have responded proactively to demands for a better, more responsible practice. However, professionalisation cannot progress beyond piece-meal resistance and individual localised responses, unless medical professionalisation in China develops collectively from the strengthening of professional ethics and institutional support, such as the establishment of independent professional associations and the profession's own self-regulated ethical codes. Such professional developments will in turn create a more balanced healthcare power dynamic in China and allow Chinese medics a position of greater influence to negotiate their relationship with centrally-controlled healthcare governance structures.

Looking to the future, no matter how the social evolution develops in China, this thesis would like to revisit the purpose of medicine – to benefit humanity. In serving patients' best interests, Chinese medical practitioners should become more professionalised. Though professionalism is not an answer once and for all (see discussion in Chapter 9), it is a valid first step.

However, one should also be aware that medical professionalism which emphasises medical professional empowerment can also ignore patients' interests. Without the possession of altruistic motives and codes, professionalism which only serves professionals' self-interest would lose its meaning. This does not mean we should abandon professionalism and self-regulation altogether either. The key question to be discussed in the next chapter is how to build up professionalism in China, and more importantly, how to balance professional autonomy and social responsibility so that professionalism is accountable and in the public interest.

CHAPTER 9 ENHANCING MEDICAL PROFESSIONISM IN CHINA: EMPOWERMENT AND THE BALANCE OF POWER

1. Introduction

In the previous chapters, I suggested that professionalisation could be a solution to solve the problem of medical deprofessionalisation, even though it is unpredictable as to which direction Chinese society will turn, or stay. In Chapter 8, I emphasised the needs for China to enhance medical professionalisation and finally achieve professionalism in healthcare. However, this is not to suggest that the Western industrialised countries' professional model is unproblematic, nor that the existing Western model of medical professionalism is the best way forward.

The notion of professionalism in China entails a call for a balance of power. This chapter considers the potential harm caused when medical professionals have 'superpower', as in America. It aims to suggest that calling for professionalism in China does not mean less patient input, but less state control. In this chapter, I offer my proposal for building accountable medical professionalism. How Chinese medical practitioners come to gain professional control and how they exercise and organise the power once they seize it within the framework of altruistic values are the main questions to be answered here.

This chapter starts by examining the pros and cons of professionalism. It then reshapes the square-shaped model of professionalisation to propose a pentagon-shaped of accountable professionalism model in order to ensure that professional empowerment will ultimately promote the public good. The pentagon-shaped model further divides into three levels of "power balancing" – the belief level of control, the interactive control and boundary control. Finally, it draws a conclusion that medical professionalism in China is both necessary and desirable so long as suitable power

balance systems are also all in place. Such an empowered identity will develop for its own sake, and more importantly, for the way it benefits others.

2. Professionalism in a Pentagon Model

2.1 Professionalism

Medical professionalism is an influential but controversial concept in the West. While pressure for changes and resistance against professionalisation is great in the West, experience in China suggests that deprofessionalisation is not the best way forward either. I propose to introduce this concept to China despite its setback in Western countries. As I will explain shortly, I do so, however, by using this established term and giving it a new meaning for the Chinese context. At the same time, important lessons presented by the Western countries on how to ensure professions are competent will be taken into serious consideration.

(1) Terminology

Vollmer and Mills use “professionalism” to refer to an outcome of a process which “may induce members of many occupational groups to strive to become professional”.⁶⁹² They also point out that professionalism as an ideology is a necessary constituent of professionalisation, but professionalism by itself is not sufficient to ensure the entire professionalisation process.⁶⁹³

Freidson indicates the nature of professionalism is a form of occupational control. A profession’s aspirations towards occupational autonomy lie not just in the immediate work setting, but in the related ability of self-governing and of acting as an autonomous source of influence in the policy process.⁶⁹⁴ It should be noted that there is a broader use of professionalism which refers to a broad, educated stratum, including personal service functionaries like barbers, bootblacks, and taxi drivers who

⁶⁹² H. M. Vollmer and D. L. Mills, *Professionalization* (New Jersey, Prentice-Hall, 1966), viii editor’s introduction.

⁶⁹³ Ibid.

⁶⁹⁴ E. Freidson, *The Sociology of the Professions: Lawyers, Doctors and Others* (New York, Robert Dingwall & Philip S.C. Lewis, 1983), 19-36.

appear to be “easily professionalised.”⁶⁹⁵; it is the narrow definition, as below, that I use in this thesis.

Chapter 8 has discussed the characteristics of a profession. Freidson argues that, in major advanced industrial nations, the position of professionals and the nature of their practice are changing; however the essential elements of professionalism are not disappearing, but are rather taking on a new form.⁶⁹⁶ Parsons further claims that the ideal qualities that are connected with a profession contain five essential behaviours. Briefly speaking, they are knowledge, community-based orientation, self-control, reward systems and autonomy.⁶⁹⁷ Parsons’ generalisation of the essence of professionalism can be further summarised into two key elements: professional principles and an institutional system.

Comments from Frankford and Konrad shed some light on ‘professional principles’: “Professionalism is not some given of the social world but rather is a normative vision sustained by a particular institutional framework”.⁶⁹⁸ Unpacking their comments, the ‘normative vision’ of professionals is that it should sustain and be possessed of competency, character, and the principle of being “moral” and so being devoted to the public good. Professionalism is understood to be an ideal to be pursued. Understandably, medics are human, and they will not always achieve the ideal, but in striving for it they should reach ever higher levels of performance.

An ‘institutional framework’ can be interpreted to refer to the ideals of the medical professional that are linked to or dependent upon institutions. The core objective of professionalism is seen by d’Oronzio as a set of institutions for embodying the expertise of individuals, so guaranteeing quality of service, and controlling the performance of workers.⁶⁹⁹ The institutional concept of a profession allows us to think

⁶⁹⁵ T. Caplow, *the Sociology of Work* (Minneapolis, University of Minnesota Press, 1954), 48, 139.

⁶⁹⁶ E. Freidson, *Professionalism Reborn: Theory, Prophecy, and Policy* (Chicago, University of Chicago Press, 1994), 8-9.

⁶⁹⁷ T. Parsons, ‘Professions’, in D.L. Sills (ed), *International Encyclopedia of the Social Science* (New York, MacMillan, 1968), 536-547.

⁶⁹⁸ D. M. Frankford and T. R. Konrad, ‘Responsive Medical Professionalism: Integrating Education, Practice, and Community in a Market-Driven Era’, 73 (1998) *Academic Medicine* 2, 138-145.

⁶⁹⁹ J. C. d’Oronzio, ‘Practicing Accountability in Professional Ethics’, 13 (2002) *Journal of Clinical Ethics* 4, 359.

of “professionalism” as, in Johnson’s terms, a way of organising an occupation,⁷⁰⁰ so that the process of professionalisation can be strengthened within or under the institutional framework.

The definitions and generalisation of the term professionalism address the specialisation of an occupation amongst others. I have discussed earlier the role of being a profession and the importance of the professionalisation process. In the healthcare arena, the model of professionalism captures a distinction important for the organisation of work and for public policy – professional autonomy. As professionals from a state characterised by politically instrumentalised deprofessionalisation, Chinese medics’ professional autonomy is what is missing and needs to be enhanced. The rise of counter-power or counter-politics, whether from non-intellectuals or professionals, is of importance to balance political power, and furthermore, to prohibit any possibility of power-abuse. Medical professionalism allows medics to stay true to their morals and values, to exercise their independent judgement and offer the right to refuse and stay true to their professional commitments, when asked to participate in acts that conflict with personal, ethical, moral convictions.⁷⁰¹ Professionalism allows room for occupational autonomy and thus it is especially important for professionals who are struggling for control.

(2) Scepticism of Professionalism

Until the late 19th century, it was common for some of the most notable scholars of the day to emphasise the importance of professionalism in modern Western societies, and to consider professionalisation to be a major social movement that transformed societies and the nature of the work.⁷⁰² Now, however, medical professionalism has

⁷⁰⁰ T. Johnson, *Professions and Power* (London, Macmillan, 1972), 45.

⁷⁰¹ J. Blackmer, ‘Current Global Trends in Medical Professionalism’, 1 (2009) *World & Health Policy* 1.

⁷⁰² H. Spencer, *The Principles of Sociology* (New York, Appleton, 1914[1896]), vol.3, part 7; S. Webb and B. Webb, ‘Special supplement on professional associations’, (1917) *New Statesman* 211, 9; R. H. Tawney, *The Acquisitive Society* (New York, Harcourt Brace, 1920), 91-122; A. M. Carr-Saunders, *Professions: Their Organization and Place in Society* (Oxford, Clarendon Press, 1928); P. A. Wilson and A. M. Carr-Saunders, *The Profession* (Oxford, Clarendon Press, 1933), 493-4; T. H. Marshall, ‘The recent history of professionalism in relation to social structure and social policy’, (1939) *Canadian Journal of Economics and Political Science* 5, 325-40; H. M. Vollmer and D. L. Mills, *Professionalization* (New Jersey, Prentice-Hall, 1966); T. Parsons, ‘Professions’, 12 (1968) *International Encyclopedia of the Social Sciences*, 545; W. E. Moore, *The Professions: Roles and*

lost its popularity and the existing model of professionalism has been brought into question. Half a century ago, Marx pointed out that the topic of professions raised fundamental issues about the relationship between social differentiation and class structure.⁷⁰³ His idea of a professional group being a privileged “class” is still relevant today. Medical professionalism gradually lost its popularity mainly because medical professionals were accused of having too much power, alongside a lack of external control.

There have been increasing doubts about professionalism, especially when there is a healthcare scandal. Public trust in medical professionalism fades away. Scandals involving poor medical practice that have been reported in the UK, from operations performed without the patients’ permission to the high profile Alder Hey scandal and the Shipman murders.⁷⁰⁴ Similar criticisms are not difficult to find in the US either. Barer describes,

“Everywhere in the United States the professions have reached new heights of social power and prestige . . . yet everywhere they are also in trouble, criticized for their selfishness, their public irresponsibility, their lack of effective self-control, and for their resistance to requests for more lay participation in the vital decisions professionals make affecting laymen.”⁷⁰⁵

Along with the public, the courts and the legislature in the US and UK have been increasingly criticised for placing too much power in the hands of medical professionals either to define certain issues (such as abortion) or to determine the legal

Rules (New York, Russell Sage, 1970); T. J. Johnson, *Professions and Power* (London, Macmillan, 1972); D. Bell, *The coming of Post-Industrial Society* (New York, Basic Book, 1976), 144; E. Freidson, *Doctoring Together: A Study of Professional Social Control* (Chicago, University of Chicago Press, 1980); E. Freidson, *Professional Power: A Study of the Institutionalisation of Formal Knowledge* (Chicago, University of Chicago Press, 1986); E. Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Chicago, University of Chicago Press, 1994); K. M. MacDonald, *The Sociology of The Professions* (London, Sage Publications, 1995); E. A. Krause, *Death of the Guilds: Professions, States, and the Advance of Capitalism, 1930 to the Present* (New Haven, Yale University Press, 1996).

⁷⁰³ K. Marx, ‘Theories of Surplus Value (Vol. IV of Capital)’, translated by E. Burns, *Theories of Productive and Unproductive Labour* (New York, International Publishers, 1969), 152-304.

⁷⁰⁴ These healthcare scandals have included the suspension from the medical register of paediatric cardiac surgeons from Bristol following an inquiry into poor standards of care, the revelation that children’s organs had been removed and retained without their parents’ consent during post mortem examinations at Alder Hey Hospital in Liverpool, and the murder by Dr Harold Shipman of more than 200 of his patients. See e.g., The Report of Royal Liverpool Children’s Inquire chaired by Michael Redfern, ordered by the House of Commons, available at: <http://www.rlcinquiry.org.uk/> and British Department of Health, Reports of independent public inquire by Dame Janet Smith DBE, *The Shipman Inquire*, available at: <http://www.the-shipman-inquiry.org.uk/reports.asp> (Last visited on Jan 21st, 2011).

⁷⁰⁵ B. Barber, ‘Control and Responsibility in the Powerful Professions’, 9 (1978) *Political Science Quarterly* 3, 599-615.

standards to which those professionals are held to account.⁷⁰⁶ More importantly, the reason for criticism is that the position adopted by Western physicians is not for patients' best interests, but for themselves.

Public supervision and state intervention in professional conduct are being gradually adapted to include a requirement for regular rectification. As Lord Woolf states,

“The courts are nowadays, with increasing frequency, being asked to adjudicate on legal points bound up with fundamental and emotive questions of medical ethics...The importance I attach to these cases is the fact that, although the expert evidence of doctors is most important on the ethical issues involved, the courts are final arbiters and not the doctors.”⁷⁰⁷

Therefore, the phrase “Doctor knows best” has been updated to “a doctor knows the best if he acts reasonably and logically and gets his facts right.”⁷⁰⁸ Deprofessionalisation, in Light⁷⁰⁹ and Walzer's⁷¹⁰ understanding, may not necessarily be a problem, because “professional knowledge and power can be dissolved by arming a lay society with sufficient knowledge: through the deprofessionalization of everyone or through the generation of appropriate expertise.”⁷¹¹ Instead, professionalism itself may be problematic, as “it stresses professional distinctiveness to the detriment of the many points of contact and connection between professional institutions and culture, and the more general lay institutions and culture.”⁷¹²

One feature of the contemporary movement of “anti-medical professionalism” is patient empowerment. The introduction of axioms, such as, patient self-determination, patient autonomy and the right to choose, indicate power has shifted from doctors to patients. Not every professional welcomes these participatory mechanisms, as they seem to indicate that the profession is incompetent and not trustworthy, which could damage the future of medicine. Having had a different view several years previously,

⁷⁰⁶ K. Veitch, *The Jurisdiction of Medical Law* (Hampshire, Ashgate, 2007), 2-3.

⁷⁰⁷ The Right Honourable The Lord Woolf, ‘Are the Courts Excessively Differential to the Medical Profession?’, Spring (2001) *Medical Law Review* 9, 13.

⁷⁰⁸ *Ibid.*, 1-16.

⁷⁰⁹ D. W. Light and A. Schuller, *Political Values and Health Care: the German Experience* (Cambridge, MIT Press, 1986), 10-11.

⁷¹⁰ M. Walzer, ‘Socializing the Welfare State’, in A. Gutmann (ed), *Democracy and the Welfare State* (New Jersey, Princeton University Press, 1988).

⁷¹¹ D. M. Frankford, ‘The Normative Constitution of Professional Power’, 22 (1997) *Journal of Health Politics, Policy and Law* 1, 213.

⁷¹² *Ibid.*

the prominent American sociologist Friedson went on to argue that ideological attacks on professionalism had distracted us from the fact that we were profoundly dependent on organised bodies of specialised knowledge and technique.⁷¹³ This assault, he said, had created a sense of distrust that further weakened the credibility of the professional institutions' ability to offer an independent and moral viewpoint.

The existing systems in the West have brought professionalism into question. The increasing domination of professional power is conceived to be a problem as it is likely to ignore the interests of patients. The solution to this problem lies in the use of countervailing power, as some scholars have suggested.⁷¹⁴ But I think that countervailing power is not the perfect answer either. Because "professionalism is a complex mosaic laid on a foundation of both competency and character",⁷¹⁵ to throw the baby out with the bath-water can do more harm than good. What we really need is to strike a balance between the "necessary freedom for the professional" and a "sufficient measure of accountability to ensure responsiveness to social needs and agreed social purposes".⁷¹⁶

Several sociological accounts of professions in post-socialist societies emphasise the relationship between the state and the professions in terms of control and discipline, suggesting that professionals lack the critical autonomy and integrity to shape their professional field.⁷¹⁷ In the West, no one would wish the professions to be totally subservient to the will and whims of the state. Equally, the autonomy to which the professions lay claim fits uneasily with self-governance, especially without the scrutiny of a third party. There has to be an accommodation between the professions and the state, so preserving the professions as independent critics of public policies

⁷¹³ See note 696.

⁷¹⁴ E. Freidson, *Professional Dominance: The Social Structure of Medical Care* (Chicago, Aldine, 1970), 76, 158, 211, 234; also cited by D. M. Frankford, 'The Normative Constitution of Professional Power', 22 (1997) *Journal of Health Politics, Policy and Law* 22.

⁷¹⁵ J. C. d'Oronzio, 'Practicing Accountability in Professional Ethics', 13 (2002) *The Journal of Clinical Ethics* 4, 359.

⁷¹⁶ P. Wilding, *Professional Power and Social Welfare* (London, Radical Social Policy, 1982), 118.

⁷¹⁷ A. Buchner-Jeziorska and J. Evetts, 'Regulating Professionals: the Polish Example', 12 (1997) *International Sociology* 1, 61-71; I. Butenko, 'The Russian Sociological Association: Actors and Scenery in a Revolving Stage', 17 (2002) *International Sociology* 2, 233-251; A. Smolentseva, 'Challenge to Russian Academic Profession', 45 (2003) *Higher Education* 391- 424; S. Pasti, 'Two Generations of Russian Journalist', 20 (2005) *European Journal of Communication* 1, 89-115; P. Osinsky and C. Mueller, 'Professional Commitment of Russian Provincial Specialist', 31 (2004) *Work and Occupations* 2, 193-224.

while at the same time securing their subordination to agreed public policies and purposes. In the following section, I will propose a pentagon-shaped model to solve the possible dilemmas caused by professionalism.

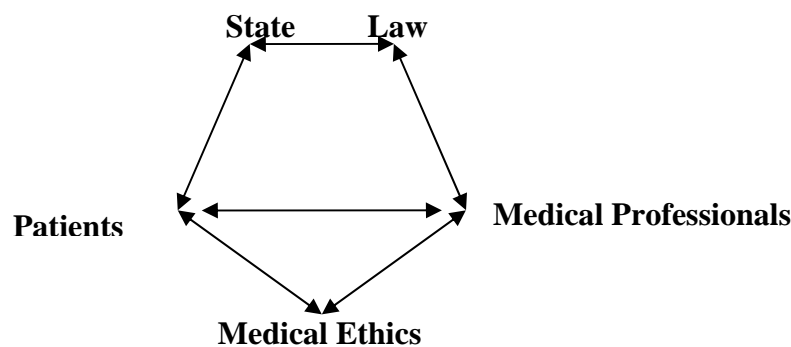
2.2 A Pentagonal Model and Three Tiers of “Power Balancing”

(1) A Pentagonal Model

‘So what I’ve said does not mean that we are always trapped, but that we are always free – well, anyway, that there is always the possibility of changing.’

Michel Foucault⁷¹⁸

This thesis has examined the triangular and top-down models drawn from the literature reviews, and the circular model derived from my empirical study, suggested a square model was necessary for the discussion of deprofessionalisation. However, none of these models is ideal for the purpose of empowering the medical professionals whilst maintaining professional accountability, and ensuring that patients’ interests are well protected within a professional empowerment movement. Medical professionalism operates in the field of power relations which entails responsibilities, reactions, effects, and even, interventions. I have faith in professional power, but I also believe the best way for Chinese medics to hold power is to give it away. Therefore, towards the end of this thesis, a pentagonal model is suggested as below:



⁷¹⁸ Foucault responded this to the critiques addressed to him ever since he initiated his work on power. Quote cited by M. Lazzarato, ‘From Biopower to Biopolitics’, 2 (2002) *Tailoring Biotechnologies* 2, 11-20.

The dynamics of this new pentagonal model are that it connects professionalism with patient participation. What is more, horizontally, this model can be divided into three tiers (state & law; medical profession & patients; ethics) where the whole model still shows a visible, compact network between the different parties in healthcare governance. In this model, empowered professionals are guided by law and can affect legislation; patients are supported by a state funded healthcare system and can voice their reaction to the state agencies; ethics is grounded for all healthcare interactions, especially for medics.

Power in this model is not held by a single party. Power, according to Foucault, can be dispersed, fragmented, decentralised, omnipresent and therefore invisible.⁷¹⁹ In the pentagonal model, neither the medical profession, patients nor government bureaucracy capture absolute power. I do not mean to suggest elimination of either professionals' or patients' power, but instead the pentagonal model suggests the necessity of their involvement in a healthcare governance network, so that the power can flow through and from those activities, in which state, law, professionals and patients can work together for a common purpose: humanity and care.

According to Light⁷²⁰ and Walzer⁷²¹, in the liberal vision, the power over health would not be delegated to the state, to experts, including professionals, or to the bureaucracies of private associations. Rather, power over health would be mutual between professionals and patients. It should also be participatory.⁷²² Medical professionals need to treat patients with dignity and respect, and to see them as partners in the process of medical decision-making and care-giving; and patients need to reciprocate professional behaviours. I argue that patient autonomy is as important as professional autonomy. The pentagonal model also reflects my argument that the power dynamic flowing between medics and patients has to seek and develop a balance between mutual respect for autonomy and accountability.

⁷¹⁹ See notes 456, 479 and 560.

⁷²⁰ D. W. Light and A. Schuller, *Political Values and Health Care: the German Experience* (Cambridge, MIT Press, 1986), 10-11.

⁷²¹ M. Walzer, 'Socializing the Welfare State', in A. Gutmann (ed), *Democracy and the Welfare State* (New Jersey, Princeton University Press, 1988).

⁷²² D. M. Frankford, 'The Normative Constitution of Professional Power', 22 (1997) *Journal of Health Politics, Policy and Law* 1, 186-219.

Moreover, accountability is more likely to be achieved in a balanced and interactive model. Therefore, finding a balance between professional power and its altruistic basis is necessary; so is establishing control mechanisms to ensure medics are competent. To suit this purpose, in the following section, I will suggest three tiers of “power-balancing” from (1) bio-ethics; (2) professional self-regulation & patient participation and (3) state stewardship.

(2) Three Tiers of “Power-Balancing”

My idea of varied levels of control for medical professionalism is borrowed and reinvented from an idea proposed by Professor Robert Simons of Harvard Business School. He suggests four control levers for business management: a diagnostic control system, a belief system, a boundary system, and an interactive control system.⁷²³ The idea of having four levels of control is to “reconcile the conflict between creativity and control” so that the necessary control can be in place when empowering employees in business management.⁷²⁴ Simons’s notion of different levels for balancing control and empowerment could also be re-invented and accommodated into the context of medical professionalism and accountability control.

To establish a responsive model of medical professionalism for China, I divide the pentagonal model into three tiers: the first tier is foundational – professional ethics; the second tier is interactive – participation of the medical profession and patients, and the third tier includes the boundary between healthcare governance and law. Each level of control aims to balance professional power and ensure its altruistic values. They are in conjunction with one another to suit the ultimate mission of the medical profession: to safeguard the health of the people.

Within the pentagonal model’s three levels of power-balancing mechanisms, the ground level is the value system – bio-ethics. Bioethical control is “to inspire and

⁷²³ R. Simons, ‘Control in an Age of Empowerment’, March-April (1995) *Harvard Business Review*, 81-88; R. Simons, *Levers of Control: How Managers Use Innovative Control Systems to drive Strategic Renewal* (Boston, Harvard Business School Press, 1994).

⁷²⁴ Ibid.

promote commitment to an organisation [medicine]’s core value”.⁷²⁵ The interactive level is to empower both the Chinese medics and patients, so that deprofessionalised medics will have more control over their work and patients will be able to exercise autonomy. As to the boundary control, state and law have a role to facilitate and oversee this partnership with and between medical practitioners and patients, but state and law should not prescribe every single rule. The state needs to ensure a funded healthcare system is in place, while law establishes the boundaries of practice and identifies actions and pitfalls that practitioners must avoid.

3. The Foundation Tier: Professional Ethics

“Conscience: An inner voice that warns us someone is looking.”

H.L. Mencken⁷²⁶

3.1 Medical Ethics: Laying the Foundation Stone for Medical Professionalism

“First, do not harm.” – the core of Hippocratic Oath,⁷²⁷ and the most quoted tradition in the history of medicine has provided the moral foundation for the practice of Western medicine since ancient Greece. Through modification over the years, the Hippocratic Oath’s ethical strength can still be seen in different forms, both internationally and locally. *The Declaration of Geneva* of the World Medical Association binds the physician with the words, “The health of my patient will be my first consideration... I will maintain by all the means in my power, the honour and the noble traditions of the medical profession”,⁷²⁸ and *the International Code of Medical Ethics* declares that, “A physician shall be dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity... [and] act in the patient’s best interest when providing medical care.”⁷²⁹ The Declaration and International Code provide the moral grounding for the

⁷²⁵ Ibid, 82.

⁷²⁶ H. L. Mencken, *A Mencken Chrestomathy: His Own Selection of His Choicest Writing* (New York, Knopf, 1949).

⁷²⁷ L. Edelstein, *the Hippocratic Oath: Text, Translation and Interpretation* (Baltimore, John Hopkins University Press, 1996).

⁷²⁸ World Medical Association, *Declaration of Geneva*, May 2006, available at: <http://www.wma.net/en/30publications/10policies/g1/index.html> (Last visited on Oct 6th, 2010).

⁷²⁹ World Medical Association, *International Code of Medical Ethics*, available at: <http://www.wma.net/en/30publications/10policies/c8/index.html> (Last visited on Oct 6th, 2010).

international medical community's consensus with respect to medical ethics. Locally, the Physician's Oath or Bioethics Code varies from region to region, but in general they share the common professional commitment: make the care of patients the medical profession's first concern.⁷³⁰

The code of medical ethics provides a behavioural standard for medical professionals. It also establishes the moral authority and independence of medics from the state in their service to others and their responsibility towards the sick. Weisz says, "Bioethics' is a social and cultural, as well as intellectual happening."⁷³¹ In Fox and Swazey's interpretation, bioethics is "not just bioethics,... and [it] is more than medical...using biology and medicine as a metaphorical language and symbolic medium, bioethics deals... with nothing less than beliefs, values and norms that are basic to our society, its cultural tradition, and its collective conscience."⁷³²

The individual medical practitioners' initial emphasis on professional ethics reflects a landmark in medicine's professional development. Professions, as Collins puts it, "are occupations which organize themselves 'horizontally', with a certain style of life, code of ethics, and self-conscious identity and barriers to outsiders."⁷³³ The code of medical ethics portrays the medical profession's moral identity as well as one of individual honour – the honour of being accountable and trustworthy. Indeed, medics' claims to autonomy and authority are dependent upon their professional knowledge and their claim to serve the public interest. A good reputation is the basis for obtaining trust and greater power. Unethical practice and breaches of trust not only conflict with the aspirations of medicine, but also endanger professional status.

I suggest that medical ethics should become the foundation stone for medical professionalism in China. This is because a code of medical ethics would give

⁷³⁰ See e.g., GMC, 'Good Medical Practice: Duties of a doctor', available at: http://www.gmc-uk.org/guidance/good_medical_practice/duties_of_a_doctor.asp; AMA, 'Declaration of Professional Responsibilities', available at: <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/declaration-professional-responsibility.shtml>; CMA, 'Canadian Medical Association Code of Ethics', available at: <http://policybase.cma.ca/PolicyPDF/PD04-06.pdf> (Last visited on Oct 6th, 2010).

⁷³¹ G. Weisz, *Social Science Perspectives on Medical Ethics* (Norwell, Kluwer, 1990), 201.

⁷³² R. C. Fox and J. P. Swazey, 'Medical Morality is not Bioethics – Medical Ethics in China and United States', 27 (1984) *Perspectives in Biology and Medicine* 336, 360.

⁷³³ D. C. Hallin and P. Mancini, *Comparing Media Systems: Three Models of Media and Politics* (New York, Cambridge University Press, 2004).

Chinese medical practitioners the confidence to stay true to their dedicated profession; it would grant them public trust and support; ultimately and more importantly, it will provide them with power to avoid micromanagement and policing, and will empower them to resist instrumentalisation.

Western medicine is currently widely practised in China, a country whose past is filled with philosophical and at times, violent rejections of the rule of law, so Chinese medical practitioners are often lost in the gap between using Western medicine and the inheritance of the Chinese values. It has been a century since Western medical knowledge was introduced into Chinese medical schools, whilst Western bioethics which should have been introduced together with the techniques and knowledge have lagged far behind. Yet, one might also argue, Western medicine and Western bioethics have never developed at the same pace, neither do they necessarily come “in the same package”, so why should I claim there is a loss in China?

Western medicine’s development embodies both values and aspirations. The image of Western medicine is as a tool for healing; medical practitioners are users. It is not enough for users only to know how to use the tool; more importantly, they need to know how to get the best use from it. Users should learn the meanings and ‘spirit’ that are embodied in the tool, so that their competence can be applied responsibly. Therefore, medical practice should be carried out conscientiously. Laying medical ethics as a foundation is also necessary to ensure that medicine is not misused for purposes other than medical one. A medical ethics foundation could be a start to approaching the problem of political instrumentalisation of medical practitioners in China. Western bioethics that was missing originally should be introduced; better late than never.

3.2 Restoring Professional Ethics in China

The lack of bioethics has profoundly affected China’s healthcare environment. There is a great need to restore it in China. I will first review the development of Chinese medical ethics from past to present, and then argue for a reform of medical ethics education in China.

(1) “Love” in Traditional and Modern Chinese Bioethics

“The achieving of humaneness depends upon oneself. If a man is not humane, what is the use of knowing norms?”

Confucius⁷³⁴

The professional value of “love” is associated with traditional Chinese medicine, developed over a period of 2,500 years.⁷³⁵ In ancient China, it was commonly recognised that one must read a vast range of books, particularly the “Four Books and Five Classics”⁷³⁶, in order to become a medical doctor. These books addressed many subjects, such as politics, ethics, and history, and the purpose of reading them was to cultivate one’s moral attitude. As a result, most medical doctors were also intellectuals. Traditionally, the word “intellectual” in Chinese implies loftiness, a sense of social responsibility, a loving heart, honesty, and scrupulous conduct.⁷³⁷ That is why in Chinese philosophy, medicine was considered a humane art that was based on the spirit of loving others. It holds that to be a good doctor one must be a morally good person. Consequentially Confucians put more weight on internal feelings than on external restraints.

Traditional Chinese medical ethics drew upon China’s major traditions: Confucianism, Daoism and Buddhism. The word “*yide*” (medical morality) in the contemporary Chinese language mainly means “professional and personal virtue of the health professional”. Ethical principles and philosophical analysis of medical practice constitute only a part of medical morality. According to Nie, moral experience itself is the basis of medical morality.⁷³⁸

⁷³⁴ Confucius, in W. E. Soothill (ed), *The Analects of Confucius* (Edinburgh, Dover Publishing, 1995), 76.

⁷³⁵ R. Peng, ‘How Professional Values are Developed and Applied in Medical Practice in China’, Special Supplement, 30 (2000) *Hasting Centre Report*, 23.

⁷³⁶ A collection of the most important Chinese classics in literature, namely, *The Great Learning, The Doctrine of Mean, The Analects of Confucius and Mencius, The Book of Songs, The Book of History, The Book of Changes, The Book of Rites, and The era of Spring and Autumn Annals*.

⁷³⁷ D. Zhang, ‘Love and the History of Chinese Bioethics’, 9 (1999) *Journal of Asian and International Bioethics* 9, 47-49.

⁷³⁸ J. Nie, ‘The Plurality of Chinese and American Medical Moralities: Toward an Interpretive Cross-Cultural Bioethics’, 10 (2000) *Kennedy Institute of Ethical Journal* 3, 239-260.

Contemporary Chinese medical ethics have developed in a country with an underdeveloped economy, a power-centralised political system and a natural law tradition. Moral intuition and moral attitudes towards medical decisions are affected both by long-standing and socially entrenched traditional values, and by the current dominant ideology.⁷³⁹ Contemporary Chinese medical ethics provides an example of a Marxist Socialist society's alternative to the Hippocratic Oath and liberal Western medical ethics.⁷⁴⁰ Renzong Qiu, a leading bioethicist and philosopher of science in China, has effectively summarised and expressed the common Chinese view of the culture of Chinese medical ethics:

“A quasi-holistic socio-political philosophy has been developed from Chinese cultural traditions. It is based on two thousand years of power-centralized, autocratic monarchy – one that has lacked any rights-oriented, individualistic, liberal democratic tradition. In recent decades, Marxism has become the dominant ideology. The historicism and social holism of this system, interwoven with traditional ideas, puts the greatest emphasis on nation, society, and country rather than on individuals.”⁷⁴¹

For both Qiu and Nie, there exists a characteristic Chinese way of thinking about and acting in public and private life, in interpersonal interactions, and in moral issues in medical practice, where Chinese culture and medical ethics give priority to country, community and authority.⁷⁴² Fox and Swazey point out that contemporary Chinese medical morality is an unbalanced combination of Maoism-Marxism-Leninism, Confucianism, Taoism, and Chinese Buddhism.⁷⁴³ Engelhardt disagrees with Fox and Swazey, as he observes that, for many of his Chinese hosts “ethics was a mode of moral indoctrination or of exegesis of a single moral viewpoint, in this case Maoist-Leninist-Marxism.”⁷⁴⁴ However, Nie states, “contemporary Chinese medical ethics is anything but a single moral perspective, no matter how hard the official “state” ideology resists cultural and moral pluralism.”⁷⁴⁵

⁷³⁹ R. Qiu, ‘Chinese Medical Ethics and Euthanasia’, 2 (1993) *Cambridge Quarterly of Healthcare Ethics* 69; also cited by E. K. Kim, ‘Neonatal Euthanasia in Modern China’, vol III *The Lantern* 1, 23.

⁷⁴⁰ R. Crawshaw, ‘Medical Deontology in the Soviet Union’ in R.M. Veatch (ed), *Cross Cultural Perspectives in Medical Ethics: Readings* (Boston, Jones and Bartlett, 1989).

⁷⁴¹ R. Qiu, ‘Medical Ethics and Chinese Culture’, in E. Pellegrino, et al. (ed), *Transcultural Dimensions in Medical Ethics* (Frederick, University Publishing Group, 1992), 170-72.

⁷⁴² Ibid; also see note 738.

⁷⁴³ See note 238.

⁷⁴⁴ H. T. Engelhardt, ‘Bioethics in the People’s Republic of China’, 10 (1980) *The Hastings Center Report*, 7-10.

⁷⁴⁵ See note 738, at 247.

In traditional China, apart from the maxims, admonitions or warnings set forth by individual physicians, there were no medical organisations or professional codes to regulate and control the relationships between medical practitioners and patients as well as those between medics themselves.⁷⁴⁶ “Hence there was no guarantee for all that the prestigious physicians said about medical ethics. The only control or restraints came from the penetrating influence of Confucian ideology.”⁷⁴⁷

Using training techniques that intermingle the Confucian virtues of benevolence with Western bioethics may give Chinese medics the basis they need to confront wrongdoing or malpractice within their profession. Another Confucian virtue – that of self-cultivation – may help create a foundation for a more autonomous profession by encouraging Chinese medical practitioners to reflect more individually on ethical issues rather than with blind obedience.⁷⁴⁸ According to Fei, Chinese society considers order, not laws, to predominate; and in this context, order means that each person must uphold the moral obligations of his or her network ties.⁷⁴⁹ So culturally speaking in China, the self-regulation of ethical codes is more socially acceptable than hard legislation (How to get this “moral obligations” agreed from one social network group to another will be addressed shortly).

What is more, I argue that bioethics is relevant to all bio-political participants, including the state and patients. Referring back to the pentagon-shaped model, ethics should serve as the foundation for all parties. It is not only important for medical professionals, but also for regulators and politicians when they need to make judgements or decisions in relation to biotechnology. An ethical dimension in bio-politics means there should be rational or moral grounds for political decisions.

(2) Bioethical Education Reform

⁷⁴⁶ R. Qiu, *Cross-cultural Perspectives in Medical Ethics* (London, Jones and Bartlett Publishers, 2000), 303.

⁷⁴⁷ *Ibid.*, 291.

⁷⁴⁸ G. MacCormack, *the Spirit of Traditional Chinese Law* (Athens, University of Georgia Press, 1996), 9.

⁷⁴⁹ See note 278, at 24.

Professional doctoring demands that a medical practitioner acts ethically. From my data, answers from Chinese medical practitioners to the question about whether medical ethics is an essential feature of professionalism remained ambivalent. This section lays emphasis on professional ethics because it can be regarded as a means of controlling the use of medical knowledge, especially when there are tensions between the demands of morality and law have been felt, and where there is a vacuum created in professional codes. In my opinion, without ethics, the practice of medicine is not truly professional; and ethics should function as the core value of professional practice.

Professions are bound by ethical codes. Berlant stresses that, as far as medicine is concerned, codes of medical ethics must be seen as organisational tools and resources used by the profession in its bid for a range of privileges, and in particular for professional autonomy and monopolization.⁷⁵⁰ In China, a medical practitioner is very likely to bear a double-duty of being a skilled healer and a party member. Under these circumstances, bioethical education becomes more important: “the discipline inspection system has the disciplinary authority to compel party members to conform to the political will for fear of punishment. But it does not necessarily have the moral authority or persuasive power over party members to engender an ‘inner sense of duty’ for them to pursue high moral standards.”⁷⁵¹

When evaluated from the perspective of the goals of medical education in a democratic society, the Chinese system leaves much to be desired. The Chinese system focuses on conveying knowledge of substantive law, legal institutions and legal processes. Medical values also come from the state rather than professional ethics. The following *Medical Student Oath* set out by the PRC Ministry of Education for the education of every Chinese medical student in their “white-coat” ceremony, is an example:

“Health related, life entrusted. The moment I step into the hallowed medical institution, I pledge solemnly –
I will volunteer myself to medicine with love for my motherland and loyalty to the people.
I will scrupulously abide by the medical ethics, respect my teachers and discipline myself.

⁷⁵⁰ L. J. Berlant, *Profession and Monopoly: A Study of Medicine in the United States and Great Britain* (Los Angeles, University of California Press, 1975), 64.

⁷⁵¹ T. Gong, ‘the Party Discipline Inspection in China: its Evolving Trajectory and Embedded Dilemmas’, 49 (2008) *Crime, Law and Social Change* 139-152, 151.

*Chapter 9 Enhancing Medical Professionalism in China:
Empowerment and the Balance of Power*

I will strive diligently for the perfection of technology and for all - round development of myself.

I am determined to strive diligently to eliminate man's suffering, enhance man's health conditions and uphold the chasteness and honor of medicine.

I will heal the wounded and rescue the dying, regardless of the hardships.

I will always be in earnest pursuit of better achievement. I will work all my life for the development of the nation's medical enterprise as well as mankind's physical and mental health.⁷⁵²

Most Chinese medical students begin their first year with such a ceremony, in which they learn the meaning of the responsibility that comes with wearing the white coat. The expectation arising from the Oath varies from their Western counterparts; the latter expects humanity and professionalism. In the Chinese Oath, nationalism and faithfulness to the state are emphasised. Verbally, it even puts the "motherland" or state's interests before "the people". Nie indicates "Like the official ideology, the socialist discourse of medical ethics in the PRC is statist and collectivist, emphasizing the almost absolute primacy of the interests of the state, the country, and the collective over those of individuals. As a result, medical professionals are morally obliged to be loyal not only to the individual patient but also to the state."⁷⁵³

Historically speaking, however, the statist and collectivist element in contemporary socialist medical morality is unprecedented. For centuries, major Chinese bioethical traditions were ruled by Confucianism, Daoism, and Buddhism which have always advocated that the primary duty of healers is to individual patients. Moreover, while some doctors interviewed in my study apparently accepted and believed in the basic principles of socialist medical morality, especially that of the primacy of the collective interest, in their hearts, some seemed not to accept them. The faith in socialism is fading, some of my interviewees told me. "Isn't China becoming more capitalist than socialist right now?" one of them asked me. Being a CCP member in a healthcare institutions does not mean a belief in communism, but means that they would be granted more opportunities for promotion and career development, so it is a way for a better living in China.

⁷⁵² Q. Liu and L. Xu, 'The Oath of Medical Students', 29 (1999) *Chinese Journal of Medical History* 4, 214.

⁷⁵³ J. Nie, *Behind the Silence: Chinese Voices on Abortion* (Lanham, Rowman & Littlefield, 2005), 187.

Chinese medical graduates may do a reasonably good job in the development of their technical skills and practical competence. Where their ability falls short, is in the development of the most essential doctoring qualities, notably, a healthy scepticism (towards both knowledge and state influenced ethics), intellectual curiosity and creativeness. This is why the values of medical professionalism need to be developed from the early beginnings of medical education. The pentagon-shaped model, which puts ethics as a foundation tier below the profession and patients, indicates that ethics could be seen as a control framework for professionalism, but could also be used to uphold professionalism. Good ethical practice will bring medical practitioners a good reputation, public trust and confidence; in return, public trust and confidence would grant the professionals the power of self-control.

4. Interactive Control: Participation of Professionals and Patients

The practice of accountability entails not only an inner sense of professional ethics, but public scrutiny is also needed through institutional settings with many observers and multiple occasions for accountability. Upholding professional power while keeping the power publicly accountable will not only be an ethical project, but also a social and political, long-term, systematic reconstruction. How to expose, confront and resolve infractions of professional ethics is a question to be answered by scrutiny mechanisms, such as, peer review (self-regulation), public oversight, and state and legal surveillance. This section discusses interactive control mechanisms including medical professionalism and patient participation, while state and legal surveillance are discussed in a subsequent section.

4.1 Building Medical Professionalism in China

In the face of China's medical de-professionalisation, I propose building medical professionalism – by requiring Chinese medical practitioners to adopt the basic requirement for a professional development regime similar to the West: establishing independent professional associations; instituting professionally-led self-regulation; and developing a professional culture with patient-orientated ethics at its base.

(1) Establishing Independent Professional Associations

Medical professionals gain their self-governmental competence by starting to group together in order to constitute a professional corporation or association.⁷⁵⁴ The Chinese Medical Association (CMA) is the largest and oldest non-governmental medical organization in China. Like a family, the CMA plays a leading and active role in the nation's medical education, training and professional exchanges for more than 430,000 members and 82 specialty societies.⁷⁵⁵ However, according to the criteria for the professions outlined in the previous chapter, the CMA group of Chinese medics have no autonomy to regulate themselves without interference from the state; they have no monopoly over a defined sphere of work; the codes of ethics are set up by the government; and although there is a system to further train medics, this also comes under the control of the state. In short, the CMA is not separate from, but actually controlled by government.

Mr Zhang Wenkang, the former Health Minister who was responsible for the SARS cover-up, was “elected” as the head of the Chinese Medical Association soon after he was sacked by the government. However, the CMA website did not give any information as to how he was “elected”. This example indicates that Chinese medical practitioners do not have a formal association that is independent of the state and state agencies. Moreover, a real sense of professional unity may have even not started yet. The same phenomenon happened in the Soviet Union which had a centrally planned political economy governed unilaterally by the Communist Party, in conjunction with state agencies, which permitted the existence of few if any independent “private” associations or enterprises.⁷⁵⁶ To sum up, the CMA cannot be the equivalent of its

⁷⁵⁴ The Association of Professional Orders of Québec, ‘From the First Professional’, *Professional System*, available at: <http://www.professions-quebec.org/index.php/en/element/visualiser/id/7#2503> (Last visited on Nov 10th, 2010).

⁷⁵⁵ Chinese Medical Association, available at: <http://www.chinamed.com.cn/> (Last visited on May 12th, 2008).

⁷⁵⁶ E. Friedson, *Professionalism Reborn: Theory, Prophecy and Policy* (Cambridge, Policy Press, 1994), 36-37.

counterparts in the West, such as the British Medical Association⁷⁵⁷ or American Medical Association which exercise professional power and are self-regulating.

In the West, doctors form powerful groups, notably the national medical associations, which act like trade unions to defend the interests of their members.⁷⁵⁸ In countries with socialised health-care systems, medical autonomy is limited by state intervention, as Gill and Horobin have noted in Britain.⁷⁵⁹ Yet, in the UK at least this does not affect the societal esteem of the occupation or their collective self-regulation. The key challenge facing each country is how to balance professional autonomy against control mechanisms. The following sections examine the pros and cons of professionally-led self-regulation, so that the complexities of this can be taken into account when suggesting medical professionalism in China.

(2) Setting up Professionally-led Regulation

a. Professionally-led Self-Regulation

It is assumed that professions understand what it means to be a professional and apply this understanding when they make decisions in their private and professional lives. As the general public do not fully comprehend the body of medical knowledge, the Western world has granted medical professionals the right to self-regulation. Autonomy is given to medics on the basis that professionals will put the welfare of both the patient and society above their own interests, and that they will be governed by a code of ethics.⁷⁶⁰

Under a self-regulation regime, medical professionals also have a right, and indeed a duty, to stipulate the pattern of service they wish to provide in the hospital, if they feel this is necessary. It is also their duty to take disciplinary action against any unethical

⁷⁵⁷ In the UK, as a doctors' union, the British Medical Association (BMA) represents the profession; while General Medical Council (GMC) is a regulatory body to medics. Comparing with BMA, the GMC aims to have an independent voice or serve as a pressure group to ensure good medical practice.

⁷⁵⁸ P. U. Unschuld, *Medicine in China: A History of Ideas* (London, University of California Press, 1985).

⁷⁵⁹ D. G. Gill and G. W. Horobin, 'Doctor, patients and the state: relationships and decision-making', 20 (1972) *Sociological Review* 4, 505.

⁷⁶⁰ S. R. Cruess and R. L. Cruess, 'Professionalism must be Taught', 315 (1997) *British Medical Journal* 1674-1677.

practice. There should be a control mechanism in place so that their every action will be guided (but not decided) by the state.

Professionally-led regulation should also be considered as a critical concept when defining medical professionalism. “Without the ability to self-regulate, medicine will relinquish control of the education, training and licensing of its members to an outside party, which in most cases will be the government.”⁷⁶¹ Although the tendency to shift professionally-led self-regulation to central regulation happens in some Western countries, such as the U.K, it is not necessarily a bad thing, as long as central government is in a better position to legislate medical law from a moral basis. The question raised is whether the Chinese legislative institution is acting in the best interests of the public? Or are they only acting for their own benefit? In which case, should the Chinese medical profession be given more power to fulfil their professional obligations?

Since law is made by the legislature, those who control this can make the law reflect their will. As discussed in Chapter 2, *the PRC Constitution* is regarded as “a general summary of [the] present policy” of the Chinese Communist Party (CCP).⁷⁶² For the first time an amendment of *the PRC Constitution* in 2004 includes the clause “the state respects and protects human rights”. This can be seen as a signal that Chinese legislators have started to take the public interest issues more seriously. In order to maintain political stability, the CCP has a certain degree of tolerance, as long as any change of law does not affect the ruling status of the Party. Professionally-led self-regulation in China thus is still possible if the CCP can perceive it as a win-win solution to the state’s healthcare system and the demands from the medical practitioners.

Hunt and Wickham maintain that Foucault gave, in *the Birth of the Clinic*, the example of the medical profession as an important source of ‘government’ activity;

⁷⁶¹ J. Blackmer, ‘Current Global Trends in Medical Professionalism’, 1 (2009) *World Medical & Health Policy* 1, 5-17.

⁷⁶² According to Jones, not only is the constitution a summary of policy, but also other laws are “more particularized statement of policy”. “[Party] policy in China is law”. See, W. C. Jones, ‘The Constitution of the People’s Republic of China’, in L. W. Beer (ed), *Constitutional Systems in Late Twentieth Century Asia* (Seattle, University of Washington Press, 1992), 59; also cited by K. Zou, *China’s Legal Reform: Towards the Rule of Law* (Boston, Martinus Nijhoff Publishers, 2006), 49.

this becomes particularly apparent in periods of significant shift in the organisation of medical practice, or in response to plagues and epidemics.⁷⁶³ For me, whether the medical profession acts as a bio-political tool or not, to some extent, must depend on the pattern of its medical regulation: state-regulation or self-regulation. It does not necessarily mean that medics in a country where direct regulation by the state prevails do not hold on to professional trust, ethics and honesty. But different forms of medical regulation tend to affect medical decision-making, especially when the state interests conflict with public interests.

b. Possible Problems in Professionally-led Regulation

Self-regulation has been subject to frequent public criticism. As far as professionalisation is concerned, Unschuld argues that,

“The emphasis on professional ethics has decisive advantages over prognosis. In diverting the interests of the public from the outcome of medical activities to its process, it allows the practitioners access to practically all the material and non-material rewards. Ultimately this is the essence of formulated ethics. Such ethics are designed to persuade the public that whoever is in control and possession of medical resources uses them in a morally trustworthy manner.”⁷⁶⁴

Freidson also contends that self-regulation is likely to prompt challenges, especially in regulatory procedures and rule-enforcement.⁷⁶⁵ He argues that physicians in a group practice may see the faults of their colleagues but usually take no action to correct them, and many even avoid or ostracise such colleagues. Under self-regulation, Cruess criticises that, “standards were considered weak, variable, and inconsistently applied, and physicians were further accused of using collegiality as a means of shielding poor performing peers.”⁷⁶⁶

⁷⁶³ A. Hunt and G. Wickham, *Foucault and Law: Towards a Sociology of Law as Governance* (London, Pluto Press, 1994), 26.

⁷⁶⁴ P.U. Unschuld, ‘Introduction: Medical System, Resources, Professionalization’, in *Medical Ethics in Imperial China: A Study in Historical Anthropology* (Berkeley, University of California Press, 1979), 5.

⁷⁶⁵ E. Freidson, *Professional Dominance* (New York, Atherton Press, 1970); E. Freidson, *Profession of Medicine* (New York, Dodd, Mead, 1970); and E. Freidson, *Doctoring Together* (New York, Elsevier, 1975).

⁷⁶⁶ S. R. Cruess and R. L. Cruess, ‘The Medical Profession and Self-regulation: A Current Challenge’, 7 (2005) *American Medical Association Journal of Ethics* 4.

In contrast to the critics, Dauphine's support for self regulation is based on his understanding of experience in the United States and Canada, which shows that self regulation can be effective and can maintain the public's trust. He also mentions that, the required infrastructure and tradition of excellence in assessment have been part of the North American medical culture for decades, and "the separation of assessment bodies from other national bodies with advocacy roles is a major advantage for North American certifying bodies."⁷⁶⁷ He thinks this experience has given US bodies the opportunity to win acceptance and, perhaps most importantly, "to take advantage of past reputations for doing their jobs at an arm's length from the professional associations."⁷⁶⁸

As discussed earlier, professionalism is a mode of occupational control. Historically, professionalism was based on the assumption that lay people were incapable of understanding or judging the effectiveness of the services provided, and professionals were given wide latitude in setting their own standards and norms. Professionally-led self-regulation is "a special way of regulating the market in the service offered by an occupation."⁷⁶⁹ It means that professional standards elucidated in professional ethical codes are generated by medical professional organisations. These professional standards are utilised by administrative and legal agencies when identifying and sanctioning unethical behaviours. The profession therefore is able to discipline its own members and oppose external regulations intruding into areas it considers its autonomous domain.⁷⁷⁰ Within the professionalism debate, self-regulation has been criticised as leading to a loss of credibility and accountability.

Critics of self-regulation are more or less asking for the control of professional power, which means that they have lost confidence in professionals and their credibility to maintain accountability. According to Haskell, driven by the Jacksonian populism of the mid-19th century, policymakers in the UK had largely rejected the legitimacy of professional expertise and stripped away regulations that had supported professional

⁷⁶⁷ W. D. Dauphine, 'Self Regulation must be made to work: GMC and the Future of Revalidation', 330 (2005) *British Medical Journal* 1385-1387.

⁷⁶⁸ Ibid.

⁷⁶⁹ M. Moran and B. Wood, *States, Regulations and the Medical Profession* (Buckingham, Open University Press, 1993), 25.

⁷⁷⁰ J. C. d'Oronzio, 'Practicing Accountability in Professional Ethics', 13 (2002) *The Journal of Clinical Ethics* 4, 362.

authority.⁷⁷¹ More importantly, this loss of authority is reflected in the decline of public confidence in the medical profession.⁷⁷² Academics such as Pawlson have argued that professionalism along with regulation, strongly influenced or controlled by professionals, has been at the expense of accountability in medicine.⁷⁷³

It is understandable that medical professionals want self-regulation, including those in China; as shown in the fieldwork, a high percentage of surveyed medics reported that they would like to be more involved in China's health legislation. The main reason for this is that, they will benefit from these regulations in a number of ways. Regulation of medical education and of the acceptability of qualifications can control the supply of medics. Market competition, both from outside and within the profession can also be limited. Regulatory machinery and processes can ensure that professionals control their own practice standards, and determine their own income. From the medical professionals' perspective, self-regulation is thus a powerful tool. This would increase their autonomy but not necessarily lead them to become followers of patient-orientated professional ethics. So actually the question becomes how trust-worthy are the medical professionals? Likely problems in professionally-led regulation thus still lie in medical ethics, which as I suggested earlier lays the foundation stone for medical professionalism.

(3) Developing a Culture of Professionalism

Apart from establishing independent professional associations and setting up professionally-led self-regulation in China, there is also a need to develop a professional culture for ongoing medical professionalism. An interpretation of professionalism as "something which defines and articulates the quality and character of people's actions within that group"⁷⁷⁴ indicates common qualities that are shared collectively within the group. There should be beliefs, behaviours, objectives, and

⁷⁷¹ T. Haskell, *Introduction to the Authority of Experts* (Bloomington, Indiana University Press, 1984).

⁷⁷² See, e.g., R. J. Blendon, et al., 'Bridging the Gap between Expert and Public Views on Health Care Reform', 19 (1993) *Journal of the American Medical Association* 269, 2473-2578; L.R. Jacobs and R.Y. Shapiro, 'Questioning the Conventional Wisdom on Public opinion toward Health Reform', 2 (1994) *Political Science and Politics* 27, 208-214.

⁷⁷³ L. G. Pawlson and M. E. O'Kane, 'Market Watch: Professionalism, Regulation, and the Market: Impact on Accountability for Quality of Care', 21 (2002) *Health Affairs* 3.

⁷⁷⁴ A. Hargreaves and I. Goodson, *Teachers' Professional Lives: Aspirations and Actualities* (London, Falmer, 1996), 4.

other characteristics common to members of the medical group. Therefore, to some extent, it can be regarded as a professional culture. In my opinion, this professional culture is a historically changing and socially constructed accommodation to professionalism. A professional culture in healthcare would nurture the development of professionalism amongst the different areas of healthcare professionals, e.g. medicine, dentistry, nursing, pharmacy and allied health professions.

A professional culture would become a supportive environment for medical professionalism. Without a supporting culture, even if professionalism, the notion and ideology born in Western liberal societies, could emerge successfully in China, I doubt whether it would flourish and be sustained for long. The notion of professionalism does not exist in China, neither historically or culturally. The enhancement of professionalisation has also not been part of its industrialisation process. What is more, the Chinese culture emphasising harmony/no resistance, nationalism/patriotism and faithfulness can become barriers to developing professional independence. The influence of cultural change might have an impact on individual professionals' attitudes so that the value of professionalism could become more socially acceptable. Developing an ongoing supportive culture amongst medics, therefore, is essential for their professional consciousness development, together with peers.

In my opinion, developing a professional culture involves: (1) enhancing a professional culture in medical schools to support early-career pre-professionals; (2) enrichment of professionalism from individual to groups of medical practitioners; (3) bridging different areas of medical professionalism and building a shared value-base amongst the professionalised community.⁷⁷⁵ Freidson suggests that power is exercised by a collective will, but not by the individual will in isolation.⁷⁷⁶ Developing a culture of professionalism would strengthen individual professional development, so that the fragmented medical professionalism of individuals from different designations could form an integrated coalition and so secure the power of medics and autonomy necessary for their commitment to patient care.

⁷⁷⁵ The idea of developing a medical professionalism culture in China needs further research and better understanding. This is still a preliminary idea from the author of this thesis.

⁷⁷⁶ D. M. Frankford, 'The Normative Constitution of Professional Power', 22 (1997) *Journal of Health Politics, Policy and Law* 1, 186-219.

4.2 Patient Engagement

Patient participation lies on the other side of the interactive control process. Patient engagement can be seen as the countervailing power in preventing the increasing power of medical professionals becoming counterproductive or even doing more harm than good. Western societies have witnessed incidents when professionally-led self-regulation fails to balance the interests of professional and patient. The decline of professional accountability raises public outrage and loses public trust. In this situation, the pressure on medics comes not only from the state and other health professions, but from the general public. Hence my suggestion is empowering together both Chinese patients and medics in the pentagon model, so that the power of medics is grounded in the public interest.

(1) Regaining Public Trust

To encourage patient engagement in healthcare governance, regaining public trust is a priority. As discussed earlier, there are frequent reports of doctors or hospitals being attacked by patients. From my own experience, I also found that the Chinese public do not trust the professionals. During my empirical study, I met a patient who insisted on standing and crying loudly in one of the doctors' offices where several doctors were filling in my questionnaires. One of the doctors told me this is not unusual. Once a patient has had a bad treatment result, they tend to blame their doctor for not fulfilling their duties well enough.

The issues of public trust in China are not confined to the healthcare arena. Nowadays, Chinese people are less likely to trust the quality of food, commodities, government policies, etc. I heard one Chinese say to another Chinese outside one of my field hospitals, "Nothing is real in China, except the fakes, which are really fake." Regaining trust from the public should not only be the task of the medical profession, but also the state, and its administrative and legal departments. Although this thesis does not focus on studying a systematic loss of public trust, the existence of this does increase the extremes of public rebellion. Patients who frequently assault medical practitioners (as discussed previously), have become a serious social problem.

The doctor-patient relationship evolves in an ever-changing society. As discussed earlier, from the 1990s, the drive towards commercialised healthcare consumption with increasing numbers of health legislation empowers patients; but, at the same time public trust in Chinese medical professionals has declined greatly ever since. Criticisms from the media are frequently and widely available. Several of my empirical study informants expressed their concern about a newly invented “job” - called “hospital violator hired by patients” to meet the increasing need for patient campaigns. In the opinion of the medics, public anger towards the Chinese healthcare system is growing.⁷⁷⁷ A large number of studies found that hospital staff in urban hospitals had experienced physical or psychological violence because of dissatisfaction with the standard of care provided.⁷⁷⁸ The trust of the doctor-patient relationship in China is in crisis. In order to grasp a general idea of how inflammatory this issue was, I typed two key words “hospital” and “attack” to a Chinese Google search engine, it provided me with 6,150,000 relevant results.⁷⁷⁹

During the process of writing up this thesis, doctor-patient relationships in China have worsened further. In July 2010, it was reported that, with the support of the local health department, 27 hospitals in Ji Lin Province started to hire policemen as deputy hospital managers, in order to strengthen hospital security to protect these hospitals from being attacked by the public.⁷⁸⁰ This decision raised wide controversy in society.⁷⁸¹ Critics argued that the police force is a public resource; and that hospitals have no legitimacy to hire policemen to prevent attacks from the public.⁷⁸² But the local Health Secretary defended the decision at an “employment ceremony”. He said, in 2009, for one year only, there had been 152 attacks in Ji Lin provincial level hospitals.⁷⁸³ In early 2010, another hospital’s emergency room and an emergency medical technician were attacked. The local government hoped that, by employing

⁷⁷⁷ See discussion in Chapter 3.

⁷⁷⁸ Ibid.

⁷⁷⁹ The number of search result was provided by the Google on June 16th, 2011, available at: www.google.com.

⁷⁸⁰ See e.g., ‘Policemen were Hired as Part-time Hospital Deputy Manager’ (in Chinese), (July 7th, 2010) *Xin Hua News*.

⁷⁸¹ G. Zhang, ‘Rights of Policemen: Embarrassing Resolution to Damaged Doctor-patient Relationship’ (in Chinese), (Sep 2nd, 2010) *Journal of China Hospital CEO*.

⁷⁸² Ibid.

⁷⁸³ Editorial Review, ‘27 Ji Lin Hospitals are Empowering Policemen to be Deputy Hospital Managers’ (in Chinese), (July 8th, 2010) *Xin Jing News*.

these hospital policemen, the problems of doctor-patient relationships could be resolved and future attacks prevented.

Ji Lin province is not the only province in China to use this measure for tackling hospital violence. Fu Jian province is another example.⁷⁸⁴ The public has used extreme methods to express their anger towards the whole system in which the professionals are serving. Local government agents, who are only in charge of part of the system, were reacting passively. Employing policemen may be of temporary use in dealing with hospital violence towards medical staff and their workplaces. But this measure cannot repair the weak relationship between the public and healthcare providers in the long run; it may further damage it.

To regain trust from the public, the medical profession must be seen to be acting in the best interests of the public.⁷⁸⁵ Philosopher Onora O'Neill has raised the importance of trust in a profession. In her Reith Lectures, she says:

“Intelligent accountability, I suspect, requires more attention to good governance and fewer fantasies about total control. Good governance is possible only if institutions are allowed some margin for self-governance of a form appropriate to their particular tasks, within a framework of financial and other reporting... Real accountability provides substantive and knowledgeable independent judgment of an institution’s or professional’s work.”⁷⁸⁶

Trust is the basis for professional power. The decline of patient trust further decreases the power of Chinese medics. As long as the Chinese public remains sceptical toward medical practice and the medical profession, progress towards professionalism will be slow. Re-gaining trust and support is necessary. In order to achieve medical professionalism, the regaining of public trust must be an urgent task for Chinese healthcare governors and medical practitioners.

Professional status and its maintenance are granted by a society on the basis of the public’s belief that professionals are trustworthy. To remain trustworthy, professionals must meet the obligations expected by society. The substance of professionalism,

⁷⁸⁴ ‘Fu Jian’s Part-time Hospital Policemen’ (in Chinese), (April 13th, 2007) *Teng Xun Da Yu net*.

⁷⁸⁵ J. Blackmer, ‘Current Global Trends in Medical Professionalism’, 1 (2009) *World & Health Policy* 1.

⁷⁸⁶ O. O’Neill, *A Question of Trust* (Cambridge, Cambridge University Press, 2002), 58; O. O’Neill, *Autonomy and Trust in Bioethics* (Cambridge, Cambridge University Press, 2002).

should be taught at all levels of medical education in China, as part of the profession's response to changing societal expectations. Apart from this, there is also a need for educating the public about professional commitments and different ways of conflict resolution e.g. from the public media. Local government needs to set up more complaint systems and build channels to make dialogue possible between medics and the public; for example, on-line or face to face forums where both parties participate; offering legal officers to manage disputes and bring them to a resolution within a framework of law. In seeking to rebuild the trust relationship between the public and medics, most important of all is the reform of the ineffective and unfair healthcare system (I discuss this shortly).

Building trust is essentially important for professionalism. The discourse of professionalism consists of a social contract, and an agreement between the State and members of the occupational group. Within this agreement, the professionals commit themselves to restrain their self-interest in return for greater status, income and freedom.⁷⁸⁷ In exchange for refraining from exploiting their expertise and superior knowledge for their own benefit and using their knowledge and skills for the common good, professions are granted a degree of autonomy and certain privileges. Essential to this discourse is public trust, which depends on the integrity of both individual medics and the whole profession.⁷⁸⁸ In other words, it will be a collective social problem if medics no longer receive the social respectability that they desire and society is not satisfied with the service they receive.

(2) Patient and Public Engagement

Ever since Eliot Freidson's landmark books about professions, the concept of professional dominance has stood to mean the ways in which the medical profession abuses its clinical expertise and legal monopoly into various forms of institutional, economic, occupational, and cultural dominance.⁷⁸⁹ Freidson's term "professional

⁷⁸⁷ M. Waters, 'Collegiality, Bureaucratisation and Professionalisation: a Weberian Analysis', 94 (1989) *American Journal of Sociology* 5, 945-972.

⁷⁸⁸ Project of the ABIM Foundation, ACP-ASIM Foundation, and European Federation of Internal Medicine, 'Medical Professionalism in the New Millennium: A Physician Charter', 136 (2002) *Annals of Internal Medicine* 3, 243-246; D. Wear and J. M. Aultman (ed), *Professionalism in Medicine: Critical Perspectives* (New York, Springer, 2006), 38.

⁷⁸⁹ See notes 484 and 485.

dominance” refers to a healthcare system whose organisation, laws and financing reflect the priorities of the medical profession to provide the best clinical medicine to every sick patient, which enhances the prestige and incomes of the profession, and protects the autonomy of professionals.⁷⁹⁰ This professional dominance model has been challenged by patient empowerment.

In Western countries, the “informed decision making” model has replaced the paternalistic model in the field of health,⁷⁹¹ which means that the public are empowered to become more active and responsible consumers rather than just recipients of medical care. This change in the doctor-patient relationship brings together doctors and patients to become more of a partnership. This relational shift has been seen as a decline of medical professionalism in the West.⁷⁹² The traditional idea that “doctor knows best” has shifted to a “consumerist” stance, accompanied by a questioning and bargaining approach to professional dominance.

Haug contends that a marked increase in educational attainment has made the public less likely to view medical knowledge as mysterious.⁷⁹³ As a result, people are more likely to challenge the medics’ authority today than ever before, while professionals can no longer be governed by their own colleagues or associations. In addition, they are now also controlled by others. Throughout the history of Western medicine, the changes to professional roles reflect a shift in social conventions, and a move from passive patients to those who are adequately informed and make fully rational decisions in their own interests. This has not resulted in deprofessionalisation, though professionals are no longer in the dominant position in taking medical decisions. The move to patient empowerment gives patients and the public freedom to choose and freedom to decide in healthcare.

⁷⁹⁰ D. W. Light and A. Schuller, *Political Values and Health Care: the German Experience* (Cambridge, MIT Press, 1986), 14 -17.

⁷⁹¹ C. Charles, A. Gafni and T. Whelan, ‘Shared Decision-Making in the Medical Encounter: What does It Mean’, 44 (1997) *Social Science and Medicine* 5, 681-692.

⁷⁹² See e.g., E. Freidson, *Professionalism Reborn: Theory, Prophecy, and Policy* (Chicago, The University of Chicago Press, 1994), 131-132, 156-157; E. Willis, ‘The Medical Profession in Australia’, in F. W. Hafferty and J. B. McKinlay (ed), *The Changing Medical Profession: An International Perspective* (Oxford, Oxford University Press, 1993), 108-109.

⁷⁹³ M. R. Haug, ‘The Erosion of Professional Authority: A Cross-Cultural Inquiry in the Case of the Physician’, 54 (1976) *Milbank Memorial Fund Quarterly* 83-106; M. R. Haug and B. Lavin, ‘Practitioner or Patient: Who is in Charge?’, 22 (1981) *Journal of Health and Social Behaviour* 212-229; M. R. Haug and B. Lavin, *Consumerism in Medicine: Challenging Physician Authority* (Beverly Hill, Sage, 1983).

Empowering patients to take a proactive role in their healthcare is necessary, not only because patients and the public can act as a counterbalance to professional power by lobbying and advocating on their own, but also for the public's sake. A more active role in healthcare, such as, prevention of illness by leading a healthy lifestyle, brings change to one's life (though discussion of this is outside the scope of this thesis). A counter-balance to professional power is important, because of "the effective power of the client to criticize the professional and hold him responsible for his actions".⁷⁹⁴

In the UK, for example, in response to pressures from below and above for patient and public involvement, building a partnership between medical professionals and citizens has become a means managing medical power.⁷⁹⁵ In China, there is no limit to the examples of challenges to medics. Therefore, a calling for patient participation is no longer to counterbalance professional power, but more to build a culture of mutual understanding and support. The success of medical professionalism in China will lie in the relationship between medical practitioners and their patients. This requires wider public education; the emergence of civil societies that support patients' rights and their welfare (for example Patient's Associations); more patient-friendly public policies; and a transparent and effective complaints management system, etc. Instead of reacting passively and trying to avoid conflicts, local government needs to give patients and the public a stronger voice. Public participation – through public hearings and open meetings, publications of draft rules and policies for public comment – is one way of getting public acceptance and compliance.

Additionally, I suggest that the public's attention should be drawn towards preventive rather than remedial measures. Instead of resorting to violence, the public needs to have affordable independent patient advocates or "patient representatives"⁷⁹⁶ – a person to whom patients can go with complaints; get solutions to a broad range of problems (both in and out of the hospital), and to have their interests in clinically

⁷⁹⁴ M. Haug, 'Deprofessionalization: An Alternative Hypothesis for the Future', 307 (1973) *the Sociological Review Monograph* 20, 95-211.

⁷⁹⁵ T. Milewa, et al., 'Partnership, Power and the 'New' Politics of Community Participation in British Health Care', 36 (2002) *Social Policy and Administration* 7, 796-809.

⁷⁹⁶ G. J. Annas, 'Medical Remedies and Human Rights: Why Civil Rights Lawyers must Become Involved in Medical Decision-Making', 2 (1972) *Human Rights* 2, 151-167.

related negotiations represented. Moreover, patients also need to realise that medics in China are also “victims” of the failed healthcare system. Most Chinese medics are dedicated to their careers, despite having insufficient power, but have not tried hard enough to protect patient interests. Chinese patients, the public and medical practitioners need to form a partnership, not only to treat each other with dignity and respect but to see each other as partners in the process of decision making and care giving through informed consent, and also to fight together for their mutual interests and empowerment. And this would bring about a strengthened form of medical professionalism “that underpins the trust the public has in doctors”.⁷⁹⁷

5. Boundary Control from State and Law

At the top level of the pentagonal model is the boundary between state and law. I suggest that the role of the state and law, namely bureaucratic, administrative, and legal governance should be soft rather than hard nosed management, so that more space can be left for the empowerment of medics and patients. Although it is assumed that healthcare professions carry moral and ethical responsibilities, boundary controls are also necessary to secure accountability and sanction those who break the rules. Qualifications for medics and professional organisations that are driven by professionalism should be tied to administrative and regulatory oversight.⁷⁹⁸

This boundary control in the pentagonal model has a dual purpose. First, it claims that the medical profession should be given secure financial and regulatory support. Secondly, it suggests that proper oversight of professional practice and its self-regulatory regime are also necessary. In other words, a nationally funded professional-friendly healthcare system, and a legal environment which facilitates and supervises professionally-led regulation, are both needed to complete the ideal model. Issues and arguments that are raised from the state and legal boundary controls are explored in the next section.

⁷⁹⁷ Royal College of Physicians, ‘Medical Professionalism – a Force to Improve Patient Care’, (December 6th, 2005) *RCP London Press Release*.

⁷⁹⁸ L. G. Pawlson and M. E. O’Kane, ‘Market Watch: Professionalism, Regulation, and the Market: Impact on Accountability for Quality of Care’, 21 (2002) *Health Affairs* 3.

5.1 State: A State Funded Professional-Friendly Healthcare System

Professionalism is not an answer in itself: it requires substantive, defensible, and valid processes. One of the key ways modern professions achieve a dominant position is by acquiring power and authority from the state.⁷⁹⁹ Freidson says, “The foundation of medicine’s control over its work is thus clearly political in character, involving the aid of the state in establishing and maintaining the profession’s pre-eminence”.⁸⁰⁰ To finally achieve a status of healthcare professionalism, building a sustainable healthcare system is the first step towards change.

As discussed earlier, the Chinese healthcare system has not preformed well since it underwent a privatisation process. Government funding was reduced, and insurance coverage rates also dropped. Due to a lack of government funding, hospitals had to rely too heavily on fee-for-service principle. For years, practitioners in public hospitals have mainly operated using profits from medical services and drug prescriptions. Without sufficient oversight, this results in rampant over-prescription and, often outright corruption. This has caused dilemmas for many Chinese medics who want to practice ethically. As discussed in the empirical studies, a reform of the healthcare financial system is at the top of the Chinese medics’ wish list.

China’s healthcare system is finally undergoing a new wave of reform. In January 2009, the PRC State Council approved *the Initiative for Health Reform*. Under a plan passed by the State Council, China is set to spend more than 850 billion RMB (78 billion British Pounds) by 2011, to build hospitals and clinics as part of an effort to provide basic, universal healthcare to the country’s 1.3 billion people by the end of 2020.⁸⁰¹ This new policy proposes major reforms in four areas: (1) the public health system, (2) the medical care delivery system, (3) the health security system, and (4) the pharmaceutical system.⁸⁰²

⁷⁹⁹ M. Moran and B. Wood, *States, Regulations and the Medical Profession* (Buckingham, Open University Press, 1993), 26.

⁸⁰⁰ E. Freidson, *Profession of Medicine: an Study of the Sociology of Applied Knowledge* (New York, Dodd Mead, 1970), 23.

⁸⁰¹ ‘State Council passes the Proposal of Health Reform’ (in Chinese), (January 21st, 2009) *Xinhua News*; also see PRC Council of State, ‘Healthcare Reform Initiative’ (in Chinese),

http://www.gov.cn/jrzq/2009-04/08/content_1280732.htm (Last visited on Oct 10th, 2010).

⁸⁰² Ibid.

China's official *Xinhua News* has said this:

“The health care sector is one of the weak links in China's social welfare system. Soaring medical fees, a lack of access to affordable medical services, poor doctor-patient relations and low medical insurance coverage compelled the government to launch the new round of reforms.”⁸⁰³

Under the new policy, central government will completely subsidise the delivery of an “essential public health package” which includes a minimum of a 90% coverage by medical insurance to cover “basic medicines”, an improved network of local-level clinics, a better public health system and increased government support in public hospitals.⁸⁰⁴

The 2009 healthcare reform opens a door of opportunity for change. Since the reforms were implemented a year ago, a series of regulations and guidelines has been introduced.⁸⁰⁵ The Chinese government has chosen 16 cities to pilot the reforms.⁸⁰⁶ The cities, including six in central China, six in the east, and four in the west, were asked to introduce the reforms from that year.⁸⁰⁷ The government plans to evaluate the success of these early trials, and possibly conduct further trials with refined guidelines, before the healthcare reform is rolled out at a national level. China's healthcare reform is therefore likely to be a lengthy process.

One question raised about the 2009 health reform plan is how it might affect the Chinese medical practitioners and their practice. There are two main areas of reform which will affect the Chinese medical practitioners directly. First, the state plans to

⁸⁰³ ‘Chinese Pin Hope on Healthcare Reform’, (Sep Jan 22nd, 2009) *Xinhua News*.

⁸⁰⁴ The Ministry of Health of PRC, ‘Implementation Plan for the Health Care Reform’ (in Chinese), April 7th 2009, available at:

<http://www.moh.gov.cn/publicfiles/business/htmlfiles/mohzcfgs/s7846/200904/39876.htm> (Last visited on Oct 10th, 2010).

⁸⁰⁵ In June 2009, the guideline on the construction of county hospitals, health centres, community health service centres, and village clinics was released; in October 2009, the guideline on the price of essential drugs was released; in January 2010, a guideline on training and development of village physicians was released; See The Ministry of Health of PRC, <http://www.moh.gov.cn/publicfiles/business/htmlfiles/mohzcfgs/s3576/list.htm> (Last visited on Sep 18th, 2010).

⁸⁰⁶ The Ministry of Health of PRC, ‘Health Reform Pilot Trials in 16 cities’ (in Chinese), available at: <http://www.moh.gov.cn/publicfiles/business/htmlfiles/mohylfwjgs/s3586/201004/46562.htm> (Last visited on Sep 18th, 2010).

⁸⁰⁷ Ibid.

reform the public health system by providing free basic care to almost all Chinese citizens.⁸⁰⁸ This means there will be much more financial support from the state to the public hospitals. Public hospital medical practitioners will be much less likely therefore to rely on over-prescribing drugs in order to make a profit for their hospital. The reform initiative, however, does not address payment methods or any financial incentive mechanism for Chinese medics, nor does it address the role that patients could have in the new healthcare system. But we can expect that, with more state funding in place, China's healthcare will become a better organised, centrally planned national health service.⁸⁰⁹ And the reform will not necessarily lead to an increase of Chinese medics' incomes.⁸¹⁰

Second, the state is promoting a primary care delivery system, emphasising a great need for medical practitioner training for the rural areas of China. Section 10 of the Implementation Plan states,

“Develop and implement free training to general practitioners as well as recruiting more practitioners for rural areas. In three years, the state plans to provide training for 3.6 hundred thousand medics in township hospitals, 1.6 hundred thousand medics in urban community health service institutions and 1.37 million medics in village clinics. The state also plans to improve urban - rural hospital partnership so that more support could be provided from urban to rural areas. The state will continue implementing the ‘thousands of physicians support rural health projects’, providing opportunities for doctors from rural areas to visit and have resident training in urban hospitals.”⁸¹¹

The health reform requires a strengthening of human resources in primary care, encouraging more training of medical residents in primary care and advanced training in rural areas, where most primary care is delivered. Relocation of healthcare resources to the rural areas is not new in China. The “barefoot doctors” in Mao's era served this aim. The current health reform plan demands a large increase in human resources. In total, the government plans to train 1.89 million more health workers. This exceptionally high number may boost China's healthcare delivery. But it also

⁸⁰⁸ See note 804, Section 1.

⁸⁰⁹ According to Enthoven, based on healthcare resource allocation, healthcare can be distinguished to be three categories: guide-free-choice system, centrally planned national health service, and Managed competition. See A. C. Enthoven, *Theory and Practice of Managed Competition in Health Care Finance* (Amsterdam, North-Holland, 1988).

⁸¹⁰ Interviews with Deputy Health Minister Huang Jiefu, S. Wang, ‘Don't Expect the Healthcare Reform will Increase Health Workers' Incomes’ (in Chinese), (Mar 6th, 2008) *China Economic Daily*.

⁸¹¹ See note 804, Section 10.

indicates there will be an increase in competition between Chinese medics for entering medical practice.

The benefit of a state-funded health service is that it brings about distributive justice, providing a safety net for the poor and vulnerable, and reducing urban-rural imbalances. It also meets the need for effective public health and preventive programmes. However, there are also limitations of a state-funded health service. Under a centrally planned healthcare system, resources and budgets are likely to be tight and insufficient. This will result in, according to Polder and Jochemsen, first, a deterioration in the quality of care; and second, a private healthcare sector will emerge and cause distributive justice problems.⁸¹²

What is more, medical practitioners are major players in the healthcare system. In the state planned national health service, the state is bound to increasingly intervene in medical practice in order to control its budget.⁸¹³ This does not mean a state planned national health service will necessarily take away professional power. Examples from the UK and Italy, which also have national health services show that, medics can have substantial autonomy under this system. But I fear that autonomy and professional power will be affected by China's state planned health service. Healthcare practitioners who work for public hospitals are employees of the state, and as such are subject to state rules and reviews. Under these circumstances, the role of the state is likely to become stronger, while the professionals' role may diminish.

“The ambitious overhaul of the Chinese healthcare system is a challenge that won't be solved by money alone”, said China's Minister of Health, Chen Zhu.⁸¹⁴ He admits that there is still an unsolved challenge that the Chinese government is struggling with. Without out-of-pocket payments from patients, how will Chinese hospitals cope with the resulting reduction in income? Minister Chen suggests that there are unsolved problems existing in the Chinese healthcare system that cannot be solved by money alone. He mentioned the role of government, hospitals, and insurance companies

⁸¹² J. J. Polder and H. Jochemsen, 'Professional Autonomy in the Healthcare System', 21 (2000) *Theoretical Medicine and Bioethics* 5, 477-491.

⁸¹³ J. S. Horner, 'Autonomy in the Medical Profession in the United Kingdom – an Historical Perspective', 21 (2000) *Theoretical Medicine and Bioethics* 5, 409-423.

⁸¹⁴ An interview with PRC Ministry of Health about the current health reform. See, S. S. Wang, 'China Health Reform 'Not Easy Job'', (September 24, 2010) *Wall Street Journal Europe* 9.

within the health reform plan. What he and *the Health Reform Initiative* have missed, I would argue, is the role of the medical profession and patients (To focus on my research question, I mainly discuss the role of the profession here).

In my proposed pentagon-shaped model, I suggest that China not only needs a state-funded healthcare system, but also a professional-friendly state-funded healthcare system. Minister Chen is concerned that a reduction in hospital income without enough back up from the state will cause problems. He dismisses the possibility that income reduction could be offset by cost-saving measures taken by the main players in healthcare delivery – medical practitioners and patients.

One main reason for suggesting an involvement of medics at the various levels of the healthcare system in the budgetary process is because a state funded-health system always has a budget. Although patients are not usually involved in budgetary decision-making, their awareness of cost-savings might contribute to their choices when facing differing treatment methods. A trusted relationship between patients and medical professionals is therefore necessary. As the direct providers and recipients of healthcare, it is medics and patients who play key roles in suggesting and deciding how much diagnostic and therapeutic intervention is needed. Though patients can take part in the medical decision-making process, it is medics who should take the leading role of budget checking and balancing the budget. This is why I suggested a professionally friendly healthcare system in the pentagonal model. Healthcare can only be developed to its fullest, if professionals are given extensive autonomy and control over services, even if within a limited budget.⁸¹⁵

It has been argued that professional autonomy means a loose and decentralized organisation that ignores prevention and public health, because too much attention is paid to ‘professional work’ without carefully monitoring costs.⁸¹⁶ But this is less likely happen in a state-funded system, where, in principle, state-administrated regulation or oversight ensures public accountability.

⁸¹⁵ J. J. Polder and H. Jochemsen, ‘Professional Autonomy in the Healthcare System’, 21 (2000) *Theoretical Medicine and Bioethics* 5, 477-491,488.

⁸¹⁶ D. W. Light, ‘Escaping the Traps of Postwar Western Medicine’, 3 (1993) *European Journal of Public Health* 4.

5.2 Law: Facilitating Professionally-led Self-Regulation

“To govern better, the state had to govern less.”

Ciccarelli ⁸¹⁷

Regulating medical practitioners is similar in many ways to regulating other occupations, but there is also a difference in regulating medicine: that is, generally, medical practitioners are regarded as professionals and have a well-developed code of ethics that distinguishes this profession from other occupations. In the pentagon-shaped model, legal control of professionalism is particularly important for ensuring that the aim of professionally-led self-regulation is to serve the public interest.

This section outlines the need for legislators to establish rules for professionally-led self-regulation in China, so that medical practitioners can be given legitimacy to exercise their autonomy whilst patients' interests are protected. It discusses the nature of law, addressing questions about how rules are made and put into effect, and what medical practitioners can gain from such a regulatory framework, rather than the detailed substance of rules.

Before undertaking a detailed discussion of how to organise this facilitating role of the law, the first question that needs to be answered is, why should there be a role for the judicial system in the pentagon-shaped model, especially in the light of earlier discussion about the ineffectiveness of legal implementation and of pro-Communist legislation. One might argue it would be of no use to argue for legislation if the state bureaucracy itself does not respect the law and regards it only as a way to express and achieve its will. The reason that I still have faith in the law, and so advocate it as part of the pentagon model is because legislation which sets up clear boundaries for the use of medicine could better protect the public as well as the doctors. Politically instrumentalised medicalisation would lose its legitimacy if such clear legislation were in place. Overall, Chinese government officers are keen to improve the legal system in order to achieve its political modernisation. Although it would appear that

⁸¹⁷ R. Ciccarelli, 'Reframing Political Freedom in the Analytics of Governmentality', 19 (2008) *Law Critique*, 307-327, 316.

there is a long way to go before legislators fully respect the law and justice, such legislation could assist progress. Clear laws can serve as a marker to remind legislators of the original purpose of legislation, and the direction in which they planned to lead the country in the best interests of its people.

China's post-Cultural Revolution Constitution (adopted in 1982), established the principle that all power belongs to the Chinese people, who are to manage state affairs; it required state organisations to “heed their opinions and suggestions, accept their supervision and work hard to serve their interests”.⁸¹⁸ The pentagon model supports this constitutional principle, by promoting greater involvement of Chinese medical professionals as well as the public, in the process of formulating the legislation and the policies related to healthcare issues. The following analysis goes on to discuss the setting-up of clear legal guidelines for professionally-led regulations, together with related supervision measures.

(1) Clear Legal Guidelines for Professionally-led Regulations

Clear guidelines and regulation must be in place to ensure transparency in professionally-led regulation. Professional standards⁸¹⁹ are developed in the social and educational structure of medicine itself and articulated in the professional publications and activities of organised medicine. The essence of these standards captures a sense of individual commitment towards the profession, which should also be internalised by practitioners during education, training and continued professional development.

Friedman has argued that best practice should encourage individuals to govern themselves, within a legal structure guaranteed by the state.⁸²⁰ “Just as a common morality is accepted by all moral persons, so most professions contain, at least, implicitly, a professional morality with standards of conduct that are generally

⁸¹⁸ The PRC 1982 Constitution, Articles 3 and 27.

⁸¹⁹ Professional standard in this context refers to ethical or legal duty of a professional to exercise the level of care, diligence, and skill prescribed in the code of practice of his or her medical profession; while the frequent used term ‘professional ethics’ or ‘bioethics’ emphasises more its ethical basis.

⁸²⁰ M. Friedman, *Capitalism and Freedom* (Chicago, University of Chicago Press, 1962).

acknowledged by those who are serious about their moral responsibilities.”⁸²¹ The notion of professionals as experts in the service of public interests could serve as an important source of standards and moral authority in a market-orientated economic society like China.⁸²²

Recognising that there are a wide variety of professional regulations, and different ways of regulating the medical profession in different countries reflects the fact that the medical profession and the state negotiate very differently over the contract governing health care delivery. Such international differences are due to varying degrees of tolerance towards competition, individualism, and the role of government within individual political cultures.

According to Moran and Wood, the role of the law in regulating medical practitioners and the degree of independent self-regulation is generally based on three broad approaches: independent self-regulation; state sanctioned self-regulation; and state-administrated regulation.⁸²³ Independent self-regulation has been criticised as presenting serious problems of accountability. In contrast to it, state-sanctioned self-regulation brings self-regulatory institutions under state supervision, whilst the institutions retain their function of carrying out the regulation of detailed tasks. The third way to regulate medical practitioners is by state-administered regulation, carried out by public institutions. This is commonly applied in welfare states where healthcare is state funded, and healthcare professionals, as employees of the state, are also subject to the rules of public accountability and review.

The degree of independent self-regulation in China is also related to the role of Chinese law in regulating medical practitioners. From my analysis, Chinese healthcare is under state-administrated regulation for the following reasons: China has a long tradition of an authoritarian state governance. Over the past two decades, Chinese leaders and legal scholars have come to recognise that achieving rational and effective regulation in a rapidly-changing modern society requires the opening up China’s law-making and regulatory processes to a far greater degree than ever before

⁸²¹ See note 326.

⁸²² B. Bledstein, *the Culture of Professionalism* (New York, W.W. Norton, 1976).

⁸²³ M. Moran and B. Wood, *States, Regulations and the Medical Profession* (Buckingham, Open University Press, 1993), 21-23.

in China's long history. *The 2000 PRC Law on Legislation* stipulates that, legislation should reflect the will of the people and requires, for the first time, that the Chinese people should "participate in legislation through various channels"⁸²⁴ Thus under a Chinese state-funded healthcare system, the role of law in the pentagon model is still very likely to be a state-administered regulation, assuming, in the first place, that Chinese leaders might not be willing to hand over too much of their power too soon to the medical practitioners. However, when changes to the healthcare system, and a culture of public and professional engagement, and more importantly, an endorsement of codes of ethics for medical practice are all in place, there will be the potential for pure state-administered regulation to mix with state-sanctioned self-regulation. Such possible change, though, not the ideal pentagon-shaped model as proposed, would be a positive sign that Chinese medical practitioners are no longer subject to absolute control by the state and would be gaining more power. This possible trend would be, not only in the interests of professionals and the public, but would also save the government administrative costs.

(2) Supervising Professionally-led Regulations

Maintaining the power of medical practitioners, within the growing trend of patient empowerment, is also an issue that needs to be taken into consideration. Accountability, according to d'Oronzio, is a social practice in which the conduct of an individual healthcare professional is reviewed in the light of public policies and professional standards of conduct.⁸²⁵ In Western societies, there has long been a history of combining external regulation, under the penalty of the law, and self-regulation by consensus of the medical profession.

To avoid potential misbehaviour from within the profession and maintain accountability, there is a need to provide surveillance over professional activities. Western experience of state-licensed legislation normally includes a full range of methods: initial licensing requirements, qualifications, continuous tracking and record-keeping of activities connected with subsequent licensing, scrutinizing failures

⁸²⁴ The 2000 PRC Legislation Law, Article 5.

⁸²⁵ J. C. d'Oronzio, 'Practicing Accountability in Professional Ethics', 13 (2002) *The Journal of Clinical Ethics* 4, 359.

to comply with requirements, pursuing complaints through active investigation and disciplining transgressors.⁸²⁶ As part of a professional architecture, a state licensing board can take action against unprofessional behaviour, in the interests of patient safety and continuing trust in the profession. On the one hand, rules of licensing, monitoring and disciplining can be regarded as a safety net, which is necessary for ensuring effective medical practice. On the other hand, such rules can become distracting and jeopardise professional autonomy, or even be decried by medical practitioners as “attacking the very nature of their profession.”⁸²⁷ However, a balance must be struck and, in my opinion, the benefit of state licensing legislation should be recognised and be introduced to China, whilst taking into account any potentially negative effects.

The law and morals do not always coincide in the guidance that they offer and there still is an unanswered question as to the extent to which the law should enforce moral judgements. Formal instruction and attempts to codify professional morality have increased in recent years through codes of medical and nursing ethics, and codes of research ethics.⁸²⁸ In areas as diverse as informed consent, medical malpractice law and confidentiality, as well as other torts and criminal law related to medical practice and treatment, there has been a huge growth in the scale of litigation brought against the medical profession, and a tendency to limit professional power through court decisions.⁸²⁹ Professional regulation, to some extent, can be seen as legislating ethics. Western scholars regard state legislative ethics reform as a scandal-driven process.⁸³⁰ The increase in legislation reflects a decline in confidence in doctors. This decline in confidence is yet another way of strengthening control when professionalism faces criticism, as discussed earlier.

⁸²⁶ See e.g., AMA, ‘Medical Licensure’, available at: <http://www.ama-assn.org/ama/pub/education-careers/becoming-physician/medical-licensure.shtml>; GMC, ‘General Information about registration and licensing’, available at: http://www.gmc-uk.org/doctors/before_you_apply/registration_factsheet.asp (Last visited on Jan 20th, 2011).

⁸²⁷ M. J. Schlesinger, B. H. Gray and K. M. Perreira, ‘Medical Professionalism under Managed Care: The Pros and Cons of Utilization Review’, 16 (1997) *Health Affairs* 1, 106-124, 1.

⁸²⁸ See e.g., B. A. Rosenson, *The Shadowlands of Conduct: Ethics and State Policies* (Washington, Georgetown University Press, 2005), 13-15; C. Ham and K.G.M. Alberti, ‘The Medical Profession, the Public and the Government’, 324 (2002) *British Medical Journal* 838-842.

⁸²⁹ *Ibid.*

⁸³⁰ A. Rosenthal, *Drawing the Line: Legislative Ethics in the States* (New York, Twentieth Century Fund, 1996); M. Goodman, et al., ‘Ethical Instruction at School of Public Health in the United States’, 89 (1999) *American Journal of Public Health* 5; B. A. Rosenson, ‘The Cost and Benefits of Ethics Law’, 8 (2005) *International Public Management Journal* 2, 209-224.

However the problem China faces is that, Chinese legislators have drawn strongly on Western experience and are following the West in drafting the law, regulations and policies in order to maximise the prevention of misconduct by medical practitioners. This has taken place in circumstances where the Chinese medics have not yet reached a position of professional dominance, and concurrently, there are still a relatively large number of illiterate people among the general public in China.⁸³¹ Many people are afraid to make decisions when they cannot fully understand the information given by their doctors. The previously discussed case – “a migrant worker in Beijing, refused to sign a consent form authorising doctors to perform a C-section on his pregnant wife, and then she and their baby died”, is a good example. Clearly, then, with regard to China’s healthcare law-making, there is a gap between professional development, public awareness and legislation.

As discussed earlier, the enacting of *the 2002 Regulation on the Handling of Medical Accidents* putting the burden of proof on medical practitioners raised great concern from those whom I encountered in the field. In the research interviews, Chinese doctors told me that they thought the law was actually de-motivating doctors from saving patients. One of them said, “I knew it was immoral to persuade patients I did not think had fully understood what I meant to sign the informed consent forms but, according to the law, I had to get that patient’s signature to save his life.” The answer to the question “Does professional regulation make physicians too anxious to take risks in treatment?” was strongly affirmative. “We need to follow the law carefully to avoid litigation, and we know that, eventually, it is the patient who bears the consequence.”

Professionally-led and state-administered regulations for medical practice should come hand-in-hand with an enhancement of professionalism. Legal development is as

⁸³¹ According to United Nation Educational, Scientific and Cultural Organisation, based on the 5th national population census of 2000, there were 85.07 million adult illiterates, of which 22.27 million were male and 63.2 million were female. Statistics of National population are based on national population census, sample survey of 1% of national population and sample survey of 1‰ conducted every 10 years, 5 years and per year. See, United Nation Educational, Scientific and Cultural Organisation, ‘Country Paper: Status and Major Challenges of Literacy in China’, June 2010, available at: http://www.unesco.org/fileadmin/MULTIMEDIA/HQ/ED/ED/pdf/E9China_literacy.pdf (Last visited on Oct 9th, 2010).

important as preserving morality. I would also argue that, to some extent, the regulation of medical ethics in China has caused a decline of ethics. For some Chinese medical practitioners, a priority was given to self-protection from litigation and sanctions, rather than humanitarian consideration. Professional regulation, which was supposed to be a mechanism for protecting patients and the public, has instead become a mechanism for the self-protection of medical practitioners. This would also explain why, in my empirical findings, Chinese medical practitioners and their associated health institutions have high levels of legal awareness. When the law is in conflict with ethics, medics would rather choose to follow law than ethics. Medical regulations in China, which are very different from those in the West, have become a shield for relatively powerless medical practitioners.

The question of balancing the supervision of ethics and self-regulation echoes back to my original question: how to retain professional autonomy within a framework of accountability? Clearly, a system of professionalism needs to be built. What is more, the system of professionalism needs to be consistent with professional regulation and governance. In the pentagon model, I classified professional regulation as a boundary control, precisely because “the law alone would be inadequate to maintain the cohesion of society: moral prescriptions are essential.”⁸³²

6. Conclusion

“We have not lost faith, but we have transferred it from God to the medical professions.”

George Bernard Shaw⁸³³

The role of the medical practitioners in China tends to be practical and technocratic. Their professional awareness is affected by the Chinese values of freedom and social control. The aims of this chapter were to point out that their professional ethics is of crucial importance in enabling them to reach a higher stage of professionalisation and

⁸³² Lord Devlin, ‘Morals and the Criminal Law’, Maccabaeian Lecture, British Academy, 1958, cited by R. A. Hinde, ‘Law and the Sources of Morality’, 359 (2004) *Philosophical Transactions: Biological Sciences* 1685-1695.

⁸³³ Famous quote, source not found, cited by M. S. Schlesinger, ‘A Loss of Faith: The Sources of Reduced Political Legitimacy for the American Medical Profession’, 80 (2002) *The Milbank Quarterly* 2, 185-235.

eventually medical professionalism. Taking into account the role of the public and the input of patients, this becomes an important factor when striking the right balance of power for the medical profession in China.

Sun Simiao, who wrote the so-called Chinese Hippocratic Oath said, “Greed was evidently one of the most serious grounds for the suspicions in which the public held the practices of physicians.”⁸³⁴ The gaining of trust is an essential trait of a formulated ethic. The essence of professional accountability is to maintain medicine as a public activity. As d’Oronzio said, “the more public the behaviour, the more likely it is to be exposed to this practice of accountability.”⁸³⁵

The nexus of accountability that surrounds medical practice depends upon transparency, as well as intact, sustained lines of communication and engagement. Thus, the major challenge facing healthcare professionals is whether or not their professionalism, whilst retaining commitment to patients’ well-being and trust, can be reinvented to include performance-based competency, scientifically-driven quality of improvement, and public disclosure of valid quality information.

Observing interactions between this profession and society in a totalitarian state such as China, it is suggested that the medical professionals could generate power if they managed to join together as an autonomous professional group, together with members of the public; and in order to sustain the power they gain, they have to respond to the public expectations and desires of being accountable and trustworthy.

Biopolitical theorists Fehér and Heller suggest that, “communism as one biopolitics had no other choice but to be part and parcel of democratic politics”.⁸³⁶ It is beyond the scope of this thesis to discuss wider political reform. But one cannot forget that the professional model is based on the democratic notion that people are capable of

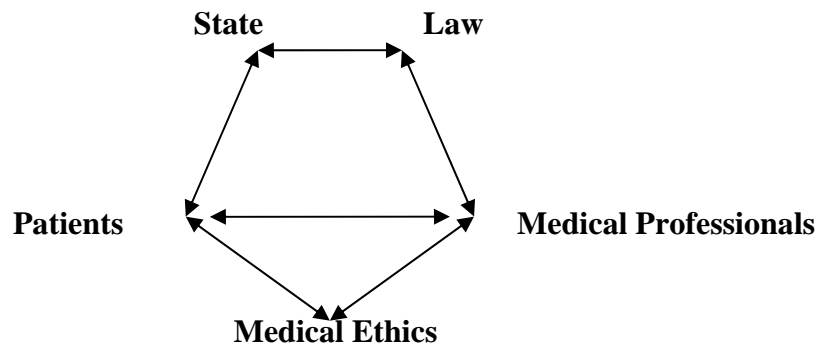
⁸³⁴ P. U. Unschuld, *Medical Ethics in Imperial China* (Berkeley, University of California Press, 1979), 28.

⁸³⁵ J. C. d’Oronzio, ‘Practicing Accountability in Professional Ethics’, 13 (2002) *The Journal of Clinical Ethics* 4, 360.

⁸³⁶ F. Fehér and A. Heller, *Biopolitics* (Aldershot, Avebury, 1994), 21.

controlling themselves by cooperative, collective means, and that those who perform a service are in the best position to make sure that it gets done well.⁸³⁷

In order to revive professionalism, this thesis calls on a structural realignment between decentralised communities (such as patient groups), professional experts, and the state in China. Three levels of control (from ethics, interactive participation and boundaries) in an age of medical professionalism would form a more balanced and ideal model as shown below:



In this pentagonal model, there would be a better balance of power in healthcare governance. It would also provide space for developing a support system for professional codes, and a better support system for “whistleblowers”. As a consequence of which, the role of professionals will be better established.

In conclusion, the effort to maintain professionalism is essentially an ethical and political project. The project is to help members of the medical community to develop within themselves the moral character required to act appropriately.⁸³⁸ Professionals could gain public support by seeking to serve the public good, rather than for the benefit of their own interests individually or collectively. Such a power-dynamic serves to promote confidence and authority, to address key relational problems between medical professionals, patients and the state, and to foster solidarity with other members.⁸³⁹ Trust would be fostered in both the process and outcome of this endeavour. Professionalisation, ultimately the development of medical

⁸³⁷ E. Freidson, ‘Professionalism as Model and Ideology’, *Professionalism Reborn: Theory, Prophecy and Policy* (Chicago, University of Chicago Press, 1994), 176.

⁸³⁸ D. Wear and J. M. Aultman (ed), *Professionalism in Medicine: Critical Perspectives* (New York, Springer, 2006), 37.

⁸³⁹ *Ibid*, 32.

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Empowerment and the Balance of Power*

professionalism, would secure a more professionally responsible and accountable environment in China.

CHAPTER 10

SUMMARY AND CONCLUSION

1. Summary

At the beginning of this study, the following questions were asked:

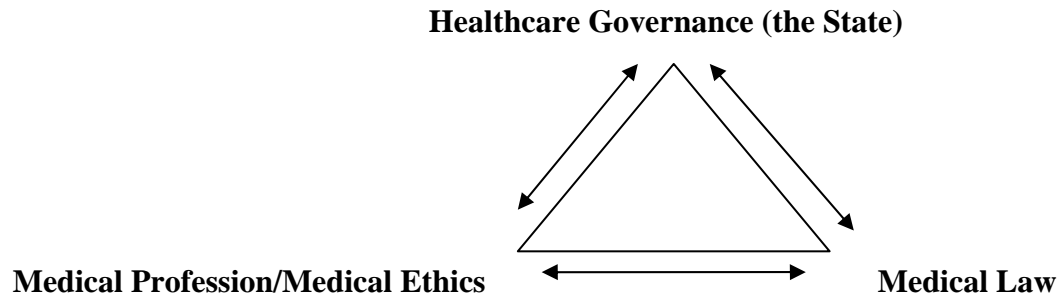
- (1) How do Chinese medical practitioners react to state governance and law?
- (2) Whether, how and why do law or political ideology take priority over medical ethics and professional knowledge, or vice versa?
- (3) Do Chinese medics feel frustration over their role within the healthcare system and think that their current position in the healthcare arena is problematic?
- (4) If so, what are the causes, effects and solutions?

Throughout the study (which consists of three parts: literature review; empirical studies findings; and reflection and discussion), I have shown that Chinese medical practitioners take the law and state policies very seriously, though confusion and moral dilemmas do exist within ethical-legal or ethical-financial conflicts. In this respect, cultural acceptance contributes to their silence, and the submission of individual professionals to the state conforms most closely to the stereotype of a captive practitioner. Although Chinese medical practitioners express high expectations for more power and professional control, in this study so far, a wide range of resistance is still less likely to happen. There are uncertainties on the Chinese medics' road to professionalism.

This thesis has moved the discussion from a hypothetical tripartite relationship between state, law and medics to a top-down model after concluding the literature review which provides background and conceptual framework. Based on the empirical studies, I modified the top-down model and suggested a circular model in light of medics' understanding of the system. I then identified a problem that had received little attention – medical deprofessionalisation in China. After examining the underlying issues which lead to medical deprofessionalisation, I called for professionalism in China's healthcare arena, thus a square model was suggested. But

it was also noted that there would be limitations for medical professionalism within the square model. This led to the final suggestion of a pentagon model which asked for the balance of power in medical professionalism.

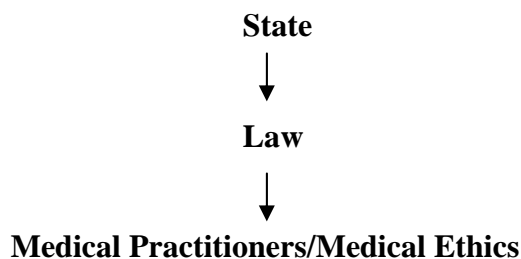
(1) A Tripartite Relationship



At the beginning, the initial question was to find out how Chinese medical practitioners interacted with law, state governance and bioethics. This thesis was especially interested in understanding the position and power of medical practitioners in the tripartite relationship, and exploring ways in which their medical practices are affected by the guiding principles, such as law or ethics, and whether they face dilemmas in choosing guiding principles in practices.

Before exploring this journey into China’s power structure of healthcare professional governance, this thesis began with a review of Western model of state, law and medical profession. In the area of Western healthcare governance, the state, based at the top, decides the nature of the healthcare system and supervise the direction of healthcare legislation. The Western medics have their say by exerting influence on state policies and even voice their resistance towards healthcare laws. Therefore a triangular-shaped model was drafted as an initial hypothesis.

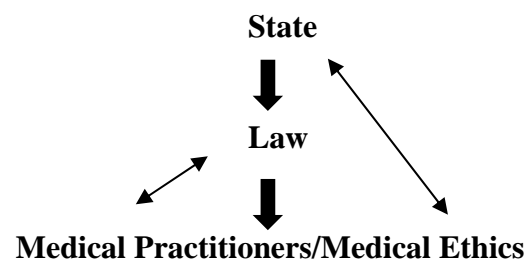
(2) Literature Review: A Top-down Relationship



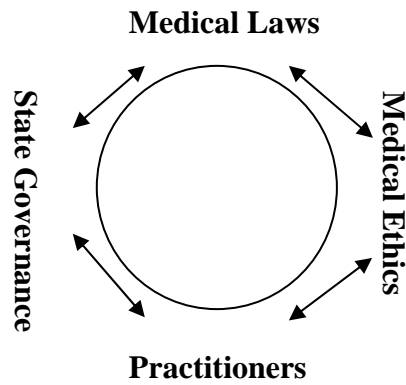
Both the historical and theoretical review indicated that, within China's healthcare power dynamics, Chinese medical practitioners are located at the bottom of a hierarchical structure. These practitioners are subject to political oversight, legal control and institutional scrutiny. The role that Chinese medical practitioners play in healthcare governance is minor. And it is hard to discover in literature their views and awareness concerning their professional responsibilities.

The top-down linear model was used to express the notion that the state remains at the top of the power structure determining the healthcare law and overseeing the legally-ruled Chinese medics. This top-down model can also be understood as a simplified healthcare regulatory framework, where the Chinese medical practitioners are based at the bottom. This top-down linear model was to be tested by the empirical studies. The main questions to be asked empirically were: how do Chinese medics prioritise law, political ideology, and medical ethics? How do they perceive their position in relation to the state, law and ethics? Do they think their role in this healthcare power dynamics is in any way problematic?

(3) Fieldwork and Findings: A Verified Top-down Model and a Circular-shaped Perception

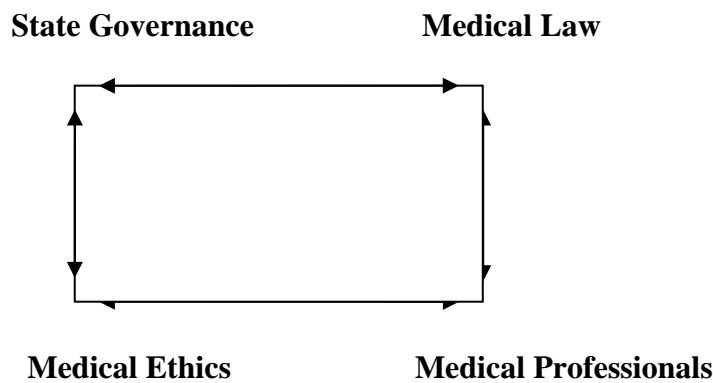


The Chinese healthcare power structure reflects a top-down, authoritarian model with centralised command and control. The authorisation of state intervention is the strongest proponent within the relationship between state, law and medics (and their ethics). The empirical investigations deepened my hypothetical understandings of medical practitioners' position in China's healthcare power dynamic: that is, they are based at the bottom of healthcare power structure; however it does not mean medical practitioners have absolutely no sense of resistance.



Findings in the empirical study were that different levels of medical institutes and medics take law seriously. They said bioethics (or professional morality) was also important. However, in practice, they did not follow professional ethics, but the law. Hospital Party branches act as the main resource for training Chinese medics in medical law and bioethics. In this training, political propaganda is mixed with law and bioethics. In Chinese medics' perception, there seems to be no clear divide between state governance, medical law and bioethics. The voices of dissatisfaction and power seeking from Chinese medics exist, but they are not loud enough to be heard. Opportunities for collective resistance are not obvious either. The circular diagram represents this fluid and confused state of affairs.

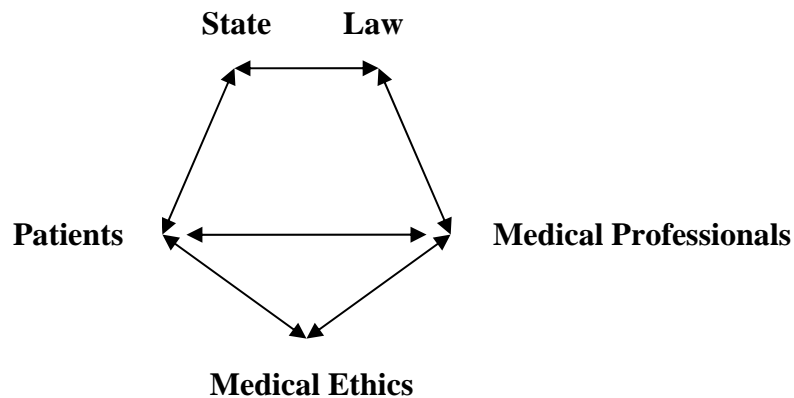
(4) A Calling for Professionalism: A Square-shaped Model



The third part of this thesis offers an analysis of the problem and a possible solution. Recognising the top-down relationship, and the “circular” understanding expressed by Chinese medics, it suggested that a new professionalism model is needed in which

medical professionals (note: not merely practitioners) become involved in healthcare governance. By including medical professionals in healthcare governance, this square-shaped model resembles a suggested change to the original triangular model, i.e. medical professionals and professional ethics should work hand in hand more effectively in healthcare.

(5) Empowerment and the Balance of Power: A Pentagon-shaped Model



Professionalism is a controversial notion to Western societies where too much power has been vested in the professionals. The pentagon-shaped model was suggested as a way to find a balance between a necessary freedom for medical professionals and a sufficient measure of accountability to ensure their responsiveness to social needs and agreed social purposes. The dynamics of this new pentagonal model are that it connects professionalism with patient participation. What is more, horizontally, this model can be divided into three tiers (state & law, medical profession & patients, and ethics) while the whole model still shows a visible compact network between the different parties in healthcare governance. In this model, the empowered professionals are guided by law and affected by legislation; patients are supported by a state-funded healthcare system and can voice their reactions to the state agencies; ethics underpins all healthcare party interactions, especially those of the medics.

Power in the pentagon model is not held by any single party. None of the party – the medical professionals, patients, government bureaucracy, should capture absolute power. It is not meant to suggest the elimination of either the professionals’ or patients’ power; instead it suggests the necessity for their involvement in a healthcare

governance network, in which state, law, professionals and patients can work together for a common purpose: humanity and care.

2. Conclusion

“Politics is part of man’s nature; man through the exercise of his reason, can make enlightened decisions, indeed, ethical decisions; put succinctly, politics is the study of ethics, emphasizing the “proper” relations among men, relations which are a function of man’s place in the larger natural order.”

I. H. Carman⁸⁴⁰

My desire to explore the gap between China’s healthcare governance system and the operation of medical law has led to the discovery of a missing role for Chinese medical practitioners. In an effort to hear the hidden voices of Chinese medics from history, from today through empirical studies and case studies, and against a robust theoretical analysis of power, my findings and my thinking have brought me to a firm conviction about the need for professionalism in China. This journey has been intellectually and emotionally challenging, and rewarding in equal measure.

I am aware that there are limitations to this research. The project would have greatly benefited from hearing the views of a range of Chinese medics from wider geographical areas. My limited number of fieldwork respondents was like “a drop in the ocean”, and while my findings are of value, I cannot claim that they represent the views of the majority of Chinese medics. If the social and political environment had permitted, it would have been useful to have heard views from a randomly chosen sample rather than from the controversial snow-ball sample. Due to financial and time constraints, the empirical data provides only a “snap-shot” of the field. The project would have contained more convincing evidence if a longer, more continuous period of field study had been possible.

However, the strengths of this research far outweigh its limitations. This research throws light upon the existing weaknesses of the Chinese system and offers up a possible strategy for the future of China’s healthcare governance. By considering the

⁸⁴⁰ I. H. Carmen, ‘Biopolitics: the Newest Synthesis?’, 99 (1999) *Genetica* 173-184.

development of Chinese medical practitioners, not just from a socio-historical perspective, but also from an empirical viewpoint, it exposes a need to assign Chinese medical professionals a ‘proper’ and ‘rightful’ place in the modern health service. The study of Chinese medical deprofessionalisation contributes to our understanding of the relationship between the medical profession and the Communist state of China. It is also hoped that, by placing such an analysis in its wider socio-cultural context, the lessons of medical deprofessionalisation in China provide further clarity and insight to discussions of the interface between professions and political forces in other societies. Last but not least, I suggest that this thesis can be used as an exemplar to demonstrate the usefulness of a multi-methods approach for studying questions concerning the relationships, complexities and boundaries between political structures, legislation, professionalism and the public interest.

Having established a distinct place for bio-power and bio-politics in this thesis, possible future research might focus in much more detail on the political theories that relate to power, medicine and medical practice. The notions of professionalisation and professionalism that the literature shows have largely been discussed by Western scholars might help to stimulate further debates on their potential contributions to underdeveloped societies. In light of the proposed pentagon-shaped model, future research might also examine the possibilities for developing patients’ input into healthcare governance, an exercise that was not possible within the confines of this thesis.

A recollection from Beauchamp and Childress brings this thesis to its conclusion: “Problems of professional ethics usually arise from conflicts over professional standards or conflicts between professional commitments and commitments of persons outside the profession.”⁸⁴¹ Chinese medical practitioners are equally faced with these dilemmas: how best to serve the country and help to make it rich, powerful, and modern without compromising intellectual and moral values. I believe China will forge its own path, though it may not necessarily lead to a Western-style, liberal democracy. However, this does not mean that medical professionalism can never be generalised in China, nor that we cannot have hope for a freer China which respects

⁸⁴¹ See note 326, at 7.

professional autonomy and self-regulation. By emphasising the values of medical ethics, professional consciousness, the need for more effective healthcare policies and laws, and by inspiring the Chinese medical profession to take back some of its power, we may move one step closer to this vision of China.

Last but not least, this study is a cross-cultural dialogue. It tends to express its findings and opinions in the most respectful ways rather than in arrogant terms. All of this is done with a hope that the Chinese government could be more accepting and responsive to the call to loosen its control over professional power. The most profound hope is that Chinese medical practitioners themselves will not view the proposal as cultural imperialism and recoil into nationalism.

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**Study of Chinese Physicians' Legal Consciousness and
Its Effects on Professional Practices**

Dear Medical Professionals, I'm so sorry to bother you all,

My name is Wei Ouyang and I am a Ph.D. candidate in Law with a specialization in medical law and medical ethics at The University of Edinburgh. I am writing today to invite you to participate in my doctoral dissertation research on '*China's Public Health Biopolitics: Roles of Law and Medical Ethics*'. The main purpose of this study is to explore the ways in which the medical practices of health workers are affected by guiding principles, such as law or ethics, and dilemmas over choosing guiding principles in medical practices in China.

If you choose to participate by completing the survey questionnaire, it will take approximately 20 minutes to complete. Your identity is in no way connected to your responses and confidentiality is given the highest priority. If you have any questions, please feel free to contact me either by email (w.ouyang@sms.ed.ac.uk) or by phone (0044 784 035 1851).

This project is subject to the institutional ethical review from the University of Edinburgh. This research project aims to design and conduct in a way that meets ethical principles of *the College of Humanities and Social Science Code of Research Ethics* and *the ethical code of ESRC (Economic and Social Research Council) 2005*.

Your opinions and experiences are very important to me. Thank you very much for your time and willingness to participate.

Sincerely,
Wei Ouyang, Ph.D. Candidate
School of Law,
The University of Edinburgh
U.K

Part 1. Medical Law and Medical Professionals

1. Are you aware of any law regulating medical practice?
 - A. Yes, I study laws and regulations relevant to my practice closely.
 - B. Yes, I learn few of laws.
 - C. Yes, but I don't know much detail about it.
 - D. No, I don't know any law related to my medical practices.
 - E. I am not sure.
 - F. No comments.

2. Do you think you understand laws and regulations that relevant to my practice clearly?
 - A. Yes, I always understand what the law requires me to do in any situation.
 - B. Yes, I understand law occasionally.
 - C. No, I am often not sure what the law requires.
 - D. No, I am never sure.
 - E. No comments.

3. Do you think it is important to apply the law regulating your area of practice to your work?
 - A. Yes, it is very important.
 - B. Yes, it is relatively important.
 - C. No, it is not.
 - D. I am not sure.
 - E. No comments.

If you answer "yes", how often do you apply it to your work?

- A. Yes, I do and I apply it to my practice carefully.
- B. Yes, I do but I'd rather follow my professional ethics.
- C. Yes, but I don't think I understand it clearly.
- D. No, I don't think it is necessary.
- E. No comments.

If you answer "yes", why do you think so? Please choose whatever you think is or are relevant.

- A. It can be a tool for use for protecting myself against possible law suits.
- B. It can be my guide to better understand patient's rights.
- C. One of my duty as a decent citizen is to follow the rule.
- D. If I didn't, I would be punished by law.
- E. It is the safest way to practise medicine in China, even though the legally rightness don't mean medically rightness.
- F. It is encouraged by current dominant political thoughts.
- G. And others: _____(please specify)

4. Are there law promotion campaigns in your hospital?
- A. Yes, it is.
 - B. No, it isn't.
 - C. I don't know.
 - D. No comments.
5. What sort of law do you pay most attention to? Please choose whatever you think is or are relevant.
- A. Professional codes, ethics consult;
 - B. Regulating general medical practice;
 - C. Regulating medical and clinical malpractice;
 - D. Legal and moral questions concerning the beginning and the end of life;
 - E. Legal aspects of medical research;
 - F. Legal aspects of medical product and medical device usage;
 - G. Legal procedure of medical law making;
 - H. And others: _____ (please specify)
6. How do you know about these laws?
- A. At school;
 - B. Through hospitals on-the-job training;
 - C. Through law promoting campaign;
 - D. From colleagues;
 - E. By self-learning from library, internet, or media;
 - F. Others: _____ (please specify)
7. What do you think the motivation of these campaigns?
- A. In reaction to patients' increasing demand, legal knowledge can be used for defending medical practices and protecting medics;
 - B. Reduce prospected suit cost;
 - C. For better protecting patients' best interests;
 - D. It is ordered by higher administrative governances;
 - E. To reduce conflict between patients and medics in order to maintain a harmonious working environment.
 - F. Others: _____ (please specify)
8. Do you think there should be more involvement of medical professionals in medical law making in China?
- A. Yes, it is very important.
 - B. Yes, it is relatively important.
 - C. No, it is not.
 - D. I am not sure.
 - E. No comments.

please continue to the next page

If you answer “yes”, could you please give a reason?

- A. Professional review of medical law is for patients’ best interests.
- B. Law should act more to protect medical professionals.
- C. I wish Chinese Medical Association should have been more actively engaged in defending our interests.
- D. Even I think so, but I personally not feel interested in involving in law drafting debate.
- F. Other: _____ (please specify)

9. Have you ever heard of “China Health Law Society”?

- A. Yes, I have joined or is planning to join in it.
- B. Yes, I heard of it, but I don’t plan to be a member of it.
- C. Yes, but I am not sure what it is.
- D. No, I have never heard of it.
- E. No comments.

Part 2. Healthcare Governance and Healthcare Professionals

1. In terms of China’s current health service, do you think it is in harmony with the public?

- A. Yes, all the time.
- B. Yes, most of the time.
- C. No, conflicts happen very often. But I believe things will be better.
- D. No, conflicts can’t be solved in a short term. The situation is so complicate.

2. Has your practice been affected by China’s health sector reform?

- A. Yes, it affects my practice in a good way.
- B. Yes, it affects my practice in a bad way.
- C. No, my practice hasn’t been affected at all.
- D. Not sure.
- E. No comments.

If you answer “yes”, could you explain how it was affected?

please continue to the next page

3. Do you think good medical practice is important to secure a “Harmonious Society”?

- A. Yes, it is very important.
- B. Yes, it is relatively important.
- C. No, it is not.
- D. I am not sure.
- E. No comments.

If you answer “yes”, could you please give a reason?

- A. Health care services are closely related with public interests.
- B. Politicians have emphasised its function to harmonious society very often
- C. Current trust crisis between doctors and patients have proved this.
- D. Others: _____ (please specify)

4. Besides of law promotion campaign, is political thought education accessible at your serving medical institute?

- A. Yes.
- B. No.
- C. I don't know.
- D. No comments.

If “yes”, where do you usually get your political thought updated? Please choose whatever you think is or are relevant to you.

- A. I get the latest political thought update from regular seminars in my hospital.
- B. Yes, I get it mostly from branch party discussion group of my hospital.
- C. Yes, I get it often from TV, newspaper or magazines.
- D. No, I am not interest in political issues.
- E. Others: _____ (please specify)

5. Do you think you should connect the latest political thought with your practice?

- A. Yes, it is very important.
- B. Yes, it is relatively important.
- C. No, it is not.
- D. I am not sure.
- E. No comments.

6. What functions does the hospital’s party branch play in hospital management?

- A. Party branch manages core spiritual theme of my hospital.
- B. Party branch cooperates with hospital’s management team.
- C. Party branch coordinates party members and non-members relationship.
- D. It doesn't affect hospital’s management at all.

E. Others: _____ (please specify)

F. No comments.

7. Have you heard of “China Health Political Thought Promotion Association”?

A. Yes, my hospital has joined or is planning to join in its local branch association.

B. Yes, I heard of it, but my hospital doesn't plan to be a member of it.

C. Yes, but I am not sure what it is.

D. No, I have never heard of it.

E. I am not sure.

F. No comments.

Part 3. Medical Ethics: Learning and Practice

1. Were you taught medical ethics in medical school?

A. Yes, I had systematic learning.

B. Yes, I had limited learning.

C. Yes, very informally.

D. No, almost none.

E. I am not sure.

F. No comments.

2. In your opinion, do you think medical ethics are important to your practice?

A. Yes, it is very important.

B. Yes, it is relatively important.

C. No, it is not.

D. I am not sure.

E. No comments.

If you answer “yes”, how important it is to your practice?

A. It is a very important self-regulation to me and I'd rather not be a medic if I can't apply it to my practice.

B. It is important, but I sometimes I have to compromise it with practical reasons.

D. I am not sure.

C. No comments

3. What is your understanding of modern medical ethics? Please choose whatever is relevant to you, and then to put them into order according to their level of importance (start from the most important one).

A. Improve the quality of patient care;

B. No disclosure of patients' medical record;

C. Non-maleficence;

D. Respect patients' autonomy;

E. Team work between colleagues;

- F. Ethical aspects of biotechnological development;
- G. Combining Professionalism and Patriotism;
- H. Safeguard public health;
- I. And others: _____ (please specify).

4. Do you find the modern medical ethics guideline understandable?
- A. Yes, I am very sure.
 - B. Yes, most of the time.
 - C. No, I got confused occasionally.
 - D. No, I often get confused.
 - E. No comments.
5. In the current situation, do you think it is easy for you to apply your understanding of medical ethics to your practice?
- A. Yes, it is naturally easy.
 - B. Yes, relatively easy.
 - C. No, I have to make difficult decisions in some situations.
 - D. No comments.
6. Have you heard of “Chinese Medical Association”?
- A. Yes, my hospital has joined or is planning to join in its local branch association.
 - B. Yes, I heard of it, but my hospital doesn’t plan to be a member of it.
 - C. Yes, but I am not sure what it is.
 - D. No, I have never heard of it.
7. Has the “Chinese Medical Association” made any impact on your work so far?
- A. Yes, a lot
 - B. Yes, but limited
 - C. No, almost none.
 - D. I don’t know.
 - E. No comments.
8. Have you ever consulted international bioethics guidelines, particularly those relating to your field?
- A. Yes, I have been keeping my eyes on international bioethical development.
 - B. Yes, but I only know a sketch of them.
 - C. No, I haven’t but I would love to learn in the future.
 - D. No, I don’t think it is necessary for me to learn.
 - E. I have never heard of international bioethics guidelines.
 - F. No comments.

Part 4. Essential Guiding Principle

please continue to the next page

1. Could you please classify what is the most important practice guideline to you? Please choose whatever is relevant to you, and then to put them into order according to their level of importance (start from the most important one).

- A. Practice guidelines of your belonging hospital;
- B. Medical law;
- C. Medical ethic or your moral consciousness;
- D. Party' political thought;
- E. And others: _____ (please specify)

2. Which area of you working life needs most improvement? Please choose whatever is relevant to you, and then to put them into order according to their level of importance (start from the most important one).

- A. Medical law;
- B. Medical Ethics;
- C. Income;
- D. Supervision of public opinion;
- E. Health care system;
- F. And others: _____ (please specify)

3. What is the guidance that is most needed by you currently?

- A. Law
- B. Technical requirements of my hospital
- C. Higher awareness of political thought
- D. Clearer medical ethic guidance
- E. Other: _____ (please specify)

4. Have you ever got a feeling of depression during or after your work?

- A. Yes, many times.
- B. Yes, a few times.
- C. No, never.
- D. No, I am quite happy with my work instead.
- E. No comments.

If you answer "yes", why did you get depressed? Please choose whatever is or are relevant to you.

- A. Income is too low.
- B. Law conflicts with my medical ethics sometimes.
- C. Professional independence.
- D. Commercial interests conflict with my medical ethics sometimes.
- E. Doctors' social reputation has destroyed. Our hard work hasn't been understood by the public.

F. Guidelines and requirements are confusing. ()

G. Others: _____ ()

Part 5. Demographic Information (Not for disclose of your identity, research purpose only)

1. Sex: ___ Male ___ Female
2. Age: ___ under 25; ___ 26-35; ___ 36-45; ___ 46-55; ___ 56-65; ___ over 65
3. Your educational level:
___ High School and Below; ___ Secondary Technical School ; ___ Junior College; ___ Bachelor; ___ Master; ___ Doctorial
4. Your health professional title:
___ Doctor; ___ Assistant Doctor; ___ Senior Nurse & Nurse; ___ Pharmacist;
___ Laboratory Technician; ___ Others
5. Your technical title:
___ Primary; ___ Intermediate; ___ Associate Senior; ___ Senior
6. Type of your servicing health institution:
___ General Hospital; ___ Traditional Chinese Medicine Hospital;
___ Specialized Hospital; ___ Health Center; ___ Sanatorium;
___ Outpatient Department & Clinic; ___ Country Clinic; ___ Others
7. Your servicing hospital by grade in 2008:
___ Third Level 1st Class; ___ Third Level 2nd Class; ___ Third Level 3rd Class;
___ Second Level 1st Class; ___ Second Level 2nd Class;
___ Second Level 3rd Class; ___ First Level 1st Class; ___ First Level 2nd Class;
___ First Level 3rd Class; ___ Others
8. Your working department:
___ Internal Medicine; ___ Surgery; ___ Obstetrics & Gynaecology;
___ Paediatrics; ___ Pain Clinic; ___ Traditional Chinese Medicine;
___ Acupuncture and Moxibustion; ___ E.N.T.; ___ Ophthalmology;
___ Assistant Diagnosis and Examination; ___ Others
9. Length of your professional serving time: ___
10. Province in which your hospital is base: _____
11. Are you willing to participate in a follow-up interview?
 Yes. My email or my phone number: _____ No.

~Thank you so very much for your participation~

致医务工作者的邀请信

尊敬的医务工作者：

您好！非常抱歉打扰您。

我是欧阳薇，目前就读于英国爱丁堡大学法学博士班，研究领域为卫生法，国家卫生管理和医学伦理。我的博士论文将就中国现阶段医疗法在医疗实践中的地位及其对中国医疗工作者临床实践的影响进行研究。期望能对卫生法的制订与修改程序贡献学术上的参考意见，使法律与医务工作者能在医疗体制改革中发挥更积极的影响，并使医务工作者的权益在立法层面上获得最大的保障。

此项研究已得到爱丁堡大学法学院研究伦理委员会的审查通过，并获得法国现代中国研究中心（CEFC）的资助。此次问卷调查将在中国 5 个省的 40 多家医院同时展开，以便了解临床医务人员的医疗卫生法律意识，执业困境，以及医务人员的医疗卫生法律认知对其执业的影响。

今天，我诚挚的邀请您参与我博士论文中的实证调查研究。期待您自愿参与。

填写本问卷大约需要 15 至 20 分钟。问卷调查采不计名的方式，您对任何问题的回答都不涉及个人的具体身份及头衔，所收集的数据将在统计后做归纳分析，受访者给予答案的保密性将被笔者列为最优先的考量。请您依要求提供意见，并将填写好的问卷放入信封，密封好，交还发放者。

如果您有任何疑问或建议，请随时联系欧阳薇。电话：(0)13826277303 或者 E-mail: w.ouyang@hotmail.com

您的意见将无比珍贵。非常感谢您百忙之中拨冗参与笔者之研究。对于您的参与，笔者致上无尽的感激。

此致。

欧阳薇

2008 年 11 月 28 日

临床医务人员的法律认知及其对医疗行为影响的调查问卷

一、中国医疗卫生法规与医务工作者

1. 请问您是否对医疗卫生之相关法规有不同程度的了解? [单选]

- E. 是的, 我会仔细学习所有与我医学实践相关之法规。
- F. 是的, 我清楚少量法规。
- G. 是的, 但我对于法规的具体内容不大确定。
- H. 不, 我不了解任何与我医学实践科室相关之法规。
- I. 无可奉告。

2. 请问您了解与您医学实践相关法规的内容和意义吗? [单选]

- A. 是的, 我总是了解它的各种意义和要求。
- B. 是的, 我有时知道它的定义。
- C. 不, 我经常不确定法律的要求。
- D. 我不确定。
- E. 无可奉告。

3. 您认为依法执业重要吗? [单选]

- A. 是的, 非常重要。
- B. 是的, 相对重要。
- C. 不, 没那么重要。
- D. 我不确定。
- E. 无可奉告。

如果您回答是肯定的, 请问您在工作中总是依法行事吗? [单选]

- A. 我一直很注意在工作中处处依法行事。
- B. 越来越依法行事。
- C. 有时依法行事, 但我经常倾向凭借医学专业的角度做决断。
- D. 我不确定。
- E. 无可奉告。

如果您的回答是肯定的, 理由为何? [不定项选择]

- A. 法律可以成为防范诉讼的工具。
- B. 它可使我更好的了解患者的权益。
- C. 遵守法律乃公民的基本义务。
- D. 守法可避免受到法律的制裁。
- E. 为了避免执业的风险, 即使在法律上站得住脚, 不代表在医学上正确无误。
- F. 国家的政治思想强调了依法治国。
- G. 如有其他 (请您补充): _____

4. 请问在您服务的医疗机构有进行过集体的法律学习吗? [单选]

- A. 有。
- B. 没有。
- C. 我不知道。
- D. 无可奉告。

5. 您最为重视哪类法律? [不定项选择]

- A. 您专业的守则及道德操守的规范。
- B. 规范医疗行为的基本总则。
- C. 医疗过失与医疗事故的相关法规。
- D. 关于管理基因/胚胎, 或安乐死等关系生死类的法律。
- E. 关于医学研究的法律规范。
- F. 医疗产品及器械的使用规范。
- G. 关于医疗法立法程序的规定。
- H. 如有其他(请您补充): _____

6. 您最主要是通过何种途径学习法律? [单选]

- A. 在学校。
- B. 在医疗机构的实习中。
- C. 医疗机构的普法宣传活动。
- D. 听同事介绍。
- E. 从书本或大众媒体中自学。
- F. 如有其他: _____ (请您补充)

7. 请问您认为普法教育最重要的目的为何? [单选]

- F. 保护医生权益。
- G. 减少可能的诉讼成本。
- H. 更好的保护患者的权益。
- I. 和谐社会的需要。
- J. 为了更和谐的诊疗环境。
- K. 如有其他: _____ (请您补充)

8. 您认为在制定卫生法的过程中, 是否需要更多医务工作者的参与? [单选]

- A. 是的, 非常重要。
- B. 是的, 相对重要。
- C. 不, 不重要。
- D. 我不确定。
- E. 无可奉告。

如果您的回答是肯定的, 理由为何? [单选]

- A. 医学专业人员对于卫生法的评议是为了患者的最大利益。
- B. 法律需要更多的站在医生的角度立法。
- C. 中华医学会应更积极捍卫医务工作者的权益。
- D. 虽然我的答案是肯定的, 但我个人对于参与卫生法律的修订不感兴趣
- E. 如有其他: _____ (请您补充)

9. 请问您是否听过“中国卫生法学会”? [单选]

- A. 是的, 我是会员或我正准备加入这个学会。
- B. 是的, 我听说过, 但我不准备加入。
- C. 是的, 我听说过, 但我不确定它是做什么的。
- D. 不, 我从未听说过。
- E. 无可奉告。

二、 医疗体制的管理与医务工作者

1. 您认为中国医疗行业的现况是否符合国家对于“和谐社会”的倡导吗? [单选]

- A. 是的, 一直都是。
- B. 是的, 大部分时间是。
- C. 不, 医患纠纷虽频繁发生, 但我对未来仍持乐观态度。
- D. 不, 医患的冲突不可能在短期内改善。情况非常复杂。

2. 请问您的工作有无受到中国医疗改革的影响吗? [单选]

- A. 是的, 受到正面影响。
- B. 是的, 受到负面影响。
- C. 没有, 并无受到任何影响。
- D. 我不确定。
- E. 无可奉告。

如果您回答“是的”, 请问具体在哪些方面对您的工作产生影响?

3. 请问您是否认为医疗服务对于国家建立和巩固“和谐社会”有重要影响? [单选]

- A. 是的, 非常重要。
- B. 是的, 相对重要的。
- C. 不, 这不重要。
- D. 我不确定。
- E. 无可奉告。

如果您的回答是肯定的, 理由为何? [单选]

- A. 医疗服务是公共事业, 与公众的利益密切相关。
- B. 政府已多次强调医疗服务对于稳定社会的重要性。
- C. 医患关系的和谐在某种程度上会影响社会稳定。
- D. 如有其他: _____ (请您补充)

4. 请问您在您所在的医疗机构除了业务学习之外, 是否有参加思想政治学习? [单选]

- A. 有。
- B. 没有。
- C. 我不确定。
- D. 无可奉告。

请翻次页

如果您回答“有”，请问您通常从何种渠道获取最新的思想教育？[不定项选择]

- A. 服务的医疗机构组织的研讨会或学习班。
- B. 党支部的组织生活。
- C. 新闻媒体，比如互联网，电视，报纸，杂志等。
- D. 同事或朋友的口耳相传。
- E. 如有其他：_____ (请您补充)

5. 请问思想政治学习对您的医学工作影响大吗？[单选]

- A. 是的，它非常重要。
- B. 是的，它相对重要的。
- C. 不，它不重要。
- D. 我不确定。
- E. 无可奉告。

6. 请问对于医务工作者，请问院党支部在医院的行政管理中发挥怎样的作用？[单选]

- A. 党支部的决策，引领医院的发展方向。
- B. 党支部与医院管理层密切合作，共同发展。
- C. 党支部协调党员与群众的关系。
- D. 党支部不干涉医院的具体行政管理。
- E. 如有其他：_____ (请您补充)
- F. 无可奉告。

7. 请问您听说过“中国卫生工作政治思想促进会”吗？[单选]

- A. 是的，我所在的医疗机构是会员或正准备加入这个协会。
- B. 是的，我听过，但我不确定我所在的医疗机构是否准备加入。
- C. 是的，我听过，但我不确定它是做什么的。
- D. 不，我从未听过。
- E. 我不确定。
- F. 无可奉告。

三、 医学伦理/医德规范的学习与实践

1. 请问您在医学院时有进行过关于医学伦理的系统学习吗？[单选]

- A. 是的，有系统的学习过。
- B. 是的，学习过一部分。
- C. 是的，但只是在副修课上学习过。
- D. 很少。
- E. 我不确定。
- F. 无可奉告。

2. 医学伦理的学习对于您的医学实践影响大吗？[单选]

- A. 是的，非常重要。
- B. 是的，相对重要的。
- C. 不，不重要。
- D. 我不确定。
- E. 无可奉告。

Questionnaire Form (in Chinese)

如果您的回答是肯定的，请问医学伦理对于您的医学执业有何影响？[单选]

- A. 它对我来说是非常重要的自我约束机制，医生执业的崇高即在此
- B. 它很重要，但理想和现实有一定差距。
- C. 我不确定。
- D. 无可奉告。

3. 什么是您理解中的医德规范？请您根据对您而言的重要性，选择相关数字选项，并按最重要、次重要，依次类推的顺序排序。[不定项选择]

- ① 自身医术的精进。
- ② 保护病患的隐私。
- ③ 不伤害的原则。
- ④ 尊重病患的自主决定。
- ⑤ 医务人员之间的相互配合协作。
- ⑥ 生物科技发展衍生的伦理问题。
- ⑦ 敬业精神与爱国主义相结合。
- ⑧ 维护群众和社会的健康。
- ⑨ 如有其他（请您补充）：_____

4. 请问您认为您理解的医学伦理是否准确无误呢？[单选]

- A. 是的，我一直非常确信。
- B. 是的，一般情况下我能确信。
- C. 不，有时会有些疑惑
- D. 不，我常常疑惑。
- E. 无可奉告。

5. 在现今中国的医学实践与社会现况，请问您是否能轻易将理想中的医学伦理与工作实际相结合？[单选]

- A. 是的，可以轻易将理论结合实际。
- B. 是的，比较容易。
- C. 我不确定，有时我需要做出困难的决定。
- D. 无可奉告。

6. 请问您听过“中华医学会”吗？[单选]

- A. 是的，我是会员或我正准备加入这个学会。
- B. 是的，我听过，但我不准备加入。
- C. 是的，我听过，但我不确定它是做什么的。
- D. 不，我从未听过。
- E. 无可奉告。

7. 请问“中华医学会”作为一个团结和组织广大医学科学技术工作者的社会团体，对您的工作有无实质影响？[单选]

- A. 是的，影响很大。
- B. 是的，有点影响。
- C. 不，几乎没有。
- D. 我不知道。
- E. 无可奉告。

8. 请问您是否有参考过国际生命伦理指南，尤其是与您医学实践相关章程的内容？ [单选]
- A. 是的，我一直关注其进展。
 - B. 是的，但我只有少许了解。
 - C. 没有，但我希望以后能有机会了解。
 - D. 没有，而且我不认为有了解它的必要。
 - E. 我从未听过国际生命伦理指南。
 - F. 无可奉告。

四、 关键指南

1. 请您区分对您工作影响最大的指南，请您根据对您而言的重要性，选择相关数字选项，并按最重要,次重要，依次类推的顺序排序。 [不定项选择及排序]
- ① 您所在医疗机构的内部规章。
 - ② 卫生法规。
 - ③ 医学生命伦理。
 - ④ 政治思想理念。
 - ⑤ 如有其他（请您补充）： _____
2. 请问您认为哪些与您工作相关的方面最需要得到改进？请您根据对您而言的重要性，选择相关数字选项，并按最重要,次重要，依次类推的顺序排序。 [不定项选择及排序]
- ① 卫生法规的学习。
 - ② 医学生命伦理的学习。
 - ③ 收入。
 - ④ 公众舆论的监督。
 - ⑤ 医疗卫生体制。
 - ⑥ 如有其他（请您补充）： _____
3. 您认为您现在工作中最迫切需要学习和掌握的是？ [单选]
- A. 卫生法的学习。
 - B. 专业技术的不断提升。
 - C. 更高的思想政治觉悟。
 - D. 更清晰的生命伦理规范的学习。
 - E. 如有其他： _____ (请您补充)
4. 您在工作中或工作后是否曾感到沮丧？ [单选]
- A. 有，很多次。
 - B. 有几次。
 - C. 不，从来没有。
 - D. 不，我反倒是一直工作得很有干劲
 - E. 无可奉告。

请翻次页

如果您回答“有”，请问您为何沮丧？ [不定项选择]

- ① 收入与社会地位。
- ② 法律与生命伦理的冲突。
- ③ 医务人员自主。
- ④ 商业利益与生命伦理的冲突。
- ⑤ 公众欠公平的舆论。
- ⑥ 工作指南多而不明晰。
- ⑦ 如有其他（请您补充）： _____

五、 个人的基本信息（*统计的需要，您的身份不会因此确定及公开*）

1. 性别： ①男 ②女
2. 年龄： ①25岁以下 ②26-35岁 ③36-45岁 ④46-55岁 ⑤56-65岁 ⑥65岁以上
3. 您的最高学历： ①初中 ②高中 ③中专 ④大专 ⑤大学本科 ⑥研究生及以上
4. 您的卫生技术职务类型： ①执业（助理）医师 ②注册护士 ③药剂人员
④检验人员 ⑤其他卫生技术人员
5. 您的专业技术职称： ①初级 ②中级 ③副高级 ④正高级
6. 您所在医院类型： ①西医医院 ②中医医院 ③民营医院 ④社区医院
⑤门诊部 ⑥乡村卫生室 ⑦其他
7. 您所在医院的等级： ①三级甲 ②三级乙 ③二级甲
④二级乙 ⑤一级 ⑥无级别
8. 您已从事医疗工作的时间：_____
9. 您所在的省份： _____
10. 您是否愿意参加后续的一对一面谈或电话访问？
 愿意, 我的电子邮箱或电话号码是：_____
- 不愿意

~ 非常感谢您的参与 ~

Guide Sheet for Semi-Structured Interview

The interviews were carried out attempting to grasp medics' opinions, feelings, attitudes and the meanings that are implicit in their actions from their own viewpoints. Technically, the qualitative research interviews were semi-structured and carried through following the same themes but not exactly the same questions to be asked to different individuals. Following questions were asked of each interviewee during the one-to-one interview. The questions were designed to be open-ended. Various follow-up questions were asked depending on the interviewee's answers.

Interviews lasted averagely around 40 minutes, within which three interviews lasted for an hour or two.

1. Can you give me your opinion on your current practice environment?
2. Do you think law is relevant to your profession? How do you understand or apply it in your daily practice?
3. Do you think political thought education is relevant to your profession? How do you understand or apply it in your daily practice?
4. Do you think medical ethics is relevant to your profession? How do you understand or apply it in your daily practice?
5. How do you prioritise ethics/law/political ideologies in your practice? Why?
6. Have you experienced any dilemma with political ideology or law conflicting with your understanding of medical ethics? Could you give me an example? If you haven't, have you heard from a colleague who has? How did you or your colleagues resolve those dilemmas?
7. Have you heard about the controversial "husband refused to sign then medics refused to treat in their capacity" in Beijing last year (2008)? If similar situation arose in your practice, what would you do?
8. In current situation, how do you feel about being a medic in China? Why?
9. Have you experienced any difficult time? How did you handle it?
10. Do you expect changes to happen in the future? What are your expectations?
11. How do you think about my fieldwork in general? Could you give me any comments? Would you mind if I contact you again in the future to verify some answers?