

The Hippocratic Dilemmas

Guanxi and Professional Work in Hospital Care in China

LONGWEN FU AND CHERIS SHUN-CHING CHAN

ABSTRACT: Patients mobilising *guanxi* (interpersonal relations) to gain access to hospital care is prevalent in post-Mao China. Yet few studies have centred on how medical professionals deal with *guanxi* patients. Based on ethnographic research and applying an analytical frame of Chinese *guanxi* developed by Fei Xiaotong (1992 [1948]) and Cheris Shun-ching Chan (2009), this article examines the dilemmas that Chinese physicians face in weighing professional standards versus *guanxi*. We divide the patients into three general categories: patients without any *guanxi*, patients with weak to moderate ties with physicians, and patients with strong ties with physicians. We find that physicians face few dilemmas when they interact with patients without *guanxi*. They largely adhere to their professional code of practice and generally display dominance over the patients. When interacting with patients with weak to moderate ties, however, physicians are caught in a dilemma between fulfilling *renqing* (interpersonal obligation) and adhering to a professional code of practice. They manage this dilemma through dramaturgical strategies such as information-sharing, emotional work, and face-giving. When interacting with patients with whom they have strong ties, however, affection and the sense of asymmetric obligation may take precedence over professional codes. Physicians deal with this dilemma through a different set of strategies, such as information-control, emotional avoidance, and altruistic care. Our analysis reveals the impacts of *guanxi* on medical professionals and the moral dilemmas they face in a *guanxi*-dominant societal context. It offers direction for possible policy reforms to mitigate the problem.

KEYWORDS: China, *guanxi*, medical professional, moral dilemma, hospital care.

We begin with a story published in *People's Daily* on 5 July 2013:

Whenever Dr. Li, a physician at China-Japan Friendship Hospital, received a phone call with unfamiliar numbers from her hometown, she knew that it must be from someone whom she barely knew asking for help. So many people called her from her hometown, and she was supposed to help them jump the queues for hospital care. Once she told a person from her hometown that instead of asking her to help him make an appointment, he could do that online by himself. She was then blamed by this person for being "heartless and disloyal" (*wuqing wuyi* 无情无义).⁽¹⁾

What Dr. Li experienced is common for medical professionals in post-Mao China. What are the dilemmas that Chinese medical professionals face when being approached by *guanxi* 关系 (interpersonal relations or connections) patients? How do they deal with these dilemmas?

We will begin by outlining some basic terminology. "Medical professionals" refers to physicians, nurses, and medical students. "*Guanxi* patients" are medical professionals' family members, relatives, friends, former classmates, former colleagues, neighbours, people from the same hometown, and anyone referred by these people. The popularity of *guanxi* patients in China is indicated by a number of studies. For instance, in one hospital in Lishui City, Zhejiang Province, it was found that 93% of the 72 physicians in the study had been approached by *guanxi* patients. Nearly 90% of these physicians agreed to see these patients in order to maintain their social relations.⁽²⁾ *Guanxi* patients are most commonly found in big hospitals at the city or

provincial level, the so-called tertiary hospitals.⁽³⁾ In a study of one tertiary hospital in Nanjing, nearly 58% of the 119 patients identified themselves as *guanxi* patients, and 81% of these patients had used *guanxi* to get access to hospital care more than once.⁽⁴⁾ Although nation-wide data are not available, it is well recognised by both medical professionals and the general public that *guanxi* patients are commonly found throughout China.

Handling *guanxi* patients is not an easy job for medical professionals. By fulfilling the demands made by *guanxi* patients, medical professionals may run the risk of breaking professional rules and regulations. But turning down *guanxi* patients' requests can incur social sanctions and ruin one's reputation in social circles. The problem is that professionalism and *guanxi* each have their own logic of action that can be contradictory to each other. On the one hand, professionalism calls for equal treatment of patients without discrimination or favouritism. According to sociologist Talcott Parsons, physicians should have internalised professional norms that emphasise universalism, functional specificity, affective neutrality, and collective orientation.⁽⁵⁾ Medical professionals are supposed to be agents of formal

1. "Kanbing buzhuo shuren xingbuxing" (Does it work if we seek medical care without *guanxi*?), *People's Daily*, 5 July 2013.
2. Wang Qiufen et al., "Yihuan boyi shijiao xia de guanxijiuyi xianxiang diaoyan: yi lishuishi mouyiyuan weili" ("Relational hospitalization" and the doctor-patient relationship: A case study of hospital care in Lishui City), *Zhongguo yixue lunli* (Chinese Medical Ethics), Vol. 26, No. 3, 2013, pp. 305-307.
3. Based on *The Rule of Tiered Hospital Management* (Yiyuan fenji guanli banfa), hospitals in China are divided into three categories: primary, secondary, and tertiary. The tertiary hospitals usually have the best facilities and personnel in a given region.
4. Yao Cheng, "Shuren shehui zhong tuoren kanbing zhi chutan" (A preliminary study on seeking health care through *guanxi* in acquaintance society), *Yixue yu shehui* (Medicine and Society), Vol. 22, No. 5, 2009, pp. 10-12.
5. Talcott Parsons, *The Social System*, London, Routledge, 1991 [1951], pp. 305-308.

knowledge and strictly adhere to the principle of formal rationalisation and functional efficiency.⁽⁶⁾ On the other hand, the logic of particularism in *guanxi* practices runs against the logic of professionalism. The nature of *guanxi* is captured by Xiaotong Fei as "differential mode of association." It is analogous to layers of concentric circles when one throws a stone into the water, with the Ego in the centre. The closer the circles to the Ego, the stronger the *guanxi* and the higher the degree of favouritism is supposed to be.⁽⁷⁾ The underlying logic of favouritism or particularism in Chinese *guanxi* is highlighted by Nan Lin's description of asymmetric obligation.⁽⁸⁾ This kind of obligation is based on the principle of need, and it serves as the base on which the expressive ties between family members are built.⁽⁹⁾

In this article, we analyse the dilemmas that medical professionals face when they are dealing with *guanxi* patients and describe how they manage the dilemmas. We take Kipnis's position that both instrumental and affectionate elements are present in Chinese *guanxi*, although their proportion varies in different types of *guanxi*.⁽¹⁰⁾ We compare physicians' logics of action when they interact with patients from different categories: from no *guanxi* connection, to weak and moderate ties, to intimate familial ties. We probe the structural dilemmas between professional work and *guanxi* obligations, explore the sources of the dilemmas, and document how medical professionals manage these dilemmas.

In the following sections, we first review the research on the institutional transformation of the health care system in China and its challenges to the professional work of physicians. We show that studies of *guanxi* patients contribute to our understanding of the complex plight haunting the Chinese physicians. Next, we introduce the analytical framework of Chinese *guanxi* developed by Cheris Chan⁽¹¹⁾ and describe our methodology. Relying on Chan's framework, we broadly divide medical professionals' relationships to patients into three categories. We describe the characteristics of each category, the corresponding dilemmas that the medical professionals face, and the strategies they employ to manage these dilemmas. We conclude the article by summarising our findings and discussing their implications for the reform of the health care sector in China and for the training of medical professionals.

Institutional changes and professional work in the era of market reform

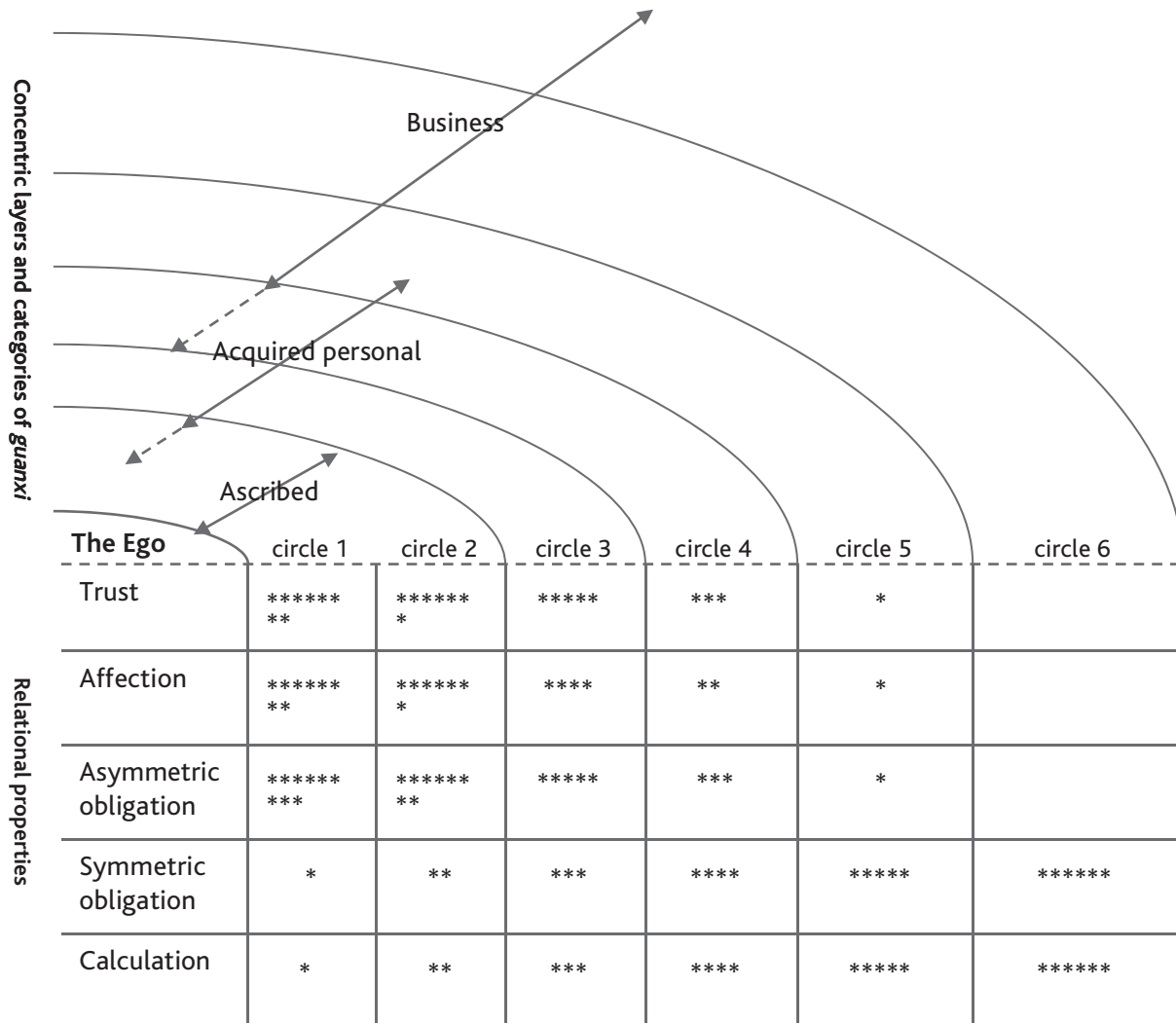
Most literature has focused on the transition of China's healthcare system from a national, centrally-planned system to a market-oriented one. One of the most salient aspects of the transition is the incentive structure for healthcare facilities. By the early 1990s, government funding had been reduced to around 10% of the facilities' total revenue.⁽¹²⁾ Healthcare facilities have to rely on out-of-pocket payments by patients as their major income source for the remaining 90% of their budget. Meanwhile, the prices of basic medical services are strictly controlled by the government and are kept at a level that is affordable to most people. The government nevertheless allows the prices of high-tech examination (e.g. CT, MRI) and drugs to rise so that hospitals can make some money. In order to survive financially in the new system, many facilities have shifted their organisational goals to "income generation" and increasingly prescribe unnecessary drugs and perform excessive tests.

The corporatisation of hospital management since the mid-1980s has resulted in a profit-driven image of hospitals and medical professionals.⁽¹³⁾ Studies have explored the catastrophic impact of market reform on the col-

lapse of clinical autonomy and professional standards of frontline practitioners. As public hospitals nowadays rely on self-financing, physicians are under pressure to bring in revenue. They are described as an "institutional scapegoat" that must absorb patients' anger and frustration toward public hospitals.⁽¹⁴⁾ Many physicians rely on extra-legal payments because their basic salaries are insufficient for them to make a living.⁽¹⁵⁾ The well-documented problem of overtreatment indicates that physicians have compromised their professional standards for financial benefit, or due to institutional pressure.⁽¹⁶⁾ In addition, Chinese physicians lack a widely-shared tradition of professionalism to resist economic incentives.⁽¹⁷⁾ Yet, economic interest is not the only factor that determines how physicians perform their professional work in the era of market reform. The popularity of mobilising *guanxi* for hospital care poses another threat to the clinical behaviour of physicians. This issue has not received enough attention in the literature of Chinese medical professionals.

Mobilising *guanxi* to obtain preferential healthcare treatment is not new to modern China, though it has become more prevalent in the post-Mao period. In the 1970s-1980s, some patients mobilised their *guanxi* with physicians to obtain quality medicine and prolonged sick leave.⁽¹⁸⁾ Chinese scholars also found that social connections helped some patients jump queues for hospital beds when they were in short supply.⁽¹⁹⁾ The use of *guanxi* in this context can be regarded as a way of dealing with the scarcity of resources. While medical resources in post-Mao China are supposed to have increased, the mobilisation

6. Eliot Freidson, *Professional Powers: A Study of the Institutionalization of Formal Knowledge*, Chicago and London, The University of Chicago Press, pp. 9-13; George Ritzer and David Walczak, "Rationalization and the Deprofessionalization of Physicians," *Social Forces*, Vol. 67, No. 1, 1988, pp. 1-22.
7. Fei Xiaotong, *From the Soil: The Foundations of Chinese Society*, Translated by Gary Hamilton and Wang Zhang, Berkeley and Los Angeles, University of California Press, 1992 [1948], Chapter 4.
8. Nan Lin, "Guanxi: A Conceptual Analysis," in Alvin So, Nan Lin, and Dudley Poston (eds), *The Chinese Triangle of Mainland-Taiwan-Hong Kong: A Comparative Institutional Analysis*, CT, Westport, Greenwood Publishing Group, 2001, pp. 156-159.
9. Kwang-kuo Hwang, "Face and Favor: The Chinese Power Game," *American Journal of Sociology*, Vol. 92, No. 4, 1987, pp. 944-974.
10. Andrew Kipnis, *Producing Guanxi: Sentiment, Self, and Subculture in a North China Village*, Durham, Duke University Press, 1997; see also Kwang-kuo Hwang, "Face and Favor: The Chinese Power Game," *art. cit.*
11. Cheris Shun-ching Chan, "Invigorating the Content in Social Embeddedness: An Ethnography of Life Insurance Transactions in China," *American Journal of Sociology*, Vol. 115, No. 3, 2009, pp. 712-754.
12. William C. Hsiao and Linying Hu, "The State of Medical Professionalism in China: Past, Present and Future," in William P. Alford, Kenneth Winston and William C. Kirby (eds), *Prospects for the Professions in China*, New York, Routledge, 2010, pp. 111-128.
13. Cheris Shun-ching Chan and Yao Zelin, "A Market of Distrust and Obligation: The Micropolitics of Unofficial Payments for Hospital Care in China," paper presented at Annual Meeting of American Sociological Association, Denver, Colorado, August 2012.
14. Cheris Shun-ching Chan, "Institutional Scapegoat: Increasing Doctor-Patient Tension in China," a paper to be presented at the annual meeting of American Sociological Association, Seattle, August 2016.
15. Gerald Bloom, Leiya Han, and Xiang Li, "How Health Workers Earn a Living in China," *Human Resources for Health Development Journal*, Vol. 5, No. 1-3, 2001, pp. 25-38.
16. William C. Hsiao and Linying Hu, "The State of Medical Professionalism in China: Past, Present and Future," *art. cit.*
17. David Blumenthal and William Hsiao, "Lessons from the East: China's Rapidly Evolving Health Care System," *The New England Journal of Medicine*, Vol. 372, No. 14, 2015, pp. 1281-1285; William C. Hsiao, "When Incentives and Professionalism Collide: The Chinese Experience Holds a Grave Lesson: Incentives Have a Powerful Effect on Physicians' Behavior," *Health Affairs*, Vol. 27, No. 4, 2008, pp. 949-951.
18. Andrew G. Walder, *Communist Neo-Traditionalism: Work and Authority in Chinese Industry*, Berkeley, University of California Press, 1986, pp. 182-184; Martin K. Whyte and William L. Parish, *Urban Life in Contemporary China*, Chicago and London, The University of Chicago Press, 1984, p. 68.
19. Chien Chiao, "Guanxi chuyi" (On *guanxi*), in Yang Kuo-shu (ed.), *Zhongguoren de xinli* (The Psyche of the Chinese), Taipei, Guiguan, 1988, p. 113; Mayfair Mei-hui Yang, *Gifts, Favors, and Banquets: The Art of Social Relationships in China*, Ithaca and London, Cornell University Press, 1994, p. 95.

Figure 1 – The categories of Chinese *guanxi* and their relational properties

Source: Cheris Shun-ching Chan, "Invigorating the Content in Social Embeddedness: An Ethnography of Life Insurance Transactions in China," *American Journal of Sociology*, Vol. 115, No. 3, 2009, pp. 712-754, with minor modifications.

of *guanxi* for hospital care has been rising instead of declining. Why is this the case? Recent studies attribute the problem to a low level of trust in the health care system. As physicians' incomes rely largely on hospital revenues, physicians are often put into a conflict of interest with their patients. The trust-based relationship between users and providers has been undermined, if not totally destroyed. Patients have begun to think of hospitals and physicians as unethical and untrustworthy. To deal with the problem of generalised public distrust, patients now rely heavily on "personal trust" that is embedded in *guanxi*.⁽²⁰⁾ Consequently, the allocation of medical resources has, to some extent, shifted from an institutional behaviour to a gift or favour exchange based on social obligations.⁽²¹⁾ Most previous research on *guanxi* patients focuses on why patients choose *guanxi* as their strategy to cope with the unreliable health care system. Yet we do not know much about how *guanxi* requests shape physicians' professional work from the perspective of medical practitioners. This paper intends to fill this gap.

Analytical framework and methodology

To describe and explain the intricacy of medical professionals handling *guanxi* patients, we adopt the analytical framework developed by Cheris

Chan in her study of life insurance transactions.⁽²²⁾ This framework extends the analysis of social relations from the dimension of tie strength to the substantive content of *guanxi*. One of the attractions of this framework is that it integrates the content of *guanxi* into the structure. Figure 1 is the framework that we adopt from Chan with slight modification.

The framework contains two major parts. The upper part refers to the structure of Chinese *guanxi* as inspired by Fei's "differential mode of association." The Ego is surrounded by concentric circles in a descending order

20. Cheris Shun-ching Chan, "Strong-Tie Chains and Generalized Exchange: The Mobilization of Social Networks for Hospital Care in China," paper presented at the Annual Meeting of American Sociological Association, New York, 2013; Cheris Shun-ching Chan and Yao Zelin, "A Market of Distrust and Obligation: The Micropolitics of Unofficial Payments for Hospital Care in China," paper presented at Annual Meeting of American Sociological Association, Denver, Colorado, August 2012; Yao Zelin, *Practicing Clinical Medicine in a Post-socialist State: An Empirical Study on Professional Autonomy of Chinese Urban Doctor*, unpublished doctoral dissertation, the University of Hong Kong, 2012.

21. Cheng Yu and Zhou Xiang, "Guanxi jiuji: zhenliao de bentuhua shijian" (*Guanxi* hospitalisation: A localised medical practice), *Sixiangzhanxian* (Thinking), Vol. 41, No. 2, 2015, pp. 37-42; Cui Xiangfen and Yao Zhaoyu, "Nongmin jiuji guocheng zhong guanxi ziben yunzuo de xingdong luoji" (The logic of *guanxi* capital in the health care seeking process of peasants), *Zhongguo nongye daxue xuebao* (China Agricultural University Journal of Social Sciences), Vol. 27, No. 4, 2010, pp. 49-55.

22. Cheris Shun-ching Chan, "Invigorating the Content in Social Embeddedness: An Ethnography of Life Insurance Transactions in China," *art. cit.*, pp. 721-724.

of closeness. Circles 1-2 belong to strong ties, circles 3-4 represent moderate ties, circle 5 refers to weak ties, and circle 6 has no ties at all. The arrows on the circles display the categorisation of *guanxi* described by David Wank.⁽²³⁾ Ascribed *guanxi* usually fall into circles 1-2 as the strongest ties. They refer to those with blood ties with the Ego. Acquired personal *guanxi* build on shared former experiences, such as schoolmates, friends, colleagues, neighbours, and people from the same hometown. They are typically represented by circles 3-4. Although acquired personal *guanxi* can be cultivated to become very close to the Ego, they are still qualitatively different from ascribed *guanxi*, and so we use dotted lines to represent the extension from moderate to strong ties. Business *guanxi* refers to the relations acquired through business transactions. We categorise the doctor-patient relationship constituted by two strangers encountering each other for the first time in hospitals as business *guanxi*. Patients could repeatedly consult the same physicians and develop a friendship with the physicians over time, which would move their tie strength from circle 6 to circles 4-5. However, except for very rare cases, they could never make it to the category of strong ties.

The lower part of Figure 1 identifies five key relational properties in Chinese *guanxi*, namely trust, affection, asymmetric obligation, symmetric obligation, and calculation. The number of stars represents the intensity of the respective relational property in relation to tie strength. For example, the strongest ties have a high level of trust, affection, and asymmetric obligation, but with a low level of symmetric obligation and calculation. Conversely, weak ties or no ties contain primarily symmetric obligation and calculation, with only low levels of trust, affection, and asymmetric obligation.

Applying this model to the doctor-patient relationship, we identify three general categories. Circles 5-6 refer to no existing *guanxi* or very weak ties between patients and physicians. Here we expect to see physicians' actions geared toward a more professional approach. If there are any dilemmas, they come from the institutionally constituted conflict of interest between patients and physicians as described above, but not from *guanxi*. Circles 3-4 refer to social ties of moderate strength between patients and physicians. As this category of *guanxi* contains a comparable weight of all five relational properties, physicians are pulled by all these forces and face the dilemma of how to fulfil both professional and *guanxi* logics. Lastly, circles 1-2 refer to close pre-existing relations between patients and physicians. The extraordinarily high level of affection and asymmetric obligation embedded in these strong ties brings another kind of dilemma to the physicians. How to maintain an objective and rational diagnosis and render scientific treatment without the interference of emotion now becomes an issue. We will illustrate the different kinds of dilemmas in relation to tie strengths in the next three sections.

The data presented in this article were mainly collected by the first author at a tertiary hospital in the southern Chinese city of Haikou, Hainan Province, in 2012. This hospital represents a typical popular hospital in urban China. An ethnographic method was adopted and data were collected through participant observation and face-to-face interviews. Observation was conducted mostly in a general internal medicine department over a two-month period. Attention was paid to the daily life and work of medical professionals and their treatment of patients with and without *guanxi*. Semi-structured interviews were conducted with medical professionals, including seven internists, two surgeons, one paediatrician, one psychiatrist, two nurses, and one administrator in charge of the office dealing with medical disputes. The gender ratio was equal, with seven males and seven females. Due to the sensitivity of the topic, we did not audio record the interviews. As an exploratory study, some of the limitations of our research

method are obvious. For example, we have a limited number of interviewees. We therefore supplemented the data by referring to medical professionals' writings posted on a popular on-line forum called "Clove Garden" (*dingxiangyuan* 丁香园). We believe that the anonymous environment on this forum should encourage medical professionals to frankly share their views. We collected 43 writings from this on-line forum related to *guanxi* patients. Pseudonyms are used throughout this paper to protect the identities of our informants.

Patients without guanxi: Maintaining a distant and professional relationship

Physicians' relationships with patients without any *guanxi* or with very weak *guanxi* (circles 5-6) fall into a professional-client category. Figure 1 indicates that relations in circles 5-6 are governed by the principle of symmetrical obligation and calculation. The level of trust and affection between physicians and patients is low. Physicians' obligation to patients is to render technical medical services by adhering to a professional code of conduct. Without any *guanxi* or with only very weak *guanxi*, patients have no reason to make particular demands on the physicians. Even if they do so, the physicians could simply ignore them with little social cost. As physicians are the party possessing technical knowledge and information, they usually assert their identity of being a clinical expert, and the patients are put in a rather passive position.⁽²⁴⁾

A typical interaction between a physician and a patient in the general internal medicine inpatient ward where we conducted observation goes like this: First, the patient or her family member is asked to pay a deposit when she is admitted for hospitalisation. Then, the physician-in-charge takes a medical history of the patient and orders a physical examination (e.g., taking blood pressure, doing an electrocardiograph, and conducting various blood tests). When the test results come in, the physician formulates diagnoses and sometimes consults other physicians if doubts arise. The physician then proposes a treatment plan. Patients' lack of technical knowledge naturally gives the physicians the upper hand in this power relation. As the ability to control is seen as the central principle of professionalism,⁽²⁵⁾ physicians normally do not welcome too many questions from patients. We observed that the time physicians spend on each patient is very short. For example, we followed Dr. Zhao for a week, and we recorded that he normally spent about 30 to 60 minutes in the morning doing ward rounds for five to ten patients or more. On average, he spent five to six minutes on each patient. His communications with patients were rather limited. Instead, he spent more time discussing cases with his supervisor in front of patients and their family members, who usually wear a vacant look on their faces. We observed that physicians often provided patients' families with general statements such as, "He is stable," "She is doing well," or "He is alright," etc., without explaining the diagnoses in detail. They also gave some practical suggestions such as "He should walk more," or "Bring him some light foods."⁽²⁶⁾

23. David Wank, "The Institutional Process of Market Clientalism: *Guanxi* and Private Business in a South China City," *China Quarterly*, No. 147, pp. 820-838.

24. Dana Yaghi and Hana Medler-Liraz, "Clinical Expert or Service Provider? Physicians' Identity Work in the Context of Counterprofessional Patient Requests," *Qualitative Health Research*, Vol. 25, No. 9, 2015, pp. 1199-1211.

25. Eliot Freidson, *Professionalism Reborn: Theory, Prophecy, and Policy*, London, Polity Press, 1994, p. 173.

26. Participant observation in the wards, Haikou, January 2012.

Cheri Chan found that when patients do not personally know any physicians, they try every means to get connected to physicians through *guanxi*, usually by going through many intermediaries.⁽²⁷⁾ We found that physicians are in fact most bothered by these patients who are only very loosely connected to them, and by the patients who know them personally but have been out of touch for many years. For example, soon after Dr. Shen became employed at a hospital, he received a phone call from a former high school classmate whom he had not seen since graduation. He was displeased with this call for help.⁽²⁸⁾ In our interview Dr. Zhou jokingly said that she once received a call from someone who claimed to be her kindergarten friend.⁽²⁹⁾ Physicians in general are bothered by demands for personal favouritism from people with very weak ties, because helping them can be costly, but refusing to help may potentially harm their social reputation. Instead of refusing to help right away, physicians often come up with excuses. For instance, they may first agree to try to help and then later tell the patients that "the beds are fully booked" or "our supervisor doesn't allow us to...."

When interacting with patients in circles 5-6, physicians almost never make decisions for patients. The patients or their family members sign a consent form at each phase of treatment. We once observed a nurse telling a physician that a patient was reluctant to have a shot, and the physician responded, "It's all up to her if she has already signed the consent form." Dr. Zhao said, "Let things drift if they do not affect us (*shibuguanji, gaogaoguaqi* 事不关己, 高高挂起). We can only tell patients the pros and cons of different treatments. We should never make decisions for them." This is not to suggest that physicians do not care about patients without *guanxi*. Indeed they do. But their concerns are confined to their medical condition. They typically care less about patients' personal life or emotional needs. When patients display emotional distress, physicians rely heavily on patients' family members to handle their emotions.⁽³¹⁾

A number of studies report that the doctor-patient relationship in China has been deteriorating since the 1990s and has worsened since the 2000s.⁽³²⁾ The corporatisation of public hospitals and the income structure of physicians (the fact that physicians live on commissions) are the root causes of this problem, which is beyond the scope of this paper.⁽³³⁾ But the tension between physicians and patients, and the increasing medical disputes and incidents of violence against physicians have pushed medical professionals to adopt a defensive medical approach.⁽³⁴⁾ Their calculating attitude concerning the risk of sharing information with patients further weakens patients' trust in them, resulting in a vicious circle of mutual distrust between physicians and patients.

In sum, physicians maintain a distant, professional relationship with patients without *guanxi* or with weak *guanxi*. Although some patients who repeatedly consult the same physicians succeed in establishing a trusting relationship with them, the physicians still maintain a largely professional relationship instead of treating the patients as "friends." Chinese patients are well aware of physicians' defensive approach, and many of them consequently try to mobilise *guanxi* to get connected to physicians in hopes of receiving better care.

Patients with moderate ties: The risk of violating the professional code and renqing etiquette

Patients who have direct or indirect acquired *guanxi* with medical professionals can be considered to have moderate ties with them. Typically they

are relatives, friends, colleagues, former classmates, neighbours, and people from the same hometown as the medical professional. Patients who do not know any medical professionals directly, but are instead referred by friends and relatives who have relatively close ties to medical professionals, can also fall into this category. Figure 1 indicates that a key feature of the *guanxi* in the middle range strength (circles 3-4) is the relatively balanced composition of the relational properties of asymmetric and symmetric obligation, as well as trust, affection, and calculation. While this balance is beneficial to economic transactions,⁽³⁵⁾ it creates dilemmas for medical professionals.

Patients with moderate ties to medical professionals often make specific demands, such as requesting to jump queues for registration, consultation, and surgery, or skipping certain administrative (or even medical) procedures in order to speed up the treatment process or save money. If the medical professionals entertain their demands, they may have to violate rules, be unfair to other patients, work longer hours, or run the risk of being sued if the treatment outcomes are not desirable. However, if they refuse to render any favouritism to the *guanxi* patients, they may be accused of being "heartless and disloyal" and ruin their reputation in their social circles. Dr. Yang, a senior physician in our interview, was sometimes too busy to take people from her hometown to meet physicians she referred patients to, which resulted in her being accused of "arrogance" in her hometown.⁽³⁶⁾

Both in their interviews with us and in their writings on the online forum, junior physicians, medical students, and nurses all complained that it took them endless time and effort to cater to the demands of *guanxi* patients. For instance, being a nurse, Ms. Sun spent a lot of time almost every day answering phone calls from relatives, friends, and former classmates, and those referred by them. She also spent quite a lot of time referring certain *guanxi* patients to physicians and walking them to the consultation rooms. She complained that this extra work negatively affected her professional performance.⁽³⁷⁾ Junior physicians and medical students often face the same

27. Cheri Shun-ching Chan, "Strong-Tie Chains and Generalized Exchange: The Mobilization of Social Networks for Hospital Care in China," *art. cit.*
28. Online post 24857802, "Zai yiyuan gongzuo, pingshi huiyou qinqingpengyou zhaoni kanbing, ni shi ruhe zuode ne" (What would you do when relatives and friends come to you for medical care when you are working at the hospital?), *Dingxiangyuan*, 2013.
29. Interview with Dr. Zhou, Haikou, February 2012.
30. Participant observation in the doctors' office, Haikou, January 2012.
31. Participant observation in the doctors' office, Haikou, January 2012.
32. Edwin C. Hui, "The Contemporary Healthcare Crisis in China and the Role of Medical Professionalism," *Journal of Medicine and Philosophy*, Vol. 35, 2010, pp. 480-483; Xinqing Zhang and Margaret Sleeboom-Faulkner, "Tensions between Medical Professionals and Patients in China," *Cambridge Quarterly of Health Ethics*, Vol. 20, No. 3, 2011, pp. 458-465; Benjamin L. Liebman, "Malpractice Mobs: Medical Dispute Resolution in China," *Columbia Law Review*, Vol. 113, 2013, pp. 187-193; Xiaoshuo Hou and Ling Xiao, "An Analysis of the Changing Doctor-Patient Relationship in China," *Journal international de bioéthique* (International Journal of Bioethics), Vol. 23, No. 2, 2012, pp. 86-89; Joseph D. Tucker et al., "Patient-physician Mistrust and Violence against Physicians in Guangdong Province, China: A Qualitative Study," *British Medical Journal Open*, Vol. 5, No. 10, 2015, pp. 1-10.
33. Cheri Shun-ching Chan, "Sources of Trust and Mistrust of Physicians in China," paper presented at the conference on "Rebuilding Patient-Physician Trust in China," a multi-disciplinary summit organized by the Harvard Asia Center, Shanghai, October 2015.
34. Alex Jingwei He, "The Doctor-patient Relationship, Defensive Medicine and Overprescription in Chinese Public Hospitals: Evidence from a Cross-sectional Survey in Shenzhen City," *Social Science & Medicine*, No. 123, 2014, pp. 64-71; Yao Zelin, *Practicing Clinical Medicine in a Post-socialist State: An Empirical Study on Professional Autonomy of Chinese Urban Doctor*, *op. cit.*, pp. 215-229.
35. See Brian Uzzi, "Embeddedness in the Making of Financial Capital: How Social Relations and Networks Benefit Firms Seeking Financing," *American Sociological Review*, Vol. 64, 1999, p. 500; Cheri Shun-ching Chan, "Invigorating the Content in Social Embeddedness: An Ethnography of Life Insurance Transactions in China," *art. cit.* p. 719.
36. Interview with Dr. Yang, Haikou, February 2012.
37. Interview with nurse Ms. Sun, Haikou, February 2012.

problem. Being new to a hospital, they only know a limited number of senior physicians. However, friends and relatives often come to them for help. Finding a good doctor for a *guanxi* patient can be exhausting, as one medical student recalled: "I have to first collect information about the medical skill and reputation of each senior physician in my department. Then, I may also need to ask for help from friends in other departments."⁽³⁸⁾

The most difficult dilemma that physicians face is that some *guanxi* patients demand to skip certain administrative or medical procedures, or demand that physicians perform certain high-risk medical procedures. Skipping certain procedures can certainly increase medical professionals' risk of committing medical errors. Incidents where physicians get themselves into trouble while trying to help a *guanxi* patient are widely reported on the online forum. For instance, a dentist described an incident in which a dental surgeon in his department performed a tooth extraction on a nurse's father. In order to save money for the nurse, he did not ask the patient to go through the regular procedure of registration, nor did he trace the medical history of the patient. He simply asked the old man if he was allergic to anaesthesia. The man said "no," but then he died immediately after the injection of anaesthesia. The dental surgeon had no way to defend himself and had his license suspended.⁽³⁹⁾

Although there is a certain level of trust and affection among those with moderate ties, trust and affection are not unconditional. Furthermore, there is a certain level of instrumental calculation among members of this group. These relational properties significantly shape how medical professionals treat *guanxi* patients with middle-range tie strength. To protect themselves from any legal liability, they never make critical decisions for the patients. For example, although Dr. Zhao was very close to his aunt, he made no decisions about her treatment. Instead, he explained to his cousin (the patient's son) the possible risks and prognoses of the treatment and answered his questions patiently and sympathetically.⁽⁴⁰⁾ Ms. Chu, the chief nurse in the internal medicine ward, also told us how she avoided making decisions for *guanxi* patients. She recalled an incident when a rather close relative was too anxious to undergo a surgery that resulted in an undesirable outcome. She helped to connect her relative to a surgeon, and a date was scheduled for the surgery. However, her relative wanted to have the surgery right away, so he went to another surgeon to get it done. The outcome was not very satisfactory, unfortunately. "In a way I felt guilty for not persuading him to stay with the original plan. But I dared not do so for fear of being blamed if the scheduled surgery did not turn out perfect either," sighed Ms. Chu.⁽⁴¹⁾

In other words, in moderate *guanxi*, trust and affection are not strong enough to abandon risk concerns and self-interest calculation. Physicians differentiate high risk requests from low risk ones and take action accordingly. In general, physicians are more willing to provide small benefits to moderate *guanxi* patients such as jumping queues or treating them with better manners. However, they often feel uneasy and at risk when involved in critical decision-making for moderate *guanxi* patients, especially under emergency and severe conditions. The dilemma in choosing between their professional code and *renqing* 人情 (interpersonal obligation) puts medical professionals in a vulnerable position.

To manage these dilemmas, especially under the circumstances of risky requests, medical professionals have to apply certain dramaturgical strategies to balance self-protection and *renqing*. We observed that three strategies are commonly adopted by medical professionals when dealing with patients with whom they have moderate ties: information-sharing, emotional work,

and face-giving. Physicians and nurses generally spend more time talking to *guanxi* patients to give them more information about their diagnoses and medical procedures. Providing sufficient information and related medical knowledge for the patients and their family members can help them make sensible decisions and eliminate unnecessary worries. Physicians are supposed to do this for every patient, including those without *guanxi*. However, the overwhelming amount of work borne by physicians makes it impossible to do so. They have to be selective, so they choose to share more information with *guanxi* patients to convey the message that "I do care for you."

Emotional work⁽⁴²⁾ and face-giving are strategies for dealing with *guanxi* patients' demands for favouritism. As it is too risky to provide technical favouritism by treating the *guanxi* patients differently from other patients in terms of medical treatment, what physicians can offer often belongs to nontechnical favouritism such as caring and attention. For emotional work, physicians and nurses often present a positive attitude when they serve *guanxi* patients. Even when they feel bothered by (unreasonable) demands, they never express their dissatisfaction, and they try their best to maintain their composure in front of patients. Besides attending to their physical condition, physicians and nurses also express concern about the patients' emotional and personal issues. They are more willing to listen to them and to comfort them. For example, Dr. Zhao often stayed longer with his aunt, and chatted with her family members about her condition and other casual matters. He also carried out medical procedures for her that were supposed to be carried out by nurses.⁽⁴³⁾ Emotional care provides a buffer for professional work. It allows medical professionals to follow closely the professional code in the technical aspect of medical treatment on one hand, and to fulfil their *renqing* obligation to a certain degree on the other.⁽⁴⁴⁾

Face-giving is another strategy frequently adopted by medical professionals. Face-giving, according to Goffman, refers to a better arrangement for a person than the person could otherwise obtain.⁽⁴⁵⁾ The most common form of face-giving is physically accompanying *guanxi* patients to see physicians whom the medical professionals know, or to a medical examination. This is a way of showing one's willingness to spend time, regardless of how busy one is, in taking care of a particular *guanxi* patient. Symbolically it represents the importance of that particular *guanxi* to the medical professional. Having a physician or a nurse going with them to a consultation room or to the medical examination room also makes patients feel assured of the quality of health care. "Just put on your white coat and go with *guanxi* patients" is a piece of advice given by physicians to medical students on the online forum.⁽⁴⁶⁾ When physicians are indeed too busy to go with a patient, they may call the doctors or technician to tell them the patient is coming, implying, "They are my friend, so please take good care of them." For cases of

38. Online post 16963908, "Dairen kanbing de wenti" (The problem of taking *guanxi* patients to see doctors), *Dingxiangyuan*, 2010.

39. Online post 7361479, "Yisheng, nixin jiushi de ying" (To be a doctor, you have to be hard-hearted), *Dingxiangyuan*, 2006.

40. Interview with Dr. Zhao, Haikou, February 2012.

41. Interview with chief nurse Ms. Chu, Haikou, February 2012.

42. Arlie Hochschild, *The Managed Heart: Commercialization of Human Feeling*, Berkeley and Los Angeles, University of California Press, 1983.

43. Participant observation in the wards, Haikou, January 2012.

44. Qu Yinghe, *Guanxi jiuqi quxiang xia yihu hudong yanjiu* (Study on the interaction between doctors and patients from the perspective of relational hospitalisation orientation), *op. cit.*, Chapter 5.

45. Erving Goffman, *Interaction Ritual: Essays on Face-to-Face Behavior*, New York, Pantheon, 1967, pp. 5-12.

46. Online post 430649, "Guanyu qinqipengyou kanbing, weinan de wo" (It is difficult for me when my relatives and friends have to seek medical care), *Dingxiangyuan*, 2003.

serious illnesses, *guanxi* patients have high expectations for medical procedures. The medical professionals may help them get a famous, experienced senior physician involved in the diagnosis.⁽⁴⁷⁾ As superior physicians possess an institutionalised cloak of competence in modern health care,⁽⁴⁸⁾ their involvement makes the patients feel assured of the quality.

Patients with very strong ties: The risk of emotional interference

Family members, needless to say, belong to the strongest ties in Chinese and other East Asian societies. When patients are family members, medical professionals face another kind of dilemma. Figure 1 shows that the relational properties among family members (circles 1-2) are predominantly trust, affection, and asymmetric obligation with minimal calculation. Family relations are basically expressive ties, and their interactions are largely governed by the rule of need.⁽⁴⁹⁾ What the medical professionals expressed on the online forum demonstrates the very unique position of family members in the hierarchical *guanxi* structure. Some senior physicians advised their juniors on how to deal with *guanxi* patients of different categories by saying, "There is no (real) *guanxi* patient except your own parents," "Anyone could possibly bite you except your father and mother," "Never sacrifice your life for anyone other than your parents."⁽⁵⁰⁾ The key message in this advice seems to warn against trusting any *guanxi* patients except one's parents. But they clearly show that familial *guanxi*, especially with one's parents, deserves special treatment in hospital care. Dr. Zhao in our interview explicitly expressed that one can say "no" to a friend for a demand that is difficult to fulfil. But "how can one say 'no' to one's own mother? One must do whatever one can to take the best care of her."⁽⁵¹⁾ When one's family members are hospitalised, any medical professionals will do their utmost to get the "best" services for these patients without much consideration of the social and financial costs. However, physicians face the risk of letting emotions interfere in their medical diagnoses.

One of the relational properties in familial *guanxi* is a very high level of trust. Chan calls the kind of trust among very strong ties as "reflexive trust," referring to a "reaction to cultural schemas of intimate relationships without forethought."⁽⁵²⁾ Dr. Yang in our interview expressed this kind of trust in parents and siblings:

If my parents were hospitalised, I would not have to worry that if there would be any misunderstandings concerning my intent. They would know that whatever I would do is in their best interest. It is the same for our brothers and sisters. But to members of the extended family, for example, the wife of your brother or the husband of your sister, you cannot take them for granted. Sometimes you don't know what is in their minds.⁽⁵³⁾

Dr. Zhou shared the same view. She said that when a patient is one's family member, one does not have to be guarded. Because of the extraordinarily high level of trust, family members usually defer to their medical advice without any questions.⁽⁵⁴⁾

At the same time, the relational property of asymmetric obligation among strong ties channels the medical professionals to serve the best interests of the familial patients in various ways. They certainly pay much more attention to these patients and adopt a very caring attitude. They arrange the best facilities for the patients if possible, and pay for their medical expenses

(if the patients are their parents). They accompany the patients to medical examinations to give them emotional support on one hand, and to ask for preferential treatment from colleagues on the other.

However, the high intensity of affection in familial ties poses a challenge to physicians. Dr. Feng describes this challenge: "We are working under two levels of pressure when we provide medical care for our family members. We are like a double agent. On the one hand, our responsibility as a physician is to provide professional service to our patients by telling them the possible risks and prognoses of different treatment plans and to let them make decisions. On the other hand, our responsibility as a son or a sibling is to help our parents or brothers and sisters to make the best decisions and to bear the consequences if things go wrong."⁽⁵⁵⁾ Being a "double agent," as Dr. Feng calls it, becomes a source of dilemma for medical professionals. We observed that the more emotional commitment the medical professionals have to the patients, the harder it is for them to offer valid diagnoses and propose effective treatment plans. Several studies on the socialisation of medical students found that internalising the rules of emotional detachment and accepting the objectification of patients is part of becoming competent in clinical practice.⁽⁵⁶⁾ The strong emotional-affective attachment in family relations is, in fact, a great barrier to achieving an objective, professional assessment of the patients' conditions. Dr. Feng's case vividly demonstrates this dilemma. Her father, who suffered from severe diabetes and icterus, was admitted to the hospital where she worked. The medical consultants all generally agreed that her father's condition allowed him to undergo a surgery, but his age made it difficult to predict the outcome. Dr. Feng, a highly experienced chief physician, suddenly did not know what to do. She burst into tears in front of other physicians.⁽⁵⁷⁾ Other stories posted on the online forum expressed the same dilemma: the deep emotional attachment to family members makes it difficult to make an objective diagnosis and choose the best treatment.⁽⁵⁸⁾

In the Western cultural contexts, physicians may also find the situation of treating family members profoundly challenging, as they are faced with a similar conflict in their roles when treating close family members.⁽⁵⁹⁾ As

47. Yang Jingqing, "The Impact of Informal Payments on Quality and Equality in the Chinese Health Care System: A Study from the Perspective of Doctors," *Health Sociology Review*, Vol. 22, No. 3, 2013, pp. 275-276.
48. Jack Haas and William Shaffir, *Becoming Doctors: The Adoption of a Cloak of Competence*, Greenwich and London, JAI Press INC., 1987.
49. Kwang-kuo Hwang, "Face and Favor: The Chinese Power Game," *art. cit.* pp. 949-950.
50. Online post 7361479, "Yisheng, nixin jiushi de ying" (To be a doctor, you have to be hard-hearted), *Dingxiangyuan*, 2006.
51. Interview with Dr. Zhao, Haikou, February 2012.
52. Cheris Shun-ching Chan, "Invigorating the Content in Social Embeddedness: An Ethnography of Life Insurance Transactions in China," *art. cit.* pp. 726.
53. Interview with Dr. Yang, Haikou, February 2012.
54. Interview with Dr. Zhou, Haikou, February 2012.
55. Interview with Dr. Feng, Haikou, February 2012.
56. Jack Haas and William Shaffir, *Becoming Doctors: The Adoption of a Cloak of Competence*, *op. cit.*; Frederick W. Hafferty, *Into the Valley: Death and the Socialization of Medical Students*, New Haven and London, Yale University Press, 1991.
57. Participant observation in the doctors' office, Haikou, January 2012.
58. Online post 27407901, "Qinren guzhe le, zuowei yisheng de ziji que youyu le" (When my family member suffered a fracture, I hesitated on what to do as a physician), *Dingxiangyuan*, 2014.
59. Talcott Parsons, *The Social System*, *op. cit.*, pp. 428-479; Frederick M. Chen et al., "Role Conflicts of Physicians and Their Family Members: Rules but no Rulebook," *Western Journal of Medicine*, Vol. 175, 2001, pp. 236-239; John La Puma et al., "When Physicians Treat Members of Their Own Families: Practices in a Community Hospital," *The New England Journal of Medicine*, Vol. 325, 1991, pp. 1290-1294; John La Puma and E. Rush Priest, "Is There a Doctor in the House? An Analysis of the Practice of Physicians' Treating Their Own Families," *JAMA*, Vol. 267, No. 13, 1992, pp. 1810-1812.

Chan maintains that "the *direction* of intensity of the relational properties in different tie strengths are universal (emphasis original)," physicians in both Western and Chinese society may face the same dilemma of emotional interference, since their relationship with those in strong ties are defined by a high level of trust, affection, and asymmetric obligation.⁽⁶⁰⁾ Nonetheless, as Chan posits it, "the *level* of intensity of the relational properties may vary under different cultural environments" (emphasis original).⁽⁶¹⁾ What makes Chinese cases different from Western ones is that certain relational properties (such as trust, affection, and asymmetric obligation) are more intense in Chinese societies, which compels participants of strong ties to offer unconditional help and prompts emotional interference.

Puma et al. surveyed 465 physicians in the US and found that only 57% of respondents said they "almost always" provided help for family members. They also found that about half of the respondents reported refusing a family member's request for various reasons. Even for their parents, only if their health is threatened by unstable circumstances in the health care system will Western physicians feel the urge to get involved. But for Chinese physicians, keeping a distance from parents' health issue can be morally unacceptable from the outset, because offering personal help carries a strong symbolic meaning of performing *xiao* 孝 (filial piety) in Chinese culture. It is therefore harder for Chinese physicians to refuse their parents' request for hospital care.

Furthermore, Western societies have rather strict institutional rules that limit physicians' discretion in providing preferential treatment to family members. For instance, under the American Medical Association's code of medical ethics, physicians can care for their own family members only for "essentially trivial illnesses."⁽⁶⁵⁾ In contrast, Chinese physicians lack institutional backing for their refusals when close family members are critically ill. In Chinese hospitals, when one of the family members of a patient is a physician, this member will very often be the one responsible for making critical decisions for the patient.

The problem is that the more one knows about the possible risks and side-effects of a treatment, the more reluctant one is to subject his/her family members to the treatment, even when it is the only means of keeping the patient alive. Thus, a physician's medical knowledge, when combined with emotional attachment to the patient, could prevent him or her from making a rational decision for the patient. To deal with this dilemma, we found that physicians may apply the following strategies: information-control, *ganqing* 感情 (feelings or affection) avoidance, and altruistic care. While physicians share more information with *guanxi* patients with moderate ties, they do the opposite to those with familial ties. They prefer not to tell the patients or other family members if there is bad news. They try to protect the family from getting worried and anxious. The family members, due to their high level of trust in the physicians, normally do not ask too many questions. But this means the physicians bear all the burden. Another strategy that medical professionals adopt to manage familial patients is *ganqing* avoidance. One way to achieve *ganqing* avoidance is to abstain from being the physician-in-charge of patients who are family members. They may also avoid accompanying the patients too often. For instance, Dr. Feng asked another physician in her team to be the physician-in-charge of her father and let him take care of her father on a daily basis so that she could keep a certain distance from the case. Dr. Feng admitted, "If I were to propose treatment plans for my father, my judgment could be biased because of my

emotional attachment to him."⁽⁶⁶⁾ Lastly, even though physicians try to avoid seeing the patients too often in an attempt to keep distance, they in fact spend considerable time seeking opinions from other experts in order to provide the best services for the patients. Their care for the patients is often altruistic and unconditional. As they sometimes do for *guanxi* patients with moderate ties, they invite experienced senior experts to take charge of their family members who suffer from serious illnesses. They do this less for the symbolic function of showing care than for their intrinsic belief that these experts may actually render better technical treatment for the patients. For example, Dr. Feng invited the director of her hospital to see her father, believing that this director as an expert in hepatic surgery could really offer the best professional care to her father, who suffered from icterus.⁽⁶⁷⁾

Conclusion

Relying on *guanxi* to seek medical care is not new to the Chinese population. However, the problem of generalised public distrust in hospitals that has escalated since the 1990s has prompted even more people to use *guanxi* to gain access to hospital care. The prevalence of mobilising *guanxi* for hospital care, however, brings various challenges to medical professionals. In this study, we examined the dilemmas that medical professionals, particularly physicians, face when they are approached by different types of *guanxi* patients, and how they deal with these dilemmas. Our findings and analyses provide wider implications for the tension between the cultural code of *guanxi* and the professional code of medicine, and the possible impacts of *guanxi* on the medical profession.

When treating patients without any *guanxi* or with very weak *guanxi*, medical professionals can simply follow their professional code of conduct. They do not have to offer special favours to the patients. At the same time, physicians normally enjoy a superior position in the doctor-patient relationship due to information asymmetry. If physicians face any dilemma, it usually comes from the tension between the profit-orientation of hospital management and the interests of patients. When physicians are approached by *guanxi* patients, however, they face an additional dilemma, which is the potential conflict between professional work and personal relations. In dealing with *guanxi* patients with moderate ties, medical professionals may be pulled by the conflicting demands of their professional code of conduct and the cultural code of *guanxi*. They run the risk of violating procedural rules or violating the cultural etiquette of *renqing*. Experienced medical professionals manage *guanxi* patients by sharing more information with them,

60. Cheris Shun-ching Chan, "Invigorating the Content in Social Embeddedness: An Ethnography of Life Insurance Transactions in China," *art. cit.* p. 721.

61. *Ibid.*

62. John La Puma et al., "When Physicians Treat Members of Their Own Families: Practices in a Community Hospital," *art. cit.*, pp. 1291-1292.

63. Frederick M. Chen et al., "Role Conflicts of Physicians and Their Family Members: Rules but No Rulebook," *art. cit.*, p. 238.

64. Yang Shanhua and Liang Chen, "Nongmin yanzhong jibing de fenlei jiqi yishixing zhiliao: Yi Hebei Y xian NH cun weil" (On the classification of diseases in peasant mind and "ritualistic treatment": A case study of NH Village at Y County in Hebei Province)," *Shehuikexue* (Social Sciences), No. 3, 2009, pp. 82-88.

65. AMA Council on Ethical and Judicial Affairs, *Code of Medical Ethics* (2014-2015 edition), Chicago, American Medical Association Press, 2015, pp. 328-329; See also Talcott Parsons, *The Social System*, *op. cit.* p. 307.

66. Interview with Dr. Feng, Haikou, February 2012.

67. Participant observation in the doctors' office, Haikou, January 2012.

Table 1 – Physicians' dilemmas and strategies in response to different categories of *guanxi* patients

Categories of <i>guanxi</i>	Dominant relational properties	Dilemmas in professional work	Dramaturgical strategies
Weak <i>guanxi</i>	Symmetric obligation, calculation	Following professional code of conduct	Maintaining a distant and professional relation
Moderate <i>guanxi</i>	Balanced composition	Vacillating between professional code and <i>renqing</i> etiquette	Information-sharing, emotional work, face-giving
Very strong <i>guanxi</i>	Trust, affection, asymmetric obligation	Taking the risk of emotional interference	Information-control, <i>ganqing</i> avoidance, altruistic care

providing them with extra attention and care, and giving them face. Nonetheless, these strategies do not work for *guanxi* patients with very strong ties, especially family members. When patients are physicians' family members, the deep emotional attachment between the patients and the physicians can pose an obstacle to objective diagnoses and effective treatment plans. To prevent the interference of emotion in medical treatment, and to protect patients and other family members from suffering high anxiety, physicians often control the information to be released, avoid emotional attachment, and offer altruistic care to the patients.

Whether medical professionals like it or not, handling *guanxi* patients has become an unavoidable part of their professional life in China. Our findings indicate that the tension between professional work and personal relations as perceived by medical professionals is deeply rooted in the cultural environment and the institutional changes that have taken place since the 1980s. The principle of financial self-reliance underlined in market reforms puts physicians under great pressure to increase revenues for hospitals, and this has damaged public trust toward medical professionals. *Guanxi* patients try their best to mobilise personal networks to deal with weak institutional trust. If the current institutional arrangements remain the same, patients will continue to use *guanxi* instead of following formal procedures, trapping physicians in the dilemma that we have described above.

An important measure to curb the trend of *guanxi* hospitalisation relies on structural changes to de-emphasise the principles of profit-making and efficiency in the current health care system. The government should take action to increase patients' trust toward medical institutions rather than toward specific physicians. New policy developments are working in this direction, as some may call it "the renaissance of government participation in healthcare."⁽⁶⁸⁾ Besides the commitment to increasing government funding for health care,⁽⁶⁹⁾ the central government has also introduced new performance-based incentive mechanisms in pilot hospitals.⁽⁷⁰⁾ Moreover, it is equally important to strengthen the professional system of medical doctors and to cultivate a sense of professionalism in medical training. To achieve this goal, as some scholars argue, front-line practitioners should turn away from profit-oriented motives and observe the norms and standards of professionalism instead.⁽⁷¹⁾

While we agree that self-regulation based on professionalism is a necessary step toward high quality health care delivery, we also recognise the difficulty of implementing a strictly professional model without any *guanxi* inference in the Chinese cultural context in the short term. It is difficult, if not impossible, for physicians to strictly obey the code of conduct at the expense of violating the principles of *renqing*. Simply imposing formal regulations of professionalism would not resolve the dilemma overnight. Instead of denying the problem, the topic of *guanxi* patients should be

included in medical training. Young physicians should learn how to cope with various *guanxi* patients without undermining the rights and interests of non-*guanxi* patients. Otherwise, junior physicians may sometimes go to extremes when they feel lost. To illustrate, we will end this article by citing a post on the online forum that attracted the largest amount of discussion. A medical student, Sheng Jing, did her best to take care of a *guanxi* patient with only a very weak tie to her. She tried every means to fulfil the demands of this patient, including skipping some administrative and medical procedures in order to save her money. Furthermore, hours before the patient had to undergo surgery, she let the patient eat some food because she was hungry. As a result, the anaesthesiologist refused to do his job because of violations by Sheng that put the surgery at risk. Sheng was severely reprimanded by senior doctors, nurses, and administrators. She was also blamed by the patient's family members. Sheng sighed, "I guess doctors should be hard-hearted!" This post prompted a great deal of advice that she should not go to extremes either by letting *guanxi* patients skip procedures or by being hard-hearted. Instead, she should learn how to properly manage *guanxi* patients of different kinds.⁽⁷²⁾ Learning how to simultaneously adhere to the professional code of conduct and fulfil the obligation of *renqing* is an indispensable part of the professional socialisation in search of a Chinese Hippocratic Oath.

■ Longwen Fu is a PhD candidate of sociology at the University of Hong Kong.

Department of Sociology, Centennial Campus, University of Hong Kong, Pokfulam, Hong Kong (jasonfulongwen@gmail.com).

■ Cheris Shun-ching Chan is associate professor of sociology at the University of Hong Kong.

Department of Sociology, Centennial Campus, University of Hong Kong, Pokfulam, Hong Kong (cherisch@hku.hk).

Manuscript received on 23 February 2016. Accepted on 2 August 2016.

68. Ling Li, Qiulin Chen, and Dillon Powers, "Chinese Healthcare Reform: A Shift toward Social Development," *Modern China*, Vol. 38, No. 6, 2012, p. 633.

69. Winnie Yip and William C. Hsiao, "The Chinese Health System at a Crossroads," *Health Affairs*, Vol. 27, No. 2, 2008, pp. 460-468.

70. Ling Li, Qiulin Chen, and Dillon Powers, "Chinese Healthcare Reform: A Shift toward Social Development," *art. cit.*, pp. 637-638.

71. David Blumenthal and William Hsiao, "Lessons from the East: China's Rapidly Evolving Health Care System," *art. cit.*; Edwin C. Hui, "The Contemporary Healthcare Crisis in China and the Role of Medical Professionalism," *art. cit.*; William C. Hsiao, "When Incentives and Professionalism Collide: The Chinese Experience Holds a Grave Lesson: Incentives Have a Powerful Effect on Physicians' Behavior," *art. cit.*; Winnie Yip and William C. Hsiao, "The Chinese Health System at A Crossroads," *art. cit.*

72. Online post 7361479, "Yisheng, nixin jiushi de ying" (To be a doctor, you have to be hard-hearted), *Dingxiangyuan*, 2006.