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FROM GRACE TO VIOLENCE: STIGMATIZING THE MEDICAL PROFESSION IN CHINA

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This study examines how the once prestigious medical profession in China has become the subject of criticism and accused of pervasive impropriety to the point of inducing widespread violence from patients. Drawing on archival documents, media articles, interviews, and secondary sources, we trace the lengthy and uneven trajectory by which the profession moved away from enjoying widespread collective approval toward ambivalence and eventual stigmatization. We develop a process model of professional stigmatization that identifies the dynamics that precipitate and then catalyze that trajectory and highlight the underpinning mechanisms. By unpacking the complex process of stigmatization, the study extends existing understanding of how aspects of stigma emerge and are attached by different stakeholders to a profession and the consequences that follow. We conclude by highlighting the implications for research on stigma and the challenge of stigma containment.

In 2015, media outlets across China reported 12 major incidents of physical violence committed against medical professionals in a span of just 20 days. One incident involved a physician being beaten by the relatives of a critically ill patient; another involved a patient lacerating an otolaryngologist's left eye; and yet another involved an oncologist being doused with gasoline and set alight by a patient (*China News Service*, 2015). This spate of incidents reflects an alarming trend showing that the frequency of physicians being assaulted by patients increased drastically from the early 2000s to the 2010s to the point that in 2012, 64% of hospitals had reported physical attacks taking place against physicians (Chinese Hospital Association, 2014). Moreover, the implications of this violence are startling. What was once regarded as the most prestigious profession in China (Lin & Xie, 1988) has become accused of pervasive impropriety and deviance from important societal norms. Our interest is in understanding how and why this dramatic fall from grace occurred. In theoretical terms, we ask: *What is the process by which stigma emerges and attaches to a profession?*

Deepening our understanding of the stigmatization of professions is particularly timely given increasing reports of professional misbehavior—such as the role of lawyers in nondisclosure agreements pertaining to the Weinstein affair, of accountants in the failures of Enron and Thomas Cook, of financial analysts in the subprime crisis, and of police in the death of George Floyd—which cumulatively suggest that the risk of professions being stigmatized is growing (Bevan & Wilson, 2013; Brooks, 2018; Dixon-Woods, Yeung, & Bosk, 2011). Given that professions are basic societal institutions, any collapse of confidence in them may have profound consequences for social stability (Muzio, Aulakh, & Kirkpatrick, 2019). Hence, understanding how and why professions might become stigmatized requires attention.

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However, despite the growing interest in stigma among management and organizational scholars (Pollock, Lashley, Rindova, & Jung-Hoon, 2019; Zhang, Wang, Toubiana, & Greenwood, 2021), relatively little is known about the stigmatization of professions. This is largely because they typically enjoy high social regard for their command of a specialized body of knowledge and their commitment to a code of ethics that foregrounds the interests of their clients (Brint, 1994; McMurray, 2011). Moreover, given their social prestige, professions often fall under the scrutiny of various stakeholders including regulators, the media, and their clients (Vough, Cardador, Bednar, Dane, & Pratt, 2013). How, then, can professions become stigmatized? Does it require that the knowledge base *and* the code of ethics both be violated? The stigmatization of professions remains an important theoretical conundrum that needs systematic exploration.

Through a longitudinal, cross-level account of the medical profession in China, we make two major contributions. Our primary contribution is an empirically derived process model of the stigmatization of a profession. The model specifies the distinctive momentum and the particular mechanisms that move a profession toward stigmatization. Whereas prior research has suggested that ethical transgressions alone can incite a process of stigmatization, we find that it is a combination of pervasive transgressions and the infliction of discernible damage to primary stakeholders that precipitates the process. Then, through what we call "a spiral of voice," primary and secondary stakeholders learn about how others are expressing their dissatisfaction, thereby amplifying tensions and encouraging similar expressions of dissatisfaction. Growing discontent with ethical transgressions is likely to pull in authoritative stakeholders who are responsible for governing and monitoring the profession. Yet, their entrance can heighten rather than reduce the perceived pervasiveness and severity of transgressions. In this way, authoritative stakeholders may unwittingly propel further movement toward stigmatization, generating a momentum that can become difficult to contain or reverse. Importantly, our model highlights that primary stakeholders tend to prescribe particularly harsh punishments, including physical violence, because of the interaction of two mechanisms relevant to professions: impotent dependence and moral resonance.

Our secondary contribution speaks to research on stigmatization more generally. Unlike previous studies that have typically assumed stigma to be a binary state, our case emphasizes that the move toward stigmatization may be more complex. Contrary to previous studies, we show that the attribution of stigma may be partial, focusing upon certain but not all aspects of an organization or profession (e.g., breaches of its code of ethics but not its knowledge base, expertise, or competencies). Further, we show that stigmatization involves multiple groups of stakeholders that have different experiences and relationships with the focal organization or profession, thereby not only implicating different responses but also the potential for struggle and even the reversal of stigmatization. Through the actions, inaction, and countermoves of different stakeholders, the move toward stigmatization is likely to be a nonlinear and oscillating process.

THEORETICAL ORIENTATION

Stigma and Processes of Stigmatization

Stigmas are discrediting marks, attributes, or labels that trigger a wide variety of negative attitudes and beliefs (Goffman, 1963; Paetzold, Dipboye, & Elsbach, 2008). In highlighting a divergence or negative discrepancy from established social norms and values, stigmas impugn a target's or bearer's moral virtue, conjuring collective perceptions of deviance or of a fundamental, deep-seated flaw (Devers, Dewett, Mishina, & Belsito, 2009; Kurzban & Leary, 2001; Link & Phelan, 2001). Whether it is an individual associated with a stigmatized social category (Allison, 1998; Flack et al., 1995; Pontikes, Negro, & Rao, 2010), an organization whose actions or core features are perceived by some audiences as somehow morally suspect or untrustworthy (Carberry & King, 2012; Hudson, 2008; Hampel & Tracey, 2017), or an industry whose activities are contested or seen as inherently harmful (Galvin, Ventresca, & Hudson, 2004; Lashley & Pollock, 2020; Vergne, 2012), stigmatization tends to come at a "significant price not only to the stigmatized but to society itself" (Ashforth, 2019: 25).

Although extant research has provided valuable insights into how "preexisting stigmas" (Devers et al., 2009: 154) are combated, deflected, and even co-opted (Anteby, 2010; Ashforth, Kreiner, Clark, & Fugate, 2007; Helms & Patterson, 2014; Lashley & Pollock, 2020; Tilcsik, Anteby, & Knight, 2015), how stigma emerges is still somewhat of a mystery (Pescosolido & Martin, 2015; Zhang et al., 2021). Within the field of management and organization studies, two conceptual models have offered potential insights. The first, by Wiesenfeld, Wurthmann, and

Hambrick (2008), has suggested that stigmatization unfolds through an "announcement" and denunciation of an unacceptable behavior, followed by an "assignment" of blame for that behavior, and then the prescription and rendering of a "judgment" regarding appropriate punishments. Using the example of corporate failures, Wiesenfeld et al. (2008) explained how stigma becomes attributed and focused on the organization's leadership (the CEO) and how this narrow focus of blame is consolidated by pulling in more audience members and by widening the scope of personal defects warranting derogation. It is only when there is some form of "de facto consensus" among multiple arbiters regarding culpability that stigma is "assigned" and a prescription of punishment is delivered (Wiesenfeld et al., 2008).

Complementing these insights, a second theoretical framework provided by Devers et al. (2009: 25) has highlighted a two-stage process of stigmatization that begins with "individual labeling," where one or more stakeholders identifies and denounces particular behaviors as being "incongruent with … deeply institutionalized norms and values." If this perceived incongruence is not seen as just some idiosyncratic incident but as a stable and "controllable" underlying feature, then it breeds distrust, suspicion, and perceptions of deviance. Movement to the second stage, that of "collective labeling," occurs when "a critical mass of stakeholder group members"—but not necessarily all members—accepts the label and vilification of the organization (Devers et al., 2009: 162; see also Jepperson & Swidler, 1994). At that point, the attribution becomes "persistent and self-sustaining" (Devers et al., 2009: 162)

By underscoring the socially constructed nature of the stigmatization process, both of the above models highlight the interpretations and societal reactions that "label" particular behaviors and actors as deviating from social norms. Once labeled, there is some form of punishment—the scope and form thereof are dependent on the perceived severity, salaciousness, or malice associated with the negative behaviors (e.g., ethical misdeeds as opposed to incompetence). As Kitsuse (1962: 248) put it, stigmatization is "a process by which the members of a group, community, or society (1) interpret behavior as deviant, (2) define persons who so behave as a certain kind of deviant, and (3) accord them the treatment considered appropriate to such deviants." Stigmatization, in short, involves "collective labeling" by a "critical mass" of influential stakeholders that certain categories of actors are "deeply flawed and discredited" and should be penalized, devalued, or vilified (Devers et al., 2009: 155; Wiesenfeld et al., 2008).

Professions and Stigma

Professions are not typically associated with being stigmatized. Their social status—based upon their members' specialized knowledge acquired through systematic training and credentialing and their widely recognized and oftentimes state-sanctioned exclusive authority over a particular domain—provides professions with a privileged position "higher up the hierarchically organized occupational division of labour" (McMurray, 2011: 803; see also Anteby, Chan, & DiBenigno, 2016; Leicht & Fennell, 2008). Further, their proclaimed adherence to a professional code of ethics suggests a commitment to ethical and competence-based standards. As Brint (1994) pointed out, professions justify the privileges associated with their prestige through their commitment to observe and prioritize social values ("social trusteeship professionalism") combined with a pledge to exercise judgment based on the application of expertise ("expert professionalism").

Given these hallmarks of professions, it is not surprising that the literature on stigma has said little about them. Even the literature on occupational stigma has rarely connected professions to the taints that define "dirty work": "physical" (work involving refuse, death, or effluent), "social" (work involving a servile relationship to others) or "moral" (work seen as sinful or of dubious virtue) (Ashforth & Kreiner, 1999: 415; Ashforth et al., 2007; Kreiner, Ashforth, & Sluss, 2006; Ruebottom & Toubiana, 2017).

That being said, Vough et al. (2013) have warned that the service orientation of professionals makes them especially vulnerable to public misperceptions and to the evaluations of "primary stakeholders" (Freeman, Harrison, & Zyglidopoulos, 2018). These stakeholders—such as patients and clients—are often salient "evaluators of professions" (Vough et al., 2013: 1054) because they interact directly and on an individual basis with professionals (e.g., physicians treat patients, accounting and law firms deal with clients, etc.) (Abbott, 1988; Muzio et al., 2019). This personal relationship stands in stark contrast to the impersonal distance between a stigmatized organization that makes cigarettes or manufactures weapons, on the one hand, and the purchaser of those products on the other.

At the same time, professions are subject to the evaluations of "secondary stakeholders" (Freeman et al., 2018) that do not directly receive their

professional services but that have an interest in the quality and safety of such services and in how the profession treats its clients. The media, for example, often focuses on professionals and renders and disseminates judgments of their moral approbation and competence (Deephouse, Bundy, Tost, & Suchman, 2017; Roulet, 2015, 2019; Vough et al., 2013). Three other secondary stakeholders are also particularly prominent because of their formal role in governing professions: professional associations (Micelotta & Washington, 2013; Ramirez, 2013; Swan & Newell, 1995), regulators and accreditation agencies (Helms, Oliver, & Webb, 2012; Sauder, 2008; Smets, Morris, & Greenwood, 2012), and governments (Helfen & Sydow, 2013; Zietsma, Groenewegen, Logue, & Hinings, 2017). These stakeholders are "institutional custodians" (Dacin, Dacin, & Kent, 2019; Montgomery & Dacin, 2019), monitoring moral compliance and professional competence (Currie, Lockett, Finn, Martin, & Waring, 2012; Helms et al., 2012).

Despite the involvement of these secondary stakeholders, the growing number of reports of misbehavior by individual professionals or firms raises the possibility of professions losing the respect of the public and of becoming stigmatized (Dixon-Woods et al., 2011; Gabbioneta, Prakash, & Greenwood, 2014; Leslie, Nelson, Deber, & Gilmour, 2018; Muzio et al., 2019). A recent poll in Italy, for example, showed that Italian bankers "who used to be seen as pillars of the community" are no longer praised and are even ranked "as among the most untrustworthy professionals" (*The Economist*, 2019: 68). As yet, however, we lack empirical accounts of the process by which a profession might experience an unexpected and dramatic fall from grace.

In approaching our case, therefore, we adopted Devers et al.'s (2009: 155) definition of stigma as a perception by a "critical mass" of stakeholders that a profession has a deep-seated flaw. In this sense, the stigmatization applied to a profession is a form of "categorical stigma" (Piazza & Perretti, 2015; Vergne, 2012) in that stakeholders interpret and perceive "the profession" as a category composed of members deserving of disapproval and derogation because of specific patterns of behavior. It is when "a profession" is the explicit subject of disapproval—rather than the acts of particular members of the profession—that we can conclude that the profession is experiencing stigmatization. For example, the U.K. medical profession *per se* was not stigmatized even though one of its members—Harold Shipman—was found guilty of murdering 236 of his patients (Smith, 2004). Similarly, the accounting profession *per se* was not stigmatized following the collapse of one of the largest accounting firms—Arthur Andersen. As Dixon-Woods et al. (2011) put it, "bad apples" do not necessarily imply a "bad orchard." But if moral disapproval collectively refers to "the profession," we can conclude that the profession is facing stigmatization—even though not all of its members behave or are treated as bad apples.

We also remained mindful of Hampel and Tracey's (2019) sensible reminder that the process of stigmatization involves movement along a continuum rather than an absolute binary shift from collective approval to collective disapproval. Stigmatization is a matter of degree. Moreover, as Helms, Patterson, and Hudson (2019) noted, the continuum is not one from legitimacy to stigma, as social evaluations may have different dimensions such that an organization may be stigmatized due to poor labor practices and cutthroat business tactics yet still be perceived as legitimate. Extending this reasoning, a profession may be morally and ethically tainted, but its core services and competences might still be (pragmatically) legitimate. In our case, we assessed the extent to which the "social trusteeship" dimensions of the medical profession lost collective approval. And, following Ashforth (2019: 27), we labeled the midway range along the continuum—where moral evaluations from stakeholders display a mixture of positive and negative orientations—as one of ambivalence.

METHODS

Empirical Context and Research Design

Shortly after the founding of the People's Republic of China in 1949, the government established a planned economy by nationalizing industries and collectivizing factors of production. As part of these reforms, all medical clinics and hospitals were absorbed into the state-funded public services and welfare system. The government became the sole regulating authority and "all independent professional associations were disbanded" (Yao, 2016: 6). In their role as "state functionaries," medical professionals were expected to "serve the State, serve the people, and provide social welfare" (ID02[1]). Importantly, they were forbidden from practicing private medicine; in return, they were given tenured

[1] In the following text, all references to interviews are noted using the format (IDX) to refer to the particular interviewee. For example, ID02 refers to interviewee number two.

positions and assured of a steady income and a wide range of benefits, including pensions and housing.

Through the 1980s and 1990s, discrepancies in the image of physicians as selfless "angels in white" began to surface shortly after the introduction of economic reforms that sought to transition China from "a state socialist redistributive economy to a market-like economy" (Nee, 1989: 663). As part of these reforms, the government drastically cut public health care funding, compelling hospitals to seek alternative sources of financing. Hospitals began pressuring physicians to generate revenue, which effectively shifted their attention away from serving the people to seeking profits. This shift created strong incentives to overprescribe and charge markups on prescription drugs (Sun et al., 2008; Zhu, 2007). Adding fuel to the fire, the government introduced a new health insurance scheme in 1998 that reduced the reimbursable portion of medical expenditures, leaving patients personally responsible for a substantial part of their medical bills.[2]

As public dissatisfaction and tensions between physicians and patients increased, the government scaled back its marketization efforts in the health care sector. Through the mid-2000s, it sought to restore the "socialist nature" of the health care system and regain societal approval of the medical profession. It denounced professional misconduct and urged the public to cease engaging in aggressive behavior toward physicians. Despite these calls for restraint, however, the media continued to vilify the profession and incidents of violence rose dramatically in a society where such acts had been atypical (United Nations Office on Drugs and Crime, 2018; World Health Organization, 2002a).

This dramatic change in attitudes toward the medical profession reflects an "extreme" case—one that provides the opportunity to gain "insights into processes and mechanisms that may not be as easily discernible under more moderate conditions" (Creed, DeJordy, & Lok, 2010: 1340; see also Eisenhardt, 1989; Pratt, 2000; Raynard, Lu, & Jing, 2020). Given the characteristics of our case, we employed an inductive, exploratory research design that covered the period from 1985 to 2015.

[2] Given China's institutional urban–rural divide based on the *hukou* system, the health care system in urban areas has been significantly different from that in rural areas. Following previous studies of China's medical system, we focus on the urban health care system and its changes in this paper (Yao, 2016; Zhu, 2007).

Data Collection

To unpack how the stigmatization process unfolded, we collected archival documents, media articles, and secondary materials with the aim of capturing different perspectives and insights into key events and changes in the health care sector. We also conducted multiple rounds of interviews to not only gain a better understanding of the firsthand experiences of physicians and patients, but also to verify and refine our emerging interpretations.

Archival documents. To create a contextual backdrop and chronological narrative in which to situate the stigmatization process, we collected national-, provincial-, and organizational-level archival documents. National-level government documents outlined regulatory interventions in the health care system. Provincial-level governmental reports described how those regulatory changes were implemented and prioritized on the ground. At the organization level, we examined internal documents from two hospitals in a major coastal city where marketization efforts were especially pronounced and a large number of medical disputes had been reported. We focused on documents outlining changes to hospital policies regarding incentive systems for physicians and drug pricing. To verify that the changes in hospital policies were representative, we discussed these documents with elite interviewees. In addition, we collected documents from the official websites and regional branches of the Chinese Medical Doctor Association, which was established in 2002, and from the Chinese Hospital Association, which was established in 2006.

Media articles. To capture media depictions and judgments, we collected articles and reports from multiple major news outlets. We began by collecting articles from the *People's Daily*, one of China's most influential and authoritative media outlets and the Communist Party's official newspaper. Using key phrases and synonyms, including a combination of "professional ethics (*zhiye daode*)" and "physicians (*yisheng*)" or "hospitals (*yiyuan*)" and "medical professional ethics (*yi de*/*yi feng*)," we collected 2,104 articles published between 1985 and 2015. After removing those that merely mentioned, but did not actually comment upon, professional ethics, we compiled a dataset of 1,390 articles.

Additionally, to better understand the changing perspective of patients, we created a separate dataset of articles that reported on patient dissatisfaction between 1985 (one year before the first reported dispute) and 2015. Through consultations with interviewees and two professors from prestigious

Chinese universities who study doctor–patient relationships, we derived a list of key phrases and synonyms that would capture the condemnation and vilification of physicians by patients: "medical dispute" (*yiliao jiufen*), "doctor–patient dispute" (*yihuan jiufen*), "doctor–patient conflict" (*yihuan chongtu*), and "medical disruption" (*yi nao*, also translated as "medical profiteer"). Applying this list, we identified 756 articles that we later separated into those involving verbal or physical violence and those without.

To corroborate data collected from the *People's Daily*, we conducted similar article searches in the *Guangming Daily* and the *Economic Daily*, both of which target professionals and businesspeople. Although these articles only covered the period from 2000 to the present, they nonetheless provided a means to triangulate and validate our emerging findings. For further corroboration, we probed two of the largest governmental news websites (*Xinhua Net* and *China News Service*); three of the largest private news websites (*Tecent*, *NetEase*, and *Sina*); and one international source, the *Financial Times (Chinese)*, which captured perspectives from both government-controlled and private news outlets.

Interviews. Our third data source was semi-structured interviews, which provided important insights into the lived experience of physicians and patients (Hudson & Okhuysen, 2014; Smets, Jarzabkowski, Burke, & Spee, 2015) and also served as a means by which to enhance the trustworthiness of our interpretations and findings (Guba & Lincoln, 2005). We conducted three waves of interviews. In the first wave, we conducted 10 pilot interviews with physicians to explore their experience and understanding of patient relationships. In the second wave, we spoke with 28 medical professionals to better understand their perspective. In the third wave, we spoke with 30 patients to gain insight into their experiences with medical professionals.

All interviewees were identified through a snowball sampling technique. Interviews with physicians covered different professional ranks (from chief physician to resident physician), leadership positions, and hospital affiliations (i.e., provincial, municipal, and district hospitals). Of these interviewees, 19 entered the profession before 1985 and were thus able to compare their experiences before and after the reforms and five held multiple senior positions[3] that required regular interactions with multiple stakeholders. We regarded these latter five as "elite interviewees" (Marshall & Rossman, 1999) because they were ideally positioned to experience the pressures exerted on hospitals by the government and the media and could explain to us the rationale behind some seemingly contradictory phenomena. Approximately half of the patients were born before the 1970s and personally experienced the phenomenon under investigation.

All interviews were conducted onsite in two major municipalities in two province-level regions where the marketization and stigmatization of the medical profession were particularly salient. To understand the scope and generalizability of our informants' experiences and opinions, we presented our emergent insights to physicians who had practiced medicine in 14 other province-level regions. We also approached patients who had worked or studied in 16 different province-level regions (e.g., Shanghai, Guangdong, Fujian, Tianjin, Liaoning, and Qinghai). These discussions reinforced the perception that the move toward stigmatization was a national rather than regional phenomenon, even though its intensity might have been lower in less marketized provinces. All interviews were conducted in Mandarin Chinese and lasted between 40 and 90 minutes with the exception of four of the "elite" interviews that lasted for two hours each. Interviews were recorded, transcribed, and then translated. The first author and a research assistant conducted 16 of the interviews together in order to minimize interviewer bias (Patton, 2002).

Secondary materials. To corroborate our measures of patient dissatisfaction and physicians' experiences, we collected statistics from the following secondary sources: the National Bureau of Statistics' *Health Yearbooks* and surveys by the Ministry of Health, the Chinese Hospital Association, and the Chinese Medical Doctor Association. These sources provided data on patients as well as physicians (e.g., personal nonreimbursable health expenses, the frequency of verbal abuse and physical assault in hospitals, and the percentage of physicians who wanted to quit their job). The majority of the surveys had broad coverage. The 2012 Chinese Hospital Association survey, for example, received responses from 8,388 physicians in 316 hospitals across 30

[3] All five elite interviewees had been the president of a hospital during their careers. Four had also served as government health department officials. Three of them had presided over the regional branches of professional associations. As such, their career paths represent those of elite members of the medical profession.

provinces. As an additional corroboration, we examined editorials in medical journals such as *The Lancet*. These accounts provided additional insight into the chronology of stigmatization as well as the roles of the various stakeholders involved.

Data Analysis

After assembling the data, we created a chronological narrative of major changes in the health sector, including the introduction of market practices and new health insurance schemes and their implications at the provincial and organizational levels. Once we had developed this cross-level narrative, we turned our attention to unpacking the processes and mechanisms of professional stigmatization that unfolded in our case.

Identifying and mapping shifting stakeholder evaluations. We began by identifying public statements made by the government that explicitly evaluated professional conduct and ethics. After marking these on the chronological timeline, we identified the evaluations of other stakeholders (e.g., the media) in order to assess how they compared to and mapped onto the government's statements. To gain a better understanding of the implications for the profession, we asked physicians whether and how these statements and evaluations affected their relationships with patients. We also examined documents from the professional associations to discern if and how they responded and the extent to which they were influenced by other stakeholders. We then consulted our elite interviewees about the role of the associations and other stakeholders.

Next, we identified shifts in the portrayal of the medical profession by the media by particularly focusing on articles that included explicit statements on professional conduct and ethics. Following Piazza and Perretti (2015), the first author read and analyzed each article, coding for whether the coverage was "negative" (i.e., if it presented a disapproving view of professional ethics), "positive" (i.e., if it presented an approving view), or "neutral" (i.e., if it reported ethics-related facts that did not have immediate connotations or presented an impartial view). Table 1 provides details on how the articles were coded and offers illustrative examples of each code. Two of the authors and a field expert formalized the coding scheme by independently coding a subsample of 50 articles and then discussing and reconciling divergences in the coding results. Further, we differentiated between articles that attributed blame to individual members of the profession and those that attributed blame to the profession as a whole. To verify the reliability of our coding, we asked a Chinese physician to reclassify a random subsample of 100 articles. The Cohen's κ value for the two ratings was 0.83, indicating a high level of inter-rater agreement (Fleiss, 1981).

Once we were confident that we had adequately captured shifts in the media's portrayal and evaluation of professional conduct and ethics, we turned our attention to evaluations made by patients. We captured changes in their evaluations by first examining media articles that reported disputes between physicians and patients and then through interviews with patients. For the disputes reported in media articles, we separated those that involved violence from those that did not. Following the World Health Organization's (2002b) definition of workplace violence in health services, and consistent with previous studies of violence in hospitals (e.g., Carmi-Iluz, Peleg, Freud, & Shvartzman, 2005), we define "violence" as incidents when medical professionals are abused, threatened, or assaulted. This definition includes both "physical violence" (e.g., beating, kicking, slapping, stabbing, and shooting) and "psychological violence" (i.e., verbal abuse, bullying, mobbing, harassment, and threats). By applying these criteria to the 756 articles reporting doctor–patient disputes, we identified 220 articles that reported violent disputes, of which 163 involved physical violence.

To verify the temporal patterns, we examined articles from alternative news outlets and surveys conducted by the Chinese Hospital Association, which recorded a similar rise in the number of disputes and a notable increase in instances of violence (as defined by the World Health Organization). To flesh out these trends and gain a more nuanced understanding of the patterns, we examined our interview data to identify whether and how patients and physicians, respectively, perceived changes in doctor–patient relationships and to what extent these changes affected and were affected by how they perceived the profession (e.g., whether they felt ashamed to be medical professionals).

Developing core concepts and relationships. Having mapped the changes in how different stakeholder groups perceived the ethical standards of the profession, we turned to considering why their evaluations moved from collective approval through ambivalence (a mixture of negative and positive evaluations) toward stigmatization. We then addressed why primary stakeholders prescribed harsher

TABLE 1
Media Coding and Illustrations

Codes	Definitions	Illustrations
Positive	The article praises medical professionals by reporting on public approval, highlighting ethical merits, or generally presenting supportive viewpoints of professional ethics.	"The medical professionals wash clothes for critically ill patients, give them haircuts, and bathe them … so that the patients feel like they are at home. The medical staff strongly adheres to professional ethics, insists that they do not let patients buy them meals or receive gifts from patients. Their excellent service has won praise from the people." (Oct. 11, 1992) "All medical staff in the hospital have unified their thoughts, consciously fulfilling their promises … everyone serves patients with superb medical skills and noble medical ethics … The patient is delighted to find the feeling of 'God,' and the medical staff has more clearly defined the responsibility of the 'angels.'" (Aug. 12, 1998) "The documents and the pennants record the flashing footprints of these physicians' exquisite medical skills and noble medical ethics serving the people … Those 'accessible' expert clinics are implemented to help the people in the poor areas in the western region." (Jan. 10, 2008)
Neutral	The article either reports on ethics-related facts that do not have immediate connotations or offers an impartial perspective of professional ethics.	"Medical supervisors have the right to supervise medical charges, drug prices, medical service quality, and professional ethics. Among the first group of supervisors are provincial governmental officials, journalists, representatives of health-related industries, as well as retired cadres." (Sept. 19, 1989) "We should actively promote the construction of medical ethics and deepen the education of the socialist concept of honor and disgrace, making the medical professionals abide by the purpose of service, enhance service awareness, improve service quality, and maintain a good professional image." (Oct. 25, 2006) "Our country is implementing a revised assessment of physicians … physicians will be regularly evaluated every two years, including the assessment of professional skills, work performance, and professional ethics. Whoever fails in any of the three items will not pass the evaluation and will be disqualified. For those who are disqualified, they must be suspended from practicing." (Mar. 4, 2013)
Negative	The article criticizes medical professionals by reporting on public opposition, discussing ethical transgressions, or generally presenting critical viewpoints of professional ethics.	"Some medical professionals solicit and accept bribes and kickbacks … causing economic losses for the State, taxes, enterprises, and patients and seriously violates the basic medical principles. These bad phenomena occur in some hospitals and [by some] medical professionals. But this severely tainted the image of 'angels in white' … People hate these serious violations of professional ethics." (Oct. 4, 1994) "This is a typical illegal case that seriously harms the interests of the people … This has not only exposed the hospitals' impulse to seek profit, but also the chaos in hospital management … The 'warriors in white' here, however, are intentionally wasting medical resources, violating fundamental professional ethics, and also trampling on the dignity of medicine." (May 11, 2006) "Where is physicians' professional pride? If we read people's comments, physicians are seen as 'wolves in white' and 'vampires.' Physicians are not treating patients well … and are prescribing drugs only to make more money. As the doctor–patient relationship worsens, professional pride has substantially diminished." (Sept. 26, 2014)

Source: *People's Daily*

punishments (e.g., physical violence) than those prescribed by secondary stakeholders.

To understand the shift from collective approval to ambivalence, we drew upon existing research that suggested that ethical violations could be an important starting point (e.g., Devers et al., 2009; Hudson, 2008; Wiesenfeld et al., 2008). As we dug into the data, however, it became clear that it was the volume, scale, and financial implications of unethical professional practices that were driving factors in

the denunciation and attribution of blame, which we label "pervasive transgressions" and "damage." In the same way, our data implicated a "spiral of voice" as stakeholders became aware of and replicated the evaluations and behaviors of others (e.g., "The more incidents the media reported and broadcasted, the more aware patients are of how other patients are responding, and the more likely they imitate and resort to disputes" [ID17]).

We used the same analytical procedure to understand why ambivalence turned toward stigmatization. From various data sources, we discerned the influence of the "authoritative judgment"—noting how the media and patients followed the government's public shaming of systemic unethical practices of the profession. To understand why physical violence increased drastically, we analyzed our interviews with patients to probe the reasons for their anger. We found statements such as: "Physicians deserve violent punishments because they are not supposed to hurt helpless patients. Instead, they are supposed to be noble and save people" (ID55). Two mechanisms surfaced: "moral resonance"—i.e., the closeness and association of a profession to the core values of society; and "impotent dependence"—i.e., the significantly imbalanced professional-client relationships in which clients are highly dependent on professional expertise.

Establishing trustworthiness. Throughout, we sought to ensure the trustworthiness of our interpretations and findings through the triangulation of multiple data sources (Guba & Lincoln, 2005). Table 2 shows the triangulation of data for each concept and also provides illustrative examples. In addition, we engaged in member checks (Langley & Abdallah, 2011) by presenting preliminary findings to elite interviewees. We also benefited from having a variant of the insider–outsider approach (Gioia, Price, Hamilton, & Thomas, 2010; Louis & Bartunek, 1992; Smets et al., 2015) in that the first author had intimate knowledge of the setting on account of having several generations of family members working in the medical profession in China, while the third author held a more "distant" perspective and adopted the role of "devil's advocate" (Gioia, Corley, & Hamilton, 2012: 19). The second author, being very familiar with the Chinese context, acted as a sounding board for both sides.

FINDINGS

Our analysis identified three phases, each defined by movement along the continuum from collective approval *through* ambivalence and *toward* stigmatization. In the first phase, beginning in 1985, physicians began engaging in ethically questionable practices and, surprisingly, did so without incurring social disapproval. Beginning in 1998, however, the situation changed. Unethical practices became more pervasive and attitudes toward the profession shifted from collective approval to ambivalence, particularly as concerns grew over the financial implications for patients. In 2005, the situation worsened. The government—and then the media—publicly denounced the unethical transgressions and attributed blame to the profession. Social evaluation of the profession moved from one of ambivalence toward one of stigmatization. Strikingly, in this phase, violence against physicians increased sharply.

The overarching story is visualized in Figures 1 and 2. The former shows the increasingly negative media attitudes toward professional ethics and the latter the gradual and then steepening rise in doctor–patient disputes and acts of violence. Below we present our empirical findings chronologically, illustrating the mechanisms that moved the social evaluations held by primary and secondary stakeholders toward stigmatization. After presenting our findings, we detail the full model, situating it within extant stigma research.

Beginnings: The Spread of Pervasive Transgressions (1985–1997)

The origins of this phenomenon can be traced back to 1985 when new regulations stipulated that while regular medical services would continue to be fully reimbursed, "special-demand" (*te xu*) services and drugs would not.[4] Hospitals began charging patients a 15% markup on all drugs and encouraged physicians to prescribe special-demand treatments not covered by the public health insurance scheme (State Council, 1989). These behaviors were further augmented in the early 1990s when the government pushed hospitals to replace "the egalitarian distribution of salaries" (Ministry of Health, 1992) with profit-seeking incentive systems that would make physicians more cognizant of the need to generate revenues for hospitals:

[4] Whereas regular health care included regular clinical consultation, regular prescriptions, and necessary surgeries, special-demand services typically included customized clinical consultation, imported drugs, plastic surgeries, luxury delivery room services, etc.

TABLE 2
Core Concepts, Data Sources, and Illustrations

Core Concepts	Data Sources	Data Illustrations
Pervasive transgressions by the professionals	Media articles	• "The issue of the purchase and sale of medications has been around for a long time, dating back to 1984 and 1985 … The system of financing hospitals by overprescribing drugs is an important reason … 60% to 70% of hospital revenues come from selling drugs." (*PD*, Sept. 20, 1995) • "Many hospitals blindly pursue economic interests, treating patients as 'cash cows' by overprescribing and discretionary charges." (*PD*, Nov. 2, 2006)
	Interviews	• "I always try to see a doctor who I know if I am sick. Or I would almost always end up having overprescribed drugs and examinations." (ID28) • "All physicians have to make money for their hospitals, which typically have an in-house compensation plan that explicitly explains the relationship between physicians' bonuses and the revenue they bring to the hospital." (ID01)
	Published statistics	• Annual growth of prescribed drug expenses (MOH, 2003–2016)
Damage to primary stakeholders	Archival documents	• "The difficulty and high expense of health care has become a significant issue … 48.9% of the people do not pursue medical attention when they are ill … " (MOH, 2005)
	Media articles	• "When patients visit doctors, their expenses are high—the prescribed drugs are expensive, hospital fees are high … " (*GD*, May 25, 2001) • "Over the years, unreasonable medical expenses have continued to grow, while the [financial] burden on the people has continued to increase. The problems of inaccessible and costly medical services are very prominent … to which the people have reacted strongly." (*PD*, Apr. 10, 2004)
	Interviews	• "Nothing could have beaten free-of-charge health services; patients would not complain about it as long as it was free … Now patients need to pay for it, of course they become unhappy." (ID18)
	Published statistics	• Annual growth of nonreimbursable health expenses (MOH, 2003–2016)
Spiral of voice	Media articles	• "The media should reduce their sensational coverage of incidents of patients confronting doctors so that the 'broken window effect'—imitation by more people—can be prevented." (*GD*, July 27, 2012)
	Interviews	• "The media reported so many violent incidents against doctors but not enough on how those who committed violence were, or might be, punished. Their reports did not mitigate the violence but actually led to imitation … Now violence has become the intuitive response for unhappy patients." (ID03) • "Patients might not have thought about making a fuss, but the newspapers seemed to tell them what they could do—that is, vilifying doctors." (ID12) • "The media were informing patients that they could resort to disputes, spreading such an idea that physicians deserved such confrontation." (ID22)
	Published statistics	• More than 70% of physicians attributed violence to the media's biased reporting. (CHA, 2014)
Strained tolerance of the professionals	Archival documents	• Professional associations were banned until the Medical Practitioners Act 1999. (National People's Congress, 1999)
	Media articles	• "Compared to bribes and kickbacks, the acquiescence and indifference to bribes and kickbacks is even more threatening." (*PD*, Feb. 24, 2006)
	Interviews	• "The medical profession in our country is regulated by the state. It has no professional autonomy like in some Western countries. If individual physicians tried to stand up against the hidden rules, they would be fired or at least sidelined by the hospital presidents or their department heads." (ID07) • "The professional associations have made a minimal impact on our daily practices. I mean, they are not directly supervising physicians." (ID21) • "I have met good physicians, but I don't know anyone who openly criticizes overprescribing." (ID51)
Authoritative judgments	Archival documents	• "Medical professionals must not hurt people's interests or adopt unjust means in order to pursue self-interest … Those unethical and illegal practices must be opposed." (MOH, 2005) • "Must strengthen the public welfare function of public hospitals, strengthen medical professional ethics … and correct the tendency of revenue generation." (MOH, 2007)
	Media articles	• "The Party has passed policies to reform the management of public health institutes … such that the tendency of blindly seeking profit should be prohibited." (*PD*, Nov. 23, 2006)

TABLE 2
(Continued)

Core Concepts	Data Sources	Data Illustrations
	Interviews	• "Things became different once the government got involved. For more than a decade, it had been supportive of market-oriented practices. But now, it made a public statement setting the tone that physicians' market-oriented behaviors should be criticized." (ID09) • "The governmental statements meant something! It was not like some nobody judging the unethical physicians. It was the government. They publicly and explicitly criticized the medical profession. It changed the public attitude toward physicians." (ID07)
Collective labeling by primary and secondary stakeholders	Archival documents	• "The significant doctor–patient contradiction … is due to prescription markups … and revenue generation among hospitals and physicians." (MOH, 2007)
	Media articles	• "The 'angels in white' has already become a shameful occupation." (*PD*, Sept. 14, 2006) • "Physicians are collectively stigmatized and 'demonized' by the media and the general public, becoming the most isolated group of people." (*NetEase*, Nov. 12, 2011)
	Interviews	• "It is not just one patient or one newspaper that blames physicians. It is a great number of patients and media that together vilify physicians. Oftentimes, I feel that the disputes are against all physicians." (ID11) • "There was no consensus among the media and the general public before the government blamed the medical profession … Now there is a common ground. Everyone blames us." (ID30)
Divergent punishments by primary and secondary stakeholders	Archival documents	• "The general public shall respect physicians, constructing a nice atmosphere of respecting medicine in the society … improve the professional environment for physicians." (State Council, 2009) • "The rights of medical professionals shall be protected … Anyone who interferes with the work and life of medical professionals shall bear legal responsibility." (National People's Congress, 2010)
	Media articles	• "Violence should be prohibited in hospitals, and medical professionals protected … The whole of society should not tolerate violence at all." (*GD*, Oct. 30, 2013)
	Interviews	• "Though the media followed the government discouraging disputes and violence, it was no longer effective. Patients continue to resort to disputes and sometimes violence." (ID16)
	Published statistics	• Growth of doctor–patient disputes and violence in hospitals (CMDA, 2015)
Impotent dependence of primary stakeholders	Archival documents	• "A major explanation for the violence against physicians is because patients are incapable of grasping the professional expertise of medicine … And they believe that physicians are accountable for their illness and pain." (CHA, 2014)
	Media articles	• "Patients are disadvantaged, which requires medical professionals to have a higher moral standard … Patients went to the doctor to 'request' rather than 'pick' a service." (*GD*, Apr. 2, 2007)
	Interviews	• "In the doctor–patient relationship, patients are powerless. They can only rely on us [physicians] to tell them what to do." (ID05) • "Physicians are different from businessmen, and hospitals are neither a free nor an equal market because patients cannot choose what to buy. When they go to a doctor, they are disadvantaged and powerless." (ID14) • "Patients are stuck with doctors. Whichever hospital they visit, they could encounter a doctor who overprescribes … because those practices can be found everywhere." (ID20)
Moral resonance of professional transgressions	Archival documents	• "Health care is relevant to billions of people, a major societal issue … and a major mission of constructing a socialist harmonious society." (State Council, 2009)
	Media articles	• "In the mind of any Chinese person, hospitals have always been 'the medical work units for socialist public welfare and social benefits.' This concept has been so deeply rooted in people's minds that no one dares to 'fiddle.'" (*PD*, Sept. 7, 1995)
	Interviews	• "Health care used to be an essential part of social welfare. Doctors had been and still are expected to devote themselves to serving the people." (ID04)

TABLE 2
(Continued)

Core Concepts	Data Sources	Data Illustrations
		• "To many people, the medical profession represents the 'conscience' of the society. When the profession becomes tainted, people may feel hopeless." (ID10) • "The fall of the medical profession symbolized the collapse of old socialist norms. Physicians are not bankers. When physicians failed, the institutions also failed." (ID35)

Notes: Chinese Hospital Association (CHA); Chinese Medical Doctor Association (CMDA); Ministry of Health (MOH); *People's Daily* (*PD*); *Guangming Daily* (*GD*).

> If a physician generates a net profit of 2,000 *yuan* per month (through prescriptions and surgeries), the physician will receive 15% of the profit as a bonus. For the next 2,000 *yuan* of net profit generated, the physician will receive 17%; for the third, 19%; for the fourth, 17%; and for the fifth, 15%. (Internal document from a municipal hospital)

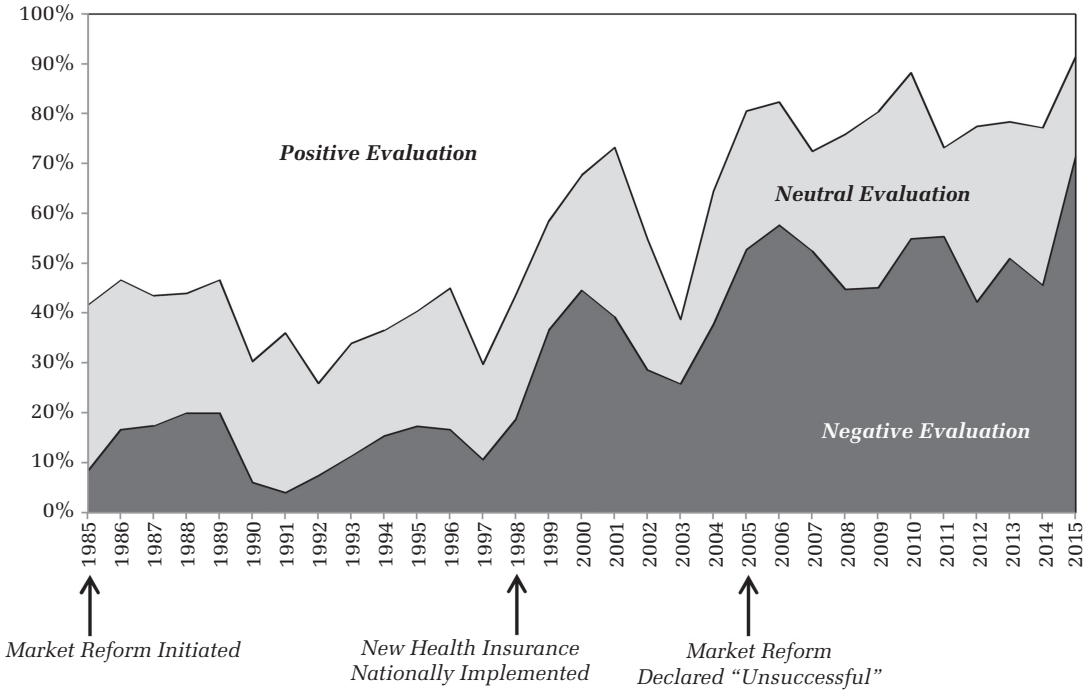
Physician transgressions. The apparent compromising of professional ethics triggered feelings of unease among physicians for whom the business-like approach ran "against the old norms" (ID26) and "against socialism" (ID06). A chief physician in a major hospital commented: "At the beginning, many of us felt awkward … How could we take bonuses if we were to serve the people?" (ID04). Nevertheless, linking compensation to revenue generation, which was originally intended to be "more of an encouragement rather than a requirement" (ID06), "gradually became a common practice" (ID01). An important unintended consequence was that many physicians became less circumspect in prescribing drugs and many began overprescribing them, as demonstrated by the increasingly "standard" practice of prescribing the "three-element soup" (*sansu yitang*) (i.e., a glucose injection of antibiotics, hormones, and vitamins) for various minor ailments (ID02). The justification was that "even if a patient did not need these drugs, prescribing them would not hurt the patient; and, more importantly, charging for those drugs was easy money" (ID21). Our interviewees reported that there was no collective effort to stem the transgressions, in part because there was no self-regulatory professional association in this phase.[5]

Despite the growing pervasiveness of overprescribing, the media in general did not criticize the profession. As shown in Figure 1, between 1985 and 1997, of the 469 articles in the *People's Daily* that referred to professional ethics, only 64 (14%) did so in a critical way. By contrast, 291 (62%) were highly positive and praised physicians for their high ethical standards: "these medical professionals are not only skillful but also ethical and noble and have a heart of gold" (*People's Daily*, Sept. 16, 1989). Moreover, 45 of the 64 negative articles criticized specific physicians or hospitals involved in the unethical practice, depicting them as exceptions in an otherwise ethically respectful profession: "there are indeed a few medical professionals who violate professional ethics, ignore the patients' pain, and are extremely irresponsible" (*People's Daily*, Dec. 27, 1994). Overall, media portrayals of the medical profession remained highly positive, which was confirmed by the more senior physicians interviewed: "the media did not immediately target us after the market reform … The image of medical professionals in the newspapers was still positive" (ID07).

The relative absence of media criticism could be explained in part by the lack of complaints from patients, as suggested by the more senior interviewees: "the media did not become hostile to physicians because people did not condemn overprescribing" (ID45). As shown in Figure 2, between 1985 and 1998, only 14 articles in the *People's Daily* reported disputes between doctors and patients. Similarly, a government survey of 100 major hospitals reported a yearly average of only 2.3 disputes per hospital. At that time, as our more senior interviewees confirmed, "the relationship between doctors and patients remained harmonious. On-call doctors would chat with patients, and patients' families sometimes brought supper or snacks for doctors … Physicians did not feel, as they feel today, that patients were against them. Disputes were rare" (ID23).

[5] All self-regulatory professional associations were disbanded after 1949. Although the Chinese Medical Association survived, it "only functioned academically" (Yao, 2016: 8), and self-regulation was assumed by the government (Davis, 2000). In this phase, there was no equivalent to Western associations.

FIGURE 1
Media Depiction of Professional Ethics by Year



Thus, although this phase witnessed an increase in medical practices that ran counter to deeply established socialist norms, the medical profession was still positively portrayed in the media. Moreover, there were few signs of disapproval or criticism from patients. In other words, primary (patients) and secondary (the media) stakeholders still held the profession in high regard. However, the shift from collective approval to a more ambivalent assessment was about to begin.

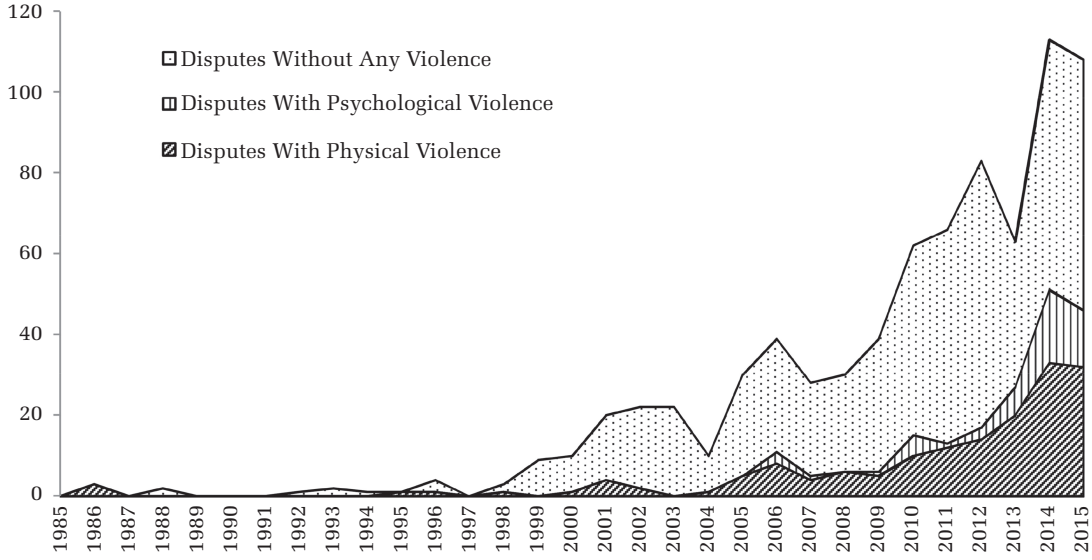
Precipitating the Shift Toward Ambivalence (1998–2004)

Discernible damage and escalating disputes. The tipping point was the introduction of a new health insurance scheme that inflicted "damage" on patients because they would no longer be able to claim full reimbursement for regular medical expenses. In Shenzhen, where the new scheme was piloted, patients became responsible for paying approximately 30% of their clinical bills. From 1998 to 2003, nonreimbursable medical expenses increased annually by 13%, making health care the third largest personal expense after food and education (Ministry of Health, 1999, 2004). Hence, the perception that health care was a public welfare service was compromised, an outcome the media blamed on increasingly profit-oriented practices:

> "Expensive medical treatment" has become a major barrier for patients to seek medical attention. It has now become common for patients to try "living with sickness as much as possible" … The price of drugs is high; and because *physicians "overprescribe," things are even worse.* (*People's Daily*, Jan. 4, 2001, emphasis added)

Nevertheless, physicians felt pressured to continue engaging in such practices because their salaries and promotions depended upon the revenue generated for the hospital. As an elite interviewee candidly stated: "Foreign physicians rely on professional skills to make money, whereas Chinese physicians rely on selling drugs" (ID08). In a similar vein, the *Guangming Daily* (Oct. 19, 2011) later reported that "our country has the most serious antibiotics overuse problem in the world … The average annual consumption of antibiotics per person in China is 138 grams, which is 10 times that in America … Physicians are incentivized by profits in [overprescribing] drugs—which has become an *unspoken rule* in the profession" (emphasis added).

FIGURE 2
Number of Reports of Disputes Between Physicians and Patients by Year



Source: *People's Daily*

It was becoming increasingly evident that doctor–patient relationships had "significantly changed." Whereas patients had previously been able to reclaim most medical expenses, they were now beginning to suffer direct and discernible "harm." Consequently, as Figure 2 shows, doctor–patient disputes increased noticeably. From 1998 to 2004, the *People's Daily* published 101 articles reporting disputes, substantially exceeding the 14 articles published during the previous phase. Likewise, between 2000 and 2004, the *Guangming Daily* and the *Economic Daily* published 106 articles describing patients confronting physicians. One elderly patient angrily complained: "Physicians must have black hearts! When sick people go to them for help, all they care about is prescribing all sorts of uncovered examinations and expensive drugs. How could patients possibly be satisfied?" (ID57). Another patient added: "Where are their consciences? Physicians have no shame … I sympathize with those who confronted the immoral physicians" (ID58).

Ambivalence of secondary stakeholders. As the number of disputes increased, the tone of the media articles became more critical. As shown in Figure 1, there was a shift in the relative proportions of positive and negative depictions. Whereas in the previous phase the majority (62%) of articles on professional ethics published in the *People's Daily* had been positive, the balance shifted between 1998 and 2004—with positive articles dropping to 43% and negative ones increasing to one-third (120) of 359 articles. The media urged physicians to be "more compassionate and caring" and more attentive to "serving the people" because their cold and uncaring attitudes were provoking patients' anger:

> Some medical professionals are contaminated with the idea of "seeking nothing but money," which leaves them a hidden hazard for medical disputes … Medical professionals should correct their relationships with patients and recognize that medical practices should be sacred. (*People's Daily*, Oct. 21, 1999)

Moreover, the collective approval once enjoyed by the profession had been lost. Instead, the problem was increasingly seen as systemic: "the moral decline has become a problem for the profession … as many people [in health care] have lost professional ethics and conscience" (*People's Daily*, Feb. 8, 2001). Of the 120 articles that adopted a negative view, 74 explicitly criticized the moral behavior of the profession—not of individual professionals. Physicians, now labeled "wolves in white" (*bai lang*), were uncomfortably aware of how the media were dramatizing these criticisms and painting the profession as unethical:

> As overprescribing became widespread, the media began to put *a general label* on the profession, making

> unethical behaviors part of a *stereotypical* physician. Such labeling made the *unethical issues* a professional characteristic and cognitively easier for people to recognize. (ID15, emphasis added)

Despite the increasingly critical stance of the media and the deepening dissatisfaction with the profession, the 2002–2003 SARS epidemic provided some respite, but this proved to be short-lived. At first, medical professionals were praised by the media for their commitment to saving patients' lives, with some even being portrayed as martyrs after they fell victim to the epidemic. President Hu Jintao publicly expressed his condolence to the families, friends, and colleagues of those who died "fighting" SARS:

> The medical professionals fighting on the front lines are carrying forward the spirit of selfless dedication and saving the wounded and dying; with a heroic spirit and fearlessness, they are fulfilling their duties, sacrificing themselves, and wholeheartedly dedicating themselves to the responsibility of treating patients. (*People's Daily*, Apr. 26, 2003)

Recalling the harrowing epidemic, an associate chief physician remarked: "During SARS, people were focusing on how brave physicians were in their effort to help people. Even the media were on our side for a moment. CCTV was playing documentaries about how physicians were saving lives" (ID25). As one participant explained, the pandemic provided "an unexpected platform for physicians' noble tradition—dedicating our lives to saving others—to be highlighted, even just temporarily" (ID09).

Once the epidemic was over, however, the media quickly resumed highlighting the unethical practices of physicians—even claiming that their heroic deeds could not erase the pervasive misconduct plaguing the profession:

> During the fight against SARS last year, the vast number of warriors in white won the respect of society with their practical actions. However, their misdeeds cannot be covered by their credits, just as ugliness cannot be covered by beauty. (*People's Daily*, Apr. 2, 2004)

As one elderly patient put it:

> While media attention was temporarily drawn to the bravery of some physicians, overprescribing remained widespread after the SARS epidemic. In fact, the epidemic *highlighted the discrepancy* between the noble traditional image of the profession and the reality of their everyday practices. (ID61, emphasis added)

Similarly, as one chief physician bemoaned: "social approval was revived during the SARS epidemic, but only for a moment. It was shocking how quickly SARS was used as a means not to praise, but to condemn us" (ID33). In short, the abrupt respite brought about by the epidemic had unintentionally drawn public attention to "the sheer contrast between the physicians' widespread misconduct and their rarely seen heroism" (ID59).

A different, albeit authoritative, secondary stakeholder—the government—played a quieter role. It did not directly intervene at this point and instead focused on monitoring performance in the health care sector through annual statistics (e.g., hospital revenues and patient coverage) and governmental surveys conducted every five years to measure the success rates of medical treatments, the level of patient satisfaction, and the costs incurred by patients. Results from the 1998 survey (the beginning of this phase) were largely positive, especially in terms of treatment outcomes. As a health department officer recounted: "most of our daily work was dedicated to examining the quality of health services. As long as there were no major problems, or scandals, we did not pay as much attention to professional ethics" (ID01).

Spiral of voice. However, as primary and secondary stakeholders began learning of how others were expressing their dissatisfaction, there was a spiral of voice (i.e., an *amplification* and encouragement of similar expressions of dissatisfaction). Our interviewees repeatedly pointed to the media's role in amplifying tensions and fueling the escalating dissatisfaction and anger of patients. As one patient pointed out: "if it were not for the media, we would not see how widespread those unethical behaviors were. Such reports really made people angry" (ID52). Patients, in other words, were learning from the media how others were responding in aggressive ways and, by implication, that such responses were acceptable:

> Media reports exaggerated the severity of doctor–patient conflict … Imagine that you were a client and were dissatisfied with my service; your first reaction might be to reason with me. But now that you read all those negative newspaper articles, you suddenly realize that you should lash out at me … An overly large number of media articles reporting on disputes easily triggered the ripple effects that stimulated more disputes. (ID20)

Moreover, the media almost exclusively focused on the misdeeds of physicians while downplaying any possibility that patients might also be at fault. One physician complained: "our profession is being portrayed as full of 'villains,' whereas patients are

always the victims. The media have totally taken the side of the patients but not with us" (ID05). As medical professionals saw it, patients were being told to confront their physicians—the consequence of which was the exacerbation of patient frustrations and the emboldening of their actions:

> These negative articles did not just vilify the medical profession. *After such misleading articles were published, the number of disputes increased rapidly.* We would see groups of 40 or 50 people gathering together, holding huge banners, shouting slogans, and passing out flyers in front of hospitals. They disrespect doctors and are aggressive. *Such incidents have become more common since the publication of these articles.* (ID17, emphasis added)

Interviewees who had entered the profession before 1998 confirmed that they had experienced a loss of social respect, and they described doctor–patient relationships as "worsening" and "deteriorating," such that by 2004, a national survey reported that 63% of physicians had serious reservations about their children entering the profession (Chinese Medical Doctor Association, 2004).

Strained tolerance. Despite this loss of social approval, the practice of overprescribing and questionable ethical conduct continued. As Yao (2016: 14), a scholar of medical sociology, later commented, "doctors always compromise their professional ethics during practice because they are unable to make decisions based only on medical knowledge; they have to consider economic interests as well." In response, some physicians became more cynical about the profession and others left it—rarely, however, did any member publicly rebel. An associate chief physician cynically remarked: "to physicians, hospitals may mean a tenured job, secured social benefits and pension, but to hospitals, every physician is just a contract of employment. The stakes are too high for us to go against systemic transgressions" (ID25). For those who were reluctant to embrace overprescribing, the choice was to tolerate such practices or "be sidelined and punished" (ID22). The overwhelming outcome was strained tolerance.

Nevertheless, a small number of physicians did protest, but they were seen by their colleagues as "Don Quixote-type heroes" who were doomed to fail. A senior interviewee recollected:

> A former subordinate of mine, a brilliant young man, got sick of the growing misconduct. He could not stand such practices, so he often shamed those colleagues who were known to overprescribe. But alone he could not stop them … Eventually, he chose to quit the profession in the early 2000s. And guess what he decided to do afterwards? He became a journalist who specialized in reporting physicians' unethical behavior. (ID09)

The inability of physicians to counteract the momentum toward stigmatization could be partially attributed to the absence of a powerful professional association that might have provided them with a collective and authoritative voice. Indeed, the Chinese Medical Doctor Association was only established in 2002, and so it lacked the experience and capacity to police the profession or to openly challenge the media. In the minds of physicians, the association was invisible: "we knew the association was being created, but barely knew what it was actually doing" (ID19).

Catalyzing Collective Labeling and Divergent Punishments (2005–2015)

Authoritative judgment. The increasingly negative perceptions of the medical profession had become difficult for the government to ignore. As one informant remarked: "starting in the late 1990s, more and more people were complaining about the costliness of medical services" and questioning whether "health care was a public service" (ID13). By 2004, the government's own five-year survey had revealed that 57% of urban residents avoided going to hospital because of the costs that would be incurred and that the average expense for an in-patient visit was now equal to the annual income of the average worker (Ministry of Health, 2004). Reflecting upon this trend, the former president of a municipal hospital stated: "we are a socialist country after all. Once public health care becomes something people cannot afford, the government needs to fix it … It has to make health care affordable; otherwise, it loses face" (ID06).

Growing public outcry prompted the government to step in and criticize physicians' "massive overprescribing at the cost of patients' health" (National Research Center, 2005). It directed blame at the medical profession, claiming that the violation of professional ethics had undermined public perceptions of health care:

> Public health care institutes are … neglecting the nature of public welfare … even at the cost of people's interests … Hospitals' profit-seeking tendency has not only led to expensive and inaccessible

> medical services for the people but also seriously impacted the societal image of medical professionals *and of the medical profession*. (Ministry of Health, 2005, emphasis added)

Over the next several years, the government called upon the profession to return to, and uphold, its public welfare role. An official document, *Opinions on Deepening the Reform of the Medical and Health Care System* (State Council, 2009), urged hospitals to"put patients at the center, optimize the service process, and standardize drug use, examinations, and clinical behavior." To further stem the practice of overprescribing, the government no longer allowed hospitals to charge patients a 15% markup on drugs, but it did not compensate hospitals for the resulting loss in revenue. Physicians thus "had no choice but to keep overprescribing unnecessary examinations and drugs not covered by health insurance in order to keep up with the profit shortage caused by the repeal" (ID16). Our informants caustically pointed to the problems caused by the government's policy changes:

> Those socialist slogans are hollow. No [physician] would believe them. The government is sending misleading messages to patients and the public … Health care has already become a business instead of a public welfare service. But the government talks about it as if it is all about social welfare. It is difficult to go back to the old days. (ID24)

By publicly calling for the profession to cease its unethical conduct, however, the government unintentionally tipped the scales and escalated public disapproval. As one informant reflected, when "the government began to publicly denounce the profession around the mid-2000s, everything changed … To begin with, the media started to follow the government's vilification of the profession" (ID10). In effect, the government had rendered an "authoritative judgment" that the unethical behavior of the profession was seriously misaligned with China's socialist principles and in doing so prompted others to take that same stance.

Collective labeling among stakeholders. The full range of media channels—newspapers, television, and radio—reinforced the government's narrative and stridently denounced the profession as "decadent and immoral" (*Sina*, Dec. 7, 2005), of "losing the patients' trust" (*Guangming Daily*, Jan. 23, 2006), and of being "dishonored" (*Sina*, Dec. 12, 2005). In a joint survey, *Sina* and CCTV (Sept. 28, 2005) proclaimed that 94% of the 17,638 respondents agreed that respect for the medical profession had collapsed. From 2005 to 2015, 291 (52%) of 562 articles in the *People's Daily* had adopted a critical view of professional ethics, with 229 explicitly blaming the profession as opposed to individual professionals.[6] In contrast, of the 114 (20%) articles that presented a positive view, the majority praised individual professionals. *NetEase* (Oct. 30, 2013) succinctly summarized the situation: "the media have collectively fallen into stigmatizing doctors." In other words, the collective portrayal of the profession in the media resonated with that of the government: "physicians today are no longer 'angels in white' in the public's eyes. Physicians are stigmatized" (*People's Daily*, Nov. 22, 2013).

Notably, however, both the government and the media focused on the unethical behaviors of the profession, not its members' expertise or competence: "between doctors and patients, there is only trust in skill, but rarely trust in ethics" (*People's Daily*, Jan. 25, 2013). Likewise, one informant noted that "the younger physicians are generally more skillful than the older generation" (ID03). Indeed, the percentage of patients whose health issues were effectively treated increased from 95.5% to 96.8%, and the percentage of physicians who obtained postgraduate degrees after their bachelor of medicine grew from 4.3% in 2005 to 11.4% in 2013 (Ministry of Health, 2003–2016).

Echoing this public denunciation of ethical lapses, patients openly blamed the medical profession at large: "I have been to big hospitals and small hospitals; I have seen chief physicians and less experienced physicians … All of them could be untrustworthy and unethical. I believe it is a problem for the profession" (ID54). One patient even went as far as stating:

> Today, the medical profession is the most *black-hearted* occupation … It is a societal *consensus*. There is no physician who has not overprescribed. This is a profession that has no conscience. I hope they will die of bad karma and retribution for their wrongdoing. (ID61, emphasis added)

[6] In addition, we examined different unethical issues (e.g., "overprescribing," "taking kickbacks," and "soliciting bribes") criticized by the media and found the same pattern. In the first phase, each misconduct was primarily attributed to individual members of the profession, whereas in the later phases, they were increasingly attributed to the profession. For example, in the first phase of the 21 articles critical of overprescribing, only 4 (20%) blamed the profession, whereas in the third phase, 157 (82%) of 192 articles did so.

For patients, the medical profession had coalesced into a category of "similar individuals, engaged in systemic unethical and malevolent activities" (ID42).

This collective labeling by primary and secondary stakeholders was not lost on medical professionals. Our interviewees repeatedly complained that "the media put dirty labels such as 'immorality' and 'greed' on the profession *as if we were all the same*" (ID23, emphasis added). They felt that "no matter whether you are a chief physician or a resident physician … as long as you wear a white coat, you are the same in the patients' eyes" (ID09).

Divergent prescriptions of punishment. Despite collectively attributing unethical behaviors to the profession as a category, primary and secondary stakeholders differed in their perceptions of the appropriate punishments that should follow. Primary stakeholders increasingly expressed their disapproval aggressively. Between 2005 and 2015, not only did reports of doctor–patient disputes increase six-fold, but incidents of violence rose sharply (see Figure 2). By 2012, nearly two-thirds of hospitals across China had reported incidents of physical violence, 60% of physicians had suffered verbal abuse and threats, and 13% had experienced physical abuse (Chinese Hospital Association, 2014; Chinese Medical Doctor Association, 2015). Critically, these incidences were occurring across the spectrum of clinical departments and hospitals—small and large—and at provincial, municipal, and district levels (Zhang & Zhao, 2014).

Moreover, there was a sharp increase in random incidents of abuse and violence. Nearly 11% of physically violent incidents involved physicians with whom patients had had no prior interactions (Yao, 2017). Particularly striking was that these incidents were taking place "with the tolerance of the general public" (Wu, Wang, Lam, & Hesketh, 2014: 8). In an online survey of how readers felt about the murder of a physician by a patient whom he had never treated, 65% of 6,161 respondents selected "happy" rather than "sympathetic," "sad," or "angry" (*Tecent*, Mar. 27, 2012). This growing randomness of violence, and the wider public's response to it, signaled that the profession was being targeted for punishment: "when a patient randomly chooses the target for retaliation, it is because the patient distrusts the medical profession" (ID07).

However, the response of primary stakeholders differed from that of secondary stakeholders who instead resorted to "shaming" the profession and urging its members to resume their traditional role as pillars of socialism (e.g., State Council, 2009), complaining that "public hospitals have become 'shopping malls' while the value of the health profession has been distorted … The nature of heath care as a public welfare service should be upheld" (*People's Daily*, Jan. 15, 2009). The government expressly condemned unethical behaviors and made it clear that such actions would be penalized and could lead to the loss of the license to practice (Ministry of Health, 2007). In short, for secondary stakeholders, the emphasis was on the need for regulatory supervision and correcting the problem of professional transgressions.

At the same time, the government appealed to the public to "respect medicine, and respect medical professionals" (State Council, 2009). The Supreme People's Court (2014) followed suit, declaring that "illegal acts and crimes against medical professionals shall be severely punished … Offenders who intentionally kill or injure any medical professional … shall be convicted and punished." This stance of admonishing patients for vilifying physicians was also adopted by the media: "a society that disrespects doctors is a barbaric, pathetic, and hopeless one" since harming doctors "is a societal shame" (*People's Daily*, Dec. 21, 2006). The *Guangming Daily* (Dec. 23, 2005) similarly underscored "the importance and urgency of building a harmonious doctor–patient relationship."

Nevertheless, patients continued to express their feelings of frustration and anger: "it seems that physicians are not following the government's regulation in their daily work. Their persistent overprescribing really pisses us off" (ID49). Moreover, the "dependence" of patients upon physicians led to feelings of helplessness: "They are the professionals, and we have no other choice but to rely on their treatment" (ID60). "Patients can hardly choose medical services overseas because when illness arrives, they need medical attention immediately; and most of them just cannot afford overseas treatment" (ID27). Not only did patients feel unable to find alternative sources of care, but their expectations of how they should be treated were no longer being met. Surveys showed that patients typically expect 15–30 minutes of consultation time but over two-thirds receive less than 10 minutes (Wu et al., 2014; see also Chinese Hospital Association, 2014). They feel rushed through the system, in part because the daily number of patients seen by

physicians rose from 5.5 in 1990 to 7.3 in 2015 and increased more significantly in large hospitals (Ministry of Health, 2003–2016). These unmet expectations fueled dissatisfaction: "a deep reason for the violence against physicians is … [patients] wait in a queue for 30 minutes but only get a three-minute consultation" (*People's Daily*, July 24, 2015).

The frustration of dependence was further exacerbated by the belief that physicians were violating profound societal values. Once the attribution of blame was clearly placed upon the profession, the moral aspect flared and became prominent. An elderly patient commented, "the medical profession is believed to uphold the bottom line of a well-ordered society. If the medical profession renounces social justice and morality, society would be on the verge of collapse" (ID54). This sentiment was echoed by President Xi, who proclaimed that the medical profession represents the "core values of socialism" (*Xinhua Net*, Aug. 20, 2016)—hence, the failure to live up to this representation was highly consequential. This expectation weighed heavily on the physicians:

> The Chinese Communist Party and Maoism have always regarded health care as an important political mission … Health care is an achievement of the socialist movement and represents the true nature of the Party … If physicians betray this socialist expectation, they would readily induce public grievances. (ID02)

Highlighting this societal purpose unintentionally "fueled expressions of anger and aggression" (ID36). Patients candidly stated that "the government's re-emphasis on the medical profession's social welfare role reminds us of what physicians should live up to and what they used to mean to the people—and, by contrast, how degenerate they have become" (ID66).

Despite their worsening relations with patients, physicians exhibited an increasingly disillusioned tolerance. Professional associations made few attempts to defend the profession other than by occasionally making public calls for respect. As the *People's Daily* (Sept. 20, 2010) remarked: "there are professional associations in health care but their functions are very limited … They do not have the right to enforce regulations." Similarly, as the president of a regional branch of the professional association despaired:

> The associations and their websites might seem fancy and classy (*gao da shang*), but in fact their statements are just fake and empty (*jia da kong*) … When the profession is in crisis, the associations have to align themselves with the government and so provide little support to the profession or the patients. (ID08)

A few individuals, however, have attempted to alter public perceptions by highlighting on social media the positive aspects of physicians.[7] These efforts have mostly been scattered and have had limited effects—as one patient pointed out: "there might be a few good physicians, but you rarely meet them in real life. You cannot extinguish a fire with a cup of water" (ID65). For the most part, therefore, the behavior of physicians "confirmed, if not further encouraged, public disapproval" (ID04).

Epilogue

Upon completion of our research, it was clear that over the course of three decades, there had been a significant move away from the collective approval of the medical profession. However, whether there will be further movement along the continuum toward stigmatization remains to be seen. Indeed, the current COVID-19 pandemic has seemingly given the medical profession some temporary respite from stigmatization, just as the SARS outbreak did in the early 2000s. In the early months of the Wuhan outbreak, both the government and the media widely praised the medical professionals who came from outside of the city to volunteer on the front lines. These "heroes" were lauded by the media for "disregarding compensation and death, and for not shying away from danger or fear … Salute to the 'warriors in white!'" (*People's Daily*, Feb. 2, 2020). As the outbreak spread, the media continued to praise medical professionals for "safeguarding the safety and health of the people with the highest sense of mission" (*Xinhua Net*, Mar. 5, 2020). On May 21, 2020, attendees of the National Committee of the Chinese People's Political Consultative Conference stood in silence for one minute to recognize the sacrifice of medical professionals in the fight against COVID-19. Through such public acclamations, the government has helped push for a restoration of the public's respect for the profession.

[7] A prominent example was Dr. Yu Ying, a surgeon in the prestigious Peking Union Hospital who opened her Weibo account (comparable to Twitter) in 2011 and within three years had more than three million followers. By 2014, there were about 4,000 Weibo accounts registered by physicians, but few attracted much attention (Zhao, 2016).

At the same time, the government has continued its efforts to curb abuse and violence against the medical profession by assigning harsher penalties (including death sentences) to perpetrators. Yet, despite these efforts, incidents of abuse and violence have remained high. In 2018, the Chinese Medical Doctor Association reported that 66% of physicians had experienced verbal abuse or physical violence—down only 7% from 2015. Moreover, reports of aggressive behavior toward physicians have remained commonplace. Strikingly, the public's reaction to a recent incident where the son of a 95-year-old stroke victim fatally stabbed a physician in the neck on Christmas Eve in 2019 was mixed, with some reactions echoing our earlier fieldwork. Of the first 100 online comments on this incident, a majority suggested that such acts of violence were a "normal" response to "unethical physicians" and the "systemic problem within the profession," for example: "We should put a bullet in the heads of corrupt physicians, upholding the professional ethics" and "the key to solving worsening doctor–patient relationships is to let patients be able to afford health care and stop physicians from getting bribes and kickbacks" (Toutiao.com, Dec. 29, 2020).

In sum, it appears that the process of stigmatization remains unsettled and is still unfolding. In particular, it remains *partial* as stigmatization is targeted on the ethical dimension of professional behavior as opposed to the profession's expertise or competence. Moreover, disagreement remains among stakeholders regarding the appropriate response and stance toward the profession. Indeed, there has even been a modest shift "back" toward ambivalence following the government's continued efforts to contain and reverse stigmatization and the temporary respite provided by the COVID-19 pandemic. Whether this reversal or containment will hold over the longer term or not remains to be seen, as patients continue to harbor misgivings and anger toward medical professionals. The stigmatization of the medical profession has not, in other words, "stabilized" (Mair, Wolf, & Seelos, 2016).

DISCUSSION

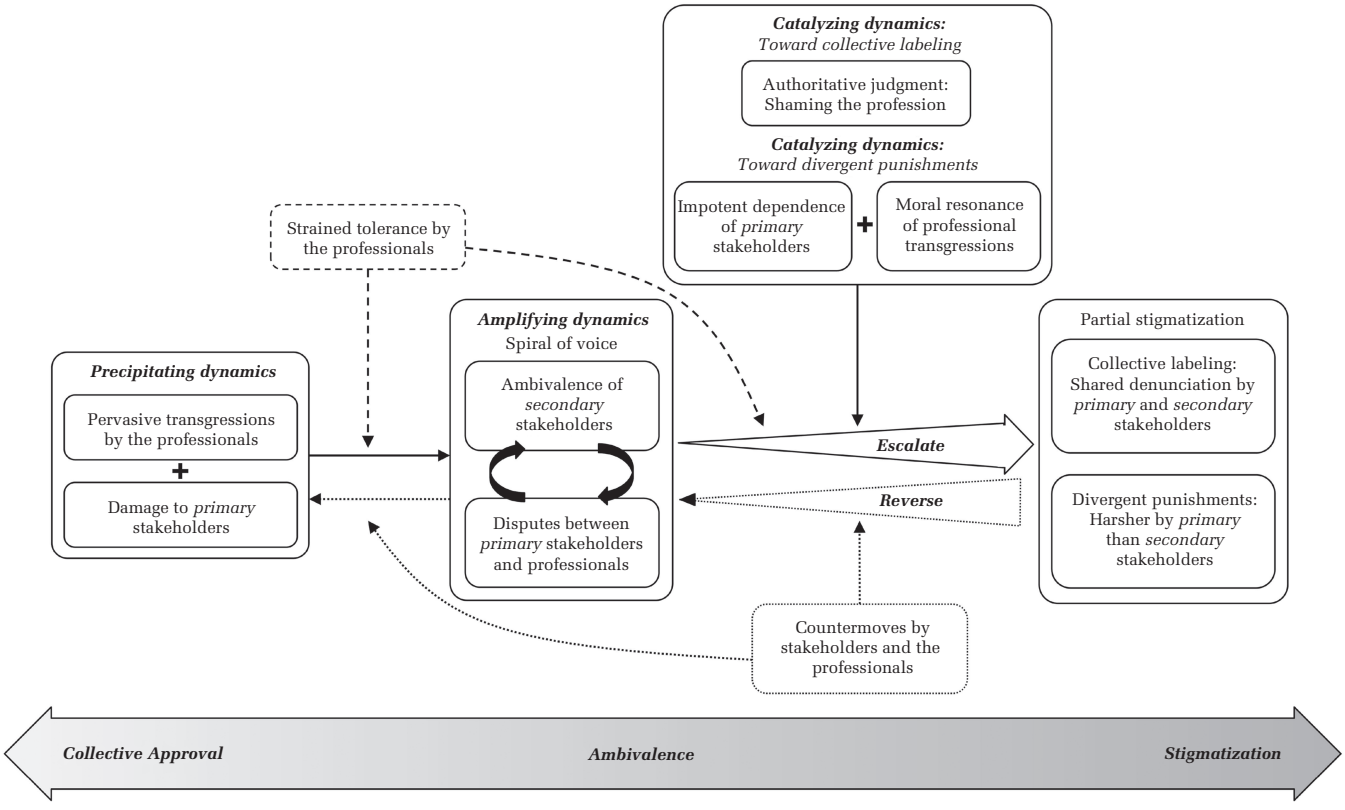
Despite growing interest among management and organizational scholars in uncovering how organizations manage the consequences of being stigmatized, there is still much to learn about the processes by which stigmatization emerges and unfolds. Our primary contribution is the development of a process model of professional stigmatization which theorizes the role of different stakeholders and the dynamics and mechanisms implicated in the fall from grace of a respected profession. Our secondary contribution offers insights into stigmatization processes more broadly. Drawing upon our case study, we point to three complexities that need to be taken into account in future research and theorizing.

A Process Model of Professional Stigmatization

As illustrated in Figure 3, the model of professional stigmatization that we derive from our case study highlights the various dynamics and mechanisms that precipitate and then amplify the initial move away from collective approval toward ambivalence, followed by catalyzing dynamics that escalate even further the momentum toward stigmatization. That momentum may become increasingly "self-sustaining" (Devers et al., 2009) and difficult, albeit not impossible, to contain. Intriguingly, however, even though secondary and primary stakeholders may collectively label a profession as acting improperly, they may diverge in their prescriptions of appropriate punishment because of their respective relationships to the profession. Our model proposes that primary stakeholders will be harsher in their judgments and that secondary stakeholders—particularly those responsible for governing the profession—may engage in countermoves or efforts to disturb or reverse the movement toward stigmatization (as illustrated by the dotted lines and arrows in Figure 3). Because of their social prestige, professions are often subject to the scrutiny of multiple stakeholders, suggesting that professional stigmatization is rarely a linear, unidirectional process, but an ongoing and oscillating one. Below we detail the precipitating, amplifying, and catalyzing dynamics that are implicated.

Precipitating dynamics. Unlike prior studies that have pointed to ethical breaches as the starting point of a move toward stigmatization (Devers et al., 2009; Hudson, 2008; Wiesenfeld et al., 2008), ethical transgressions alone had little effect on the widespread social approval of the medical profession. One possible explanation is that Chinese society is more tolerant of professions because their social status counteracts such negative reactions (Ashforth & Kreiner, 1999; Wiesenfeld et al., 2008). That the unethical behaviors in our case continued for over a decade without precipitating a loss of approval strengthens the possibility that misconduct *alone*

FIGURE 3
A Process Model of Professional Stigmatization



needs not trigger the process toward professional stigmatization.

Instead, for social approval to be undermined, it seems that unethical behavior need to inflict visible "damage" upon *primary* stakeholders. In our case, the stigmatization process was touched off by a change in the health insurance scheme that had adverse financial implications for patients. The importance of damage is underlined by the fact that the transgressions were no different *after* the introduction of the insurance changes from those of the previous decade when minimal patient backlash had occurred. Moreover, government surveys showed that medical treatments had even improved slightly in terms of the percentage of patients who were successfully treated. Thus, our case suggests that it is the combination of pervasive transgressions and damage to primary stakeholders (i.e., patients or clients) that precipitates the shift from collective approval toward ambivalence.

Amplifying dynamics. Once initiated, the momentum toward ambivalence is fueled by a "spiral of voice." Secondary stakeholders (e.g., the media) generate awareness and legitimation of the negative stances and reactions of primary stakeholders and in doing so further their diffusion. As those affected learn of how others are expressing their dissatisfaction, they too feel justified in adopting and expressing a similar form of disapproval. There occurs, in this respect, the opposite to Clemente and Roulet's (2014) "spiral of silence" (i.e., that those holding a minority view increasingly become and remain silent). In our case, the media's sympathetic reporting of incidents of abuse toward physicians gave credence to the view that "voice" (Hirschman, 1977) in the form of disputes and abuse was acceptable and appropriate, thus triggering further incidents.

Such a pattern is in line with the standard depiction of mimetic diffusion, which argues that as ideas and practices diffuse, they gain legitimacy and become accepted as the normal and appropriate practice to the point where they are adopted uncritically (Boxenbaum & Jonsson, 2017; Deephouse et al., 2017). In a professional context, however, where primary stakeholders rely on the technical competence

of the professional but lack the expertise to appraise whether that competence is being appropriately deployed, this "need" for the legitimating evaluations of others may be especially high.

Before turning to the move from ambivalence toward stigmatization, it is worth noting an unusual feature of our case, that of "strained tolerance" (i.e., the absence of any systematic pushback by the profession, as illustrated by the dashed lines in Figure 3). As criticisms and reporting of ethical transgressions grew, some physicians chose to leave the profession, others sought to fight back (albeit unsuccessfully), but most became disillusioned. Together, these responses unwittingly condoned or tolerated further transgressions, as unethical behavior appeared to be acceptable. The geographically distributed nature of professions, we suggest, may be one reason why professionals may not be able to easily and collectively defend themselves. But this difficulty in providing a defense is particularly acute if a profession lacks an effective collective voice, as the medical profession did in China, where the physicians' professional association was established only after the transgressions had noticeably begun to spread; and even later, it lacked the autonomy and authority to suppress ethical transgressions or counter the narrative in the media.

Catalyzing dynamics: Toward collective labeling. Prior studies suggested that severe and protracted transgressions by professionals, once publicly disclosed, will prompt repair efforts by regulators and governments. Herepath and Kitchener's (2016: 1133) study of the U.K.'s National Health Service, for example, detailed how the government stepped in to effect institutional repair by explicitly highlighting the harm inflicted by severe breaches of professional codes of conduct. The intention was to prompt professionals to self-monitor and self-regulate. In our case, the government employed a similar strategy of rendering an authoritative judgment and of engaging in public shaming in an attempt to "suppress transgressive behavior and restore normative conformity" (Creed, Hudson, Okhuysen, & Smith-Crowe, 2014: 280; see also Hudson & Okhuysen, 2009). Importantly, however, the government unintendedly shifted the debate from an emphasis upon the transgressions of individual professionals to placing responsibility upon the profession as a whole. This broadening of the target of stigma contrasts with prior models that depicted a narrowing of the target, such as the shift from stigmatizing an organization to stigmatizing its leadership (Wiesenfeld et al., 2008). Our case suggests that when transgressions within a profession become pervasive and generalized by an authoritative stakeholder, the targets of stigmatization might move to a broader category as opposed to individual scapegoats.

In other words, our model suggests that the judgments rendered by authoritative stakeholders can severely breach the shield of social respect that surrounds a profession (Brint, 1994). Further, once rendered, such judgments may escalate the momentum toward stigmatization by catalyzing the collective labeling by primary and secondary stakeholders. In our case, both the media and patients adopted the authoritative stakeholder's stance and even used similar language. This suggests that when an authoritative stakeholder proclaims and attributes a judgment of blame, other stakeholders may follow suit, thereby triggering a chorus of criticism that hastens the move from ambivalence toward stigmatization.

Catalyzing dynamics: Toward divergent punishments. The momentum unleashed by an authoritative judgment moves the evaluations of primary and secondary stakeholders toward stigmatization. But, interestingly, instead of converging upon an "appropriate" punishment—as prior models would suggest (e.g., Devers et al., 2009; Wiesenfeld et al., 2008)—stakeholders may prescribe *divergent* forms of punishment. In our case, the government and the media resorted to shaming and called for greater regulatory supervision, whereas patients called for much harsher punishments—even supporting violence. This divergence supports Helms et al.'s (2019) contention that stigmatization may elicit different reactions from heterogeneous audiences. In professional contexts, this divergence in punishments, particularly the harsher punishments prescribed by primary stakeholders, can be attributed to two characteristic features of professions.

First, primary stakeholders typically depend strongly on the profession. This dependence runs counter to most portrayals of stigmatization situations which implicitly assume that "exit" (Hirschman, 1977) is an option, meaning that those affected can "shun" (Adut, 2008; Hampel & Tracey, 2017) or limit their relationships with the stigmatized (Devers et al., 2009; Wiesenfeld et al., 2008). Such shunning and bypassing are means by which stakeholders can escape from or exit their relationship of dependence. However, these options may not be feasible in the case of professions. Primary stakeholders may be unable to withdraw from relationships with a profession—in effect, they are in situations of "impotent dependence," which acutely matters in professions such as medicine and the law. If that dependence

is abused, it will inflame strong emotions of "resentment and a desire to restore justice" (Wiesenfeld et al., 2008: 239) and, as in our case, precipitate harsh penalties.

The second feature of professions that can prompt harsh penalties is the high expectation of moral behavior. If a profession is evaluated as morally corrupt, the sheer discrepancy between its actual social identity (i.e., what it is) and its virtual identity (i.e., what it is expected to be) will antagonize stakeholders and prompt a more aggressive response—especially toward professions that more fundamentally reflect societal norms, as in the Chinese context where the medical profession is perceived as an exemplar of state socialism rooted in and reflective of the deeply institutionalized value of "serving the people" (Davis, 2000; Sidel & Sidel, 1973). The underlying implication is that professions that have high "moral resonance" are held to higher expectations, such that betrayals of those expectations can incite acts of emotional retribution and more aggressive punishments than might be applied to other professions. These two mechanisms highlight an important aspect of the process by which a profession moves toward stigmatization. While ethical transgressions often trigger emotional responses, such responses in the professional context may be heightened by the personal and dependent relationship of the primary stakeholder upon the profession. Further, if the ethical transgressions violate fundamental societal values (i.e., if the moral resonance is particularly high) then responses will be harsh and even rise to the level of physical violence.

Pulling the above together, the model we propose shows that the stigmatization of a profession is an ongoing process which may not unfold in a linear or consistent manner. Because stakeholders have different experiences and relationships with professions, their responses and roles in the stigmatization process will likely vary. Moreover, both the stigmatized professionals and authoritative stakeholders may engage in countermoves to contain or reverse the stigmatization process. In our case, the government admonished both patients and the medical profession, implementing stricter regulations and punishments for violence and ethical transgressions. These efforts resulted in a modest shift back toward ambivalence, suggesting that countermoves may disturb the momentum toward stigmatization.

Unfolding events also influence the move and momentum toward stigmatization. In our case, SARS and the COVID-19 pandemic altered the context of the stigmatization process. Such events illustrate how external changes can shift the way stakeholder groups portray and perceive a profession and offer opportunities for stakeholders to promote their particular stance. The process of stigmatization, in other words, is an ongoing and possibly oscillating process shaped by the actions and countermoves of different stakeholders within the context of societal events.

The Stigmatization Process

Our theorization depicts professional stigmatization as an inherently complex process. This depiction, we propose, is relevant to processes of stigmatization more generally. Stigmatization processes are complex because (a) they may be partial in their focus upon certain aspects of organizational or professional behavior; (b) they involve multiple stakeholders, suggesting the potential for an ongoing struggle between competing perspectives; and (c) the movement toward or from stigmatization, and the pace of that movement, may be affected by the actions (or inaction) and countermoves of stakeholders as they respond to unfolding events.

In referring to the partial nature of stigma, our study is consistent with that of Helms et al. (2019) who argued that while audiences may stigmatize particular aspects of an organization's practices, they can still perceive the organization as legitimate. As Hampel and Tracey (2019) put it, stigmatization is not a "binary" evaluation. Our study empirically confirms and elaborates this theoretical position by raising an important implication, namely that the focus of stigmatization will shape the particular mechanisms involved and the particular punishment that follows. For example, in our case, moral resonance may not have been triggered by breaches arising from incompetence. Likewise, the punishment for incompetence might not have been violence but shunning and professional devaluation (Wiesenfeld et al., 2008). For a more complete understanding of the stigmatization process, it is important to consider the focus, sources, or roots of stigmatization.

Further developing an understanding of the stigmatization process also requires paying attention to the range of stakeholders involved. Most studies of stigma have attended to a small number of stakeholder groups, often only the media (exceptions include Helms & Patterson, 2014; Lashley & Pollock, 2020). Yet, our study demonstrates that not only are multiple stakeholders often involved, but they play different roles in the process. It follows, then, that

the relationships between the target of stigmatization and each stakeholder group should be examined in addition to the relationships between the different stakeholders. Although stakeholders may "pile on" each other's judgments and converge into a "consensus" at a particular time (Devers et al., 2009; Wiesenfeld et al., 2008), they may just as easily diverge in their views. In our study, public shaming by an authoritative stakeholder unwittingly created a general target and propelled collective labeling by both primary and secondary stakeholders; whereas primary stakeholders persisted in advocating aggressive punishment, secondary stakeholders began to urgently call for restraint. An appreciation of the potentially wider range of stakeholders involved may implicate a less convergent or linear process than is often portrayed (Devers et al., 2009; Wiesenfeld et al., 2008; Zhang et al., 2021). In other words, including a range of stakeholders may provide a more nuanced understanding of how and why stigmatization is expressed in particular ways and the varied responses of those stigmatized.

Moreover, our case shows that the relationships between stakeholders shape the direction and pace of stigmatizing momentum. If stakeholders are in agreement, then momentum can become "self-sustaining" and difficult to contain or reverse (Devers et al., 2009)—especially following the expression of an authoritative judgment. However, if stakeholders differ in their positions and their respective actions (or inaction), such an authoritative judgment may undermine the momentum, thereby slowing, containing, and perhaps even reversing the movement toward stigmatization. Stigmatization, in other words, may be an oscillating rather than a unidirectional process. Hence, instead of assuming that stigmatization is "complete" when a particular stakeholder defines a pattern of behavior as warranting societal disapproval, or concluding that stigma is eliminated when disapproval is temporarily silenced, it would be more appropriate to adopt a more historical and longitudinal approach that acknowledges the various complexities of the stigmatization process.

Future Research

Given that ours is an extreme case, further work is needed to confirm and develop the insights that the case provides. As our primary interest concerns the stigmatization of professions, we propose two promising directions for future research that are especially relevant for that context—although they would also inform studies of stigmatization more broadly.

Containing stigmatization. An intriguing and important stream of future research is how the process of stigmatization can actually be contained—or even reversed—and by whom. Prior research has suggested that professions attempt to contain and repress early intimations of nascent stigmatization (Ashforth & Kreiner, 1999; Gabbioneta, Greenwood, Mazzola, & Minoja, 2013; Wiesenfeld et al., 2008). Yet, in our case, there was little such action or effort to do so. One reason was the late formation of a professional association that could represent and guide the profession. But more importantly, being newly established and under the direct supervision of the government, the professional associations in China had neither the capacity nor the authority to redress ethical transgressions. Future research, therefore, is needed to explore whether a more active professional association could contain the move toward stigmatization and perhaps even reverse that process.

However, even in Western countries, including the U.K., Australia, and Canada, professional associations have shown relative weakness in addressing pervasive transgressions (Leslie et al., 2018; Marriage, 2019). In the U.K., for example, the General Medical Council, established in 1858, so consistently failed to prevent transgressions that the collegial model of professional self-regulation was abandoned in the 1990s (Dixon-Woods et al., 2011). Similarly, the accounting profession in the U.S. and the U.K. has been chastised for its weak control of audits, leading to new regulatory arrangements (e.g., Eley & Kinder, 2019). Even so, it is important to uncover whether, and under what conditions, associations might influence the process toward stigmatization. Comparisons across countries would be especially informative. A related line of research could inquire whether, and in what contexts, other actors (e.g., prestigious professional firms, judges, media celebrities, political parties, and the church) might have sufficient "discursive legitimacy" (Phillips, Lawrence, & Hardy, 2004) to influence the momentum toward stigmatization.

A complementary line of research could explore the means by which the process might be contained and reversed. The public shaming in our case underlined that the profession is to blame and unwittingly created a general target for escalating disapproval. But what if a strategy other than public shaming were adopted? Would the simple removal of the specific causes of the "damage" to primary stakeholders

(in our case, funding and incentive systems) enable the resumption of respect for the profession? Our suspicion is that restoring societal respect would not be that easy. Alternatively, would strictly punishing patients who violently attack physicians reverse the process? Again, our case suggests that it would not be that easy. The government recently introduced regulations against physical violence in hospitals, but threats and verbal abuse remain widespread, and physical violence still occurs. Future research into how the momentum of stigmatization of a profession might be slowed or even reversed is clearly needed.

Another promising line of research would be to explore whether the timing of interventions affects the process of stigma containment and reversal. In our case, the government began to police the profession only after ethical transgressions had become pervasive, which raises the question of whether earlier entries might have more influence. Would the restoration of professional respect be more likely during and after a health crisis, such as which seemed to occur during the 2002–2003 SARS epidemic and is now occurring during the COVID-19 pandemic? While a crisis could immediately highlight the importance and devotion of medical professionals, the evidence from the SARS epidemic showed that respite from stigmatization may be short-lived. Whether the current COVID-19 pandemic becomes an opportunity for the government and the profession to restore moral approval is of immediate interest and provides a timely opportunity for scholars and policymakers to explore important aspects of stigma containment.

Rendering violence: A moral imperative? The second direction for future research that we propose pertains to the role of moral resonance and its association with prescriptions of violence. Ours is a rare empirical study that shows widespread physical violence toward professionals for their failure to meet the moral expectations of primary stakeholders. This pattern of behavior is, in a sense, an emotionally driven moral equivalent to Zuckerman's (1999) "categorical imperative." The categorical imperative focuses upon the consequences of failing to align with the cognitive framework of stakeholders. If securities analysts (in Zuckerman's case) do not comprehend an organization because it does not fit their prevailing classification of organizations, they will not review the organization, leading to adverse financial consequences for that organization. Our case, in contrast, suggests that adverse consequences follow from failing to align with the *moral* expectations of stakeholders. Further, whereas violations of a categorical imperative prompt rational and calculative penalties (i.e., an "illegitimacy discount"), violations of a moral imperative evoke acute emotions of repugnance and anger, prompting aggressive reactions.

The moral imperative, we suggest, is particularly relevant to professions because of their presumed commitment to an ethical code and claim to a particular expertise. But the moral imperative may apply more notably to some professions than others, specifically to those that embody core societal values, the actions of which may have particularly high "moral resonance." Future research should compare the moral resonance of different professions within the same societal context and observe the particular punishments applied.

Further, since the particular professions associated with fundamental societal norms may vary across contexts and over time (Hampel & Tracey, 2017), it would be especially interesting to compare the risks of moral resonance faced by different professions in particular countries. Candidates for attention include the legal profession, which in many Western countries symbolizes the rule of law and thus is expected to occupy the moral high ground (Smets et al., 2012). Others would be the Catholic Church, because of the widely exposed sexual abuse of minors by priests (Gutierrez, Howard-Grenville, & Scully, 2010; Palmer & Feldman, 2018), and politicians, whose actions have sparked riots and upheaval (Obrador & Uhlmann, 2018). Such comparisons could probe not only whether particular professions are held to a higher standard of moral resonance but also whether the punishments associated with moral resonance are the same across countries.

CONCLUSION

The stigmatization of professions is an important and evolving problem. Given that the growing incidences of violence against physicians have occurred "across the globe" (World Medical Association, 2015) and that the decline of confidence in professions could have serious implications not only for those directly affected but also for social stability, the need to understand professional stigmatization is compelling. It is, in this respect, a disquietingly neglected "grand challenge" that warrants further attention (George, Howard-Grenville, Joshi, & Tihanyi, 2016). Our hope is that the analysis and model provided in this paper will inform and inspire future work in this critically important area.

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