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MEDICAL DOCTORS OF THE PEOPLE'S REPUBLIC OF CHINA: THE PROFESSION, PROFESSIONALIZATION, PROFESSIONALISM AND PROFESSIONAL COMMITMENT

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Medical Doctors of the People's Republic of China: The Profession, Professionalization, Professionalism and Professional Commitment

Belinda Tin Yan Chow

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Philosophy

August 2009

CERTIFICATE OF ORIGINALITY

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___________________________________ (Signed)

______Belinda Tin Yan Chow__(Name of student)

Dedicated to My Family, Dr. Hongxing Hu, Prof. Keli Zheng

and

PYNEH Renal ward

ABSTRACT

From a planned economy to a market economy, medical practitioners in China have moved back to the track of being professionals, after served as ordinary state workers for decades. Mao's romantic ideology of "popularity" and "simplicity" has now been replaced by the pragmatic idea of professionalism to meet the need of healthcare reform and the growing demand of healthcare services in the post-Mao era. This has put Chinese medical doctors back to the track of professionalization. The purpose of the current research is to investigate the extent to which medical doctors have been professionalized in the People's Republic of China and how far the process of professionalization has been institutionally constrained.

A theoretical framework was developed in the review of literature on professionalization with focusing on linking the concepts of profession, professionalization, professionalism, and professional commitment. All these have to be considered under the rubric of state-profession relation which is particularly relevant in the Communist authoritarian setting of China. With heavy reference to Friedson's ideal model of profession, this study sets to examine the medical profession in China from an institutional perspective.

This is a qualitative study with in-depth interviews of medical doctors and related stakeholders as the main research tool for data collection. Guangzhou was selected as the location for this study given its relatively advanced development. A total of thirty medical doctors aged between 25 and 75 in three different age

groups from major hospitals in Guangzhou were interviewed in 2007. To allow an objective assessment of the medical profession and its professionalization, 17 different stakeholders consisting of 11 patients, 3 medical association representatives and three hospital presidents were interviewed in Guangzhou in May, 2008. All the interview records were categorized and analyzed to address the theme of professionalization.

The interviews with medical doctors in three different age groups in Guangzhou provided solid evidences of how institutional constraints affected the professionalization of each generation under the growing influences of Western professional values. Their opinions provided an overview on how the profession has followed the path of professionalization under a top-down hierarchical political setting. Under the strong state influence, the profession has enjoyed limited professional autonomy which hindered the pace of professionalization. Though this somehow has arrested their professional commitment, especially the younger ones, medical doctors still held a positive attitude toward the future prospects of the medical profession. The market economy did create different kinds of challenges to the profession, especially their roles in and attitudes to healthcare provision. However, it has also given rise to opportunities for further improvement of their professional competences and for greater achievement of resource enrichment. The interviews of major stakeholders highlight their expectations from the medical doctors, namely, the provision of extensive individual care, better outcome, and quality service. The current tense doctor-patient relation has negatively affected the professionalization as the lack of trust from patients and the public has undermined the morale and the

enthusiasm of medical doctors.

In some respects, the professionalization of medical doctors in China has had elements in common with the West. However, medical doctors have only been granted limited autonomy under the dominance of the Communist state. The State-driven professionalism has focused mostly on the professional standards and service quality without much concern over developing the profession for itself. To align with international norms, the State has basically followed the institutional roadmap adopted by Western countries for the professionalization of the medical profession in China. The professionalization of the medical profession in China is by no means straight-forward when one considers the institutional constraints from the hierarchy, community and the market:

Hierarchical constraints. Though the top-down approach of organizing the medical profession has been liberalized as the process of professionalization progresses, it still imposes a lot of hierarchical constraints from the state machinery on moving the medical profession toward independence, autonomy and self-regulation.

Community constraints. The interests of the profession itself are effectively subordinated to the community medical well-being. The profession and the professionalization cannot be detached from the community from which they should derive their professional identity. The gap between market value and community value may not be easily bridged. To balance the interest (and power) between the medical profession on the one hand, and that the State and society on

the other hand, the empowerment of the medical associations as the guidance of medical doctors may be a way out.

Market constraints. As a whole, the healthcare reforms have restricted market autonomy and hence the professional autonomy of medical doctors in the pursuit of their market and professional value. How to handle the problematic relationships with tremendous pressure from both the State and the patients while keeping the professionalization progress has constituted the major challenge to the medical profession.

From what have been mentioned, unless the three parties, namely, the State, the medical doctors and the patients, can interact with each other in harmony within the healthcare system, it is difficult for the medical profession to progress smoothly in the professionalization process which is beneficial to the society as a whole. Thus, only with strong institutional settings could the medical profession be granted with authority in terms of its professional locus and status; the community should engage themselves in knowledge advancement and maintain the professional morale through the building of trust with patients which can serve as an intrinsic motivation for professional innovation and professional well-being; and the market should regulate the profession and provide them with necessary extrinsic motivations through the use of the pricing system.

To conclude, the Western model of medical professionalization might not be fully applicable to the medical profession in China under different institutional settings. The role of the State is still salient in future development of the medical

profession though under a marketized economy. With the rising power of the public and patients, the medical profession needs to put more efforts in striving for professionalism. Rather than mimicking from the West, the medical profession should work out its own way to professionalization, under the State's guidance with market as a stimulating force.

This study has provided a snap-shot of professionalization of medical doctors in China with a lot of insights and sound observations. However, its small scale with one-city focus may limit the generalizability of its findings. Much research has to be done in the future to provide a stronger empirical basis for a more conclusive understanding of the medical profession in China.

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CHAPTER 1 – INTRODUCTION

From a planned economy to a market economy, medical practitioners in China have moved back to the track of being "professionals", after having served as ordinary state workers for decades. Mao's romantic ideology of "popularity" and "simplicity" (Kamaka, 1962) indeed deprofessionalized the medical profession by categorizing medical doctors as the working class to achieve his communist ideal of an equalitarian society. In the process of proletarianization, medical professional became members of the proletariat mass, that is, medical workers, and professional knowledge was simplified to basic medical training. An extreme version of this relegation of professionalism is seen in the widespread "barefoot doctors" in rural China. The traditional professional prestige of medical doctors had been taken away. Their professional status was under state suppression and the professional development was under tight state control. In fact, the medical history in the three decades of Maoist rule could be conceptualized as a disaster for the medical profession in China and as a persecution of Chinese medical doctors. In sum, the Chinese medical profession was incorporated into the state to strictly serve the interests of the state. This led to the erosion of professional quality and the retrogression of profession as a whole. After all, this state-profession relationship with medical doctors state-located and state employed under socialism (cf. Gu, 2001) was harmful to the healthy growth of the medical profession.

The medical profession had made a promising start to embed itself in the society during the Communist Regime of the People's Republic of China when the State Council promulgated two provisional regulations on medical doctors (*yishi*) and

Chinese medical doctors (*zhong yishi*) in 1951. Its professional status, so well-entrenched and prestigious in Western democratic countries, was clouded with uncertainties and the fate of medical doctors was thrown to the mercy of the Chinese Communists with the subsequent surge of revolutionary fervor propelled by a strong anti-intellectual and anti-professional sentiment ignited by Mao Zedong. The medical profession as a profession failed to survive the political turbulence of the "Anti-Rightist Campaign", the "Great Leap Forward" and the "Cultural Revolution", and Chinese medical doctors were forced to surrender their professional integrity to political subservience. Under the dictatorship of party-state, there was simply no room for a medical profession and state-profession interactions were considered political subordination.

The marketization of the Chinese socialist economy in the Post-Mao era has seen the relaxation of the state's grip on the medical profession as the state has gradually rolled back from the public domain to allow a civil society and a market economy to emerge (Lee and Lo, 2001). The full resumption of university medical schools and the launch of nation-wide healthcare reforms have contributed to the rebirth of the medical profession in China. On the one hand, these medical programs have produced a new generation of medical doctors with formal medical education and a professional orientation. On the other hand, the reform of the healthcare system has created a demand for medical doctors with a high degree of professional competence for improving the medical services and for providing quality health care. As the regime's concern of political subordination has given way to professional quality, the Chinese medical doctors have been able to revive the profession, to acquire professional status and to develop professionalism with

decreasing political interference. However, these three decades of professionalization have been consistently proceeding under the visible hand of the state as public provision remains the dominant mode of healthcare services. This corporate form of state-profession relation (see Gu, 2001) has restricted Chinese medical doctors from leveraging the full benefit of the growth of marketization and globalization, as their fellow professionals of lawyers and certificated public accountants (CPA) have been able to enjoy through the introduction of private practice and the accordance of greater professional self-determination (Lo and Snape, 2005; Snape, Lo and Redman, 2008).

The increasing professional outlook of medical doctors has raised the professional expectation from the state and society. There have been growing demands from different stakeholder groups for greater professional competence, higher professional standards of medical service, and a stronger sense of professional mission and integrity. This conceptualization of medical doctors has indeed converged with the Western ideal type of a professional medical doctor in terms of competence, passion and ethics, thanks to China's quest for globalization. As a result, social pressure for medical professionalism among Chinese medical doctors has increased. Is the medical profession in China ready for the professional challenges ahead? Are Chinese medical doctors prepared to deliver professional medical services to their patients? Indeed, even amid growing professionalization, many are doubtful of the professional quality of Chinese medical doctors as unhealthy tendencies in the medical community have been frequently detected and unscrupulous practices as well as unethical behaviors among medical doctors have been widely reported and criticized. Recent

developments show that the trust between doctors and patients has been severely tested and the doctor-patient relation has been growing tense. These are alarming results for the medical profession in China and may indicate limited professionalization. How far has the socialist reform staged by Deng Xiaoping and his followers released the medical profession in China from the yoke of communist political tyranny to return to the process of re-professionalization? How far has the medical profession in China achieved professionalization in terms of professional standard, self-regulation and quality of services in the reform era? How far have Chinese medical doctors rebuilt themselves as a profession in itself to forge a strong sense of professional identity and hence professional commitment? How far has the medical profession regained its lost professional prestige and the medical doctors found their work a platform for self-performance and fulfilling one's professional potentials? What are the institutional supports for them to deliver their professional services and what are the institutional constraints keeping them from being professional? This study sets to answer these important questions to help capture the prospect for medical professionalism in China's transitional economy.

1.1 The study of Medical Profession in China

The study of medical profession in post-Mao China has not received serious scholarly attention. In contrast, the research on barefoot doctors in rural China has captured the interest of a sizable number of scholars who were fascinated by Mao's novel way of organizing medical services to poor rural settings. The aspiration was to explore the possibility of extending this alternative yet inexpensive model for delivering basic health care to a large rural population in

developing countries, where there were severe shortage of medical doctors and training for medical professionals was too expensive. For researchers in China's health care reform, the focus is on capacity building in terms of institutional reform and health care financing, with the profession of medical doctors as a peripheral issue. In comparison, the research of other professions, most notably, the study of lawyers and CPAs, has been developing quickly. One may justify that these two professions are important pillars to the growth and development of market economy in China, while the contribution of the medical profession to economic transition at this stage is rather marginal. Nevertheless, the study of the medical profession in China has its own academic value and practical importance. Academically, the development of the medical profession in China provides an empirical context to test the applicability of Western theories of professionalization in a contrasting setting to see whether the convergence or divergence thesis will hold. This will deepen our understanding of professionalization and enrich its theoretical formulations. Practically, the cultivation of a highly professionalized community of medical doctors is of paramount important for improving the quality of healthcare services in China which has long lagged behind international standards. This will in turn help to enhance the competitive advantage of China in the world economy in the long run.

How should one examine the medical profession in China? Two major theoretical perspectives can be identified in current research on professions. The more traditional one is the institutional perspective which provides a theoretical link among the key concepts of profession, professionalization, professionalism, and

professional commitment. It is sociological in nature and is the dominant paradigm. The other one is a state-centered perspective which focuses on the dominance of the state over the profession in the dynamic interactions of state-profession relations. It is political in nature and is arguably more appropriate for the study of profession in authoritarian regimes where state domination is prominent. This study will visit these two bodies of literature with a view to looking at state-profession relation from the institutional perspective.

1.2 Research Objectives

This thesis will study China's medical profession in post-Mao China from the institutional perspective with a focus on the dynamic state-profession interactions. It will investigate the resumed process of professionalization under state tutelage in the last three decades of market reform. Specifically it will try to capture the Chinese medical doctor's (changing) perception of the medical profession in their quest for professionalism. Finally, it will assess the professional quality of medical doctors from the eyes of different stakeholder groups of the medical profession.

In sum, the research objectives of this thesis are four-fold:

1. To study the progress of the professionalization of the medical professions in China.

2. To examine the opinions of Chinese medical doctors on their professional practices and performance.

3. To identify the views of major stakeholders on the professional quality of medical doctors.

4. To consider institutional factors constraining the professionalization of the medical profession and the quest for professionalism of medical doctors.

1.3 Research Design and Methodology

For a proper study of the medical profession in China within the context of marketizing socialist economy, this thesis will select Guangzhou as its empirical basis for research. Guangzhou was chosen as the site for the study because medical doctors in this city are amongst the most advanced in China, in terms of their professional development and market exposure. In this regard, the Guangzhou study is likely to provide us with a perspective that effectively reflects the forces of modernization and the possible tensions which they generate for individual medical doctors. Guangzhou is the largest city and a major commercial center in the Pearl River Delta Region in southern China, with an area of 7,434.6km^2 and a population of over 10 million in 2008. It is one of the most economically advanced cities with a highly developed enterprise sector with a GPD of over 700 billion yuan in 2007, ranking third in China, behind Shanghai and Beijing (CIA World fact book). Among all major Chinese cities, Guangzhou has been a forerunner in urban health care reform and has one of the most developed medical communities with the third largest group of medical doctors providing healthcare services for the region. Specifically, Guangzhou has a number of established and prestigious medical schools, most notably, the Sun Yat-sen Medical School with its own teaching hospitals. Figure 1.1 provides some basic healthcare statistics in Guangzhou to give a picture of its solid foundation for the medical profession in this municipal city of Guangdong Province.

Figure 1.1: Healthcare Statistics of Guangzhou, 2005-2008

Year	No. of Health care Institutions	No. of Doctors	No. of Beds	Doctor- patient Ratio
2008	2387	30K	47K	1:1.57
2007	2544	26K	45K	1:1.73
2006	2603	27.3K	50K	1:1.83
2005	2591	25.8K	48K	1:1.86

Source from: PRC Ministry of Healthcare Yearbook[1]

After all, the medical community in Guangzhou is less politicized than that in Beijing and is more liberal than that in Shanghai.

This is a qualitative study with in-depth interview as the major research tool. It included two rounds of data collection in Guangzhou conducted between 2007 and 2009. The first round covered interviews of thirty medical doctors in three different age groups conducted between 2007 and 2008. The second round were interviews of major stakeholders groups performed in 2009. QSR Nvivo 8 was the computer package used for organizing and analyzing the interview data. The details of research design, research methodology, data collection and data analysis are provided in Chapter Four.

1.4 Organization of the thesis

This thesis consists of seven chapters. Chapter One is the Introduction which provides the research background of this study. Chapter Two is the review of current literature on medical profession and professionalization to identify existing research gaps. Chapter Three formulates the theoretical framework for the

[1] http://www.moh.gov.cn/publicfiles//business/htmlfiles/zwgkzt/ptjnj/index.htm

study of the medical profession in China. Chapter Four details the research design, methodology, and data collection of this study. Chapter Five examines the professionalization of the medical profession from the institutional perspective. Chapter Six presents the analysis of interview data in regard to the professionalism of Chinese medical doctors. Chapter Seven discusses major research findings and considers institutional constraints of professionalization. Chapter Eight is the concluding chapter which sums up this study of China's medical profession.

CHAPTER 2 – LITERATURE REVIEW – PROFESSION, PROFESSIONALIZATION, PROFESSIONALISM, AND PROFESSIONAL COMMITMENT: AN INSTITUTIONAL PERSPECTIVE

This chapter reviews the body of literature on the study of profession and related topics including professionalization, professionalism, professional commitment and state-professional relation. The objective is to identify a sound theoretical basis for formulating an analytical framework for the study of medical doctors in China as a profession from an institutional perspective.

2.1 Profession

The study of professions has attracted serious scholarly attention since the turn of twentieth century, particularly from researchers in social science, which can be traced back to the classical works done by the founders of sociology like Durkheim, Weber and Marx (Leicht and Fennell, 1997). This academic inquiry into professions was driven by the growing interest in the challenges faced by different professions resulting from rapid organizational and societal changes. In addition, it was suggested that a deeper understanding of a profession would provide insights on the study of large workplace changes, a pet topic of sociological research at that time. Scholars engaging in the study of profession have displayed diverse focuses. Three main approaches have been identified, namely, the process approach, the structural-functional approach and the power approach, to address different research agenda.

The process approach focuses on exploring the historical development of profession which aimed at tracing the origin, evolution and development of a profession. This brand of research allows a deeper understanding of a profession. By drawing facts and experiences from historical development, this could inform the strategic planning for the profession and could contribute to the enhancement of professional development. The major shortcoming of this approach is that it may not be able to provide an in-depth evaluation on how institutional settings have shaped a profession.

The structural-functional approach undertakes institutional analysis with the focus on differentiating professions from other occupations. This line of research examines the nature of institutional features of a profession and how these structural strains bridge the profession with the society (Goode, 1960). Researchers who adopted this approach are interested in studying how structural evolution within a professional community would affect the nature of profession and professional control, or in their jargon, professional power. In studies informed by the structural-functional approach, professions are believed to be formed by a set of social values like the three "A", as argued by Ritzer and Walczak (1988), that is, *altruism*, *autonomy* and *authority* (italics added). These social values are structured and constrained by general community or "a larger society", as referred by Goode (1957). This approach could also be named as trait approach, since the core of the task was on the evaluation of a profession with certain traits which empower the profession and enable it to enjoy monopolistic privileges granted by the community. Accordingly, profession is defined as "an

occupation that has had the power to have undergone a developmental process enabling it to acquire, or convince significant others (for example, clients, the law) that it has acquired a constellation of characteristics we have come to accept as denoting a profession" (Ritzer and Walczak, 1986, p. 62).

The power approach is interested in investigating the authoritative nature of a profession in monopolistic knowledge and dealing with uncertainty in health aspect, grounded on institutional theory similar to the structural functional approach. As described by MacDonald, the research focus was on "the relations between producer and consumer of professional services and the extent to which the producer could or could not control the relationship and thereby benefit from it" (1995: 5). Since the idea of "power" could not be separated from the idea of "conflicts", it was argued that the whole concept of power was derived from a "Marxian tradition", though researchers who subscribed to this approach did not indiscriminately copy Marx's ideology of class conflicts (MacDonald, 1995). In general, this school of thought is concerned with the external forces in the institutional settings outside the professional community that challenge the professional power, or what they termed "professional autonomy" – the key feature to differentiate a profession from other occupations. Profession, accordingly, was defined in terms of the following properties: the possession of a body of special knowledge, practice within some ethical framework, fulfillment of some broad social need, and a social mandate which permits a significant discretionary latitude in setting standards for education and performance of its members (Freidson, 1998). The "power" addressed by this group of scholars is mainly derived from the uniqueness of knowledge possessed by a profession.

According to MacDonald, one group of scholars who adopted the power approach later shifted the attention to study the process of how a profession evolves. Instead of exploring what institutions form a profession, they believed that it seemed to be more sensible to examine how practitioners within an occupational community would strive for professionalization through socialization so as to attain professional identity and control (MacDonald, 1995). This could be done by studying the institutionalization of a profession. For example, Leicht and Fennel (1997) have conducted a comprehensive review on how institutionalization has affected the nature of profession and provided insights on the relationship between professionals and their employment settings that institutions are like vehicles engineered professionalization through initiating peer socialization. They argued that the multi-facet threats to profession have changed the terms and conditions of their work nature. They went on to suggest that researchers should examine the role of profession in different contexts with diverse backgrounds. With growing tensions from cost attainment and structural changes, researchers could also explore the effect of these contextual constraints on a profession and its institutionalization. Their works have shown that the study of institutionalization of a profession helps to provide a link between the study of professional control and organization theory. This has opened an avenue for adopting the power approach to conduct professionalization research.

On the whole, the power approach, with a high degree of theoretical sophistication, has gained higher popularity in the study of profession than both of process and structural-functional ones.

2.2 Professionalization

Three major models can be identified in the study of professionalization, namely, the attribute or traits model (e.g. Hall, 1968; Hellmann & Puri, 2002; Turner & Hodge, 1970; Flint, 2001), the process model (e.g. Abbott, 1991; Reed & Anthony, 1992; Weber, 1947; Wilensky, 1964; Yang et. al. 2004), and the power model (E.g. Freidson, 1988; Harrison & Ahmad, 2000; Larson, 1977; Starr, 1982; Xu, 2001). Each of these models examines different features of professionalization.

The attribute model assessed professionalization by extracting the professional attributes of a profession as the key variables for evaluation. Here, Hall (1968) has presented the most influential analysis of this area. In the review of a wide range of essential attributes of professionalization from both structural and attitudinal aspects of a profession, he concluded that professionalization could be translated as bureaucratization. The existence of professionals would lead to hierarchical changes within the organizational structure. Bureaucratization emphasizes the importance of knowledge on human resource allocation. Therefore, the establishment of bureaucratic hierarchy helps to professionalize an organization. In return, such a hierarchy also professionalized the professionals. In this way, he has somehow extended Weber's (1947) classic work on bureaucratization to the study of professionalization. Scholars in this line of thinking emphasized the important role of education, accreditations, code of conducts and client relationships (Abbott, 1991). They agreed that the role of professional association is critical for maintaining the central norms.

The process model approaches professionalization by mapping out different stages

of development from a historical perspective. Researchers in this area accorded great importance to education and training, as constructing knowledge of a profession is crucial, and therefore intellectual institutions should appear in the early stage of professionalization (Abbott, 1991: 357). Wilensky's (1964) paper provided a thorough report on the 'evolution' of profession in terms of eliciting the sequences or steps of professionalization among different professions. However, this brand of research has ignored the importance of professional autonomy which is a crucial referent of the degree of professionalization.

Lastly, the power model considers professionalization through the analysis of the impact of institutions on the delivery of professional power. The power here is translated as professional autonomy (Johnson, 1972). Autonomy means that the professional body can enjoy relatively strong locus of control on the profession through the implementation of their own set of rules and standards. The rules and standards help to define the ethos and character of a profession (Kennerley, 1993, p. 43). Therefore, research in this area also placed great interest on the role of professional association as a referent of professionalization (Freidson, 1988; Harries-Jenkins, 1970; Kennerley, 1993; Scott, 1965). Among definitions by different scholars, Larson's (1977) definition of professionalization seemed to be more concrete one. He argued that professionalization should be composed of relatively abstract knowledge and susceptible of practical application. Though its market is supposed to be driven by social and economic developments, professionalization would still dominate ideological climate.

Taking professionalization as the core research focus, scholars have examined a

wide range of different professions, most notably, nurses, lawyers, and medical doctors. In his study of the nurse profession, Porter (1992) argued that the rise of managerialism has hindered the professionalization of nurses by restricting its professional autonomy. He also found that patients, as the healthcare consumers, have played a crucial role in shaping the professionalization of the nurse profession. Keogh (1997) later added the importance of institutional elements like education, code of ethics, autonomy etc. in the professionalization of the nurse profession, which are critical in upholding their professional status. He went on to stress that the main problem faced by the nurse was inadequate government legislation that caused a redundant supply of nurses leading to possible unemployment. Other than this, professional autonomy granted is restricted. Both problems play a key role in process of professionalization.

The professionalization of the legal profession has also been extensively researched, particularly within the context of Western countries. One of the few exceptions was the recent study of the legal profession in the contrasting context of Communist China conducted by Lo and Snape (2005). Their work has provided a thorough analysis of the impact of institutional constraints on lawyers' professionalization mainly related to the limitation of professional autonomy contributing to the ineffectiveness of their professional association. They remarked that the role of *guanxi* (that is, the informal relationship network) in the judicial process was the main obstacle to build public trust of the legal profession. The profession was also hungers for further improvement of their professional status through re-professionalization. Still, the active involvement of the state in supporting the professional infrastructure, professional standard and professional

association is necessary at this stage.

In the research of medical profession, Kim and Lim (2004) have investigated whether the type of medicine would affect doctor’s professionalization. With participants recruited in the Korean context, the authors found that the path of professionalization for both traditional doctors and those practicing western medicine was quite similar.

With institutional changes and rapid economic development as the major contextual focus, scholars who are interested in advancing the theories in professionalization seem to have gradually shifted their research interest to consider the impact of institutional constrains on professionalization (e.g. Clarke, et. al., 2004; Curnow and McGonigle, 2006; Fourcade, 2006; Kim and Lim, 2004; Lo and Snape, 2005; Lounsbury, 2002). The reason behind this is deeply rooted in the institutional theory, that is, institutional changes could lead to uncertainty as the old order are being replaced by a new one (Lounsbury, 2002) and the productivity of practitioners would also be affected unless additional resources are invested in education and training (North, 2005). In that sense, institutions can refresh a profession and at the same time bring out new obstacles to further development within a profession. Consequently, there has been growing scholarly attention to examine the institutional constraints in the study of the professionalization of a profession.

2.3 Professionalism

This section will consider professionalism. As a starting point to understand

professionalism, the Oxford English Dictionary has explained it as “Professional quality, character, or conduct; a professional system or method. In early use frequently: the characteristics of a particular profession; (now usually) the competence or skill expected of a professional”. This definition is quite comprehensive as it tries to embed dimensions covered by different disciplines. In the field of social science, professionalism has been studied from three different approaches, along the same vein of professionalization as mentioned in the previous section.

As Swick (2000) pointed out, one of the reasons for growing interest in professionalism research is mainly due to the complexity of its definition which comprises many different connotations. His comments could be best illustrated in the following table, which presents various definitions of professionalism provided by scholars from two major disciplines of sociology and medicine with diverse perspectives.

Table 2.1: Definitions of Professionalism in different disciplines

Source	Definition	Discipline /Perspective
Collins, 1979	Professionalism represents unjustified elitism that reinforces the class system, and that its exclusionary “social closures” limit opportunity	Sociology - class perspective – in terms of social class
Freidson, 1994	Professionalism is being reborn in a hierarchical form in which everyday practitioners become subject to the control of professional elites who continue to exercise the considerable technical, administrative, and cultural authority that professions have had in the past.	Sociology – power perspectives – in terms of locus of control
Freidson, 1988,	Professionalism … is the end stage of professionalization…	Sociology – process perspective – in terms of the end of professionalization

Sullivan, 2000	Professionalism is the moral understanding among professionals that gives concrete reality to this social contract. It is based on mutual trust. In exchange for a grant of authority to control key aspects of their market and working conditions through licensing and credentialing, professionals are expected to maintain high standards of competence and moral responsibility	Sociology – moral perspective – in terms of professional moral standard
Freidson, 2001	Professionalism exists only if members within an occupation to ensure self-regulation though enjoy considerable privileges while performing their work which is unique when comparing with other occupations	Sociology – a trait perspective - in terms of condition of existence
Latham, 2002	Professionalism -- its "speaking forth" -- thus occurs in the public articulation by and through professional institutions of the profession's standards, both technical and moral. Importantly, these standards, though they may be articulated by the profession through its institutions, are not simply the profession's private property -- not, as it were, Masonic mysteries. In order both to properly socialize professionals and to inspire the public's trust and respect, the profession's standards of competence and ethicality must be fully acceptable and to a large extent be transparent to the public.	Sociology – legitimacy perspective – in terms of the socialization of the profession
Pellegrino,2002	…characteristics of professionalism...unquestioned loyalty to other members of the same profession, a certain exclusivity and elitism based on credentials, and a concern for titles or self-interests common to the group. In its more distorted from professionalism can become an ideology, or a symbol of a guild; it can generate a union mentality focused on defending the group's own interests.	Sociology – ideological perspective – in term of ideology
Goldstein, et. al., 2006	The ecology of professionalism that we describe here is characterized by institutional interdependence, in which addressing professionalism at one level of an institution influences or opens up the need to address it at other levels.	Sociology – institutional perspective – in terms of institutional relations
Fryer, et. al., 2007	professionalism is a dynamic and evolving process that benefits from regular and systematic attention, (2) separate activities are good, and linking them into a coherent whole is better, (3) cynicism can take root quickly—it should be identified and acted on to keep the institutional climate healthy, and (4) all members of the institution must be enlisted in this process, because we all influence and are influenced by it.	Sociology – process perspective – in terms of professional development
ABIM, 1994	(Medical) Professionalism… delineated its elements, including not only humanism but also altruism, duty and service, accountability, and excellence.	Medicine – trait perspective – in terms of properties
Reynolds, 1994	Medical professionalism is a set of values, attitudes, and behaviors that results in serving the interests of patients and society before one's own.	Medicine – attribute perspective – in

	Honesty and integrity are values essential to medical professionalism. The professional physician has an attitude of humility and accountability to patients, colleagues, and society.	terms of attributes of the medical profession
Barodes, 2003	Professionalism in the clinical activities of the physician is based in the Hippocratic tradition and relates primarily to the role of the physician as healer, committed to the welfare of the patient. It concerns also important personal priorities, a choice of obligation over self interest, even in the face of the inevitable tension between the two.	Medicine – ethical perspective – in term of the altruistic nature of the medical profession
Sox, 2003	Professionalism is the basis of medicine's contract with society. It demands placing the interest of patients above those of the physician, setting and maintain standards of competence and integrity, and providing expert advice to society on matters of health.	Medicine – social contract perspective – in terms of contractual relations
Smith, 2005	Most articles define (medical) professionalism as a set of virtues, including altruism, honesty, compassion, and integrity, then create behavioral definitions under each of these virtues that are quantifiable in physicians… The core of professionalism is the personal transformation of self that takes place in stages during the early years of medical training and practice.	Medicine – attribute perspective – in terms of properties
Arnold and Stern, 2006	(Medical) Professionalism is demonstrated through a foundation of clinical competence, communication skills, and ethical and legal understanding, upon which is built the aspiration to and wise application of the principles of professionalism: excellence, humanism, accountability, and altruism.	Medicine – attribute perspectives – in terms of professional features
Cohen, 2007	Professionalism, in my view, is a way of *acting*. It comprises a set of observable behaviors. In aggregate, those behaviors, which in the context of medicine have been codified recently in the *Physician Charter*, are the means by which individual physicians fulfill the medical profession's social contract with society. Based on a set of overarching principles (i.e., the primacy of patients' interest, patients' autonomy, and social justice), professionalism entails actions that are required of physicians to meet the expectations of patients and the public.	Medicine – behavioral perspective – in terms of contractual relations

In a recent effort, professionalism has been categorized into seven clusters: *Nostalgic*, *Entrepreneurial*, *Academic*, *Lifestyle*, *Empirical*, *Unreflective*, and *Activist* (Wear and Aultment, 2006, p. 9; Table 14). The authors have employed cluster analysis by asking the participants who were medical doctors to rate ten items that developed according to their own preferences. The ten items reflected

the professional values of the participants and results were categorized into the abovementioned seven clusters. Since their chosen research context was the U.S.A., with the problem of cross-cultural difference and different institutions, the application of this construct to understand medical professions in non-democratic political systems or in a transition economy like that of China should be cautious. Despite this limitation, the study has provided insights on how medical doctors should behave as the attributes of medical professionalism have been used as the criteria for assessment within the medical profession. To strive for the benefit of research in the study of profession in changing societies, there is an urgent need for researchers to reach a commonly accepted definition of professionalism.

Professionalism in the medical profession would mean medical doctors would not be rated as behaving professionally unless they had achieved the set of attributes that forms professionalism (Arnold, 2002; Block, 2004) – the International Code of Medical Ethnic (Appendix 3). Arnold (2002) conducted a thorough review of these attributes and he commented that these attributes are variables for assessing professionalism since there is currently no reliable and valid evaluation of professional behavior available in the academic community. Among the literature that the author has cited, we can find that the most frequently mentioned attributes including competency, honesty, integrity, altruism and respect for others. Professional bodies, such as the American Board of Internal Medicine (ABIM) and the Accreditation Council on Graduate Medical Education (ACGM), have additionally included excellence, accountability, humanistic behaviors, honor, ethical and moral standards and duty or advocacy (2002, p. 503). These attributes are considered as obligatory essentials for doctors since they would shape the

doctors professional behavior. However, as illustrated by Perloff and his colleagues (2006), on one hand, the effect of self-fulfilling prophecy would result in biased expectation and would affect patients' perception of discrimination. On the other hand, the cultural competency of the doctor would affect communication with their patients, especially those from the minority racial group.

To cope with concurrent economic and social influences on the healthcare sector in a changing society, and to answer the need of renewing research focus on the importance of professionalism, Veloski (2005) and his associates have presented comprehensive meta-analytical evidence on the evolution of professionalism research. They shared studies of professionalization that adopted the attribute approach. The main objective of their research is to evaluate the measurement of professionalism in order to provide a refined scale of measurement for practical use in the assessment of medical students and graduates of medical education in the United States. Their results show that over 75% of literature dated between 1980s to 2002 defined and explored professionalism by focusing on specific elements or aspects like ethics, humanism, multiculturalism, abuse or cheating in educational environment. Around one third of the research works reviewed were on ethical behavior as a component of professionalism. They criticized that the overall quality of research on medical professionalism was opened to doubt since only approximately 25% of the studies visited achieved strong validity. One of the explanations might be the reliance on a convenient sample of professionals during the process of construct validation. Their research findings have indicated that a common ground for the measurement of professionalism has not yet been achieved in the research community. Their study has also revealed the weaknesses

of using attribute approach to evaluate professionalism.

2.3.1 Sociological View of Professionalism: An Institutional Perspective

From Parson to Freidson, the strength of institutional approach in capturing the essence of professionalism has been gradually developed. Parsonic professionalism considered the importance of professional autonomy which underpinned in power of knowledge as the legitimacy of a profession (Latham, 2002). Freidson's model of ideal professionalism (1994), which was an extension of Goode's(1960) work, has been widely adopted. Freidson (1994) argued that professionalism is independent from the profession as it is frame-worked by a set of institutions. Accordingly, an ideal type of professionalism should embed the following institutional characteristics (Freidson, 1992: 215):

- ♦ A body of specialized knowledge grounded in their theories.
- ♦ Actor must go through formal and prolonged training controlled by the professionals and professional bodies.
- ♦ An association that could safeguard their jurisdiction and access political autonomy.
- ♦ A code of ethics for regulating the whole profession and served as professional norms.
- ♦ Specialized work legitimized by State licensure.

He argued that professionalism should be defined as the end stage of professionalization. This implied that to achieve professionalism, a profession must fulfill the criteria which comprise a set of institutional controls that are grounded within the profession. Here the criteria refer to a series of institutional setups as listed above.

2.3.2 Views of Professionalism from the Medical Community: An Institutional Perspective

In the field of medicine, further evidence on the appropriateness of adopting an institutional approach to understand professionalism can be found in the visions of medical education. A group of scholars (Arnold and Stern, 2006; Cruess, et. al., 1999; Goldstein, et. al., 2006; Reynolds, 1994) have put strong emphasis on the delivery of professionalism and how to achieve professionalism through medical education with the intention to frame medical students with the right mindset. The enhancement of professionalism would increase public trust of the medical profession (Cruess, 1999) and the only way of doing this is through vigorous training. Apart from basic training for medical students, there is evidence that medical practitioners are also required to enhance their professionalism through continuous professional development due to the growing real life challenges from the society and the government.

For example, Barry and his associates (2000) administered a self-reporting survey containing six challenges on scenario basis towards professionalism among medical practitioners. Out of the 961 respondents, over 40% reported that they have experienced four out of six challenges as listed and shared the needs to improve training in professionalism. Fryer (2007) and his colleagues reported in their study that apart from the promotion of professionalism among medical students, they have also tried to integrate such enhancement with the hospital community. This aimed to cultivate organizational culture within hospitals. To cultivate professionalism within the profession, their study stressed the important

role of professionalization. The team defined professionalization as “a continuous process, built on concrete expectations, using mechanisms to facilitate learning from missteps and highlighting strengths. To this end, ... working towards improvements in feedback, evaluation, and reward structures at all levels (student, resident, faculty, and staff) as well as creating opportunities for community dialogues on professionalism issues within the institution” (Fryer, et. al., 2007: 1073). Finally, they argued that only through professionalization can professionalism enhancement among practitioners be achieved.

Due to institutional changes such as institutional reforms which might lead to the refinement of the institutional settings of professionalism as proposed by Freidson (1988, 2000), Parsonic professionalism seems to be gradually losing appeal and becoming obsolete. This prompted a re-assessment of the nature of professionalism. Barodes (2003) has demonstrated the importance of institutional setting in the research of medical professionalism. He emphatically pointed out that the rising forces of corporations and governments, which challenged the traditional professional autonomy, could not be neglected. In current market situation, corporations, which have now emerged as the major “customers” of the medical profession, have undermined its authoritative privileges. This indicates that the growing consumerism of medical profession has gradually put the professional quality under external monitoring, which at the same time, restricted its professional autonomy. Pressure from the government has mainly come from its limited financial effort put into the healthcare sector. This has adversely affected public trust of the medical profession which has already been marred by the problems of healthcare cost escalation and uneven distribution of healthcare

service. On the whole, the author sufficiently studied the contemporary challenges on medical professionalism but fell short of addressing the institutional constraints that may hinder future professional development of the medical profession.

Schlesinger and his associates' (1997) analysis on the efficacy of utilization review of medical professionalism have lent solid support to the explanatory power of institutional approach in understanding professionalism. They stated that institutions have encroached the professional autonomy of the medical profession by imposing excessive expectations on the profession and increasing the existing professional responsibilities. The institutions here refer to external review, distraction from administrative and bureaucratic paper work, standardized treatments to fulfill the requirement of external review and ethos that might result from closeness with business enterprises. Though these institutions may hinder professional autonomy in some ways, they also contribute to the establishment of professional norms for quality assurance. This enabled them to examine the strategies adopted by utilization review firms. Results showed that utilization review firms have considerably respected professional authoritativeness of the medical process. In terms of the intrusion to professional autonomy, though a great majority of the firms have employed standardized treatment as the review criterion, there was still a lack of consistency across the industry in the adoption of assessment criteria, since about 40% of the firms were discretionary in practice. In this way, the validity and the reliability of utilization reviews are highly questionable. The compliance-monitoring power of these firms is also limited as inappropriate cases or risky treatments are rarely reported to the State agency and therefore their contribution to professionalism education has been limited. Rather,

firms have increasingly played an active role to educate patients about the appropriateness in the delivery of healthcare service from the medical practitioners. In sum, their research revealed the incapability of the third-party utilization review in monitoring accountability of the medical profession and in serving as an agent for promoting professionalism. The major weakness of the research, its statistical reliability and validity as the measurement scale, has not undergone factor analysis or other validation tests. Their suggestion of relying on other institutions like professional associations and accrediting agents in the scrutiny of professionalism from medical doctors has provided strong support to the importance of professional institutions in upholding and upgrading professionalism.

2.4 Professional Commitment

Professional commitment is the commitment to the professional ideology of service in the form of a transcendent value manifesting the vision and mission of the profession concerned. As Lo and Snape (2005) indicated, it plays a crucial part in professionalization. Though this construct was not measured, its influence on professionalization should be properly assessed in the study of profession.

The concept formulation of professional commitment can be traced back to work commitment, which was grouped into four categories by Cooper and Viswevaran (2005). Table 1 shows the four categories of work commitment: organizational commitment, career commitment, work ethic endorsement and union commitment. This categorization shows that career commitment is one of the categories of work commitment which was later termed by Meyer, Alan and Smith (1993) as

“professional commitment” – the focus of this study.

Table 2.1: Taxonomy of work commitment proposed by Cooper & Viswevaran (2005)

Proposed Taxonomy of Work Commitment Terms	
Dimension	**Sub-dimension**
Work Commitment	
Organizational Commitment	Calculative organizational commitment
	Attitudinal organizational commitment
	Affective organization commitment
	Normative organization commitment
Job Involvement	
Career Commitment	Professional commitment
	Occupational commitment
	Career salience
	Career involvement
	Professionalism
	Affective occupational commitment
	Continuance occupational commitment
Work ethic endorsement	Protestant work ethic endorsement
	Work ethic
	Work involvement
	Employment commitment
Union commitment	Union loyalty
	Responsibility to the union
	Willingness to work for the union
	Belief in unionism

According to Allen and Meyer (1990), professional commitment, like organizational commitment, could be generally sub-divided into three dimensions: affective, normative and continuance. Affective commitment can be defined as individual affective or emotional attachment to one’s profession or organization. Usually the stronger one is committed to one’s profession or organization the more one cherishes one’s identity. Normative commitment reflects one’s wish to stick with one’s profession or organization, due to an obligation that one would like to fulfill (Allen and Meyer, 1990). Continuance commitment refers to one’s needs to attach to one’s profession or organization for subsistence purposes and calculating the cost of quitting one’s profession or organization. The three

component model of commitment has been widely adopted among those interested in commitment studies (Vandenberghe et. al., 2002). According to Myer and Allen (1991), the three different types of commitment are commonly experienced by professionals and their interactions will lead to different kinds of profession related outcomes. Among all, work experience bears the strongest and most consistent relationship with the three types of commitment (Meyer et. al., 1993).

In connection, there is a wealth of research studying possible outcomes of professional commitment, such as job satisfaction (Shann, 1998, Lu et. al., 2001), job performance (Suliman & Iles, 1996), service quality (Vandenberghe et. al., 2002), and customer satisfaction (Harter et. al., 2002). The dominant pattern is that the higher the affective commitment that one induces, the weaker one's cognitive intention to leave one's profession or organization (Snape & Redman, 2003) and the more attached to one's professional development (Lo & Snape, 2005).

Conceptually, professional commitment appears to be a crucial attribute that affects professionalization. Lu and his associates (2001) found that job satisfaction and professional commitment could significantly predict nurses' intention to leave their profession. Later, similar findings have been recorded in the teaching profession (Shann, 1998), legal profession (Lo & Snape, 2005) and accounting profession (Snape & Redman, 2003). In this way, professional commitment may be an expression of professionalization.

Hence, professional commitment is a good indicator for measuring the degree of professionalization (Lo & Snape, 2005). In their study of law profession in China, Lo and Snape (2005) concluded that with strong institutional influences, the Chinese lawyers have relatively higher normative and affective commitment but relatively lower continuance commitment when comparing with other professions in the West. One of the key findings showed that professional orientation could somehow affect the level of professional commitment, especially affective commitment. The professional orientation stands for factors of entry in any profession. Apart from personal factors, it was found that institutional settings also affect the level of professional commitment and professionalization. On the whole, findings from existing research have conclusively confirmed the effect of professional commitment in professionalization.

2.5 State-Profession Relationship

Previous studies in the West have seldom focused on State-profession relationship under the ideology of professional autonomy and democracy. The dominant view is that the development of profession should be independent of the state: the profession should remain at arm's length from the state in order to be autonomous and self regulated, two qualities that are considered essential properties of a profession and major features of professionalization. As Gu observed (2001), previous studies in profession mainly focus on analysis of profession-client relationship, professional structures, mobilization, different constrains that restrict professional autonomy or focus on discussing professional education settings. Rarely has the state-profession relationship been the research topic.

The notion of the state-profession relationship is indeed rooted in political science. Drawing from existing research, the ideology of pluralism, corporatism and syndicalism seems to visualize different types of state-profession relationships as introduced by Schimitter and Lehmbruch (1979). As defined by Almond (1983: 249) based on Schimitter's definitions, "pluralism is a system of spontaneously forming, non-legal, competitive associations interacting in informal and unregulated ways with each other and the state; corporatism is a system of comprehensive, compulsory, monopolistic associations, licensed by the state and syndicalism, the associations interact with each other without reference to or interference from the state." In western literature, scholars focused on the role of the state over and its interaction with social institutions or different interest groups in the society of various political systems. Critics on pluralism are concerned the heavy weight put on socioeconomic drivers rather than focusing on governmental hierarchy, policies and intra-organizational factors (Almond, 1983: 253). So far rare examples can be found of that practice pluralism. Rather, corporatism seems to be a more popular choice of political system for different countries. Due to different political ideologies adopted across different countries, corporatism later split into different categories as well. In totalitarian countries under the influence of classic Marxism, the state bears the dominant role in the practice of corporatism, as what Anderson (1978: 1478) decoded "with comprehensive mobilization and politicization of society". Later, scholars linked corporatism with the Weberian concept of bureaucracy. That is, the role of the state shifted a bit by allowing room to negotiate on the balance of power in between the state and the social institutions through a different kind of welfare policies (Lehmbruch, 1987).

Following the socioeconomic changes during the turn of twenty-first century, the notion of the state-profession relationship has been brought to study profession, particularly in non-democratic political systems. For example, Gu (2001) examined the state-profession relationship in China context across three different professions of accountants, lawyers and journalists. He formulated the state-profession relationship into four different types in terms of state control over profession with pluralism as the minimum in one end and the tightest state control in the other end: Pluralism, Social Corporatism, State Corporatism and State Socialism. China moves away from state socialism to state corporatism, the state-profession relationship has changed in such a way that the degree of state control over profession is relaxing. His study has underlined that the core of the state-profession relationship in the study of profession in non-democratic countries.

In the context of the healthcare sector, the state-profession relationship is crucial in the evolution of the medical profession, both in democratic and non-democratic political settings. Indeed, in the healthcare system, the state and the medical profession are actually mutual dependent. In his study of the medical profession in UK, Klein (1990: 700) pointed out that, "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 the command. On the other hand the state became dependent on the medical profession to run the NHS and to cope with the problem of rationing scarce resources in patient care." This displays an interdependent relation of two-way interaction between the state and the medical profession in democratic socialism.

Accordingly the state should be more dominant over the medical profession and the interaction should be one-way in authoritarian regimes characterized by a top-down hierarchy. In this way, the state matters in the study of medical profession, particularly in China's context.

2.6 The Theoretical Direction to the Study of Medical Profession in China

To sum up this chapter, I have first examined research about profession in which three approaches have been reviewed and identified the appropriateness in analyzing profession. Literature that covered professionalization is also reviewed in the second section. Three different conceptual approaches adopted by existing scholars who are interested in exploring professionalization have also been considered to bring out the strengths of Freidson's (1994, 2000) institutional approach in the research of professionalization. This was followed by another section that revisited the nature of professionalism and related it to medical profession. Professional commitment as an expression of professionalization was explored to indicate its locus and relevance to the study of profession. Finally the institutional setting of a profession was explored in the form of state-profession relation to highlight the degree of state domination over different regime types ranging from pluralist to totalitarian. On the whole, it was shown that profession, professionalization, professionalism, professional commitment and state-professional relation are all major components of an in-depth study of a profession, particularly in the non-democratic political setting of China. In this way, this chapter sets up the task for formulating an analytical framework to link

these different components together for researching the professionalization of medical profession in China in the next chapter.

CHAPTER 3 – THEORETICAL FRAMEWORK

The literature review in the last chapter has indicated that the study of profession has been dominated by the institutional perspective from the very beginning. Other competing perspectives like the functionalist, trait and socio-historical approaches have been proven either too simplistic, partial, or with limited generalizability to allow any in-depth and all-round study. Internally, the institutional perspective brings the key components of profession, professionalization, professionalism, and professional commitment together to form a coherent framework for a holistic study of profession. Externally, it links profession with its institutional setting to show the relevance of the state in regard to the study of power locus of a profession in society. While the rediscovery of the importance of the state to a profession was a major contribution of the power approach, the implication is particularly strong on the study of profession in authoritarian regimes where the state is too controlling to set professions free from its dictation. From the institutional perspective, profession is defined in terms of major institutional characteristics instead of traits and functions. Professionalization is the process through which a profession achieves the end of professionalism. Here, professionalism is defined as a set of institutions for embedding professional expertise in individuals, assuring quality of service, and assessing the performance of professional work. Professional commitment is the expression of personal identification with the institutions of the profession. Finally, state-profession relation centers on the degree of institutional autonomy of a profession independent of state regulation. This theoretical linkage has contributed to this study of medical profession in China.

3.1 Institutions and Professions

As institutional perspective has provided a strong theoretical underpinning for the study of profession, it does make sense to take a closer look at the concept of institutions before formulating an analytical framework for this study.

In general, institutional theorists believe that institutions could structure human behaviors (North, 2005) as well as organizational structure (Scott, 2000).

3.1.1 Institutions

Institutions are rules of the game in a society, "or more formally, are the humanly devised constraints that shape human interaction" (North, 2005: 3). Scott (1995: 48) has provided an even more concrete definition of institutions:

- Institutions are social structures that have attained a high degree of resilience.
- Institutions are composed of cultured-cognitive, normative and regulative elements that, together with associated activities and resource, provide stability and meaning to social life.
- Institutions are transmitted by various types of carriers, including symbolic systems, relationship systems, routines, and artifacts.
- Institutions operate at multiple levels of jurisdiction, from the world system to localized interpersonal relationships.
- Institutions by definition connote stability but are subject to change processes, both incremental and discontinuous.

As explained by North (2005), the characteristic of institutions include its function

of shaping human behavior in political, social or economical exchange and evolves through history. The influential power of institutions has first been addressed in the mid-nineteenth century by institutional economists (Scott, 1995).

The role of institutions is to eliminate uncertainties and to structure human behaviors. This has been illustrated in studies by classic institutionalists (Meyer, 1977, DiMaggio and Powell, 1983; Rowan, 1982; Tolbert and Zucker, 1983). For example, DiMaggio and Powell (1983) proposed a strong conceptual framework of institutional power which generates significant effect on human behavior in terms of three different forces: coercive, mimetic and normative forces. Coercive forces come from formal rules and regulations enacted by the State or an authority that one should comply with; mimetic forces result from the needs to deal with future uncertainty; normative forces would mean peer pressure or social norm. The three different forces have been demonstrated to be significant in changing human behaviors and organizational structures in such a way that if one does not follow norms forged by these forces, one will have to suffer from the loss of support and legitimacy (Scott & Meyer, 1983).

3.1.2 The Three Pillars

Along the line of the three-force concept, Scott (2000) later proposed the three-pillar framework which comprised of regulative, normative and cultural-cognitive pillars. However, Scott's three-pillar framework aims at differentiating institutional studies in terms of three pillars. The regulative pillar used to be employed by economists in dealing with compliance issues. It is believed to be the essential part for the functioning of institutions in defining

violations and appropriate punishments (North, 1989). Though the regulatory pillar could monitor unethical behaviors, there might be a chance that the actor is enjoying great power that could impose greater influence on others through the use of threats in form of regulatory means. This implies that there is the need to examine the political structure and its efficiency on enforcement (North, 1990). This can only be done through exploring the role of the State and how it interacts with other actors within the institutional framework (Scott, 2000).

The second pillar is the normative pillar which is grounded on personal and social obligations. Values and norms are the main ingredients. The former is defined as "preferred or the desirable, together with the construction of standards to which existing structures or behavior can be compared and assessed", while the latter is defined as legitimate means to pursue valued ends (Scott, 2000: 55). It is the existing social system that imposes pressure on the actors. Researches that fall in this dimension normally believe in the power of social values on upholding social stability.

The third pillar is named "cultural-cognitive" pillar. Research studies grounded on this pillar explore "cognitive dimensions of human-existence" (Scott, 2000: 57). Actor's perceptions become the main focus other than analyzing contextual variables. In other words, how actor makes sense with institutions. Though institutions can influence human behavior, such influence still depends on the role interpretation of actors. This marks the distinction of neo-institutionism from the classic institutionalism Geels (2004) is a good example. According to Geels (2004), evolution economists and sociologists of innovation are fans of the third

pillar. In his study, the sectoral system of innovation was examined where he conceptualized the dynamic interactions between actors, rules and socio-technical systems. His discussion offers insights in how system transmission, which could be termed in a more simple way – innovation, would be constrained by actors' perceptions and behaviors, and vice versa. The system here has a broad definition. It can be a computer system (e.g. from punched card machine to personal computer) or transport system (e.g. from horse and carriage to automobile). Finally he indicated that further research could be conducted to explore the socio-technical system of interaction between actors and institutional changes. This line of thinking shows that in the evolution of a profession, the professional development would be affected by the contextual factors as their "incentives to acquire pure knowledge are affected not only by the structure of monetary rewards and punishments, but also by a society's tolerance of its development" (North, 2005, p. 75).

3.1.3 Institutional Theory: the Power Approach

Freidson argued (2001) that professionalism of any occupation cannot merely be concerned about the code of ethics but also moral problems caused by economic, political, social and ideological circumstances (2001: 216). That is, professional ethics plays a critical role in sustaining professional power. Therefore, Freidson (2001) pinpointed that both "practical ethics" and "institutional ethics" should be in great concern. The former is defined as "deal with the problems of work that are faced by individual practitioners addressing ethical issues familiar to everyone but which have assumed exotic guises that need sorting out and recognizing" (Freidson, 2001, p. 216), while the latter "are concerned with moral legitimacy of

the policies and institutions that constrain the possibility to practice in a way that benefits others and serves the transcendent value of a discipline. They are animated by moral concern for the ultimate purpose of disciplines" (Freidson, 2001, p, 216). In this way, by maintaining a balance between the internal development and external institutional development of a profession, "harmonious working relationship" and the "ideology consensus" among the professionals could be established (Rowan, 1982). Thus, a profession is actually a by-product of social development as 'the institutional framework will shape the direction of acquisition of knowledge and skills and that direction will be the decisive factor for long-run development of that society" (North, 2005, p. 78). Consequently, it is commonly found in the body of literature on profession, professionalization and professionalism, researchers have drawn heavily on the institutional perspective in the study of profession.

3.1.4 Institutional constraints

In light of the above discussion, institutional constraints are believed to be highly relevant in the professional development of a profession, particularly in the authoritarian political system of China because of the dominant role of the state in respect to the society. In the case of lawyers, Lo and Snape (2005) have shown that institutional constraints emanating from state domination have brought negative impact on the professional development of legal practitioners from the institutional perspective. The most notable one is the denial of a high degree of autonomy of the lawyer's professional associations (2005, p. 453). However, the law profession can still proceed with its professionalization to consolidate the professional identity of legal practitioners under the rapid development of the

legal system. As this study identifies, institutional constraints mainly come from the State that the formal rules and settings directly affect the allocation of power. On the one hand, the profession has increasingly enjoyed a greater degree of professionalism in the practice as China has been moving away from a totalitarian mode of governance. On the other hand, the State has maintained a high degree of control on the profession in the institutional setting of one-party dictatorial rule. As commented by the authors, though the institutional constraints have imposed restriction on the professional development of the lawyers, it may still be desirable at the current stage of professionalization where the profession itself is far from being mature.

3.2 Toward a Framework for Analysis

This thesis studies the professional development of Chinese medical doctors under a rapidly changing institutional setting. As informed by the power approach, tracing the institutionalization of a profession can help to shed light on how medical doctors cope with institutional forces that boost and restrain their professional development. Therefore, the study of institutions is the main focus of this study because institutions can bring stability to a profession, but it can also be revolutionary under change. To answer a broad range of research questions relating to the Chinese medical profession within the context of socialist reform in the authoritarian setting of China, the traditional market model which has been widely referenced in the study of profession in Western democratic countries seems to be less applicable. Under the market model, a free market is a utopia for the neo-economists. Professionalism is expected to be an obstacle for a free market operation as expertise knowledge is said to have monopolized the

professional privileges. Professions that gain their privileges would hazard the free market operation as the price would no longer be adjusted by the normal supply and demand but by the profession. Instead, it is more appropriate to subscribe to an alternative model which emphasizes the hierarchical power emanating from the bureaucratic system, although professionalism would then be criticized for hindering strategic planning of the bureaucratic system. This can be solved if the bureaucratic system is centralized.

In the transitional economic and communist authoritarian political setting of post-Mao China, the core focus is on the shape of the medical profession after more than three decades of professionalization under the national policies of economic marketization and political liberalization. The most relevant question here is how far has the medical profession progressed in its professional development in this period under the deliberate effort of the Communist state? The starting point for answering the question is to operationalize the concept of "professionalism" which is the end of professionalization. Here this thesis models on Freidson's ideal type to formulate a framework for analyzing medical professionalism. Accordingly, the institutional characteristics of an ideal profession for assessing Chinese medical doctors are as follows (Freidson, 1992: 215):

1. A body of specialized knowledge grounded in their theories.
2. Actor must go through formal and prolonged training controlled by the professionals and professional bodies.
3. An association that can safeguard their jurisdiction and access political autonomy.

4. A code of ethics for regulating the whole profession and served as professional norms.
5. Specialized work legitimized by State licensure.

Hence, this study is to assess the professional development of medical doctors in China from an institutional perspective. Given the theoretical relevance and political reality, it is of primary importance to fathom out the role of the state in the professionalization of the Chinese medical profession. Therefore it is necessary to get a clear understanding of the institutional characteristics of the Chinese Marxian state and its healthcare system, which provide the institutional foundation for the medical profession and condition the state-profession interaction (in terms of autonomy and independence). It is highly uncertain how far China will allow its medical profession to go towards the Western model, given the commitment of medical practitioners to the communist state is at stake. In this way, professional commitment is an important indicator of professionalization on the part of Chinese medical doctors. From here, we can assess how far medical doctors have set themselves free from unconditional loyalty to the communist regime to allow them committed to the provision of medical services in a professional way. On this basis, this study will identify various institutional constraints arising from the healthcare policy and reforms implemented as well as the stakeholders' perceptions of the medical profession to reflect a third-party's views of the professionalization of Chinese medical doctors. The next section will come across with a more practical side of Chinese medical doctors. Professional development will also be discussed.

Chapter 4 – Professional Development of Medical Doctors in China

There was no Chinese synonym of 'profession', 'professional' and 'professionalism' in the 1940s (Xu, 2001) till the post-reform period (Gu, 2001), mostly due to Mao's hostility and suspicion toward the privileged status and arrogance of all professions, indeed to intellectuals as a whole. There was no exception for medical doctors whose professional status was only officially recognized with the promulgation of the Law on Practicing Doctors of the People's Republic of China (1998: Article 3). Accordingly, a medical doctor defined as a profession with sound professional ethics and high levels of medical competence, should demonstrate humanitarianism and fulfill the sacred responsibility for preventing and treating diseases; heal the wounded; rescue those who are dying and safeguard the health of people (Ibid: Article 3). The tortuous path of professional development of medical doctors in China can be divided into three periods: De-professionalization during the Maoist era, the professional restoration under Deng's reform, and professionalization with an international orientation in the post-Deng era.

4.1 The Institutional Foundation of the Medical Profession in China

Since the founding of the People's Republic of China in 1949, China has been under the strong influence of Marxist Socialism. The Communist party has stayed as the dominant ruling party enjoying absolute political power and aligned with Marxist ideology. In the adoption of one-party rule, the highly centralized national

government could monopolize the top-down communication and exercise central control over every direction of national development with a highly bureaucratic establishment as the policy execution machinery.

Similar to those in other socialist regimes, the medical profession in China was put under the State's control and has played a significant role in early state development. Being categorized as unit-workers owned and operated by the State, the medical profession could only perform the role of execution by aligning with national healthcare policy. Such healthcare settings allowed the provision of free healthcare service to general public and this enabled the State to secure the eagerness in upholding the socialist policy objectives (Gu & Zhang, 2006).

Gu and Zhang (2006) presented an overview of the health care institutions' evolution in China. Defects could be identified in other socialist health care system, like the shortage and low quality of healthcare service, heavy healthcare expenditure have gradually become a burden to the State while limited choices for end-users, that is, the patients. The State thus sensed the needs to drive for modernization in the mid-1980s under the Deng's regime. From then onwards, the medical profession started to have a taste of limited autonomy.

The authors further mentioned that due to incomplete reforms with fragmented institutional support, such as lacking parallel enforcement and regulating devices, the State-profession relationship gradually change to a conflicting status. Though without direct confrontation, the members of the profession are still under strong State influence. On the one hand, the State would like to drive for change;

whereas on the other hand, it still wanted to extent certain control over the medical profession so to address the community needs.

With growing conflict of interest and needs between the State and the medical profession, it has led to the incompatibility of the old health care regime with economy marketization launched after 1980s. Hence, the situation has paved the way for the later discontent of the medical profession, especially the newer generation who has been exposed to the Western medical ideology.

4.2 The Medical Profession in Comparative Perspective

Similar to professionalization research targeted at the legal profession in Western world (Lo & Snape, 2005), the process of professionalization of medical profession varied across nations. The professionalization of the medical profession in U.K. has gone through a bottom-up direction and it was engineered by private professional associations. In Germany, the State has played a contrastingly strategic role in the process of the medical profession's professionalization that a top-down approach has been adopted (Neal & Morgan, 2000). The divergence in the process of professionalization in the Western world could be explained by their unique institutional features like constitutions, political ideology, culture and the structure of medical profession, and all contributed to such cross-nation variation.

Freidson (2007) has illustrated that medical profession enjoy monopolized political and legal power in their professional association under the highly autonomous U.S. national health system (thereafter NHS). They could determine

the national healthcare policy and professional regulations for their profession. Similarly in U.K., the medical profession is granted the power of political negotiation such as a say in the NHS policy. Generally, they possess higher degree of professional autonomy with least state intervention. By enjoying monopolized power, the medical profession could therefore achieve a relatively high social and economic status in both U.S. and U.K. However, in recent decades the medical profession is facing with different challenges arising from different dimensions, with their clinical autonomy being intruded bit by bit under the striking institutional changes. Especially after gradually becomes technology intensive in practice, with pressure from the government and corporations who are the key players of the healthcare market, in line with escalating health care cost that result the need of rigid cost management (Barodes, 2003), all these difficulties are salient to the medical profession.

The medical profession in Western countries tends to share common features. They have professional associations; code of ethics which carries a regulatory function; prolonged medical training with unique body of knowledge which granted the profession with high social status; and licensure after attended a qualifying examination, which functions as professional standardization in terms of competence that marks their professional status (Freidson, 2007). In regards to the growing consumerism and patients' expectation of health care service, the medical profession is conscious of the urgency of upholding professionalism to further improve the quality of care. This has further stimulated their professional commitment (Troyen, 2000). Wallace(1995) has posited arguments on a government and corporate driven market from which medical profession would

face rigid cost management. However, they monopolized their power in work content with their expertise and would still be highly committed to their profession. Rare research has been in touch with measuring their professional commitment and that the premises have not been seriously challenged.

In comparing with the counterparts in the democratic countries, the medical profession in non-democratic countries could only attain relatively limited degree of professional autonomy within their profession. They are restricted to their content of work and technical instructions contrastingly in those who adopted a totalitarian regime and with sole influence of Communism. Unlike their Western counterparts, the socialist states have adopted a top-down control over the medical profession. For example, in Soviet Union who has been dominant by socialist regime, the medical profession could merely participate in decision-making on any health care policy on national level but could only be front-line executor, though they could still have a seat in the advisory and administration broad (Freidson, 2007). Similarly in Poland, though there are professional associations in existence, memberships are not privatized like those in U.S. or U.K. but under the sole control by the State and the professionals could not influence political affairs (Sokolowski, 2001). In other words, unconditional commitment to the State is the core element of medical profession for survival. The harmony between the State and the medical profession was harmed by the highly institutionalized State-driven professionalism. Lo & Snape (2005) therefore commented that this is worthless to explore the professional commitment as it is politically incorrect. Nevertheless, the State-driven professionalism in socialist countries is grounded simply in the unique skills and procedural instructions of the profession. On the

contrary, the Western concept of professionalism is professional-centered, more complex in their perception of expertise and concerned about the competence in execution.

Similar to the legal profession, in some communist countries which are undergoing political and social transformation, and at the same time are a mild authoritarian regime, the governments might still try to mimic some Western strategies in boosting professionalization of the medical profession. This can be illustrated in the Chinese context as discussed in the following section.

4.3 The Deprofessionalization of Medical Profession in Mao's Era

Chinese Medical doctors were put under state control soon after the founding of the People's Republic of China in 1949. The surge of Mao's popular line of communist rule had killed off the early dream of establishing a western-style of medical profession marked by a high degree of professional autonomy and independence, and set off the move to close the gap between the medical profession and the popular mass. It was the state's belief that the professionalization of the medical profession would distance medical doctors and the general public, creating class distinction and class conflicts – and most important all of, the underprivileged working people would not be able to get and afford expensive medical services. This has forced the process of de-professionalization to strip off the professional properties of medical doctors and integrate them into the working class. The domination of state over the medical profession was to ensure its popularization for realizing the ideological vision of building a communist society without class distinction (Gu, 2001).

Under the planned economy, doctors were treated as unit worker employed by the State to serve the public.

Throughout Maoist era, the state-profession relation took such a way that the medical profession was prepared to withering away in a state-sponsored fashion while medical doctors were tightly supervised by the State to achieve popularization of health care services to the general public (Engel, 1969). Making medical doctors stay close to the community development and serve the community need were the primary focus. Although medical doctors were still allowed to run their own professional associations, that is, the China Medical Association established in early twentieth century. They performed the role of facilitating medical knowledge building among doctors which were closely supervised with any professional autonomy. The nation-wide violent political purge during the Cultural Revolution under strong anti-intellectual sentiments hit hard on the medical profession (Gu, 2001). The class struggle was soon spread to the medical community as medical doctors were classified as "bourgeois intellectuals" which resulted in class revenge: a large number of them, mostly senior and experienced, were sent to rural areas as "political education". As some doctors recalled their memories at that time:

> "*During the Cultural Revolution, senior doctors were sent to villages, younger ones like me had to work at the Emergency and Out-patient Department. After the Cultural Revolution, I resumed my practice as a doctor specialized in internal medicine.*" – Doctor 23

> *"During the Cultural Revolution, we were obliged to consider the future*

because all of us were sent to the rural area as teachers and, simultaneously, we had to look after the living of our students. We had to take care of them if they were ill." – Doctor 24

"*I was sent to Hai Nan Island as a village doctor as a punishment. Our hospital was governed by the Ministry of Health ... It was a political movement from whichnobody could be exempted, and I'd no choice and no say but accepted the decision. At that time, they arrested the chief surgical doctor of Hai Nan Island Hospital who was judged and indicted by the general public as criminal of the society, that was what we called "being dumped into the bullpen", so there was no surgical doctor in that hospital. As the head of the hospital knew that I was from a State level hospital, he asked me to take up the post and head the surgical department.*" – Doctor 28

Added to the woe was that all formal medical training programs were suspended from operation as all universities were closed down and all medical associations were banned from conducting activities.

It followed that all academic medical research was terminated and the *Chinese Medical Journal* was suspended. The attacks towards the so-called bourgeois doctors by *dumping them into the bullpen* with accusations of their political ideologies affected heavily the normal operation of hospitals and drove the profession to enter into a proletarianization period. Consequently, the professional community no longer existed, the professional status disappeared, and the

professional quality has declined.

The cultivation of barefoot doctors, while it was considered as an innovative initiative to cope with the tremendous demand of medical care in rural China in a cost-effective way, was heavily informed by the dominant paradigm of a popular vision of medical doctors. Here, the barefoot doctors were trained up as village doctors to strengthen the healthcare force in rural areas since the 1960s (DeGeyndt, Zhao, & Liu, 1993) and support the Village Cooperative Medical Scheme. This group of doctors did not require formal and intensive professional training. Instead, the approach was to provide them with basic medical training and let them develop their medical competence through practice. As stated by one doctor (Doctor 29):

> *"In 1965, the village brigade sent me to study to be a medical doctor in the county. I take a course in midwifery. A year later, I became a village doctor."*

Thus Mao's motto – 'saving the dying ones and helping the wounded' vision (Peng, 2000) – was translated into action and became the vision of barefoot doctors in particular and the medical community in general. As a result, the experience driven approach prevailed over the formal professional model which had further diluted professional essence of medical doctors. Such an approach of developing the medical profession was in conflict with the western perspective of professional growth which was a deepening process focusing on quality enhancement and standard advancement – both were believed to be an un-ended quest. Under the top-down hierarchy adopted by the Communist regime, State intervention had greatly reduced the professional flavor of medical doctors while

empowered the general public to access medical services. However, in such a state-profession relationship, where medical doctors were put strictly under the influence of state socialism with absolute state domination over the profession (Gu 2001). This was not always in harmony given the lingering effect of professionalization-popularization tension. The demand for professionalization was suppressed but not totally eliminated. In short, the Chinese medical doctors were completely proleterianized under a socialist mode of state-professional relation which had deprived them of the pursuit of their professional well-being and constrained the development of medical profession.

It may not be fair to say that the Maoist legacies on the development of medical profession are all destructive and negative. The Communist government under Mao made diligent efforts to rebuild the healthcare system as part of the state-building endeavor, particularly in early years of the Communist rule. Medical schools for providing formal training were established and student hospitals were built. With heavy government investment, the number of medical doctors increased and quality of medical doctor was improved, as witnessed by one doctor:

> "*I was nurtured under the nation's 5-year plan (1959-1961). There were 600 pupils in our class of which 200 came from Hong Kong. We were the first batch of students graduated in medical science. As Hong Kong is so close to Guangzhou, the living standard of two cities was similar. At that time, government and businessmen were making efforts to vitalize the economy and brought up talents through building of factories and rural area as well as universities. There were not many university students. Our*

school fees were paid by the government."

At the same time, medical associations became active, academic medical research was supported, and medical journals were launched. In particular, Chinese medicine received proper and serious attention to forge the path for the eventual Sino-Western medicine integration. In this way, the foundation of a medical profession was gradually laid down. Mao's critical bias against the medical profession, though having disastrous effects on its professionalization, constructively brought in a community perspective and provided the development of profession with a strong sense of community purpose. This may help the Chinese medical doctors to internalize the community value and serves as a reminder that professionalization cannot be detached from the community: professionalization serving community should always take precedence over the self-interest of the medical profession itself – perhaps the core of communist ideology which Mao had certainly overdone. In this way, one may say that the Maoist ideology influences on medical profession have opened a Chinese way of professionalization for the post-Mao leadership to restore the profession. Figure 5.1 provides a chronology of key incidents in the professional development of medical doctors in Maoist era.

Figure 5.1: Key incidents in the professional development of medical doctors in Maoist era

Year	Key Incident
1950	•Admission of high school graduate as medical students under a 5-year scheme •Provision of war field rescue assistance during the Korean War
1951	•Provision of regulations for medical doctors
1952	•Initiation of germ defensive warfare research by China Medical University

	•Faculties re-structuralization of Faculties among medical schools e.g. Detachment of Faculty of Pharmacy from China Medical University following the establishment of North-East Pharmaceutical university
1954	•Centralization of Medical Education under supervision of National Health Bureau
1955	•Implementation of medical research scheme and started graduate courses •Reallocation of medical professionals across different provinces
1960	•Suspension of all medical journals publication till 1963
1961	•Initiation of a 6-year scheme medical education with Japanese as medium of instruction
1966	•Suspension of all medical journals publication till 1978
1967	•Suspension of all medical programs in universities till 1975
1975	•Resumption of publication of national level journal – the Chinese Medical Journal
1976	•Import of foreign students in local medical universities
1978	•Resumption of professional conferences

4.4 Professional Development of Medical Doctors in Post-Mao China

The anti-institutional and anti-intellectual paradigm of Mao's dictatorship had left the Chinese health care and medical system almost in a complete disaster after the Cultural Revolution – the system had disintegrated, the medical community was suppressed and demoralized, and the professional quality had significantly dropped. Popularity and simplicity in the organization and provision of health care service had proved to be an illusion and destructive. Much had to be done to rebuild the national system for providing adequate health care services to the people in the post-Mao era. Given the urgency of medical care for the nation, Deng's government had launched nation-wide health care reforms soon after he had consolidated his power in the Third Plenum in 1979.

The post-Mao health care reform has made full restoration of the medical profession and its professionalization necessary in order to provide adequate

formally trained medical doctors and lift the quality of health service. The positive role of medical doctors envisaged in Deng Xiaoping's idea of professional quality of medical care has replaced Mao's deep-seated hostility towards the medical profession and hence reversed the process of deprofessionalization. In the communist regime where politics takes command, the pace of professional development of medical profession has inevitably proceeded under the tight control of the State.

However, the rejection of the Western model of professionalization (in which the "loyalty" rests with the profession instead of the state) in the Maoist era did not leave the Chinese Communists a coherent theory of professionalization, in particular, a Communist version of medical profession, to guide the process of professionalization within the context of growing marketization. Therefore, the Chinese Communist state has been going through the journey of professionalization in a tentative way, without a clear idea of timeframe, the sequential steps, and the set of institutions to be established. Amidst this lack of direction, a salient trend in the last decade has been increasing reference to the model of medical profession in Western countries. This was mainly due to the regime's increased medical exchange with the West since the revival of market reform a few years in the wake of 1989 June-Fourth Incident. This has indeed paved the way for speeding up the pace of professionalization at the turn of the twentieth century, given the strong desire to rejoin the world community.

Although almost starting from scratch, the Chinese Communist government was not totally in lack of experience in the task of professionalization and was not

unfamiliar with the institutional characteristics of the medical profession. Therefore under the deliberate effort of the party-state, the process of professionalization commenced soon after the launch of the health care reform in 1979 and progressed quickly thereafter. In this respect, the repudiation of Mao's notion of popular approach – the propelling force of deprofessionalization in the Maoist era – signified the reconfirmation that the medical profession involves formal trainings grounded in a body of medical knowledge. Therefore, the first two major efforts focused mostly on the professional competence of medical doctors which included the restoration of medical undergraduate programs and the resumption of medical postgraduate programs in universities in 1981.

Indeed, the medical postgraduate program plays a crucial role in doctor's professionalization. According to a pre-field study telephone interview with a doctor from Zhuhai, after five years' basic university training, medical graduates could decide whether to be a pathological doctor or a research doctor. For being a pathological doctor, one needs to find a job in any hospital as resident doctor. For the first stage of being an attending doctor, one must have job rotation in different general wards (e.g. Surgery, Urology, Nephrology, Obstetrics & Gynaecology, Paediatrics, Radiology, Orthopaedics & Traumatology, Ophthalmology) for three years. After one has passed the assessment prescribed in every single ward, one can then choose to work for the ward one is most interested in and starts the second stage of continuous learning.

In the second stage, one must be capable of developing a thorough understanding of the chosen specialty, followed by further developing a focus within the chosen

specialty for future immersion. After that, one will need to sit for another specialty assessment. If one makes good achievements in both practicum and written examination, one could be promoted to senior doctor and would be granted a clinical doctorate academic title.

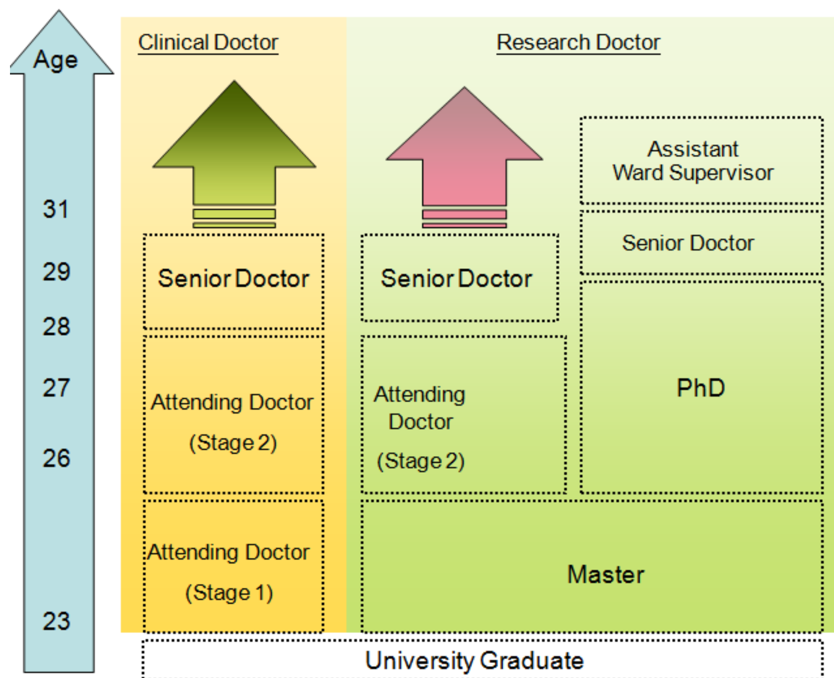
For some university hospitals under direct control of Ministry of Health, a clinical doctorate graduate needs to return to the hospital where he or she has previously worked for unless he or she is a member of the Communist Party. If one further accumulates five years' clinical experiences, and provided that the hospital has got the headcount available, one would be promoted to supervising doctor; i.e. a middle management position in business term. Further career promotion from senior doctor to assistant ward supervisor or higher would highly depend on other contextual factors such as resources availability, human network (i.e. *guanxi*), credits earned from continuous education and publication records etc. Such way of getting immersed has been termed by Xu (2010) and his colleagues as role learning.

To be a research doctor who just focuses on clinical research and merely involve in clinical practice, one could apply for master degree courses of any university hospitals. Research master degrees programs offer on-campus courses, laboratory courses and thesis writing (i.e. report about laboratory results obtained). After the completion of a three-year master course, a research master graduate could resume hospital work as a practical doctor. One needs to undertake internship for a period of one year before moving to the second stage, following the same career path of a clinical doctor thereafter. One could also continue a doctorate (Ph.D.)

study for another three years. A PhD graduate as medical doctor will be granted a job title of senior doctor once starting working and could be further promoted to assistant ward supervisor after working for two years.

Both the clinical and research degree assessments include thesis writing and oral defense. The only difference between the two is the nature of the thesis. The clinical degree requires clinical research results with data obtained through daily clinical in-ward cases, while research degree requires laboratory experiment results. A clear differentiation between the career path of clinical and research doctors is tabulated in Figure 4.2 below.

Figure 4.2 Career path of clinical and research doctors



What has been illustrated above is consistent with the research conducted by Xu and his associates (2010). They have provided an overview on the structure of medical education after reforms implemented in the past two years. The authors

addressed that to better utilize resources, and improve institutional coherence so to facilitate interdisciplinary work, the Ministry of Health merged the western medicine schools in Peking Union Medical College, Beijing, and China Medical University, Shenyang located in northern China (2010: 1). As per Xu and his associates, such proposal of merging provincial medical colleges though might help in better off resource allocation, aroused controversy and therefore has still been hold. Their works also criticized that such education model has out too much focus on clinical and pathological knowledge but merely in touch with soft skills development like relationship building. Therefore, in addition to other institutional factors, this carries some negative impact on the tensed doctor-patient relationship other than other institutional factors.

The growing tension in the doctor-patient relationship due to the intensification of medical disputes has brought the professionalization to the second stage focusing on the ethical embedment of the profession in late 1990s. Indeed the number of complaints against the ethical standards and the integrity of medical doctors resulting from the marketization of medical practices had rapidly increased in the first two decades of the health care reform. It seemed that the self-interest of the profession has overwhelmed the community well-being as the progress of socialist market economy has been gradually eroding the financial support of the health care from the State. The development of doctors' profession moved from the basic level of professional competence to a higher level of professional ethics, widely known as entering into an 'Ethical Renaissance'. For example, The State passed Provision of regulations for foreign medical doctors to perform short-term medical practice in 1992 which allowed more overseas medical exchange. *The Provisional*

Qualifying Examination Regulations of Practical Doctors of People's Republic of China and *Provisional Licensing Regulations of Practical Doctors of People's Republic of China* were promulgated in 1999. Professional autonomy was later given some hope with the initial establishment of medical associations in different fields of specialization (Huang & Ke, 2000) in early twenty-first century. Following the increasing exchanges between Chinese medical professions with their Western counterparts focusing on achieving internationalization in terms of medical practices and medical research, the professionalization has thus acquired an international orientation. For example, Novo Nordisk, a Multi-national Pharmaceutical Corporate, started to collaborate with Chinese Academy of Medical Sciences & Beijing Union Medical College on clinical research in 2000 (People's Daily Oversea version, 2000/08/05). This opened an avenue for the medical profession to step in global labor division of pathological, clinical and biotechnological professionals. Meeting the western medical profession did bring tremendous outcome to doctor's professionalization. This could be revealed from the incident of Prof. Buchanan's visit from UMIT. During his visit to Beijing to receive his honorary PhD title, her wife broke her leg on the Great Wall and could not find an international qualified hospital that they could trust. Finally the incident marked the urgency to get global recognition of quality for local hospitals so to cope with globalization (Zhezhang Daily, 2007/05/28). Therefore the profession was said to be 'reprofessionalized'.

To sum up, the Milestone events of professionalization are chronologically listed as follows (see Figure 5.3 for summary):

1. The full resumption of medical universities in early 1950s (Xu et.al., 2010)

2. Resumption of medical postgraduate program in 1981 by introducing 7-year medical training program (Xu et.al., 2010).
3. Resumption of the Chinese Medication Association in 1984.
4. Promulgation of the *Law on Standardization and Execution of Code of Medical Ethics* in 1988.
5. Establishment of the China Health Law Society in 1993. The committees must be Communist Party members and currently among the senior management of medical and law intelligentsia, such as ex- or current senior management of Ministry of Health and the Ministry of Law.
6. Promulgation of the *Law on the Practical Doctors of People's Republic of China* in 1998.
7. Promulgation of the *Provisional Qualifying Examination Regulations of Practical Doctors of People's Republic of China* in 1999.
8. Promulgation of the *Provisional Licensing Regulations of Practical Doctors of People's Republic of China* in 1999.
9. Initiation of 3-year emergency doctors' training in Beijing, 2001 (Beijing Daily, 2001/07/11).
10. Establishment of the Chinese Medical Doctors' Association in 2002.
11. Standardization of 4- or 5-year in-ward doctors' specialization practical training in Jinan, 2004 (Dazhong Daily, 2004/08/12).
12. Establishment of first field hospital with Certificate of International Disaster Relief awarded by the International SOS in 2004 (Xinhua Net, 2004/10/14).
13. Promulgation of the *Guidelines of Initiating Medical Ethics Assessment* in December, 2007.

Figure 5.3: Milestone Events of Professionalization of Chinese Medical Profession

The professionalization of medical doctors in the past three and a half decades in the post-Mao era can be conceptualized into two distinct stages. The period between resumption of medical postgraduate program till the establishment of China Health Law Society in 1993 can be characterized as the institution-building stage to establish the standards of professional competency and ethical requirements through legal means under the domination of the Ministry of Health, which provided the legal foundation for later promulgation of the *Law on Practical Doctors of People's Republic of China* at the turn of twentieth century. From 2002 to present, ever since establishment of Chinese Medical Doctors' Association, the process of doctors' professionalization has initiated the de-statization stage which has seen the growing autonomy and independence of the medical profession and phasing in of market practices, under the tutelage and

guidance of the Ministry of Health. Some key aspects of professionalization will be addressed in further details.

Government-sponsored licensing legislation. The Law on Practical Doctors of the People's Republic of China was adopted in 1999 which provided a standardization framework for professionalization through institutionalization of a comprehensive list of professional responsibilities; and a legal foundation for the Provisional Licensing Regulation of Practical Doctors of People's Republic of China. The profession was granted with higher degree of autonomy from Ministry of Health that it could enjoy more independence such as the right to establish its own professional bodies. The legislative act intended to raise the professional identity and status as described in Article 3 of the law aforementioned. However, the effect of the Act was neutralized because of its ambiguity in legitimizing doctors' legal rights (CMDA, 2005).

Medical services. The three-tier system as addressed previously was adopted and health institutions were thus classified according to their scale and resources owned. Marked by the promulgation of the Interim Measures for Administration of Chinese-foreign Joint Venture and Cooperative Medical Institutions (2000), followed by the establishment of people-owned hospitals or private hospitals and privatization of state-own hospitals, the nature of healthcare institutions has entered into the stage of internationalization. However, individual private medical practice is not yet legitimized, the fact that doctors could only work in registered health institutions ever since the 1970s remains unchanged.

With increasing population, healthcare expenditure kept growing and became a heavy burden for the State. Therefore, in the 1990s, the State started to put medical savings account (thereafter MSA) on trial (Yip & Hsiao). All along the years with progressive moderation on the MSA policy, the current institutional structure of the MSA can be said as rather clearly defined as follows.

Medical Savings Account in Guangzhou

Guangzhou has been chosen as the research context of current research. Hence, this section would provide a brief account of the implementation of the latest medical insurance policy in 2011. This would shed lights at further understanding on the current working constraints of the medical profession on policy level.

According to a local insurance information website[2], Guangzhou citizens have to follow below income contribution percentage as assigned by the State to their medical savings accounts on annual basis. For those who work in a unit as appointed by local bureau on behalf of the State, the percentage contributed to their individual medical savings account from monthly income varies. This is depends on the total deposit per staff and 8% of this total sum will be settled by one's unit. He or she will need to contribute additional 2% from the grand total of the mean of last year's annual income and total sum of income received this year. For contract staff, they will need to contribute 4% of their last year average monthly income. For staff from other regions currently working in Guangzhou will need to contribute 1.2% of their last year average monthly income on their

[2] Xiangrikui Insurance Site, 07/01/2011, http://www.xiangrikui.com/shehuibaoxian/yiliaobaoxian/20110107/85099_5.html

Guangzhou medical savings account (See Table below). Amount saved in MSA can be accumulated and inherited by family members if the owner is deceased.

Individual or Unit Contribution/ Category		Deposit	Contribution %
Employee	Unit	Sum of total deposit per staff in unit	8%
	Individual	Mean of Last year annual Income (paid Income tax) + total monthly income this year	2%
Flexi-employed (contract staff)		Last year average monthly income	4%
Employee (Outsider)		Last year average monthly income	1.2%

Figure 5.4: Employee's contribution to Medical Savings Account in Guangzhou

Other than their own contribution, the State or their employer will need to contribute certain amount of percentage to their MSA on a monthly basis. For example, (1) 2% for those aged below 35; (2) 3% for those aged 35-45; (3) 3.8% for those aged above 45 till retirement; (4) 4.1% for retired staff. Amount contributed is allocated to a social risk pool. The next section will illustrate how the social risk pool works.

How MSA function in better off medical expense

The major objective for implementation of MSA is to lower medical expenditure for the public while reducing State's healthcare expenditure. After providing a summary on how the general public contributes to their medical savings account, this section would explain to what extent their contribution helps to reduce their financial burden when they need to get access to healthcare service. In general, the subsidy entirely depends on the kind of hospital the patient visits.

For medical consultation, individual employees, whether they are permanent staff, contract staff or those from other regions can receive a subsidy of RMB300 for

medical expense each month from their own MSA. This amount is effective on a monthly basis but not accumulable. Permanent and retired staff can enjoy 65% subsidized by the social risk pool if on visit community medical service unit excluding 2-tier and 3-tier hospital; and 50% subsidy if they visit signature hospital. For contract staff or staff originated from other regions, subsidy available will be 10% lower as shown in following table.

Consultation/ Category		Paid by Social Risk Pool		Max Contribution (monthly)
		Community Medical Service Unit (exclude 2nd & 3rd tier)	Other Signature Hospitals	
Employee	Employee	65%	50%	RMB 300/head Effective in each, cannot accumulate.
	Retired			
Flexi-employee		55%	40%	
Employee (Outsider)				

For hospitalization, percentage that can be cash back also depends on which hospital did the patient visit and unless amount exist the baseline. This would mean patient will still need to pay for out-of-pocket amount as shown below:

Types of staff		1st tier hospital (RMB)	2nd tier hospital (RMB)	3rd tier hospital (RMB)
Employee	Existing	400	800	1600
	Retired	280	560	1120
Flexi-employee (contract)		400	800	1600
Employee (Outsider)		200	400	800

The remaining amount existed the baseline will be covered by social risk to lower patient's financial burden. Rather than providing a fix amount to be available for individual from their MSA, as reference to below table, cash back percentage to be available from patient's MSA for 1-tier, 2-tier and 3-tier hospital will be 10%, 15% and 20% respectively for both permanent and contract staff; 7%, 10.5% and

14% respectively for retired staff; 28%, 32% and 36% respectively for staff originated from other regions.

Hospitalization/ Category		Paid by Social Risk Pool			Paid by Individual MSA		
		1st tier	2nd tier	3rd tier	1st tier	2nd tier	3rd tier
Employee	Employee	90%	85%	80%	10%	15%	20%
	Retired	93%	89.5%	86%	7%	10.5%	14%
Flexi-employee		90%	85%	80%	10%	15%	20%
Employee (Outsider)		72%	68%	64%	28%	32%	36%

Percentage and data as presented above were from Xiangriqui.com in which provide all insurance information. The reason of setting higher percentage available for medical claims in community hospital and lower tier hospitals is to encourage the public to utilize these medical resources rather than rushing to top tier hospitals for all kind of needs. From medical perspective, doctors working community hospital bear the role of general practitioner like those the West. In such sense, they bear the role of preventive care and gate-keeper of the National Healthcare System (Harris & Mercer, 2001). By encouraging the public not to rush to top tier hospital would also help to better prioritize the patient's needs by grouping healthcare resources as per degree of seriousness regards patient's syndromes. This has proven to be effective in Yip & Hsiao (1997) research though conducted in Zhejiang Province. Authors illustrated that the medical profession did reduce the number of service and restricted to highly necessary ones to patients due to cost constraints. There were also examples for the doctors in community hospital refused to admit those who are seriously ill but transfer them to higher tier hospitals for advance treatment as a mean of cost reduction.

This has been consistent with interview result of this research with details illustrated in Section 6.4.3. However, from interview result, such policy seems unable to maximize its effectiveness on cost saving for patients. More discussion on this aspect will be stressed and elaborate more with real life examples in Section 6.4.3.

Due to the implementation of the social security insurance and the initiation of medical savings account in the context of the fixed-price policy, the gap of the number of daily patient-visits between top-tier hospitals and community hospitals has widen in recent decades, this resulting in heavier workload for doctors who are working in top-tier hospitals (China Health Statistic Digest, 2007).

The fixed price policy

Simultaneously, the new fixed-price policy has helped hospitals relying on pharmaceutical income to alleviate their financial difficulties. For example, price of the following treatments are fixed in 2006 in Guangdong: the cost of Nuclear Magnetic Resonance for brain scan is reduced from RMB1162 to RMB500; that of CT Scan from RMB780 to RMB350; and that of Ultrasound from RMB63 to RMB40. However, doctor's consultation fee per visit has just risen from RMB7 to RMB9. Doctors are obliged to prescribe expensive drugs in order to cover cost and expenditure (Liu, et. al., 2000). The above scenario is revealed from the high proportion of pharmaceutical expenses for each patient-visit (>60%, China Health Statistic Digest, 2007). The situation impaired the doctor-patient relationship, which led to the increase of medical disputes. Doctors commented that the practice of defensive medicine for self-protection is becoming more popular

(Meng, et. al., 2004).

Professional association. The Chinese Medical Association (CMA) has enjoyed a long history since its establishment in 1915. After the resumption of medical research in 1975, the association was also re-instituted. The CMA is responsible for national medical publications and contributes to medical research. The Chinese Medical Doctors' Association (CMDA) was established in 2002. It provided a professional exchange channel for doctors. Like the West, the association is under the guidance of Ministry of Health and the Ministry of Civil Affairs but grounded in the Marxist ideology. Their major control mechanism is to recruit former or current influential top cadres from the Ministry of Health. For example, Professor Dakui Yin, the former Associate Minister of Health, served concurrently as Chairman of CMDA. Another institutional control exercised by the State is exploiting her rights of supervising the licensing process and the qualifying examinations. It is also worth to note that both professional bodies are not empowered to interfere with decision-making of any health related policy though their advices will be considered. On the other hand, the China Health Law Association, with its committee constituted of purely Communist Party members, took up the role of consultancy in healthcare policy consultation since 1993.

Qualifying examination. According to the *Provisional Regulations of Doctors' Qualifying Examination* promulgated in 1999, the State is responsible for supervising the annual nation-wide medical qualifying examination for practical doctors. The examination is divided into 4 disciplines: Pathology (i.e. western medicine), Traditional Chinese Medicine (TCM), Dental Care and Public

Healthcare. The assessment criteria consisted of practical skills and general written assessments of medicine. Enrollment requirements, examination syllabus and examination period are set by the Medical Doctors' Qualifying Examination Committee of the Ministry of Health (MOH). The National Medical Examination Center is responsible for executing all kinds of examination arrangements under the supervision of the MOH and the Medical Doctors' Qualifying Examination Committee. Though some former top cadres of the MOH suggested giving the role of supervision to professional bodies recently (Xinmin Magazine, 2007), there is no schedule to make the CMA or CMDA take charge of the qualifying examination.

A code of ethics. Before the establishment of the People's Republic of China in 1949, the medical professions used to follow an ancient medical classic – Five Don'ts and Ten Dos (wu jie shi yao). After 1949, medical ethics was built, in addition to the classic on 'Dr. Bethune's Spirit' as advocated by Mao. Surprisingly it is noted that standards and unified code of ethics were not available till the promulgation of the *Law on Standardization and Execution of Code of Medical Ethics* in 1988. Later, promulgation of the *Law of Practical Medical Doctor of People's Republic of China* in 1999 by the MOH has further standardized the responsibilities and rights of practical doctors. On 7 December, 2007, the MOH promulgated the *Guidelines of Initiating Medical Ethics Assessment* in which clear assessment criteria were available for reference. The assessment will be conducted annually; other then self-assessment, candidates have to be rated by peers and supervisors. Assessment results will directly affect candidates' permanent appointment, promotion and bonus allocation. Doctors not up to the

standard will be penalized at different levels. However, critiques have been raised concerning assessment bias and accuracy without patients' participation as some listed criteria are too vague for peers' or supervisors' assessment unless relevant complaints are received. After some hospitals had established the Medical Ethics Record in late 1980s (Zhongguo Zhiye Daode Zai Xian, 2005/12/05), Shanghai became the pioneer in institutionalizing the implementation of the Medical Ethics Record Database for Practical Doctor for local hospitals in 2007 (Xinhua Net, 2007/04/04). The database included the information of doctors' on-job ethical records (e.g. complaint and praise), degree of social responsibility (e.g. voluntary community and charity services), as well as on-job ethical training. Unlike their counterparts in the legal profession, medical professional bodies though enjoy autonomy in handling the discipline of the profession (Regulations on Handling Medical Accidents, 2001), do not have their own Code of Medical Ethics.

To understand a profession, other than the mentioned contextual institutional settings, the entry requirement also plays a crucial role. Lo and Snape (2003) illustrated that profession orientation could somehow affect later professionalization through fostering professional commitment. The next section would shift the focus to doctors' post-graduate education and career path.

The institutional settings as illustrated above provided a snap-shot on the degree of doctors' professional autonomy. The profession did not possess similar degree of professional autonomy like that of the West which enjoys a higher tendency on political influence on healthcare issues through a relatively powerful professional association. The Code of Ethics and the law regulating the profession in China

were all passed by the State in 1988. Even the top management of the professional association must be appointed by the Sate. The association is merely an organization contributing to the promotion of professional knowledge without any political power.

CHAPTER 5 – METHODOLOGY

This study adopted a qualitative approach to examine the professionalization of Chinese medical doctors. Qualitative research methods employed in this study included semi-structured interview, field trips, and documentary analysis.

Though contribution to the advancement of scientific knowledge is an important goal for every researcher, Pearce (2004) once commented that scientific knowledge sometimes is not capable of solving practical problems. Rather, through multi-facet sources drawn from a context, we can get a proper understanding of the social development (Bazeley, 2002). Multi-facet sources are often embedded in experiential knowledge. Though experiential knowledge might not always be correct, to a considerable extent it could provide insights for theory-building. Bourdieu (1990) and Giddens (1984) added that individuals make sense with what they experience in their daily life so to construct their own social perceptions. Every social group carries structural characteristics derived from their social perceptions and then form social norms. Through the investigation of their social behaviors by bringing out the meaning behind their experiences or perceptions, we can discover the norms which contribute to our overall understanding of existing contexts. To capture experiential knowledge, in-depth interview is always considered as the most appropriate tool as it helps to unveil the contextual complexity of reality especially the “in-process nature of meanings and interpretations” that could counteract the limitation of quantitative analysis (Liamputtong & Ezzy, 1999).

Liamputtong and Ezzy (1999) have put forward a sound argument to support the adoption of in-depth interview, though in general this research tool has been widely criticized for its reliability, validity and causing bias. According to them, if interview agenda is drawn on "an interpretative theoretical framework that emphasizes meanings are continually constructed and reconstructed in interaction" (1999, p. 54), in line with a non-intervention approach of keeping silent and letting the doctor "talk", bias presumed can be avoided (1999, p. 56). Therefore the key is to skillfully conduct the interviews which the interviewer is conscious of preventing this typical error in order to enhance the reliability and validity of the data collected in the process. This proved to be very useful since the current research has relied on in-depth interview as the major research tool to excerpt experiential data from the Chinese medical doctors.

Random sampling is the procedure crucial to maintaining the reliability of quantitative analysis. However, purposive sampling is the usual practice in qualitative research. We need to interview subjects that are representatives of the issues of our inquiry and can help us draw a big picture to explain the phenomenon under investigation. Since the current research falls in the understanding of the professionalization of medical profession in China, I therefore purposively target at the protagonists – Chinese medical doctors in major hospitals in Guangzhou and related stakeholders. Professionalization is all about their professional development within the medical profession and how the whole profession has been evolving to achieve professionalism (c.f. Freidson, 1998, 2000). It is therefore crucial to collect information on the career path of

medical doctor; to explore the professional identity among them, and the professional status they perceived in different stages of professional development that would affect their expectation from the profession and shape their perception of the prospects of their professional career; and to identify the difficulties encountered in their professional work and career development. So such purposive sampling in the selection of doctors (from the medical profession in China) can be seen as theory-based which can help to search for "manifestations of theoretical construct of interest" (Polgar & Thomas, 2008, p. 38), that is, the professionalization of Chinese medical doctors in this study.

The stakeholder groups of Chinese medical profession also fall into the scope of subject selection in this study because they can describe the social norm that reflects the power structure and social expectation. The exploration into these social institutions as perceived by different stakeholders could be helpful for overcoming the institutional constraints faced by the medical doctors (e.g. on-job difficulties) and for ascertaining their effects on the professionalization of medical doctors (Fredison, 2000). This also explained why secondary data sources drawn from national statistics, constitutions, legal documents and newspaper cuttings should be appropriately consulted as far as practically possible. The main purpose of consulting these secondary data sources is to identify the role of the State and its expectation of medical doctors. This would enhance our understanding of the degree of state intervention of the professionalization of medical doctors which is the major institutional constraint as far as all stakeholder groups are concerned. The degree of state intervention congruent with social expectations as perceived

by the general public would directly shape the development of the medical profession (Adler, 2008).

With purposive theory-based sampling aforementioned, this study is able to achieve ecological validity, that is, “another facet of external validity: the situation in which an investigation is carried out might not be generalizable to other situations” (Polgar & Thomas, 2008, 39).

5.1 Data

A total of thirty medical doctors aged between twenty-five and seventy-five across three different age groups from major hospitals in Guangzhou were chosen to be the first round participants in a series of interviews. Interviews of the medical doctors were conducted in Guangzhou, the capital city of Guangdong Province in the People’s Republic of China. Guangzhou was selected, out of careful deliberation, as the location for this study. Most importantly, it is the most economically advanced and developed city in the Pearl River Delta region, ranked third in terms of GDP just behind Shanghai and Beijing (Lo & Snape, 2005, p. 446). Equally important is that there are major medical universities with a long history of development in Guangzhou which provides a sizable pool of highly professionalized medical doctors for this study. The selection of thirty medical doctors for interview was because such a number of qualitative interviews is methodologically optimal to achieve theoretical saturation. There should be fear or no new ideas further apprehended (Poglar & Thomas, 2008) with any number

of sample marginally increased thereafter.

In the preparation for the interviews, this study formulated a set of questions for a semi-structured interview of medical doctors, based on the interview questions template adopted by Lo and Snape (2005) in their investigation of professionalization of lawyers in China. In particularly, some questions were added to fit the current research agenda (cf. Appendix 1). Semi-structured interview means that the interview uses a set of fixed but open-ending questions that can explore individual perceptions on constructs covered in the study (Davies, et. al., 2003).

During the first stage of data collection, thirty semi-structured in-depth interviews with medical doctors of three different age groups, namely, under 35, between 35 to 55 and over 55 were conducted in early February, 2007. Since each age group represent different time segment, recruiting doctors from three different age groups allowed us to capture the doctors' professionalization during different period of time since the founding of the People's Republic of China.

They were from five different hospitals: four in Clifford Hospital (Panyu), four in Guangzhou Second People Hospital, twelve in Sun Yat-sen First Affiliated Hospital; One in Sun Yat-sen Second Affiliated Hospital, Six in Guangdong Province Second People Hospital, and the remaining one was a barefoot doctor from the countryside of Xunde in Guangzhou. Participants were aged from twenty-five to seventy. Equal number of participants, were chosen from each age group, ten of each. Individual medical doctors were given the details of the study

before getting their verbal consent. All interviews were conducted in Chinese (either Mandarin or Cantonese) and took place either in their ward offices or in the nearby restaurants. Each participant was presented with a small gift (a Parker ball pen) as a token of appreciation.

Among the 30 participants, there were only three females from the age group under 35 and two from the age group of over 55. Analysis bias could therefore be foreseen under such male-dominant pattern. As for the participants' career specialties, there was one from Internal Medicine, one from Hematology, three from Urology, one from Obstetrics and Gynecology while all the others were specialized in surgery. Though surgeons were dominant participants, the career specialties should not significantly affect the sample analysis as the professional development would be the same for all medical disciplines in the People's Republic of China.

The thirty interview records were transcribed according to the questions asked in Chinese. For example, one of the questions was 'Please evaluate the role of professional association in professional development'. Interviewees' or doctors' answers were recorded after the relevant questions to create an interview profile for each of them. The transcriptions were then translated into English. To ensure translation validity, the English versions were recorded alongside the Chinese ones for cross reference as shown in Appendix 2. To facilitate the performance of content analysis at the later stage, career summaries were created in Chinese for each doctor to record their career development since they joined the profession.

The second round of in-depth interviews targeted at different stakeholder groups and was conducted in Guangzhou in May, 2008. These interviews of individual stakeholders helped to collect opinions on existing social norms and expectations of medical doctors from individual stakeholders, thus allowing a 360 degree assessment of the Chinese medical profession. These may be the sources of social constraints that have challenged the professionalization of medical doctors in China. Opinions were collected by semi-structured interviews followed by content analysis. The following paragraphs outline the design and administration of these interviews.

In the preparation stage, the interview protocol was formulated with questions to be asked carefully considering the set of questions developed for the interview of medical doctors (Appendix 1a). A total of seventeen stakeholder interviews were planned, which included stakeholder groups such as patients (eleven patients), hospital management (three hospital presidents), and medical associations (three representatives from local and national medical associations). Among the eleven patients interviewed, two were out-patients while the rest were in-patients. As for the hospital presidents and medical association representatives, interviews were conduct in restaurants after lunch or before dinner. The seventeen interview records were transcribed according to the questions addressed in Chinese then translated into English. To ensure translation validity, the English versions were recorded in parallel with the Chinese ones in the same treatment of the interview records of medical doctors, before using Nvivo 8 for coding.

Apart from the use of interviews for data collection, primary and secondary

resources were referred to, such as official year books, constitutions, statistics from relevant institutions and the official websites of regional health departments. As indicated by Meyer and Rowan (1977), incorporating historical analysis is essential to create a clear overview of the primacy of environment that would be a driving force affecting the professionalization of medical doctors. Like the treatment of the interview data set, relevant phrases selected from the secondary sources are translated in English in parallel with the original Chinese text. This is eased the later coding stage by including relevant secondary data as well.

5.2 Data processing & analysis

The transcribed and translated interview data and secondary data source in Word files were exported to QSR Non-numerical Unstructured Data*Index Searching and Theorising (NUD*IST) NVivo 8. This software allows free editing and coding, and places them in a nonhierarchical structure. The aim of the analysis was to extract information from the interview data and the secondary data source, then categorize into different themes, so as to ease data interpretation a later stage. Each theme could project a picture on an area touched while data put into sub-themes would provide details on the main theme. To ensure the translation validity, the translated phrases are placed alongside the original text for cross reference before and after imported to NVivo.

For data coding, this study followed the suggestions of Bazeley and Richards (2002). Key words of each open-ended question were inserted and bracketed followed by doctors' descriptive responses in parallel with the English translation (See Figure 3). The key words were subcategorized into four broad categories in

English: Career Activities, Professional Orientation, Professional Situation, and Suggestions for Professional Improvement for Medical Doctors. The coding categorization for the stakeholder groups is slightly different with the four broad categories as Professional Situation, Role of Doctors, Role of the State, Suggestions for Professional Improvement according to individual stakeholder groups' social functions. Therefore this does not affect the later data interpretation process. These can be defined as codes. "A code is a label attached to section of text to index it as relating to a theme or issue in the data (King, 2006: 257)."

As a method of content analysis was adopted, new themes were identified and categorized. These themes are listed in Figure 4.2 below. New emergent sub-categories identified were put under the aforementioned four broad categories or codes and form the lower level of themes identified. Followed by identification of themes, detailed analysis and interpretation was made to identify institutional constraints, doctors' perceptions towards doctors' profession and professionalization in different aspects. Similar opinions, agreements or disagreements under the same theme are group together to form data matrix. For example, when come up to examining the role of the State, doctors' comments are put under different age groups and sub-divided into positive and negative views respectively. This help to reflect the number of interviewee agree or disagree with corresponding theme then provide insights with the pattern drawn. Data were checked for internal validity.

Figure 4.1: Sample of text imported in Nvivo.

1. 醫生的事業

(投身專業原因) 1956年醫科畢業於中山大學醫學院。在那時，讀那一科是被調派的，不能自己選擇的。
I entered the Sun Yat-sen University of Medical Sciences in 1956. At that time, we could not make our own choice of subject which was appointed by the government.

(投身前對專業形象的理解) 醫生是一個中性的行業。無論在那一個社會，在工作保障和收入方面，醫生這個行業都可以保持一定程度的穩定性，可以找到生活，不會捱餓。無論在資本主義或共產主義的國家，因為要維護健康，大眾都需要和醫生保持良好的關係。這是一種尊重。
Doctor is a neutral occupation. No matter in which society, doctors could be able to maintain a level of stability in terms of job security and annual income. You won't be starved and could maintain your own living. No matter under Capitalism or Communism, everybody needs to maintain a good relationship with doctors for the sake of their health. This is a kind of respect.

(投身後對專業形象的理解) 當醫生後，我發覺主要的動力使我投身醫生專業是來自成功醫好病人後所得到的那一份滿足感。因為我能醫好病人，社會地位也逐漸提高。直到現在我也認同醫生這職業是救死扶傷的職業。
After I entered the career, I found that the major motivation that made me commit to my profession was the job satisfaction I got from healing my patients. In addition, my social status improved gradually because of this. Up till now, I still believe that the goal of being a doctor is healing and curing.

The coding framework is shown in Figure 4.2 as listed below. The analyses of the transcriptions generated from the two rounds of data collection will be presented in the next chapter.

Figure 4.2: Sample Coding Framework of Doctors

1. Doctors
    - 1.1 Career activities
        - 1.1.1 Action to be taken to deal with difficulties
            - 1.1.1.1 No definite plan
            - 1.1.1.2 Yes
                - 1.1.1.2.1 Job advancement
                - 1.1.1.2.2 Self formal study
                - 1.1.1.2.3 Self informal enhancement
                - 1.1.1.2.4 Through communicative methods
        - 1.1.2 Professional activities
            - 1.1.2.1 Least favorite aspects of his work
            - 1.1.2.2 Most favorite aspects of his work
        - 1.1.3 Professional difficulties

1.1.3.1 Have not faced any challenges or difficulties
1.1.3.2 Major challenges
1.1.3.2.1 External
1.1.3.2.2 Institutional support
1.1.3.2.3 Personal
1.1.3.2.4 Resources
1.2 Professional orientation
1.2.1 Career development
1.2.1.1 Career plan
1.2.1.1.1 Long term
1.2.1.1.2 Short term
1.2.1.2 Specialization
1.2.1.2.1 No specialization
1.2.1.2.2 Internal
1.2.1.2.3 Surgical
1.2.1.2.4 Others
1.2.2 Career qualification
1.2.2.1 Training
1.2.2.1.1 Formal training
1.2.2.1.1.1 Advanced
1.2.2.1.1.2 Basic
1.2.2.1.2 Informal training
1.2.3 Professional choices
1.2.3.1 Academic training
1.2.3.2 Family influence
1.2.3.3 Peer influences
1.2.3.4 Personality
1.2.3.5 Pragmatic influences
1.2.3.5.1 Income earning ability
1.2.3.5.2 Involuntary administrative arrangement
1.2.3.5.3 Others
1.3 Professional situation
1.3.1 Assessment of overall professional status
1.3.1.1 Future of the medical profession
1.3.1.1.1 Optimistic
1.3.1.1.2 Pessimistic
1.3.1.2 Impact of reform on the medical profession
1.3.1.2.1 Financial remuneration
1.3.1.2.2 General welfare
1.3.1.2.3 Healthcare service
1.3.1.2.4 No idea
1.3.1.2.5 Not much differences
1.3.1.2.6 Quality of the medical workers
1.3.1.2.7 Resource support
1.3.1.2.8 Structural problem
1.3.1.2.9 Work load
1.3.1.3 Perceived social image
1.3.1.3.1 Economic status
1.3.1.3.1.1 Positive
1.3.1.3.1.2 Negative
1.3.1.3.1.3 Neutral
1.3.1.3.2 Political status
1.3.1.3.2.1 Positive
1.3.1.3.2.2 Negative
1.3.1.3.2.3 Neutral
1.3.1.3.3 Social status
1.3.1.3.3.1 Positive
1.3.1.3.3.2 Negative
1.3.1.3.3.3 Neutral
1.3.1.4 Professional autonomy
1.3.1.4.1 Positive
1.3.1.4.2 Negative
1.3.1.5 Professional ethics

1.3.1.5.1 Positive
1.3.1.6 Professional improvement
1.3.1.6.1 National health bureau
1.3.1.6.2 Hospital
1.3.1.6.3 Regional or local medical bureau
1.3.1.6.4 Medication association
1.3.1.7 Professional Quality
1.3.1.7.1 Positive
1.3.1.7.2 Negative
1.3.1.8 Professional Support
1.3.1.8.1 Positive
1.3.1.8.2 Negative
1.3.1.9 Role of medical association
1.4 Suggestion for professional development
1.4.1 Academic exchange
1.4.2 Continuous education
1.4.3 Definition of medical doctor in market economy
1.4.4 Independence, autonomy and self regulation
1.4.5 Marketization
1.4.6 Professional ethics
1.4.7 Research and development
1.4.8 Resource support
1.4.9 Salary and welfare of medical profession

Chapter 6 – Professionalism of Medical Doctors in China: The Case of Guangzhou

Chapter Five has provided us with a historical review of the professionalization of medical doctors in China with the focus on the institutional development of the profession. Basing on this foundation, this chapter gives an evaluation of the views of medical doctors regarding professionalization and professionalism of the medical profession. Through the in-depth interviews of thirty medical doctors collected from medical school hospitals in Guangzhou, I intended to find out the professional attitudes of medical doctors toward their work and their professional commitment in contemporary China. The interviews were semi-structured, with three sets of questions on the doctor's career, his/her work as a medical doctor and his/her views on the medical profession.

6.1 Evidences from interviews

6.1.1. Profile of interviewees (Doctors)

The thirty medical doctors interviewed can be categorized into three age groups: one group of those under thirty-five, one between thirty-five and fifty-five, and one over fifty-five. According to doctors' career path, doctors would normally be promoted to mid-level by the age of 35 and would be categorized as experts and ready to start their retired life on reaching the age of 55. Such age group categorization also aligns with the medical insurance system (i.e. Medical Savings Account) in which age 35 is the first cut between the first two age groups and age 55 is chosen to be baseline for retirement. There are a total of eleven doctors in the first age group who are mainly postgraduates. Four of them have been licensed and the remaining seven were doing their master or doctorate degrees at that time.

Among these seven younger medical doctors, six of them are doing their two-year's job rotation to prepare for the licensing examination. For those nine medical doctors in the middle age group, they have obtained substantial medical experiences and have been promoted to the post of attending doctor or above. They enjoy a stable income; they are all married and have children. Nine out of the ten in the last and the eldest group are retired professors but continue to work as a consultant in different hospitals; the only exception is still working as a senior doctor and planning to retire in the coming year. They are holding a high career status among all the doctors interviewed and are respected by the peers for their expertise. The ratio of male and female is twenty-six to four. Table 6.1 presents the demographic information of these doctors and the details of the interview questions are available in Appendix 1.

Among the thirty interviews conducted, there are twenty-one of them which are highly usable with information more complete and more comprehensive. Highly usable information means that it has not any missing data or vague answers to interview questions. In general, the interviews of medical doctors in the youngest group have provided more information on their career perspectives and expectations. Medical doctors from the middle age group have given better analyses on current problems faced by the medical profession. Since most of the medical professors from the oldest age group have mostly retired and have rich in-field experience, their interviews provided us with more information on the historical background of the institutional development of the profession in the early years of the Communist regime.

Table 6.1: Demographic statistic of the semi-structured interview

Demographic Statistic of the Semi-structured Interview (n=30)	
Age	
Below 35	11
35 – 55	9
Over 55	10
Gender	
Male	26
Female	4
Job Title	
Master/PhD Student [ab]	7
Attending Doctor	4
Associate Professor (Clinical)	4
Associate Professor (Research)	1
Professor (Clinical)	2
Professor (Research)	1
Retired Professor (Clinical) [c]	10
Retired Bare-Foot Doctor [b]	1
Hospital	
Sun Yat-sen 1st Affiliated Hospital	14
Sun Yat-sen 2nd Affiliated Hospital	1
Guangzhou Second People's Hospital	4
Guang Dong Province Second People's Hospital	5
Clifford Hospital	3
Retired	3

Note. Job title sub-categorized as 'Clinical' means he or she was promoted according to his or her in-ward diagnosis experiences and achievement, while 'Research' stands for those who were promoted according to his or her research experiences and achievement. For promotion path of doctors in China, please refer to the section of 'Medical Education in China'.

[a] All Master/PhD students are below the age of 30. [b] female. [c] Three of them are female.

6.2 Joining the profession and Career development

6.2.1 Factors for Joining the Medical Profession

As regards the factors that attracted them to join the medical profession, five out of six factors mentioned by our doctors are non-economic. The first is that the medical profession has good image and is deemed to be a respectable career, held in high social esteem. The second factor is the meaningful contribution of the profession to the well-being of people's health. The third factor reveals the challenge faced by the profession, leaving rooms for individual achievement and self-development. The fourth is that the profession gives great job satisfaction. Curing patient's serious diseases makes one feel highly satisfied with one's

achievement. The last factor is the profession provides a stable income. All interviewees had basically acquired a positive impression of the medical profession before they decided to join the profession. The impression was derived from the media's promotion of a positive image of medical doctors, the influence of their parents (coming from professional backgrounds), and their study of medical curriculum in full-time education.

Amongst the youngest group of doctors, family influence is the most frequently cited factor for entering the profession. More than half of them from this group indicated that they chose to be a medical doctor because one or both of their parents are currently in the profession. The family influence upon career choice among doctors is summarized in Table 6.2.

Table 6.2: Family Influence on the Career Choice as Medical Doctor

Reason for the career choice of medical doctor	Age Groups		
	<35 (n=11)	35-55(n=9)	>55(n=10)
Family Influence	…my mother advised me to choose medicine in university. If I were ill again, at least there would be doctors and professors round the corner to save my life. [Doctor 02]. My parents wanted me to become a doctor [Doctor 03]. My parents were medical doctors. I therefore knew how doctors passed there lives when I was young. I am interested in the medical profession. At the time when my parents were young, being a doctor was holy professional [Doctor 05] When graduated from high	My father was a traditional Chinese medicine practitioner. He wanted me to succeed to his business. I prepared to relinquish the right as a medical science student if I was admitted by the university [Doctor 13]. My family was poor. When I was a student, I saw many people fall sick and I wanted to heal them. So in 1985, I entered the Jiangxi Medical University [Doctor 14]. My parents were professors of an engineering university. They said that if there was a medical doctor among the family members, he could treat and look after the family [Doctor 15].	My father was a teacher in a secondary school. Four members of my family were doctors and my parents wanted me to be a doctor as well [Doctor 26].

	school in 1994, I intended to choose a subject in which I interested, but my family thought that doctors had steady incomes; I therefore entered the Zhejiang Medical University [Doctor 07].	I chose to be a medical doctor as my parent wished and subsequently I was appointed to the Wuhan Medical College [Doctor 18]. Since my parents said that it was good to be a doctor, I chose the profession and was subsequently admitted to the Southern Medical University in 1985 [Doctor 19].	

What is worth mentioning here on the medical doctors from the middle age group is that they did not have the liberty to choose their career. The choice of career was dictated on them by the state when they were about to enter university. For example, one doctor told us that "*I entered this profession by chance. When I sat for the university entrance examination, I didn't think of majoring medicine but industrial development. It was because I wished to enroll in the Northern Industrial University of where architecture was a hot discipline. However, the government representative asked me whether I would accept the official allocation if I was not accepted by my preferred university. Of course I had to agree. It was because if I didn't agree, I would need to take the risk of being turned down by all universities, and I would not be able to further pursue my tertiary education. Finally, I was arranged to study medicine in the Jiang Xi Medical School. This was not my choice. It's all about the system.*"

High social esteem is another commonly mentioned factor in these doctors' career choice (see Table 6.3 below). Doctors from different age groups generally admitted that the high social status of medical doctors and their positive image among the public were the driving forces of their entering the profession, in the hope of obtaining the professional prestige. This means that the medical

profession is respectable. This is a crucial ingredient in forging medical doctors' professional identity. As remarked by Block (2004), professional identity is critical in boosting individual professionalization to pursue medical professionalism. Therefore, it is not surprising that even though medical doctors from the middle age group entered the profession because of state arrangement, a high degree of social recognition has been able to motivate them to keep upgrading their professional quality.

Table 6.3: High Social Esteem as the Reason for the Career Choice of Medical Doctor

Reason for the career choice of medical doctor	Age Groups		
	<35 (n=11)	35-55(n=9)	>55(n=10)
High Social Esteem	…doctors enjoy high social status. [Doctor 03]. Doctor's role is saving the death and healing the wounded. Indeed it is a great profession. [Doctor 04]. a doctor was a holy professional [Doctor 05] it seemed to be a sacred occupation. [Doctor 09].	I thought the status of doctors was high. [Doctor 13]. Medical doctors enjoyed high social status in the eighties. [Doctor 14]. I felt that medical doctors process a lofty and perfect image, at the same time it is good to cure and save the lives of patients [Doctor 15]. To me, doctors were a mystery image at the very beginning. They are tall, they are like angels when putting on a white gown. [Doctor 16]. My impression of doctors was good even before I was a doctor. [Doctor 19].	I always thought that being a doctor is a respectable and lofty profession. [Doctor 20] I felt that doctors are respected by the society and it is a profession. [Doctor 21] No matter it was in the past or at present, the society regards being a medical doctor as a lofty and respectful profession. [Doctor 26]

Unlike the West, a stable income is not a crucial factor of profession orientation in

China (See Table 6.4). This may be due to the fact that Chinese medical doctors have traditionally not been able to enjoy a high economic status. The factor of income has been almost exclusively mentioned by four doctors in the youngest group. None in the middle age group have mentioned this factor and only one doctor in the oldest group quoted this reason. Indeed, most medical doctors have not shown much concern about their income because traditionally their income status has been relatively low to other professions.

Table 6.4: Income Earning as the Reason for the Career Choice of Medical Doctor

Reason for the career choice of medical doctor	Age Groups		
	<35 (n=11)	35-55(n=9)	>55(n=10)
Income earning ability	…because of the stable income with high satisfaction, I gained my family's support. [Doctor 01]. Though they are not doctors, they think that being doctor would be not unemployed. I do agree with them. If I could not find a job, I could still open a clinic. Therefore, I was admitted to Wuhan Medical School in 1998. [Doctor 03]. doctors would have stable income and better material well-being. [Doctor 05] It was hard to find a job in 1997. While the prospect in getting a job in the medical field was good at that time, so medical science became a favorite subject for students. I also entered The Sun Yat-Sen University of Medical Sciences in that year. [Doctor 10].		I didn't feel aspired at the beginning, I just wanted a stable job, [Doctor 25].

6.2.2 Career Path

The career paths of doctors in three different age groups shared some common features. All obtained their qualifications through licensure examination before starting to be practical doctors. All have pursued or are pursuing a higher degree to further develop specialism through post-graduate fellowship. Still, their career paths exhibited much variation in some aspects.

The career summaries from the youngest group of doctors indicated a strong research orientation as a great majority of the doctors are clinical research students or graduates of clinical research, except three are still on the roll-shift preparing for the licensing examination. These eight young medical doctors said that they would like to engage in clinical research in the near future. Apart from the two who are currently doctorate student or doctorate graduate, all the others stated that they planned to pursue a doctorate degree in clinical research. For instance, the doctor 07, aged 30, told us that she would like to enroll in a doctorate degree specialized in clinical research a few years later when her son was seven months old at the time of interview.

For medical doctors from the middle age group, they have mostly worked as post-doctorate fellows for a few years before starting the professional career as medical practitioner. They were allocated to a local hospital for a period of two to three years after the completion of a five-year medical education. They normally joined a higher tier hospital with a high medical technological level and a better reputation after the fellowship to fulfill their career ambition. For example, when asked *"Why did you choose to work in Nanfang Hospital?",* the doctor said that *It*

is because it is a hospital with a high prestige in the local healthcare sector. In addition, I can fulfill my military terms of service during my stay as an army doctor.

It is found from the doctors in this group that the supervising professors have strongly influenced their career development after the post-graduate study. Five out of ten have stayed in the same specialty because of the good relation with their supervising professors. One notable example is that: when asked *"Why did you shift to Guang Dong Shao Xing Medical College from Xin Jiang for your pathological master degree?",* the doctor said that *it was because the State implemented the policy of cross region manpower importation at that time. My ward supervisor accepted their job offer and therefore brought me with him as his assistant.*

The career summaries of the oldest age group are the most interesting. Their career development was heavily shaped by the turbulent institutional changes during the Cultural Revolution. Some of them were sent to the rural areas in the period between mid-1960s to mid-1970s, as Mao had endeavored to improve the health career provision and promote the hygiene level in these poorly developed and backward areas. Some doctors said that they continued their study in rural hospitals and the relocation of their job had seemed to induce positive motivation for their professional development, though they had to endure low living standards. Under the class struggle staged against intellectuals and professionals during the Cultural Revolution, most doctors were forced to go to rural areas or emergency and out-patient departments. Their professional trainings and the

shortage of medical practitioners helped them to survive from the political purge. Because of these advantages, they were able to further their pursuit of medical knowledge. For example, all doctors from this age group said that after the completion of the five-year medical curriculum in medical schools, they were allocated to the affiliated hospitals as attending doctors. They were not able to pursue a research path since all post-graduate medical courses were closed at that time. In addition, they were required to take up teaching duties immediately after they became medical doctors in hospitals. Unlike those doctors in the middle age group who earned higher professional qualifications mostly through formal post-graduate avenues, they were given the title as professors out of their life-long experience in the medical fields and their contribution to medical practices.

6.2.3 Medical Profession as a Life-long Career

In comparison with the medical students in the West, the post-graduate education of medical students in China is quite different and their choice of specialization are more limited. The fellowship arrangement has created the barrier of entry to specialization and potential medical doctors may not be able to pick their preferred area of interest. In the long run, this will affect their professional development. Lo and Snape (2005) showed that the professional orientation of a professional tends to affect his/her professional commitment which in turn will be a booster of professionalization. When a medical doctor can pursue his/her own preference of specialization, this means that he/she can fulfill their professional aspiration. The fulfillment of professional goal will increase his/her intrinsic attachment to the field that may increase their professional commitment (Wallace, 1995) and serve as a propelling force for his/her continuous effort of professional

well-being.

As regards the medical profession as a lifelong career, the doctors showed conflicting sentiments.

It is worth to note that out of the nine young medical doctors interviewed who have commented on whether they have ever thought of leaving the profession, six of them answered no since they all have planned for further study. For the other three who were preparing for qualifying examination at the time of interview, they felt uncertain about their career future.

All doctors from the middle age group were specialized in surgery majoring organ transplant with the exception of one who was specialized in anesthesiology. Since five out of ten have already obtained their doctorate degree, it is natural that they will go for enhancement of their surgical, pathological and clinical knowledge in further years. Although one or two doctors had expressed that they were not satisfied with their job due to the low salary, heavy workload and poor doctor-patient relationship, all medical doctors interviewed in this group have never considered leaving the profession. Leaving the medical profession was a critical decision for them given the heavy family burden as they were all married with children. Most important of all, they have spent a lot of time and substantial efforts on their career development. Family needs and the investment of time and efforts constituted the two major stabling factors for keeping them to stay in the medical profession. This supports Neapolitan’s (1980) finding that the lack of family support would give rise to the intention to quit one’s profession. Such a

phenomenon can be interpreted that medical doctors in the middle age group may cherish a stronger continuous and normative professional commitment.

Distribution of specialism of the doctors in the oldest group shows much variation. There are one bare boot doctor, three surgical doctors and six others specialized in different streams of internal medicine. Evidence showed that all the doctors in this group never thought of leaving the profession on the day they entered the profession and all, except two, are still serving for the patients with weekly medical consultation after their official retirement. Examples can also be drawn from the interview evidences, such as doctor 21 mentioned that he has never thought of leaving the profession because he loves this profession and would be willing to cure the patients without any returns. Doctor 28 also stated that "*I have not thought of changing my profession. The motivation of being a doctor stemmed from the satisfaction I got from the recovery of my patients and the fact that they paid me with great respect*." These can tell the doctors of the oldest group bear strong professional commitment mainly due to the fact that they can obtain job satisfaction from their affective commitment, which is derived from their own passion towards the profession.

6.2.4 Career Objectives and Plan

Having short-term and long-term career plans is a good indicator of professional ambition and commitment. Looking forward, most of them were able to set clear career aims over the next five to ten years. These include both material (for example, to earn more money) and non-material objectives (for example, to become a good doctor widely recognized by peers, to develop a specialized career

profile, to improve one's medical knowledge through lifelong learning, and to make their hospital established and renowned).

Our interview evidences have showed that more than half of the doctors have developed their own five-year plans (Table 6.5). For doctors in the youngest group, they are desperately keen to improve their professional quality in both knowledge and skills, given they are relatively inexperienced in clinical practice. Their aspiration for career development is among the strongest. In contrast, for the middle age group, less than half of the doctors told us that they have formulated a short-term plan. This may signal that they need some motivation to re-ignite their passion for further professional development and career advancement.

There are a number of institutional factors that may adversely affect their career plan and professional aspiration. The most frequently cited one is the growing tension between doctor and patient. For example, doctor 11 told us that "*currently I don't have the intention to further advance my professional knowledge through further study. It is because the current health care environment is not that favorable to us. Patients often bully the hospitals. Some of their family members are like barbarians. If the doctor fails to cure the patient, they would kick off chaos in hospital. For example, in our neighbor hospital, some family members tried to set fire on it. Very often, doctors are beaten by patients or their family members.*" Further evidence can be found from the news reported by Chinese Medical Doctor Association (2007/06/05), there were approximately 6000 medical staff members were attacked in the year 2006. Another doctor (Doctor 18) from the same age group held the similar view that he was satisfied with the

current position since he did not want to get any troubles from the deterioration of doctor-patient relationship. Uncertainty of the contribution of medical training to career development is another discouraging factor. Most notably, doctor 11 has pointed out that one of the main reasons that make medical doctors hesitate about going for oversea trainings is the future uncertainty after return. He said that oversea trainings mostly focus on laboratory works but not pathological training. This is particularly disadvantageous to clinical doctors specialized in the surgical field whose clinical experience is the most crucial indicator of their professional competence and the deciding factor for their promotion and career advancement.

Table 6.5: Short-term plan of doctors

Theme	Age Groups		
	<35 (n=11)	35-55(n=9)	>55(n=10)
Short-term Plan	Within the coming five years, I think I'll find a job after graduation or seek for further advanced immersion. [Doctor 01]. In the coming 5 to 10 years, I will keep on my post-graduate study while working. If there is any opportunity open up to me, I would consider to be a PhD student. However, currently I won't consider to get involved in any research. It is because I am a newbie and I need further on job immersion. May be after a few years, I will consider conducting research. [Doctor 02]. In the coming 5 years, I am planning to get a PhD. [Doctor 03] I am planning to sit for the general practitioner licensing examination within the coming 5 years. [Doctor 04]. In the coming 6 months, I'll take an examination for professors. If I could state with the 1st Affiliated Hospital of Sun Yat-Sen University, like my boss who is specialized in organ transplantation, I wish for further advancement opportunities. For the time being, I would not consider to working as a hospital administrator,	For me, since I don't have hospital management ability. I would try my best to be a good doctor. [Doctor 11] Hope that I could be a good doctor in the next 5 years so that I can save patients. [Doctor 12] It is difficult in the next 5 years, I've to transform from a traditional Chinese medicine to western medicine doctor; from a physician to a surgeon. I hope I could be more active in organ transplantation, I also hope to perform multi-organ instead of single-organ transplantation. There are a lot of conflicts in considering switching profession, just like switching from the use of Chinese to English. [Doctor 13]. Well, in my age, I don't have any long tern goal. As long as I have tried my best to fulfill my job duties and responsibility, it is fine. [Doctor 14] I have been in this profession for years therefore I haven't considered further achievement. As long as I could fulfill my job duties would be fine. [Doctor 15]	Retired, so no 5-10 years plan provided.

	rather I'll consider this when I have the required ability in future. [Doctor 05]. I wish I could engage in further study through overseas exchange in the coming 5-10 years. [Doctor 06]. Because our country is controlling the birth rate, I believe this is a promising chance for development of obstetric, I therefore decided to stay with my work on obstetrical check. [Doctor 07]. In the next 5 years, I will try to do more research and clinical work. [Doctor 08]. In the next 5 years, I will further develop my professional skill and study for become a PhD. [Doctor 10].	Hope that I can have a better development in the next 5-10 years so that I can enjoy an independent working environment. [Doctor 17]. I'm an assistant director, I hope I can be a director within the next five years. [Doctor 19].	

6.3 The work

All except one of our doctors were able to spot out work aspects that could achieve high satisfaction. Frequently mentioned preferred work aspects included patients' recovery, patients' respect, peers' recognition, and opportunities to transfer their medical knowledge.

6.3.1. Job Arrangements: independent and autonomy

From what our doctors said, the top-down hierarchy in organization appears to be an obstacle for medical doctors to work independently with a high degree of autonomy. For doctors from the youngest group, since they are in entry level, they do not enjoy autonomy like the senior but just take the role of executing actions as instructed. However, Doctor 10 also stated that in some cases there is still room for negotiation as "w*ith more experience, I will have more autonomy. Generally, we may have some limitations in choosing certain types of medicine, yet we can discuss and compromise with our senior."* For those from the middle

and the oldest age group, they admitted that they are granted with full degree of autonomy on clinical decision-making. Though job allocation and professional entrance were under state control, it is surprising that the professional commitment of doctors in both groups was merely affected. There are even complaints that the degree of the State involvement is not strong enough. Evidence can be drawn from Table 6.6.

The limited autonomy in line with political persecution during the Cultural Revolution, like an invisible boundary of development, slowed down the pace of professionalization. However, the process somehow formed the ground work for later professionalization of the profession. The authoritarian approach adopted by the State in handling doctors' entry to the profession, especially the middle age group, did not bring too much negative effect on doctors' professional commitment. This may be due to the fact that at that time, there was limited oversea exchange and doctors still perceived the doctors' image as proletarian workers in the Cultural Revolution remained unchanged. Though they treasured the resumption of post-graduate education and most of them showed a strong will to attain professionalization, they admitted that doctors had only limited autonomy and had no say in professionalization of the profession. One of the doctors therefore commented that: *"With regards to power granted through professional autonomy, I don't think we are in an ideal situation. I hope I can broaden my knowledge and gradually apply it as a doctor. Due to the interference of the Ministry of Health, the autonomy of doctors is affected. The academic effect is obvious in medical science whereas foreign governments give little interference. [Interview17]"*

Under invisible hand approach adopted by the State, limited profession autonomy (See Table 6.6) granted played a crucial role in constraining professionalization of the profession. Other than State's influence on the institutionalization stage, the role of the profession is still a crucial vehicle of their professional (Adler, et. al. 2007). Power granted though professional autonomy could help to consolidate doctors' professional status as this was shown by the medical profession in the West (Jones & Green, 2006). In the context of China, it seemed that the contrary was found and the doctors' professional status was adversely affected (See Table 6.7).

6.3.2. Job Satisfaction

How far have medical doctors in China achieved a high level of job satisfaction, like their Western counterparts? Our doctors had their stories to tell. All the doctors admitted that their job satisfaction as a medical doctor was mainly came from the cure of their patients. This lent a lot of support to their staying in the medical profession (see Table 6.8). Job satisfaction is found to be the major motivating factor for career development among the oldest group of doctors interviewed. It served as a propelling force to sustain their effort to pursue professional enhancement and quest for better clinical skills. As for their preference, most doctors in the youngest group indicated that they would like to be a surgeon because of its direct and visible effect in curing patients' illnesses – the most important source of job satisfaction for medical doctors, indeed.

Table 6.6: Professional autonomy perceived by doctors

Theme	Age <35 (n=11)	Age 35-55 (n=9)	Age >55 (n=10)
Professional Autonomy	The majority commented that due to the fact that they are juniors, they do not enjoy autonomy like the seniors but just accept the role of executing actions as instructed. Evidence: "Since I am a newbie in this profession, there are lots to learn. I need guidance from senior doctors. Therefore, I always have to seek for their advice." – Doctor02 "I think I'm doing well within the parameter of my duties. I will consult my senior if there is any problem, otherwise I would be regarded as irresponsible to my patients. There are a lot of clinical skills that I've to learn; this is the difference between senior doctors and the green ones." Doctor04 *Impression:* - Since doctors are still at a junior level, it is reasonable that they do not enjoy the same degree of autonomy as their seniors because of their limited diagnosis experiences.	The majority stated that they could enjoy full autonomy in clinical decision making. Evidence "I think my autonomy is high within the medical profession. With regard to execution and administration, I've to follow my senior's instruction." Interview18 "I've been in this profession for a long time, so I don't have any problem in autonomy." Doctor14 *Impression:* - It is indeed quite surprising that even though the majority entered the profession by central allocation, none of them blamed the active involvement of the State. Rather some even complained that the State involvement is not strong enough. - Though the majority said that they enjoy	Majority stated that they could enjoy full autonomy on clinical decision making. Evidence: "We've full autonomy within our profession." Interview22

Table 6.7: Professional status perceived by doctors

Theme	Age <35 (n=11)	Age 35-55 (n=9)	Age >55 (n=10)
Professional status	None of them has directly answered this question – reflecting strong uncertainties and lack of clear idea Evidence: "I'm satisfied with my profession status because I'm a surgeon as well as a physician. When compared with smaller hospitals, the professional level of our hospital is a lot higher. I feel very satisfied when patients give me favorable comments." Doctor5	The majority bear negative perception on their professional status Evidence: "The human right is better in China now. Due to our tradition, status of local doctors is a lot lower than that of our foreign counterpart. I think our status will become get higher gradually. In China as a whole, as a result of the media's somewhat biased view against doctors, the status of doctors is lowered than in those years in the fifties and sixties; and we are not respected by the general public. The tension between doctors and patients became greater as result of the unfavorable comments of the media and the nation's policies" Doctor15 "Due to the negative reports made by media, the status of doctors is not as high as previously. The development of tense relation between doctors and patients also aggregate the situation. The status of doctors is far below than that of foreign countries. The income of doctors in China is greatly lower than the contributions they've made. During my grandfather's era, doctors enjoyed high social status and were well respected by the society " Doctor17	The majority commented that the general professional status was much higher in the 1970s and that patients no longer respect them as in the past. Evidence: "In the 1960s, people respected doctors. they were a lot simpler at that time. Conflicts between doctors and patients seldom occurred. By now, there are high demands from patients, e.g. they make a lot of troubles before they are fully recover if they have settled the medical fees. " Interview27 "There were only a small number of doctors in the past, so their social status was much higher than nowadays. When I graduated, for 108 medical students there were only 3 assistant professors and 4 lecturers. Within a ward, there was no professor, but just one senior doctor plus 4 resident doctors. During my time, as there were only 3 professors at the age of mid-40s, when they walking past, nobody dared to look at them. We would take another way out. So you can see the authority they enjoyed, and their superiority in the eyes of students… The social status of doctors is the lowest among all professions! Especially there are lots of criticisms towards our profession from the media, such as medical accidents, red pockets, medical chaos…all these negative incidents usually happened in our profession. In the past, the doctor-patient relation was just like the supply-demand theory. Patients were "begging" for cure, so we enjoyed much higher social status. However, in nowadays society, patients' role has changed and they "command" us to heal them. In my case, I graduated at the age of 21 and became the department head and supervised all surgical doctors. Everybody would be afraid of me for I was an assistant professor." Doctor28

However there are different views on job satisfaction from doctors in the two age groups. In contrast to the youngest group, job satisfactory was not that important to medical doctors in the middle age group. Doctors from this group were mostly designated by the state to become medical doctors. Still, quite a number of them told us that they enjoyed getting job satisfaction from the outcome of their medical work.

As for the oldest group of doctors, their medical career was a state decision, not a free choice of their own. Their job satisfaction has its own unique feature. As mentioned by the doctors, job satisfaction came only after they have spent some time in the medical profession. In the old days of communist rule, they generally enjoyed a higher social status and received more respect from their patients, even though they had the lowest economic status among medical doctors in the three age groups. They were all professors of whom some are holding a position in the top management of national and local medical associations in their specialized fields. As we can see, experienced professors in their old age were still able to enjoy a high social status even after their retirement as a medical doctor. A few doctors are still very influential acting as vice president in national professional associations. One doctor specialized in surgery has been honored by his peers as the Best Four Surgeons in Southern China. Respect also comes from their former students. For example, they were invited to be medical consultants by their students with fee amounting to a few thousand yuan from each hospital where they provided diagnosis advice to their former students. The high professional respect and status enjoyed by them can be best illustrated by the description of an doctor from this age group: "*When I graduated, among 108 medical students,*

there were only 3 assistant professors and 4 lecturers. Within a ward, there was no professor, but just one senior doctor plus 4 resident doctors. During my time, as there were only 3 professors at the age of mid-40s, when they walking past, nobody dared to look at them and would rather take another route. So you can see the authority they enjoyed, and their superiority in the eyes of students." Therefore all of them stated that they did not regret for joining the medical profession and spending their life as a medical doctor. The idea of leaving the profession had never come into their mind since they were highly satisfied with their medical works, the professional prestige enjoyed, and the full respect from the patients and their families. This is consistent with Georgellis and Lange's (2007) observation that when people are getting old, they could capture higher degree of job satisfaction due to their expertise.

Table 6.8: Job satisfaction of doctors

Theme	Age Groups		
	<35 (n=11)	35-55(n=9)	>55(n=10)
Job satisfaction	I am currently satisfied with my living and my job. [Doctor 01]. The most satisfactory experience is that patients were in critical state when they were admitted but then recovered and in perfect state when being discharged [Doctor 02]. I can attain great job satisfaction as my patients like me and being a doctor is also my favorite occupation. [Doctor 03] I am satisfied with my current work as I can apply what I learned and I can achievethe professional	I could attain job satisfaction when my patients are discharged after recovery. [Doctor 11] The unhappy experience was caused by the misunderstanding from patients and by my senior, but I feel fine as I watch my patients fully recovered when leaving the hospital. [Doctor 13]. I feel very happy when I cure those patients who are seriously ill. [Doctor 14]. What satisfied me is that I have got a feeling similar to the creation of a piece of art when I completed a medical operation successfully for a	…, as being able to save life is the source of my satisfaction. I feel enthusiastic and happy as long as I'm a doctor. [Doctor 20] I feel happy if I can cure my patient. [Doctor 21] Now, I'm satisfied to have retirement benefits, and can have meals and get pay. [Doctor 22] I'm fully satisfied when I cure my patients. [Doctor 23] As conditions for patients would return closely to normal after kidney

	level. [Doctor 04]. Being a doctor, I will be satisfied if I could cure my patients with full recovery. [Doctor 06]. For doctors, there is nothing that can override the major premise of healing patients. [Doctor 07]. I like my profession simply because I can cure and save people's life. [Doctor 08]. I'm satisfied with my profession because I'm a surgeon as well as a physician. When compares with smaller hospitals, the professional level of our hospital is a lot higher. I feel very satisfied when patients give me favorable comments. [Doctor 10].	patient. It gives much satisfaction to me when patients recover as expected. In the process, it just likes creation of a perfect product. [Doctor 15]. I feel satisfied as a medical doctor. It is difficult to describe the feeling when I cure patients. This may be enjoyment of work. [Doctor 16]. I am happy when I cure my patient. [Doctor 17]. I'm cheerful and happy when I find out what's wrong with a patient and cure him. [Doctor 19].	transplantation, I like what I do at the moment. [Doctor 25] All in all, I'm satisfied with my status quo. [Doctor 26] I feel happy whenever I cure my patient. [Doctor 27] Being a medical doctor had made my life very satisfactory. … The most important is I have lots of friends. My colleagues treat me as their role model. [Doctor 28] I'm happy I can be a doctor for such a long time. I felt most satisfied whenever my patients recovered. I was greatly respected by my fellow villagers. [Doctor 29]

This shows that job satisfaction has played a crucial role in sustaining the professional commitment of medical doctor. Much support has been seen in the findings of Lu and his associates (2002) in their study of nurse profession in China that job satisfaction and professional commitment are positively correlated with each other, while negatively correlated to the intention to leave the profession. Similarly, in the study of teaching profession, Shann (1998) found that apart from teacher-pupil relationship which plays an important role in affecting their retention and professional commitment, the level of job satisfaction obtained is also the major factor. In particular, teachers' job satisfaction is mainly derived from positive teacher-pupil relationship. By the same token, job satisfaction of medical doctors can be derived from good doctor-patient relationship which in turn can increase their professional commitment. It will also serve as the

motivator for sustaining their continuous effort for professional well-being. In this way, if the current tense doctor-patient relationship can be improved, it will benefit the professionalization of medical doctor as a whole.

6.3.3. The Worst Part of the Work

Proper doctor-patient relationship has now emerged as an important topic for medical doctors. Medical disputes arising from worsening doctor-patient relations have already produced damaging effect in the professional development of all the doctors interviewed. They admitted that it was the worst part of their work. All of them said that to rebuild the trust of patient on medical doctor was the biggest challenge of the time to their profession. The bad doctor-patient relationship greatly affects their emotional attachment to their job. All of them expressed that the involvement in medical disputes with patients and their family has caused much frustration and made them feel helpless (see Example 6). One doctor told us:

> "*I'm not happy because patients misunderstand doctors; especially when the tension between doctors and patients become strained. Patients feel that they are cheated by doctors. It seems that they keep guessing how doctors are trying to cheat them. This makes me feel bad.*" – Example 6

More sadly, another doctor said that he had been assaulted by a patient who was in a bad mood (see Example 7). Even worse, the doctor said that a patient from the hospital next to his working unit was suffering from a complication (i.e., outbreak of another disease due to the original one) and he accused the doctor of not doing

the job properly and therefore, therefore his family set fire on the hospital. Here is the grievance from the doctor:

> "*My unhappy experience was that I was beaten and bullied by a patient. He thought that I was not a medical supervisor. He thought my supervisor should deal with the case, not me. He also thought that since I was not a senior, I didn't have the right to be respected.*" – Example 7

6.3.4. Difficulties and Challenges

In touching with the aspect of main job difficulties or challenges, their opinions covered various aspects. Their comments are mainly concerned with the lack of State's financial support, the misallocation of resources, the controversies exaggerated by media, public's irrational expectations of the profession, the growing consumerism, the poor doctor-patient relationship, and the globalization of the doctor profession in China. To meet those challenges, most indicated that they would seek personal improvement through further study.

The highly volatile working environment in hospitals has caused medical doctors to perform defensive medical care for their patients. It becomes quite a wide practice that a medical doctor asks the patient to do as many clinical testing as practically allowed before proceeding to diagnostic decision-making (Studdert, et. al., 2005). Over 80% of the doctors expressed that this practice of defensive medicine, while may risk their professional integrity and fidelity, would somehow safeguard their position when they received unjustifiable accusation of negligence from their patients. Thus building a trust relationship with their patients has become a challenge to them.

Current healthcare financing arrangements have contributed much to the rise of defensive medicine. The medical saving account (MSA) policy has imposed a lot of financial constraints on doctors' diagnosis decision-making (see Example 8). The MSA policy in China covers mainly the urban population. Insurance scheme under the policy are a kind of "third-party insurance that provides comprehensive benefits with minimal cost-sharing" but small amount of cost-sharing on end users aligned with fee-for-service payment adopted by the hospitals became obstacles in the effective use of medical service and cost inflation (Yip & Hsiao, 1997: 244). As per MSA policy, the amount contributed to the account is fairly little as it is around 6 percent of total income, because the general income level of the public is relatively low when comparing with other nations.

Under such arrangements, medical doctors are forced to prescribe expensive drugs for their self-financed patients or ask them to receive unnecessary high-tech treatments or testing in order to cover the cost and generate income (see Example 9). This practice also serves as the underlying cause of the conflict-ridden doctor-patient relationship which undermined patients' trust in medical doctors (See Table 6.9 for doctor-patient relationship perceived by the doctors):

> "*Doctors need to leverage patients' medical insurance usage, the so-called medical savings account. Doctors need to make sure whether the patients are self-finance or direct-debiting their medical savings account before making any treatment decisions. If the patient pays by medical savings account, the doctor needs to calculate the daily amount of medication*

> *prescribed and the cost incurred. The doctor needs to make sure the total cost incurred can be covered by the patient's medical savings. Therefore, doctor's decisions on treatment or drug prescription will be based on the cost-recovering consideration rather than on patient's actual needs.*" *by Medical Association Representative* – Example 8

> "*Since government subsidies are limited, all hospitals need to maintain their profitability…The State has shifted the financial burden from them to hospitals so they are required to create profit for investing in advanced medical facilities and for remunerating medical doctors. Therefore, medical doctors are normally under tremendous pressure to make profit. This has led to the practice of imposing unnecessary medical expenses on patients*" *by Doctor 11* -- Example 9

Other challenges pointed out by the doctors included ambiguity of the health care reform objectives. On the one hand, the State gradually opened the healthcare market; on the other hand, it ignored the needs of a parallel buffering policy like a standardized mechanism to deal with social controversy. Secondly, emergence of blurred professional identity arises among doctors in the younger generation. The cognitive gap of doctors in younger generation has been widened. This can be explained by the changing values and perception on their professional, social and economic status after being influenced by the increasing medical knowledge from the West. Last but not the least, the globalization of China called for professional standardization within the doctors. This is due to the fact that incoming advanced medical skills and knowledge revealed the loopholes of the healthcare system. For

example, one hospital president commented, "*Amongst all healthcare institutions, the doctors' professional standard of the third tier hospitals and those University-hosted hospitals are comparatively higher than those from low tier hospitals*". The globalization of China also brings forward the impact of marketization which aimed at catching up with international standard in every aspect. Under marketization of China's health care sector, doctors are opened to new challenges from the fourth social power -- the media, as a monitoring agent (see Example 10). Doctor 10 and 14 also commented, "*As the relation between doctors and patients is under strain now, I think the opening of medical market will provide patients with more choices. When patients are willing to pay their medical charges in a public hospital, they will surely get better medicines. However, marketization of the China's healthcare sector would surely lead to keen competition within the medical profession. Yet, this is good because it would surely motivate the doctors in their professional development as doctors must continuously improve their skill and aptitude to avoid being purged. After all, medical doctor is a service profession.*" The issue on marketization of healthcare service as brought out also revealed that the profession is facing greater challenge from market forces such as competitions among different hospitals. As a result, there is a change of role to the doctors who now need to put more effort in contributing profit-making for sustainability of their hospitals. Though this brings pressure to the profession, alternatively it raises their consciousness of the need of further professionalized so as to improve their professional competence. They clearly know this is the only way to seek for long-term sustainability. So this is not surprising that because of all these difficulties and challenges, most of them said that they would continue their study in order to upgrade their professional

quality and make themselves more prepared.

> "*I think the problem in doctor-patient relation is due to the ambiguous role of the government in marketization. On one hand they want to open the medical market gradually but on the other they don't set up a proper standardized process. For example, the government is not prepared in dealing with unfavourable cases reported by the mass media. This further deepens the public suspicion towards our professional role as well as straining the doctor-patient relationship.*" – Example 10

Table 6.9: Doctor-patient relationship perceived by doctors

Entry Reasons	Age Groups		
	<35 (n=11)	35-55(n=9)	>55(n=10)
Doctor-Patient Relationship	All doctors commented that the current overall doctor-patient relationship is under strain. Evidence: "My unhappy experience was that I was beaten and bullied by a patient. He thought that I was not a medical supervisor. He thought my supervisor should deal with the case, not me." Doctor08 *Impression:* 1. The tense Doctor-patient relationship also led to the practice of defensive medicine. Evidence: "Due to the tense doctor-patient relationship and the fact that we are a	All doctors commented that the current overall doctor-patient relationship is tensed. Evidence: "I'm not happy because patients misunderstand doctors, especially when the tension between doctors and patients becomes strained. Patients feel that they are cheated by doctors. It seems they keep guessing how doctors are trying to cheat them. This makes me feel unwell." Doctor16 2. The tense doctor-patient relationship becomes a great challenge to the profession Evidence:	The overall doctor-patient relationship is in harmony because of their professional status Evidence: "My unhappy experience was that I was beaten being beat and bullied by a patient, he thought that I was not a medical supervisor. He thought my supervisor should deal with the case, not me." Doctor08

	profession that is always open to high risks. We have to be more careful in daily diagnosis, and surgical process. We must reduce our workload because the more we diagnose the heavier our risk burden will be." Doctor06	"Due to the tense relation between doctors and patients, I consider the greatest challenge is to communicate with patients." Doctor18	

The arrangement of medical consultation is a source of conflict. Under the current appointment system, patients are not allowed to choose the medical doctor they prefer to consult. Consequently, patients cannot reach the doctors they trusted which directly affect their relationship building with the doctors allocated. Doctor 5 echoed that if patients do not trust doctors, the diagnosis process would surely be affected. The majority of patients stated that if doctors treat them nicely, they will be willing to respect them and be cooperative (See Table 6.10).

Table 6.10: Doctor-patient relationship perceived by stakeholders

Theme	Hospital President (n=3)	Medical Association Representative (n=3)	Patient (n=11)
Doctor-Patient Relationship	1. Two stressed the importance of equality between doctors and patients Evidence: "Doctor-patient relationship should be equal." Hosphead01 "Doctor-patient relationship should be interactive and fair. For example, when doctors diagnosis the illness of their patients, they have the responsibility to decide what kind of medication and treatments. However, if the patients would settle their bills by the medical saving accounts or social security insurance, doctors' decision-making will be based on the cost of medications and treatments rather than patients' needs. It is because if excessive cost has been incurred in medication or treatments, it cannot be claimed. Therefore, the system simply can not match with doctors' professional role. In addition, patients could not accept all the suggestions given by their doctors due to the cost problem. Therefore, to further improve the general healthcare service as well as to clarify and fully utilize our professional role, the State	3. Majority commented that the current doctor- patient relationship is strained Evidence: "The strained doctor-patient relationship is due to different causes including negative cases reported by the media. On the other hand doctors should also bear some responsibilities, so should the patients. All parties involved should be responsible." Asso03 "Doctor-patient relationship is a conflicting one. Here, patients used to be settling their bills by their medical savings account of social security account. If we can cure them, we have already fulfilled our professional role. Some would treat patients' recovery as job satisfaction and professional outcome. However, some would treat monetary return as their professional outcome and therefore are not happy with the current situation as our remuneration package is really unsatisfactory." Asso02 4. One of the doctor expressed that it is hard to comment on the doctor-	1. Majority stated that if doctors treat them nicely and could successfully cure or heal them, they would in return show great respect to the doctors. 2. Doctors also emphasize the importance of maintaining a close relationship with the patients which would affect their willingness in cooperation. Evidence: "My relationship with the doctors is cordial, very friendly and casual and the doctors never refuse to answer any questions I raised." Patient03 "Doctor-patient relationship is like family, very close." Patient05 "Doctor-patient relationship is just like one of the friends, everything is negotiable, the closer that of the better." Patient06

	has to bear the responsibility fine tune the current health care reform. Though the origin of medical system is to reduce patients' financial burden, with the low coverage rate of less than 10%, our profession really needs additional input from the State in financial subsidy and medical resources." Hosphead02 2. One pointed out the importance of trust in maintaining a harmonious doctor-patient relationship Evidence: "The perfect doctor-patient relationship is that the doctor fulfills his responsibility while the patients fully trust the doctor." Hosphead03	patient relationship which is too complex because of the Guanxi network. Evidence: "Doctor-patient relationship is complex in China. Chinese used to be conservative. Therefore, when someone needs to see a doctor, one would base on word of mouth and peer or relative referral. Because of the Guanxi network, doctors have to put patients in the highest priory. It is not because they have to fulfill their role to cure the patients, but because their patients fall into their own social network. Therefore, sometimes doctors refuse to take the patients referred to them as they want to avoid making mistakes." Asso01	

6.4 Views on medical profession

Considering the challenges faced by the medical profession in China, doctors did not conceal their concern over both the difficult external environment and the problematic internal situation of the medical profession. China's backward health care system to accommodate increasing popular demands for higher quality medical service was a common concern. Hospital management is to some extent poorly organized and unable to provide a professionally amicable working environment for medical doctors to perform their duties, develop their professional competency, and pursue their career advancement. The professional consciousness of government officials seems to be limited, as reflected in administrative interference with medical profession and their lack of respect for medical practitioners. This has had negative implications for the medical profession, which is often characterized as being in lack of care for patient, money seekers, with limited medical knowledge, in lack of a community sense of medical services, and unable to uphold the dignity of medical profession. Finally the declining social status and the inferior economic status have all made the medical profession less attractive in a marketizing socialist economy.

6.4.1. Problems of the Medical Profession as a whole

The profession itself has been seen as having serious problems by more than half of our doctors. First, the quality of medical doctors is heterogenious because of the loose examination requirements in the past, so the overall professional standard is not high. This perhaps explains why there have been a lot of complaints from patients against the quality of medical consultations. Second, unhealthy competition occurs among hospitals and medical doctors for generating

more income, adversely affecting the quality of services and the reputation of the profession. Third, China's accession to the World Trade Organization (WTO), may place Chinese medical doctor in a less competitive and prestigious position vis-à-vis their Western counterparts, who tend to have better professional quality and higher academic standards. Fourth, the organization of the medical profession is scattered, as seen in the lack of cohesion among medical doctors. Fifthly the management of the medical profession is far from being regularized. Although improvements have been made, there is still a long way to go before the standard of practice is firmly established and the system of management is regularized. Lastly, greater losses than gains were experienced by the medical profession in the transition from a planned economy to a market economy as the state rolls back from the economy. The core problem, as one doctor put it squarely, was that the medical profession lacked an independent status with due recognition from the state.

The sources of trouble for the medical profession can be systemic one originating from the medical reform. The poor doctor-patient relationship has impaired doctors' professionalism and made patients unhappy. This stems mainly from the current public health care financing system. The consultation fees charged under the fixed-price policy are not sufficient to allow hospitals to be self-financing and provide a respectable income for their medical doctors. As a result, a lot of irregular medical practices among doctors take place when they are interacting with their patients in order to generate income for the hospitals. The problem of expensive medication has made the situation worse as hospitals cannot directly purchase medicines from pharmaceutical factories but have to go through several

layers of pharmaceutical agents. The unhealthy development of the pharmaceutical market has made the cost of medical services unnecessarily high. These systemic shortcomings have already undermined the professional prestige and tainted the traditionally positive image of the medical profession. The backlash is that the demands for greater regulations and monitoring of the medical profession from health care authorities which hurts the professional independence and restricts its autonomy. The doctors were all critical of the medical reform in respect to the financial support to the health care sector. One doctor expressed his anger as follows:

> "*The medical reform is unsuccessful since the government has provided little financial support and resources to hospitals; the general public accuses that hospitals are the principal culprits and should be responsible for the high cost for and difficulties in getting medical treatment. In fact, medical doctors are forced to give up their bonuses on some occasions. The medical reform has caused conflicts between medical doctors and patients as both parties are not happy. The situation is aggregated by negative coverage from the media, adding grieves to already deteriorating doctor-patient relation.*" – Doctor 05

As the relationship between medical doctors and patients turns sour, the numbers of medical complaints and disputes have increased. Although the judgment of these cases are always in favor of the medical doctors as most of the accusations are unjustified, the settlements ordered by the arbitration bodies or law courts always involve compensation to the patient sides out of sympathetic consideration. In this way, the mud-sling effect on the medical profession cannot be effectively

eliminated. The crisis of faith, trust and credibility on the medical profession on the part of the patients has already built up. Consequently, the suspicion on the professionalism medical doctors has silently crept in among medical doctors, though it is still too early to say the possible emergence of any identity crisis. This explained why in a 2007 survey done by the Chinese Medical Doctors Association reported that approximately 80% of the subjects cried for severe punishment should be adopted to avoid further medical disputes so as to improve their working environment (Health Daily, 23/04/2007).

Table 6.11: Professional status perceived by doctors

Theme	Age Groups		
	<35 (n=11)	35-55(n=9)	>55(n=10)
Professional Status	None of them has directly answered this question – reflecting strong uncertainties and lack of clear idea Evidence: "I'm satisfied with my profession because I'm a surgeon as well as a physician. When compared with smaller hospitals, the professional level of our hospital is a lot higher. I feel very satisfied when patients give me favorable comments."	Majority bear negative perception on their professional status Evidence: "The human right is higher in China now. Due to our tradition, status of local doctors is a lot lower than that of our foreign counterpart. I think our status will come up again gradually. China as a whole and as a result of the media's somewhat biased view against doctors, the status of doctors is lowered than those years in the fifties and sixties and; we are not respected by the general public. The tension between doctors and patients became strained as result of the unfavorable comments of the media and the nation's policies" Doctor15 "Due to the negative reports made by media,	Majority commented that the general professional status were much high in the 1970s and patients no longer respect them as in the past. Evidence: "In the 1960s, people respected doctors; they were a lot simpler at that time. Conflicts between doctors and patients seldom occurred. But now, there are high demands from patients, e.g. they make a lot of disturbances before they are fully recovered if they have settled the medical fees. " Doctor27 "There were only a small number of doctors in the past, so their social status was much higher than nowadays. When I graduated, for 108 medical students,

		the status of doctors is not as high as previously. The development of tense relation between doctors and patients also aggregate the situation. The status of doctors is well below that of foreign countries. The income of doctors in China is greatly lower than the contributions they've made. During my grandfather's era, doctors enjoyed high social status and were well respected by society" Doctor17	there were only 3 assistant professors and 4 lecturers. Within a ward, there was no professor, just one senior doctor plus 4 resident doctors. During my time, as there were only 3 professors at the age of mid-40s, when they walked past, nobody dared to look at them. We would take another way out. So you can see the authority they enjoyed; and their superiority in the eyes of students… The social status of doctors is the lowest among all professions! Especially there are lots of criticisms towards our profession from the media, such as medical accidents, red pockets, medical chaos…all these negative incidents heard are usually happened in our profession. In the past, the doctor-patient relation was just reflected in the supply-demand theory. Patients' role was "begging" for treatment, so we enjoyed much higher social status. However, in nowadays society, patients' role have changed and they "command" us to heal them. In my case, I graduated in the age of 21 and became the department head and supervised all surgical doctors. Everybody would be afraid of me for I was an assistant professor." Doctor28

Indeed, there has been a growing awareness of the lack of status of the medical profession among the interviewees. The professionalization of the medical doctors

in the last three decades has virtually added little value or brought little (tangible or intangible) benefit to the medical profession. In terms of professional status, evidence can be drawn from Doctor 28, "*In the past, the doctor-patient relation was just reflected in the theory of supply-demand. Patients' role was "begging" for cure, so we enjoyed much higher social status. However, nowadays, patients' role has changed and they "command" us to heal them.*" The decline of respect gained from patients as spotted is a solid proof of decline in doctors' professional status.

On the whole, the perceived professional status is quite negative. In economic terms, most of the doctors admitted that their income has been consistently below average in comparison with that of other professions. The comparison with medical doctors in developed countries in terms of income is even more frustrating to them. We were told that the best a younger medical doctor can earn every month is in the region of RMB 4,000 if he/she works in a top-tier (i.e. third tier) hospital (see Example 11). The salary would be reduced to RMB 3,000 in a second-tier hospital and further down to RMB 2,000 in a first-tier hospital in rural areas. Research students could only get a monthly allowance of roughly RMB 900, even though they have already spent a few years working as a full-time attending doctor after their graduation.

> "*The salary of medical doctors has gradually become lower. A few years ago, doctors earned approximately RMB four to five thousand in provincial hospitals; RMB two to four thousand in municipal hospitals, or even less at one to two thousands, and the salary has not been raised since then. When the economy was better, the salary of doctors in provincial hospitals could*

be as high as RMB five to seven thousands a month in Dongguan. Temporary doctors may get less than RMB one to two thousands, after three years, one may get a permanent job and earn a salary of RMB six to seven thousands. I'm now working in a municipal hospital with a salary over RMB four thousand which is already comparatively high." *by Doctor 05 –* Example 11

The income of medical doctors interviewed in the middle age group appeared to be better as they earned around RMB 10,000 per month and most of them could afford to get their own property. As for the medical doctors in the oldest group, they have experienced the worst economic time under the Communist rule during the Cultural Revolution. At that time, the salary of medical doctors working in urban city hospitals was around RMB 60 per month while those in rural areas could only earn RMB 40 plus in the 1960s to 70s. Bare-foot doctors could only wait for patients' annual *gift* like crops they grew or meat from their cattle as each consultation fee is just around RMB five cents. One old medical doctor, in his 68 when interviewed, who was formerly the president of a hospital aged 68 has provided us with a vivid example:

"In the 1960s, the central government paid RMB 800 million for a film production company to make a film about Dr. Sun Yat-sen. RMB 800 million at that time was equivalent to RBM two billions today. However, we just earned around RMB 60 which was later increased to roughly a hundred. Right now, I just earn RMB 20,000 a month."

That is, though the government could afford huge spending on movie-making as political propaganda, it would not be willing to contribute to the medical profession by raising the general salary of doctors. It is because, to the State, the high professional status of doctors would be threatening to the ruling party if they were too authoritative with the monopoly of knowledge. If such a situation occurred, it would violate the spirit of Communism for establishing a classless society. Therefore, the State deliberately maintained a low professional status for the doctors and controlled the general income level of the profession.

Mao's legacy of low economic status for the medical doctors (See Table 6.12 below) has not been eliminated by the health care reform or the resumption of the medical profession in the post-Mao era. The expectation of better economic treatment has been growing among medical doctors, particularly those in the younger generation, as the general living standard rises in China and the increasing knowledge on the staggering salary packages received by their Western counterparts. The lack of improvement of their material status will inevitably undermine the professional commitment of medical doctors in the long run as they find that they are not been able to share the wealth of the economic well-being. Indeed, "moonlighting" or taking a second job has become quite a common practice among the profession in order to boost one's income.

Table 6.12: Doctors' perceived economic status

Theme	Age Groups		
	<35 (n=11)	35-55(n=9)	>55(n=10)
Economic status	None of them has directly answered this question – reflecting strong uncertainties and lack of clear idea	Majority bear negative perception on their professional status **Evidences:**	Majority commented that the general professional status were much high in the 1970s that patients are no longer respect them as

	Evidences: Right now my salary is just one thousand something but will be raised after a few years. However, compared with those in other occupations and professions, we earn far less than others. [*Doctor02]* The salaries of doctors become lower gradually. 3 to 4 years ago, doctors earned approximately 4-5 thousand dollars in provincial hospitals; 2-4 thousand dollars in municipal hospitals; or even less, at 1-2 thousands. As the economy is better lately, the salary may be as high as 5-7 thousands in Dongguan. Temporary employees may get less at 1-2 thousands, after 3 years. One may get a permanent job at 6-7 thousands. I'm now working in a municipal hospital with salary over 4 thousand dollars. *[Doctor05]* …doctors used to engage in heavy workload but with very low income. The situations in small scale hospitals are even worse. [*Doctor06]*	…our economic status is low because of low salary. [*Doctor11]* The income of doctors is not proportional to their work. Their incomes is only 20% of that of the doctors in Hong Kong and are even much lower than that of the American doctors. [*Doctor13]* The financial status of doctors was not high in the eighties, but it is better now. Yet the salaries of those doctors working in small hospitals in villages and counties are low and; doctors would often get their pay a few months late. Without salary payments, it is difficult for doctors to subsist. It also reveals that the government has put too little resources into the medical system. The small hospitals have difficulties in sustaining their operations; some may have to close soon. [*Doctor14]* our … financial status is lower than that of the foreign doctors. [*Doctor15]* I think the economic status of doctors is a little bit lower than medium. [*Doctor18]*	in the past. **Evidences:** We are very different from foreign doctors. We get very little financial rewards. During my four decades tenure as a doctor, I was very poor in the former twenty to thirty years. My financial position has improved only in the recent ten years. [*Doctor20]* I was not happy with my meager salary. *Doctor21* The financial status of doctors needs to be improved. [*Doctor23]* The financial status of doctors is not good. In the sixties, the government paid 8 million Yuen to a film producer for the making of a film about Dr Sun Yat-Sen, the money spent is equivalent to 200 million at present. However, our monthly salary was 60 Yuen at that time but subsequently rose to 100. 60 Yuen was sufficient at the sixties since the cost of living was very low. My present salary is 20000 per month, although it is a lot higher than before but the cost of living is comparably higher as well. [*Doctor26]* The financial status of doctors is low. From 1986… My monthly salary was 9.50 dollars, a year later; my pay was increased to 23 dollars as my seniors considered that I was working so hard at late hours. At that time, it cost a few cents for a catty of vegetable and 5 cents for an egg. By now, the

			medical charge in the village is still very low. Someone asked me whether I could afford my living with my income. [*Doctor29*]

The inferior salary package for medical doctors is indeed detrimental to the professionalization of the medical profession. A low salary is always a breeding ground for irregular practices of income generation, particularly when the sentiment of cross-profession inequity has started to grow. The professional integrity and service ethics of medical doctors have already been under severe test as it is not infrequent that medical doctors received red packets from patients and rebates from pharmaceutical agents. The repercussion is the recent call for the introduction of medical ethics assessment and the establishment of medical ethics database. This shows the urgency for providing a proper material basis for promoting and sustaining the professional ethics in the medical profession.

State control of the professional qualification is another problem area. The licensing process and the qualifying examination have been under the control and supervision of the Ministry of Health (MOH). The bureaucratic style of management has not been proved effective in the promotion of professionalization as the professional quality has not been significantly lifted, the professional standard has not been effectively tightened up, and the quality of services has not been greatly improved. For example, a hospital president commented that "*in the past 16 years, though professionalization of doctors and hospitals has been rapid. Among all healthcare institutions, the doctors' professional standard of medical schools and third tier hospitals are comparatively higher than those from low tier hospitals*." This reflected that there is a professional standard difference across the

medical doctors, even though with same job title and ranking. Another hospital president also mentioned that "*Related governmental units are limited while the related legislation is complex that it caused enforcement problem. It is very difficult to rely on the State to monitor the profession is very difficult. It is even impossible to pass such responsibility to the hospitals because of limited resources.*" As one doctor (Doctor 28) put it squarely, *guanxi* is still a problem in medical journal publications, which directly affects professional integrity and competency.

> "*For example, you've to pay money if you want to publish an article… So how to get your work published? It all depends on your supervisor's and your relationship with the editorial group of the journal, as well as how much you are going to contribute to the "administration fee". In other words, social connection is a must… If you need to have your paper published in order to get promoted, you can directly negotiate with me (If I am the president of the medical association) for the price that you can afford, RMB3,000 to RMB9,000; the actual amount could be further negotiated.*" – Doctor 28

Unhealthy competition among hospitals for profit making has been increasingly detected and visible in the commodification of medical services under current market reform. Simply speaking the provision of medical services is now seen as a source of income for both hospitals and medical doctors. In particular, China's entrance to the WTO has opened the health care sector for medical tourism. In particular, the national economic well-being has created business opportunities for

non-clinical (or non-traditional) types of medical services, like health building, body check, body slimming, and plastic surgery. A lot of hospitals and medical doctors have now already leveraged in this market because of increasing demands from the public. The keen competition has already cost the reputation of the profession. There have been a lot of complaints against the low quality of the medical services, unscrupulous practices in charging, and the lack of proper medical expertise. For example, regarding the internal promotion criterion based on number of research papers published, one of the doctor revealed that it is easy to get your research paper published could be easy solved as long as you have a good *guanxi* with an influential supervisor and if you are willing to pay, even if your research report is just fake (Doctor 28). Prof. Gao Qiang, a key government officials from the MOH, has also criticized about the problem of medical bribery between the pharmaceutical representatives, the pharmacists and the doctors that the final mark-up margin of a kind of drug might reach 390% (Xinhuanet.com, 2006/03/28).

The shortage of (high quality) medical doctors has adversely affected the healthy grow of the medical profession. The medical profession has found it increasingly difficult to meet the growing demand for good quality and high-end medical services from the public. After implementation of marketization policy and a series of healthcare reforms initiated in 1980s. Under marketization of the healthcare sector, the privatization of hospitals result in low retention rate in top tier hospitals as some doctors long for better remuneration package and better working environment. The privatization of hospitals and healthcare reform which advocate the fee-for-service model gave rise to the pharmaceutical industry.

Medical representative in the industry enjoy better income level than that of the doctors, which impacts medical students' professional values. Some would consider shifting to the pharmaceutical industry rather than remaining to be a doctor for a better living, as Doctor 01 did mention that he has though of changing his occupation. This implies that fewer doctors would like to stay in the profession. Other than this, to cope with the national direction of putting more focus on clinical research, doctors who seek for further promotion must be engaged in research. Unless making more efforts in clinical research, hospitals can gain more resources and establish their marketing position with the help of government or foreign research funding. This means the younger generation prefers to put more efforts in clinical research rather than pathological practice. As a result, doctors with rich pathological experiences are getting less in the future, whereas research-oriented doctors would be more dominant within the profession. The medical sector has encountered the problem of having a "geological fault" within the profession, that is, there is a supply gap between the oldest generation and the middle ones. Consequently the oldest group needs to continue their service after the age of retirement due to shortage of manpower in their specialism.

Marketization of the heath care sector has its pros and cons for our doctors. More than 90 percent of the doctors welcome the opening up of the healthcare sector to outside world. This will encourage the development of private hospitals and clinics which will bring medical experts from overseas to China and facilitate international exchanges. Greater exposure to market forces and international medical community will benefit the professionalization of medical profession and the professional development of medical doctors in China. As some doctors have

pointed out, the introduction of market in the healthcare sector would put hospitals under greater competition which would drive them to improve their professional competency and quality of services in order to be more competitive. The backlash is that this will widen the gap among hospitals in terms of financial resources, medical facilities, and quality of medical services as top-tier hospitals can easily out-compete lower-tier hospitals for the provision of paid medical services in a free market. Likewise, the income gap will also become more visible among medical doctors themselves as there are usually greater demands for more well-known medical doctors from patients. Uneven demand has already been detected as there is a salient trend for patients to choose medical services provided by top-tier and city hospitals instead of lower tier or rural ones. This brings uneven distribution of workload among medical doctors in different tiers of hospitals. The increased workload for medical doctors in top-tier hospitals has already affected the service quality, as indicated by a patient we interviewed (Patient 04). In this way, competitive market may be destructive for the health care sector which gives rise to uneven distribution of resources and workload, imbalance utilization of hospitals, and unhealthy competition among hospitals. Finally, the free market development will hinder the professional development of healthcare sector in rural areas as rural hospitals will find it difficult to attract and retain high quality medical doctors and to get better medical facilities in a tight resource situation and with low income earning ability. The gap of professional competence between medical doctors in urban and rural hospitals has already detected by the patients themselves:

"*We came from Hunan. After 9 months, the doctors there still could not find*

out what's wrong with me. Later, our village senior referred us to here. It just only took only 2 days for the doctors to confirm my illness." – Patient 04 (*stayed in a top-tier hospital for surgery in Guangzhou during interview*)

Although the growing number of private hospitals has created more career opportunities for Chinese medical doctors, the proper regulation is an important issue. Thus, the management of private hospitals has emerged as a new issue for protecting the healthy growth of the medical profession. (China Young Post, 2006/03/23) showed that the 'new' owners of people-owned private hospitals do not put non-medical professionals in charge of the hospital management. The choice of top management is based on one's *guanxi* with the owner. More importantly, there is not sufficient quality control in these hospitals and there were reported cases of granting medical licenses to medical doctors below standard to practice in these private hospitals simply because of their good *guanxi* with the top management. In order to build up their medical team in a short period of them, these private hospitals now try to attract medical doctors, particularly medical specialists, from top-tier public hospitals with better salary packages as attraction. This has created the human resources crisis for the public hospitals and significantly weakened their capacity in providing high quality medical services to the patients. For example, Prof. Xinbo Liu, currently the vice President of Guangdong Healthcare Bureau, commented "*We all treat hospital because the government as every action taken by public hospitals reflects governmental values. Then, can our government contribute a little more in the healthcare system? Personally I think this should be their responsibility.*"

6.4.2. Possible Solutions to Deal with Difficulties and Challenges

Our doctors suggested several ways deal with the aforementioned challenges. Two doctors mentioned that the government should take initiative to further monitor professional standard. For example, the State should get more involved in the quality assurance of hospitals, for example, to formalize surgeries categories for hospital from different tiers. One of the hospital presidents pointed out that "t*he actual situation is, if you have enough resources and are bold enough, even though you are in lower tier hospitals, you can still perform surgery used to be done by specialists in 3rd tier hospitals. Therefore, the government should standardize the surgeries available in hospitals from each tier*."

For the poor doctor-patient relationship and the diminishing trust from patients in medical doctor, the majority of the doctors wish that the government could take prompt actions to improve the situation and protect medial doctors from any further physical attacks. Some doctors expressed to play safe in the short run that they would practice defensive medicine to avoid possible medical disputes with patients and their families. One doctor made this explicit: "*We have to be more careful in performing medical diagnosis and conducting surgeries. We must reduce our medical consultations because the more we diagnose the patient's illness the higher will be our risk.*" All of our doctors shared that the government should invest more resources in the healthcare sector and assure a more even distribution of resources among hospitals in urban cities and rural areas in order to reduce excessive demands and the burden of overload on city hospitals. This view was supported by Prof. Xinbo Liu. In his blog, he wrote:

"We all treat hospital as the government because every action taken by public hospitals reflects governmental values. Then, can our government contribute a little more to the healthcare system? I think this should be their responsibility." (19/11/2008)

With regard to state-profession relationship, the doctors sadly expressed that the State does not show any respect for the medical doctors. The fixed-price policy is unable to better off patient's medical need, but has indirectly intensified the doctor-patient relationship. They all hoped that the State would step in to tighten the regulation of the healthcare market so as to allow healthy competition and promote proper management of private hospital. Most important, the MOH should provide more channels for two-way communication so that medical doctors' voices can be fully heard. In short, there is quite a strong consensus among the doctors that state plays an important role to promote and facilitate the professionalization of medical profession and their presence is always welcome (See Table 6.16 for state-profession relationship perceived by doctors).

6.4.3 Views on Professional Association

In general the doctors expressed their disappointment with the professional bodies as the medical associations only play a pure academic role in their professional development. Though the professional bodies regularly organize seminars and conferences for academic exchange, much anger is aroused from the young doctors, especially those student-doctors at the undergraduate or post-graduate level, as they are normally not allowed to attend these events which are mostly organized for senior doctors. Nearly all of them expressed that the medical

associations could neither protect their rights nor fight for their interests. These associations completely fail to stand up to the expectation of a professional body in Western sense. Whenever a doctor got involved in a medical dispute with the patient, it was the hospital which helped to settle the case. There was seldom a case that the medical association played an active role to provide necessary advice and support for the medical doctor accused. It made medical doctors feel desperate and helpless in this difficult situation. Therefore, medical doctors criticized the professional associations for hiding behind without taking action to defend the professional image and prestige. Added to the grievances of the medical doctors was the inability of these medical associations to help their members to secure a better remuneration package or a more favorable working environment. They would like to see the medical associations in China to be in a prestigious position as their Western counterparts, capable of leading the medical profession and promote the welfare of the members. A large majority of the doctors concurred that the role of professional associations should be reviewed with the view to strengthening them as the guardian of the medical profession and spokesman for medical doctors. These medical associations should play an active role to promote the professional image of medical doctors, communicate to the public the rights of medical doctors, and educate the public on the proper ways to interact with medical doctors. Only one doctor considered that the professional associations had done enough to maintain the professional standard and protect members' rights.

Since the medical associations have neither the authority to lead the profession nor the determination to serve the interests of their members and their

performance has on the whole let their members down, it is not surprising that many doctor pressed for professional autonomy. In general, they are quite satisfied with the current situation even though they don't have a major role to play in the reform of the medical profession, even less in the healthcare reforms. They are fully in control in their specialism, both in clinical practice and medical research, without much state intervention. They consider that medical association should focus on the assurance of the quality of medical doctors and ensure the provision of proper medical training for all. As one doctor remarked that. "*CMA should co-ordinate training of doctors at different levels. This is to ensure the maintenance of service standards of hospitals at similar level" (by Doctor 05*). Finally, they should formulate a proper strategy for developing the medical profession and enhancing the professional standing of the medical community. The doctors' views on the medical professional associations are summarized in Table 6.14.

The interviews of the three representatives from the local medical association in Guangzhou provided a clearer picture on its role in the professionalization of medical doctors. They pointed out that with most power resting with the health bureaus, the associations can only focus their role on promoting the professional quality of medical doctors. This is similar to the situation in post-war Poland which was also a communist country with planned economy (c.f. Sokolowski, 2001:56), medical professional associations acted mostly as a state agent to handle and resolve the conflicts between medical doctors and the public, and as a state instrument regulating the profession. However, they can hardly protect the medical profession though they are responsible for performing medical audit in

medical accidents for the State. In general, their power is quite limited under state domination. The most they can do is to provide opportunities for professional exchange with overseas medical experts by organizing research seminars and conferences. Indeed, the visible of these medical associations are so little known that the public are hardly aware of their existence, not to mention the public's knowledge of their role in cultivating the medical profession. This is a big contrast with the medical associations in the West which are so influential, powerful, and authoritative with professional prestige beyond challenge. The interviews in this part are summarized in Table 6.15.

6.4.4 Future Prospects

As for the future perspectives of the profession, a handful of the doctors were pessimistic because of diminishing trust from patients and insufficient intrinsic and extrinsic rewards for their professional works. For example, one of the doctors from the oldest group has commented, "*as the doctor-patient relation is deteriorating and every doctor is losing his zest and earnestness in his work, I don't have hopes in the future of this profession as well.*" In addition to the tensed doctor-patient relationship which diminishing their hope for an optimistic future, institutional constrains is also a key issue which account for some doctors' pessimism in the future prospects of the profession. Doctor 14 from the mid-age group pointed out that "*I think the road of medical development is bumpy because the government is implementing a stern policy. The future is gloomy. I hope the government can make more announcements, such as, on death of the brain now widely discussed internationally. I also hope the government can promote doctor's image.*"

In general, the majority of them were optimistic as they considered that the health reform would be able to benefit the medical profession in the long run. The privatization of the health care sector is far from being a trend, even less is the trend for medical doctors to seek for private practice. One doctor said that privatization would help to effect a better allocation of medical resources as the rich can afford to see private doctors and more public resources could be used to serve the poor. (see Table 6.18 at the end of this section). However, as mentioned previously, privatization created labour problems. Therefore, the idea of general doctor has also been raised that in the hope of solving these labour problems. Doing so will help to provide more opportunities for the doctors and ease the workload of those working in the top-tier hospitals. It is because general doctors could act as gate-keepers of the healthcare system so as to better utilize the existing resources and improve resource allocation because "*specialist doctors should not act as family doctors*" as commented by doctor07. This implies that if more effort can be made to put in the suggestions into practice, doctors will still believe that they can have a bright future and will strengthen their professional commitment.

6.5 Stakeholders' Perspective of Medical Profession in China

After examining doctors' views on their profession, the market and relationship with the State, this section will look at the medical profession from a different angle through the eyes of the stakeholders, such as hospital presidents, medical association representatives and patients.

From hospital presidents' perspective, their positions may enable them to have frequent contacts with government agents like local Health Care Bureaus. They could provide more evidences to prove the State dominance in doctors' professionalization with institutional compliance. For example one of the hospital presidents pointed out that "*the State is trying to standardize the profession…promotion in top tier hospitals must meet a set of assessment criteria … All these are standardized by the State, both continuous education assessment system and the internal promotion system.* Unless with stronger State intervention in standardization of the profession, the professional quality would be uphold. Hospital president 02 criticized that "*It is easy for doctors to get their professional licensure in China. Even those who graduated from colleges can also sit for the licensure examination. These lead to the complex hierarchy structure within the profession... As a result, the professional standard among doctors varies across the nation. Only those medical school located in city center could maintain the professional benchmark"*. As for their relationship with the medical association, the majority explained that the role of medical association is academic oriented though they are also responsible for medical audit of medical accidents and are under strong State influences and control. Hospital president 01 put this squarely that the association would "*just responsible for organizing and promoting professional exchange so to assist our professional development.*"

From the perspective of medical association representatives, all commented that the role of the State to the profession is like a guardian that holds the responsibility of monitoring and educating the profession. Their interviews provided an explicit functional view of medical association. One of them

described ‘*Medical Association is an organization that has no political power, no administrative power, no professional authority, and no financial management power. It is just a “shadow organization” working for the State. It is insignificant in the healthcare system. It is a governmental organization with a few doctors working for it, but over 90% of the staffs are not doctors but civil servant. Therefore, it doesn't have any social function*’. What they described solved the paradox of medical association in terms of its function and role in the eyes of doctors and the State. The key fact is that their comments revealed the limitation of professional autonomy compared to those in the Western society.

From patients’ perspective, the majority commented that the State is like the guardian of the doctors that holds a dual responsibility in monitoring the profession as well as its development. One of the patients expressed that “*the State should improve the healthcare system. This will help to upgrade doctors' professional ethics and proficiency. Only by providing them with better remuneration under a fair system, the doctors will be willing to fulfill their obligations in terms of ethics and professional development*”. To them, the role of doctors is a healer, and all expect full-recovery after consultancy and treatments which is supposed to be doctors’ responsibility. Only one patient has heard about the existence of medical association. This implied that the image and function of the medical association is indeed too new to the general public that future community is needed. This would indeed help to strengthen patients’ trust towards the profession if they know that there is an agent that serves the purpose of quality assurance for healthcare services provided.

In general, as perceived by stakeholders within the profession, doctor is a profession that serves the public like a warrior of the national health to defense against illness. To sustain the quality of service, standardization is necessary. In terms of autonomy, the profession could only have limited access as the dominant role of the State somehow constrains their professionalization. The State should play a greater role in political and financial support. The former refers to executing State's influence on the profession through different legislations. For example, by unifying quality assurance through a set of laws and constitution which will provide a surveillance system monitoring the profession. The latter refers to the clamor for extensive resource support from the State so as to boost the pace of professionalization of doctors. At least doctors would no longer need to share the role of profit-making as a form of contribution to hospital sustainability which has been a consequence of increased peer competition because of heathcare service marketization.

As in the eyes of the patients, fee-for-service indeed increases their consumerism and thus they have a higher expectation of healthcare service quality. However, they do not see the complete picture of doctors' profession and function. This implied that community education should be considered as a tool in changing their existing perceptions. The State and the profession may take this as suggestion for further goal in professionalization, that is, to put some efforts in educating the public about the profession like those available in the West. More details about stakeholders' view towards the profession can be found in Tables 6.15 and 6.17 listed below.

Table 6.14: Relationship between the doctor profession and their professional association.

Theme	Age <35 (n=11)	Age 35-55 (n=9)	Age >55 (n=10)
Association-Profession Relationship	1. 4 → not clear about the role of medical association (∵ not a member yet) 2. 6 → Academic oriented 3. 1 → Not representative enough 4. 6 → Cannot protect the profession *Impression:* 1. The association does not play its role effectively (comparing with western ones) 2. Professional autonomy is constrained by the State ∵ associations' close relationship with the State 3. Not representative enough → failed to buffer doctor-patient conflicts. 4. Neglected those at entry level who need more attention because of their "freshness". Evidence: "We are in lack of medical association. When holding medical conferences, the China Medical Association (CMA) only invites senior doctors to attend, inexperienced doctors can only rely on universities to improve their knowledge" Doctor05 "Professional association is helpful in	1. All are members 2. All stated that medical association is purely academic oriented that and does not take up any other roles played by the foreign med association e.g. mandating code of ethics/ participating in policy discussion/ protecting the profession/ "spokesman". 3. All agreed that the medical association could contribute to their professionalization by organizing conferences, seminars and lectures for professional exchange. Evidence: "I am a member of the Chinese Medical Association. The medical association is not helpful to our profession. Their main role is to host conferences and seminars which are not significant in advancing our professional standard. The conferences and seminars are open to all no matter whether you are member or not. Hospital would count our credits in continuous learning. Such criterion varies across different hospitals. For example, someone's inviting you to attend a seminar would also count as credits. Some hospitals are more advanced in surgery. You can apply for on-job	1. Not all are members but some are experienced committee members 2. Majority agreed that the medical association is purely academic. 3. Majority commented that the medical association is "useless" for professional development. 4. Only one commented that the association is "useful" to the profession. His senior position in the association committee at national level might be able to explain why he makes such a comment. *Impression:* 1. It seems that the general impression towards the medical association is not too positive in terms of its contribution to the profession in addition to professional development. Evidence: "Chinese Medical Association ("CMA") was formed in 1980. I'm the deputy supervisor of the haemodialysis team of the CMA. Basically, this association organizes seminars and I've the chance to be speaker. In addition, CMA would hold annual meeting and publish journals periodically to enhance the professional knowledge of its members.

	terms of academic learning. They bridge the academic and the practical world together through organizing academic conferences and journal publications. Profession Association: However, I didn't see any effort made to safeguard our rights " Doctor04	exchange to these hospitals. However, you must get approval from your ward and hospital. It is because they are responsible for your salary and remuneration package." Doctor11	Professional Association: However, it does not have the duty to handle mal-practices of its members, a task assumed by Ministry of Health." Doctor20 "I should say, the role of medical association is to organize academic functions like seminars and discussion forum. However, it becomes more & more commercialized. For example, you've to pay money if you want to publish an article. Honestly, when I read an article, I would only read the introduction and the conclusion, ignoring the middle part of the text, as all the statistics are untrue. The author had pre-determined on what the result should be beforehand. He simply made up the result that he wanted. The laboratory works simply did not produce the facts as indicated in their paper. Therefore, I don't read the content which is meaningless " Doctor 28

Table 6.15: Role of professional association from stakeholders' perspective.

Theme	Hospital President (n=3)	Medical Association Representative (n=3)	Patient (n=11)
Association-Profession Relationship	1. Majority explained that the role of medical association is academic oriented though they would also be responsible for medical audit of medical accidents. 2. In spite of these, they are under the State control. Evidence: "Medical association is just a social organization without any political power. It is just responsible for organizing and promoting professional exchange so as to assist our professional development. These conferences and seminar would help to maintain doctors' professional standard. It is because medical association used to organize such conferences or seminar annually with the most advanced professional knowledge gathered from different disciplines. Then they would publish a set of exercise, requesting their members to finish it. If the result is bad, membership will be revoked. " Hosphead01 "Medical association is responsible for organizing conferences and seminar to the	1. All the three revealed the dominance of the State as medical associations do not enjoy any political power but mainly delivering opportunities for professional exchange through seminars and conferences. 2. The medical association could merely protect the profession though they bear the responsibility of medical audit in medical accidents for the State. 3. From the State, prospective, professional associations just act as an institutional tool for monitoring the profession. Evidence: "Medical Association is an organization that has no political power, administrative power, professional authority, and financial management power. It is just a "shadow organization" working for the State. It is insignificant in our healthcare system. It is a governmental organization with a few doctors work for it, but over 90% of staffs are not doctors but civil servant. Therefore, it doesn't have any social function. " Asso01	1. Majority stated that they are "not familiar with the medical association" with some even "have never heard of its existence". *Impression*: 1. The general public is not aware of the function of medical association, not even their existence. 2. There are needs to further empower the medical association in monitoring the profession follows by further promote their role. Once if they are empowered with a clear public image, it might be able to contribute to community and patient education which would be critical factor in reducing medical bullies.

	purpose of professional exchange. Their daily operation cost comes from our membership fees which we could claim back from our hospitals. If anyone complains about medical accidents, there is a subsidiary under each medical association which is responsible for inspection of medical accidents chaired by a group of medical experts. Some of them will take up the role of arbitratorduring the process. The Ministry of Health would be responsible for the final verdict of any medical disputes or accidents. " Hosphead02 "The medical association in China is useless as it's only responsible for technical or experiential exchange among doctors but can not monitor the profession though medical accident audit is also one of its responsibilities…The local medical associations are useless. Related governmental units are limited while the related legislation is complex that it caused enforcement problem. It is difficult to rely on the State to monitor the profession is very difficult It is even impossible to pass such responsibility to the hospitals because of their limited resources." Hosphead03	"Medical associations do not have political power and they could not intervene in hospital administration either. They would be responsible for peers and academic exchange through organizing conferences and seminars so as to advance our professional standard. Secondly, they would be responsible for medical accidents' inspection and assessment. Thirdly, they would be responsible for maintaining the Code of Conduct. " Asso02 "Medical association initially was a local organization and now it is an official organization representing the government because it is monitored and managed by the local medical bureau. The committee of the association needs to go through the process of election. The main role of the committee is to organize gatherings for professional exchange. " Asso03	

Table 6.16: State-profession relationship perceived by doctors

Theme	Age <35 (n=11)	Age 35-55 (n=9)	Age >55 (n=10)
State-Profession Relationship	• All of them stated that they just play a passive role in any policy or reforms implementation. None of them mentioned the role of the State Evidence: "Doctors' role is to execute the reform as front-line staff but we have no say in the policy consultation stage." Doctor07	• Majority commented that the State has been dominant in professional development ever since they entered the profession. Evidence: "All hospitals are managed by Ministry of Health. Under the Ministry of Health, we have the Provincial Health Bureau and local health bureau. Doctors must prescribe drugs available in their hospitals so as to safeguard their patients. The State would be drug merchandizer for hospitals through public bidding. Doctors have no say in drug purchase. They could make suggestions but there is no guarantee that their suggestions will be accepted. However, out-patients could purchase their medicine on their own with doctors' prescription. " Doctor11 "Our management team is affected by the Ministry of Health, while we are not. Since doctors like us are not involved in the management of our hospital, we can exercise autonomy easily." Doctor19 "With regard to power of autonomy, I	1. They respect the State very much because of their experience in Cultural Revolution. 2. They already get used to State- dominant situation since their entry to the profession. 3. One has provided strong evidence on decentralization has happened since 1970s which marked beginning of health reforms planning. It might be able to argue that the State has shifted its monitoring strategy from power- oriented to institution-oriented. Evidence: "I was appointed to the 1st Affiliated Hospital of Sun Yat-Sen University after graduation. In 1971, I was sent to the Guangzhou Chinese Medicine College to attend a course for western-chinese medicine, as assigned by the government, without consultation of the medical profession, trying to mix the application of western and Chinese skills in the health-care profession. I was sent to Dongguan as a teacher during the Cultural Revolution until the revolution ended. I found that, under certain circumstances, western medicine does not produce the desired result. As I'm interested in Chinese medicine and subsequently found that mix application of

		don't think we are in ideal situation. I hope I can broaden and gradually apply my knowledge as a doctor. Due to the interference of the Ministry of Health, the power of autonomy of doctors is affected. The academic effect is obvious in medical science of which foreign governments give little interference." Doctor17	Sino-western medicine was better for healing some kind of illnesses, such as nephritis, I found more interest in and love of my medical career after I won prize on applying the sino-western medical treatment." Doctor24 "Upon the government's implementation of the partial decentralization policy, Sun Yatsen First Affiliated Hospital was allocated with power to run its own business for profit and to defray its own expenses. Therefore the main responsibility of the top management was to focus on the economic and financial development of the hospital. The initial annual income was 40 million to 80 million; 4 years later, we were able to raise the annual income to 200 millions…should be that figure if I haven't mixed it up. Even the current bonus system was established by us at that time. At that time, our department got 6 colleagues responsible for three different aspects including education, research and health care. By now, it involves 6 offices taking these jobs, and each office has at least 5 people! After I returned to Sun Yatsen First Affiliated Hospital, I was promoted as an associate professor within a very short time. There were 4 professors, two of them were responsible for staff development. There were altogether 4 dimensions of work, and we still had to perform diagnosis and inspect the clinical wards. In fact, the problem of dispute between

			doctors and patients existed since the old time. Amongst six of us, two seniors would only involve in really big issues, the remaining 4 of us had to deal with every single incident." Doctor28

Table 6.17: State-profession relationship perceived by stakeholders.

Theme	Hospital President (n=3)	Medical Association Representative (n=3)	Patient (n=11)
State-Profession Relationship	Impression: • Their positions may enable them to have frequent contacts with government agents like local Health Care Bureaus and they can provide more evidences to prove the State dominance in doctors' professionalization. Evidence: "The State takes up the role of healthcare strategic planning at national level and monitors the hospitals through regional and local medical bureaus." Hosphead01 "The relationship between the State and the doctors is that of boss and employees" Hosphead02 "The State is trying to standardize the profession…promotion in top tier hospitals must meet a set of assessment criteria …All these are standardized by the State, both continuous education assessment system and the internal promotion system." Hosphead03	1. All stated that the role of the State to the profession is like a guardian that holds the responsibility of monitoring and educating the profession. Evidence: "The relationship between the State and us is that of boss and workers." Asso01 "It's the State who manages the doctor profession." Asso02 "The State is responsible for managing organizations like a guardian. …Local medical bureau also organizes some activities to allow doctors' professional exchange or to spend a year teaching in suburb areas. The government sometimes also organizes surgical tour for some corporations to pay a visit to our surgical theatre while we are having surgery. The aim is to explore for any insights for future research." Asso03	1. Majority commented that the State is like the guardian of the doctors that holds a dual responsibility in monitoring the profession as well as its development. Evidence: "The State should be responsible for the professional development of doctors by standardizing the whole system of professionalization. " Patient05 "The State should improve the healthcare system. This will help in upgrading doctors' professional ethics and proficiency. Only by providing them with better remuneration under a fair system, the doctors will be willing to fulfill their obligations in ethics and professional development." Patient11

Table 6.18: Future prospects of doctors.

Theme	Age <35 (n=11)	Age 35-55 (n=9)	Age >55 (n=10)
Future Prospects	1. Majority are optimistic. However, the general professional environment is disappointing. Evidence: "I think the road of medical development is bumpy because the government is implementing a stern policy. The future is gloomy. I hope the government can make more announcements, such as, on death of the brain now widely discussed internationally. I also hope the government could promote and clarify doctor's image. On the whole, I'm optimistic about the future of doctors." Doctor10 - Even though only a minority stated that they are pessimistic, their main worries are the current institutional settings within the healthcare sector. Evidence: "I think the current health care situation is really bad because of the controversy. There are still lots of people holding very negative views towards our profession because of the media. For example, they would challenge our services quality. Some of the negative report released by the media just focused on patients' perspective and never sought for our explanation. These further deteriorate the doctor-patient relationship." Doctor04	1. Majority feel optimistic with their profession 2. For those who feel pessimistic with their profession mainly because of the tensed doctor- patient relationship, unsatisfactory reward and the nature of their specialty. Evidence: "I do have hope towards the future development of China's medical professional, as all patients must see doctors. The doctor- patient relation is not good at the moment, while I hope the government would inject more resources in the medical system, I also hope that the tensed doctor-patient relation could be relaxed. Improvement on both of the just aforesaid matters just mentioned will greatly help the development of medical profession." Doctor14	1. Some are optimistic while some are not. 2. Those who are optimistic did not provide a clear explanation. Evidence: "Optimistic. If not I won't be requested to continue my job after retirement. " Interview27 3. Those who are pessimistic mainly because of their disappointment with the low remuneration package and tensed doctor-patient relationship. Evidence: "As the doctor-patient relation is deteriorating and every doctor is losing his zest and earnestness in his work, I don't have hopes in the future of this profession. " Doctor2

CHAPTER 7: OBSERVATIONS AND REFLECTIONS

After providing a clear picture of the professionalization of medical doctors in the China, this chapter will focus on the implications of the findings of this study. Specifically, it will examine the institutional settings of the medical profession in China in a comparative perspective. The main objective is to detect the Chinese characteristics in the pathway to professionalization in order to fathom out how far the medical profession in China has been professionalized. On this basis, it will consider existing institutional constraints that may hinder the development of the medical profession and frustrate the progress of professionalization. Finally it will reflect the theoretical and practical implications of this research.

7.1. Professionalization of China Medical Doctors in a Comparative Perspective

In many respects, the development of the medical profession in China has had elements in common with the West. Here the West would refer to theoretically west in general under democratic political system but not particularly pointing to any particular nation. Comparing the medical profession in China with that of different political system can reflect different healthcare structure and professional development of the medical doctors. This assumption is built upon the theory of institutional theory as discussed earlier. The West as I referred, within the profession of medical doctors, has in general standardized university education programs, instituted a licensing examination, established national and local medical associations, and adopted a code of ethics. However, as revealed from the interviews, the medical profession in China appears to face greater restrictions

when comparing with that of the West.

7.1.1 Different from the West – Constraints from three dimensions

This section will examine the constraints faced by the medical profession in China with the focus on professional autonomy. In Freidson's (1988, 2001) ideal model of profession, professional autonomy is the key criterion for assessing whether a profession is on a healthy path of professionalization. Before evaluating the professional autonomy of medical doctors in China, it would be helpful to take a closer look at the role of the medical profession.

Hierarchical constraints. Hierarchical constrains refer to the institutional pressure derived from the State, the regulators (Adler, et. al., 2008). Like other professions, medical doctors in China served as "state workers" for the State to achieve socialist ideals in Mao's era (Gu, 2001; Lo & Snape, 2005). However, they are no longer "state workers" in the post-Mao era as the State has gradually rolled back to steer China away from a planned economy. Nor have they become private (or self-employed) medical practitioners which is still a new concept to the community of medical doctors as well as to the general public under market reforms. Instead, their identity has been changed to a "unit-based employee", serving the interests of the hospital they are employed. Though the hospitals are state-owned, as the front-line workers in the provision of medical services under the national healthcare policy, the majority of the medical doctors have found that politics is no longer in command in their workplace: their link to the state has been increasingly remote and the political content of their operation has been greatly diluted. Such sense has become stronger as market reform advances.

Although individual medical doctors can now work more autonomous from political scrutiny and administrative control, the medical profession is still under the "tutelage" of the state, both at the policy and operation levels. Though the top-down approach of organizing the medical profession has been liberalized as the process of professionalization progresses, it still imposes a lot of hierarchical constraints on the medical profession's toward independence, autonomy and self-regulation.

To a larger extent, the hierarchical constraints on the medical profession in Western contexts are less influential. The bottom-up approach of organizing the medical profession has allowed the medical doctors to perform their professional role and exercise strong political influence. The profession is empowered by the constitution to be self-governed from which individual professionals derive a higher degree of professional autonomy. For example, they can freely express their concerns in both national and local health care policies through different channels. The medical professional associations operate independently with full autonomy free from government intervention. Most notably, all committee members are elected by members without any government representatives there. The birth of the Charter of Medical Professionalism is an outstanding example, which has drawn the attention of medical doctors from the U.S. and the U.K and provided them with support to advocate professional commitment in patients' welfare and social justice (c.f. Sox, 2002). Comparatively, professional association in the Western world enjoys a higher degree of professional autonomy though there are increasing numbers of lay people being involved in the decision-making on policy issue. As addressed by Irvine (2001, 2004), the UK

parliament is always upholding skeptical attitude towards the profession especially after some recent dysfunction medical cases which aroused public anger. To cope with a more harmonized relationship with the State and the public, the professional bodies including the associations are having more lay people who are to some extend influential in their operational policy matter. Under such empowerment of parliament's influence over the profession, the professionalization of Western doctor is fulfilling the hidden hierarchies of professionalism proposed by Gilb (1960) -- government, the profession and the community (which refers to the public) form the iron triangle with professionalism upholding in the middle. To modernize the profession and better boost the professionalism, Western doctors in the twentieth century also promulgate the necessity of increasing state intervention on professionalization. As commented by Jenkins (2006), though in the UK the General Medical Council which enjoys a more influential role in national level issues has put huge efforts on professionalism development, the author emphasized that the State which points to the Ministry of health and individual doctors' involvement are still crucial.

Community constraints. Community constrains means the pressure caused by peers' practice, the existing professional rituals, values and beliefs within a profession (Adler, et. al, 2008). With the working identity now as "unit-based employees", it actually limits doctors' in-ward diagnosis decision-making power. Under this identity concept, Chinese medical doctors are described as "servants" to serve the interests of the hospital, the State and the general public according to the interpretation derived from their definition of a doctor's role in the *Law on Practicing Doctors of the People's Republic of China* (1998: Article 3). Even

today, Mao's legacy of popularity persists because the State sees serving the public as the primary function of medical doctors (e.g. "Doctor's role is saving the death and healing the wounded." by Doctor04). Compared with the definition of medical doctor in the West, the Chinese one is still remaining at the technical level within the profession while the Western one gets a broader definition which covered community dimension – "advocacy for and participation in improving the aspects of communities that affect the health of individuals" (Gruen, et. al, 2004). The interests of the profession itself are effectively subordinated to the community medical well-being. Indeed, "ox" is the term used by the medical association person we interviewed to describe the professional status of Chinese medical doctors in a sarcastic and cynical way. This term has captured the hardship of Chinese medical doctors that the remuneration is not totally commensurate with their efforts on professional trainings and the level of workload. The "public-ness" or the socialist nature of medical profession has made the profession move from the confine of the state in the past to that of the society today – the profession and the professionalization cannot be detached from the community from which they should derive their professional identity. Under the socialist mode of thinking, the ideal of profession for itself is still a dream for Chinese medical doctors.

As the medical profession is kept in the public domain with the value and remuneration strictly defined by the State and increasingly by the community, it will be difficult for Chinese medical doctors to acquire their market value as their Western counterpart can do. The gap between market value and community value may not be easily bridge: the general public asks for medical care, with best

quality and good services at a lower price. The term "ox" also best reveals the difficult path to being a medical doctor in China: it demands someone with a high level of intellectual ability to spend huge efforts for years to acquire the qualification of the knowledge intensive profession of medical doctor – no easier than the path in the West (Freidson, 1988). The grievances from our doctors are clearly that their hard work and contribution are not properly rewarded in the way as the medical doctors in the West are. This lack of proper reward is very discouraging for them and they had a lot of as complaints about their low income during the interviews, as an doctor (Doctor 09) stressed that they [medical doctors] were not saints but still had to satisfy their basic needs before they could serve the patients. The adverse effect on the morale of the medical profession was already there.

To balance the interest (and power) between the medical profession on the one hand, and that the State and society on the other hand, the empowerment of the medical associations as the guidance of medical doctors may be a way out. This will transform medical associations from state agents to representations of the organized interests of the medical profession which will allow the profession to cope with community pressure collectively and medical doctors to conduct the so call "collective bargaining". In the long run, having its own vehicle for the medical profession to pursue their interests will make it feel less inferior and less powerless, and this will be helpful to create a harmonious relation with the state and the public. Thus some of the doctors expressed their wishes that the medical associations could fight for their interests and protect their rights. However, the role of medical associations in China is currently only restricted to academic

purposes like the provision of continuous professional trainings for medical doctors and the organization of conferences and seminars. Never have they been given the opportunity to participate in policy-making. Because of these limitations, some medical doctors in the interviews pointed out that these medical associations could hardly protect the profession from the arrogance of the state and the public pressure. Instead, doctor told us that it is "the responsibility of Ministry of Health" to protect doctors' professional interests and uphold their rights.

This is another big contrast with the Western practice as medical associations in the West serve primarily as the professional unions of the medical doctors instead of the agents of the state or the community. They are the manifestation of profession in itself which almost single-mindedly works to protect the rights and interests from the coercion of the state and society. The stress on market value instead of community (or state) value of the profession within the framework of professional ethics has enabled the medical profession relatively free from community constraints to pursue their own professional value and aspirations.

Market constraints. Market constraints can be defined as force induced from end users and competitors (Adler, et. al., 2008). Despite the rapid professionalization of the medical profession after its restoration in the post-Mao era, the professional status of medical doctors has not been recognized by the State and the general public. The perception of a lower economic, political and social status among the doctors has fully demonstrated their frustration. From the patient's perspective, the role of medical doctor is primarily a tool to cure their illnesses, that is, the provision of timely medication and effective treatment. Error in the medical and

treatment process is strictly unacceptable. Although this is also what the patients in the Western countries ask for, patients in China today are strictly transactional without much consideration given to medical doctors. However, unlike the West, Chinese patients have an irrational demand for absolute recovery and that natural illness deterioration is also unacceptable. This client-centered approach has created much hostility and suspicious toward medical doctors. At the same time, Chinese medical doctors are hampered by resources constraints, shortage of manpower, inadequate medical facilities, heavy workload, the unreasonable medical-fee charging system, and most frustration of all, the pressure to generate income to allow them perform well and to take care of the psychological feelings of their patients. All of these have made them less able to win the mind and heart of their patients.

The emergence of a client mentality among Chinese patients resulting from the introduction of medical fees under the market reform has made them increasingly demanding to the quality of medical services and the professional standards of medical doctors – we pay for the medical treatment! The consequence is the oversubscription to medical services of top-tier hospitals and the long queue for well-known medical doctors. A lot of conflicts between medical doctors and patients have been created under this stressful situation of excessive demands. For medical doctors, the long working hours and the overloaded consultation sessions have severely affected their working mood and performance. They complain about shorter time for each consultation session, less time for rest, no spare time for self-improvement, and most of all, no reasonable income commensurate with their work. On the other hand, patients' complaints are mostly related to long

waiting hours, short consultation session and not well-attended, limited access to well-known doctors, unnecessary medical treatments and tests, expensive medicine, and most of all, long medication process. As observed by one of the medical association representatives, the key role of medical doctors today is "actuary" which has vividly described their "new" job function resulting from the implementation of healthcare financing reform (e.g. medical savings accounts and social security scheme). The growing market awareness of the patients has to a considerable extent led medical doctors to play safe in their diagnosis and treatments for their patients – this has indeed become another source of doctor-patient conflict. As a whole, the healthcare reform with the current financing system and charging arrangements has not improved the working environment of medical doctors or allowed the patients to receive better medical services. Rather, these measures have restricted the market autonomy and hence the professional autonomy of medical doctors in the pursuit of their market and professional value

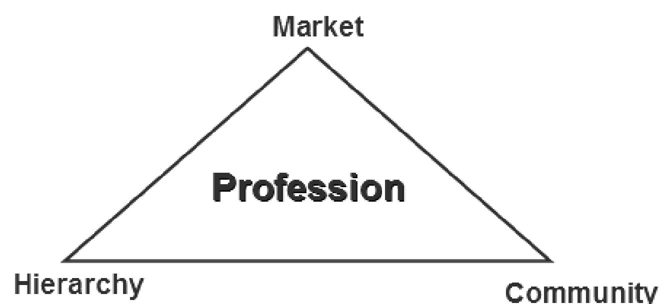
These imperfect market developments have highlighted the difficult path of institutional development of the healthcare sector in the post-Mao era: the healthcare reform has transformed the centrally-planned and hierarchically structured healthcare system to one with market ingredients on the demand side. The reform initiatives such as medical savings account and the social security policy introduced in late 1990s has made patients adopt a client perspective to see their relation with medical doctors and their use of medical services. However, the slow progress in the market reform of the state-owned structure of the healthcare sector, together with government's cut in of its resource support to the healthcare

service, has rendered hospitals and medical profession shortage of resources to satisfy patients' increasingly high expectation and growing appetite for service quality. The state is even slower to grant market autonomy to the medical doctors who have now found that they have been consistently overstretched by both of the state and the community without getting a fair pay in terms of their market value. The limited introduction of privatization in the supply side has created a market situation unfavorable to medical doctors who are now facing a two-front war. On the one end, they are battling for greater resource support from the state which has been disengaging from its full financial commitment to the healthcare sector. On the other end, they are struggling hard to provide market-standard service to the seemingly insatiable patients who have increasingly seen themselves empowered as clients in the healthcare system. In short, the health care reform has redefined the tripartite relations among the State, the medical profession, and the patients (or the community) in such a way that no party is happy or the winner. How to handle these awkward relationships with tremendous pressure from both the State and the patients while keeping the professionalization progress has constituted the major challenge to the medical profession.

Reflections and Observations. From what have been mentioned, unless the three parties, i.e., the State, the medical doctors and the patients can interact with each other in harmony within the healthcare system, it is difficult for the medical profession to progress smoothly in the professionalization process which is beneficial to society as a whole. This perspective of analyzing their subtle relations is put forward by Adler, Kwon and Heschker's (2007: 2) ideal model of profession, as illustrated in Figure 8 below. He argues that a harmonious relation

can only be achieved if the hierarchy, the community and the market could appropriately perform their respective functions: the hierarchy (that is, the State) should cultivate the professional identity through the exercise of its power to establish professional standardization. Only strong institutional settings could grant the professional the authority of knowledge monopoly; the community should engage itself in knowledge advancement and maintain the professional ethics through the building of trust with patients which can serve as an intrinsic motivation for professional innovation and professional well-being ; and the market should regulate the profession and provide them with necessary extrinsic motivations through the use of the pricing system. From the institutional perspective of Friedson (1998, 2001), the institutional setting of these three different dimensions will form the foundation of the professionalization of medical doctors.

Figure 7.1: Adler, Kwon and Heckscher's ideal model of profession (2007):



7.1.2. Institutional Constraints for the Medical Professional in China: the Legacy of the Planned Economy

This section will focus on the institutional constraints on the medical profession in

China. The planned economy under the Communist totalitarian rule of Mao had inhibited the growth of the profession more than fueled the professional development of medical doctors. This miserable historical development for the medical profession in Mao' China is not strange from the Western perspective as the presence of a market economy is always considered as a precondition for the healthy growth of a profession.

Since the introduction of market reform in the 1980s, the role of the State has gradually rolled back in its public domain but it has still maintained a high degree of control over the healthcare sector. From the interviews of medical doctors, particularly those from the middle age group, we have come to know that government intervention in the medical profession has not been reduced and it has left little room for professional autonomy and independence. On the positive side, medical doctors, with state sponsorship, can enjoy a more structured post-graduate training, as government funding is the most crucial sustainability of any post-graduate fellowship. The fellowship arrangement is important as it is a basis for medical students to cultivate a social network of *guanxi* for the development and advancement in their eventual professional career. The fellowship may loosen the implementation of professional standard as it put more emphasis on supervisor-student *guanxi which is also supposed to play* an important role in the professional community. As interview evidence shows, a medical doctor usually choose the same specialism as his/her supervisors. They will then work closely with their supervisors, from organization to organization, in the early stage of their career. It is always the case that if a hospital can keep the supervisors working for it, their students will stay with them. Such a *guanxi* creation system

will give rise to a high mobility of medical doctors especially after the implementation of privatization of hospitals. That is, if supervisor is being hunted to another hospital, his or her students would also quit their post and follow. With urgent needs of experienced renowned doctors from top-tier hospitals to cope with the expansion, private hospitals very often offer much higher remuneration package to them. With much better remuneration offered by the private hospitals and relatively less workload, experienced senior doctors, as targets of head hunting, are likely to accept offers. Hence, once a private hospital can successfully recruit an experienced senior doctor, it means the hospital can own a whole team of professional junior doctors lead by this experienced senior doctor. This directly affects the retention rate of top tier public hospitals. High retention of medical doctors in the state-owned hospitals is important for maintaining the stability of manpower and the service quality. Such a phenomenon of fellowship-driven mobility may not appear in the West within a market context.

Another constraining factor is the fixed-price policy under which all public hospitals are not allowed to set up their own pricing system for all services and treatments provided. They have to follow the price list fixed by the State. The listed prices are normally affordable for the general public and far lower than those listed in private hospitals but can hardly cover the cost induced. Such fixed-price policy for the provision of medical service implemented under healthcare reform has brought adverse impact on the professionalization of medical doctors. This fixed-price policy prescribes hospitals to charge low and uniform fees for providing medical services to their patients. The situation is worsened as the healthcare sector has had their budget cut by the government. The

consequence is that most hospitals have encountered financial difficulties in offering their medical services in a high standard, effectively and efficiently. More difficult is to provide a decent salary for retaining high quality medical doctors and allowing them to focus on their medical works. This financial stress has directly affected the works of the medical doctors as they are now required to take up the burden of income generation. To earn more money for supporting the operation of their hospitals, medical doctors have been indeed performing the function of “financial planner” for the patients making them look more than a professional “actuary” than a professional medical doctor. Such a non-professional-related task has taken up much of doctors’ time and attention. Therefore the marketization of the demand side with corresponding measure to marketize the supply size is problematic to the operation of the health care sector and detrimental to the medical profession, unless there is adequate resource support from the government to realize the market value of medical doctors, as governments in many developed countries have done. The majority of our doctors therefore support marketization of the healthcare sector in order to introduce market mechanisms to regulate the existing uneven demand of the healthcare services among hospitals and workloads among medical doctors. Only when medical care provision is under market force will medical doctors be able to receive better resource support for improving their medical practice and upgrading their professional quality.

However, a complete marketization of the health care sector is equally undesirable, as Adler and associates (2007) warned that this would give rise to commercialism of medical services. The unhealthy tendencies of commercialization which make

medical doctors single-mindedly go for money earning in their medical practices will bring disastrous effects to the medical profession by damaging the caring image and hence the professionalism. “Heart” is still the very essence of the medical profession which should under no circumstance be compromised to “money” in the delivery of medical service to patients. Therefore, there should be a proper check and balance among the three dimensions of the hierarchy, the community and the market to prevent the appearance of extreme situation – the domination of the hierarchy will restrict the autonomy and independence of the medical profession, the over-stress on the community interest will render medical care as community service, and excessive commercialization will vulgarize medical doctors as money-seekers. All these situations are not conducive to the healthy growth of the professionalization of the medical profession.

7.1.3. Different Institutional Features of Medical Profession in China

The Role of the State. In the professionalization of the medical profession, not much effort has been made by the State to standardize university medical education with attention given mostly to the strategic direction for the improvement of national health. The resumption of post-graduate 7-year programs for medical graduates since 1980 (Jin, 2004) has provided a learning path for them to pursue further education and receive research training in different medical fields. All the medical doctors from the middle and youngest age groups interviewed have indicated that they were benefited from the institutionalization of postgraduate medical programs. However, there were criticisms that the current university medical trainings are too theoretical with limited practical relevance during internship. Because of the neglect on medical practice, the doctors

expressed their concern about the readiness of fresh graduates from university medical programs to go for clinical practices and criticized their limited ability to deal with contingent medical situations. This opens the doubt for the professional standard of medical graduates and at the same time, questions the appropriateness of university medical programs to provide sound professional training.

The introduction of the seven-year medical program in which a medical student can go straightly for the study of a master degree without interruption after the completion of the five-year undergraduate study is aimed at lifting the professional quality of medical doctor through formal training. To a certain extent, the provision of this avenue has encouraged medical students to plan a longer term for their career in order to get better equipped for clinical practice. At the same time, there is an option of being a medical researcher as their career. Evidence from interviews shows that medical doctors are highly altruistic, giving a lot of care to their patients. Though with rather unsatisfactory economic status, doctors seemed to bear higher altruism as they enjoyed higher social status and respect from patients. This social respect is an important source of spiritual support for medical doctor to sustain their enthusiasm for continuous improvement of their professional quality. The synergetic effect is that the effort of their professional well-being has furthered received trust and praises from patients. This positive interaction will help to cultivate a better doctor-patient relation. We judge that the trust and respect from patients is a motivating factor for medical doctors in their pursuit of professionalism. Below table listed career motivation derived from job satisfaction as stated by doctors in different age groups:

Table 7.1: Career motivation derived from job satisfaction of doctors

Age Groups of Doctors		
<35 (n=11)	35-55(n=9)	>55(n=10)
I am satisfied currently with my living and my job. [Doctor 01]. The most satisfactory experience is when I saw patients were in critical state when they were admitted but then recovered and in perfect state when being discharged [Doctor 02]. I could attain great job satisfaction as my patients like me and being a doctor is also my favorite occupation. [Doctor 03] I am satisfied with my current work as I could apply what I learned and the professional level I could achieve. [Doctor 04]. Being a doctor, I would be satisfied if I could cure my patients with full recovery. [Doctor 06]. For doctors, there is nothing that can override the major premise of healing patients. [Doctor 07]. I like my profession simply because I can cure and save people's life. [Doctor 08]. I'm satisfied with my profession because I'm a surgeon as well as a physician. When compares with smaller hospitals, the professional level of our hospital is a lot higher. I feel very satisfied when patients give me favorable comments. [Doctor 10].	I could attain job satisfaction when my patients are discharged after recovered. [Doctor 11] I feel good as I can walk through my patients' recovery. [Doctor 13]. I feel very happy when I cured those patients who are seriously ill. [Doctor 14]. What satisfied me is the feeling similar to creation of a piece of art when I completed a medical operation successfully for a patient. It derives much satisfaction when patients recovered as expected. In between the process, it just likes creation of a perfect product. [Doctor 15]. I feel satisfied as a medical doctor. It is difficult to describe the feeling when I cure patients. This may be enjoyment of work. [Doctor 16]. I am happy when I cure my patient. [Doctor 17]. I'm cheerful and happy when I find out what's wrong with a patient and cure him. [Doctor 19].	…, as being able to save life is the source of my satisfaction. I feel enthusiastic and happy as long as I'm a doctor. [Doctor 20] I feel happy if I can cure my patient. [Doctor 21] Now, I'm satisfied to have retirement benefits, can have meals and get pay. [Doctor 22] I'm fully satisfied when I cure my patients. [Doctor 23] As conditions for patients would return closely to normal after kidney transplantation; I therefore like what I do at the moment. [Doctor 25] All in all, I'm satisfied with my status quo. [Doctor 26] I feel happy whenever I cured my patient. [Doctor 27] Being a medical doctor had made my live very satisfactory. … The most important is I have lots of friends. Being a doctor, my colleagues treat me as their role model. [Doctor 28] I'm happy I can be a doctor for such a long time. I felt most satisfied whenever my patients recovered. I was greatly respected by my fellow villagers. [Doctor 29]

Medical Professional Bodies. One of the major criteria for measuring the professionalization of the medical profession is the degree of its professional association to perform self-regulation of the profession. In Western countries, most notably in the U.S.A. and the U.K., the medical associations are independent of the government and are highly autonomous from its domination. At the same time, these medical associations perform an influential role in the policy process of medical and health care. For example, the American Medical Association plays actively the role of developing position paper on how the health system should be organized and operated. As for the British Medical Association, they manage financial affairs like National Health System (NHS) pension scheme for their members and play an active role to protect the profession.

In contrast, both the Chinese Medical Association and the Chinese Medical Doctor Association are under close supervision of the Ministry of Health. Although the top management personnel like the chairman and the deputy chairman in these two associations are elected by their members, their appointments have to be approved by the Ministry of Health. The associations serve mainly as a government agent for promoting the core values of the medical profession as well as lifting the professional quality of medical doctors through the organization of lectures, seminars, in-ward practicum, and medical publications. With the intensification of conflicts between medical doctors and patients, the associations also provide a platform for medical doctors to seek for peer assistance, advice and possible solutions. Unlike medical associations in the West, the Chinese Medical Doctor Association which was established in 1995,

does not have much influence on issues relating to the medical profession issues. The Chinese Medical Association (CMA) was established in 1915 and enjoys a longer history than the Chinese Medical Doctor Association (CMDA). It serves mostly the academic purposes of coordinating the publication of medical journals as well as organizing and facilitating professional exchanges among local and overseas medical doctors through the organization of domestic and international medical conferences. Different from CMDA, CMA also bears the training and assessment responsibilities for doctors who would like to further immerse their expertise. Therefore the role of medical professional associations in China is quite narrow in their contribution to Chinese medical doctors.

From the interview data, it is noticed that the role of professional associations for the medical doctors in China is not untypical. Instead of mimicking the western ones, the Chinese professional associations for medical doctors are just "representative organization" under state corporatism (cf. Gu, 2001; Unger & Chan, 1995). Nonetheless, it is still able to make their contributions to the professionalization of the Chinese medical doctors in terms of academic quality through the organization of research seminars and academic conferences. However, from doctors of the youngest age group, we find that medical students can only join the associations after they have got their licenses for medical practice while student membership for medical student is available in the West. Interestingly, medical doctors from the middle age group pointed out that one is eligible to attend functions organized by the associations after passing the qualifying examination and having got the license without being a member. On the one hand, they set entry barrier for medical students, while, on the other hand,

they are not strict in membership requirement for experienced and licensed doctors. It seems that the associations employ different yardsticks in membership recruitment and such an inconsistence could make doctors confused with their professional identity. Shared by the doctors from the youngest age group, medical students in China would not be able to attend these lectures and seminars for building their professional quality. This explains why the professional development of medical doctors has been stuck in the mud. As for protection for the professional interests of medical doctors from medical associations, only one out of thirty doctors said that the associations could somehow protect the profession while the rest considered that the associations could hardly protect the profession. Because of the weak position of these professional associations to protect the interests and the rights of medical doctors, a large majority of medical doctors interviewed pointed out that they would be highly cautious in their medical practice and would play safe in diagnosis and treatments to their patients. This is perhaps the best way to protect them from causing any trouble and disputes in a deteriorated doctor-patient relation. Below table listed comments addressed by doctors interviewed from different age group regarding their view on association-professional relationship:

Table 7.2 – Comments on Association-Professional Relationship as per Doctors

Age < 35	Age 35-55	Age >55
1. Doctor 04 → not clear about the role of medical association (∵ not a member yet) 2. Doctor 06 → Academic oriented + Cannot protect the profession 3. Doctor 01 → Not representative enough *Impression:* The association does not play its role effectively (comparing with western ones) 1. Professional autonomy is constrained by the State ∵ associations' close relationship with the State 2. Not representative enough → failed to buffer doctor-patient conflicts. 3. Neglected those in entry level who need more attention because of their "freshness". Evidence: "We are lack of medical association. When holding medical conferences, the China Medical Association (CMA) only invites senior doctors to attend, inexperienced doctors can only rely on universities to	1. All are members 2. All stated that medical association is purely academic oriented that do not involve any other roles bear by the foreign med association e.g. mandating code of ethics/ participating in policy discussion/ protect the profession/ "spokesman". 3. All agreed that somehow the medical association could contribute to their professionalization by organizing conferences, seminars and lectures for professional exchange. 4. *Impression:* 1. It seems that in general impression towards the medical association is not too positive in terms of its contribution to the profession other than professional development. Evidence: "I am a member of the Chinese Medical Association. The medical	2. Not all are members but some are experienced committee members 3. Majority agreed that the medical association is purely academic. 4. Majority commented that the medical association is "useless" for professional development. 5. Only one commented that the association is "useful" to the profession. His senior position in the association committee in national level might be able to explain why he makes such comment. *Impression:* 1. It seems that in general impression towards the medical association is not too positive in terms of its contribution to the profession other than professional development. Evidence: "Chinese Medical Association ("CMA") was formed in 1980. I'm the deputy supervisor of the haemodialysis team of the CMA. Basically, this association organizes seminars and I've the chance to be speaker. In addition, CMA would hold annual meeting and publish journals periodically to enhance the professional knowledge of its members. Professional Association: However, it does not carry a duty to handle mal-practices of its members, a task

improve their knowledge" Doctor05 "Professional association is helpful in terms of academic learning. They bridge the academic and the practical world together through organizing academic conferences and journal publications. However, I didn't see any effort made to safeguard our rights " Doctor04	association is not helpful to our profession. Their main role is to host conferences and seminars which are not significant in advancing our professional standard. The conferences and seminars are open to all no matter whether you are member or not. Hospital would count our credits in continuous learning. Such criterion varies across different hospital. For example, someone invite you to attend a seminar would also count as credits. Some hospitals are more advanced in surgery. You can apply for on-job exchange to these hospitals. However, you must get approval from your ward and hospital. It is because they are responsible for your salary and remuneration package." Doctor11	assumed by Ministry of Health." Doctor20 "I should say, the role of medical association is to organize academic functions like seminars and discussion forum. However, it becomes more & more commercialize. For example, you've to pay money if you want to publish an article. Honestly, when I read an article, I would only read the introduction and the conclusion, ignoring the middle part of the text, as all the statistics are untrue. The author had determined on what the result should be beforehand. He simply made up the result that he wanted. The laboratory works simply do not produce the facts as indicated in their paper. Therefore, I don't read the content which is meaningless" Doctor 28

As the aggravating doctor-patient relation has led to the increase of medical disputes between medical doctors and patients, the State should grant Chinese Medical Association a higher degree of autonomy to serve the professionalization of medical doctors. A more authoritative CMA would help to lift professional status and strengthen professional identity of individual medical doctors. With a more prestigious professional body behind them, medical doctors could stand in a stronger position to command greater respect from their patients which would be conducive to the cultivation of a more amicable doctor-patient relation to reduce unjustifiable accusations. In this way, it helps to promote the morale of medical

doctor. Such an action would significantly balance the mediating role in handling medical accidents and monitoring role in doctor's professional ethics of the professional associations under a socialist market economy.

7.1.4. Medical Profession in 2012 China

In recent two years, the Chinese government kicked off another stage of medical reforms with revised policies launched. Among all, there are two major changes which will bring significant impact on professionalization of the medical profession.

According to the most recent reform announcement made by the Ministry of Health by the end of July, 2011, the State would like further develop a system for general practitioner (GP). The contents of the announcement provide professional advice on different aspects. For example, a medical program to support the training of GP will be implemented. It is a 5-year foundation training on medicine, followed by another 3-year GP training. GPs will still receive regular income as a registered practitioner while the additional 3-year training will be paid by the State. A professional association for the GPs will also be established, and it is expected to play a similar role as the general medical association.

Another key advice included is the local healthcare policy revision which provides job security of the GP graduates. GP graduates will be allowed to work in lowest tier hospitals either full-time or part-time. By linking up the GP profession through a written agreement between the local government bureau and the local citizens, GP graduates can also provide healthcare service either in form

of individual practice or by forming a team of healthcare profession available in lower-tier hospitals on their own. Their income will be secured by the fixed-term return from patients' medical saving accounts. Those in backward areas where the general living standard is lower will receive government subsidy.

In addition to preparing a new syllabus to train up GP from freshmen, the State also provides top-up course for existing doctors working in rural or low tier hospitals. This allows them to gradually turn to be a GP through the top-up course and with on-job training in parallel. By doing so, it can help to close the gap of manpower shortage before the first batch of GPs are qualified to serve the community.

The above new policy sets a milestone for the professionalization of medical doctors in China. Playing a dominant role, the State is highly influential as a booster of doctors' professionalization in form of policy setting. Through increasing the number of GP and providing job opportunities for them, the foreseeable impact on national healthcare system is to promote the provision of preventive care at the national level.

CHAPTER 8 CONCLUSION

This thesis studies the medical profession in China with a focus on the professionalization of medical doctors in the post-Mao era. Historical review has shown that the medical profession had been under the tight control of the Communist state to achieve the Mao's romantic revolution ideal of popularity and simplicity. The medical profession was inevitably deprofessionalized and medical doctors were treated as healthcare workers to serve for the mass. With the rise of Deng's socialist modernization in the post-Mao era, the medical profession was restored as the revolutionary fever was replaced by a pragmatic approach of state-building. The national healthcare reform has made the professional of medical doctors revive and proceed steadily under State guidance. As Mao's hostility toward professionalization has gone, institutional infrastructure for rebuilding the medical profession has taken shape with the stress now on the professional training and professional quality of medical doctors. The marketization of the socialist economy has produced mixed impact on the medical profession as a whole and individual medical doctors' professional career. Nevertheless, both the nature and content of the state-professional relation has undergone qualitative changes despite the State has maintained a close touch with the profession, most notably from suppressing professional growth in the past to sponsoring professionalization in the current development.

The interviews of thirty medical doctors in major hospitals in Guangzhou have allowed us to look closely the professional path of medical doctors, their career plans, their professional commitment, as well as their professional expectation.

Doctor's career path and their career plan are similar to those in the West as both must undergo a long medical education, sit for qualifying examining to get licensed and be engaged in life-long professional development. In terms of professional commitment, the young Chinese doctors seemed to be less committed to their profession but the majority of them still have displayed rather strong professional commitment though optimistic professional expectation has served as a solid proof. Further empirical research is therefore still needed for validation purpose. On this basis, we can see that medical profession has been rebuilt, that the community of medical professional has already emerged, and that professional development has received wide support. However, under the influence of the state and the thrust of market force, Chinese medical doctors have yet to develop a strong sense of professional identity. The sense of profession in itself and for itself has far from being established as the medical profession has not been granted full autonomy and independence. The professional standard, quality, integrity of individual medical doctors have been openly challenged with the growth of a client orientation and an aggravating doctor-client relation. The market path of healthcare reform has strained of the medical sector rather than increased the resource support to it. The relatively low self perceived political, social, and economic status among the medical doctors interviewed has revealed that they are psychologically uncomfortable with current path of professionalization. Professionalization with Chinese characteristics may be necessary but should not be pursued to the detriment of the well-being of the profession, nor less should it create uncertainties and perplexities among individual medical doctors concerning their professional career and future development. However, there are more opportunities than threats for the medical

profession in a changing institutional environment marked by the decline in the arrogance of the state, the increase in the pressure for the Chinese medical field to align with international practices, and the growth of market force in the medical sector. Here, we find this same sentiment among the doctors as most of them hold an optimistic, though cautious view on the future of the medical profession and the prospects for professionalization.

The interviews of different stakeholders have provided much insight to our observations. It indicates the growing expectation from medical doctors, that is, the provision of personalized healthcare, result-oriented medical treatment, and high service quality. The current tension in the doctor-patient relation has negatively affected the professionalization as the lack of trust from patients and the public has undermined the morale and the enthusiasm of medical doctors. The term “ox” also best reveals the demanding path to be a medical doctor in China: it demands someone with a high level of intellectual ability to spend huge effort on hard work for years to acquire the qualification of the knowledge intensive profession of medical doctor – by no mean easier than the path in the West (Freidson, 1988).

In some respects, the professionalization of medical doctors in China has had elements in common with the West. However, medical doctors have only been granted limited autonomy under the domination of the Communist state. The State-driven professionalism has focused mostly on the public interests in terms of professional standards and service quality without much concern over developing the profession for itself. To align with international norms, the State has basically

followed the institutional roadmap adopted by Western countries for the professionalization of the medical profession in China, but made it serve the policy objective of the state and subordinated it to the interests of the state. The professionalization of medical profession in China is by no mean straight-forward when one considers the institutional constraints from the hierarchy, community and the market:

Hierarchical constraints. Though the top-down approach of organizing the medical profession has been liberalized as the process of professionalization progresses, it still imposes a lot of hierarchical constraints on the medical profession's move toward independence, autonomy and self-regulation.

Community constraints. The interests of the profession itself are effectively subordinated to the community medical well-being. The profession and the professionalization cannot be detached from the community from which they should derive their professional identity. The gap between market value and community value may not be easily bridge. To balance the interests (and power) between the medical profession on the one hand, and that of the State and society on the other hand, the empowerment of the medical associations as the guidance of medical doctors may be a way out.

Market constraints. As a whole, the healthcare reform has restricted the market autonomy and hence the professional autonomy of medical doctors in the pursuit of their market and professional value. How to handle the awkward relationships with tremendous pressure from both the State and the patients while keeping the

professionalization progress has constituted the major challenge for the medical profession.

From what have been mentioned, unless the three parties, i.e., the State, the medical doctors and the patients, can interact with each other in harmony within the healthcare system, it is difficult for the medical profession to progress smoothly in the professionalization process which is beneficial to the society as a whole. Thus, only strong institutional settings could grant the professional with authority in terms of knowledge monopoly; the community should engage themselves in knowledge advancement and maintain the professional moral through the building of trust with patients which can serve as an intrinsic motivation for professional innovation and professional well-being; and the market should regulate the profession and provide them with necessary extrinsic motivations through the use of the pricing system.

To conclude, the western model of medical professionalization may not be fully applicable to the medical profession in China under different institutional settings. The role of the State is still salient in the future development of the medical profession, despite the growing marketization of the socialist. The rise of a consumer-orientation among patients may create greater pressure on the medical profession for further professionalization in term of professional quality and integrity. Rather than mimicking the Western historical process, the Chinese medical profession should find their own path and direction to reach the destination of professionalization under the tutelage of the State guidance as market stimulation remains limited.

This study has provided a snap-shot of professionalization of medical doctors in China with a lot of insights and sound observations. However, its small scale with one-city focus may limit the generalizability of its findings. On top of this, the time frame of data dated back to 2007 to 2008 while the institutional settings of the medical profession has been changing along with series of new healthcare reforms being kick off. Hence, more research has to be done in the future to provide a stronger empirical basis for a more conclusive understanding of China medical profession. Since stakeholders still missing academics and government officials due to difficulties incurred in approach them without relevant network, it is also suggested to include them as their opinions would be insightful in future research.

To further enrich current study, it is suggested to investigate the degree of professional commitments among the Chinese doctors by applying Meyer & Allen's (1993) three-component model. The survey result is believed to be able to enrich the current analysis of the professionalization of Chinese doctors. Because investigation of professional commitment is believed to be a significant indicator of how deep the Chinese doctors are being professionalized, as Lo & Snape (2005) has reported its significance on indicating lawyers' level of professionalization. This will help to strengthen the generalizability of current research in theoretical perspective, and will also shed lights on the impact of institutional constrain on individual level within the profession through revealing the degree of doctors' attachment to their profession in contemporary China.

APPENDIX 1 -- Interview Agenda

Chinese Doctors Research: Interview Agenda

During this interview, we have a series of questions regarding your career, your medical work, professional status and development.

This is not a questionnaire that we would like to find out not only yes or no answer but your views on the issues concerned. Therefore, please say as much as you can.

We promise that the interview will be kept strictly confidential.

<u>Part 1: Your Career</u>

We would like to start with your medical career:

When did you decide to be a doctor?

Why did you choose doctor as your career? Are there any reasons that stimulated your likeliness towards medicine?

Would you please provide a brief career summary starting from your entrance to the profession?

Included:

Where and when were you qualified to be a doctor?

Where did you work: hospital and region?

Your specialization?

And others……

Regarding the future development, what are your goals within the coming 5 to 10 years? Please explain.

Did you ever consider of quitting the profession and start a new career?

Why/ Why not?

Under what circumstances would you quit the profession?

Probability: Very much possible, possible, hardly possible?

<u>Part 2: Your work</u>

1. Generally speaking, what do you like best regarding your job? Why?
2. Generally speaking what do you hate most regarding your job? Why?
3. Regarding your job, what are the major difficulties or the biggest challenges? Please explain.
4. How did you deal with these difficulties or challenges?

Part 3: Opinions on the healing profession

1. What are the major difficulties or challenges facing by your profession? Please explain.
2. In your opinion, what is the best way to deal with these difficulties and challenges? What should be the role of the following agents do you think is the most appropriate when dealing with these difficulties or challenges?
   Ministry of Health
   Other government agents
   Professional Association
   Others …
3. Could you please comment on the effectiveness of the Chinese Medical Association and the Chinese Medical Doctor Association? Please explain.

   Could you provide some suggestions for the future development of these associations?
4. In your opinion, to whom should the profession directly responsible for?

   Please rank the following and explain:
   Our Nation
   Society
   Patients
   Others
5. Do you think your profession deserve a better social and economical status? Why?

Part 4: Policy & Reforms

1. In your opinion, please comment on the effect of marketization upon your profession.
2. Could you please comment on the internal and external impacts of medical reforms upon your profession?

This is the end of the interview.

Do you still have any questions that you want to put forward? Or is there any important issues that we have not mentioned or asked?

!!!THANK YOU!!!

APPENDIX 2 -- Basic Statistics on Public Health in Main Years (Guangzhou)

主要年份衛生事業基本情況（廣州）
Basic Statistics on Public Health in Main Years (Guangzhou)

年 份 Year	卫生机构数(个) Health Care Institutions (unit)	# 医院 Hospitals	卫生技术人员(人) Medical Professionals (person)	# 医生 Doctors	卫生机构床位数(张) Hospital Beds (bed)	# 医院 Hospitals	每万人口医生数(人) Doctors per 10000 Population (person)	每万人口医院床位数(张) Hospital Beds per 10000 Population (bed)
1978	1589	140	31547	12014	17109	14382	24.88	29.78
1979	1657	140	33239	13049	17530	14725	26.45	29.84
1980	1802	141	35792	14566	17673	14747	29.02	29.38
1981	1883	148	37914	15012	19228	16335	29.41	32.00
1982	2032	152	40213	16510	20896	17162	31.82	33.08
1983	2118	156	41436	17770	21671	17592	33.74	33.40
1984	2194	164	42279	17912	22280	18040	33.44	33.68
1985	2098	163	42522	18079	23830	19439	33.17	35.67
1986	2319	165	44666	19152	25031	20020	34.48	36.05
1987	2173	174	45818	19557	26599	21544	34.61	38.13
1988	2387	182	46957	20094	27981	22663	34.83	39.28
1989	2409	186	47988	20913	28988	23458	35.72	40.07
1990	2353	190	48276	21015	29930	24395	35.36	41.05
1991	2347	194	48618	21026	31293	25286	34.91	41.99
1992	2323	200	49052	21304	32646	26901	34.80	43.94
1993	2094	210	50097	22153	32399	27339	35.52	43.84
1994	2131	216	50819	22401	33086	27871	35.17	43.75
1995	2238	221	52851	23321	34139	28721	36.06	44.41
1996	1987	222	52450	22384	34338	29728	34.12	45.31
1997	1989	224	53654	22829	35301	30067	34.25	45.11
1998	2013	224	54053	22817	35306	30791	33.85	45.67
1999	1670	250	54480	23068	36431	31284	33.68	45.67
2000	1703	252	55677	23503	38758	33716	33.54	48.12
2001	2257	253	56262	23949	39417	34558	33.61	48.50
2002	2265	196	54652	22169	40430	32736	30.76	45.43
2003	2349	183	57274	23464	42210	34140	32.36	47.08
2004	2443	188	59943	24493	45687	35979	33.20	48.77
2005	2517	211	64182	25852	47888	39359	34.44	52.44
2006	2603	223	69091	27338	50500	42821	35.94	56.29
2007	2543	225	76791	29056	52640	45209	37.57	58.45

注:1. 2002 年起卫生指标按照新的《中国卫生统计调查制度》统计。其中，医生为执业(助理)医师数；护师、护士为注册护士数。

2. 从 2004 年起医院不包卫生院。

Note: I. Since 2002 the statistics of health care have been based on China Health Care Statistical Investigation System of which, doctors, refer to medical practitioners and associate medical practitioners, senior and junior nurses refer to registered nurses.

II. The hospitals haven't included the township hospitals since 2004.

主要年份衛生事業基本情況（北京）
Basic Statistics on Public Health in Main Years (Beijing)

年　份	医院(卫生院) 个　数(个)	执业(助理)医师 (人)	注册护士 (人)	床位数 (张)	每千人拥有 执业医师数 (人)	每千人拥有 注册护士数 (人)	每千人拥有 医院床位数 (张)
1978	389	28435	16085	29767	3.35	1.89	3.11
1979	387	31842	17398	30231	3.66	1.87	3.08
1980	393	34365	17492	32453	3.88	1.97	3.22
1981-1985	**1654**	**203097**	**107663**	**184410**	**4.36**	**1.85**	**3.56**
1986	371	43403	25362	43786	4.47	3.72	4.21
1987	398	46007	27497	47538	4.66	2.81	4.49
1988	445	48216	30250	53078	4.82	3.02	4.87
1989	470	49361	32056	55623	4.83	3.14	5.08
1990	512	50934	34565	59036	4.93	3.35	5.37
1991	525	52309	35714	61744	5.03	3.44	5.65
1992	535	53254	36768	63230	5.10	3.52	5.73
1993	548	53906	36687	65621	5.13	3.49	5.93
1994	629	53865	36608	67112	5.07	3.45	6.07
1995	629	54114	36719	66925	5.06	3.43	6.00
1996	645	54091	37712	66760	5.02	3.50	6.02
1997	673	54909	38630	67946	5.06	3.56	6.06
1998	676	51902	38883	69095	4.76	3.56	6.13
1999	686	52646	39625	69465	4.79	3.60	6.15
2000	674	51570	39900	71245	4.66	3.60	6.25
2001	673	52100	40537	73053	4.64	3.61	6.31
2002	647	47236	38879	75188	4.18	3.44	6.46
2003	646	47887	39912	74298	4.21	3.51	5.89
2004	657	49091	41557	77155	4.25	3.60	6.54
2005	692	50642	42897	79077	4.32	3.66	6.65
2006	705	52795	45647	81440	4.44	3.84	6.77
2007	686	54989	50890	83736	3.37	3.12	4.71

注：2006 年及以前年份,每千人拥有执业(助理)医师数、每千人拥有注册护士数、每千人拥有医院床位数按平均户籍人口计算；从 2007 年起,

上述指标按年末常住人口计算。

APPENDIX 3 – The International Code of Medical Ethics

THE INTERNATIONAL CODE OF MEDICAL ETHICS

DUTIES OF DOCTORS IN GENERAL

A DOCTOR SHALL always maintain the highest standards of professional conduct.

A DOCTOR SHALL not permit motives of profit to influence the free and independent exercise of professional judgment on behalf of patients.

A DOCTOR SHALL, in all types of medical practice, be dedicated to providing competent medical service in full technical and moral independence, with compassion and respect for human dignity.

A DOCTOR SHALL deal honestly with patients and colleagues, and strive to expose those doctors deficient in character or competence, or who engage in fraud or deception.

The following practices are deemed to be unethical conduct :-

(a) Self-advertising by doctors, unless permitted by the laws of the country and the Code of Ethics of the National Medical Association.

(b) Paying or receiving any fee or any other consideration solely to procure the referral of a patient or for prescribing or referring a patient to any source.

A DOCTOR SHALL respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences.

A DOCTOR SHALL act only in the patient's interest when providing medical care which might have the effect of weakening the physical and mental condition of the patient.

A DOCTOR SHALL use great caution in divulging discoveries of new techniques or treatment through non-professional channels.

A DOCTOR SHALL certify only that which he has personally verified.

DUTIES OF DOCTORS TO THE SICK

A DOCTOR SHALL always bear in mind the obligation of preserving human life. A DOCTOR SHALL owe his patients complete loyalty and all the resources of his science. Whenever an examination or treatment is beyond the doctor's capacity he should summon another doctor who has the necessary ability.

A DOCTOR SHALL preserve absolute confidentiality except where others are endangered on all he knows about his patient even after the patient has died.

A DOCTOR SHALL give emergency care as a humanitarian duty unless he is assured that others are willing and able to give such care.

DUTIES OF DOCTORS TO EACH OTHER

A DOCTOR SHALL behave towards his colleagues as he would have them behave towards him.

A DOCTOR SHALL NOT entice patients from his colleagues.

Adopted by the 3rd General Assembly of the World Medical Association, London, England, October 1949, amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968, and the 35th World Medical Assembly, Venice, Italy, October 1983.

APPENDIX 4 – Data Analysis Matrix

Stakeholders' Perspectives on Medical Doctors in China

Theme	Registered Doctor Age <35 (n=11)	Registered Doctor Age 35-55 (n=9)	Registered Doctor Age >55 (n=10)	Hospital President (n=3)	Medical Association Representative (n=3)	Patient (n=11)
Role of profession	1. 8 → Saving the death and healing the wounded; 1 → Serving your clients (Doctor is service industry); 1→ not directly addressed 2. Role perception did drive them to play their role effectively. *Impression:* 1. Very clear about their professional role. 2. They would treat their professional	1. Majority stated that the role of doctor is to cure and healing the patients. *Impression:* 1. Very clear about their professional role. 2. Though unlike the younger generation, their professional entries are not on voluntary basis. Rather, due to the institutional settings, they were	1. All of them expressed their view that the role of doctor is saving the death; healing the wounded/ Serving the public *Impression:* 1. Very clear about their professional role. Among the three groups, this group emphasized much on the altruistic nature of the	1. All of them expressed their view that the role of doctor is saving the death; Healing the wounded/ Serving the public *Impression:* 1. Very clear about their professional role. 2. They would treat their professional role as career goal and motivator of their job satisfaction 3. Therefore, they would try their best to play their role effectively.	1. The general perception on the role of profession is quite different from doctors' group though they are also full time doctors that bear a dual identity: doctor and medical association committee member. 2. One used Ox and Actuary to describe the role of the profession. The main aim is to bring out the	1. All stated clearly that doctor's role is to heal and cure their sickness successfully. They emphasized "successfully". *Impression:* 1. Unlike that of the doctors, their perception is outcome-oriented. This might be explained by their identity as consumers. 2. Perceived doctors'

	role as career goal and motivator of their job satisfaction. Evidence: “Doctor's role is saving the death and healing the wounded. Indeed it is a great profession.” Doctor04 “Currently I think it is not easy to be a doctor in China. Sometimes patients’ misunderstanding and mistrust would intensify the doctor-patient relationship. Since we belong to the service industry, no matter what	all allocated to be a doctor by the government according to their academic result. Still, majority likes their profession because they could attain job satisfaction from their patients. Evidence: “I entered this profession by chance. When I sat for the University entrance exam, I didn’t think of majoring medicine but industrial development. It is because I wish to enroll Northern Industrial University in which architecture was a hot discipline. However, the government	profession. 2. The strong altruistic role perception could also explain their high job satisfaction and strong professional commitment. 3. Unlike the younger generation, this group of doctors emphasize the importance of universal coverage in healthcare that majority bare high recognition of their timeless social functions. Evidence: “After I entered the career, I found that	Evidence: “In Chinese Healthcare system, the role of doctor is curing patients. For hospital, doctors are the forerunners of healthcare directions, strategic plans and policies. The most important is to serve the public. During the process, institutions are crucial as they could assess doctors’ service outcome.” HospHead01 “The role of doctors is to provide professional knowledge for our patients with good professional ethics.” Hosphead02 “Role of doctors is to provide healthcare service. In China, the service provided by different	fact that the general workload is very heavy and the institutional setting has imposed financial constrains on the profession. This would directly affect their diagnosis decision-making. 3. The other two interviewees have not provided a clear “definition” for the role of the profession. Rather, they marked the role conflicts with the current institutional settings which happened to	ability and capability to fulfill their role as index of service quality 3. Their strong service- oriented perceptions on doctor’s role might transform to anger and irrationality if they are not successfully cured or healed. This reflects the urgent needs of the empowerment of general practicians. By doing so, the GPs would be able to act as gatekeeper of the national medical system as well as serving the role as community health

	happened, we still have to confront with any problems arisen." Doctor02	representative asked me whether I would be willing to accept official allocation if I am not accepted by my dream university. Of course I have to agree. It is because if I don't and no university is willing to accept me. I would have to terminate my study. Finally, I was being allocated to study medicine in Jiang Xi Medical School. This is not my choice. It's all about the system." Doctor11 "Before I became a doctor, I think it is good to cure patients from sickness and pain...I feel very happy when I cured those patients who are seriously ill."	the major motivation that made me commit to my profession was the job satisfaction I got from healing my patients. In addition, my social status improved gradually because of this. Up till now, I still believe that the goal of being a doctor is healing and curing." Doctor28 "I came here from a poor village. At that time, the medical condition of my village was very poor; I therefore wanted to be a doctor to help people." Doctor27 "I've retired but still working here. I'm	hospitals vary, therefore our expectation for doctors from different hospital would varies too. Hospital would expect doctors could cure general illness and would also wish that they would bear a good attitude and temper, at least not to frighten the patients which would create communication blockade. However, in China, it is difficult for doctors in top tier hospitals to spend time in communicating with their patients." Hosphead03	increase the complexity of their job responsibility and deeply affect the general morale. *Impression:* 1. Dual role happened to broaden doctor's role perception. Evidence: "The role of doctor is just like an ox. Why? The responsibility of curing patients is huge as the State, the public and the patients would expect far more out of what they contribute from their doctors.	care educators. Evidence: "I think the role of doctor should be curing diseases. Currently I am quite satisfied with their service for I could feel the effort that they have contributed. " Patient03 "The role of doctor should be curing. We came from Hunan. After 9 months, the doctors there still could not find out what's wrong with me. Later, our village senior referred us to here. It just only took 2 days for the doctors to confirm my illness. I am really happy as I was so frustrated when

		Doctor14 3. Though minorities are feeling miserable with their job, the origin is the tensed doctor-patient relationship. Evidence: "I'm pessimistic about the professional prospect of doctors. Amidst emphatic derogatory comments made by media on medical practices, the status of doctors in China is at the lowest ever. According to the senior professors, medical failure is inevitable and it happened previously. With the hostile attitude of the media	rather happy as I'm free for two to three days in the week. Apart from treating patients, I also exchange with them, with my knowledge on Chinese medicine, the ways to keep fit and healthy." Doctor24		Chinese government can pay very little to recruit professional proficiency doctors. Doctors are just like the artists, they need to put huge effort and time in training and learning to be become qualified… However, after graduated and become a practitioner, they do not receive fair compensation and return." Asso01 "the right role of Chinese doctors is like actuaries before fulfilling the role as a doctor. It is because doctors need to leverage patients' medical insurance usage, the so-called medical	I was in Hunan that the doctors could not figure out what's wrong with them for few months!!" Patient04

		at the moment, doctors turn defensive and are not willing to take any risk; they just do what they are asked." Doctor17			savings account. Doctors need to make sure whether the patient would be self-finance or direct-debiting their medical savings account before making any treatment decisions. If the patient will pay by medical savings account, the doctor needs to calculate the daily amount of medication prescribed and the cost incurred. The doctor needs to make sure the total cost incurred could be covered by the patient's medical savings." Asso01 "General speaking, doctors could	

					perform the role effectively. Level of professional standard varies across different hospitals. Large hospitals used to have high professional standard whist those from the county hospitals or even village hospitals would have lower professional standard. This is due to the pathological experiences. It is because patients all rushed to large hospitals, however due to lack of manpower, we have to manage heavy workload. Therefore, we	

					accumulated our professional experiences through heavy workloads. In contrast, patients rarely head for small hospitals so doctors from these hospitals would lack of pathological practice." Asso02 "We are facing a problem on appraisal assessment which would directly affect our routine reward that the assessment criteria often based on educational qualification comparison. As commented by my teacher, as a doctor, the main responsibility is to	

					cure patients. If we need to spend time on research as well like writing journal articles, we need to solve problem that we faced. For example, time constrains resulted from daily diagnosis. If I need to provide daily consultation for my patients, how could I afford enough time to write research articles? Therefore, the current assessment criteria are unfair to those who enjoy good reputation among patients because of their professional diagnosis skills but no time to contribute in research article	

					writing. " Asso03	
State-Profession Relationship	Impression: • All of them stated that they just play a passive role in any policy or reforms implementation. None of them mentioned the role of the State Evidence: "Doctors' role is to execute the reform as front-line staff but we have no say in the policy consultation stage." Doctor07	Impression: • Majority commented that the State has been dominant in professional development ever since they entered the profession. Evidence: "All hospitals are managed by Ministry of Health. Under the Ministry of Health, we have the Provincial Health Bureau and local health bureau. Doctors must prescribe drugs available in their hospitals so as to safeguard their patients. The State would be drug merchandizer for hospitals through public bidding. Doctors have no say in	Impression: 1. They respect the State very much because of their experience in Cultural Revolution. 2. They already get used to State-dominant situation since their entry to the profession. 3. One has provided strong evidence on decentralization has happened since 1970s which marked beginning of health reforms planning. It might be able to argue that the State has shifted its monitoring strategy from power- oriented to institution-oriented.	Impression: • May be because of their positions which would involve frequent contacts with government agents like local Health Care Bureaus. They could provide more evidences to prove the State dominance in doctors' professionalization with institutional compliance. Evidence: "The State takes up the role of healthcare strategic planning on national level and monitors the hospitals through regional and local medical bureaus. " Hosphead01 "The relationship between	2. All stated that the role of the State to the profession is like a guardian that bears the responsibility of monitoring and educating the profession. Evidence: "The relationship between the State and us is boss and workers." Asso01 "It's the State who manages the doctor profession." Asso02 "The State is responsible for managing organizations like a guardian.	2. Majority commented that the State is like the guardian of the doctors that bear a dual responsibility in monitoring the profession as well as its development. Evidence: "The State should be responsible for the professional development of doctors by standardizing the whole system of professionalization." Patient05 "The State should improve the healthcare system. This would contribute in upgrading doctors' professional

		drug purchase. They could make suggestions but there is no guarantee that their suggestions will be accepted. However, out-patients could purchase their medicine on their own with doctors' prescription. " Doctor11 "Our management team is affected by the Ministry of Health, while we are not. Since doctors like us are not involved in the management of our hospital, we can exercise autonomy easily." Doctor19 "With regard to power of autonomy, I don't think we are in ideal situation. I hope I can broaden and gradually apply my knowledge as a doctor. Due to the interference of the	Evidence: "I was appointed to the 1st Affiliated Hospital of Sun Yat-Sen University after graduation. In 1971, I was sent to the Guangzhou Chinese Medicine College to attend a course for western-chinese medicine, as assigned by the government, without consultation of the medical profession, trying to mix the application of western and Chinese skills in the health-care profession. I was sent to Dongguan as a teacher during the Cultural Revolution until the revolution ended. I found that, under certain circumstances, western medicine	the State and the doctors is boss and employees" Hosphead02 "The State is trying to standardize the profession…promotion in top tier hospital must follows a set of assessment criteria …All these are standardized by the State, both continuous education assessment system and the internal promotion system." Hosphead03	…Local medical bureau also organize some activities to allow doctors' professional exchange or to spend a year teaching in suburb areas. The government also organizes surgical tour sometimes for some corporations to pay a visit to our surgical theatre while we are having surgery. The aim is to explore for any insights for future research." Asso03	ethics and proficiency. Only by providing them with better remuneration under a fair system, the doctors would be willing to fulfill their obligations in terms of ethics and professional development." Patient11

		Ministry of Health, the power of autonomy of doctors is affected. The academic effect is obvious in medical science of which foreign governments give little interference." Doctor17	does not produce the desired result. As I'm interested in Chinese medicine and subsequently found that mix application of Sino-western medicine was better for healing some kind of illnesses, such as nephritis, I found more interest in and love of my medical career after I won prize on applying the sino-western medical treatment." Doctor24 "Upon the government's implementation of the partial decentralization policy, Sun Yatsen First Affiliated Hospital was allocated with power to run its own			

			business for profit and to defray its own expenses. Therefore the main responsibility of the top management was to focus on the economic and financial development of the hospital. The initial annual income was 40 million to 80 million; 4 years later, we were able to raise the annual income to 200 millions…should be that figure if I haven’t mixed it up. Even the current bonus system was established by us at that time. At that time, our department got 6 colleagues responsible for three different aspects			

			including education, research and health care. By now, it involves 6 offices taking these jobs, and each office has at least 5 people! After I returned to Sun Yatsen First Affiliated Hospital, I was promoted as an associate professor within a very short time. There were 4 professors, two of them were responsible for staff development. There were altogether 4 dimensions of work, and we still had to perform diagnosis and inspect the clinical wards. In fact, the problem of dispute between doctors and patients existed since the old			

			time. Amongst six of us, two seniors would only involve in really big issues, the remaining 4 of us had to deal with every single incident." Doctor28			
Association-Profession Relationship	1. 4 → not clear about the role of medical association (∵ not a member yet) 2. 6 → Academic oriented 3. 1 → Not representative enough 4. 6 → Cannot protect the profession *Impression:* 1. The association does not play its role effectively (comparing with western ones) 2. Professional autonomy is	1. All are members 2. All stated that medical association is purely academic oriented that and does not take up any other roles played by the foreign med association e.g. mandating code of ethics/ participating in policy discussion/ protecting the profession/ "spokesman". 3. All agreed that the medical association could contribute to their professionalization by organizing	1. Not all are members but some are experienced committee members 2. Majority agreed that the medical association is purely academic. 3. Majority commented that the medical association is "useless" for professional development. 4. Only one commented that the association is "useful" to the profession. His senior position in	1. Majority explained that the role of medical association is academic oriented though they would also be responsible for medical audit of medical accidents. 2. In spite of these, they are under the State control. Evidence: "Medical association is just a social organization without any political power. They just responsible for organize and stimulate professional exchange so to assist our	1. All the three revealed the dominance of the State as medical associations do not enjoy any political power but mainly delivering opportunities for professional exchange through seminars and conferences. 2. The medical association could merely protect the profession though they bear the responsibility	1. Majority stated that they are "not familiar with the medical association" with some even "have never heard of its existence". *Impression*: 3. The general public is not aware of the function of medical association, not even their existence. 4. There are needs to further empower the medical association in monitoring the profession follows

	constrained by the State ∵ associations' close relationship with the State 3. Not representative enough → failed to buffer doctor-patient conflicts. 4. Neglected those at entry level who need more attention because of their "freshness". Evidence: "We are in lack of medical association. When holding medical conferences, the China Medical Association (CMA) only invites senior doctors to attend, inexperienced doctors can only rely on universities to improve their knowledge" Doctor05	conferences, seminars and lectures for professional exchange. Evidence: "I am a member of the Chinese Medical Association. The medical association is not helpful to our profession. Their main role is to host conferences and seminars which are not significant in advancing our professional standard. The conferences and seminars are open to all no matter whether you are member or not. Hospital would count our credits in continuous learning. Such criterion varies across different hospitals. For example, someone's inviting you to attend a seminar would also	the association committee at national level might be able to explain why he makes such a comment. *Impression:* a. It seems that the general impression towards the medical association is not too positive in terms of its contribution to the profession in addition to professional development. Evidence: "Chinese Medical Association ("CMA") was formed in 1980. I'm the deputy supervisor of the haemodialysis team of the CMA.	professional development. Doctors attending these conferences and seminar would help to maintain their professional standard. It is because medical association used to organize such conferences or seminar annual with the most advanced professional knowledge gathered from different disciplines. Then they would publish a set of exercise, requesting their members to finish it. Once the result returned is bad, membership will be disqualified." Hosphead01 "Medical association is responsible for organizing conferences and seminar to the purpose of professional exchange. Their daily operation cost comes from our membership fee which we	of medical audit in medical accidents for the State. 3. From the State, prospective, professional associations just act as an institutional tool for monitoring the profession. Evidence: "Medical Association is an organization that has no political power, administrative power, professional authority, and financial management power. It is just a "shadow organization" working for the	by further promote their role. Once if they are empowered with a clear public image, it might be able to contribute to community and patient education which would be critical factor in reducing medical bullies.

	"Professional association is helpful in terms of academic learning. They bridge the academic and the practical world together through organizing academic conferences and journal publications. Profession Association: However, I didn't see any effort made to safeguard our rights " Doctor04	count as credits. Some hospitals are more advanced in surgery. You can apply for on-job exchange to these hospitals. However, you must get approval from your ward and hospital. It is because they are responsible for your salary and remuneration package." Doctor11	Basically, this association organizes seminars and I've the chance to be speaker. In addition, CMA would hold annual meeting and publish journals periodically to enhance the professional knowledge of its members. Professional Association: However, it does not have the duty to handle mal-practices of its members, a task assumed by Ministry of Health." Doctor20 "I should say, the role of medical association is to organize academic functions like seminars and discussion forum. However, it	could claim back from our hospitals. If anyone complaint about medical accidents, there is a subsidiary under each medical association which is responsible for inspection of medical accidents chaired by a group of medical experts. Some of them will take up the monitoring role during the process. Ministry of Health would be responsible for the final verdict of any medical disputes or accidents." Hosphead02 "The medical association in China is useless as it's only responsible for technical or experiential exchange among doctors but could not monitor the profession though medical accident audit is also one of its	State. It is insignificant in our healthcare system. It is a governmental organization with a few doctors work for it, but over 90% of staffs are not doctors but civil servant. Therefore, it doesn't have any social function." Asso01 "Medical associations do not have political power and they could not intervened hospital administration as well. They would be responsible for peer and academic exchange through organizing conferences and seminars so to advance our	

			becomes more & more commercialized. For example, you've to pay money if you want to publish an article. Honestly, when I read an article, I would only read the introduction and the conclusion, ignoring the middle part of the text, as all the statistics are untrue. The author had pre-determined on what the result should be beforehand. He simply made up the result that he wanted. The laboratory works simply did not produce the facts as indicated in their paper. Therefore, I don't read the content which is meaningless " Doctor 28	responsibilities…The local medical associations are useless. Related governmental units are limited while the related legislation is complex that it caused enforcement problem. If we just rely on the State to monitor the profession is very difficult It is even impossible to pass such responsibility to the hospitals because of limited resources." Hosphead03	professional standard. Secondly, they would be responsible for medical accidents' inspection and assessment. Thirdly, they would be responsible for maintaining the Code of Conduct." Asso02 "Medical association originally is a local organization and now it is official organization representing the government because it is monitor and managed by the local medical bureau. Being committee of the association needs to go through the	

					process of election. The main role of the committee is to organize gatherings for professional exchange." Asso03	
Doctor-Patient Relationship	All doctors commented that the current overall doctor-patient relationship is under strain. Evidence: "My unhappy experience was that I was beaten and bullied by a patient. He thought that I was not a medical supervisor. He thought my supervisor should deal with the case, not me." Doctor08 *Impression:* • The tense Doctor-patient relationship also led to the	All doctors commented that the current overall doctor-patient relationship is tensed. Evidence: "I'm not happy because patients misunderstand doctors, especially when the tension between doctors and patients becomes strained. Patients feel that they are cheated by doctors. It seems they keep guessing how doctors are trying to cheat them. This makes me feel unwell." Doctor16 *Impression:*	All doctors commented that the current overall doctor-patient relationship is under strain. Evidence: "My unhappy experience was that I was beaten and bullied by a patient. He thought that I was not a medical supervisor. He thought my supervisor should deal with the case, not me." Doctor08 *Impression:* • The tense Doctor-patient relationship also led to the	2. Two stressed the importance of equality between doctors and patients Evidence: "Doctor-patient relationship should be equal." Hosphead01 "Doctor-patient relationship should be interactive and fair. For example, when doctors diagnosis their patients, they have the responsibility to decide what kind of medication and treatments. However, if the patients would settle their bills by the medical	6. Majority commented that the current doctor- patient relationship is tensed Evidence: "The tensed doctor-patient relationship is due to different causes for example negative cases reported by the media. On the other hand doctors should also bear some responsibilities, so are the patients. All	3. Majority stated that if doctors treat them nicely and could successfully cure or heal them, they would in return show great respect to the doctors. 4. Interviewees also emphasize the importance of maintaining a close relationship with the patients which would affect their willingness in cooperation.

	practice of defensive medicine. Evidence: "Due to the tense doctor- patient relationship and the fact that we are a profession that is always open to high risks. We have to be more careful in daily diagnosis, and surgical process. We must reduce our workload because the more we diagnose the heavier our risk burden will be." Doctor06	• The tense doctor- patient relationship becomes a great challenge to the profession Evidence: "Due to the tense relation between doctors and patients, I consider the greatest challenge is to communicate with patients." Doctor18	practice of defensive medicine. Evidence: "Due to the tense doctor- patient relationship and the fact that we are a profession that is always open to high risks. We have to be more careful in daily diagnosis, and surgical process. We must reduce our workload because the more we diagnose the heavier our risk burden will be." Doctor06	saving accounts or social security insurance, doctors' decision-making would base on the cost of medications and treatments rather than patients' neediness. It is because if excess amount has been incurred in medication or treatments, it cannot be claimed. Therefore, the system simply could not match with doctors' professional role. In addition, patients could not accept all the suggestions given by their doctors due to the cost problem. Therefore, to further improve the general healthcare service as well as to clarify and fully utilize our professional role, the State has to bear the responsibility fine tune the current health care	parties involved should be responsible." Asso03 "Doctor-patient relationship is conflicting. Here, patients used to be settling their bills by their medical savings account of social security account. If we could cure them, we have already fulfilled our professional role. Some would treat patients' recovery as job satisfaction and professional outcome. However, some would treat monetary return as their professional outcome and therefore are not happy with the	Evidence: "My relationship with the doctors is cordial, very friendly and casual who never refuse to answer any questions I raised." Patient03 "Doctor-patient relationship is like family, very close." Patient05 "Doctor-patient relationship is just like friends, everything is negotiable, the closer the better." Patient06

				reform. Though the origin of medical system is to lighten patients' financial burden, with the low coverage rate of less than 10%, our profession really need additional input from the State no matter in terms of financial subsidy or medical resources." Hosphead02 5. One pointed out the importance of trust in maintain harmonic doctor- patient relationship Evidence: "The perfect doctor-patient relationship is doctor fulfills his responsibility while the patients fully trust the doctor." Hosphead03	current situation as our remuneration package is really bad." Asso02 7. One of the interviewee expressed that it is hard to tell the doctor-patient relationship which is too complex because of Guanxi network. Evidence: "Doctor-patient relationship is complex in China. It is because Chinese used to be conservative. Therefore, when someone needs to see a doctor, one	

					would base on word of mouth and peer or relative referral. Because of such Guanxi network, doctors have to put patients in the highest priory. It is not because patients are ill or sick, so we have to fulfill our role to cure them, but because their patients fall into their own social network. Therefore, sometimes doctors refuse to diagnosis the patients referred as they want to avoid making mistakes." Asso01	
Professional Standard	1. Since all of them are in their entry level, not all of them have commented on	1. Doctors did not provide judgement on their professional standard.	1. Doctors did not provide clear comment on the general professional	1. Two commented that the professional standard varies across different tiers. Those from	1. All commented that doctors from top-tier hospitals bear higher	1. Majority are satisfied with doctors' professional standard. However, two commented that

	the general professional standard. However, majority do admitted that they need to keep learning in different wards on role shift for a year before focusing in one specialty. They are trying hard to brush up their professional skills through benchmark examinations and academic research. Evidence: “High requirements exert high pressure on me at present, some research works	2. One stated that whether a doctor bears professional standard could be defined by the number of patients one has and also one’s workload. Evidence: “I don’t know what effects it will have when foreign doctors could practice here in China, as I’ve ever seeing them working here. If a doctor is capable, people in medical profession would discuss and know who is good. When friends fell sick, we would recommend them to see good doctors. According to this practice, good	standard. 2. With one spotted out the deprofessionalization of doctor and pointed out the hidden problem of deprofessionalization Evidence: “Nowadays, fresh graduates are just like students! It just takes 10 yrs to finish all the so-called medical academic training. A PhD would be promoted to professor after two years on job experience, by that time, he is only 35. So how the general public would recognize and respect a person	top tiers are having higher professional standard than those from lower tier hospitals. The reason behind would be the inconsistence of medical education system 2. Evidence: “In the past 16 years, professionalization of doctors and hospitals has been rapid. The general pace of professional development is rapid. Among all healthcare institutions, the doctors’ professional standard of medical schools and third tier hospitals are comparatively higher than those from low tier hospitals. ” Hosphead01	professional standard than those from lower tier hospitals. Evidence: “Doctors’ professional standard could meet international standard, just like our organ transplant which is being ranked the second globally in terms of professional standard in both skills and research. Though on the whole the medical research in China is a bit lower, this is purely because of lack of investment from the State and financial support	doctors’ professional standard varies across different places. Echo with some doctors’ comments that the professional standard in top tier hospitals are higher than that of those in lower tier hospitals Evidence: “We came from Hunan. After 9 months, the doctors there still could not find out what’s wrong with me. Later, our village senior referred us to here. It just only took 2 days for the doctors to confirm my illness. I am really happy as I was so frustrated when I was in Hunan that the doctors could not

	and research papers are of high quality. We've to develop a research theme to apply for funding; this caused keen competition amongst doctors. Clinical work is good, but it does not involve research. We would not be promoted if we don't carry out research. A successful research has great impact on the medical ward as it provides a direction for the ward to follow. Now, everything is change at quick pace. To avoid wastage, we should focus on quality rather than enlarging employment. We should provide more	doctors could not take a rest even he works all day. On the contrary, incapable doctors have a lot of free time although they receive the same salary. There is keen competition between hospitals, those that employ good and capable doctors could generate more income than they previously earned. In China, people usually recommend doctors to friends; this would burden doctors with too much work that they could not handle." Doctor12	only with academic training but without hands on experience and practical skills? As a result, hospitals are short of resident doctors by now. What we need are only one or two resident doctors in each ward as they process practical experience. As you know professors won't be the doers but only act as consultants. The current situation is we only concern about academic abilities when considering promotion. However, I think skills and experiences are far more important for training up good	"It is easy for doctors to get their professional licensure in China that even those who graduated from colleges could also sit for the licensure examination. These lead to the complex hierarchy structure within the profession. For example, we are now having 8-year doctor training program that graduates will be granted with a doctorate agree.. However, for those who graduated from colleges, they could also get the licensure after working as a full-time doctor for 2 years in registered hospitals. Ordinary universities (not specialized in medicine like the medical schools) and those so-called medical colleges at village level could also be registered doctors as long	which is common in overseas countries." Asso01 "Level of professional standard varies across different hospitals. Large hospitals used to have high professional standard whist those from the county hospitals or even village hospitals would have lower professional standard. This is due to the pathological experiences. It is because patients all rushed to large hospitals, however due to lack of manpower, we have to manage heavy workload.	figure out what's wrong with them for few months!!" Patient04 "I come from Dalin, the doctors did very well and made us feel secure and relieved. Their performance is highly satisfactory and could reach high professional standard. Originally I am not familiar with them but I just come here because of their reputation I learned from my neighborhood. I am really satisfied with their service provided." Patient03 2. There is one spelled out the key criterion for patients to judge

	resources on medical training. Government must have an open mind to learn the techniques of foreign management. I think what we want is the good system of foreign countries. I like to be a doctor; a doctor with high professional knowledge." Doctor05		doctors. If we put to much focus on academic abilities, our profession would only enter a dead end." Doctor28	as one could proved his educational background and 2 years working experiences.. As a result, the professional standard among doctors varies across the nation. Only those medical school located in city center could maintain the professional benchmark. Those from low tiers hospital, their professional quality are difficult to guarantee. " Hosphead03	Therefore, we accumulated our professional experiences through heavy workloads. In contrast, patients rarely head for small hospitals so doctors from these hospitals would lack of pathological practice." Asso02 "For professional standard, it varies across different places." Asso03	whether a doctor is professional or not. That is, one's diagnosis history. Evidence: "General speaking, doctors have achieved high professional status. For doctors in this hospital, their professional status is definitely high as they enjoy great respect from patients. Whether a doctor is professional or not all depends on the number of successful diagnosis case one has achieved. " Patient05
Professional Ethics	1. None has clearly commented on the general professional ethics. However,	*Impression:* 1. Though none have commented on their professional ethics, Due to the	1. It can't be denied that there are mal-practice existed in the	1. All are satisfied with the general professional ethics. Evidence:	1. Majority agreed that the general professional ethics is good. However, there	1. Majority agreed that the general professional ethics is good. However, there are broken

	some mentioned that the changing nature of doctor-patient relationship did bring challenges and forced them to be more cautious in decision- making. Evidence: "Because of the healthcare reforms, the whole professional environment has changed because our patients have become more right-conscious." Doctor04 "Unfavorable comments of the public exert high pressure on doctors;	general perception of tensed doctor-patient relationship, it seems that they have strong motive to commit to professional ethics. Evidence: "Under the tensed doctor-patient relation at the moment; it's a pity that patients misunderstand doctors. The antagonism between doctors and patients has hurt the once harmonious environment when the outcome of medical treatment is not within expectation and when the fee is over budget. " Doctor13	profession. However, the general professional ethics are good. Evidence: "… there are lots of criticisms towards our profession from the media, such as medical accidents, red pockets, medical chaos…all these negative incidents heard are usually happened in our profession." Doctor28	"The professional ethics of Chinese doctor is food. Each hospital has appraisal system for their doctors. Supervisors need to assess their subordinates in terms of what and how many journal articles one has produced, how is one's ethical performance etc annually. Our profession also has our own Code of Conduct and diagnosis regulations. Therefore, the general professional ethics is good. " Hosphead01 "Since hospitals are subsidiaries of the regional and local medical bureaus, therefore, medical association could hardly contribute in advancing our professional ethics awareness. However, the	are broken branches in any in tree therefore mal- practice cases cannot be avoided. Evidence: "Over 95% of doctors' professional ethics is high. They could manage to conquer multi-dimensional stress from the society, the State, patients' misunderstanding, the healthcare system, healthcare management, different medical units, technology and even symptoms which keep on changing because of environmental destruction. Engineer would	branches in any in tree therefore mal-practice cases cannot be avoided. Evidence: "Not absolutely. We have a Chinese idiom, our fingers are not in the same length. Some are longer while some are shorter. Same in the medical profession, there are some doctors who are highly ethical while some are less ethical. Therefore, it is difficult to comment on the general ethical standard among the doctors in China." Patient02 "Doctors from the old generation would be more ethical and considerate than the

	providing doctors with little breathing and living space. If you read the newspaper recently, you would have noted that doctors and hospital staff are putting on helmets in hospital because they were beaten up by patients. This had lead to patients not trusting doctors and affected treatment process. Unsuccessful of the medical reform is due to government providing little financial and other resources to hospitals; the general public accuses hospitals are the principal culprits who should responsible for the high cost for	"In order to reduce problems arising from the tense relation between doctors and patients, we have to ensure that we perform according to rules and regulations. " Doctor19 2. This also proved that community could somehow monitor doctors' professional ethics. However, there are needs to further improve the current institutional setting so to prevent the practice of defensive medicine which eternally would shift the risk to the		current institutions are quite standardized in maintaining professional ethics. " Hosphead02 "I am very satisfied with the general professional ethics." Hosphead03	only need to take 4 years professional training then they could pick up their professional work. However, doctors must engage in life-long learning through daily work. Therefore, Chinese doctors' professional ethics is very high as they did not give up. They have successfully overcome all kind of difficulties that should not be confronted by them, just for the purpose of their patients."Asso01 "In general, professional ethics is good. However, there are	young doctors whose attitude used to be less caring. " Patient11 "As I've learned from the media about medical accidents, therefore I believed that not all of them are good guys. There must be some bad guys. However, generally speaking, most doctors' ethical standard is good." Patient 08

	and hardship in getting medical treatment. In fact, doctors have to give up their bonuses in some occasions. The medical reform has resulted in causing conflicts between doctors and patients when both parties are not satisfied. The situation is aggregated by negative comments of the media and leading to the vicious circle of stressed doctor-patient relation; medical association would not help doctors on this matter. It gained the trust of the public when SARS happened but everything remained	patients' health and speed of recovery.			exceptional cases like there is doctor from small hospital who keeping calling his brokers during surgery. " Asso02 "On the whole doctors' professional ethics are good. Most of us are good men though the media would report that there are minority who accept red pockets which I think would also happens in other countries." Asso03	

	unchanged thereafter. Our government is avoiding the matter as there are too many people in our country. Therefore the problem of strained doctor-patient relation becomes serious." Doctor05					
Professional Status	None of them has directly answered this question – reflecting strong uncertainties and lack of clear idea Evidence: "I'm satisfied with my profession because I'm a surgeon as well as a physician. When compared with smaller hospitals, the professional level of our hospital is a lot higher. I feel very	Majority bear negative perception on their professional status Evidence: "The human right is higher in China now. Due to our tradition, status of local doctors is a lot lower than that of our foreign counterpart. I think our status will come up again gradually. China as a whole and as a result of the media's somewhat biased view against doctors, the status of	Majority commented that the general professional status were much high in the 1970s and patients no longer respect them as in the past. Evidence: "In the 1960s, people respected doctors; they were a lot simpler at that time. Conflicts between doctors and patients seldom occurred. But now, there are high	1. Majority commented that the current professional status of doctor is good. 2. With one did not provide a clear comment on this aspect but reported that upgrading professional status should be lifetime career goal of doctors Evidence: "Our professional status has greatly improved and	1. Interviewees did not provide clear judgement on doctors' professional status. *Impression:* 1. It seems that they are trying to avoid the question. Evidence: "Being a professional doctors	1. Interviewees have not been asked to comment on this aspect directly. *Impression:* 1. It seems that as long as doctors could successfully cure or heal them, they would show great respect to the doctors. Evidence: "Doctors and nurses

	satisfied when patients give me favorable comments.”	doctors is lowered than those years in the fifties and sixties and; we are not respected by the general public. The tension between doctors and patients became strained as result of the unfavorable comments of the media and the nation’s policies” Doctor15 “Due to the negative reports made by media, the status of doctors is not as high as previously. The development of tense relation between doctors and patients also aggregate the situation. The status of doctors is well below that of foreign countries. The income of doctors in China is greatly lower than the contributions they’ve	demands from patients, e.g. they make a lot of disturbances before they are fully recovered if they have settled the medical fees. ” Doctor27 “There were only a small number of doctors in the past, so their social status was much higher than nowadays. When I graduated, for 108 medical students, there were only 3 assistant professors and 4 lecturers. Within a ward, there was no professor, just one senior doctor plus 4 resident doctors. During my time, as there were only 3 professors at the age of mid-40s, when they walked past, nobody dared to	this should serve as our goal in professional development.” Hosphead01 “As for our economic status, there is room for further improvement.” Hosphead02 “Doctors should treat upgrading their professional status as their career goal. However, since doctor's job responsibility is different across different tiers, it is irrational for everyone to set the same goal -- working in 3rd tier hospitals. From hospital prospects, different hospitals should recruit doctors with different professional standard. In 1st tier hospital, their role is to provide general consultation therefore they	means doctors must put their patients’ benefit on the top priority. For example, in site-building, engineers must keep a strict eye on the quality control. A professional doctor must also engage in continuous education and bounded by the law.” Asso01 “Whether a doctor is professional or not would depend on how specialize is one’s discipline and of course the skills must be mature too. One must also treat his profession as life time career by treasuring the profession as one’s	care about us and they are enthusiastic as they often send us greetings. Therefore I am very satisfied with their service. I’d give them full marks.” Patient04

		made. During my grandfather's era, doctors enjoyed high social status and were well respected by society" Doctor17	look at them. We would take another way out. So you can see the authority they enjoyed; and their superiority in the eyes of students… The social status of doctors is the lowest among all professions! Especially there are lots of criticisms towards our profession from the media, such as medical accidents, red pockets, medical chaos…all these negative incidents heard are usually happened in our profession. In the past, the doctor-patient relation was just reflected in the supply-demand	do not need to employ specialist but their doctors should not give up continuous education to sustain professional development. The current healthcare system is complex and in chaos, sometimes 1st tier hospitals would also perform surgery that should be carried out by specialists from 3rd tier hospitals. This would eternally cause diagnosis problems. The actual situation is, if you have enough resources and bold enough, even though you are in lower tier hospitals, you could still perform surgery that used to be done by specialists in 3rd tier hospitals. Therefore, the government should standardize the surgeries available in hospitals from each tier." Hosphead03	ideal career goal "Asso02 "My teacher has once said, we have to do our best. My teacher is highly respected by peers and students so he's being called professor. He's being highly respected because he treats his patients as his master. What we earn from a state-owned hospital is enough to support our living, but doctors would compare their compensation with peers like complaining that they could not afford their apartment and car while some of their	

			theory. Patients' role was "begging" for treatment, so we enjoyed much higher social status. However, in nowadays society, patients' role have changed and they "command" us to heal them. In my case, I graduated in the age of 21 and became the department head and supervised all surgical doctors. Everybody would be afraid of me for I was an assistant professor." Doctor28		peers could do so. If you have such perception why do you still chose to be a doctor? Currently doctors have to worry about their income and how to earn enough to settle their monthly salary. We don't need worry about this but just to fulfill our responsibility in the past. We just need to try our best to cure patients and no need to worry about our income as the State would take care of our income. Therefore, doctors would not want their sons to enter the profession while the sons would not like to be doctors as they	

					know the actual toughness from their parents. As a matter of fact, like other professions, we also need to support our family's living and we should belong to middle class. However, other occupations or professions do not need to take serious job responsibilities like we do. " Asso03	
Professional Autonomy	The majority commented that due to the fact that they are juniors, they do not enjoy autonomy like the seniors but just accept the role of executing actions as instructed. Evidence: "Since I am a newbie in this profession, there are lots to learn. I need guidance from senior doctors. Therefore, I	The majority stated that they could enjoy full autonomy in clinical decision making. Evidence "I think my autonomy is high within the medical profession. With regard to execution and administration, I've to follow my senior's instruction." Doctor 18	Majority stated that they could enjoy full autonomy on clinical decision making. Evidence: "We've full autonomy within our profession." Doctor 22	1. Interviewees have not been asked to comment on this aspect.	1. Interviewees have reported the dominant role of the State in monitoring the profession. Evidence: "Doctors should first be responsible to the patients. However, Chinese	1. Interviewees have not been asked to comment on this aspect.

	always have to seek for their advice." – Doctor02 "I think I'm doing well within the parameter of my duties. I will consult my senior if there is any problem, otherwise I would be regarded as irresponsible to my patients. There are a lot of clinical skills that I've to learn; this is the difference between senior doctors and the green ones." Doctor04 *Impression:* - Since doctors are still at a junior level, it is reasonable that they do not enjoy the same degree of autonomy as their seniors because of their limited diagnosis experiences.	"I've been in this profession for a long time, so I don't have any problem in autonomy." Doctor14 *Impression:* - It is indeed quite surprising that even though the majority entered the profession by central allocation, none of them blamed the active involvement of the State. Rather some even complained that the State involvement is not strong enough. - Though the majority said that they enjoy			doctors used to be responsible to their hospitals first, then the State, finally their patients. It is because of the health care system has categorized the patients into self-financed or subsidized."Asso01 "Doctors should be responsible for the State, the hospital and the patients. It is because the professional training was subsidized by the State while our remuneration is paid by the hospital. Why we should be responsible to our patients? It's simply because we are bounded to do so because of our	

					professional nature"Asso02 2. Though doctors could still carry out professional decision- making but just limited to their job only. On the whole, doctors' professional development is constrained by current institutional settings. Evidence: "We are facing a problem on appraisal assessment which would directly affect our routine reward that the assessment criteria often based	

					on educational qualification comparison. As commented by my teacher, as a doctor, the main responsibility is to cure patients. If we need to spend time on research as well like writing journal articles, we need to solve problem that we faced. For example, time constrains resulted from daily diagnosis. If I need to provide daily consultation for my patients, how could I afford enough time to write research articles? Therefore, the current assessment criteria are unfair to those who enjoy good	

					reputation among patients because of their professional diagnosis skills but no time to contribute in research article writing. ”Asso03	
Future Prospects	2. Majority are optimistic. However, the general professional environment is disappointing. Evidence: “I think the road of medical development is bumpy because the government is operating a stern policy. The future is dimming. I hope the government could make more	3. Majority feel optimistic with their profession 4. For those who feel pessimistic with their profession mainly because of the tensed doctor-patient relationship, unsatisfactory compensation and the nature of their specialty. Evidence: “I’ve high hope on the	4. Some are optimistic while some are not. 5. Those who are optimistic did not provide clear explanation. Evidence: “Optimistic. If not I won't be requested to continue my job though retired. ” Doctor27 6. Those who are pessimistic mainly because of	Interviewees did not ask to comment on future prospects of the profession.		

	announcements, such as, on death of the brain now widely discussed internationally. I also hope the government could promote and clarify doctor's image. On the whole, I'm optimistic about the future of doctors." Doctor10 - Even though the minority stated that they are pessimistic, their main worries are the current institutional settings within the healthcare sector. Evidence: "I think the current	future development of China's medical professional, as all patients must see doctors. The doctor-patient relation is not good at the moment, while I hope government would inject more resources in the medical system, I also hope that the tensed doctor-patient relation could be relaxed. Improvement on both of the just aforesaid matters would greatly help the development of medical profession." Doctor14	their disappointment with low remuneration package and tensed doctor-patient relationship. Evidence: "As the doctor-patient relation is deteriorating and everyone doctors losing their zest and earnest in their work, I don't have high hopes in the future of this profession as well. " Doctor21	

	health care situation is really bad because of the controversy. There are still a lot of people baring very negative views towards our profession because of the media. For example, they would challenge our services quality. Some of the negative report released by the media used to be just focusing on patients' perspective and never seek for our explanation. These further deteriorate the doctor-patient relationship." Doctor04			

REFERENCE

Abbott, A. (1981). Status and status strain in the professions. *The American Journal of Sociology, 86(4)*, 819-835.

Abbott, A. (1991). The order of professionalization: An empirical analysis. *Work and Occupations, 18*, 355-384.

Adams, T.L. (2004). Inter-professional conflict and professionalization: dentistry and dental hygiene in Ontario. *Social Science & Medicine, 58,* 2243-2252.

Adler, P., & Jermier, J. (2005). Developing a field with more soul: Standpoint theory and public policy research for management scholars. *Academy of Management Journal, 48*(6), 941-944.

Albert, T. (2001). AMA's principles of medical ethics may be infused with the new "lofty ideas". *American Medical News*, *Jan. 1/8.*

AMA. (2007). *History of the principles of medical ethics*. American Medical Association.

AMA. (1847). Code of medical ethics of the American Medical Association. American Medical Association.

Anderson, C.W. (1978). Reviewed work(s): Authoritarianism and corporatism in Latin America by James M. Malloy *The American Political Science Review*, 72(4), 1478-1479.

Anderson, L.A., & Dedrick, R.F. (1990). Development of the Trust in Physician Scale: A Measure to Assess in interpersonal trust in patient-physician relationships. *Psychological Reports, 67,* 1091-1100

Almond, G.A. (1983). Corporatism, pluralism and professional memory. *World Politics, 35(2),* 245-260.

Arnold, L., (2002). Assessing professional behavior: Yesterday, today and tomorrow. *Academic Medicine, 77*, 502-515.

Arnold, L., & Stern, D.T. (2006). What is medical professionalism? In D.T. Stern. (ed.) *Measuring Medical Professionalism.* UK: Oxford University Press.

Avolio, B.J., Waldman, D.A., & McDaniel M.A. (1990). Age and work performance in non-managerial jobs: The effects of experience and occupational type. *Academy of Management Journal, 32,* 407-422.

Barodes, J.A. (2003). Medicine and professionalism. *Archives of Internal Medicine, 163,* 145-149.

Barry, D., Cyran, E., & Anderson, R.J. (2000). Common issues in medical professionalism: Room to grow. *American Journal of Medicine, 108,* 136-142.

Bazeley, P. & Richards, L. (2002). *The NVivo: Qualitative Project Book.* New York, US: Sage Publications.

Bell, J. (1992). Populism and elitism: Politics in the age of equality. Washington, DC: Regnery Publishing.

Blau. G. (1985). The measurement and prediction of career commitment. *Journal of Occupational Psychology, 58,* 277-288.

Blau, G., & Lunz, M. (1998). Testing the Incremental Effect of Professional Commitment on Intent to Leave One's Profession Beyond the Effects of External, Personal, and Work-Related Variables. *Journal of Vocational Behavior, 52*(2), 260-269.

Blau, G. (1999). Early-career job factors influencing the professional commitment of medical technologists. *Academy of Management Journal, 42,* 687-695.

Block, D. (2004). Professionalism and the physician leader. *Physician Executive, 30(6),* 50-53.

Blumenthal, D. (1996). Effect of market reforms on doctors and their patients. *Health Affairs, 15,* 170-184.

Bourdieu, P. (1990) *The logic of Practice,* US: Standford University Press

Bova, C, Fennie, K.P., Watrous, E., Dieckhaus, K., & Williams, A.B. (2006). The Health Care Relationship (HCR) trust scale: development and psychometric evaluation. *Research in Nursing & Health, 29,* 477-488.

Breines, P. (1981). Review: "The Two Marxisms": Vintage Gouldner. *Theory and Society, 10(2),* 249-264.

Bucher, R., & Strauss, A. (1961). Profession in process. *American Journal of Sociology, 66(4),* 325-334.

Bungener, M., & Paicheler, G. (1994). Social trajectories and diversity of careers, Two aspects of the evolution of the medical professional in France (1925-1989). *Social Science & Medicine, 38,* 1439-1447.

Callister, R.R., & Wall, J.A., Jr. (2001). Conflict across organizational boundaries: managed care organizations versus health care providers, *Journal of Applied Psychology, 86,* 754-763.

Calnan, M., Rowe, R. & Entwistle, V.A. (2006). Trust relationship in health care: An agenda for future research. *Journal of Health Organization Management, 20,* 477-484.

Chapman, C.M. (1977). Concepts of professionalism. *Journal of Advanced Nursing, 2,* 51-55.

Chen. S (2004). Sino-German Medical Exchange, *Journal of Peking University(Health Sciences), 36(6),* 636.

Clarke, D.B., Doel, M.A., & Segrott, J. (2004). No alternative? The regulation and professionalization of complementary and alternative medicine in the United Kingdom. *Health & Place, 10,* 329-338.

Cockerham, W.C. (1989). *Medical Sociology*. Englewood Cliffs, US: Prentice Hall.

Cohen, J.J. (2007). Linking professionalism to humanism: What it means, why it matters. *Academic Medicine, 82,* 1029-1032.

Collins, R. (1979). *The Credential Society. New York, US: Academic Press.*

Colyer, H.M. (2004). The construction and development of health professions: Where will it end? *Journal of Advanced Nursing, 48,* 406-412.

Conrad, P. (1992). Medicalization and social control. *Annual Review of Sociology, 18,* 209-232.

Cooper, D.J. (2006). Accounting, professions and regulation: Locating the sites of professionalization. *Accounting, Organizations and Society, 31,*415-444.

Cooper, J.A. (1978). Academic medical centers and government: An indispensable partnership. *Journal of Medical Education, 53,* 998-999.

Crawford, R. (2006). Health as a meaningful social practice. *Health: An Interdisciplinary Journal for the Social Study Health, Illness & Medicine, 10,* 401-402.

Cruess, R.L., Cruess, S.R., & Johnson, S.E. (1999). Reviewing professionalism: An opportunity for medicine. *Academic Medicine, 74,* 878-884.

Curnow, C.K., & McGonigle, T.P. (2006). The effects of government initiatives on the professionalization of occupations. *Human Resource Management Review, 16,* 284-293.

Dacin, M.T., Goodstein, J., & Scott, W.R. (2002). Institutional theory and institutional change: Introduction to the special research forum. *Academy of Management Journal, 45,* 45-46.

Dalton, G.W, Thompson, P.H., & Price, R.L. (1977). The four stages of professional careers: A new look at performance by professionals. *Organization Dynamics, 6,* 19-42.

D'Aunno, T. (2005). Management scholars and public policy: A bridge too far? *Academy of Management Journal, 48,* 949-951.

DeGeyndt W., Zhao, X., & Liu, S. (1993). From barefoot doctor to village doctor in rural China. *World Bank Technical Paper No. 187*. Asia Technical Department Series. The World Bank, Washington, DC, 1993.

DiMaggio, P.J., & Powell, W.W. (1983). The iron cage revisited: Institutional isomorphism and collective rationality in organizational fields. *American Sociological Review, 48(2),* p. 147-160.

Du, Z.Z. (2000). On the development of teachers of medical ethics in China. *Hastings Center Report, Jul-Aug,* p.S37-S40

Durkheim, E. (1981). *The Realm of Sociology as Science.* US: The University of North Carolina Press.

Dutton, J.E. (2005). Bridging the gap between management-organizational research and public policy. *Academy of Management Journal, 48,* 956-957.

Editorial (2008). The Second International Cancer Conference, *Chinese Journal of Clinicians, 36(10),* 80.

Eggleston, K. Li, L., Meng, Q., Lindelow, M., & Wagstaff, A. (2006). Health service delivery in China: A literature review. *World Bank Policy*

Research Working Paper 3978, World Bank.

Engel, G.V. (1969). The effect of bureaucracy on the professional autonomy of the physician. *Journal of Health and Social Behavior, 10(1),* 30-41.

Entwisle, V.A., & Quick, O. (2006). Trust in the context of patient safety problems. *Journal of Health Organization and Management, 20,* 397-416.

Epstein, I. (1970). Professionalization, professionalism, and social-worker radicalism. *Journal of Health and Social Behavior, 11(1),* 67-77.

Evetts, J. (2003). The sociological analysis of professionalism: Occupational change in the modern world. *International Sociology, 18,* 395-415.

Feldman, M. S. (2005). Management and public management. *Academy of Management Journal, 48*(6), 958-960.

Flint, K. (2001). Competition, race, and professionalization: African healers and white medical practitioners in Natal, South Africa in early twentieth century. *The Society History of Medicine, 14,* 23.

Fourcade, M. (2006). The construction of a global profession: The transnationalization of economics. *American Journal of Sociology, 112(1), 145-194.*

Freidson, E. (1970). *Professional Dominance: The Social Structure of Medical Care*. Chicago: Aldine.

Freidson, E. (1986). *Professional Powers: A Study of the Institutionalization of Formal Knowledge.* Chicago, US: The University of Chicago Press.

Freidson, E. (1988). *Profession of Medicine: A Study of the Sociology of Applied Knowledge.* New York, US: Dodd Mead.

Freidson, E. (1994). *Professionalism Reborn: Theory, Prophecy, and Policy*.

Chicago, US: University of Chicago Press.

Freidson, E. (2001). *Professionalism: The third logic*. Chicago, US: University of Chicago Press.

Fryer-Edwards, K., Eaton, E.V., Goldstein, E.A., Kimball, H.R., Veith, R.C, Pellegrini, C.A., & Ramsey, P.G. (2007) *Academic Medicine, 82,* 1073-1078.

Foster, P., & Wilding, P. (2000). Whither welfare professionalism? *Social Policy and Administration, 34(2),* 143-159.

Geels, F.W. (2004). From sectoral systems of innovation to socio-technical systems: Insight about dynamics and change from sociology and institutional theory. *Research Policy, 33,* 897-920.

Georgellis, Y., & Lange, T. (2007). Participation in continuous, on-the-job training and the impact on job satisfaction: Longitudinal evidence from the German labour market. *The International Journal of Resource Management, 18*(6), 969-985.

Gerrity, M.S., Earp,J.A.L., DeVellis, R.F, & Light, D.W. (1992). Uncertain and professional work: perceptions of doctors in clinical practice. *American Journal of Sociology, 97*, 1022-1051.

Gilb, C.L. (1966). *Hidden Hierarchies: The Professions and Government.* New York, US: Harper & Row, Publishers.

Gilbert, T.P. (2005) Impersonal trust and professional authority: exploring the dynamics. *Journal of Advanced Nursing, 49,* 568-577.

Goldstein, E.A., Ramoncita, R. M., Fryer-Edwards, K., Wenrich, M.D., Oelschlager, A.A., Baernstein, A., & Kimball, H.R. (2005). Professionalism in medical education: An institutional challenge.

Academic Medicine, 81, 871-876.

Goode, W. J. (1960). Encroachment, charlatanism, and the emerging profession: Psychology, sociology, and medicine, *American Sociological Review, 25,* 902-914

Greenwood, R., Suddaby, R., & Hinings, C.R. (2002). Theorizing change: The role of professional associations in the transformation of institutionalized fields. *Academy of Management Journal, 45*(1), 58-80.

Gruending, D. L. (1985). Nursing Theory: A Vehicle of professionalization? *Journal of Advanced Nursing, 10*(6), 553-558.

Gu, E. (2001). State corporatism and the politics of the state-procession relationship in China: A case study of three professional communities. *American Asian Review, 19(4),* 163-199.

Gu, W. & Zhang, J. (2006). Health care regime change in urban China: Unmanaged marketization and reluctant privatization. *Pacific Affairs*, 79(1), 49-71

Hall, R. H . (1968). Professionalization and bureaucratization. *American Sociological Review, 33(*1), 92-104.

Hall, M.A. (2002). Law, medicine and trust. *Standford Law Review, 55,* 463.

Hall, M.A., Zheng, B., Dugan, E., Camacho, F., Kidd, K.E., Mishra, A., & Balkrishnan, R. (2002) Measuring patients' trust in their primacy care providers. *Medical Care Research and Review, 59,* 293-318.

Harries-Jenkins, G. (1970). Professionals in organizations. In J.A. Jackson. *Professions and Professionalization.* London, UK: Cambridge University Press.

Harrison, S., & Ahmad, W.I.U. (2000). Medical autonomy and the UK state

1975-2025. *Sociology, 34(1),* 129-146.

Haywood-Farmer, J., & Stuart, F.I. (1990). An instrument to measure the 'degree of professionalism' in a professional service. *The Service Industries Journal, 10(2),* 336-347.

Hellmann, T., & Puri, M. (2002). Venture capital and the professionalization of start-up firms: Empirical evidence. *The Journal of Finance, 57(1),* 169-197.

Hem, M.H., & Heggen, K. (2003). Being professional and being human: One nurse's relationships with a psychiatric patient. *Journal of Advanced Nursing, 43,* 101-108.

Henderson, G.E., & Cohen, M.S. (1984). *The Chinese Hospital: A Socialist Work Unit.* New Haven, US: Yale University Press.

Hillman, A.J. (2005). Reflections on service orientations, community, and professionals. *Academy of Management Journal, 48,* 185-188.

Hitt, M.A. (2005). Management theory and research: potential contribution to public policy and public organizations. *Academy of Management Journal, 48,* 963-966.

Hoff, T. J., & Mandell, J. (2001). Exploring dual commitment among physician executives in managed care / practitioner application. *Journal of Healthcare Management, 46*(2), 91-111.

Howell, J. (2004). *Governance in China.* US: Rowman & Littlefield Publisher, Inc.

Hu, S., Chen, W., Cheng, X.M., Chen, K.Y., Zhou, H.Y., & Wang, L.X. (2001). Pharmaceutical cost-containment policy: experiences in Shanghai, China. *Health policy and Planning, 16(Suppl 2)*, 4-9.

Huang, Y.C., & Ke, B.Z. (2000). The role of medical associations in developing professional values. *Hastings Center Report, Jul-Aug,* S17-S19.

Imanaka, Y. (1997). Professionalism and consumerism: Can they grow together? *International Journal for Quality in Health Care, (9)6,* 395-397.

Irvine. D. (2001). Doctors in the UK: their new professionalism and its regulatory framework. The Lancet, 358, 1807-12.

Irvine. D. (2004). Professionalism: dead or alive? *The Lancet, 364*, 1479-80.

Jackson, J.A. (1970). *Professions and Professionalization.* London, UK: Cambridge University Press.

Jacob, M., & Bosanac, S.E. (2006). *The Professionalization of Work*. US: de Sitter Publications.

Jenkins. J. (2006). Correspondence -- Doctors in Society. *The Lancet, 367*, 646.

Johnson, T. (1972). *Professions and Power*. London, UK: Macmillan Press.

Kater, M.H. (1985). Professionalization and socialization of doctors in Wihelmine and Weimar Germany. *Journal of Contemporary History, 20(4)*, 677-701.

Kay, J., & Blythe, M. (1984). Professionalization of the older medical student. *Journal of Medical Education, 59,* 559-566.

Kennerley, J.A. (1993). Professional autonomy in the medical field. *Journal of Management in Medicine, 7(2),* 43-47.

Keogh, J. (1997). Professionalization of nursing: development, difficulties and solutions. *Journal of Advanced Nursing, 25,* 302-308.

Kim, C., & Lim, B. (2004). Modernized education of traditional medicine in Korea: is it contributing to the same type of professionalization seen in Western medicine? *Social Science & Medicine, 58,* 1999-2008.

Klein, R. (1990). The state and the profession: the politics of double beds. *British Medical Journal, 301,* 700-702.

Kwon, I. G., & Banks, D.W. (2004). Factors Related to the Organizational and Professional Commitment of Internal Auditors. *Managerial Auditing Journal, 19*(5), 606.

Larson, M.S. (1977). *The Rise of Professionalism: A Sociological Analysis.* University of California Press, Berkeley, CA, USA.

Latham, S.R. (2002). Medical professionalism: A Parsonian view. *Mount Sinai of Medicine, 69(6).*

Lehmbruch, G. (1987). Reviewed work(s): Corporatism and political theory by Alan Cawson *The American Political Science Review*, 81(4), 1384-1385.

Leitch, K.T., & Fennel, M.L. (1997). The changing organizational context of professional work. *Annual Review of Sociology, 23,* 215–31.

Liamputtong R.P, & Ezzy D. (1999) *Qualitative Research Methods: A Health Focus.* Melbourne: Oxford University Press

Liu, Z.X., Liu, Y.L., & Chen, N.S. (2000). The Chinese experience of hospital price regulation. *Health policy and Planning, 15(2)*, 157-163.

Lo, C.W., & Snape, E. (2005). Lawyers in the People's Republic of China: A study of commitment and professional. *The American Journal of Comparative Law, 53(2)*, 433-456.

Lo, C.W., Snape, E., & Redman, T. (2004). Assessing a Multi-Dimensional Model of Occupational Commitment: A Study of Lawyers in China.

Lounsbury, M. (2002). Institutional transformation and status mobility: The professionalization of the field of finance. *Academy of Management*

Journal, 45(1), 255-266.

Lu, K.Y., Lin, P.L., Wu, C.M., Hsieh, Y.L., & Chang, Y.Y. (2002). The relationships among turnover intentions, professional commitment, and job satisfaction of hospital nurses. *Journal of Professional Nursing, 18,* 214-219.

Macdonald, K.M. (1995). *The Sociology of the Professions.* London, UK: Sage Publications.

Marcus, E.R. (1999). Empathy, humanism, and the professionalization process of medical education. *Academic Medicine, 74,* 1211-1215.

McKinlay, J.B., & Arches, J. (1985) Towards the proletarianization of physicians. *International Journal of Health Services, 15(2)*, 161–194

McKinlay, J.B., & Marceau, L.D. (2002) The end of the golden age of doctoring. *International Journal of Health Services, 32(2)*, 379–416

Meng, Q., Sun, Q., & Hearst, N. (2002). Hospital charge exemptions for the poor in Shandong, China. *Health Policy, 68,* 197-209.

Meng, Q., Rehnbery, C., Zhuang, N., Bian, Y., Tonson, G., & Tang, S. (2004a). The impact of urban health insurance reform on hospital charges: a case study from two cities in China. *Health Policy and Planning, 17(Suppl 1),* 56-63.

Meng, Q., Shi, G., Yang, H., Gonzalez, M., & Blas, E. (2004b). Health policy and system research in China. WHO.

Merton, R.K. (1957). *Social Theory and Social Structure.* New York, US: Free Press.

Merle, J., & Bosanac, S.E. (2006). *Professionalization of Work,* US: de Sitter

Publications.

Meulenbergs, T., Verpeet, E., Schotsmans, P., & Gastmans, C. (2004). Professional codes in a changing nursing context: literature review. *Journal of Advanced Nursing, 46(3),* 331-336.

Meyer, J.P., Allen, N.J., & Smith, C.A. (1993). Commitment to organizations and occupations: extension and test of a three-component conceptualization. *Journal Applied Psychology, 78,* 538-551.

Meyer, J.W., & Rowan, B. (1977). Institutionalized organizations: Formal structure as myth and ceremony. *American Journal of Sociology, 83(2),* p. 340-363.

Millerson, G. (2006). T*he Qualifying Associations: A Study in Professionalization.* London : Routledge.

Mills, A., Vaughan, J.P., Smith, D.L. & Tabibzadeh, I. (1990). *Health System Decentralization: Concepts, Issues, and Country Experience.* Geneva: WHO.

Montagna, P.D. (1968). Professionalization and bureaucratization in large professional organizations. *The American Journal of Sociology, 74(2),* 138-145.

Neapolitan, J. (1980). Occupational change in mid-career: An exploratory investigation. *Journal of Vocational Behavior, 16,* 212–225.

Neal, M., & Morgan, J. (2000). The professionalization of everyone? A comparative study of the development of the professions in the United Kingdom and Germany. *European Sociological Review, 16(1),* 9-26.

North, D.C. (1989). Institutions and economic growth: An historical introduction. *World Development, 17(9),* 1319-1332.

North, D.C. (2005). *Institutions, Institutional Change and Economic Performance: Political Economy of Institutions and Decisions.* UK: Cambridge University Press.

Ohlen, J., & Segesten, K. (1998). The professional identity of the nurse: Concept analysis and development. *Journal of Advanced Nursing, 28*(4), 720-727

Paterson, H. (1974). *Health Care in China. An Introduction: The Report of a Study group in Hong Kong.* Geneva: Christian Medical Commission.

Pearce, J. (2004). What do we know and how do we really know it? *Academy Management Review*, 29(2), 175-179

Pearson, S.D., & Raeke, L.H. (2000). Patients' trust in doctors: Many theories, few measures, and little data. *Journal of General Internal Medicine, 15,* 509-513.

Pellegrino, E.D. (2002). Professionalism, professional and the virtues of the good physician. *The Mount Sinai Journal of Medicine, 69(6),* 378-384.

Peng, R.C. (2000). How professional values are developed and applied in medical practical in China. *Hastings Center Report, Jul-Aug,* S23-S26

Perloff, R.M., Bonder, B., Ray, G.B., Ray, E.B., & Siminoff, L.A. (2006). Doctor-patient communication, cultural competence, and minority health. *American Behavioral Scientist, 49(6),* 835-852

Pettigrew, A.M. (2005). The character and significance of management research on the publics services. *Academy of Management Journal, 48(6),* 973-977.

Polgar, S. & Thomas, S.A. (2008). *Introduction to Research in the Health Sciences* (5th ed). Edinburgh: Churchill Livingstone.

Porter, S. (1992). The poverty of professionalization: a critical analysis of

strategies for the occupational advancement of nursing. *Journal of Advanced Nursing, 17*, 720-726.

Quah, S.R. (1989). The social position and internal organization of the medical profession in the Third World: The case of Singapore. *Journal of Health and Social Behavior, 30(4),* 450-466.

Reed, M., & Anthony, P. (1992). Professionalizing management and managing professionalization: British management in the 1980s. *Journal of Management studies, 29(5),* 591-613

Reynolds, P.P. (1994) Reaffirming professionalism through the education community. *Annals of Internal Medicine, 120(7),* 609-614.

Reynolds, W.J., & Scott, B. (2000). Do nurses and other professional helpers normally display much empathy? *Journal of Advanced Nursing,31(1),* 226-234.

Ritzer, G. (1975). Professionalization, bureaucratization and rationalization: The views of Max Weber. *Social Forces, 53,* 627-34.

Ritzer, G., & Walczak, D. (1986). *Working: Conflict and Change*. 3d ed. US: Prentice-Hall.

Ritzer, G., & Walczak, D. (1988). Rationalization and the deprofessionalization of physicians. *Social Forces, 67(1),* 1-22.

Roberts, L.M. (2005). Changing faces: professional image construction in diverse organizational settings. *Academy of Management Review, 30,* 658-711.

Rosenthal, M.M. (1987). *Health Care in the People's Republic of China: Moving Toward Modernization*. Westview Press, Colorado, US.

Rosenthal, M.M. Pongor, P., 1987, 'Rural Health Care Delivery in the People's Republic of China: Is it Equitably Distributed?' In M.M. Rosenthal,

Health Care in the People's Republic of China: Moving Toward Modernization. Westview Press, Colorado, US.

Rowan, B. (1982). Organizational structure and the institutional environment: The case of public schools. *Administration Science Quarterly, 27,* 259-279.

Rynes, S.L. & Shapiro, D.L. (2005). Public policy and the public interest: what if we mattered more? *Academy of Management Journal, 48,* 925-927.

Saks, M. (1995). *Professionals and the Public: Medical Power, Altruism and Alternative Medicine.* New York, US: Routledge.

Schlesinger, M.J., Bradford, H.G., & Perreira, K.M. (1997). Medical professionalism under managed care: The pros and cons of utilization review. *Health Affairs, 16(1),* 106-124.

Schlesinger, M. (2002). A los of faith: The source of reduced political legitimacy for the American medical profession. *The Milbank Quartly, 80(2),* 185-235.

Schmitter, P.C. & Lehmbruch, G. (1979), *Trends Toward Corporatist Intermediation* Beverly Hills, Calif.: Sage.

Scott, W. R. (1965). Reaction to supervision in a heteronymous professional organization. *Administrative Science Quarterly, 10(1),* 65-81.

Scott, W.R., & Meyer, J.W. (1983). *Organizational environments: Ritual and rationality.* US: Sage.

Scott, W.R. (1987). The adolescence of institutional theory. *Administrative Science Quarterly, 32(4)*, 493-511.

Scott, W.R., 1995. *Institutions and Organizations*. Sage Publications, London/New Delhi.

Scott, C. (1998). Specialist practice: advancing the profession? *Journal of*

Advanced Nursing, 28(3), 554-562.

Scott, W. R. (2000). *Institutions and Organizations*. Thousand Oaks: SAGE.

Shann, M.H. (1998). Professional Commitment and Satisfaction Among Teachers in Urban Middle Schools. *The Journal of Education Research*, 92(2), 67-73

Shapiro, D.L. & Rynes, S.L. (2005). The role of management scholarship in the public sector: using the commentaries to move forward. *Academy of Management Journal, 48,* 989-998.

Sheldon, M. (1971). Investment and involvement as mechanisms producing commitment to the organization. *Administrative Science Quarterly, 16(2),* 143-150.

Smith, L.G. (2005). Medical professionalism and the generation gap. *The American Journal of Medicine, 118(4),* 439-442.

Sokolowski, S.W. (2001). *Civil Society and the Professions in Eastern Europe: Social Change and organizational Innovation in Poland.* New York: Kulwer Academic/Plenum Publishers.

Sox, H. C. (2003). Medical professionalism in the new millennium: A physician charter. *Annals of internal Medicine, 136,* 243-246.

Starr, P. (1982) *The social transformation of American medicine.* New York, US: Basic Books.

Studdert, D.M., Mello, M.M., Sage, W.M., DesRoches, C.M., Peugh, J., Zapert, K., & Brennan, T.A. (2005). Defensive medicine among high-risk specialist physicians in a volatile malpractice environment. *JAMA, 293(21),* 2609-2617.

Sullivan, W.M. (2002). Medicine under threat: professionalism and professional

identity. *Canadian Medical Association Journal, 162(5),* 673-675.

Sutton, S. (1998). Predicting and explaining intentions and behavior: How well are we doing? J*ournal of Applied Social Psychology. 28,* 1317–38.

Swick, H.M. (2000). Toward a Normative Definition of Medical Professionalism. *Academic Medicine, 75(6), 612-616.*

Thom, D.H., Hall, M.K., & Pawlson, L.G.. (2004). Measuring patients' trust in physicians when assessing quality of care. *Health Affairs, 23,* 124.

Thompson, P.H., Baker, R.Z., & Smallwood, N. (1986) Improving professional development by applying the four-stage career model. *Organizational Dynamic, 15(2),* 49-62.

Thornton, R. (1970). Organizational involvement and commitment to organization and profession. *Administrative Science Quarterly, 15(4),* 417-426.

Tolbert, P.S. & Zucker, L.G. (1983). Institutional source of change in the formal structure of organization: The diffusion of civil service reform, 1880-1935. *Administrative Science Quarterly, 28*, p. 22-39.

Troyen, A.B. (2002). Physicians' professional responsibility to improve the quality of care. *Academic Medicine*, 77(10), 973-980

Turner, C., & Hodges, M.N. (1970). Occupation and profession. In J.A. Jackson. *Profession and Professionalization.*UK: Cambridge University Press.

Unger, J., & Chan, A. (1995). China, corporatism, and the East Asian model. *The Australian Journal of Chinese Affairs, 33,* 29-53.

Unschuld, P., (1985). *Medicine in China: A History of Ideas*. University of California Press, LA, US.

Veloski, J.J., Fields, S.K., Boex, J.R., & Blank, L.L. (2005). Measuring professionalism: A review of studies with instruments reported in the

literature between 1982 and 2002. *Academic Medicine. 80,* 366–370.

Wallace, J.E. (1995). Organizational and professional commitment in professional and nonprofessional organizations. *Administrative Science Quarterly, 40(2),* 228-255.

Wang, S. (2004). China's Health System: From Crisis to Opportunity. *Yale-China Health Journal, 3*, 5-49.

Wang, N.S., & Zhang, L.C., (1996). PRC country cooperation system developmental history and experience-learning. *China Health Economics*, 15(8), 14.

Weber, M. (1947). *The Theory of Social and Economic Organization.* New York: Oxford Univ. Press.

Wilde, G. (1998). *China to 2010: the pace of reform.* London, UK: Economist Intelligence Unit.

Wildt, G., Chandramohan, D. & van der Meer, J. (2000). International health aid and professional independence: the need for quality standards and self-regulation. *Health Policy and Planning, 15(2),* 235-236.

Wilensky, H.L. (1964). The professionalization of everyone? *The American Journal Sociology, 70(2),* 137-158.

Tolbert, P.S. & Zucker, L.G. (1983). Institutional source of change in the formal structure of organization: The diffusion of civil service reform, 1880-1935. *Administrative Science Quarterly, 28*, p. 22-39.

Wang, S. (2004). China's health system: From crisis to opportunity, *Yale-China Health Journal, 3,* 5-49.

Weinberg, M.S., & Haavio-Mannila, E. (1967). The Medical profession in Finland. *Journal of Health and Social Behavior, 8(3),* 228-233.

Weiss, G.L. (2003). *The Sociology of Health, Healing, and Illness.* Upper Saddle River, US: Prentice Hall.

Wilde, G. (1998). *China to 2010: The pace of reform*. London: Economist Intelligence Unit.

WHO (2005). *China: Health, poverty and economic development*. Office of the World Health Organization Representative in China and Social Development Department of China State Council Development Research Center.

WHO (2006). *Working together for health: The world health report 2006.* WHO.

WHO (2006). Application of International Health Regulation. In *Fifty-ninth Assembly Agenda Item 11.1*, WHA59.2

Xu, X. (2001). *Chinese Professionals and the Republican State: The Rise of Professional Associations in Shanghai, 1912-1937*. New York, US: Cambridge University press.

Xu, D., Sun, B.Z. , Wan X.H. & Ke, Y. (2010). Reformation of medical education in China, *The Lancet*, *375 (9725)*, 1502 – 1504.

Yang, C.I., Gau, M.L., Shiau, S.J., Hu, W.H., & Shih, F.J. (2004). Professional career development for male nurses, *Journal of Advanced Nursing, 48(6),* 642–650.

Yip, W.C. & Hsiao, W. (1997). Medical Savings Accounts: Lessons from China. *Health Affairs*, *16(6),* 244-251

Zhang D. & Cheng, Z. (2000). Medici ne is a human art: The basic principles of professional ethics in Chinese medicine. *Hastings Center Report, Jul-Aug,* S8-S12

Zucker, L.G. (1977). Institutional theories of organization. *Annual Review of*

Sociology, 13, p. 443-464.

中文参考文獻：

馬文元 (2003)《醫德變革的形勢》中國職業道德在線:

http://www.zgzydd.com/news/ShowArticle.asp?ArticleID=152

金紅梅 (2006) 中國研究生教育地區發展差異及其對策研究，《現代大學教育》第一期, 89-94

劉鵬 (2006). 《合作醫療與政治合法性：一項衛生政治學實證研究一》,《華中師範大學學報》(人文科學版), 第二期。

李剛 (1994) 大學的終結 – 1950 年代初期的"院系調整", 香港中文大學大學服務中心數據庫 http://www.usc.cuhk.edu.hk/wk_wzdetails.asp?id=2526

《關於中國醫師註冊的有關規定》香港醫學組織聯會文庫 23/01/2008 13:09p.m.

http://www.fmshk.org/article/786.pfd

《醫家五戒十要》http://www.foyin.org/Ciguang/ShowArticle.asp?ArticleID=70766

《中國醫科大學歷史沿革》http://www.cmu.edu.cn/new/showpage.asp?pageid=324

《我院是怎樣建立醫德檔案的》中國職業道德在線

http://www.homejob.cn/cms/html/law/daode/1365.html

《我國將建立醫務人員醫德考評制度》重慶法制網

http://www.cqfzb.com/n15726c43.aspx

《廣東醫療終結政府定價 改為政府指導價》南方網

http://news.163.com/06/0626/09/2KHL5OAO0001124J.html

《中國醫科大學歷史革命沿革》2007/12/19 15:15

http://www.cmu.edu.cn/new/showpage.asp?pageid=324

《中山大學醫學院》2007/12/19 15:10

http://zssom.sysu.edu.cn/column.aspx?cid=256

《臨床醫學八年制 -中山大學醫學院》

http://zssom.sysu.edu.cn/newsView.aspx?id=641

「醫藥學人才培養模式的變化(1)-(3)」高等教育出版社，《人民網》，2009/04/22

「醫療差錯讓全球頭痛業內: 應讓醫生敢匯報差錯」《人民網 – 生命時報》，2009/04/21

「患者多多多 醫生不堪重負難招架」《天府早報》，2007/05/29

「調查顯示: 七成患者就醫時不相信醫生或半信半疑」《中國青年報》，2007/05/29

「我國醫務人員壓力大 醫患關係緊張 醫生改行賣藥」《中國青年報》，2006/09/16

「醫改調查: 宿遷三年來回應『賣光式』醫改」《中國青年報》，2006/03/23

「院士轟醫療水平遜非洲 『小康不小康 關鍵看健康』」《明報》, 2007/03/12

「廣東省正式出台醫療服務價格規範和調整方案」《新華網》, 2006/06/24

「高強痛批醫藥購銷領域的商業賄賂」《新華網》, 2006/03/28

「新華視點：院長帶頭搞腐敗 醫生七成吃回扣」《新華網》，2006/02/17

「醫師不得擅自外出會診」《南方日報》2005/07/01

「一到醫院錢就不是錢了，七成公眾表示擔心」《央視國際》，2005/06/06

「北京首批具高級職稱的社區全科醫生即將產生」《北京青年報》2004/11/18

「50 名住院醫師 "入院上課"」《大眾日報》2004/08/12

「跨國公司研發機構紛紛落戶北京」《人民日報海外版》，2000/08/05

「中國醫改: 醫生為何沈默」《新民週刊》466 期

「中國內地醫院首次敲開國際市場大門」《浙江日報》2007/05/28

中華人民共和國衛生部 (1988)《醫務人員醫德規範及實施辦法》

中華人民共和國衛生部 (1988)《醫師、中醫個體開業暫行管理辦法》

中華人民共和國衛生部 (1999)《執業醫師法》

中華人民共和國衛生部 (1999)《執業醫師注冊暫行法》

中華人民共和國衛生部 (1999)《醫師資格考試暫行法》

中華人民共和國衛生部 (2007)《關於建立醫務人員醫德考評制度的拍導意見(試行)》

中華人民共和國衛生部 (1999)《衛生部衛生立法工作管理辦法》

中華人民共和國衛生部 (1987)《醫療事故處理辦法》

中華人民共和國衛生部 (2002)《醫療事故技術鑒定法》

中華人民共和國國務院學位委員會 (1981)《學位條例暫行實施辦法》

中華人民共和國國務院 (2011) 《關於建立全科醫生製度的指導意見》(國發〔2011〕23 號)

中國醫師協會《中國醫師協會簡介》

中國醫師協會 – 維權行動 (2005/11/11) 《眾多醫生為何擔憂執業環境》

中國醫師協會 – 新聞中心 (2007/06/05) 《去年近 6000 醫務人員被打傷》

中國醫師協會 – 新聞中心 (2007/04/24) 《八成醫師希望改善執業環境》

中國醫師協會 – 新聞中心 (2007/03/26) 《醫療服務行業成為衛生監督重點》

中國醫師協會 – 新聞中心

AMA official website, http://www.ama-assn.org/

BMA official website, http://www.bma.org.uk/

Chinese Medicine Association, http://www.cma.org.cn/ ;

Chinese Medical Doctors Association, http://www.cmda.gov.cn/