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Three modes of power operation: Understanding doctor-patient conflicts in China's hospital therapeutic landscapes

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ABSTRACT

Doctor-patient conflicts in contemporary China are increasing in numbers and severity. This health geographic study shows how hospitals as a type of therapeutic landscape can shape doctor-patient relationships. First, the comprehensive nature of therapeutic landscapes with an emphasis on power operation within symbolic environments is provided as a framework for this study. Second, the results from participant observation and interviews with patients and doctors previously involved in conflicts are reported from Internal Medicine and Surgery Departments, within four hospitals in Anhui Province, Eastern China. The study finds that the spatial and temporal arrangements of spaces, the inside decorations and the different modes of discourses can build or ruin harmonious doctor-patient relations. The research concludes that adaptations to current hospital therapeutic landscapes can improve trust between patients and doctors, resulting in fewer conflicts and better health outcomes in China.

1. Introduction

Over the last twenty years, conflicts between patients, families and doctors have escalated in China. Since 2002, such conflicts increased 22.9% annually (Wang and Li, 2012). According to the Ministry of Health of the People's Republic of China (China Annual of Sanitation., 2011), 98.4% of hospitals had on average 40 dispute incidents per year. Importantly, 90.0% of such disputes involved violence perpetrated by patients and families toward their health care provider (herein referred to as doctor-patient conflicts). Doctor-patient conflicts occur in various forms, including the eruption of violent attacks on individuals, blockade of hospital entrances and the disruption of clinical work by family-operating funerals within hospitals (Tu, 2014). While central and local Chinese governments have implemented a series of reforms to increase the visibility of doctor's authority within hospitals, the mushrooming of doctor-patient conflicts and attacks have not declined, largely because their underlying cause(s) are not well understood (Liu, 2010). Since doctor-patient conflicts are important societal and health care problems that are also on the rise in China, there is a need for further investigation.

Previous research on doctor-patient conflicts is limited. In the United States, studies have focused on patient's lack of trust in the professional authority of health care providers (Parsons, 1951; Friedson, 1985; Roter and Larson, 2001). Freidson (1985) concluded that while physicians often view patient's bodies as "detached medical objects", patients are also hesitant to give full control of their bodies over to the authority of physicians, especially as they become more educated in medical knowledge through media sources. These studies share the assumption that professional authority –i.e., authority based on physician's professional knowledge legitimates physician's control over patient's bodies and a lack of this authority will contribute to doctor-patient conflicts. Despite these assumptions and findings, there is no evidence that improvements in doctor's practices, such as increased knowledge and medical technology, will lead to greater professional authority to avoid these types of conflicts in China. Furthermore, with only a few exceptions (Maynard and Heritage, 2005; Curtis et al., 2013; Neuwelt et al., 2015), there is a continued need to investigate the various techniques (discursive and/or non-discursive) that doctors use to build trust with their patients and persuade them to follow their prescribed treatment orders. Importantly, Curtis et al. (2013) has shown that techniques doctors use to build trust may also prevent patients from asserting their rights –i.e., to find a good doctor, to learn about their condition(s) and to ensure they are being treated properly—findings that could help in part explain doctor-patient conflicts.

This research investigates 30 doctor-patient conflicts by studying doctor-patient relationships in four reformed primary care hospitals in China. Therapeutic landscape is the theoretical framework used to understand doctor-patient relationships and conflicts in this study. The departments and clinics within the hospitals are viewed as a type of

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therapeutic landscape, within which doctor-patient relationships are managed, resulting in successful or unsuccessful therapeutic processes. The notion of therapeutic landscapes (Gesler, 1992; Kearns and Moon, 2002; Smyth, 2005) is used to understand how the "healing process works itself out in place (or situations, locales, settings and milieus)" (Gesler, 1992, p. 743). Place is defined by Kearns and Moon's (2002, p. 609) as "an operational 'living' construct which 'matters' as opposed to being a passive 'container' in which things are simply recorded". Therapeutic landscapes here include three types of environments that define place, including the physical/built environment, the social environment and the symbolic environment (Curtis et al., 2013). Here we highlight the interaction between the physical, social and symbolic environments in two departments (Internal Medicine and Surgery) within four hospitals in Anhui Province, Eastern China by focusing on the hospital's architecture and indoor physical settings – e.g., spatial arrangement and room design that influence doctor-patient relationships (Bettelheim, 1974; Gesler, 1992; Gillespie, 2002).

2. Therapeutic landscapes in clinics

Curtis et. al. (2013) describe therapeutic landscapes as an interactive system between the physical, social and symbolic environments. The physical environment refers to the built environment or the settings of medical encounters. The social environment refers to the social relations between different medical encounters, which may affect particular doctor-patient interactions in situ. Physical and social environments can interact through symbolic environments, also referred to as symbolic mediators (Gesler et al., 2004). For example, within hospitals, physical environments range from the decorations of consulting rooms, the appearance of doctors and the format of prescriptions. The construction of social environments between doctors and patients include their conversations, as well as their performance of selves and their understandings of the settings of their conversations. To understand doctor-patient relationships, it is therefore important to acquire an in-depth understanding of hospital's physical environments, and most importantly the symbolic meanings of such physical environments, from different medical encounter perspectives.

It is also important to recognize that 'landscape' is ultimately a subjective mental construct (Jackson, 1989) and its meaning may be similarly or differently understood by members of different groups (Anderson and Gale, 1992). Divergent interpretations of landscapes may therefore, vary not only between doctors and patients but also between different patients and their families. As Gillespie (2002) reports, "A physical environment that is therapeutic for some may actually be harmful/exclusionary for others." Furthermore doctors can create physical landscape environments as techniques of governance over their patients –e.g., wearing a white coat or the decorations in a clinic. In addition, instead of working through disciplinary actions, doctors in modern clinics in China are considered practitioners of Foucault's concept of governmentality (please see next section), using discourse to persuade patients to obey their medical orders (Foucault, 1991; Allen, 2008). In particular clinical circumstances, doctors may talk with their patients about medical conditions and orders in different ways and within different physical landscapes. Doctors talking with their patients in certain ways however, may limit other possibilities of persuasion that increase trust and obedience. In contrast, patients may try to find good doctors, learn about their conditions and better therapies (Curtis et. al. 2013) via both linguistic and landscape discourses. While linguistic discourse, such as doctors' prescriptions as a technique of power have been widely utilized and studied in clinics (Foucault, 1976), landscapes such as doctor's appearances or decorations in clinics have been studied less, but can also transmit both proper and figurative meanings. Interpreting and manipulating such "microbe-like, singular and plural spatial practices" to language, as De Certeau suggests (1984) has provided a paradigm to apply discourse analyses on the physical environments of clinics.

Finally, therapeutic landscapes may not only vary among different groups but may also change within time and space (Kearns and Gesler, 1998). While studies have shown how hospital landscapes have changed their meanings with social transitions in history (Cosgrove, 1984; Yang, 2006; We, 2014), little research has been conducted on how power relations have changed within certain landscapes and different spatial and temporal circumstances. It is still a puzzle why some doctors lose their patient's trust while others do not–and why certain doctors are attacked in certain places and times -e.g., in different departments of the same hospital and different times of the day. Gillespie's (2002) research on doctor-patient conflicts has focused on the organization of rooms as a technique for doctors to govern their relations with patients but tells little about how the connecting space-units operate in particular time periods. Foucault's (1977) concept of micro-power provides useful techniques of governance in contingent localized clinical circumstances. One of the techniques is the organization of space (Foucault, 1977). Foucault (1977) provides examples in modern institutions such as schools, workshops and hospitals to indicate the importance of temporal management in power operation, which provides a potential paradigm to investigate the tactics of temporal management of doctor-patient relationships.

According to the theoretical debates above, a comprehensive nature of therapeutic landscapes with an emphasis on power operation within symbolic environments would be deeply helpful in understanding doctor-patient conflicts and thus in evaluating environmental techniques of the governance in doctor-patient relationships. Physical settings and the organization of space, particularly in contingent localized circumstances are not simply revealing the functions of therapy but a micro-physics of power operation among medical encounters. The next section will consider this background in the history of doctor-patient conflicts in Chinese clinical settings.

3. Doctor-patient relationships in China's context

The history of doctor-patient conflicts in China can be traced back to the late 19th century, when missionaries from western countries established the earliest hospitals in China (Yang, 2006; Tian, 2011). These hospitals for most Chinese patients invoked strangeness, misunderstanding and fear. These feelings led to over 700 recorded anti-missionary attacks between Chinese patients and western medical missionaries (Tian, 2011). To compromise, western doctors have had to partially give up their authority to their patients and families; thus they diagnose and treat patients under the surveillance of their families. Today most Chinese hospitals allow family members to accompany patients in wards overnight and take the place of nurses when doctors and nurses are absent.

Doctor-patient conflicts in China are also situated in a reformed and transitional society. Before the late 1970s, hospitals in urban China were mostly funded by the central government. Health service providers were state employees who received fixed salaries (Ma et al., 2008). Patients' medical costs were paid by their enterprises and the government as social welfare. Health services were therefore, advocated as a kind of altruism by the government on which the authorities of medical professionals were built. Although a large number of doctors only received basic medical training, they were widely respected (Lei, 1999).

Along with the Reform and Opening Up Policy, the decline of state-owned enterprises in the 1980s marked the end of free public health/medical services. These state-owned hospitals were gradually reorganized into profit institutions, and most of them have tied doctors' incomes to their performance and the profits acquired through the prescription of medical treatments, including drug prescriptions (Wang and Li, 2012). Thereafter, doctors in hospitals were not merely cooperators and collaborators but also competitors. If a doctor would like to earn more, he or she would be expected to make more profit for the hospital, meaning that they would see more patients, prescribe more clinical tests and treatments, and even over-prescribe (Wang and