Chapter 6 Power Game of *Nao*: Violent Disputes in the Chinese Medical Sector

The medical sector in China has witnessed increasing disputes between doctors and patients over the past several years. According to a 2012 report (Wang and Li 2012), medical disputes in China have increased at a rate of 22.9 percent annually since 2002.[97] Especially disturbing are the violent attacks, fights with and even murders of health professionals by patients. Such events are generally known as *yinao*. *Yinao* – the combination of the word '*yi*' (doctor, medical care, hospital, etc.) and '*nao*' (a disturbance or the act of speaking loudly and acting violently) – refers to the medical disputes waged by patients' families against medical personnel and medical institutions that involve violent or illegal means.[98] These disputes can take various forms, including the display of corpses at a hospital, the blockade of a hospital entrance, the destruction of property, attacks against health professionals, and in some cases, the employment of gangs by patients' families in order to pressurise medical institutions for more compensation in instances of malpractice. China's CCTV reported that in 2010 alone there were 17,243 cases of *yinao*, an increase of almost 7,000 incidents from five years earlier (People's Net 2012c). Statistics from the Ministry of Health show that medical violence had increased by 70 percent from 2006 to 2010 nationwide (CPG 2013d). The official People's Net claims that over 10,000 Chinese health professionals are attacked or injured every year (People's Net 2011b). A ten province survey conducted in 2008 in 60 hospitals finds that more than half of health professionals had been verbally abused, nearly a third had been threatened, and 3.9 percent had been physically assaulted by patients or their relatives (Zhang and Sleeboom-Faulkner 2011). Research in a three-tiered hospital in Shanghai found that there were 577 cases of medical violence between 2000 and 2006, taking up 61.55 percent of all medical disputes that took place in this hospital during this period (Xu and Lu 2008). Besides these recorded cases, there are innumerable *yinao* cases that are unreported and solved locally under the political pressure to maintain stability. In the municipality in which my field site is located, there were 550 recorded medical disputes that took place between 2008 and 2011,

[97] Chinese reports and articles gave different increase rates nationally. The rates also varied from place to place. Due to the sensitive issue of disputes and the tendency of the local government to conceal disputes, it would be difficult to find out the accurate data. The rate 22.9 percent is the result of a survey conducted by the Chinese Hospital Management Association, which is comparatively more official than other reports. The number is also quoted by some Chinese journal articles and media reports (all did not mention when the survey took place, but the data itself only emerged after 2012).

[98] *Yinao* can also refer to the people who use violence in medical dispute. Narrowly, it refers to the special groups of gangs employed by the patients' families to argue for more compensation. The word *nao* can be used as both a noun and a verb.

approximately one medical dispute every two days. Medical conflicts and disputes erupted in local hospitals every month. Rising numbers of health professionals have experienced verbal or physical violence from patients.

Various factors contribute to this increase in medically-related disputes: a rising consciousness of patient rights, the deepening misunderstanding between patients and doctors, inflammatory media reporting, the absence of a formal institution for dealing with medical disputes, and problems related to the health system more generally. Yet, the use of *nao* in medical disputes has got little social science scrutiny. This chapter tries to fill this lacuna by studying the outbreak and practice of *yinao*. It explores how both patients and doctors employ the tactics of *nao* to defend their interests, and in the process reconfigure the power relations between patients and doctors. The use of 'power game' rather than 'power dynamic' is to emphasise the performance side of *nao* – how people use the tactics of *nao* and carry them out will influence the result of *nao*. *Yinao* being tolerated, solved or unsolved suggests not only the relationship between patients and doctors, but also the ways in which the state relates to the citizens. Thus, this chapter also reflects on the current government measures to contain disputes: how the state frames civilised and legal behaviour, and tries to control *nao* – the uncivilised and backward practice. It highlights the strategies, complexities, and limitations of the practice of *nao* in an era of 'harmonious society', explores the power dynamics between patients, doctors, hospitals, and governments in the process of *nao*.

The Outbreak of *Yinao*: from Forgiveness to Revenge

During my fieldwork, several cases of doctors being attacked by patients have been widely circulated and discussed nationwide. One of the most influential cases is the 'Harbin' incident described in the beginning of this thesis. A young man in the city of Harbin in northern China stabbed four members of hospital staff in March 2012. Since this incident, I began to incorporate it into my interviews. I asked my respondents to comment on this incident. The question always evoked emotional responses from local residents. While many people showed their sympathy towards the deceased physician, stating that it was wrong to kill, they also expressed a high degree of understanding towards the extreme behaviour of the patient. 'There must be something wrong with the doctors or the hospital, or else how could the patient come to attack you [doctors]!' many of my interviewees speculated. Indeed, for many

interviewees, their first reaction was to suspect the doctors and hospital involved of wrongdoing. My respondents recalled their own unhappy encounters with doctors and hospitals or recounted stories of others' experiences that they had heard about: instances where patients were overcharged, rejected from a hospital for not having sufficient money, mistreated by health professionals, or ignored, literally, to death. Typical was the way this elderly couple that I interviewed expressed their views:

> Grandpa Xu: I reckon the doctor might have done something bad, caused great resentment. You [the health professional who was killed] were a doctor, how could he [the patient] kill you [without a reason]? …
> Grandma Xu: In the past, it was less typical. He [the patient] could forgive you [the doctor]. Honestly, in the past, how did you [the doctor] behave towards patients? Your primary concern was to save him, your professional responsibility was to save the patient. Thus, the patient's family could forgive you. Now, even for a minor illness, your main focus is to make money, therefore if something goes wrong, they [the patient's family] will certainly argue with you until they take back more money from you.
> Grandpa Xu: The people [patients and their relatives] are just too resentful. His [the doctor's] attitude is really bad…Some [doctors] are too arrogant, they [patients' relatives] killed you then, anyway, one life redeems another life… (Interview P32)

Grandpa and Grandma Xu's comments were informed by memories of an earlier era. During the Maoist period, the socialist system provided almost universal, albeit very basic, healthcare to Chinese citizens. Doctors were encouraged to selflessly 'serve the people' and put saving lives first. Patients recognised that doctors had dedication, which enabled them to be more 'forgiving' when medical accidents occurred. However, in the post-reform era, patients often depict doctors as insensitive towards human suffering, and as putting profit before patient care. Patients become increasingly resentful: they get little information about their treatment, are frequently ignored by health professionals, and sometimes are even pressured to give gift or have expensive drugs. As an interviewee vividly described, 'we patients are like the meat on the chopping board, everyone wants to cut a piece. The doctors say how much [to pay], we [patients] have to pay that amount, we have no choice' (Interview P37). It depicts a picture of 'vulnerable and disadvantaged patients' vs. 'powerful and authoritative doctors'. Doctors' higher rank in the distributive structure was transformed into power to control and profit from patients. The commercialised healthcare sector opens patients up to an unparalleled regime of exploitation. In response, patients cannot hold lenient

attitudes towards doctors and hospitals. When medical accidents occur or misfortune strikes, angry patients and families often target doctors as well as other health professionals, including nurses and administrators, for revenge. In people's reasoning, good intention and good deed are responded with forgiveness, bad intention and action are reacted with violent revenge, and a lost life is replied by taking another life (*yiming di yiming*).

Patient's violence is structured by a moral vision of health care. Hospitals and doctors in the post-reform era seriously violate this vision. In local people's accounts, there is a clear 'us-versus-them' dichotomy, in which doctors are seen as patients' main adversaries. If othering of medical professions shows people's suspicion and hostility, then the demonization of doctors can justify the attacks. Grandpa Xu's words epitomised many locals' explanations of the violence: patients or their families 'intentionally ignored the law, because by using the law [the doctor escaped punishment or only received a prison sentence], you [the doctor] would continue harming others [after being released from prison]…they just killed you, that's all'. (Interview P32) Killing the 'bad doctor' is understood as a pre-emptive act, a way to prevent future medical malpractice. According to this logic, not only the demonised doctor does not merit a patient's trust, but it is even acceptable for the doctor to experience violent forms of retribution, including murder.

The Power Game of *Nao*: Violence, Protest and Inequality

Nao in daily medical setting

In China, medical institutions at the community level are poorly-equipped.[99] The number of patients overwhelms the upper level medical institutions. The increasing health insurance coverage under the new healthcare reform also enables more patients to seek hospital care, leading to growing numbers of patients in medical institutions at all levels (see Figure 15 and Figure 16),[100] but the number of doctors has not increased accordingly. There are 1.5 doctors

[99] Under the new healthcare reform, medical institutions at the community level are built up by the state with the hope to take the gatekeeper role, but the effects of these institutions are still limited.

[100] My research of more than 10 local hospitals at the county and township level finds rapid increases of patient number in all these hospitals since the new healthcare reform. The People's Hospital, the biggest hospital in Riverside County, had 500 inpatient beds, but the actual inpatient number ranged from 800 to over 1,000 per day in 2011. In 2010, the hospital's annual outpatient number was over 490,000, more than 1,300 outpatient visits per day. The TCM Hospital had around 450 beds, but the daily inpatient number usually surpassed 1,000.

per thousand of the population in China, many of whom are poorly qualified; the density of doctors with five years of training including an internship is only 0.33 per thousand people, compared with an average of 3.1 per thousand in the OECD area (Herd, Hu and Koen 2010). Since the market reforms, health care in many hospitals have been streamlined to increase efficiency and economic productivity. Under the new healthcare reform, many hospital staff face a doubled workload. Doctors must further speed up their diagnoses and treatment, increasing the number of patients or procedures performed per day. In the local county hospitals, outpatient doctors at the forefront see dozens or even hundreds of patients a day. Pressured by the productivity requirement, doctors have only a few minutes to spend with each patient, which contrasts with each patient's lengthy wait for registration, diagnosis, medication, and tests. Inpatient doctors are also overworked, with long operating lists. Health professionals in the county hospitals are pushed to their very limits. Emotionally drained and exhausted, they have neither the time nor energy to pay close heed to individual patient's concerns. These overburdened health professionals sometimes neglect patients' requests. It is their survival strategy to rest whenever they can and sometimes withdraw slightly from their responsibility by ignoring patients' questions and requests, which means that, sometimes, patients who really need help are ignored.

When patients are indeed ignored by health professionals, *nao* is one of their strategies for arguing back. Auntie Liu, a local resident, told me her change from a 'silent and obedient' patient into a 'strong and violent' patient during a hospital visit in 2011:

> Auntie Liu: Now if you don't act violently, he [the health professional] won't pay attention to you...Last winter, I went to the TCM Hospital, he [the doctor] asked me to go into hospital…Later, I waited a long time [in the inpatient department], nobody came to give me a drip. I had handed the prescription to the nurse a long time ago. I asked them about it, and they said they were preparing it for me. Before I went upstairs [to the impatient department], they said they had booked a bed for me, but when I went upstairs, nothing at all, not even a chair to sit on, and nobody gave me a drip. We went to *nao* with them. After the argument, they came to apologise and treated me immediately. If you don't *nao* with them, they just ignore you.

Public hospitals add extra beds in wards and corridors. The overcrowded arrangements have many problems: exhausted health professionals, patient complaints, possible medical mistakes and accidents, etc.

> Community Guard: …Now they are only scared of tough people, if you ask them toughly, they will react to you. If you really think about them, consider how busy they are and wait, then even half a day later they will not have come to you…
> Auntie Liu: Yes, it's like that. At the beginning I stood there waiting quietly, I thought the staff were busy, I should wait, but I waited until all these nurses began to rest and chat to each other, they still didn't pay any attention to me. I spoke to them, and a nurse even said 'You should find a chair for yourself to sit down'. This angered me. I said: 'I'm an inpatient, you ask me to find a chair, where can I find one? Inpatient care should have a bed. If you don't have a bed [for me], at least you should find me a seat'. She said I should find it by myself…How could I find a seat? All these places are full of patients [and their relatives], only if health professionals went to ask, they would spare one. If I went to ask myself, they [the other patients] who were sitting on them wouldn't spare one [seat] for me, only your hospital staff could do that. If I did not *nao*, they would not react. After my argument, the head [of the department] came, and asked her [the nurse] to find a seat for me… (Interview P37)

In the busy hospital environment, patients are frequently unheard, misheard, or heard but ignored. Patients feel helpless, diminished and resentful, and so choose to *nao* to resist the unfavourable circumstances. Auntie Liu's experience of being ignored and mistreated in the hospital led her to give up obedience to act violently, which finally forced the hospital staff to react. Similar experiences were shared by many locals, who agreed that, in many situations, they had to act strongly, complain violently, or report misconduct to a higher authority in order to have their issue solved. The patients, who had paid their medical fees but were left waiting endlessly, began to use *nao* to interrupt the temporal flow of time and space of the hospital until their issue was solved.

In the market, people increasingly become atomised individuals, who need to secure their own welfare, face conflicts, and defend their interests by themselves. Melinda Cooper (2011a) attributes the rising number of medical disputes to the general decline in health insurance coverage in China during the past three decades, which lead to the restratification and reprivatisation of risk. The reduction in insurance security forces people to negotiate good care and defend their interests by themselves, which produces a new kind of Chinese biopolitical subject – 'the individual risk-bearer and contractor in personal services' (2011a:325). Recently, most Chinese patients have taken out health insurance, but, as Chapter 4 shows, the new health insurance schemes do not guarantee anything beyond a minimum

level of healthcare coverage. Patients are still required to take responsibility for overseeing their own care and the quality of their care. Besides, the government has failed to respond effectively to medical negligence, accidents and scandals. There are few independent investigations, no public apology, and insufficient official attention. Dissatisfied patients cannot obtain an efficient response if they recourse to the official channels. People are concerned that no-one will listen to them, and so resort to measures like *nao* to attract attention. *Nao* is an individual patient's technique for attracting proper attention, enabling them to be heard and obtain response in an overcrowded hospital environment.

Figure 15: Waiting Patients in the TCM Hospital

Figure 16: Long Queues in front of the Registration and Cashier Widows

(Left: the TCM Hospital, Right: the People's Hospital)

The practice of yinao: a weapon of the weak?

In Riverside County, several cases of patients committed suicide while in the hospital happened just before and during my fieldwork. The medical dispute that took place in one county hospital in 2011 was especially controversial. It was widely discussed by the locals and repeatedly mentioned by the health professionals I interviewed. The patient had been diagnosed with terminal cancer and was hospitalised. Overwhelmed by pain, she jumped off the hospital building one night and died. After the incident, the patient's relatives gathered in the hospital, placed the coffin at the hospital entrance hall, and asked for compensation. The family also employed gangs to *nao* in the hospital. Quarrels broke out between the patient's family and the hospital, resulting in the injury of several members of the hospital staff, including the hospital director. Drawing from archival and online sources, I found many cases of patient suicide that led to violent disputes between hospitals and patients' families. These cases aroused intense discussions about hospital responsibility. When the overcrowded public hospital attributed some daily care responsibility to the patient's family, the family expressed that the hospital should take full responsibility if accident happened during the patient's hospitalisation. Further complicating this matter, existing laws did not specify the distribution of responsibility in cases of suicide in medical facilities. When these disputes went to court, the adjudications varied from case to case. Many families thus relied on themselves to *nao* in order to seek just compensation.

In the case happened in Riverside County, I was not able to hear directly from the patient's family, but I found a long complaint posted on a local internet forum that had been written by the patient's husband soon after the suicide. From the post, I learnt that the patient was left unattended by hospital staff even though they had been informed about the patient's unstable emotional state and suicidal tendencies. Additionally, the corpse was transferred to another mortuary outside the hospital before the family had been informed. In order to 'seek justice' (*tao gongdao*), the family used the internet as a channel to air their complaints. The post was filled with grievances. In the forum discussion, others expressed sympathy towards the family and criticised the hospital violently.

Taking this suicide case as an example, *yinao* is manifested in various scenarios. When a patient dies in a medical setting, the family and extended kin quickly gather together. They wear white gowns, sit or camp in or outside the hospital, set up mourning halls, refuse to move

the corpse, display funeral wreathes, burn spirit money, broadcast funeral music, and cry out loudly in the hospital. Sometimes patient's families march around the city, holding banners and placards with emotional words in black and white, such as 'return the life of my parent'. Crying, group gatherings, the employment of traumatic language, and the performance of death rituals are all strategies of *nao*.

The practice of *nao* in medical dispute is infused with local social and cultural meanings. Crying out loud, acting emotionally, displaying funeral equipment, and broadcasting funeral music are common practices in conventional mourning. When a patient dies, the family is justified to engage in these mourning rituals even at the hospital or clinic. Sometimes angry families verbally or physically attack health professionals. At the moment of *nao*, social etiquettes (between patients and health professionals) were temporarily discarded. The patient had just passed away; the relatives overtaken by emotion are entitled to act out of normal social customs. Besides, most of the practices of *nao*, albeit controversial, do not directly violate the law. The hospital and government have to tolerate public demonstration of post-traumatic emotions as long as it does not constitute something that threatens the government. Moreover, the public tends to sympathise with the weak, in this case, the mourning family. The long list of grievances the public has about profit-driven hospitals and 'irresponsible' health professionals also increases their tolerance towards *nao*, which is thought to target those in power.

At the same time, the visible, public, and persistent *nao* is disastrous for health professionals and hospitals. While the position of the patient's relatives as victims affords them moral capital in countering health professionals and hospitals, health professionals who hold less moral capital have limited resources. They generally do not respond to verbal attacks until the situation escalates. In addition, the crying and the display of funeral equipment and corpses meet with Chinese people's fear and avoidance of things related to death. These funeral performances at the hospital are thought to bring '*mei*' (bad luck) to the people who encounter them. These intentional actions by the patient's family are meant to drive patients away, causing the hospital and doctors bad luck in their business. Also, these striking and noisy displays put hospital and doctors in an awkward, humiliating position, and threaten their 'face' (*mianzi*) – the reputations of individual doctors as well as that of the clinic or hospital. Many medical institutions and doctors cannot survive these troubles. In order to save their business

and their 'face', hospital administrators and doctors are pressured to meet the family's requests.

Nao has traditionally been used by people in various settings. As the Chinese proverb says, disadvantaged people have three measures to defend their interests: 'first cry, second *nao*, and third threaten to hang oneself' (*yiku ernao sanshangdiao*). People subtly manipulate shouting, crying, and bodily movements to publicly decry mistreatment. In the wider society, people increasingly use extreme measures like *nao* to solve their issues which otherwise would be ignored (Pei 2010; Jing 2010).[101] *Nao* is frequently adopted by people from the lower social strata, who subjectively feel that they have less power and fewer channels to have their voice heard, who are pushed to the extreme and have no other way to defend their interests. Through *nao*, the comparatively weak party who has little to lose reverses the power relations with the other party who needs to preserve their existing interests and reputation. In the health sector, it is the disadvantaged who face a greater possibility of suffering as a result of negligence or bad attitudes (see Chapter 3, page 68 and 69). The accumulative pent-up anger born of innumerable small indignities, resentment, social and medical neglect break out in the form of violence, leading to a political act of considered resistance by the social margins. Although *nao* may not be the perfect solution, it is a 'weapon of the weak' (Scott 2008), deployed by the marginal groups to counter the unequal power relations between patients and doctors, and creates new sites for contestation over rights.

The pressure of preserving stability

Moreover, the ritualised gathering together of the patient's family, kin, and in some cases, hired gangs has symbolic power. In an era of 'harmonious society' – the political agenda promoted by the Hu-Wen leadership since 2004 to reduce social conflicts – the government feels increasingly insecure in the presence of large group gatherings and demonstrations. For this reason, the government frequently pressurises hospitals to solve disputes as soon as

[101] Minxin Pei (2010:29) suggests that ordinary resisters in China are likely to employ simple and direct forms of defiance; their weapon of choice is street demonstrations, blocking major railways and highways, strikes, and even violent attacks on government building. Jun Jing (2010) also writes about the violent contestations and actions, as well as the use of funeral stuffs in Chinese protests. He points out that the transfer of funeral symbolism to social protests is an important feature of China's political culture. In some recent protests, people also employ funeral symbols to demonstrate their demands, such as the white cloth scroll with black and red petition words on top taken by people in the famous Wukan protest in 2011.

possible and meet patients' demands. Ironically, the government effort to build a harmonious society, to some extent, empowers patients.

In the suicide case I mentioned earlier, the hospital later initiated efforts to negotiate with the family, but no agreement had yet been reached when I conducted research in the county hospital in 2012. 'The amount asked by the family was too much' and the family's attacks on hospital staff effectively suspended the negotiation. The hospital director was furious about being attacked and revealed the bind he found himself in, with the family demanding compensation, on the one hand, the government demanding that the hospital maintain stability, on the other:

> At the mediation scene, there were the personnel from health bureau and government office, even two members of the police. I bent down to talk with him [the deceased's husband]. Suddenly he took a tea cup from the table and hit me with it on my head. It hit the corner of my eye, caused the rise of the intraocular pressure, the brain blood pressure increased too, it may have potential risk for my brain…What can I do? I had to be there, to *weiwen* [preserve stability]. The hospital head shouldn't be at the mediation scene. Without the hospital head at the site, the conflict could be eased a little, but the government leader didn't understand this. He only wanted to reduce his pressure [in preserving stability]. There isn't any cooperation [between the hospital and the government]. (Interview D47)

As the hospital director explained, the patient's family would wait for an 'influential' person to show up, then act strongly and even violently to show their determination. The hospital director was aware of the importance of avoiding direct confrontation. 'Instead of forcing the hospital head to go [to meet with the family], it should be the staff specialised in solving disputes who conduct the negotiations', the director commented. However, the local government's pressure to maintain stability forced him to meet with the family, which incited the conflict, leading to the attack even in the presence of police and government personnel. The hospital director further complained about the government's irresponsibility:

> When there is a conflict, the police come to tour the hospital then leave…The court just *moxini* [literally, mix the mud], and even if we win the lawsuit, we still lose. We win the lawsuit but lose the money…Now the state promotes the 'harmonious society', it pursues harmony without the premise of the legal system, this is stupid. It's the government's irresponsibility…The effort to conceal conflict cannot really solve the problem…I feel

> that our society is headed towards a crisis. The crisis is waiting to happen. That's why our government is so nervous, focusing on maintaining stability which outweighs all other concerns, even pursues stability without principle. They are scared that they cannot control the situation if the fire starts and spreads.

According to my respondents, when medical disputes erupted, the police usually arrived, watched, and then left without doing anything. The police's main concern was to preserve social order at the site. As a result, they were often reluctant to interfere for fear of further escalating the conflict. Given police inaction, the conflict dragged on. When the local government was pressured by the existence of protest group of the patient's family and their loud supporters, it, in turn, pressed the hospital to solve the dispute at any cost. The hospital then became the sole target of medical dispute and the only negotiator with the patient's family. The hospital director pointed out the problem of the court that *moxini* – mediated differences at the sacrifice of principle. The director explained that even if the hospital won the lawsuit, they still needed to pay the patient's family in order to 'buy peace'. The government pursued harmony without the premise of the legal system, acted to peace conflicts but failed to address the root of the conflict. When stability trumps all other goals, a bigger crisis ensues.

The inequality of nao

Nao is not only employed by the disadvantaged group, but also consciously used by those who have influence and power to argue for more compensation. During a focus group interview in the local community, the residents told me two stories:

> Resident A: In my village, there was an old lady, she was treated in hospital and was about to be discharged. Before leaving hospital, she accidentally fell on the toilet floor [and died]. Her daughter was working at a police station, she asked a group of people [from the police station] to go with her and they surrounded the hospital, demanding compensation. The hospital director came to negotiate with her many times, explaining that her mother's operation had been successful, and she fell by herself [but it did not work]…After several days' *nao*, the hospital director learnt that the old lady's daughter was from the police office, and then paid her 80,000 Yuan in compensation. They were from my village, the old lady died…They surrounded the hospital, did not allow anybody to go inside, even the ambulance with a patient was not allowed to enter…

> Resident B: Yes, they said you needed to have power, have influence [to get compensation]…If it was ordinary people, they [the hospital] would not respond to you.
> Resident A: They were a gang of people [surrounding the hospital]…They would not leave until you [the hospital] give money.
> Resident B: Oh, last time, my nephew, his wife went to give birth in hospital, she was pregnant with twins. At first, they didn't know [they should give a red-packet]. If they had known, they would have given a red-packet earlier, then the twins could have been saved. In the end, the twins died in the womb. (JT: Why?) Because the doctor did not treat her for a long time, did not come to her, because they [the family] did not pay [extra] money…How was it solved at last? My nephew did not want to go to court, he said a lawsuit would take a long time...Finally, it was negotiated privately, the hospital compensated them 20,000 Yuan. It was twins, only 20,000 Yuan, too little…It happened only two or three years ago. They did not know they should give a red-packet, thus the doctor did not operate on her [in time]… (Interview P36)

The contrasts between these two cases are obvious: one with power used violent measures to *nao*, and thus obtained 80,000 Yuan compensation, while the other did not have equivalent influence to *nao* and was reluctant to bring a lawsuit, so negotiated privately for only 20,000 Yuan compensation. It is impossible to evaluate the worth of a life in pure monetary terms. What matters is the local people's comparison between those who 'have power and influence' and the ordinary people. The powerful ones were able to obtain the compensation they desired within a short period by manipulating their power and influence, while the ordinary people had little choice but to accept the private negotiation and limited compensation. Even *nao* – the weapon of the weak – is mediated by the uneven distribution of power and resources. When adopted by both the weak and powerful, it reinforces the inequality and advantages those who are already advantaged.

Besides, when hospitals are forced to compromise with those who engage in *nao*, this reinforces the sense that more violence begets more compensation. Over time, this encourages people to use violence and society to follow 'the Rule of the Jungle', as shown by the increasing involvement of organised gangs in medical disputes. Health professionals and administrators notice that organised gangs (employed by the patient's family to perform *nao* on their behalf) have developed a mature model to argue for compensation: first, they do not allow medical appraisal and autopsy; then, they organise groups to *nao* in hospital and disturb the hospital's order; afterwards, they burn spirit money and display banners around the

hospital; last but not least, they use other tools like the internet to influence public opinion, and threaten to invoke 'mass incidents' (*qunti shijian*) (Qiu and Yang 2012). These *yinao* gangs clearly understand the pressure that hospitals and the government face with regard to maintaining stability, and consciously manipulate the protocol of a 'harmonious society' to achieve their demands. During medical disputes, many families strive to attain just compensation, but it is clear that some families work together with *yinao* gangs, trying to take advantage of medical disputes to demand a larger compensation package. Sayings like 'want to become rich? Have surgery; after the surgery, sue the doctor' (*yaoxiang fu, zuo shoushu, zuowan shoushu gao daifu*) indicate that doctors reap profits by performing surgery, and patients also strategically sue doctors following surgery to obtain money in the form of compensation. The doctors' attempt to make money out of surgery in the first place supplies a justification for the patients' subsequent extortion behaviour that frequently involves the *yinao* gangs. After successfully helping a patient's families to obtain a high level of compensation, the *yinao* gangs then claim a large portion of it, thereby reducing the actual benefit to the patient's family while at the same time causing the hospital to suffer an unreasonable loss. In this sense, both the patient's relatives and hospital are being hijacked by the *yinao* gangs.

Doctors' vulnerability, defensive measures, and the reversal of power

Medical disputes have become a headache for both the medical institutions and professionals. Hospitals pay large sums annually to solve disputes. Health professionals who are accessible, unarmed and unprotected bear great uncertainty in their daily work. Doctors invariably relate their work to 'risks' and complain about the possibility of being sued or attacked by patients. Some even abandon the medical profession or express an unwillingness to let their children study medicine.[102] In the interviews with health professionals, almost everyone complained endlessly about medical disputes. A young female doctor who had been attacked by a patient told me that she had felt dramatically less secure ever since:

> When I was an intern in the hospital, an old woman in a critical condition passed away one night when I was on duty. Next morning, I had finished work and was chatting with another doctor in the corridor before going home. A middle-aged man came to us and

[102] See various survey results and innumerable media reports (for instance, People's Net 2014a) about doctors' unwillingness to let their children study medicine. The rising tensions and conflicts between patients and doctors are one of the contributing factors.

> asked 'Who was the doctor on duty last night?' The man looked like an ordinary person in the hospital. I responded, 'It was me', without a second thought. At that moment, the man brought out a walking stick from behind his back and tried to strike me with it. I was immobile with shock. The male doctor next to me warded off the blow with his arm, which was immediately broken. Later, the hospital paid compensation to the patient's family, and also had to fund the treatment of my colleague's broken arm. Prior to this incident, the door to my office was always open so that patients could see me whenever they needed to but, after this attack, I always close my office door. If a patient knocks on it, I always ask who it is before opening it. In the past, my computer was opposite the door, near the window. After the accident, I can't work on my computer sitting with my back to the door. I moved my computer so that I can see at once if someone walks in. My trust in others has decreased dramatically since then. (Interview D39)

These attacks occur without warning, undermining the doctors' sense of security and trust towards others. Although this attack was prevented by another doctor, who was hurt instead, the young doctor remains traumatised by this incident. Insecurity prevails among health professionals, who employ many self-defensive measures: refusing seriously-ill patients, exaggerating patients' conditions at the beginning to avoid trouble in the future, avoiding administering shots and drips to uncertain patients, and so forth. Medical practice is being increasingly constrained by the boundaries of 'safe practice', limiting doctors' efforts to save patients.

The laws regulate that, in medical disputes and lawsuits, medical institutions shall bear the burden of proving their innocence.[103] Health professionals therefore devote an enormous amount of time and energy to keeping meticulous records, which are pivotal evidence in medical disputes and lawsuits. 'Our doctors devote more than 30% of their time to taking records, recording all kinds of mistakes and errors, and make even more efforts to find mistakes' (Interview D52), one local hospital director complained. Health professionals have also increased the tests for patients in order to collect evidence for possible disputes and litigation. The same director justified this practice as follows:

[103] In 2002, 'Some Provisions of the Supreme People's Court on Evidence in Civil Procedures' released by the Supreme People's Court (http://www.court.gov.cn/bsfw/sszn/xgft/201004/t20100426_4533.htm, retrieved 14 January, 2013) and the 'Ordinance on the Handling of Medical Malpractice' released by the State Council (http://www.gov.cn/banshi/2005-08/02/content_19167.htm, retrieved 14 January, 2013) both regulate that the medical institution shall take the responsibility to prove there is no medical fault and no causation between medical practice and harmful consequence in a tort case, in contrary to other civil lawsuits that require the party who litigates to provide evidence. Patients without professional medical knowledge are regarded as the disadvantaged party who are difficult to get medical evidences, thus the burden of proof rests on the medical institutions and health professionals.

> There are many unpredictable factors during treatment. Infectious diseases, such as HIV/AIDS and Hepatitis, are more widespread nowadays. We must provide a comprehensive physical examination of patients prior to treatment. If not, there is risk that our health professionals may become infected. More importantly, patients may blame the hospital for their infections. In this case, hospitals must prove that the infection occurred before they went into hospital. All this wastes a lot of time for us.

The safety consideration together with economic motivation has made physical examinations and tests popular in Chinese hospitals. Tests are expensive and largely uncovered by medical insurance. It is a significant source of profit for hospitals, but adds a greater burden to patients, correspondingly provoking more complaints from them. Later, in 2009, the new Tort Law changed the former rule of requiring medical institutions and professionals to provide evidence in the case of medical accidents. It tried to 'balance' evidence from both patients and health care providers. Yet, the uncertain medical environment and economic motivation continue to encourage doctors to order extra tests.

Conflicts and uncertainties not only make health professionals undertake much 'unnecessary' work, but also challenge their morale. When interviewing a group of young doctors, one of them commented:

> Although only a few people *nao*, 'one rotten apple spoils the whole barrel'.[104] If I [a doctor] treated 1,000 patients, and 999 of them were nice to me…but as long as there was one person who engaged in *nao* and spoke badly of me, I would [be cautious]…Scared of this kind of patient, I have to do a lot of things to prevent disputes, a lot of unnecessary work. Now, we feel that our work isn't stable at all. Something might go wrong if we lose focus for a second…Oh, now our *yishi* [mentality] of being a doctor has changed. Going back 20 years ago, doctors then thought about curing patients' illness to their best ability. Although sometimes they might have wanted to make a little money, they still put patients first...but now it's different. Now, the first thing we think about is how to protect ourselves, not how to treat patients...Our thinking has changed. The influence is not good for patients either. (Interview D28)

The occasional outbreak of *nao* can tarnish trust irreparably. The 'few bad cases' are enough to make physicians scared of being condemned or sued for malpractice, and thus they treat

[104] The original words this doctor use is *'yike haozishi dahuai yiguo tang'* (a rat's dropping spoils a whole cauldron of soup).

the majority of their patients with caution. Yet, under the name of 'self-protection', the measures for making a profit are also justified. This young doctor felt worried because doctors now think more about self-protection than treating patients. He felt that his morale was challenged in his daily medical practice compared with his ideal when pursuing a medical profession and with doctors 20 years ago who put patients first. Saddened by the patients' mistrust and suspicion and shocked by patients' attacks, doctors have become moral agnostics and some feel more justified about doing what is best for themselves instead of what is best for the 'suspicious' patient. A public doctor in her 50s expressed her frustration as follows:

> For me, the doctor, you [the patient] don't trust me anyway, no matter what I do, you don't trust me, thus I take some drug kickbacks, even if I did not take a cent, you [the patient] still don't understand me, you don't think I have benefitted you in any way… (Interview D64)

The doctor justified her grey income by mentioning the patients' mistrust in the first place. The more disputes, suspicion and attacks on the part of patients, doctors are more justified in putting their own interests first, which however led to more resentment and frustration on the part of innocent patients.

When the assault and killing of health professionals happen repeatedly, they increasingly become 'the weak' who cannot protect themselves in the face of violence. They employ a 'scalpel vs. dagger' metaphor, protesting that they use a scalpel to save patients only to be 'repaid' with a dagger. Health professionals accuse patients who chose *nao* instead of legal channels of being greedy for more economic compensation. They compared *yinao* with extortion behaviour in the wider society where someone who lends a helping hand is extorted by the very person he or she helped.[105] The latter situation makes people too afraid to help. *Yinao* also makes health professionals reluctant to save dangerous patients, treat all patients with caution, and place their own protection prior to saving lives. Outraged by the 'misleading' media reports that put all blame on hospitals and health professionals, the health professionals whom I interviewed generally expressed a sense of anger and powerlessness. As one hospital staff member put it, 'Now the social atmosphere and medical environment are like this [antagonistic towards health professionals], if the state doesn't create a policy to

[105] Such as the *pengci* people who pretended to be hit by a passing car and demanded compensation from the driver for injuries not actually received, or the Good Samaritans that help others have been extorted by the very person being helped (see Yan 2009b).

address these conflicts, we health professionals have no rights, no power, and no way to negotiate with patients at all' (Interview D45). Lacking government and police protection, some hospitals even employ thugs to counter the *yinao* groups. These conflicts sometimes deteriorate into scuffles between the hospital (comprised of hospital professionals and security guards) and patients' family, friends and hired thugs. Without enforcement agencies, patients and health professionals are forced to take disputes into their own hands, but responding to violence with violence triggers further resentment and conflict between patients and health professionals.

Doctors regard themselves as the scapegoats of the health system and blame the government for its minimal involvement in conflict mediation and the protection of health professionals. In retaliation, health professionals have begun publicly to express their grievances and called for increased government intervention. They, too, employed *nao* by taking to the streets, protesting in front of government buildings, and demanding 'respect and dignity' (*huanwozunyan*), 'justice', and 'punishment of the murder' (*yanchengxiongshou*) – referring to patients who have killed doctors.[106] These tactics finally forced the government to respond.

Governing Disputes: Criminalising *Nao*, Civilising Patients and Juridifying Conflicts

Criminalisation of nao

Since 2012, the Chinese central and local governments have implemented a series of new regulations and decrees to contain *yinao*. Before 2012, most hospitals in Riverside County used the decree issued in the late 1980s banning the *yinao*. The *Joint Notice on the Maintenance of Public Order in Hospitals* was issued by the Ministry of Health and the Ministry of Public Security on 30th October 1986, due to 'a series of sabotage and looting of hospitals, attacks and insults of health professionals happened repeatedly in recent months, which seriously disrupted regular hospital work' (MOH and MOPS 1980). The decree included a list of rules. Apart from one clause that mentioned the mutual responsibility of health professionals and patients, all of the other seven clauses targeted patients' 'uncivilised'

[106] See reports such as Sina 2009.

behaviour.[107] In 2001, the Ministry of Health and the Ministry of Public Security released a new decree – *Maintenance of Public Order in Medical Institutions to ensure Clinical Treatment Carry out Orderly* (MOH and MOPS 2001). The 2001 decree was a revised version of the 1986 decree and suggested the new efforts made by governments to curb medical disputes after years of neglect. In four of the eight clauses of the new decree, patients and health professionals' mutual rights and responsibilities were mentioned.[108] On the other hand, Clause Five specified eight kinds of misdemeanour committed by patients who violate public security management and even the law. Clause Eight regulated the 'proper' way to handle a corpse when a death occurs. By the 2000s, medical disputes and instances of violence were ever more prominent in the public discourse, particularly with the advent of the internet. However, only after a series of shocking stabbings and killings of health professionals in 2011 and early 2012, a new decree – *Notice on the Maintenance of Public Order in Medical Institutions* was finally issued by the Ministry of Health and the Ministry of Public Security in April 2012 (MOH and MOPS 2012). In three of the seven clauses of the 2012 decree, patients' rights and health professionals' responsibilities are specified. Compared with the 1986 and 2001 notices, the new decree further stresses patients' rights as well as medical institutions and professionals' responsibilities. On the other hand, Clause Seven of the new decree lists a series of behaviour that violates public security management or the law: 1. burning spirit money, setting up a funeral parlour, displaying funeral wreathes, displaying corpses, or gathering trouble-makers together in a medical institution; 2. making trouble in medical institution; 3. illegally taking dangerous, inflammable or explosive items and forbidden tools into medical institution; 4. insulting, threatening, intimidating, and intentionally hurting health professionals, or illegally restricting their personal freedom; 5. the sabotaging, theft, or robbery of public and private property in medical institution; 6. the reselling of medical institutions' registration number (ticket) for profit; 7. other behaviour

[107] These clauses are: patients need to pay medical fees according to regulation; nobody is allowed to check, ask, change or destroy clinic record without the permission of the hospital; patients are not allowed to occupy a hospital bed (after being discharged from the hospital) and refuse to leave; the corpse is not allowed to be put in places other than the morgue of the hospital, any feudal funeral activity is not allowed in the hospital; forbidding to use 'medical accident' as an excuse to *nao* in the hospital without reason; forbidding to make trouble, damage or sabotage in the hospital, forbidding to attack or condemn health professionals, and so on.

[108] The four clauses are: patients' legal rights in medical institution are protected by the law while patients and their families should also obey medical institution's regulation; the society should respect health professionals whose works are protected by the law, while health professionals should serve people wholeheartedly, improve service attitude and quality, pay attention to medical ethics, and improve medical skill; health professionals and patients should maintain good relationship with mutual-understanding and mutual-trust, when medical dispute happens, medical institution should share information with patients and their families, while patients and their families should solve medical disputes through the legal channel; medical institution should improve its transparency on fees and charges, is forbidden to charge arbitrarily, should give emergency treatment to serious patients, while patients should pay the medical bill according to regulation.

that disturbs the medical institutions' regular order. These 'misbehavers', as defined in the 2012 decree, show that a new comprehensive effort is being made by the authorities to control disputes.

Immediately prior to the release of the 2012 decree by the central government, the local municipality of Riverside County had already issued a local decree on 30th December 2011 – *Notice on the Control of 'Yinao' and other Illegal Activities according to the Law to Maintain the Regular Order of Medical Institutions*. The content of the local notice was solely targeted at patients' 'misbehaviour' and 'illegal behaviour', which are a synthesis of all of the misbehaviour listed by earlier national decrees. Besides, the local decree also defines six categories of medical accident that do *not* constitute medical malpractice, a recount of the regulation in the *Ordinance on Handling Medical Malpractice.* Due to the local governments' pressures to preserve stability, many local governments had issued their local decrees to contain *yinao* prior to the issuance of the national regulation in 2012. In Riverside County, the poster containing the local decree was widely circulated around the county and township hospitals to village clinics and community health centres. The large poster was displayed in every eye-catching place in medical institutions: near the hospital entrance, registration window, stairs, elevator, etc. At the bottom of the black and white poster, there were five red seals of the municipal Court, Procuratorate, Police Bureau, Health Bureau, and Government Legal Affair Office, respectively, adding an aura of authority to the decree. The notice was also widely-broadcast by local TV and radio stations. The high 'visibility' of the state power is warning potential violators of the serious punishment.

These decrees supply legitimacy for the enforcement agencies to contain the *yinao*. In May 2012, the Ministry of Health made an announcement to guide the implementation of the above 2012 national decree. It suggested that all hospitals above Grade 2 should set up an internal police office (*jingwushi*) (MOH 2012b). In 2013, the NHFPC and the Ministry of Public Security issued a safety guide to hospitals, suggesting that they should strengthen their protective equipment and security personnel.[109] In Riverside, local hospitals have generally

[109] In 2013, after a new series of violent attacks and killings of hospital doctors, the NHFPC and the Ministry of Public Security released a new document – 'Guidance on Strengthening of Hospital's Safety Preventive System' (see NHFPC and MOPS 2013), aiming at building 'safe hospitals' (*pingan yiyuan*). The guide includes suggestions such as hospitals should assign one security guard per 20 beds, and security guards should account for no less than 3 percent of the total medical staff.

expanded their security personnel.[110] Under pressure to preserve stability, many local hospitals also set up an extra 'comprehensive management and stability preserving office' (*zongzhi weiwen bangongshi*) next to their security office. In December 2013, 11 central government departments released a joint *Action Plan to Fight Medically-related Illegal and Criminal Actions to Preserve Health Care Order* (Xinhua Net 2013b). This special task force began to target the *yinao* as 'illegal and criminal actions'. Since 2012, patients and their relatives have begun to be forcefully detained or punished for disrupting the hospital order and any acts of violence.[111] In April 2014, two patients who had killed doctors were given the death penalty (Xinhua Net 2014), the most serious sentence to date. Meanwhile, the media and official discourses began to link *yinao* with criminal gangs, although the involvement of gangs in medical disputes is uncommon in small counties like my field site. The decrees and official reports frequently describe the *yinao* with words like 'lawbreakers and criminals' (*weifa fanzui fenzi*), 'illegal and criminal actions'. These new measures thus effectively criminalise people who engage in violent *nao* and collective contestation that may 'disturb social order'.

'Civilising' patients and juridifying conflicts

In addition, these official discourses and rules produce power/knowledge that shapes individual conduct. The official decrees and the media form a dominant discourse that frames *nao* as an uncivilised, backward, and irrational form of behaviour carried out by people with low *suzhi* (social merit and quality), while suggesting that educated, civilised, and modern citizens use legal means to protect their interests. Having carried out a careful, close reading of local people's discourses, I find a complex and ambiguous attitude towards *nao*. Although many sympathised with patients who *nao*, they clearly showed their attitude by describing *nao* as a rude, backward practice and a tactic of the poor and peasants who lack *suzhi*. The public, on the one hand, complained about the difficulties of taking out lawsuits, while on the other emphasised the importance of learning about the law to fend off backwardness,

[110] For instance, despite the People's Hospital is located just opposite to the police office, the hospital director's office has still been stationed by two security guards since he was attacked in a medical dispute in 2011. In the TCM Hospital, extra security guards have been recruited, counted to 15 formal guards in early 2012, and a police station plaque was installed outside the guard office at the entrance of the hospital to add more symbolic authority to the office. The county hospitals installed CCTV camera in every corner of hospital buildings. Even private clinics have installed home-camera to record evidence in order to prevent serious loss in cases of dispute.

[111] There are many media reports about patients and their families who acted violently being detained (see, for example, Ifeng 2012a, Sina 2013)

modernise minds, and better protect one's interests. Even those who employ *nao* to defend their rights may not regard it as an 'honourable' choice. *Nao* is thus heavily marginalised. However, the situation is not that people of 'low *suzhi*' actively choose *nao*. Rather, it is that their relative powerlessness places them in a structural position where *nao* is their only option.

While containing *nao*, the authorities also promote legal channels to solve disputes, as characterised by the release of the Tort Law in 2009. Chapter VII of the Tort Law regulates on the 'Liability for Medical Malpractice'. It specifies the conditions under which hospitals and health professionals should take responsibility and compensate patients; the conditions under which patients and their relatives can ask compensation from relevant responsible party; and health professionals' rights to be protected, etc. It supplies legal bases for medical dispute resolution and the division of responsibility in medical malpractice, but the juridification of medical disputes also effectively individualises medical accidents, making the pursuit of compensation the responsibility of individual patients and holding individual healthcare providers responsible for compensation. Cooper points out that the introduction of a comprehensive statute on tort law displaced responsibility for managing medical accidents from the administrative structures of the state to the legal channels of civil litigation: hospitals and doctors are made formally liable for medical accidents and other acts of negligence in the course of care (2011a:319); patients are forced to litigate against medical negligence under tort law, becoming, in the process, 'one who must become individually responsible for his or her exposure to risk and refrain from the collective act of protest represented by the mass group incident' (ibid.:320). Both patients and healthcare providers are thus required to become responsible juridical subjects.

The limits of dispute governance

Although the state seeks to channel disputes into the legal system, lawsuits are still frequently avoided. Figure 17 below illustrates the four channels used to solve medical disputes in Riverside County. The first, private negotiation, is where patients frequently practice *nao* to argue for greater compensation from the hospital. It is direct and less bureaucratic. The second, administrative mediation, is carried out by the County Medical Dispute Mediation Centre, which consists of officials from different government departments. They are suspected of having a connection with the local hospitals and are frequently mistrusted by

patients' relatives. The third, accident appraisal and mediation, have the most complex procedures and involve a long process. The fourth, lawsuits, appears simple, but are costly and time consuming. They are also suspected by patients of favouring hospitals and health professionals that have a connection with the court. The result of the lawsuit is unpredictable and uncontrollable by patients. The official institutional channels, the legal means and administrative forms of mediation, are considered expensive, complicated, unreliable, and unjust. Accordingly, many prefer to take matters into their own hands, through *nao*. Unlike the official institutional procedures, the practice of *nao* is a more familiar, straightforward, and less costly way to air a medical grievance. *Nao* always enables patient's relatives to achieve something, no matter whether it is a large amount of compensation or a small sum for appeasement. *Nao* thus could be understood as 'alternative politics' (Sztompka 2000:164) from below to replace the official politics, which is distrusted by and less attractive to people. It is politics at the margin of the formal political structure to enforce people's own vision of justice.

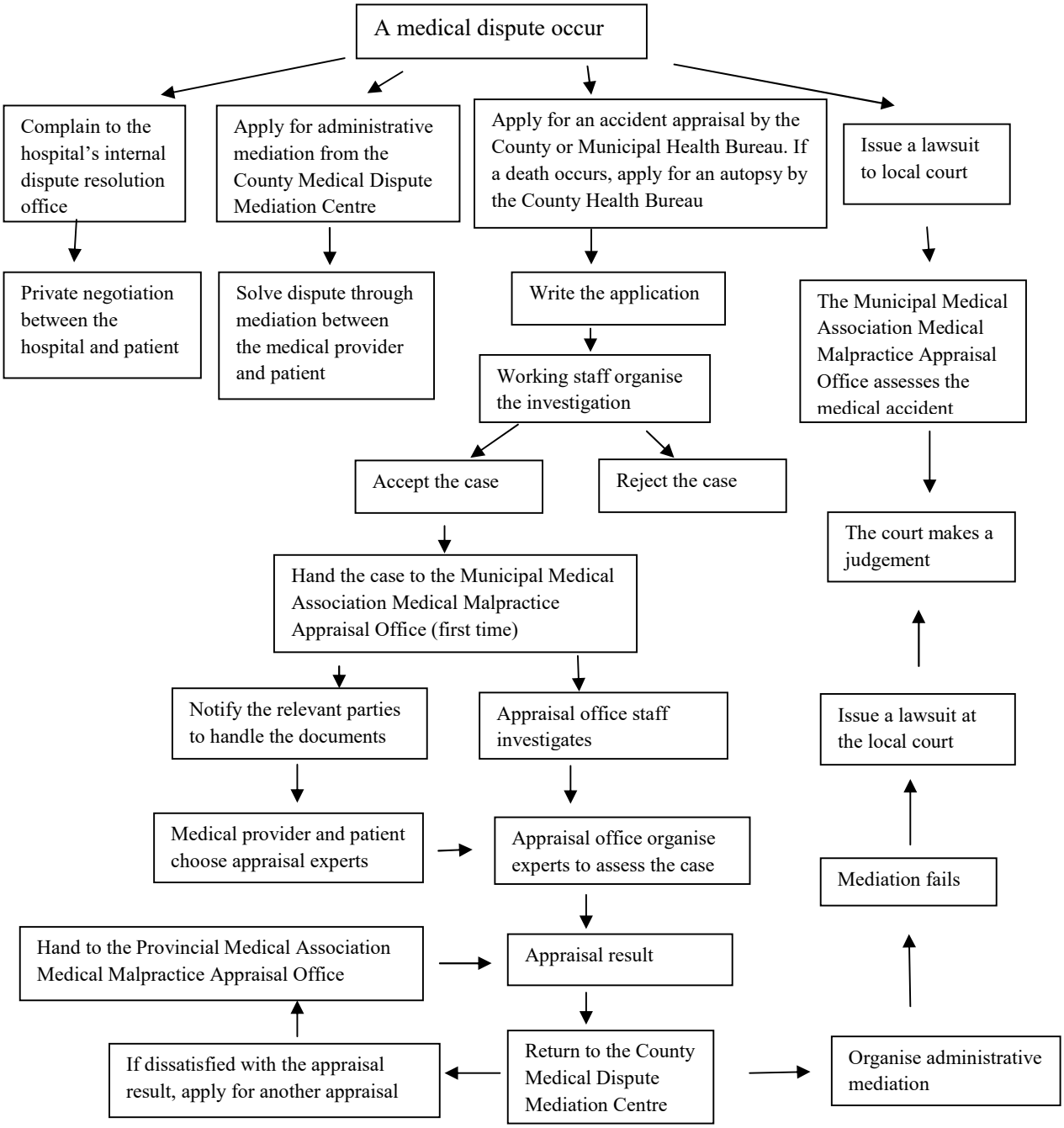
The state displays limited tolerance to the alternative politics of *nao* and acts to control and diminish it when it endangers the stability that official policies aims to sustain. However, the current system provides patients with few effective and reliable alternatives to *nao*. The government's efforts to contain *nao* effectively threaten marginalised groups' very means to defend themselves. It is those very disadvantaged people who have little choice but to *nao* who become the target of deterrence and control. The patients who really have power and resources can still use their influence to argue for their interests, have more chance to overcome the government's rules, use *nao* to the extreme, even hijacking health professionals, hospitals, and local governments with the 'harmonious society' protocol.[112] The containment of *nao* in the Chinese medical context thus further deepens inequality, reproducing the sub-citizenship (of the disadvantaged group) and super-citizenship (the rich and powerful, who are less likely to be punished).

The rules and laws issued by the state constitute a moral and normative order impact on social practice. Patients are encouraged to solve their own problems including disputes, being exhorted to act civilly and use the law to defend their interests. Yet, without effective

[112] A very influential case occurred in 2012 (Ifeng 2012b), when a patient, from a very influential family in local society, died in a private hospital in Shaanxi, the hospital staff (over 40 health professionals) were pressurised to kneel down in the patient's mourning hall to make an apology. Besides, the hospital had to compensate the family 3 million Yuan.

alternatives to solve their problem, patients continue to ignore the normative order, employing the 'rude, backward, uncivilised' practice of *nao* to defend their interests. As Chinese netizens discussed, when *nao* was forbidden in the hospital, people could still go to *nao* at the doctor's home or on the street, which would be even worse (Deng 2012).

Figure 17: Local Medical Dispute Resolution Procedure[113]



[113] This dispute resolution procedure image is drawn by the author based upon the image used in local hospitals.

Besides, although the state promotes legal channels through which to solve disputes, it also delivers a blow to the rule of law in the name of stability. The dispute containment efforts, from the special task force in the central government to the 'comprehensive management and stability preserving office' at the bottom, are all temporary institutions outside the existing government and legal system (although constituted by members of the government departments). In the process, local governments are given further impetus and justification to intervene in the local medical sphere and control any 'disharmonious' threat to social stability by resorting to suppressive measures. The strong stance by the authorities to contain *yinao* may evoke people's cynicism about the rules and laws, and even aggravate the sense of injustice among patients, and trigger more violent actions.

Moreover, it is a mistake to think that the violence facilitates genuine participation and control by patients. Although, *nao* allows the relatively weaker party to reverse the power relations, it is only a momentary reversal. Bryan Turner (1986:26) suggests that in Western history, 'the critical factor in the emergence of citizenship is violence, that is, the overt and conscious struggle of social groups to achieve social participation'. However, the result of employing violent *nao* in the Chinese medical sector is often uncertain and arbitrary – hardly a guarantee that the basic rights of citizenship are restored. The increasing violence on the part of patients consists of individual efforts to argue for immediate economic compensation. When medical malpractice or accidents occur, patients tend to attribute blame to individual doctors and/or hospitals. Individual patients and their relatives employ *nao* against the medical institutions and professionals, in the process seeking help from the government to realise their demands, but do not argue for their rights vis-à-vis the state. Patients' relatives want *gongdao* (justice) and seek just compensation. In the unequal socio-economic order of post-reform China, patients' sense of deprivation and injustice further encourages the practice of *nao* to resist the unequal health system they encounter and the disadvantaged economic situation in which they live. *Nao* in medical disputes should be regarded not as an action for citizenship rights, but as individual agentive efforts to achieve social-economic justice, which sometimes works and sometimes fails.

Conclusion: the Power Game of *Nao*

Various factors contribute to the increase in medically-related disputes: a rising consciousness of patient rights, the deepening misunderstanding between patients and doctors, inflammatory media reporting, the commercialised health care that infringe on people's moral economy, and the absence of a formal institution for dealing with medical disputes. The growing violence is situated in the market transformation of the Chinese health sector. Patients' outrage at being overcharged, neglected or mistreated, their sense of injustice and exploitation, and their bodily and mental pain when facing illness and malpractice unite to make doctors 'unforgivable' for resentful patients. When medical accidents or misfortune occur, disputes easily break out in which doctors become the direct target of the patients' resentment and desire for revenge.

In medical disputes, patients (and their relatives) and doctors (and hospitals) compete in a struggle for power over the control of their interests and safety, and over their moral definitions of justice and rights. When patients are mistreated or die, the moral sentiments of the public who shares many unhappy healthcare experiences are on the side of the patients and their relatives. Patients' relatives who suffer a loss are entitled to act outside the normal social rules, while health professionals and hospitals, having little moral capital, are forced to compromise in front of the patients' relatives. Patients' relatives form a righteous discourse of compensation, which expressively manifests itself in *nao* – the explicit accusation, intrusive noise, and provocative actions that are intended dramatically to disrupt the routine hospital order. The locus of power is shifting from health professionals to patients. However, when health professionals are attacked or killed, they become the weak ones, who cannot protect themselves from violence. They begin to win over public sentiment, gradually accumulating moral capital through their compromises and tolerance, which justifies them in fighting back. They accuse patients' of engaging in violent *nao*, propose government regulation changes and legal action, and finally force the government to release new regulations and subsequent punishments for patients. People use moral power in their daily contestation, and the state also responds to moral power in its efforts to act as a moral agent, but moral power is losing its force, as society comes increasingly to emphasise economics and money.

In the market, both patients and doctors are urged to take responsibility and risks themselves. Patients have to secure just compensation by themselves. Health professionals and hospitals are also required to prove they are not at fault or use the law to defend themselves. There is no public institution that plays a mediating role between the two parties, so patients and doctors/hospitals confront each other directly. The hospital has become like a market place where responsibility and compensation are intensely disputed. For the patients' families, *nao* may help them to obtain some immediate compensation and slightly shift the power hierarchy. However, it is uncertain and arbitrary, and cannot structurally change the unequal distribution of power and resources. The resentment and sadness of the patients' families after a medical accident are used by profit-motivated *yinao* gangs to extort hospitals and health professionals. When measures like *nao* are used by both the powerful and disadvantaged, people who have power and influence can gain far more than the disadvantaged. The subversive measures of *nao*, under the uneven distributions of power and resources, in turn reinforce the existing inequality. It cannot secure people's citizenship rights, and has little effect on mitigating people's sense of injustice, but ferments an even deeper crisis.

Patients' *nao* leads to the attack, extortion, and even killing of health professionals. Health professionals who are at the receiving end of these attacks see themselves as victims not just of angry patients but also of a failed health system. They blame the governments for its reduced involvement not only in health care investment, but also in mediating conflicts and protecting health professionals. At the same time, the government retains its intervention in hospital affairs and transfers the political pressure of preserving stability to the hospitals. The government frequently presses the hospitals to solve disputes and meet the patients' demands. The government's aim of building a harmonious society thus, to some extent, empowers 'weak' patients, who otherwise have little power to counter the hospitals and government bureaus. However, it also encourages *nao*, for many have been led to believe that greater violence leads to greater compensation.

When *nao* endangers the stability that the official politics attempt to sustain, it becomes the target of containment. Government measures try to criminalise *nao*, civilise patients and juridify conflicts. The new decrees and regulations issued by various levels of government effectively criminalised people who employ violent *nao*. Besides, the official discourses define *nao* as an uncivilised, backward, and low-class practice. The normative regulations and official discourses delegitimise and stigmatise *nao*, subtly reshaping individuals' conduct

and punishing people in the case of transgressions. The incorporation of medical malpractice into the Tort Law juridifies conflicts. The juridification places the responsibility for seeking proper compensation on the shoulders of individual patients and holds hospitals and health professionals responsible for compensation. However, the law cannot provide people with effective resolution and assured justice. Without an effective alternative channel by which to solve disputes, the containment of *nao* endangers many people's main or even last measure to defend themselves. Without other means, people continue to ignore the dominant discourses of civility and rule by law, using *nao* to defend their very interests, although its effect becomes more uncertain.

In the governance of *nao*, both patients and health professionals are easily subjected to the state power once the state steps in to intervene in disputes. Yet, the government measures fail to control disputes, but merely lead to more resentment and conflict, contributing to a vicious circle of conflict, conflict prevention, and even more conflict. The combination of authoritarian power, the promotion of rule by law, and the (de)moralisation of individual behaviour in governing disputes will face more tests in the configuration of power among patients (who try to seek better care and argue for proper compensation), health professionals (who seek to make money and protect themselves), commercialised hospitals (that seek to maximise profits and avoid disputes), the local authorities (that attempt to conceal disputes and preserve stability), and the central state (that tries to improve health care, and preserve political legitimacy and social harmony).