Mistrust of physicians in China: society, institution, and interaction as root causes

Cheris Shun-ching Chan

Abstract

Based on two years’ ethnographic research on doctor-patient relations in urban China, this paper examines the causes of patients’ mistrust of physicians. I identify the major factors at the societal, institutional, and interpersonal levels that lead to patients’ mistrust of physicians. First, I set the context by describing the extent of mistrust at the societal level. Then, I investigate the institutional sources of mistrust. I argue that the financing mechanism of public hospitals and physicians’ income structures are the most crucial factors in inducing patients’ mistrust. Hospitals’ heavy reliance on self-finance has basically caused public hospitals to run like private hospitals, resulting in blatant conflicts of interest between hospitals and patients. Related to this is physicians’ reliance on bonuses and commissions as part of their regular incomes, which has inevitably resulted in overtreatment and, hence, mistrust from the patients. At the interpersonal level, I describe how individual physicians’ attitudes toward and interaction with patients may also affect patients’ sense of trust or mistrust in physicians. In conclusion, I discuss the ethical implications of the mistrust problem, and suggest changes at the institutional and interpersonal levels to mitigate the problem.

KEYWORDS
bioethics, China, medical ethics, mistrust, doctor-patient relation

INTRODUCTION

The following poem posted on a popular online forum in January 2011, though polemical, conveys the public mistrust and resentment of physicians in China:

Robbers usually rob only at night, doctors rob all day....
Robbers rob only what you have with you at the moment, doctors rob all of your savings....
Robbers rob with fear and caution, doctors rob openly without fear; Robbers are afraid of being caught, doctors even rob police....
Robbers dress as evil-doers, doctors dress up as angels; Robbers run away after robbing you, doctors kick you out after robbing you; Robbers will be put to death if they rob too much, doctors will be admired for their contributions if they rob too much.... Doctors perhaps will not be robbed by robbers in their lives, robbers surely will be robbed by doctors; Doctors must have been robbers in their previous lives, robbers wish to be doctors in their next lives.1

The public mistrust of physicians has led desperate Chinese patients to rely on social networks and unofficial payments to assure themselves that physicians will fulfill their fiduciary obligation.2 The problem of mistrust has also led to increasing tension between patients and physicians. China has recently seen a dramatic rise in the number of conflicts between patients and physicians, from about 5,000 documented cases in

1“Qiangdao yu Yisheng” [Robbers and Doctors].”Tianya Shequ [The Remotest Corner of the Earth Community], posted in January 2011. Available from http://bbs.city.tianya.cn/tianyacity/content/59/1/602281.shtml. Tianya Shequ has been one of the most popular online forums in China since the mid-2000s. As of March 2013, it has 85 million registered users.

2002 to over 17,000 cases in 2010. Physical violence against physicians in China has become an urgent social problem that has even drawn attention from the editorial board of The Lancet. The imperative to rebuild physician-patient trust has become a prime concern of scholars and researchers across disciplines. One significant consequence of patients’ physician-patient trust has become a prime concern of scholars and researchers across disciplines. One significant consequence of patients’ mistrust is that physicians have become highly guarded when they interact with patients, thus adversely affecting their clinical treatment. But to mitigate the problem, we have to first understand its root causes.

Based on two years’ ethnographic research of doctor-patient relations in urban China, I explore the sources of patients’ mistrust of physicians at the societal, institutional, and interpersonal levels. As Yan in this volume has already provided an in-depth analysis of mistrust at the societal level, I will focus more on the institutional and interpersonal levels. In doing so, I bring a sociological perspective to understanding both the structure and the process that have led to the problem. I argue that the most critical causes of mistrust are rooted in institutional arrangements, particularly the financing mechanism of public hospitals and physicians’ income structure. Just as Nie warns against stereotyping East-West cultures in a dichotomy when we examine differences in medical ethics, I maintain that the sources of the mistrust problem in hospital care in China nowadays are primarily institutional. In addition, individual physicians’ attitudes toward and interactions with patients also affect patients’ perception and, hence, trust or mistrust of physicians.

The data presented in this paper were collected from July 2011 to September 2014 through observations and interviews conducted by myself and my research assistant in Guangzhou, Beijing, Shanghai, and Xi’an. We conducted observations in outpatient and inpatient wards in major hospitals in these cities and completed 164 interviews. The interviewees included 61 physicians, 14 medical students, 20 nurses, administrators, and social workers, 44 patients and 25 patients’ family members. They were recruited through three different channels: (1) we contacted our friends in China to reach out to the personnel in hospitals and to the local residents who had received hospital care (or had a family member who had done so); (2) we employed “cold calling” to reach out to physicians in various hospitals; (3) we conducted non-random sampling surveys to identify patients and their family members who were willing to be interviewed. We deployed different means of interviewee recruitment in order to strike a balance among the biases that may arise from each method. However, we still cannot eliminate the self-selection bias among the physician interviewees. The physicians who were willing to be interviewed were usually those who patients approved of, the so-called “good doctors.” Those who tended to over-prescribe medicines and exercise other “unethical” practices were less willing to accept our interview invitations. Fortunately, most non-medical-related laymen were very willing to talk to us about their experiences of seeking medical care, regardless of whether their experiences were good or bad. The patients/family members we interviewed had seen doctors of different types in different hospitals, and their accounts of what happened to them helped us grasp the whole picture.

In the sections that follow, I first define the concepts of trust and mistrust based on a sociological perspective. Then, I describe the problem of mistrust in medical care in general terms in order to position the Chinese case. Using interview data, I identify three major sources of patients’ mistrust of physicians in China at the societal, institutional, and interpersonal levels, respectively. I particularly highlight institutional factors as the root cause of mistrust and suggest possible changes to mitigate the problem.

2  |  THE CONCEPTS OF TRUST AND MISTRUST

Definitions of trust are diverse across different disciplines, and there is much conceptual variation even within the sociological literature. What is shared in common, nonetheless, is that trust is inseparable from vulnerability and intent. Trust, by definition, is an expectation that other parties have goodwill and benign intent in interacting with an agent who is lacking perfect information, or incapable of correctly detecting the intent of the other parties who have incentives to act dishonestly. This definition centers on the motivational basis of trust, and highlights the absence of pertinent information about another party’s future actions. Social uncertainty or ignorance, thus, is a precondition for trust, without which trust is unnecessary. This definition underscores the asymmetric dependence and vulnerability of the trusting agent.

What distinguishes trust from confidence is the nature of ignorance. Ignorance can refer to a lack of knowledge claimed by technical experts, or a lack of knowledge about the intentions of the persons on whom an agent relies. The former refers to the expectation of a partner’s competence, which defines the concept of confidence. The latter refers to the partner’s benign motivation, which qualifies the concept of trust. Confidence and trust, though related, are logically independent. For instance, a patient told by a surgeon that she/he is in need of surgery could have confidence in this surgeon’s technical skills, but still suspect that the surgeon is conducting the surgery for his own

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economic or professional interest rather than for the patient's benefit. Or she/he may trust the surgeon's intent, but not have confidence in the surgeon's skills. The intent or the motivation of the other party, therefore, is primary in constituting trust or mistrust.14

The conceptual variation in theories of trust inevitably led to disparate conceptualizations of mistrust and its relation to trust. While some define mistrust as a negation of trust and posit trust and mistrust on a continuum, others conceive trust and mistrust as separate, though linked dimensions and, hence, allow them to co-exist in some circumstances. If we adopt Yamagishi and Yamagishi's delimited definition of trust in motivational terms, it is impossible for both trust and mistrust to coexist. Instead, mistrust is the opposite of trust in terms of the perceived intent of the other party. It is defined by having anxious or pessimistic views of the intent of the other party and the expected results. As we can speak of degrees of trust, we can also speak of degrees of mistrust.

### 3 | THE PROBLEM OF MISTRUST IN MEDICAL CARE

The problem of mistrust of physicians in China is not a peculiar case, but it is an extreme case. A number of studies have shown that there has been a declining public trust in medical care and in physicians' moral standards even in developed countries during the past few decades. Economists attribute the problem to information asymmetry between patients and physicians, and to patients' inability to judge the quality of services rendered. As information asymmetry and the uncertainties inherent in medical care are temporally and geographically universal, they cannot explain the recent decline in trust of physicians. Nonetheless, they do highlight patients' sense of uncertainty in seeking medical care, which calls for reliance on trust in medical care providers.

However, trust is a risky investment. Given their information asymmetry, patients have to accept asymmetric dependence on medical care providers and expect their physicians to act in their best interest. As the principle of profit-maximizing is incompatible with the condition for trust in medical care providers, physicians cannot act, or at least appear to act, as if they are maximizing their incomes. Fidelity, with which care providers pursue patients' best interests and do not take advantage of their vulnerability, is a prime component of trust in medical care. Medical ethics scholars propose that physicians' restraint on the desires of private interests is a crucial condition for patients' trust of physicians. On the contrary, if physicians pay attention to profits and are seen by the public as being profit-driven, they are likely to induce mistrust from patients. Studies have found that various financial incentives to American physicians for remunerative causes, along with increased scrutiny from the media, have shaken the general trust relations between patients and physicians in the United States in recent decades. The erosion of public trust in medical care, according to sociological analyses, is a consequence of the managed care model that structures hospital management and the financial incentives of physicians. Nonetheless, despite growing public mistrust, the evidence shows that the overwhelming majority in developed countries still express trust in their physicians. At the same time, the well-established institutions of professionalism and legalism in the United States provide a mechanism of assurance for patients. Doctors' status in the United States (and most English-speaking countries) is derived from corporate disinterested professional services and ethical compliance. The general public in these countries deals with the problem of trust by advocating for patients' rights as consumers and through lawsuits.

The societal and institutional setting in the People's Republic of China (PRC) is quite different. Traditionally, the source of trust in Chinese medical doctors was based on the moral foundation of Confucianism, Taoism, and Buddhism. However, as Yan details in this volume, the traditional moral principles were, to a large extent, shattered in the process of marketization in post-Mao era. At the same time, medical professionalism has not been developed in China. Even today doctors in the PRC have no independent professional associations to regulate their ethical practices or to provide them with occupational support. Furthermore, the legal framework for medical disputes in China is ambiguous and neither patients nor physicians...
have confidence in its capacity for handling patient-physician conflicts efficiently and fairly. As the lack of professionalism and legalism intersects with a societal moral decline in post-Mao China, and the health care system channels physicians’ attention to profit, the problem of mistrust of physicians in China has become intense.

We were surprised to find that almost all of the patients and families we interviewed expressed some degree of mistrust in physicians. Those who had ever had unpleasant experiences for themselves or a family member (for example, overtreatment, an undesirable treatment outcome, or poor attitudes from physicians) expressed the highest degree of mistrusting physicians. Even those who had no bad experiences, still expressed a certain degree of mistrust of physicians based on the media’s reports of the “unethical” practices of physicians and hospitals (such as receiving kickbacks from pharmaceutical companies, subjecting patients to unnecessary treatments and diagnostic tests, and poor surgical outcomes, etc.). Our data do not suggest a pattern in the degree of mistrust in relation to socio-economic status (such as the gender, age, education, or income level) of the patients. The physicians and medical students we interviewed were very much disturbed by the general public’s mistrust of them, blaming the media for being biased against them. In response, they tended to exercise defensive medicine, what they called dabao (or an encompassing) approach, to protect themselves. The “encompassing” approach means prescribing more diagnostic tests, procedures, and drugs for the patients to make sure that “nothing is missed” in order to shield themselves from medical disputes. This approach has inevitably intensified the overtreatment problem and added fuel to the tension between doctors and patients. As I will discuss in the following section, the overtreatment problem was initially brought about by the financing mechanism of hospitals, and it is one of the sources of mistrust of physicians.

4 | ROOT CAUSES OF PATIENTS’ MISTRUST OF PHYSICIANS IN CHINA

4.1 | At the Societal Level

To examine the causes of patients’ mistrust of physicians at the institutional and interpersonal levels, it is important to first lay out the macro context of Chinese society. Sociological and anthropological studies document that visible interpersonal mistrust began to emerge in the PRC during the Cultural Revolution (1966-1976) and it developed into generalized mistrust in the aftermath of the Revolution. With the end of political turmoil and the beginning of market reform in the 1980s, the moral landscape began to change from collective to individual ethics. Subsequently, the progressive market reforms in the 1990s resulted in an ethical shift from responsibilities to rights. Pursuing self-interest, which was socially illegitimate as late as the 1980s, became legitimate towards the end of the 1990s. Getting rich became “glorious” and being “selfish” came to be seen as “part of human nature.” Consequently, “the changing moral landscape” in post-Mao China has bred societal public mistrust that poses a big challenge to medical ethics.

China in the 2000s has been experiencing an unprecedented moral outcry and widespread generalized mistrust since the economic reforms. The public mistrust in many sectors of life, such as food safety, law and courts, schools, and government bodies, are well reported. Ms. Tang from Beijing had the following comments:

People as a whole don’t have a sense of trust in physicians. We often suspect that each prescription given by physicians is driven by self-interest…. But this is not just about the physicians. The whole social atmosphere is like that. When I buy something from a department store or from a supermarket, I have the same suspicion.

The extent of mistrust at the societal level is not limited to certain professions. It is widespread in people’s daily life and daily encounters. This explains why thousands of mainland Chinese have been travelling to Hong Kong to purchase cans of formula and other daily necessities.

While consumers do not trust food producers and service providers, commodity providers do not trust their customers either. My own experience of shopping at the big chain supermarkets in Guangzhou is telling of this societal mistrust. All potential customers were supposed to lock up their handbags in the lockers at the entrance. Those who did not do so would have to go to a service counter to have their handbags or backpacks’ zippers locked by a plastic strip so that one could not open her/his bag inside the supermarket. This procedure was to prevent anyone from stealing things from the supermarket. And, even if someone wanted to buy just a couple of apples, she/he must put the

38Ibid.
39Ibid.
41Interview, Beijing, October 2012.
We don’t trust anything. If my parents knew that I was going to have an interview with you and would be talking to you like this, they would say, “Watch out! You might be cheated.” They would not want me to talk to you. They don’t trust anyone.44

Under this societal context of mistrust, physicians certainly cannot assume that patients will trust them once they walk into the hospital. Even worse, the institutional structure of hospital care in contemporary China often induces more suspicion than trust.

4.2 | At the Institutional Level

The Chinese health care system has been facing tremendous moral challenges.45 The online poem presented at the introduction of this paper highlights the general public’s worry that unethical medical practices could be driven by financial incentives. Our interview data indicate the same worry. While patients can tell whether a hospital is up to a certain standard in terms of medical technology and personnel by its ranking, they cannot tell if the physicians place the patients’ interests above their own. Ms. Tang from Beijing explained why she still worried when she went to a large tertiary hospital:46

To me, I worry more about the medical ethics than the medical skills issue. Those physicians who could work for a tertiary hospital must have a certain level of medical skill. Even if the physicians are junior and inexperienced, if they take your interest to heart, they could consult their supervisors or recommend that you see other specialists. That’s not a problem. What’s problematic is the conflict of interest, the fact that physicians can make money on me. As a result, I may have spent a lot of money and yet the disease may not be cured…. This is most worrisome and unethical. And this has happened a lot. My friends and colleagues and their children all have had this kind of unpleasant experience.47

What Ms. Tang said is typical of what other patients told us when it came to the question of trust and mistrust of physicians. When a physician gives them a prescription or orders a medical examination, they do not know if the physician is doing so for the patients’ benefit or for their own financial benefit. The ultimate source of this sense of mistrust, I argue, is rooted in institutional arrangements, namely the financing of public hospitals and physicians’ income structure.

Despite the appearance of private hospitals in major cities, public hospitals remain the largest medical care providers in mainland China today. By 2010, public hospitals provided 89 percent of the nation’s inpatient beds, and their utility rate was 90 percent, compared to only 59 percent in private hospitals.50 These public hospitals, however, have been suffering from dwindling government budgets in supporting their operation. While government budgets accounted for about 30 percent of hospital revenue in the 1970s and around 20 percent in the 1980s, the figures sharply dropped to around 6–7 percent in the 1990s and continued to remain low during the 2000s.49 In many places, government subsidies could no longer cover the basic payroll of health facilities. To make up for these losses, the state loosened some restrictions on hospitals’ operations to encourage them to raise money through other means, particularly by charging fees-for-services and marking up drug prices.50 At the same time, hospitals were permitted to link self-generated revenues to staff benefits and compensation (most commonly in the form of allowances, bonuses, and commissions). This freedom tempted hospitals to associate physicians’ incomes with the amount of revenue they generated.51 As a result, those physicians who had more patients, who prescribed more expensive drugs, and who ordered and performed more technologically advanced medical examinations could have higher incomes. Even those physicians who did not care about extra bonuses and commissions were still under pressure to meet quotas for consultations, prescriptions, and medical examinations set by their hospitals’ management teams. This problem began to surface in the 1990s and escalated in the 2000s.

The Ministry of Health was aware of the problem, and in 2004 issued a statement prohibiting linking physicians’ wages to prescriptions or medical examinations.52 However, reports of overtreatment were

46Interview, Guangzhou, November 2012.
48According to “The Rule of Tiered Hospital Management” (Yiyuan Fenji Guanli Banfa), public hospitals in China are divided into three categories: tertiary hospitals at the city and provincial level, secondary hospitals at the county level, and community hospitals and clinics below the county level. The tertiary hospitals have the best facilities and personnel for treating the most complicated illnesses and for conducting medical research.
49Interview, Beijing, December 2012.

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47Interview, Beijing, December 2012.
still frequent. For instance, in August 2005, an elderly patient was charged over 6 million yuan (US$722,891) for enormous amount of unnecessary treatment in a teaching hospital in Harbin. This patient died in two months after he was hospitalized, resulting in six top hospital administrators being fired.53 Yet, in December 2007, a young man who died soon after seeking treatment in Ningbo Tonghe Hospital for a common cold was found to have been injected with two types of antibiotics at the same time. The media investigation reported that the hospital had linked doctors’ incomes to prescriptions and diagnostic tests, and had issued warnings to some department heads for failing to meet economic targets.54 Available figures show that income from drug sales consistently made up around 45 percent of total hospital revenue from 2004 to 2011.55 In the meantime, because hospitals are their biggest customers, drug manufacturers often compete against each other by offering various kinds of benefits to hospital administrators and doctors. The most common benefits include kickbacks, non-cash gifts, free conferences and travel.56 Media coverage about over-prescription and overprovision of diagnostic tests was widespread, which consequently produced generalized public mistrust of hospitals and physicians.57

The problem persists, despite passage of the Tort Liability Law in 2010 that prohibits overtreatment and overprovision of diagnostic procedures. In a survey conducted in December 2013, more than 80 percent of physician respondents admitted exercising overtreatment in some form.58 One reason is that the Tort Liability Law shifted the burden of proof to establish medical fault from medical institutions to patients.59 Another reason is that traditionally, Chinese patients rarely resorted to litigation to settle medical disputes. Medical malpractice litigation is still infrequent, even after the implementation of the Tort Liability Law.60 During our data collection from 2011 to 2014, we never heard physicians or medical students talking about this new law. The law might have invited debate among policy makers and in the legal profession, but it did not seem to be a concern of medical professionals on the front lines.

The fact that public hospitals’ daily operations are self-financed is widely known to the general public. Not only do patients fear that physicians care less about their patients than about generating revenue for their hospitals, even the physicians themselves admit that hospitals operate like profit-oriented corporations. Dr. Wu, a junior physician in a tertiary hospital in Beijing, admitted that physicians were under pressure to prescribe certain drugs:

*Now all the hospitals are basically self-financed. To ensure that we (hospitals) have enough revenue to pay employees, we got to meet the basic quota. That is, when you (patients) come to my hospital for consultations, it is impossible for me to give all of you the cheapest medicines and examinations. Otherwise, my hospital will not survive. We all understand this.*61

Another junior physician, Dr. He in Shanghai, directly pointed to the economically-oriented governmentality of the state and the hospital management:

*Hospitals are absolutely profit-oriented. The amount of money that the government puts in for our education and health care is disproportionately small. As hospitals do not generate GDP, the government won’t give much money to physicians. Hospitals must rely on self-generated revenues.*62

Hospitals’ reliance on self-generated revenues puts pressure on the directors of various divisions to meet a “performance quota” (yeji, which refers to the turnover rates of patients and financial balance sheets). During my ethnographic study in one of the 3A hospitals in Guangzhou, I observed that the administrators listed a few divisions which had not met the “performance quota” at a meeting to shame them and to pressure them to admit more profitable patients.63

Hospitals’ reliance on self-finance directly and indirectly structures the incomes of physicians. In China, the income of a physician in a public hospital is typically composed of three parts: (1) basic salary according to a fixed scale set by the government; (2) various kinds of allowances, bonuses, and commissions given by hospitals’ management; and (3) “grey income” that refers to “red envelopes” containing cash (called hongbao in Chinese) from patients and kickbacks from pharmaceutical and medical equipment companies. Items (1) and (2) are legitimate incomes whereas item (3) is illegitimate. However, the basic salaries for all levels of physicians are embarrassingly minimal. For instance, the basic salaries for Office Physicians have been around 1500 – 2000 yuan (~US$240–320) per month from 2006 to 2013.64

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54Yang J. The power relationships between doctors, patients and the Party-state under the impact of red packets in the Chinese health-care system. Unpublished manuscript of PhD dissertation, School of social sciences and International Studies, University of New South Wales. 2008.
61Interview, Beijing, October 2012.
62Interview, Shanghai, August 2013.
63Observation, Guangzhou, February 2013.
64The source of the basic salary scale comes from “Recommendation for Medical Institutions on the Implementation of ‘The Scheme of Public Institutions Personnel’s Income Distribution’,” issued by the Ministry of Personnel, the Ministry of Finance, and the Ministry of Health, 2006. The scale was raised in October 2014 but employees were required to pay for pension premium starting in 2014. Consequently the actual amount they received remained low.
Accordingly, basic salaries normally account for only one-third to one-tenth of physicians’ legitimate incomes. The other two-thirds to ninetenths come from hospitals’ self-generated revenues. Some hospitals link physicians’ incomes directly to the amount of prescriptions, examinations, and tests that they order. Others distribute the revenues relatively evenly among physicians of similar ranks. Many variant distribution models were discerned in our studies. Nonetheless, regardless of model, physicians’ incomes largely rely on hospital revenues. The fact that physicians’ incomes are determined by self-generated hospital revenues constitutes the primary source of patients’ mistrust in physicians.

Many of our patient interviewees held a rather negative image of hospitals, seeing them as “money-snatching” institutions. They either experienced overtreatment firsthand or had friends and relatives who did so. For example, Mr. Tian in Xi’an explained why he mistrusted hospitals and physicians:

Once I suffered from the flu and I went to the hospital. What did the doctor do? He first ordered a test of my saliva. Then, he said my throat suffered inflammation. The doctor should have just given me some medicine, right? But he ordered an X-ray of my lungs, and then a CT scan…. It cost me almost a thousand yuan, just for the flu.66

Likewise, Ms. Rebecca Cheng in Guangzhou recounted how her cousin was subject to over-diagnostic tests when she suffered from cancer:

My cousin was diagnosed to have breast cancer in a tertiary hospital near her home. She wanted to consult a breast cancer specialist in a more famous hospital. Through many people she was finally referred to a specialist in XXX Hospital. However, it was not a good experience. The physician ordered a lot of clinical tests and examinations for my cousin. It took her an entire month to complete all these tests and examinations, and they cost a fortune. Her money was like “flowing to the river” (liushui).66

Ms. Cheng said she also encountered physicians who only cared about giving her “big prescriptions” (dachufang). A “big prescription” refers to prescribing many medicines. Intriguingly, many of the patients in my interviews used the amount of medicines a physician prescribes to judge whether the physician was trustworthy or not. They believed that the more medicines a physician prescribes, the less trustworthy this physician was. Indeed, patients often judged whether a physician was ethical or not by the amount of drugs the physician prescribed. Ms. Li from Guangzhou said she was generally dissatisfied with physicians because:

Some physicians only care about giving you medicine. The “ethically superior” ones will not give you too many medicines. But some physicians prescribe drugs to patients that cost a few hundred yuan. Some of the examinations they order are obviously unnecessary…. Although physicians are not poor and they don’t really need that extra money, some of them just want to pursue more and more.67

Dr. Wen, a senior physician in a secondary hospital said the majority of physicians did observe medical ethics. He repudiated the public accusation against doctors by saying that only few of them prescribed unnecessary medicines for commissions or rebates:

Physicians would not want to hurt patients on purpose. We all want to help our patients. Physicians’ commissions and rebates are given when we prescribe the medicines properly. These medicines are required for curing disease and they are used in the appropriate amount. The commissions and rebates are like a by-product of our proper treatment of patients.68

I believe Dr. Wen is right that the majority of physicians prescribe medicines primarily based on clinical considerations. However, Alex He found that over-prescription was correlated with the income level of physicians.69 The median- and low-income physicians were more inclined to over-prescribe as compared to the high-income group. In other words, their prescriptions could be driven by economic incentives rather than purely clinical considerations. In any case, patients have little knowledge to judge if certain drugs and procedures are absolutely necessary or not. The fact that part of the physicians’ income comes from drug commissions or rebates further promote a sense of mistrust. As long as hospitals rely on drug sales to support physicians’ incomes, patients will think that physicians prescribe this or that medicine for their own economic benefit. Just as Dr. Qi in a community hospital said:

Some patients are quite rude to us. When we order an examination, some patients say, “I know you want to make more money.” Or when we give them prescriptions, they say, “I know you want to get some rebates.” Their mistrust of physicians has reached an unbelievable extent.70

Thus, our interview data clearly show that the income structure of physicians significantly affects patients’ perception of their intent and motivation. It is a prime cause of patients’ mistrust and suspicion of physicians.

4.3 | At the Interpersonal Level

Another factor that contributes to the mistrust problem is individual physicians’ attitudes and the way they communicate and interact with patients. Physicians’ attitudes and manners are often taken seriously by patients in assessing their trustworthiness. When asked what kind

66Interview, Xi’an, July 2013.
67Interview, Guangzhou, November 2012.
68Interview, Beijing, October 2012.
70Informal chat, Beijing, September 2012.
of physicians could give him a sense of trust. Mr. Zheng in Shanghai said:

The most important is attitude, a kind and caring attitude. I trust those physicians who are attentive and patient when they communicate with me. I have no knowledge to judge their medical skills. I can only see how they treat the patients through their manner and attitude. Their attitude indirectly reflects their medical skills.71

Likewise, Ms. Ku in Guangzhou expressed the same view:

I don’t have any medical knowledge.... Well, first, attitude is important. Some doctors simply kick you out quickly; whereas some examine you thoroughly. Some doctors would look at your throat and advise you to drink more water. These doctors are more caring.72

Just a kind attitude can induce trust from patients, those physicians who seem uncaring, inattentive, impatient, and careless earn mistrust from patients. Ms. Ku in Guangzhou recounted a moment when she felt vulnerable and distressed in part due to the physicians’ playful attitude during a surgery:

I was undergoing a minor surgery on my ear. I was lying on the bed, and was surprised to find that the two surgeons who were working on my ear chitchatting with each other casually. They were chatting about the beverages that were distributed to them by their department. They sounded happy that they were given some free beverages.... They gave me the impression that they were not serious and attentive while they were performing the surgery on me. They shouldn’t chitchat about these trivial matters while they are conducting a surgery, no matter how minor it (the surgery) is.73

Ms. Rebecca Cheng in Guangzhou complained that physicians are often impatient to answer questions from patients and they are unwilling to bear responsibilities:

I suffered eczema last year and my husband accompanied me to the emergency unit at the YYY Hospital. As I wanted to get pregnant soon, I was very cautious about taking drugs, especially antibiotics. I didn’t want to take in too many medicines. When the doctor gave me a prescription, I asked her if that medicine would have side-effect. She didn’t say anything but gave me another prescription. I asked the same question if that medicine would have side-effect. But the doctor seemed annoyed and unhappy. She said, "All drugs have side-effects! If you don’t want to take any, then just go home and drink a lot of water!" She then wrote a full page on my medical record. At first, I thought that this doctor was so caring that she wrote in detail about my problem and concern. When we walked out of the consultation room, I told my husband that this doctor seemed very serious by writing so much down on my record. We then took a look at her writing. Wow, it was shocking! What she wrote is: "The patient already knew the consequence of not taking medicine and yet she was unwilling to take it." I was shocked to see that the doctor was so defensive.... She didn’t explain to me the consequence of not taking the medicine and yet she wrote that I already knew the consequence in order to shy away from taking any responsibilities. It’s terrible!74

The information asymmetry problem puts patients in a vulnerable position when they interact with physicians. Unfortunately, poor doctor-patient relations prompt physicians to behave defensively, which further worsens their already strained relations with patients. Since patients generally lack the technical knowledge to assess physicians’ professional competence, physicians’ attitude toward them during their first encounter is of paramount importance in building mutual trust. This is especially true for Chinese patients who are most concerned about physicians’ moral ethics when it comes to the problem of mistrust.75 Previous work has also cited a lack of communication and poor physician attitudes as major non-clinical causes of medical disputes.76

5 | ETHICAL ANALYSIS AND IMPLICATIONS

In this paper, I identify the major factors at the societal, institutional, and interpersonal level that lead to patients’ mistrust of physicians in China. I argue that the root causes of the public outcry against physicians’ moral ethics largely stem from the financing mechanism of public hospitals and the income structure of their physicians. The fact that public hospitals rely on self-finance to support their daily operations gives hospital management teams no choice but to impose pressure on the frontline physicians to bring in revenues. This gives public hospitals a money-snatching, mistrustful image to the public. The income structure of physicians, unfortunately, has further added fuel to the fire. As a conflict of interest is intrinsically untrustworthy,77 physicians’ income structure is incompatible with the condition for trust in medical care providers. When physicians’ regular incomes largely depend on commissions and bonuses, and patients generally lack the technical knowledge to judge if a medical procedure is necessary, the potential

71 Interview, Shanghai, July 2013.
72 Interview, Guangzhou, November 2012.
73 Interview, Guangzhou, November 2012.
74 Interview, Guangzhou, February 2012.
conflict of interest is likely to lead patients to interpret physicians’ treatment of them in a negative light (regardless of the real motives behind physicians’ treatment). This is in line with Yan’s observation in this volume that patients’ judgments about physicians’ intentions is often the key factor affecting the development of a medical dispute.

The information asymmetry inherent in medical care puts patients in a vulnerable and dependent position that calls for trust in medical care providers. As trust is defined in terms of the perceived intent and motive of the other party, it is imperative for physicians to perform their fiduciary obligations to patients wholeheartedly in all circumstances if they are to win trust from their patients. The benevolent intent of medical doctors was emphasized in traditional Chinese society even before the advent of Western medicine and ethics. The idioms of yizhe fumuxin (treating the patient with a parent’s heart, or treating the patient as if you were his/her parent) and renxin renshu (benevolent heart and skillful execution) are telling of the societal moral expectations on medical doctors. However, the self-financing funding mechanism of hospital care, combined with physicians’ income structure in contemporary China, has resulted in a dilemma for doctors. Chinese physicians now face conflicting demands of serving the best interest of their patients, while generating revenues to their divisions. The widespread problems of overtreatment, performing unnecessary diagnostic tests, selecting profitable patients, and early discharge of economically unsound patients all point to the fact that it has not been easy for the physicians to manage this dilemma. The horrible incidents of physical violence against physicians in the past two decades can be attributed to patients’ increasing mistrust of hospitals and physicians and their frustration with hospital care. The problem of mistrust of physicians has also bred the use of cash gifts and personal connections to gain access to hospital care as Zhu et al. and Zou et al. describe in this volume.\(^\text{78}\)

Such practices cause further public anxieties concerning the integrity of medical care practitioners. In some extreme cases, patients have even refused medical care due to mistrust in hospitals.\(^\text{79}\)

The intensified mistrust in hospitals and medical doctors and the escalating tension between doctors and patients also reveal the failure of the state in providing citizens with quality health care and maintaining social justice. The governmentality of the Chinese state, well described by Dr. He in Shanghai in an earlier quote, is to generate GDP and to showcase magnificent infrastructure to the world. Social goods, such as local education and medical care, that are relatively invisible to outsiders, often lag behind in gaining massive financial support from the government. As public hospitals do not obtain sufficient financial support from the state, they run like private hospitals and treat patients as medical consumers. However, the level of trust that is required for a physician-patient relationship is far higher than that is required for a commercial commodity.\(^\text{80}\) It is ethically problematic to structure the physician-patient relationship as a commercial contract.

To rectify the problem, there is a pressing need for the state to take a proactive role in restructuring the institutional arrangements. I agree with proposals that physicians’ incomes should be separate from patients’ payments.\(^\text{81}\) However, this is not enough because, strictly speaking, Chinese physicians’ incomes in most major hospitals are no longer directly linked to patients’ payments. Instead, it is the composition of their income that leads to the conflict of interest. Physicians’ income structure should be reformed in order to reorganize their incentives. The basic salaries of physicians should be raised substantially. Policy makers could look to the model for remunerating physicians in other countries. For example, in Hong Kong, physicians in public hospitals are paid fixed salaries based on seniority. In the U.K., physicians’ clinical performance and patients’ health improvement index are also taken into account in addition to physicians’ fixed salaries. In any case, the state is required to substantially reform the financing mechanism of hospital care.

A caring and attentive attitude by individual physicians could also ease some of patients’ worries and anxieties, and could minimize suspicion from the patients. Therefore, individual physicians may contribute to building mutual trust by patients by caring more about the psychosocial needs of their patients and interacting with them in a more empathetic and professional manner. The importance of providing more medical ethics training for medical students in order to highlight the fiduciary duties of physician and to improve their communication with patients has been stressed by other contributors to this volume. I would like to add that physicians’ promotion criteria should also be reformed to reinforce quality clinical care. In our interviews, physicians in tertiary hospitals complained that in addition to handling a high volume of patients, they were under tremendous pressure to conduct research and publish academic articles. The quantity and quality of their research, rather than their clinical performance, are often used as the primary criteria for assessing their eligibility for promotion. I propose that the promotion criteria should be designed in a way that favors clinical outcome and doctor-patient interaction. If the assessment criteria for physicians’ performance is not restricted to research, but also based on the quality of their clinical care in terms of technical competence and interpersonal attitude, it will help to assert the central role of “the moral face of caregiving” that Kleinman calls for.\(^\text{82}\)

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\(^{79}\)In November 2007, a man refused to sign a consent form to let his wife undergo a Caesarean section when she suffered critical lung infection because he “distrusted the hospital.” As a result, his wife and the baby died due to the lack of medical intervention. See “Zhanguo Houhui Song Qi Ruyuan [The Husband Regretted Taking His Wife to the Hospital].” Beijing Wanbao [Beijing Evening News], 3 November 2007. Available from http://news.sina.com.cn/s/2007-11-23/144214373635.shtml.


CONFLICT OF INTEREST

No conflicts declared.

CHERIS SHUN-CHING CHAN, PhD, is Associate Professor of Sociology at the University of Hong Kong. She received her PhD from Northwestern University and a postdoctoral fellowship at UCLA’s International Institute. She is the author of the award-winning book, *Marketing Death: Culture and the Making of a Life Insurance Market in China* (Oxford University Press, 2012). Her writings have also appeared in the *American Journal of Sociology, British Journal of Sociology, Theory and Society, Social Psychology Quarterly, China Quarterly*, and *International Sociology*.

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