Improving the Doctor-Patient Relation in China Through a Three-Level Framework

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Abstract

This thesis discusses the controversial doctor-patient relation problem in contemporary China. The key issue it aims to address is how to improve the doctor-patient relation with efforts from multiple levels. This thesis reviews literature on China’s healthcare service as a way to identify the causes of the doctor-patient tension. It then recommends possible interventions drawing on international experiences. The recommendations follow a three-level—macro-, meso- and micro-level—framework. What this thesis found is that the tension between doctors and patients is not only the fault of the frontline health workers. As a result, interventions for its improvement cannot target exclusively doctor’s behavior. Meanwhile, since the doctor-patient relations problem is not unique to China, we should also learn from the successful lessons in the global society. It is not our goal to resolve the problem in China’s healthcare system. With the discussion in this thesis, we hope to show that there is the potential to alleviate doctor-patient tension in China with joint efforts in the society.
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Healthcare improvement is a global challenge. The situation in China is especially complicated with its history and unique social features. It was not until I started this project that I realized how intertwined healthcare is with other social issues. In this project, I tried my best to disentangle the complexities of the doctor-patient relation and to show the importance of mutual understanding. I am aware that the reality is not as simple as can be explained in the paper. Nevertheless, I hope this project can contribute to the development of the doctor-patient relation, as well as China’s healthcare system in the future.
Introduction

Healthcare in China is a controversial topic. On the one hand, as the living standard has improved, people’s expectation on healthcare changes. More and more individuals have become interested in health issues. On the other hand, there is a transition of disease burden from infectious diseases to chronic conditions. Statistics from the WHO warned that 38 million, or 68%, of the 56 million death globally in 2012 was due to non-communicable conditions (WHO). However, although the burden of disease has changed, the healthcare system fails to keep pace with the transition. Such a transition is problematic for health workers and patients in that, globally, the current system is designed to address acute problems and urgent needs. As a result, there is a large discrepancy between the service and the need.

This is true for China. In China where the economic growth is unprecedentedly rapid, changes in healthcare are also dramatic. On the policy level, the past two decades have witnessed broad healthcare reforms. The central government launched a series of programs aiming to improve the accessibility and affordability of healthcare. At the same time, the public belief about health evolves overtime. Healthcare was not a priority focus for ordinary Chinese people due to economic constraints. Its accessibility and affordability were poor. People were less dependent on the public health service than on themselves.

Two turning points in the 21st century changed that view. The first is the outbreak of SARS in 2003. The SARS crisis rang the alarm for the Chinese population that self-reliance is not enough for overcoming a national health crisis which can be more destructive than people imagine. Thus,
for better protection, it became evident that a well-function healthcare system was necessary and deserves more attention and investment. The second event was the Beijing Olympic Games in 2008. The Olympic Games, unlike the SARS crisis, served as a positive stimulus for more attention on health. In fact, it is precisely due to the Olympic Games that the Chinese people established the idea of “public health.”

Unfortunately, the progress of policies has yet to match the increasing needs. Such a gap has led to new problems while intensifying some unsolved ones. One of the most controversial issues is the doctor-patient tension. Evidence shows that the Chinese doctors experience high level of tension (The Lancet, 2014). In recent years, the problem has raised national attention.

This thesis discusses the controversial doctor-patient relation in current China. From our perspective, this tension is by no means the failure of some specific sector. Doctors cannot be the only side to blame. Instead, a systematic failure which involves the macro, meso and micro levels is what leads to the explosion of tension. In the first two chapters, this thesis reviews literatures on China’s healthcare service, aiming to identify the limitations in the current system. These limitations all contribute to the doctor-patient tension in one way or another.

In the next two chapters, varied suggestions are given to different levels based on successful international experiences. This thesis is aware that those experiences may not be applicable to the Chinese setting, or not effective enough to alleviate the situation. Nevertheless, they suggest alternatives that can be reflected on in future reforms. The goal of this thesis is not to solve the problem for China. It is to show that the doctor-patient tension is not unique to China, neither is
the situation unchangeable. The key lies in the joint effort from multiple levels—the policy level, health organization level and the frontline level.

Chapter 1 introduces the various problems with the healthcare service. It lends insight into China’s healthcare system. Some of the problems are inherited from the past, while others are newly developed in the modern era. Whichever is the case, they fail to be fully addressed by the current reforms. Although the various problems seem to be unrelated, they all add to the ultimate deterioration of the doctor-patient relation, and the interventions from the central government are far from being adequate for the situation’s improvement.

Chapter 2 focuses specifically on the doctor-patient tension problem in China. It begins with an overview of the current situation, and is followed by the necessity to intervene. A brief history of the doctor-patient relation is included. The goal is to contrast the past with the present. What Chapter 2 reveals is that China’s doctor-patient relation problem did not grow overnight. The relation deteriorates gradually, but has not been sufficiently recognized until the recent decade.

Based on all that background information, Chapter 3 and 4 provide detailed interventions for China’s doctor-patient problem. Overall, the interventions follow the three-level framework proposed in the Pruitt et al. (2002) article. Chapter 3 is about the macro and meso level recommendations. In terms of policy reforms, this thesis chooses to focus on wise government investment and drug regulations. It is only one of the paths China could take. Policy reforms take long time to implement. They can be related to many uncontrollable factors or extend to other public service sectors.
On the meso level, three strategies are proposed. First, health organizations must reform the medical education in China. The current knowledge-focus education has resulted in doctors’ lack of soft skills. Ignorance of soft skills, such as communication, is a major contributor to the tensional doctor-patient relation. Second, health organizations can draw on the breakthrough series collaborative model (BTS). This model is aimed at promoting practical skills for certain health topics. The BTS is beneficial on many aspects. Its effectiveness has been confirmed by ample international experiences. Third, in order to minimize the impact of workforce shortage, health organizations should adopt task-shifting, that is using paraprofessionals to assist with basic clinical procedures. The use of paraprofessionals not only can lessen the burden for doctors, but are ideal for informal doctor-patient communication.

In Chapter 4, interventions are proposed to address the frontline failures, that is the ineffective communication between doctors and patients. As far as this thesis is concerned, doctor-patient communication is the most direct determinant of a successful relations between doctors and patients. For patients, the macro and the meso level limitations seem to be less relevant. Health workers, by contrast, are their only contact with the healthcare sector. To put it another way, patients experience healthcare through their providers. Thus, the provider behavior during treatment is fundamental to the improvement of doctor-patient relation.

The first task for the Chinese health workers would be developing appropriate attitudes. Improper attitude is a main barrier that prevents behavior change. This is exactly the case in China. In order to change that reality, this thesis suggests hosting conversation-based meetings in
departments and hospitals to encourage healthcare providers to reflect on their clinical performance, exchange the lessons they have learned, and share their concerns and fears. Such an informal meeting would assist with attitude change, which further contributes to behavior change.

Second, it is vital for providers to understand patient behavior. Healthcare is provided to address patients’ needs. If it is delivered without the other side receiving it, or not solving their problems, the effort will be in vain. Specifically, this thesis advocates that providers should put more attention to patients’ emotional aspect during treatment. Instead of curing disease, doctors should be able to treat patients’ illness which goes beyond physical symptoms. If doctors are emotionally supportive for patients, there is higher likelihood of positive relation and fewer conflicts. For the Chinese doctors, the emotional aspect of treatment has been a blank field. This, to a large extent, explains why the doctor-patient tension is so serious today. The emotional aspect is a small act for providers, but can have deep meanings for a healthy doctor-patient relation.

Emotional supports cannot substitute for the actual treatment. To increase the effectiveness of care delivery, health workers need to use better communication strategies. In general, health messages should be tailored to the needs of different patients. People all have different traits. So do patients. If clinical instruction is given uniformly without noticing the personality variations of patients, the communication is likely to be invalid and problems are likely to occur. Hence, healthcare providers must first identify patients, and deliver instructions accordingly. In addition, in terms of message framing, health providers must take into consideration the health literacy level. Complex structures and numeric evidence should be avoided for more effective patient
Finally, what is equally important from the point of this thesis is patient empowerment. Patients, as their doctor partners, are participants in healthcare. There are obligations they should fulfill. It is not enough to only rely on the providers for improvement. For that purpose, this thesis suggests using media campaigns. Modern media can be an ideal tool for patient empowerment considering its broad coverage and fast message diffusion. It contributes to the healthy doctor-patient relation in two aspects. First, it advocates positive provider images. Second, it distributes reliable health information for patients’ reference.

In addition to traditional media campaign, this thesis also supports using mHealth as a supplement to the traditional media campaign. mHealth is healthcare and public health practice supported by mobile devices (Hamine et al., 2015). Different from the traditional media, the health information delivered through mHealth is more detailed and personalized. The benefit will be elaborated when paraprofessionals participate in mHealth. Patients can form informal interaction with paraprofessionals. They can ask questions, raise concerns, and receive health-promoting information that is relevant to their condition. This personalized service is made easier with the Chinese national smartphone application of WeChat.
I. **Background and Current Challenges**

Since the beginning of the economic reform and opening up in 1978, China has put great effort into healthcare service reform (Yip et al., 2010). As the country enters a new development stage in the 21st century, China has launched a new round of health reforms, especially in the past decade, to counter new challenges and barriers. The overall principle is to “achieve universal health coverage by 2020” (Wong, 2016). In line with it, programs including the new Urban Resident Basic Medical Insurance scheme (URBMI) in 2007, the new Health System Reform plan (HSR) in 2008 and the 12th Five Year Plan in 2015 all show the country’s determination to improving health services for its population.

Although the reforms have achieved substantial success in many aspects such as a better health insurance plan for the rural population, better medical equipment in hospitals, and better provider capacity to deal with disease incidents, they still fail to address some important issues that either are newly generated or have long been omitted. In many ways, the new policies do not adequately address the core of the existing problems. It is not uncommon for policies to be ineffective because they are made by people who lack real-life experience.

Additionally, with the power of modern social media, healthcare organizations and workers are faced with unprecedented challenges. Hospitals and health providers are under strict public inspection. Every controversial action can be put in social media, and magnified in a negative way. A minor mistake that happens in one place can easily evolve into a healthcare crisis on the national level. Furthermore, as the way of life is changing, people have more interaction with hospitals and
healthcare providers. Modern Chinese are no longer like the old generation who tended not to seek professional help due to economic constraints (Wong, 2016). Instead, they have become aware of the available sources and have started to make use of them. This increasing interaction can create more potential conflict with healthcare providers.

More importantly, the development of healthcare does not match the speed of economic growth. Until 2014, China’s total health expenditure (THE) was only 5.5% of GDP. This number is small compared with other BRICS\(^1\) countries (see Table 1.), not to say with OECD\(^2\) countries like the US (17.1% of GDP), or other better-developed Asian neighbours like Japan (10.2% of GDP) and South Korea (7.4% of GDP).

Table 1.
Total Health Expenditure (% of GDP) of the BRICS Countries, 2000-2014.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Brazil</td>
<td>7.03</td>
<td>8.28</td>
<td>8.24</td>
<td>8.65</td>
<td>8.27</td>
<td>8.09</td>
<td>8.26</td>
<td>8.48</td>
<td>8.32</td>
</tr>
<tr>
<td>China</td>
<td>4.60</td>
<td>4.32</td>
<td>4.59</td>
<td>5.08</td>
<td>4.89</td>
<td>5.03</td>
<td>5.26</td>
<td>5.39</td>
<td>5.55</td>
</tr>
<tr>
<td>India</td>
<td>4.26</td>
<td>4.23</td>
<td>4.34</td>
<td>4.38</td>
<td>4.28</td>
<td>4.33</td>
<td>4.39</td>
<td>4.53</td>
<td>4.69</td>
</tr>
<tr>
<td>South Africa</td>
<td>8.07</td>
<td>7.53</td>
<td>7.75</td>
<td>8.39</td>
<td>8.50</td>
<td>8.61</td>
<td>8.79</td>
<td>8.78</td>
<td>8.80</td>
</tr>
<tr>
<td>Russian Federation</td>
<td>5.42</td>
<td>5.38</td>
<td>6.22</td>
<td>7.44</td>
<td>6.83</td>
<td>6.51</td>
<td>6.88</td>
<td>7.09</td>
<td>7.07</td>
</tr>
</tbody>
</table>

Collected from the World Bank databank


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\(^1\) BRICS countries: The acrimony for Brazil, Russia, Indian, China and the later-added South Africa.

\(^2\) OECD: The Organization for Economic Co-operation and Development. Established in 1961 with its headquarter in Paris, France, the organization now has 35 member countries which are mostly developed countries (OECD.org, 2016).
In China, public care is the major form of healthcare, constituting more than 50% of the total service. Yet, the expenditure on public care accounts only for 3.1% of GDP (WHO, 2014). Among that, over 40%—namely 1.25% of GDP—is spent on drugs. That fraction is even higher in county hospitals and other lower level health organizations (Wong, 2016). The reason for this imbalance is that the pharmaceutical industry is profitable. Drug companies are crucial contributors to the GDP growth, but none of the public hospitals can be, especially when survival has become an issue for many health organizations. Considering the large population base and disparities, the reality is only worse.

Despite the tough situation, actions are insufficiently taken both at the national level and the frontline. This could be due to the lingering mindset that Chinese people formed in the past. Historically, healthcare is not a priority focus for the general public, particularly after the economic reform in 1978 (Wong, 2016). The majority population struggled with basic living activities, while
at the same time, health service became increasingly expensive. Because of these changes, healthcare became a luxury service that could not be consumed by the ordinary people. Gradually, people consider it a waste to spend money on healthcare. Healthcare is intangible with no immediate returns. It is neither as urgent as food and shelter, nor as valuable as developing economy.

Unfortunately, what people fail to realize is that the inadequate support—in terms of both financial support and other policy support—at the national level directly results in the dysfunction at the frontline. In the past thirty years, China has amazed the world by its fast growth. As China has become the second largest economy in the world, it is comparable to OECD countries in many aspects. Unfortunately, this is not the case in the healthcare sector.

On the one hand, many general hospitals in second- or third-tier cities struggle with essential facilities. According to the 2012 WHO profile, the numbers of MRI units and CT scanners for per 1,000,000 population are 0.18 and 0.57. The OECD average level, by comparison, are 12.5 (2010) and 22.6 (2009). Further fallback occurs in the number of healthcare professionals. In 2010, the numbers of practicing physicians and nurses for per 1000 population are both 1.4 in China, whereas the average number in OECD countries are 3.1 and 8.7. These stark contrasts have resulted in the inefficient healthcare service in China (see Table 2 & 3).
Table 2.
Number of Health Facilities in China

<table>
<thead>
<tr>
<th>Indicator</th>
<th>China</th>
<th>OECD average</th>
<th>Year</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total health spending as percentage of GDP</td>
<td>5.1%</td>
<td>9.5%</td>
<td>2010</td>
<td>2010</td>
</tr>
<tr>
<td>Total health spending per capita</td>
<td>379 USD</td>
<td>3268 USD</td>
<td>2010</td>
<td>2010</td>
</tr>
<tr>
<td>Total health spending funded by public sources</td>
<td>53.6%</td>
<td>72.2%</td>
<td>2010</td>
<td>2010</td>
</tr>
<tr>
<td>Practising physician per 1 000 population</td>
<td>1.4</td>
<td>3.1</td>
<td>2010</td>
<td>2010</td>
</tr>
<tr>
<td>Nurses per 1000 population</td>
<td>1.4</td>
<td>8.7</td>
<td>2010</td>
<td>2010</td>
</tr>
<tr>
<td>Acute care hospital beds per 1 000 population</td>
<td>4.2</td>
<td>4.8</td>
<td>2010</td>
<td>2010</td>
</tr>
<tr>
<td>MRI units per 1 000 000 population</td>
<td>0.18</td>
<td>12.5</td>
<td>2010</td>
<td>2010</td>
</tr>
<tr>
<td>CT scanners per 1 000 000 population</td>
<td>0.57</td>
<td>22.6</td>
<td>2009</td>
<td></td>
</tr>
<tr>
<td>Life expectancy</td>
<td>73.1 years</td>
<td>79.8 years</td>
<td>2010</td>
<td>2010</td>
</tr>
<tr>
<td>Prevalence of obesity among adults *</td>
<td>5.7%</td>
<td>22.2%</td>
<td>2008</td>
<td>2008</td>
</tr>
<tr>
<td>Proportion of adults smoking everyday</td>
<td>24.1%</td>
<td>21.1%</td>
<td>2010</td>
<td>2010</td>
</tr>
</tbody>
</table>

Source: OECD Health Data 2012 – Country Notes: How does China Compare
*World Health Organization


Table 3.
Number of Medial Staff in China (2011)

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number</th>
<th>Number per 10 000 population</th>
<th>TCM practitioners included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical practitioner</td>
<td>2020154</td>
<td>1.49</td>
<td>267,225</td>
</tr>
<tr>
<td>Assistant medical practitioner</td>
<td>445940</td>
<td>0.33</td>
<td>42,047</td>
</tr>
<tr>
<td>Registered nurse</td>
<td>2244020</td>
<td>1.66</td>
<td></td>
</tr>
<tr>
<td>Pharmacist and assistant pharmacist</td>
<td>363993</td>
<td>0.27</td>
<td>100,116</td>
</tr>
<tr>
<td>Technician and assistant technician</td>
<td>347607</td>
<td>0.26</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>781144</td>
<td>0.58</td>
<td>10,941</td>
</tr>
<tr>
<td>Total Health workers</td>
<td>6202858</td>
<td>4.60</td>
<td>420,329</td>
</tr>
</tbody>
</table>

Source: China Health Statistics Yearbook 2012.


What’s worse, without the support of adequate government funding, hospitals and healthcare providers lack the incentives to provide good-quality service, especially in the face of heavy patient load. In the long run, their enthusiasm in the occupation will decline. Students become less
interested in attending medical schools, and current healthcare providers turn to pursue better-paid jobs (Liuliu, 2010, p. 200). This will exacerbate the situation for the under-staffed health sector.

In addition, policies and reforms have been focusing predominantly on the problems of accessibility and affordability, as if they are the only issues that plague the healthcare sector. Most reforms launched in the past 10 years including the Urban Residential Basic Medical Insurance (URBMI) in 2007 and the two health service reforms in 2006 and 2008 have targeted directly at solving the affordability problem. In one of the most recent reforms on Jan 15, 2016, for example, the National Health and Family Planning Commission announced that they aim to reduce the out-of-pocket expenditure (OOP) in 200 cities so that more ordinary people—especially the rural population and low-income city dwellers—could receive certain level of healthcare (Guan et al., 2016).

Yet, directly reducing the service fee cannot cure China’s problems. Experiences from the early reforms show that such an act fails to improve service affordability because it intensifies hospitals’ profit-pursuing incentives by limiting their source of revenue (Guan et al., 2016). The service fee is one of the major sources of income for health institutes. If it is cut without sufficient government funds reaching hospitals, the only option for survival would be increasing other fees, such as prescription and insurance. Either way, it is the patients that would take the toll. Though an accessible and affordable healthcare is the ultimate goal that not only China, but also the world should aim to achieve, it is the long-term goal and cannot be achieved independently. Thus, before reaching the ultimate goal, some more urgent issues China must deal with include the increasing
burden of non-communicable diseases, limited human workforce, unequal resource distribution, and the doctor-patient tension.
II. **Doctor-Patient Relation**

2.1 Current Situation

Like the old saying “Rome wasn’t built in a day”, the doctor-patient tension does not evolve overnight. It has existed for a long time, but fails to be sufficiently addressed. In fact, until recent years when this tension finally explodes in many parts of the country, hardly any action has been taken.

In fact, the doctor-patient tension is not unique to China. In countries like the US, doctor-patient relation is also a tricky problem that fails to be sufficiently addressed (Ofri, 2017). Because of dissatisfaction with hospitals and healthcare providers, patients worldwide may act irrationally and sometimes violently. What is unique in the Chinese setting, however, is the scale and severity of irrationality and violence. Statistics show that about a third of Chinese physicians have experienced conflicts at work. Thousands of healthcare providers have been injured. Many even pay with their life (The Lancet, 2014). This does not appear to be happening to other countries.

Recently, after a sensational healthcare crisis in April 2016, a set of spoof images reflecting the doctor-patient tension spread on the internet. In the pictures, doctors examine patients with rifles on their shoulders (see Figure 1. & 2.). The images may have exaggerated the reality, but it nevertheless reveals the pathetic fact that there is deep distrust between doctors and patients.
In response to the increasing tension, doctors adopt the principle of self-protection as the priority. They avoid unnecessary interaction with patients. Few physicians would try to persuade patients into using specific treatment or medication, fearing that they would be accused of being corrupt (Liuliu, 2010, p. 66-67). More seriously, providers would rather listen to patients’ suggestion during diagnosis and prescription, than trust their own judgement. Doctors often ask patients what problem they believe themselves to have, and what medication they want to take.

A doctor in the neurosurgery department, for example, is not likely to suggest a MRI test for his headache patient if the patient has decided to simply take some painkillers. In the event of unfortunate results, such as a brain tumor, at least the doctor does not need to take responsibility given that it was the patient’s decision. In short, fewer and fewer doctors are willing to take risk for patients’ benefits. Every clinical decision may have a 5% failure. Yet, the fact that patients focus overwhelmingly on that 5% has deterred doctors from fighting for their patients. Once a
dissatisfying outcome occurs, it will be the doctor’s life that is in danger.

2.2 Necessity to Reform the Doctor-Patient Relation

The reason why China must alter the situation is not just the risky situation of physicians. In fact, ignoring the doctor-patient tension as a legitimate health problem not only slows the pace of reforms, but mitigates the efforts to pursue accessible and affordable healthcare. The core issue behind the tension is a crisis of trust. Unless people could reestablish trust in the healthcare service and its providers, they can never fully benefit from the system. Since doctors and nurses are the most direct, and many times the only contact point patients can access, the most effective way to improve patients’ trust is through interaction with the providers (Berwick, 2003).

In China, many complaints about healthcare center on the concern that the frontline providers are not competent. The incompetence may not necessarily refer to physicians’ professional skills—although in many places, their professional knowledge is a problem—but it is definitely true in terms of their “soft skills.” The nature of doctor-patient communication is a salient one. For example, one of the most common complaints about the patient experience is the arrogant and indifferent attitude of providers (see Chapter IV). Yet, many providers have argued that the large patient volume has drained their ability of effective communication.

Health workers complain that providing healthcare today is tough because people require too much from the providers. Healthcare is different from other public services. It is characterized by increasingly higher expectations, deep personal commitment and low tolerance of mistakes and
failures (Berwick, 2003). The problems of healthcare providers are exacerbated by the population burden and poor payment, and the high expectations of patients are beyond doctors’ ability to fulfill. After all, doctors are only humans like their patients.

Objectively speaking, the provider-complaints are not unreasonable. Chinese doctors are faced with particular barriers. According to the 2011 WHO data, there are only 6.2 million health workers for the 1.3 billion Chinese population. That equals to 4.6 total health workers for per 10,000 population (see Table 3). The heavy patient load has dehumanized doctors as working machines and patients as products on the assembly line. In reality, it is not uncommon for a general outpatient doctor to see 80 patients per day. This number can be even larger in the country’s best hospitals in Beijing or Shanghai (Liuliu, 2010, p. 126). If a doctor works non-stop for eight hours, the time spent on each patient is only a little more than five minutes. Within this time, he has to finish the process of interview, diagnosis and prescription. It is difficult for him to remain attentive or keep smiling to all the patients.

Despite the unique challenges, however, this should not be an excuse for poor patient relations. China is a populous country. It is a reality no one can change, not to say that the same challenge exists among other public service providers. On the one hand, we must admit that there is an atmosphere of irresponsibility and ignorance among the providers. Rarely do the providers reflect on the problems in their clinical behavior when a tension occurs. On the other hand, the providers need to be reminded that treatment does not simply refer to symptom relief. What make it more important for providers are the soft skills, such as communication skills, in addition to professional
knowledge.

This is not saying that improving doctor-patient communication is the panacea to the doctor-patient tension, but it is nevertheless a key component of the entire chain. Meanwhile, considering the many flaws with the healthcare system, we must note that improving either the doctor-patient relation alone or the system alone would not be enough for deeper reform. In other words, reducing doctor-patient tension is not possible without the support of a well-functioning healthcare system. Likewise, simply increasing government funding, provider payment, or the number of well-trained physicians and advanced infrastructure in public hospitals cannot necessarily alleviate the distrust issue in doctor-patient interaction since from the patient perspective, these invisible changes seem irrelevant to their wellbeing.

2.3 History of the Doctor-Patient Relation in China

It is worth noting that many problems that China is currently experiencing—whether service accessibility and affordability or doctor-patient tension—did not exist historically. China used to have universal health coverage (UHC) (Liang, 2013). The general population enjoyed at least some kind of public health service. In the 1960s, China once amazed the world by supporting the health of 20% of the world population with only 1% of the world resources (Angel Heart, p. 109). With the large number of rural population, the healthcare system was decentralized with the aim to provide basic welfare to the local community confronted by illness, injury or old age (Dixon, 1982). Unlike the mode of care in the West, this rural-centered system emphasized collective welfare:
service was provided by barefoot doctors or the workers in community healthcare centers; patients barely sought help from better hospitals in cities due to the long distance and poor transportation.

Under that background, the doctor-patient relation was simple. The main reason was because patients had trust in their healthcare providers. Both doctors and patients were part of the same community. Their production life and personal life were deeply intertwined. The inadequate number of doctors, their limited knowledge and poor equipment did not discourage people from building a stable relation with their local health workers. To a large degree, the healthy relation between the providers and the receivers contributed to the success of health service delivery as opposed to the later situation.

The turning point occurred in the mid-1980s when China was transforming from a planned economy to a market-oriented economy (Yip et al., 2010). An open economy brought more opportunities and better living standards for the public. An increasing number of rural residents moved into cities, forming the first tide of migrant workers. These new city dwellers started to consume a new type of health service that is different from the one provided by village doctors. In the meantime, closer interaction with city dwellers raised people’s expectations back in the rural areas. Village doctors could no longer meet people’s needs due to the outdated professional knowledge and the lack of professional training (Ni et al., 2016). As a result, more interaction was established with formal hospitals and well-equipped city doctors, and the personal relations between doctors and patients started to dissipate.

On the other hand, the transition to a market economy largely cut the government revenue.
More money was circulating in the market instead of going to the central government. As a result, government subsidies to public hospitals were sharply reduced from 50% to 10% (Yip et al., 2010). This left the burden of surviving completely to hospitals and their staff, meaning that health workers had to learn how to generate profits before performing the duty of rescuing and curing, and the most direct way is through user’s fee and medicine prescriptions.

Unfortunately, the situation soon went beyond the scope of pursuing survival and self-rescue, and turned into greedy corruption. In the words of Yip et al. (2010), it marked the beginning of “an erosion of professional medical ethics”: hospitals started to receive kickbacks from drug companies; doctors earned secret bonuses by prescribing certain medicines or using certain products. Over-prescription, excessive services, and grey incomes became the norm. The once normal health service system was completely distorted. Along with it also collapsed the doctor-patient trust.
III. Recommended Interventions: A Three-Level Framework

Based on the complex nature of the doctor-patient tension, intervention on one level cannot necessarily alleviate the situation. Efforts must target different aspects that lead to the tension. In general, the healthcare system can be divided into three levels: the macro level, the meso level and the micro level. This is a framework identified in the Pruitt et al. (2002) article. The macro level is referred to as the policy level. It involves the overall values, principles and strategies for developing healthcare service. The meso level refers to all kinds of healthcare organizations such as urban hospitals and community health centers in rural societies. It is where human resources and infrastructures are gathered for service delivery. It is also the channel through which policies made on the macro level are implemented. The micro level is the frontline level. Activity at the frontline is constituted by healthcare providers and patients. All the three levels are interrelated. Consequently, failure in the outcome can be traced to dysfunctions on multiple levels (see Figure 3).

Figure 3:
The Three-Level Framework.

Following this logic, although the doctor-patient tension is a micro level failure, interventions cannot target only frontline activities. This observation is in line with the assertion of this thesis. The previous chapters have shown that the explosion of tension can be traced to flaws on the macro level including the design of healthcare policies as well as decisions from other public service sectors. Thus, the first part of intervention involves policy reforms. However, it should not be ignored that changing policies or the system takes a long time, and it is impossible to introduce complete reforms that would alter traditions and habits. Apart from that, macro level interventions can create a safe ground for other interventions to take place, especially with the workforce shortage in China.

In the second part, attention will focus on the efforts that can be made by the meso level health organizations. Lessons and models from the international experiences would be drawn on. These lessons are integral for further actions at the frontline, because they can be the guidance for the providers to practice certain skills. Finally, detailed suggestions will be given on the actual interaction at the frontline. Specific strategies will be proposed for facilitating healthy doctor-patient relation. With the guided-practice on the meso level, health workers are expected to expand patient satisfaction, and improve the tensional relation. The micro level intervention would involve both providers and patients. After all, relation amelioration should be the joint effort by all participants.
3.1 Macro Level Interventions: Policy Changes from the Government

As is identified, the most relevant policy to the doctor-patient tension is inadequate government health budget. There are many reasons for it. First of all, healthcare service is time- and effort-consuming. It is a long-term battle without immediate returns. Health investment is like a black hole because there is always more input than visible output. As in education, health improvements do not show immediately. In the face of the financial crisis of 2008, for example, the Chinese government spent 4 trillion RMB to rescue the market. The majority of this money went to railway infrastructure, power stations, environment management, and private entrepreneurs because their revenues are more possible to achieve and easier to detect. By contrast, only a small proportion was put on health (Liuliu, p. 37). Besides, the outcome is determined by many uncertainties: political climate, environment issues, economy fluctuations, transportation and others. In short, it is unpredictable with so many factors that can impose an effect on health.

This unprofitable nature of healthcare service leads to the second reason: the imbalanced investment within the health sector. From the perspective of this thesis, this is more problematic than the mere lack of funding. Instead of putting more money into healthcare, the suggestion is to make wise investments. The international lessons have show that the quality of health service is not determined by the amount of money spent on it. The 17% GDP on THE does not guarantee UHC for Americans. Similar problems of affordability and accessibility also plague ordinary people. A recent article on The Fiscal Times shows that although 20 million people have gained insurance since the implementation of Obamacare in 2010, there are still 29 million Americans
living outside the protection of the healthcare system, accounting for 10% of the total population (Cooper, 2016). Singapore, by contrast, sets an example of using small THE (4.9% of GDP in 2014) to provide good-quality of service (WHO, 2014). A similar situation applies to Thailand where people have UHC with THE accounts for 6.5% of GDP (Tangcharoensathien et al., 2012).

Some may argue that the situation in China is different from the US, Singapore or Thailand. The unique economic and demographic features can make the problem more complex. Although such argument has its merit, the complexities do not change the reality that the current healthcare service is primarily profit-oriented on the macro level and does not meet public needs (Liu, 2009). Almost half of the public investment has been given to profitable pharmaceutical and technology companies (Pruitt et al., 2002). There is little emphasis on building provider capacities and infrastructure. If this is the case on the macro level, how can we only blame the decision-takers on the micro level?

In order to alleviate this situation, a simple act to take is to cut expenditure on medication. This does not simply mean to restrict the budget on medication, which is the way drug reforms are following in many places. Instead, efforts should be on 1) regulating drug price. The price increase of medicine and materials must be banned in the market. The central government should be the one that sets the uniform price of a drug instead of drug companies. Each regional government can receive national subsidies depending on the province’s economic ability to afford. 2) limiting the freedom of prescription at the frontline. Set strict rules about the types and number of expensive drugs allowed in health organizations based on their size, number of beds and patient volume. New
drugs cannot circulate freely in hospitals without the recognition of the Ministry of Health (MoH).

By establishing closer inspection of the medical industry, the government can reduce market failures caused by monopoly and disparity (Guan et al., 2016). More importantly, it will save the unnecessary health expenditure so that the government is able to focus on capacity building both on the micro and meso levels. More investment should be made to support medical education, create physician incentives, upgrade infrastructure especially in rural areas, and ameliorate the medical legislative structure so that both patients and doctors are better protected, and that the dramatic spoof will never come true in reality. Apparently, the depth and broadness of the current drug regulation need increasing. This will only happen if the top mission on macro level turns from economic growth and development to truly public welfare. Policymakers must remember their duty of serving the people.

3.2 Meso Level Interventions

On the meso level, health organizations fail to equip healthcare providers with the essential skills for providing quality care. Like the macro level policymakers, the attention of hospitals focuses primarily on profit-earning. As the previous section has pointed out, drug prescription is the major source of income in hospitals. Before the recent reforms, many hospitals had connections with certain drug companies. With their sponsorship, little effort is needed for generating profits. Doctors need not care about their professional knowledge as long as they sign the contract with the company and advertise their products to patients. In a way, doctors are no longer healthcare
providers, but are drug salesmen.

If hospitals could be relieved from the economic constraints by receiving more government funding, their priority attention should be paid to provider cultivation. This does not only refer to their clinical expertise, but more importantly to their “soft skills”. So far, some pioneer hospitals in big cities have started such programs (Yip et al., 2010), but the scale and depth of the current programs are far from enough. In the view of this thesis, there are three tasks that should be accomplished on the meso level.

A. Medical Education

The first is to reform the medical education in China. The medical education—or education in general—is knowledge-based rather than practice-based. The current system, especially the evaluation standards, only values students’ academic skills. Emphasis is put overwhelmingly on publications, funding and patents (Zhai et al., 2016). Students prefer to spend time in laboratories rather than practice clinical skills or medical ethics in real-life environments. In such a context, the junior doctors are far from being competent providers despite their 5- or 7-year training. The major difference between a PhD student and a master student is their time doing research, regardless of quality. In short, there is a mismatch between research knowledge and clinical practice (Zheng & Shi, 2016).

The inappropriate education design exacerbates the doctor-patient tension in that it results in patients’ misperception about health workers. Doctors’ performance does not match patients’
expectations of their background. Many people believe that health workers with higher degrees are more professional. However, what patients do not understand is that the quality of health service does not depend on the education level of the providers, but on their clinical skills. Healthcare is an act of practice. If the current training standards remain unchanged, the gap between providers’ capacity and patients’ expectation will not disappear.

The lesson of Tu Youyou provides strong evidence. In 2015, the 84-year old Tu won the Noble Prize in Physiology and Medicine. Being the first Chinese woman to win the prize, Tu is an untypical “three-nos”—no doctorate degree, no experience of study abroad, and no membership in any Chinese national academy (Zhai et al., 2016). Based on the educational evaluation standards, Tu may not be a qualified candidate for the prize. Yet, it is her abundant clinical experience that has led her to the achievement.

Tu’s success is powerful enough to call the medical education into question. Currently, the medical performance does not correspond to providers’ degree levels because the education keeps a poor balance between research knowledge and practical skills. A 7-year professional training in formal medical institutions does not necessarily make a PhD student more competent than a community health worker without a college degree. Unless the knowledge-based medical education can be reformed, inadequate practice will be a persisting disadvantage for students (Wan & Long, 2016). The accusation of providers’ incompetence will remain, and the situation of the doctor-patient tension is hard to improve.

In the US, medical students are required to fulfill residency as part of the degree. In contrast,
the requirement of practical skills is less strict in China. Although there is a required 3-year residency before fulltime work, it is rarely met due to the lack of incentives (supervision is casual), and the financial challenges (no salaries or funds will be given during this period). Consequently, new doctors are often caught in patient-confrontations: their judgement is questioned and their incentives are contested. Although they are not necessarily unqualified doctors in essence, the clinical skills they present to patients harm their credibility.

If we can create more opportunities with better incentives for medical students to practice, our doctors will show less disconnection between what they know and what they can perform. Furthermore, they can receive more respect from patients, fostering a healthier doctor-patient relationship in the long run. For that purpose, hospitals should collaborate with lower level organizations such as community healthcare centers. At least a one-year paid residency in lower-level health organizations or in rural health centers should become the requirement for a medical degree. Apart from that, students should be encouraged to volunteer in community health centers that have collaboration with their education institutions. They can substitute regular doctors during weekends and holidays. The time of volunteering and the type of duties they perform will both determine their job opportunities after graduation.

This can create a win-win situations for medical institutions and lower-level organizations. For students, they enjoy more opportunities to see patients in real-life setting. The actual interaction is more rewarding than simply running errands in their original institutions. For community health centers and rural hospitals, they have more well-trained providers without the
need to spend money and hire them.

B. Breakthrough Collaborative Model

In addition to collaborating with local health centers, health organizations should also learn from international experiences. One of the successful models is the Breakthrough Series Collaborative (BTS).

According to the Institute for Healthcare Improvement (IHI), the BTS Collaborative is “a short-term (6- to 15- months) learning system that brings together a large number of teams from hospitals or clinics to seek improvement in a focused topic area (IHI, 2004)” . The collaborative is characterized by the joint support of “subject experts” and “application experts” and each collaborative alternates between “learning sessions” and “action periods” (see Figure 7). Since its launch in 1995, the BTS has achieved great success on various health topics. Today in the US, the BTS has been applied to other sectors such as education, and has also received positive results.
In China, there is no such model that promotes providers’ practical capacity in service provision. If the BTS were adopted by our health organizations, different aspects of provider competence could be improved. Overall, there are three benefits of adopting the BTS. First, the BTS programs are short term. They would not have deep impact on participants’ regular activities. Second, it combines learning and practice. Unlike most training programs in China which are learning-based, the model requires participants to apply new knowledge on the spot. Practice takes place with the professional trainers or other peer participants. Either way, a common knowledge background and a cooperative atmosphere will guarantee the effectiveness of learning.

Third, the BTS is cost effective. In recent years, many health organizations establish exchange programs with the world-leading institutions. More Chinese doctors should be able to access the advanced resources in foreign hospitals. Yet, such programs are costly. Some are too short to make
a difference. Others can cause the problem of professional-drain. With the BTS, these concerns can be resolved. Instead of sending a limited number of doctors abroad, the BTS allows organizations to invite more experienced trainers from various fields. Moreover, it can extend to providers other than professional doctors, such as nurses, community health workers, providers in county and rural health centers and even medical students.

C. Task-Shifting

Another meso level intervention aims at solving the workforce shortage problem. Arguably, the cause of workforce shortage lies in policy failures, not in health organizations. But from a practical point, making and implementing policies on provider incentives or the rewarding system require time. It is not realistic to do nothing during this policy-absent period.

What this thesis proposes is to use task-shifting. Task-shifting is a strategy widely used in the mental health sector. It is defined as “delegating tasks to existing or new cadres with either less training or narrowly tailored training (Kakuma et al., 2013)”, or in other words, using paraprofessionals for basic medical treatment. It is an important response to the human resource shortage in mental health and has proved to be particularly helpful in many low- and middle-income countries (LMICs) (Maes, 2015).

The success of task-shifting in mental health is informative for general healthcare in China. Putting aside the incentive and payment issues, hospitals can train paraprofessionals to assist with basic procedures. For example, during the hour-long waiting time, nurses or students can complete
the interview and record-keeping processes. When a doctor finally meets the patient, he already knows the basic information for diagnosis. Similarly, after the meeting with doctors, patients can turn to paraprofessionals for detailed drug instructions or further concerns. This will save time for both sides.

Task-shifting also brings job opportunities in health sector because it allows more people to engage in medical activities. In China, there is a paradox about the healthcare workforce: on one side, the current system lacks sufficient number of total health workers; on the other side, medical students have a hard time finding suitable jobs in hospitals. Task-shifting will help reduce this conflict by increasing the need for unspecialized health workers. In addition, while working as non-specialists, paraprofessionals also accumulate practical experience. The actual interaction with patients gives the unexperienced providers advantages in later professional work.

Paraprofessionals are aimed to relieve the burden faced by doctors, allowing them to concentrate on treatment within the limited time they have with patients. They do not need extensive training or excellent professional knowledge. Compared with doctors, paraprofessionals are easier to form informal relation with patients because the communication between them is less stressful. They can also be the ideal source to empower the patients by providing after-treatment instructions or promoting healthy behavior. This will be further discussed in the next chapter.
IV. Micro Level Interventions: Doctor-Patient Communication

Just like all types of unequal dyadic relation such as sellers and consumers, or interviewers and interviewees, there is the problem of information asymmetry. It is the first obstacle in doctor-patient relations. By nature, people are wary and conservative about trusting strangers. We are hard to convince by the unfamiliar, not to say if one’s life is in the hands of others. In doctor-patient relations, increasing professional knowledge has put doctors in the absolute authority position while leaving patients as the underrepresented group. It is emotionally challenging and frustrating for patients. If the communication is not effective, it becomes even harder to develop trust between the two sides. Without trust, the medical practice cannot benefit patients’ wellbeing, or provide doctors with any basic protection.

Considering these features of the doctor-patient relation, simply providing more information is not sufficient for effective communication. It is essential for health workers to apply communication strategies. In some ways, doctors should learn from the seller-consumer relation which is a most successful example of trust-establishment and persuasion. From another perspective, the doctor-patient communication is different from the seller-consumer communication. Doctors, unlike sellers or interviewers whom anyone could become, are characterized by high education, good cognitive skills and professional knowledge. These features may not exist in the majority patient population.

Studies have shown that health literacy is low among the general population. Health literacy is the capacity to obtain, process, and understand basic health information and services needed to
make appropriate health decisions (Institute of Medicine Committee on Health Literacy, 2004). Globally, people lack the ability or opportunity to be health-literate. In the US, 36% of the population—that is 75 million people—have basic or below basic level of health literacy. The majority (53%) are in the intermediate level. Only 12% have proficient health literacy rate (National Center for Educational Statistics, 2006). In addition, health literacy is not necessarily consistent with ordinary literacy. In some of the best educated countries like Japan, the result is also disappointingly low (Nakayama et al, 2015).

Figure 5.
Health Literacy in the US

![Health Literacy in the US](https://nces.ed.gov/NAAL/health_results.asp)

Even for the well-educated population, their ability to process can be impaired in a stressful setting such as the doctor’s office. Patients are particularly vulnerable. They are burdened with concerns either for themselves or their loved ones. This could mitigate their comprehension or cognitive ability. Because of the information asymmetry and emotional burden,
miscommunication and misunderstanding are likely to occur. The failure to convey ideas appropriately can lead further to disastrous outcomes including mistreatment, improper operation, or death.

Patient vulnerability shows the necessity to adopt smart communication strategies. The low health literacy rate and lack of initiatives make patients blind to the thousand accidental reasons that may result in failure. From the patient perspective, failure is always the doctors’ fault. If patients were alive when they arrived at the hospital, why are they dead after doctors’ treatment or an operation? Thus, as providers, it is pivotal to ensure patients and their families listen and comprehend the instructions. Otherwise, it does not make sense to release words without the other side receiving them.

Imagine communicating with a patient’s family who has just been informed the patient has a brain tumor. Most likely and commonly, doctors would explain the treatment options by presenting plain statistics: an open-head operation can guarantee the patient’s living but has up to 85% possibility of brain death, whereas the traditional chemotherapy cannot save the patient’s life but will delay the death for at least one year. While statistics can be the best evidence for persuasion on many occasions, it is futile for the shocked heartbroken family. In this circumstance, the only information they could processed is the two single words— “living” and “death”. Neither the 85% likelihood of brain death nor the one-year usual life is within their current cognition. However, if the patient ends up brain dead after the operation, it is not unlikely for the patient family to blame their doctor. After all, no one is willing to think of himself as the unfortunate 85%.
The situation will be even worse if there is a similar patient who luckily survives the operation. What makes their outcome different from ours? Is our doctor professionally incompetent? Is it because we did not give him bribes, or not enough bribes, so he did not try his best? Why did not the doctor make clear the outcomes of the operation? Is it because the hospital wants to earn money from us? Patients and families can have various negative guesses about the failure they have experienced. In the extreme situation, violence will be adopted for revenge.

This is what current healthcare workers in China frequently complain about: patients are irrational and unreasonable; they do not understand the medical process; they are hard to deal with. In a word, patients lack understanding of their providers due to extreme stress on them. What they fail to realize, however, is that most people are reasonable and communicable. They only become difficult when the people they interact with show unfriendliness. Imagine ourselves in an encounter with some strangers. It is not easy to be especially nice to a stranger, but it is also not very likely to be aggressive or hostile at the first sight. The same applies to the doctor-patient relation in China. While doctors complain about patients being unreasonable and demanding, they forget to reflect on themselves. Chances are, it is their own behavior that causes the tough interaction.

In recent years, a number of studies have shown that effective doctor-patient communications can have a significant (positive) impact on the health outcome, especially for chronic conditions like cancer, diabetes, hypertension and others (Pruitt et al., 2002). In 2014, a study conducted by a group of Canadian researchers reveals the positive effect of communication on successfully treating chronic back pain (Fuentes et al., 2014). A recent article in New York Times also discusses
the importance of active doctor-patient communication, which the author identifies as the “conversation placebo.” In his argument, doctor-patient communication can optimize the effect of medical treatment. In many cases, the communication itself is a way of treatment (Ofri, 2017). This is how traditional healers like shamans, witch doctors and assorted mystics heal. Basically, their healing mechanism is based on patient communication and interpersonal connection. However, in the modern medical system, doctor communication skills have been largely neglected together with these unrecognized healers.

The techniques for developing effective doctor-patient communication can be plenty. From the perspective of this thesis, one of the most effective ways is to focus simultaneously on doctor training and patient empowerment. Chinese doctors must adopt effective communication skills in treatment. This will not only maximize the effect of treatment. Considering the frequency of conflicts and the severity of violence, it is also a manner of self-protection.

4.1 Doctors’ Behavior

A. Face the Problem

From the classic knowledge-attitude-behavior (KAB) model, we know that in order to change behavior, the primary source is knowledge accumulation; with that, people will have attitude changes; and finally, the two premises jointly promote behavior change (Miller, 2010, p. 102). For Chinese health professionals, the biggest challenge for achieving behavior change is not necessarily the lack of professional knowledge. Instead, it is the lack of proper attitude to patients
Specifically, healthcare providers seldom consider the shortcomings in their clinical performance. They are less likely to reflect on their own behavior. Like all ordinary people, healthcare workers can find it easier to blame others when there is a problem, especially when there are “many promising targets for blame (Berwick, 2003)”: the government, regulators, the media, the pharmaceutical industry, insurance companies, and even patients. The variety of factors has hindered doctors from detecting their own shortcomings. Rather than acknowledging that they might be the source of the tension, doctors see themselves as the victims of the system, and consequently, are less likely to change their behavior.

In China’s hierarchical society, doctor attitude can be a particular issue. To some extent, this resonates with the Confucius ideology about the teacher-student relation: what comes from the higher hierarchy is right without doubt. On the one hand, with the increasing information accessibility in the modern era, the gap between doctors and patients is narrowed.

On the other hand, while patients become aware of their rights, doctors fail to accept the change. Doctors believe themselves to be the absolute authority that must be fully respected. They do not like being suspected or challenged. They are unwilling to take time and explain complicated professional knowledge to “ordinary people.” In the event of a tension with patients, few health workers can reflect on their clinical performance or the nature of their interaction except for condemning the various sources that have contaminated their absolute authority. Seen in this light, it is not easy to facilitate positive doctor-patient communication without the healthcare providers
changing their attitude and facing their shortcomings.

According to the Institute of Medicine Roundtable, three major problems with healthcare providers are overuse of procedures that do not help people get better, underuse of helpful ones, and misuse or errors (Chassin et al., 1998). These problems are not unique to China, but are rarely discussed in the Chinese society. The silence about these issues has contributed to the ignorant attitude among healthcare providers.

Some may argue that the additional challenges such as heavy workload and insufficient payment may disrupt doctors’ capacity of changing attitudes. Certainly, the change is not possible without support from the other levels. A well-established payment system, for example, can help avoid the profit-driven overuse and underuse problem. Likewise, increased professional training from the hospital can help lower the mistreatment and error rate. But none of these other interventions would be sufficient if the people involved do not realize the problem.

One strategy this thesis proposes is to hold regular conversation-based meetings using different sessions including the department session, across-department session, and the hospital session. The goal of such meetings is to bring the provider-performance issue to light, and emphasizes its relevance to improving the doctor-patient relation. During the meeting, participants would discuss unpleasant experiences with patients. They can be experienced by the participants in person, or can be heard from other places.

Participants should explain their decisions and the lessons they have learned, if any. They could also their share their concerns, anger or disappointments in the event of unfair experiences.
All participants could give opinions or suggestions, but should avoid judging other providers’ decisions. This conversation-based meeting aims not only to create an informal atmosphere that allows participants to share personal stories without experiencing potential humiliation, but also to inspire providers to reflect on their behavior. Moreover, a group of participants with the insider’s view can establish a supportive environment, especially when violence is experienced.

B. Understanding Patients’ Help-Seeking Behavior—the Emotional Aspect

When the attitude is changed, the next step for doctor-patient relation improvement is understanding the help-seeking behavior among patients. This is one of the most pivotal step as far as this thesis is concerned. A trustful relationship is not possible without the clear understanding on both sides. Particularly since there is a power-mismatch, providers must learn the pattern of patient behavior and the underlying mindset in order to address them in the treatment. Universally, there are common features about patients’ help-seeking behavior. Chinese doctors might learn from international lessons before considering our distinct features.

First of all, healthcare providers should remember that their obligation in service delivery is more about healing illnesses than curing diseases. What this implies to the Chinese doctors is that patients are lively humans, not automatons. Humans have emotions. The emotional aspect is what distinguishes illness and disease. In fact, much evidence has shown that treating emotions can be more meaningful to patients than treating physical symptoms (Auguste & Smith, 2012, p. 18).

Such an emotion-focus treatment is rarely adopted by the Chinese doctors. On the contrary,
it is typical for the providers to remain pokerfaced to patients. Hardly will patients receive a friendly welcome from their providers. There is no smile or even eye contact, not to say any emotional support during the treatment. When patients talk about their symptoms, doctors are busy writing their medical record with few responses, as if the patients are talking to the air. Who would dare to expect emotional considerations from the doctor?

Once again, people argue that the Chinese healthcare providers are unlike others in terms of the heavy workload, excessive work time, and short period spent with each patient. Yet, from the perspective of this thesis, it is more often the case that our providers are unwilling to be interactive than unable to be. The more positive doctor-patient relation in lower-level health centers supports this view.

In smaller health organizations, such as the rural health centers, patients tend to form better relations with their providers. A 2009 documentary, *100 Patients of Dr. Jia*³ (Wang, 2009), recorded the normal doctor-patient communication in a small rural clinic over the whole year. A secret camera was put in Dr. Jia’s office which most patients did not notice. Overall, Dr. Jia’s treatment was conducted in a relaxing atmosphere. He joked with his patients to help them relax. With foreign patients, he tried to speak their dialect which immediately shortened their distance. Since it was shot over the 2008 Szechuan Earthquake, the documentary also recorded Dr. Jia showing his concerns for some patients from Szechuan province.

³ A Hundred Patients of Dr. Jia: a documentary directed and made by Wang Hongjun in 2009.
It worth pointing out that Dr. Jia was in no way ingratiating himself with the patients. He would blame the guy who attempted to fake his record in order to skip work, or the teenage girl who became obsessed with weight-loss and diet. Yet, none of that affected the trust Dr. Jia’s patients had in him. His office was full of harmony because of the emotional ties and interpersonal relations with patients.

This is what the majority of health providers need to learn. In fact, offering emotional support can be simple. It does not necessarily take much time. Some verbal responses to their description, such as “yes”, “really?”, “I see”, “what else?”, “I’m sorry” or “that must be awful” are encouraging and reassuring to the patients. Additionally, non-verbal communications as simple as keeping eye contact or smiling can also be helpful. In short, paying attention to patients’ emotional aspects is not an impossible task for the Chinese doctors. In the words of Dr. Gu who is a real-life example described in Angel Heart, it does not cost one anything to just give the patient a smile. It is a small act for providers, but can be substantially effective to patients.

In Smith’s Patient-Centered Interviewing, the authors identify six premises of patients’ help-seeking (see Table 4). From the perspective of this thesis, the most useful lessons are 1) patients do not seek care only because of a symptom; and 2) patients bring more than one concern when seeing the clinician. These are the two valuable lessons for China. To some degree, the current problematic healthcare service can deter people from seeking professional care. In rural areas, patient have fewer accessible resources, more economic constraints and lower health literacy. In cities where there are better resources and a higher health literacy rate, patients are held back by
the high opportunity cost. Most public hospitals in cities are packed with patients. For instance, the average outpatient number per day in the Beijing Tiantan hospital—one of the best hospitals across the country—is 2,437 (Beijing Government Office for Taiwan Affairs, 2016). That means, seeing a doctor may take more time than people can afford, especially when most of the time is spent waiting. It is not uncommon that the actual treatment time is only five minutes after a five-hour wait.

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<th>Table 4.</th>
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<td>Six Premises Behind Patients’ Help-Seeking Behavior:</td>
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<td>■ Patients often do not seek healthcare only because of a symptom</td>
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<td>■ Patients usually bring more than one concern to their clinician</td>
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<td>■ Allowing the patients to tell her or his symptoms story is diagnostically useful</td>
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<td>■ Allowing the patient to tell her or his symptom story is therapeutic</td>
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<td>■ Patients do not want us to try to “fix” everything they tell us about</td>
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<td>■ Patients may not experience our caring and compassion unless we give voice to them</td>
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This background in China can help us better understand the above premises that the problem is always beyond one physical symptom when a patient decides to seek professional help. Accompanying the costly decision are always the patient’s emotional concerns. For example, a patient will not see the doctor only for his consecutive headache, but he may do so immediately when he is worried about having a brain tumor—especially if a colleague of his has just been diagnosed with some type of tumor—or when the headache has resulted in other symptoms like

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4 opportunity cost: an important term in economics which refers to the value of the next best opportunity. In other words, it is what one must give up when making a choice. In this context, the opportunity cost means that patients must spend hours, which they can alternatively spend on other more important tasks, in hospitals or in the waiting rooms to be treated. This price can be too high to pay for many Chinese patients.
insomnia, poor appetite and bad temper which has affected his ordinary life. In either case, simply treating the physical symptom may not be reassuring to the patient.

Not realizing the multiple non-physical concerns can have severe negative impacts, because it is closely related to patient satisfaction with the clinical experience and their relation with the providers. Research shows that, on average, patients seeking primary outpatient care bring three or more concerns to the doctor, and the first concern they raise may not be the most important one (Kaplan et al., 1995). By contrast, what they save to the last is critical because it can be the most concerning one.

In the above headache example, the patient may mention he has headache, insomnia, severe weight-loss owing to the poor appetite and finally, unstable mood. Among all the symptoms, the last-mentioned mood may be most concerning to the patient because his colleagues are unwilling to be in the same group as him, his wife complains about his capricious behavior, and his daughter becomes too afraid to speak with him. If the doctor fails to catch his concerns and simply gives him aspirins, the patient may feel his problems unsolved and furthermore, consider his doctor as incompetent or irresponsible.

To sum up, based on the universal help-seeking behavior of patients, the first lesson the Chinese healthcare providers must realize is that treatment is not just curing physical symptoms. Disease symptoms are not powerful enough to trigger help-seeking behavior. Closer attention is needed on the emotional aspects. As noted in Smith’s Patient-Centered Interviewing, patients expect more emotional support and responsive interactions compared with being “fixed” of all
their problems (Auguste & Smith, 2012, p. 6). For them, doctors’ capacity to identify and address the emotional needs is a better treatment. On the doctors’ side, such a strategy can counter their weaknesses in professional skills while not necessarily impacting patient satisfaction. It forms the basis of a healthy doctor-patient relation.

C. Communication Strategies

Important as offering emotional supports is, it should by no means replace the treating procedure. The emotional aspect is the first step for a successful doctor-patient communication because it establishes trust. When trust is established, doctors need specific skills to deliver instructions and important information. Effective communication strategies can help avoid unnecessary procedures or potential conflicts, especially when the patient population has low health literacy.

Various studies have proved that low health literacy can be a main barrier for effective doctor-patient communication. Low health literacy patients can have less knowledge about illnesses and diseases (Kalichman et al., 2000), about informed consent (Miller et al., 1996), about discharge instructions (Spandorfer et al., 1995), and about self-care after surgery (Wilson et al., 1997). In addition, health literacy has a decisive role in patient experience and health outcome. Jensen et al. (2010) found health literacy is positively correlated with critical thinking about healthcare. Low health literacy patients are less likely to raise concerns about treatment procedure and are adhere less to health instructions (Jensen et al., 2010). In China, a large proportion of patients fall into the
category of low health literacy. Considering this reality, it is critical for the healthcare providers to minimize the potential unpleasant outcome with effective communication strategy.

First, doctors should avoid jargon or numeric information. As discussed earlier, what seems obvious to doctors can be oblivious to patients. It does not make sense to patients when they are told that they have type II diabetes if they do not understand the concept of blood sugar. Likewise, a symptom reduction of 40% by taking a certain drug, or the 80% survival rate of an open-chest surgery, does not mean anything to them. Communication skills like this may not seem relevant to improving doctor-patient relation, but if patients do not understand their situation clearly, they are more likely to engage in risky behaviors which are not predicted by doctors. When disastrous results occur, patients blame their providers for being irresponsible or unprofessional. Although this is a misunderstanding about healthcare workers and institutions, it is common in China as well as elsewhere.

The alternative path is to measure the information specifically to an individual patient. In other words, instead of giving identical instructions to all patients, doctors should alter the message accordingly to different patients. In Smith’s Patient-Centered Interviewing, the authors categorize patients—or people in general—into seven types based on their most obvious personality: the dependent type, the obsessive type, the histrionic type, the self-defeating type, the narcissistic type, the paranoid type and the schizoid type. Each type of patient has distinctive characters and medical needs. When interacting with patients, doctors should 1) be able to identify their types; and 2) offer instructions by addressing their specific needs. Table 5. illustrates in detail of the basic needs,
clinical presentations, and suggestions for response for each patient type. Although variation may exist among the Chinese patients, this guidance for patient classification is nevertheless a useful learning material for our providers.

Table 5.
Patients’ Personality Style

**Dependent Style**

**Basic need:** to assuage fears

**Clinical presentation:** normal and greater degrees of requests for advice, need for detailed directions, checking of plans in order to do things “right”, a history of “superindependence” (such as deferring to a spouse for answers and decisions), and problematic oral habits like overeating, smoking, excessive drinking and other addictions.

**How to respond:** incorporating much support in the conversation and actions by showing interest in patients aside from their disease, giving more detailed guidance and arranging more frequent checkups.

**Obsessive-Compulsive Style**

**Basic need:** to maintain control, especially of emotional expression

**Clinical presentation:** normal and greater degrees of orderliness, precise speech, detailed accounts of body functions and symptoms, self-discipline, tidiness, conservatism, punctuality, conscientiousness and concern with right and wrong. Although patients may ask many questions, they do not listen and obsessively focus on selected details as a way to control anxiety. When asked how they feel, they characteristically respond with what they think.

**How to respond:** giving information in appropriate detail, which can include written material, and specific plans for treatment. It helps to involve patients actively, giving them a sense of control in decision-making (eg. which procedure to take). It also helps to compliment such patients on their knowledge, reasoning, self-sufficiency and high standards (eg. “It looks like you have done some research on that.”).

**Histrionic Style**

**Basic need:** to merge emotionally with others, especially of the opposite sex

**Clinical presentation:** normal and greater degrees of charm, colorfulness, liveliness, attractiveness, sexual appeal, gregariousness, romanticism, sentimentality, artistic interest and creativity. Concern about appearance and bodily integrity is paramount. Such patients may have a short attention span, decreased ability to concentrate and handle factual data erratically.

**How to respond:** brief compliments on the patient’s appearance; show and express interest in such
patients as a person rather than an object of attention. Allow them to ventilate fears and concerns, but do not foment or encourage them. Reassurance works better than intellectual explanations.

**Self-Defeating (Masochistic) Style**

**Basic need:** to suffer which, nevertheless, symbolizes love and attention

**Clinical presentation:** normal and greater degrees of guilt and need to atone for misdeeds, complaining bitterly about their problems, and feeling unworthy of success. There is resistance to encouragement, denial of improvement, and a spurning of efforts to help.

**How to respond:** avoid reassurance, suggestions of improvement, or promises of cure. Empathy works nicely for this. Framing tests or treatment as yet another burden to endure.

**Narcissistic Style**

**Basic need:** to overcome low self-esteem and lack of confidence in maintaining personal identity

**Clinical presentation:** normal and greater degrees of expressing opinions and feelings, often appearing smug, vain, arrogant supercilious, disdainful of others’ opinions, possessing mysterious knowledge, and exaggerated self-confidence. Patients typically manifest an attitude of superiority to clinicians, being only content with the “best” clinicians (always the chief of service).

**How to respond:** acknowledging patients as a person of unique achievement. Show an attitude of respect and concern rather than one of warmth and caring. It helps to engage them as a colleague whom one can share ideas with.

**Paranoid Style**

**Basic need:** to assuage their fear of their own faults, weakness, impulses and of infringement by others.

**Clinical presentation:** normal and greater degrees of suspiciousness, critical evaluation, alertness, cynicism, complaining, planning ahead, rigid limit-setting, and ruminating on negative problems. Such patients may irritate or frighten clinicians by demanding for more attention, better food, less noise and better personnel.

**How to respond:** giving full information about plans and treatment, being more detailed than usual. A friendly, courteous approach that avoids closeness works best. Avoid inadvertent slights. Do not reinforce, dispute, or ignore patients’ paranoid assertions.

**Schizoid Style**

**Basic need:** to protect against certain disappointment when relating to others

**Clinical presentation:** normal and greater degrees of distance in relationships and comfort in being alone. Such patients can be unsociable, out of touch, and have solitary interests. Though appearing independent and disturbed by their problems, they are often oversensitive and fragile. They are frequently of low socioeconomic status, and be brought in by relatives or neighbours. They can fail to follow up on recommendations especially at the beginning.
**How to respond:** maintaining a considerate interest that is quiet and reassuring, and that does not demand reciprocation. Accepting their unsociability, but do not permit withdrawal. Try to engage such patients to a degree they can tolerate.


This identify-and-address strategy may become a turning point for development of the doctor-patient relation in China. As has been discussed in the beginning of this section, most patient dissatisfaction evolves from the communication aspect rather than the actual problems like bribing or prescription. The majority of patients are reasonable. People understand the flaws our system and providers face. Not to say that some “hidden rules”—such as red envelopes or the “back-door” phenomenon—are not unique to the health sector, and even not unique to the Chinese setting. What ignites patients’ dissatisfaction usually lies in the way providers interact with their patients.

Take a dependent type patient who tends to demand more details about the usage of a medicine for example. Must I take it three time per day? When exactly should I take it? What if I forget for once? Is it before a meal? Is there any food I should avoid? Does it have side effects? These are the questions he may ask even after the doctor’s explanation. He may not stop talking while the doctor is concentrating on writing his record or prescribing. He may still linger when the next patient comes in. Although dependent-type patients may not be a welcoming type, it will be the providers’ fault if they cannot face the challenge. If the provider shows any signs of impatience or disgust, the patient experience is disrupted. Dissatisfaction will occur which gives rise to potential conflicts.
Applying the identify-and-address strategy can be difficult especially with the short time period spent with each patient. There is also the issue of judgement accuracy. Sometimes, patients’ personality features are not so obvious. Other times patients may present more than one feature. Most importantly, even with the BTS model and other role-play practices, it takes time for the providers to adjust. From another perspective, however, the heavy patient volume can provide a unique strength for our providers to become experts in doctor-patient communication. After the painstaking effort in the beginning, doctors will be more confident and proficient in identifying patient types and address their features in the treatment. Eventually, the new strategy will become part of the regular procedure.

4.2 Patient Empowerment

Except for the actions from providers, it is equally—if not more—important to empower patients. As the old Chinese philosophy goes, teaching a man how to fish is more useful than directly feeding them with fish. Both in terms of the doctor-patient relation and the healthcare in general, patients have their obligations to fulfill. Put it another way, patients are participants in healthcare, not just the beneficiaries, and definitely not outsiders. The ways this thesis suggests for patient empowerment are media campaign and mHealth. Each of them will be expanded in the following section.

Above all, patient empowerment does not mean that patients must understand their condition without seeing the doctor. It does not require patients to be able to self-diagnose or self-prescribe.
Rather, it supports patients to actively equip themselves with basic health knowledge. The pursuit of better health literacy does not conflict with seeking professional help from doctors. Empowered patients can gate-keep for themselves in the event of misdiagnose or mistreatment. Such empowerment is being self-responsible rather than saving the providers’ work. As has been mentioned in the previous chapter, patients with high health literacy rate often enjoy better health outcomes.

Patient empowerment should be an essential step to healthy doctor-patient relation by altering patient expectations of healthcare providers. This addresses one of the complaints from health workers. Patients must be realistic. Over-expectation and under-expectation can both inhibit patients from benefiting the most from healthcare service. A diabetes patient, for example, who understands the concept of blood sugar is less likely to blame his doctor if he does not mention the risk of eating rice. Likewise, a well-literate hypertension patient tends to avoid using soy sauce, which is an indirect source of salt, other than reducing direct salt consumption without the doctor’s instruction.

Changing patient expectations is not the same as lowering them. It is about establishing the proper patient attitude to the providers, to health service, and to their rights in healthcare, just like the attitude change for the health workers. Expectation change is hard, but once achieved, it will contribute to mutual understanding between the two sides. Since it takes two to tango, attempts from providers alone is not enough for the improvement of their relation. With the improved health knowledge, or health literacy rate, there can be less miscommunication between doctors and
patients.

A. Media Campaign for Healthcare

One of the best ways for patient empowerment would be media campaigns. Media is an ideal tool for information distribution, especially to a large audience. Furthermore, it has a critical role in influencing public opinion. During the WWII, for instance, the US successfully used media campaign, or propaganda, to inspire millions of people to fight for their country. Today, with modern technologies, the influence of media is only greater and faster. Therefore, from either aspect, media is an effective way to reach the Chinese patient audience.

For instance, when SARS broke out in China in 2003, preventive behavior, such as washing hands regularly, wearing masks in public space and inspecting body temperature, were widespread in the media. In the meantime, true stories about the heroic health workers as well as the tough patients were frequently reported in the media. The idea was to encourage the whole nation—no matter doctors or patients—to fight hand-in-hand against the daunting health crisis. The mass media campaign against SARS turned out to be a great success. It contributed substantially to the final overcome of the crisis.

However, because of the power of modern media, its convenience can also be dangerous in the field of healthcare in that media allows the free circulation of both positive and negative information. From the opinion of this thesis, the media in China has resulted in deteriorated doctor-patient relation in two aspects. First, the health workers and organizations are represented
overwhelmingly in a negative way. Most reports on healthcare are associated with topics like treatment failure or corruption. This has left patients with bad impressions about hospitals and health workers.

There is little appreciation for the providers’ work. A Chinese metaphoric term for health workers is “Bai Yi Tian Shi”, that is “angels in white.” Sadly, the term rarely appears in today’s society. If patients are rescued or cured, the providers are just people fulfilling their jobs who do not deserve mentioning; if a treatment fails, however, the providers immediately turn into devils, and the failure will be magnified by the media. Such biased representation is not fair for health workers. On any occasion, there are the “the exceptions.” It is not a phenomenon exclusive to the health sector. We cannot deny the existence of those unprofessional health workers, but that minority should by no means devastate the mainstream representation.

To alleviate the situation, we must reinforce the positive images of healthcare workers and hospitals rather than focusing primarily on the negatives. Positive representations offer an incentive for providing good-quality service. It not only is more effective than material incentives, but also helps increase provider confidence in their work. The truth is, the overwhelming negative representation does not necessarily result from the lack of positive examples. Leading figures as famous as the national hero Dr. Zhong Nanshan⁵ and the Nobel-winner Dr. Tu Youyou, or as ordinary as a selfless doctor in a community health center and one of the few persistent barefoot

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⁵ Dr. Zhong Nanshan: the former president of the Chinese Medical Association, a renowned member of the Chinese Academy of Engineering, and a SARS hero. In 2002, Dr. Zhong led his team into the treatment of SARS in Guangdong province, which won the highest survival rate in the world. He was therefore awarded the Touching China 2003.
doctors in a remote village all deserve to be appreciated by more audience. The efforts health workers have made, as well as the challenges they face should be learned by their patients.

Second, the health information in media can be misleading. In many circumstances, the circulating information is unverified. Ordinary people, especially those with low health literacy, do not have the ability to tell the legitimacy of information. The sensational Wei Zexi incident in April 2016 provides a tragic example. Wei Zexi was a 21-year old sophomore in a Chinese university. He was diagnosed with a rare cancer and was told that the traditional radiation and chemotherapy treatment would not avoid his death. After reading an online advertisement about the bio-immunotherapy treatment from the largest search engine in China, Wei regained hope and decided to try this “new experimental treatment”. Yet, he soon discovered it was nothing but a lie. The so-called “experimental bio-immunotherapy” had been discarded twenty years ago in the US (The MIT Press, 2016). Before his death in April, Wei shared his story on the Internet. His experience outraged the Chinese society. Heated debates were triggered on “who should be responsible for Wei’s death.”

This unfortunate example has shown the risk of having unregulated health information in the media. To avoid future tragedies like Wei’s, the government must have clear rules about the types and validity of information that can circulate in the media. Media advertisements can only be made for products that have been officially registered at MoH. Whenever there is a rule-breaker, severe punishment would be inflicted. Only in this way can we ensure the role of the media as an empowering tool, not a harming one.
In summary, the media could be a crucial support for better health service and healthier doctor-patient relation in China, if used properly. The role of media in improving patient experience in China is 1) facilitating healthy doctor-patient relation by advocating positive provider images; 2) empowering patients by distributing reliable health information. It is influential for establishing a healthy atmosphere for both providers and patients to participate in public health. It can be used to advocate healthy behavior and basic knowledge. To alleviate the doctor-patient tension and to ultimately improve the quality of care, China needs to take advantage of the media power.

B. mHealth

Apart from the traditional media campaign, we can also adopt social media as a supplement strategy for better doctor-patient relation in China. What this thesis recommends is the use of mHealth. MHealth is healthcare and public health practice supported by mobile devices (WHO, 2011). The idea of mHealth was based on the wide coverage of cellphones and people’s increasing attachment to them. Thanks to the strong dependence on electronic devices even in less-developed places, mHealth can improve service delivery and impact health outcomes. In recent years, mHealth is adopted not only for general care, but also for public health practice for communication, data collection, patient monitoring and education, and to facilitate adherence to chronic disease management (Hamine et al., 2015). It makes possible real-time monitoring and interaction without the actual visit in person. In a word, mHealth has proved to have enormous impact on chronic disease management worldwide.
In China, the biggest advantages of mHealth would be stimulating informal doctor-patient communication. While the traditional media campaign aims at a large audience, individuals may not necessarily feel the message is relevant to them. With mHealth, people are more engaged with detailed and personalized messages in an interactive way. Despite that most mHealth practices are delivered through SMS or special devices (such as sensors), this is made easier in China with the nation-wide coverage of WeChat.

The impact of mHealth can be enlarged with the participation of paraprofessionals. Hospitals can train mHealth-focused paraprofessionals in addition to those who work onsite with patients. The goal is to facilitate informal interaction between health workers and patients. During the interviewing period, paraprofessionals can share the hospital’s official WeChat account, or their personal account on patients’ requests. Through the official account, hospitals can distribute health-promoting knowledge like in traditional media campaign. More importantly, when there are private questions about after-surgery care, medicine instructions or other related concerns, patients can directly contact the paraprofessionals, or the official account with questions that will be answered by the trained paraprofessionals or the doctors themselves. In a way, the combination of mHealth and paraprofessionals makes it possible for the Chinese patients to enjoy personal healthcare.

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6 WeChat is a smartphone chatting application. It can be viewed as the combination of Facebook and Messenger, only that it is used by almost every Chinese person, regardless of age, origin, gender, profession, and class.
Conclusion

It should become clear that the remedies to the doctor-patient tension exist on various levels. Just like the problem was not generated from one source, no interventions could be effective enough to solve it in one click. Efforts must come from different directions simultaneously. From another perspective, it is also vital to recognize that the frontline health workers are not the only side to blame. Due to the history of eroded medical ethics which is exacerbated by the overwhelming negative representation in the media, hospitals and healthcare providers are seen as irresponsible, incompetent and profit-pursuing. Until very recently, the public has never contemplated on the issue “who is to blame in the face of medical incidents”. The sensational “Wei Zexi incident” in April 2016 was the first to make people realize the medical failure is not the only fault of hospitals and physicians.

Although this thesis does not aim to find excuses for doctors, we cannot deny that the healthcare system as well as other public service sectors have their roles in this tension. Doctors are not an isolated profession. They depend on the healthcare system and are subject to the flaws in it. Likewise, the health sector is not independent. It intermingles with other public sectors such as education. It is constrained by uncontrollable forces such as government funding and media reports.

On the other hand, patients also have responsibilities. A popular saying in China goes, “It takes two to tango.” Yet, when it comes to healthcare, people seem to forget this lesson. In many cases, patients act irrationally, unreasonably and selfishly. Some expect good quality of service without
giving proper respect to their doctors. Others expect too much from care providers that exceeds the duty of their job. In short, the success of doctor-patient relation should not just regard doctors’ effort. It should be a collaboration of both doctors and patients. It is deeply involved with other public services.

Nevertheless, it is not unreasonable to prioritize “reforming” the frontline health workers because they are the most direct, and often the only agent patients interact with. Therefore, health workers have the obligation to overcome barriers and recover the healthy doctor-patient relation, but this obligation cannot be achieved without patients’ cooperation and the system’s support.

Overall, this thesis reveals that the issue of doctor-patient tension is complicated. What has been identified here does not represent all the contributing factors. In the same way, effective solutions may not be easy to find for China. Some strategies that work elsewhere, including the BTS collaborative model and mHealth, may not apply to the Chinese setting. Other lessons, such as the identify-and-address communication strategy or media regulation, may not be practical considering social, cultural and political constraints. Furthermore, even if all the interventions can be implemented, changes will take time. After all, behavior change is a long-term process. It requires investment beforehand, as well as support afterwards. This may also cause further pressure to the burdened healthcare system.

Despite the complexity, the discussion provides references for future reforms to draw on. It is not this thesis’s goal to solve the tension in China. It is, instead, to raise awareness for the people—doctors or patients or policymakers—that the doctor-patient problem is not unique to China. More
importantly, the problem is by no means unsolvable. The key to success should lie in mutual understanding and joint effort from all levels. From policymakers to health organizations to healthcare providers and finally to patients, each level is supposed to recognize their duty and admit their limitations in healthcare. It won’t help by blaming others.

The extraordinary victory against SARS in 2003, the after-earthquake pandemic in 2008 and the H1N1 swine flu in 2009 show that the Chinese people have the capacity to overcome health crises with nationwide contributions. Those stories should give us the reason to believe that such success was not by chance. Despite the different nature of each crisis, we should remain positive about duplicating that success in the doctor-patient crisis. As long as all the participants act on their duty, the achievement of a healthier doctor-patient relation, and ultimately an accessible and accountable healthcare system with good quality of service will not be an impossible mission for China.
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