‘STILL ARGUING OVER COST’: BARGAINING, ETIQUETTE AND THE MODERN PATIENT IN REPUBLICAN BEIJING

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Abstract

In this article I have endeavoured to show how conflicting notions of consumer etiquette and patient behaviour played out during negotiations between social workers and patients at Peking Union Medical College Hospital (PUMC) in the 1930s. Organisational technologies such as quantification, record keeping, statistics, standardisation and systematisation were essential aspects of the American-style scientific medicine that PUMC aimed to introduce to China in the Republican period. Chinese patients brought assumptions of their own to the American hospital, however. Wealthy women in particular insistently bargained over the price of treatment, thereby adopting a selective approach to hospital therapies. In response, hospital social workers, who were allowed considerable flexibility about the manner of negotiating prices, adapted payment customs to satisfy this class of patients. At the same time, social workers wielded their control over resources with an eye toward disciplining patients in various ways. They investigated patients’ financial circumstances, gathering evidence in order to compel more truthful self-disclosure, or a posture of deference toward scientific and institutional authority. In Republican Beijing a ‘modern’ Chinese patient role thus evolved through a process of mutual, if asymmetrical, negotiation. Themes that become visible in the process of negotiating payment are suggestive of ways PUMC, as a model of administrative modernity and scientific organisation, was both linked to—and diverged from—consumer practices and concepts of distributive justice rooted in a distant society.

In 1936, when Zheng Bi-wu went to the American-style hospital in downtown Beijing (Beiping), she declared she could pay her hospital and surgical fees, but not the radon expenses.\(^1\) Noting that Mrs Zheng wore ‘large pearl ear-rings’, ‘golden spectacles’ and ‘a new cotton blue gown to cover the silk one’, hospital social workers asked

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\(^1\) Peking Union Medical College Hospital, Medical Records Department, patient # 15518. Patients’ names have been changed to respect their privacy.
how she had been paying her bills up to that point. 'Pt (patient) dressed very well + doesn't look like a 54 years old woman's dressing', her social worker noted.² For six months, social workers persisted in their attempts to persuade Zheng that further radiation treatment was necessary, and that she would have to pay to get it. But Mrs Zheng refused, always insisting on a reduction in cost, to 'get a good bargain', she said. Her American surgeon, Dr McKelvey, recorded his frustration in the form of a terse ultimatum: 'She is not to return until she has had X-ray. Still arguing over cost. Do not see again unless has X-ray', he instructed sternly in her chart.³

Becoming a patient of modern medicine at the Peking Union Medical College (PUMC) hospital involved a complex process of negotiation, in which differing sets of standards and norms—for the most part, never directly articulated—came into contact. The PUMC, a Rockefeller-funded showcase of world-class scientific medicine for China, first opened its doors in 1921.⁴ Famously described as an 'American

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² Recorded by Tien, 27 January 1936. PUMC patient # 15518.
³ I went to Beijing to collect medical and social work case records from PUMC in 2001, supported by a National Science Foundation dissertation grant. Conditions under which I gained access to records allowed me little control of the sampling method. Records I obtained cover the years 1921–1952, excluding the period when PUMC was under Japanese occupation (1941–1945), but are very unevenly distributed over any year and not sufficient to sustain quantitative analysis. Still, the records do provide fascinating 'snapshots' of some of the unanticipated difficulties encountered when practising scientific medicine in China. The records lend themselves well to qualitative analysis, which is how I have attempted to use them in this paper.

Medical and social work case records from PUMC's early years are kept by the hospital's medical records department. The older case records were not separated in any systematic way from records currently in use in the hospital. The PUMC has over one million patient records, and they are simply lined up on shelves in chronological order from patient # 1 to patient # 1 million. The patient numbers referred to in this essay fall between # 600 (arriving in 1921) and # 85000 (the early 1950s). The method of citation used is: Peking Union Medical College Hospital, Medical Records Department, followed by the case number. I did not record page numbers for passages I have quoted, because although the forms were sometimes stamped with sequential page numbers, new pages were often inserted later by nurses, doctors, and other members of the staff over time. The numbering on the pages was therefore often incomplete and usually not reliable. Copies of all cases cited in this paper are in my possession, and continue to reside at the PUMC where access to the records is severely restricted.

⁴ The Rockefeller Foundation’s China Medical Board (CMB) invested millions in PUMC’s ambitious goal of promoting ‘the gradual development of a system of scientific medicine for China’. They regarded science and science education, as the most effective way of modernising the Chinese mindset. ‘Far and away the most
transplant’ in Beijing, PUMC’s American style of scientific medicine encountered patients who were accustomed to a wider range of therapeutic choices. They were also less habituated to seeking care in mass institutions. Patients’ conceptions of their role—of how they should interact with hospital staff—challenged the institution’s ability to carry out medical treatments. Disagreements over diagnosis, price and understanding of cure all could end in incomplete treatment, with sometimes dire consequences. In this paper I show how conflicting notions of consumer etiquette and patient behaviour played out during negotiations between social workers and patients at Peking Union Medical College Hospital in the 1930s, the high tide of its institutional expansion under Rockefeller auspices, and a time of strong American support for the Guomindang government.

fundamental and essential work that is possible among the Chinese’, one board member wrote in 1914, ‘is the change from the old method and spirit of thought to the new. This transformation can only come through the rising generation. The adults cannot change except in rare individual cases. Superficial changes in the adult population are all that is possible.’ Science education, then, was the antidote needed to ‘redeem the Chinese mental condition’ from a traditional emphasis on literary education and government service. Rockefeller Foundation Archives, series: Rockefeller Boards, sub-series: CMB, box 11 folder 88 Letter to Gates, Chicago, Ill., 22 January 1914, p. 4.

From the project’s inception in 1914, the China Medical Board looked hopefully on a nascent climate of ‘hospitality toward science’ in China. They aimed to capitalise on 4 May spirit of nationalism which had linked science and patriotism, hoping PUMC could initiate a cultural transformation so profound its effects would survive future political upheavals, whatever their consequences for foreigners and foreign institutions in China. ‘This Health School system has a prospect of remaining, whatever may happen to the existing schools’, the board member anticipated, ‘for the Chinese people are quite certain to want these hospitals, nurses, teachers and doctors permanently, whatever happens in political, socialist, or religious affairs, and that is a vital point. It is a fixed and unconcealed determination of the Chinese people to slough off foreign domination in every form, advisory or otherwise, just so soon as they are able. It is only their weakness, and their good sense in seeing their weakness, that makes them pliable now. The more superficial the foreign efforts the sooner the Chinese will measure their depth and take over all that is worth while in them and slough off the rest. The more fundamental the work and the more indispensable its nature the longer will they retain it.’ Rockefeller Foundation Archives, series: Rockefeller Boards, sub-series: CMB, box 11, folder 88 Letter to Gates, Chicago, Ill., 22 January 1914.

Bullock 1980.
'From the old spirit of thought to the new': bringing medical modernity to China

The style of 'scientific medicine' PUMC introduced to China was itself quite a recent development in the United States. This transformation—one might call it the industrialisation of American medicine—had been greatly accelerated by funding from Rockefeller philanthropy. One consequence was that medical theory and practice in the United States were becoming increasingly homogenous, compared with other places in the world to which it began to spread. PUMC, they believed, would bring science and modernity to China.

Americans regarded the homogeneity and standardisation that characterized their modern institutions as self-evidently desirable. These qualities were essential aspects of 'modernity'—attributes that, for

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6 Through the activities of professional associations such as the American Medical Association, in conjunction with government regulatory efforts, proponents of 'scientific medicine' began in the late nineteenth-century United States to rapidly displace competing schools of medicine and practitioners. These included schools of herbal medicine, such as the Eclectic and Thompsonian physicians, as well as older, European humoral-based theories of illness and therapeutics, which were no longer being taught by 1920. Scientific medicine rapidly achieved a near-monopoly of cultural authority in the Progressive Era, along with practical control over medical resources in the United States. Legislation outlawing midwifery, for example, was brought about through American Medical Association campaigns that condemned female competitors as ignorant quacks and a public health menace, while simultaneously denying women access to modern medical education on the basis of gender. Leavitt 1986.

7 In 1910, the Carnegie Foundation had commissioned educator Abraham Flexner to prepare a report on the state of medical education in the United States. Up to then, medical schools had been profit-oriented trade schools. Flexner critiqued existing medical education as a lax system of apprenticeship, and advocated a demanding 'system' of medical education in urban, university-affiliated research hospitals based on a German model that emphasised laboratory research in basic sciences along with hands-on clinical training. The first example of this in the United States was Johns Hopkins. Hopkins demanded doctors simultaneously be trained as researchers in basic science, care for patients and engage in bedside teaching. The Rockefeller Foundation then invested in the vision of medical education outlined in the Flexner report, bringing about an organisational revolution in American medicine. Flexner himself was a member of the Rockefeller Foundation's Second China Commission (along with Dr William Welch and Frederick Gates) to assess the potential for fostering a modern medical system along similar lines in China. Ferguson 1970, p. 25.

8 In the late nineteenth century, a new generation of practitioners who regarded themselves as 'scientific', critiqued humoral-based medicine as unsystematic or 'empirical'. These critiques were easily recycled for use against Chinese medicine, which appeared as a unified entity only to foreigners who knew too little about it to distinguish Chinese natural science from what they regarded as 'superstition'.
many Americans, seemed to justify transparently attempts to establish a medical ‘system’ in the first place. Professional associations and medical schools promoted standardised procedures as limiting risks for patients and—in theory at least—they appeared to reflect a widely valued ideal of social equality. Standardised protocols, for example, seemed to promise all patients equally high-quality treatment and corresponded to a certain bureaucratic ideal of egalitarian etiquette. In the realm of things social, standardisation appeared to guarantee objectivity and equality; one might go so far as to say that for Americans, on a broader trajectory toward a growing sensitivity to social inequalities, it suggested the impartial justice of the machine. At the same time, rather paradoxically, modern hospitals reproduced social hierarchies characteristic of the societies that birthed them. (Like other US hospitals, PUMC routinely provided three classes of accommodations at different prices.) Still, as with the extension of citizenship rights in the United States, which (at least in some regards) tended to raise the status of previously excluded social groups, the ‘universal patiethood’ implied by modern medical standards aimed

9 While PUMC administrators were not willing to compromise in pursuit of the ‘highest possible scientific standards’, in the US more generally professional standards actually operated by attempting to enforce minimum standards of treatment below which no doctor or institution should fail.

This ideal, that bureaucracy should treat people impartially, like the custom of waiting in lines, suggests each person has a right to goods and services offered, if they are simply willing to wait (and have sufficient cash—which they implicitly don’t need is special connections). It seems, then, queuing up implies a particular notion of (distributive) justice or the expectation of some type of impartiality or equality. For how long have westerners been waiting in lines? Leung and Renshaw have noted that as early as the Sung dynasty there were Chinese benevolent institutions offering free medical care to the poor. Missionaries operating on the principal ‘first come, first served’, adopted the Chinese practice of giving each patient a bamboo slip with a number to indicate the sequence in which they could see the doctor. Whether or not there was a Chinese practice of waiting in lines before Westerners came along, taking numbers in a waiting room served the same purpose as waiting in lines, and ought not perhaps be regarded as a distinctively ‘modern’ behaviour. Nonetheless, one thing is certain: the meaning and rationale for such a practice could differ greatly according to context. To an extent waiting in lines implied a notion of justice to Americans. It reflected the manner in which American institutions frequently ensured social equality in a formalistic sense that ignored obvious economic inequalities, and sometimes implied that acquired wealth was the result of virtuous behaviour.

10 According to one social worker’s retrospective account, second and first class accommodations were for da2 guan1 gu1 ren2 ‘nobility and officials’ (a phrase meaning the rich or the upper class). Zhang Zhong Tang 1987, p. 369.
at allaying the concerns of paying, upper-class patients. One adaptation necessary to satisfy this class of patients in China involved institutional flexibility about negotiating prices. The tensions that resulted in the course of such compromise reveal how PUMC, as an American model of administrative modernity and scientific organisation, was linked to—and diverged from—consumer practices and concepts of distributive justice rooted in American society’s historical evolution.\(^\text{11}\)

The cases that form the basis of this paper all involve women diagnosed with cancer, each of who bargained to avoid paying full price for radiation while adopting a selective approach to PUMC’s standardised treatment regimens.\(^\text{12}\) Patients pursuing modern medi-

\(^{11}\) PUMC was planned and established in the first decades of the twentieth century, when the factory production line was coming to symbolise the efficiency and rationality associated with modernity. Since the Progressive Era, new patterns of expanding bureaucratic and human organisation effectively functioned as technologies, by implication making social planning possible on a scale previously unimaginable. In the United States, an expanding class of technocrats, managers, administrators and engineers were designing a wide array of multi-tiered institutions characterised by explicit standards and procedures, intended to operate as great social machines. These new patterns of organisational complexity appeared effective when applied to public health, fire departments, educational institutions and corporations. Still, few institutions compared to hospitals in the value placed on a strict, near-military style of discipline and hierarchy.

Some Western observers—including one medical missionary responding to an early Rockefeller Foundation (China Medical Board) questionnaire—perceived the difficulty of achieving effective large-scale organisation in China as due to a ‘morass of ignorance, centuries old superstition and illiteracy’. Framing differences he encountered as a lack, one missionary doctor expressed the view that moral failings and a lack of large scale corporate organisation among Chinese limited potential enterprises there, whether for public health or profit. ‘The variance between the Chinese methods of conducting large and small businesses’, he stridently asserted, ‘has been a fact observed and acknowledged by both foreign and native opinion, without exception; in small individual business the Chinese are in a sphere peculiarly adapted to their ability for success, but there has not yet been a successful attempt of purely Chinese character to conduct business on a large scale as involved in running modern mines, railroads or other corporations that has been a success. The reasons for this are the centuries old habits of nepotism, “face”, invariable political meddling and the utter lack of moral rectitude in the big business corporations.’ Collection: Rockefeller Foundation Archives, series: Rockefeller Boards, sub-series: CMB, box 11, folder 88 Synopsis—Fundamental purpose of the IHB Collection: IHB, Record Group 5.2, Series: Subseries: Box 55, folder 344, p. 6.

\(^{12}\) This could signal that there was generally greater acceptance of surgery than of radiation. Patients quickly learned that radiation was both uncomfortable and repetitive, while surgery often took place only once. Though particular strengths of Western medicine in areas such as surgery were widely appreciated in China, in the early twentieth century, much of scientific medicine was not necessarily more effective than ‘traditional’ approaches to common, chronic ailments, such as tuberculosis. Even so, patients’ rights to make medical decisions and choose among multiple options appeared to be at stake in their negotiations with social workers.
ical care navigated a complicated mix of consumer cultures coexisting in a state of flux. At least some of the time, imported goods brought with them the notion of standardised prices. Norms from a foreign market culture (one that posited itself as inevitable, as transparently neutral, as the expression of universal laws of economics) came into contact with an older style of consumption, one exemplified by temple markets in which haggling was common practice. The case of Liu Pei-yi, a young Manchu widow, illustrates a pattern of bargaining or consumer etiquette frequently encountered by social workers at PUMC.  

### A young widow bargains for her life: asymmetric bargaining and the strategic bluff

Diagnosed with breast cancer, Liu Pei-yi agreed to admission to the hospital for radiation and surgery. Though a bed was available, she just as quickly changed her mind, saying she could not afford the cost of radiation treatment. Many more days passed. Still balking at the price, on 15 November 1937, social workers sent her to the hospital Admitting Office (AO) to determine her capacity to pay. They warned the Admitting Officer in advance that Liu had given them an ultimatum, offering to pay $2 for x-ray treatment, ‘otherwise (she) would not take the x-ray at all’. When consulted on the matter, her physician, Dr Zitu (Szutu), promptly parried with an ultimatum of his own; ‘... pt should pay at least $10 for x-ray, otherwise send her away’, he instructed.

With no other institution like PUMC in China, most patients had little to which they might compare it in order to recognise a fair price. Given the gap between the American and Chinese economies at the time, and the challenges to transporting equipment and personnel to China, the cost of treatment at PUMC appeared exorbitant. Servants and coolies housed and fed small families for an entire month for the price of a single X-ray treatment ($10 Mexican silver). And

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13 PUMC patient # 24765.
14 With the possible exception of Johns Hopkins medical school in Shanghai.
15 At PUMC as at many other foreign institutions prices were calculated in terms of Mexican silver dollars, which they regarded as a more stable currency in which to evaluate costs.
standard protocol for cancer dictated that radiation treatments were to be repeated multiple times. The vast majority of people were simply unable to afford such extravagant prices, even if they believed their lives did depend on it. But bargaining could mediate and soften the inherent asymmetry between social workers and doctors, who exercised control over medical resources, and patients under pressure to take risks in order to save their own lives.

Moreover, the institution’s association with foreigners undoubtedly shaped patients’ approaches to PUMC in a variety of ways. On one hand, word of financial assistance and fee reductions dispensed by the Social Service fit with expectations of charity fostered by missionary hospitals. On the other hand, over a century of imperialism had earned foreigners a reputation for willingness and skill at gaining unfair advantage in pursuit of trade, and this too may have played a part in patients’ inclination to impose bargaining over the price of treatment on the American-style hospital. The combination of resentment and admiration (or envy) towards foreign power might easily extend to hospital authority and its control over resources.

The next day, the young widow’s ‘aunt’ offered to pay $5, at most, per X-ray treatment on her behalf, but ‘(t)he bargaining has no result

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16 Rockefeller planners hoped that providing financial assistance to some patients, though it could never meet the need for care, might achieve several goals. First, the hospital needed access to patients as ‘clinical material’ for research and instruction. Social workers arranged the provision of free care to patients whose conditions doctors deemed ‘interesting’. (For visiting and teaching faculty from Europe and the United States, a stint at PUMC offered valuable opportunities to see ‘exotic’ diseases in advanced stages of development.) But free treatment or reduced fees might also convince the Chinese public of Rockefeller’s good will, allaying some suspicion of all manner of foreign presence in China. While there was suspicion of the ‘Oil King’s’ motives, few would have suspected that not only did the hospital provide charity, but like many missionary institutions, it never produced a profit during the decades prior to its nationalisation when it was supported by the Rockefeller Foundation. Year after year, even throughout the Great Depression, it ran millions of dollars over budget, inciting controversy at the Foundation at a time when many American institutions were suddenly failing. The Foundation had hoped that the Nationalist government or other Chinese sources would eventually contribute to PUMC’s support, making it a fully Chinese institution, yet this support never materialised. Through the 1930s, public health programmes already under control of city government—such as the city-run infectious disease hospitals and the Sanitation Bureau (wei sheng bu)—were chronically under-funded. The costs of war and lack of government revenue also meant many of the city’s government officials and police officers did not receive their salaries for periods of time.

17 Whether bargaining is to be seen as a defensive or an aggressive posture remains open to debate.
and pt went away’, the social worker recorded, adding coolly, ‘She threatened to go home [to] Tientsin in a few days’. Such ultimatums and threats evidently yielded no result. The family made four offers, breaking off negotiations three times, before reaching agreement on a final price of twenty dollars total for a course of treatment. Medical missionaries had observed that in serious illness, friends or family of patients sometimes pooled money to hire the most expensive doctor they could afford. One speculated that perhaps this was to assure themselves that if the person did not get better, they had nonetheless provided the ‘best medicine that money can buy’. Sending someone to the expensive American hospital could be a gesture of personal loyalty or feeling toward a patient, or a public show of living up to familial obligations. As a childless widow remaining among in-laws, Liu Pei-yi had agreed to lead a life among women, and seemed to have at least some genuine advocates in the extended family.

Liu Pei-yi and her female kin, it appears, had attempted a classic marketplace bargaining ploy: to get a good price, one had to be willing to walk away without buying. It was an awkward situation with uniquely high stakes, however, since if they believed the hospital’s prognosis, Liu’s life hung in the balance; she could walk away only by risking her own death. Unlike bargaining in a marketplace demonstrating readiness to walk away in Liu’s situation failed to conceal the fundamental asymmetry of their negotiating positions. In her chart, social workers had concluded that her family could pay more than they had offered. They apparently judged that Liu understood her need for treatment was more urgent than their obligation to provide it—after all, there was no shortage of patients.

Liu’s rapid reversals and reliance on intermediaries suggest real distress, and she may have felt the hospital was exploiting her position. Confucian-style doctors informed patients or caregivers of the likelihood of impending death for quite a different purpose than physicians at PUMC; they declared cases ‘incurable’ as a way of declining

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18 Liu Pei-yi, case record entry, 15 November 1937 (Tientsin = Tianjin).
20 This is one instance where hospital social workers evidently did not take umbrage at the women for haggling. Perhaps it was simply that everyone knew the formerly wealthy and privileged Manchus had fallen on hard times. But bargaining was a behaviour they had seen far too often to be at all surprised. On the social workers’ scale of values, bluffing still fell short of a lie. Somewhat ironically, the bluff concealed the family’s conviction that Liu was in desperate need of hospital treatment to save her life.
to treat patients, often to avoid being blamed for their death. In contrast, given a diagnosis of cancer, PUMC presented patients with a grim prognosis while offering an exorbitantly priced chance at a cure. For some, it was a high stakes gamble. The pressure such situations generated seemed to be felt most acutely by people who had something to lose; patients of some means who came intending to pay, yet found themselves confronting the limits of their resources.  

In Beijing, a city where street markets remained a form of popular entertainment, negotiating skill as well as degrees of relationship still determined the price of goods and services. Profit ratios were negotiated during each encounter, with prices varying from person to person for the same thing, depending on the nature of the relationship the buyer established with the seller. In contrast to the (superficially) impartial etiquette of newer stores, one buyer was emphatically not

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21 Michelle Renshaw's insightful overview of the history of payment practices for medical services in China suggests that PUMC's expectation of paying patients and its concern to reserve free care for only the truly destitute followed precedents set by American missionary institutions in China, where—as at PUMC—the vast majority of patients were treated as outpatients through dispensaries or clinics. Renshaw illuminates much about how and why medical missionaries adapted their payment practices in a Chinese context. She found that in China, medical missionaries had difficulty supporting the costs of a free dispensary, which in the United States would have been funded by fees from private patients. Though missionary hospitals in China did accept paying private patients, they did not see enough patients of this sort to cover the costs of hospital operations or provision of free care. Renshaw highlights a debate conducted in the pages of the China Medical Missionary Journal over whether and how to charge fees as a solution to this problem. Concerns that charity would result in 'pauperization', she observes, were as common among missionaries in China as in the United States. Although some missionaries doubted that charging fees was compatible with the desire to demonstrate Christian charity, others felt their generosity abused by patients who thought only in terms of their own interests, like 'the fish who takes the bait and gets away.' (Renshaw 2005, p. 110). Some noted that patients who were well-off expected to pay and some missionaries accepted payment delivered as red envelopes (hong bao). By the twentieth century, most American missionary hospitals in China had settled upon the practice of charging ordinary patients minimal fees for virtually all services, including dispensary visits, hospital stays, particular procedures, medicine and food. They charged higher fees for private rooms, and to patients who did not want to wait their turn, or who wanted to be seen outside of regular hours. (Renshaw 2005, p. 108) Coming from a prosperous treaty port that boasted several foreign hospitals in the 1930s, it seems somewhat unlikely that Liu's well-to-do family would have mistakenly anticipated the lower fees associated with missionary clinics and hospitals that lacked extensive surgical facilities and costly X-ray machines. In the early twenty-first century, with economic reform and increasing privatization of medical services, payment in hong bao has been making a comeback in hospitals as a way of supplementing the low salaries set for doctors by the state.

22 Dong 2003.
like another. Geographic proximity mattered; neighbours paid less than people from other towns; strangers speaking the same dialect paid less than those speaking unfamiliar ones. The further the social or geographic distance between buyer and seller, the weaker the relationship, and the higher the price.\footnote{When approaching a large-scale institution bringing people together from distant places, expectation of fair prices was probably low, while the possibilities for presenting oneself falsely to get a better deal or receive charity were greatly magnified. And at a foreign institution, the social consequences of getting caught doing so were negligible. Rural people without connections in the city could expect few favours from urbanites, who gave no discounts to people from far away with whom they anticipated no mutually beneficial, long-term relationship.} How people portrayed themselves during small talk, how well they related, had material consequences. PUMC patients’ use of bargaining to negotiate prices (in contrast to their counterparts at hospitals in the US), suggests that for them, a hospital was not fundamentally different from other types of consumer contexts, one that demanded a wholly different etiquette or expectations about communication.\footnote{In so-called ‘traditional’ medical contexts, prices could be negotiated directly between the practitioner and patient or caregivers. Patients and practitioners living in the same community would often have had some degree of mutual acquaintance. Under such circumstances there would have been fewer questions about a person’s real capacity to pay. At PUMC, patients negotiated with social workers, who put a more human face on an otherwise vast, confusing institution.}

\textbf{Gendered cultures of consumption in Republican Beijing}

The style of haggling over the price of treatment Liu Pei-yi performed in the Social Service Department of PUMC reflected a mode of consumer behaviour associated with an older economy, one where periodic temple markets (generally on the outskirts of the city) were the primary locus of exchange, and where women were often a majority of the consumers.\footnote{During the Qing dynasty, according to Susan Naquin, nearly everyone in Beijing relied on temple markets held outdoors at regular intervals according to the seasons and holidays marked by the lunar calendar. Such markets provided reputable women with the otherwise rare experience of outdoor entertainment and an opportunity to exercise legitimate social agency outside the family courtyard. Though it was nearly impossible for most women (apart from a small number of educated professionals or prostitutes) to earn sufficient cash to support themselves—or anyone else—in families, women usually managed household finances and were often responsible for shopping, as they were more familiar with the daily work of the household and the items it required. In the temple markets lower middle-class consumers, particularly housewives, were highly visible, but people of all classes could} Prices at these ‘old style’ markets were

*STILL ARGUING OVER COST*
determined by haggling. In contrast to modern stores downtown, these markets had an informal atmosphere, and women purchasing for their households could freely handle, pick and choose items, as well as bargain over prices. PUMC was located downtown, near the foreign legation and only a block from Wangfujing, the most prestigious of the new commercial districts drawing wealthy consumers away from the dusty crowding of the temple markets.

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observe each other's negotiations with vendors. (Naquin 2000) According to Madeleine Dong, prices at temple markets were not necessarily lower than in the department stores that began to appear in 'permanent markets' downtown, but they were situated in places where goods produced by rural cottage industries could be exchanged for urban dwellers' cash, and were more accessible to the lower middle class women who generally resided 'in the corners of the city'. (Dong 2003)

26 On the other hand, during the Qing, bargaining in street markets contrasted with the ('masculine?') commercial ethos and etiquette of luxury stores that catered to a male clientele of government officials. Such stores promised authentic goods at honest prices, and idealized 'business practices that downplayed business'. In such places it would be a humiliation for a man to argue over small amounts of money. Patients' bargaining styles therefore were strongly influenced by a combination of gender and class. (It seems possible that class distinctions in consumer etiquette among men were more conspicuous than among women.) Not only were men who came to PUMC less likely than women to be referred for social work in the first place, they also appear to have engaged less frequently in the sort of overt bargaining behaviour demonstrated by Liu Pei-yi than women did.

Madeleine Dong describes this style of consumption as follows: 'Old-style shops that had served Qing officials offered no discounts or sales. Such practices would imply that its customers cared about saving a small amount of money or, in other words, about gaining a petty advantage—an attitude that did not befit an official. Both merchants and customers emphasised the authenticity of the merchandise and honest prices. The consumer's social status was already established, not determined by what they purchased. Overt concern with the monetary aspects of the transaction was avoided and in fact was seen as a threat to the status quo. This translated into business practices that downplayed business: there were no promotions, no sales, no tricks. In the words of the literary critic Zhao Yuan, it was the non-professionalism in commerce that was appreciated. An ideal merchant was one who did not behave like a businessman. The Qian Gate area shops that had epitomized luxury in the Qing essentially borrowed their prestige from their official patrons, much as the moon radiates the brilliance of the sun.' (Dong 2003, p. 161)

27 Shops on Wangfujing catered to wealthy Chinese and residents of the nearby Foreign Legation districts, offering goods that were either imported or mass-produced by a handful of large factories and handicraft workshops in Beijing. Modern shopping districts allowed newly prosperous Beijing residents to pursue forms of status mobility and competition not previously possible, based on their purchasing power alone, as opposed to moral reputation or official standing. 'At the highest level, the most famous shops at Wangfujing confirmed their customers' social status in a manner reminiscent of the Qian Gate shops of the Qing. The prices in these establishments, like the ceremonial gates of the palace, were conspicuously high and exclusive—consumers able to pay them were never merely anonymous. And in certain cases money was not enough. A rich prostitute wearing furs might still be refused service at one of these stores. The most famous stores in Wangfujing served foreign
Modernity as an imported, ‘impersonal’ culture of consumption was associated with new ‘permanent’ shopping districts (outside Qian Gate, at Xi Si and Wangfujing) in contrast to the older, more interactive street-market etiquette. Where fixed prices were the rule, as at Wangfujing, everyone—regardless of status or income—was expected to accept them with the equanimity of a gentleman, as if $5 held the same meaning for a peasant or rickshaw puller as for a merchant or official. Imported consumer etiquette likewise demanded impartial courtesy from clerks, a ‘standardised’ approach to customers. Clerks suddenly found themselves obliged to give away small gifts and chat with customers, even ‘lowly soldiers, janitors, and waitresses’.\(^{28}\)

Like the shops on Wangfujing, PUMC instructed hospital staff to adopt a similar type of modern etiquette.\(^{29}\) Among patients, it was cosmopolitan, wealthier women—not farmers’ wives—who bargained with the greatest impunity, incorporating etiquette associated with temple markets into modern consumer behaviour.

PUMC promoted an ideal of egalitarian etiquette that American bureaucracies aspired to, one that—on the surface—showed no regard for class distinctions and did not discriminate among patients or

diplomats, missionaries, professors, doctors at the Union and German Hospitals, wealthy merchants, and the children of wealthy families.’ (Dong 2003, p. 162)

The new shopping districts with their impersonal etiquette were ‘egalitarian’ only in the sense that any person who appeared to have some money was entitled to shop there, and to enjoy the display of status that was part of doing so. Expensive stores routinely kept peasants out. (Dong 2003, p. 161) Thus the pattern of shopping that emerged as ‘modern’ was a more socially stratified, class-segregated one than that of the temple markets, which were attended even by palace residents. ‘Consumption both broke down and confirmed social status.’ (Dong 2003, p. 171)

Madeleine Dong describes the transition to a ‘segregated market pattern’ in the Republican era this way: ‘In Qing Beijing, almost everyone depended on temple markets. The Qian Gate district, the most prestigious permanent market, though extremely important, nowhere near supplanted temple markets, which were attended even by people from the palace. But in Republican Beijing, the gap between commercial centers like Wangfujing and temple markets like Huguosi grew very wide. Different types of consumption occurred in these two places. . . . A new, more rigidly stratified hierarchy of markets developed. . . . Wangfujing did not sell the sort of homespun daily necessities and peasant handicrafts found at temple markets.’ (Dong 2003, pp. 169–170)

\(^{28}\) Dong 2003, pp. 160–161, summarising the point of view of Xin, an elderly clerk who tries to adapt to working at one of the glamorous modern stores in Lao She’s story, ‘An Old Shop’.

\(^{29}\) PUMC social workers were allowed unique flexibility to mediate financial relationships between Chinese patients and the hospital’s American-style bureaucracy. In the hands of social workers, the rules of exchange could be subject to compromise in ways that other aspects of medical practice could not.
customers. In the American context, this reflected a mutually reinforcing relationship between consumer etiquette and concepts of citizenship based on notions of abstract, universal equality. The House Officer's Handbook, for example, instructed resident physicians, to '(b)e considerate and thoughtful throughout the hospital. Remember that patients and nurses and orderlies and coolies and the entire hospital staff are human and entitled to the same sort of consideration and cooperation that you yourself desire to receive.' This bureaucratic etiquette mediated the hospital's strict professional hierarchy and softened the social gap between hospital staff and patients. At the same time, it imposed expectations about how patients should present themselves to staff in a healthcare bureaucracy.

In theory, what made medical practice at PUMC 'scientific' was a pervasive, if vague, methodology for arriving at truth. Practices for generating evidence for analysis pervaded disparate aspects of hospital activity. This epistemology tended to assume the true nature of things was to be found in hidden structures beneath (sometimes deceptive) surface appearances, and that truth emerged through a confrontation of facts and hypotheses in an observable public realm. In the American context, widespread use had stretched the meaning of the word 'scientific' to apply to a seemingly unlimited range of things, all claiming greater legitimacy and truth value by association with the word. Hospital administration, social work, psychiatry and

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30 Handbook for House Officers 1929, p. 1. Moreover, the Handbook instructed doctors to behave the same way in the Outpatient Department (which treated a different class of patients) as they would in the Hospital, urging that they 'be prompt', because 'patients are often very ill and have been waiting long for your arrival. Try to see them as early as possible, and even though they are beggars, be kind and courteous and considerate.' Handbook for House Officers 1929, p. 5.

This etiquette facilitated patient education through the hospital experience. The House Officer's handbook reminded doctors-in-training that many patients were unfamiliar with western medicine and hospitals: 'Become acquainted with the patients on the wards quickly and do all that you can to keep up a good morale among them,' it advised. 'Remember that many of them have never been inside a hospital and know nothing of western medicine. Treat them kindly, listening to their complaints and doing what you can to make them comfortable and content. Always take time to explain. Explain both to the patient and his family what the nature of his disease is and what you hope to do, or have already done about it. Pictures are easily understood. Draw diagrams to explain a hernia, a carcinoma of the esophagus, an hypertrophies prostate, or a dislocated joint. Never tell a patient, 'ni bie guan'. (i.e., 'It's not your business.') Never have a patient sign his release for lack of proper attention; this occurs less frequently now than ever before, and the house-officer should keep his record clean in this regard.' Handbook for House Officers 1929, p. 1.
a host of other service-oriented professions all proclaimed themselves ‘scientific,’ by which they generally meant little more than systematic analysis and standardisation of procedures. Modern organisational ‘technologies’ such as systematic data-collection and record-keeping were an essential aspect of PUMC’s distinctive brand of clinical practice and hospital administration.

Beijing’s pluralistic medical culture posed particular challenges to carrying out treatment at PUMC. Patients did not assume that different styles of medicine might be mutually contradictory or could not be used at the same time. Patients used other, local forms of therapy before going to the hospital, simultaneously with hospital treatments, and after abandoning hospital medicine. Even if PUMC doctors assumed the primacy of one medical worldview over another—that the truth of the body was to be found under a microscope—in Beijing, no single medical philosophy or practice enjoyed a monopoly over all others parallel to that which scientific medicine had attained in American cities. The professional paradigms through which social workers and clinical staff viewed patients implicitly challenged the continuing validity of local forms of knowledge and experience when confronting scientific authority. Although hospital employees may have been convinced the medical worldview that provided a basis for therapeutic action at PUMC was the fundamental truth, how they saw things did not necessarily matter beyond hospital walls.

Textually-based Confucian medicine, the most prestigious type of Chinese medicine existed alongside an array of local healers that included herbalists, midwives, bone setters, acupuncturists, shamans, and temples devoted to deities specialising in particular diseases, birth or longevity. Not unlike some of their later Western critics, Confucian-style physicians, like the great philosopher Zhu Xi (1130–1200), derided the competition, referring to them as ‘sorcerer physicians’ (wu-yi) who ‘beat the drums and perform dances, who recite prayers and prepare sacrifices (to ward off) suffering and diseases’, and accusing them of ‘replacing medicine with magic’.31 In their appeals to reason and the evidence of experience, the rhetoric of Confucian physicians resembled that employed by proponents of scientific medicine in the west, who were, however, more organised and successful at putting their competitors out of practice. But the contrasts

31 Unschuld 1979, pp. 40–41.
between rational and supernatural approaches among Chinese medical practices were apparently invisible to a majority of Western onlookers, who were inclined to regard all Chinese medicine as 'superstition' in contrast to 'science'. With the exception of the pharmacology department's chief, professional demands left PUMC's doctors little time for extensive research into local medical practices. In patients' charts, all varieties of local practitioners, including the literate, Confucian-style physicians would be referred to as 'Old Style doctors' or, sometimes, 'native doctors' without distinction. (Uncertainty about how to translate names for such practitioners into English, where equivalents often did not exist, may have been part of the reason.) At the same time, due to the influence of foreign institutions and the power of the scientific paradigm, local medical practices were, through their own efforts, coming to be redefined as 'traditional' (rather than 'modern') and 'Chinese' (as opposed to universal)—in contrast with scientific medicine.

Obscured by apparently neutral professional vocabularies, old questions about science, superstition and truth remained implicit in the politics of encounters between hospital staff and patients. As the proponent of a hegemonic universalism, the notion of a single, unitary, fundamental truth underlay PUMC's research epistemology. Applied equally to diagnosis as to questions about patient finances, the willingness to confront directly people's crafted life stories with evidence gathered from 'investigations' of their lives produced tensions in patient-staff relations that became most visible when a patient's ability to pay was in question.32

Having themselves grown up in Chinese families, PUMC social

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32 Social Service Chief Ida Pruitt articulated a philosophy of social work consonant with PUMC's scientific ethos in her 1929 annual report, stressing that social work was 'modern,' 'logical' and based on factual investigation of problems: 'Medical social service is the logical outgrowth of the modern attitude of mind toward medicine; that all causes leading to disability must be known before diagnosis is made, that treatment if it is to be more than palliative only, must deal with and eradicate causes that a doctor's responsibility toward a patient is not finished until that patient is again functioning as normally as possible as a member of society, and that cause and cure are often to be found in the personality of the patient, and in his environment. Therefore, in social service the collection of social facts and the weighing of them are very important preliminaries to any action, and the studying of causes and the relieving of distress must both be done as in any other branch of medicine.' This reductionist-sounding approach, while intended to satisfy the demands of Foundation Trustees in New York, was not reflective about ways that cultural bias started in the framing of problems. Pruitt 1930, p. 4.
workers were generally familiar with 'traditional' medical practices. In encounters with patients, however, social workers saw themselves as representing practices they deemed 'scientific'. One of the most common social work diagnoses listed on patient charts was simply 'ignorance'. Cross-cultural insight and respect for local ways of doing things, it seemed, had limits. It was the social workers' institutional duty to persuade reluctant patients to complete hospital therapies, an activity known as 'explanation', through which patients should come to recognise for themselves the truth of the matter. This stance, of course, started and ended with the presumption that hospital staff possessed a superior relation to truth than their culture-bound clients.

Still, in other regards, social workers possessed a unique mandate to adapt institutional practices to the local context. Even as they accommodated patients' communication styles, social workers began to impose a new set of bureaucratic expectations on patients through their power to grant or deny access to high cost modern medical care. In the process of educating patients about scientific medicine, social workers were also teaching them how to become patients of scientific medicine.33

Social workers also had to ascertain which patients were telling the truth when it appeared 'financial insufficiency' posed an insurmountable barrier to treatment. When social workers arrived unannounced and found a patient not home, they did not hesitate to peer through windows and question neighbours or servants, generating evidence—one could call it 'scientific snooping'—against which they would weigh patients' own accounts of their circumstances. Social workers used evidence they gathered investigating patients' circumstances to compel more truthful self-disclosures, trust or deference toward scientific and institutional authority. An intrinsic aspect of bargaining—persuasive self-representation, including artfully selective indications about one's financial and social circumstances—was intensified (and challenged) by hospital rituals requiring patients

33 Pruitt wrote: 'A social worker must constantly interpret the hospital, the doctors and modern ideas to the patients. She must constantly seek for ways to help the patients to bridge over from the old mode of thinking to the new. She must constantly take time to go over and over with the patients the instructions the doctors have given, until these instructions become a part of the patient's thinking. She must think of ways to give to the patients' confidence in the hospital and doctors. All this must be done in a more or less degree to every patient seen, and this type of service is not always easy to list in a table.' Pruitt 1931, p. 68.
narrate their life circumstances explicitly and repeatedly for the record. Patients recounted their personal histories in a manner intended to elicit help. Tensions emerged when savvy consumers encountered institutional pressure for truth-telling and financial self-disclosure from social workers, as backed up by such ‘modern’ evidence gathering techniques.

Questions of etiquette and morality figured in social workers’ decision-making; they were the nexus in a system of triage that determined the distribution of PUMC’s resources. They weighed competing institutional priorities, starting with a doctor’s request for a particular patient on account of her value for medical instruction or research, alongside other considerations that included the severity of a patient’s condition, treatability, financial need, and—more intangibly—character and bearing.34 In one annual report, Pruitt defended her department’s ‘scientific’ or modern credentials through assertions of ‘efficiency’ that amounted to making good investments based on essentially moral evaluations of patients.35 She identified ‘character insufficients’, ‘drifters’ and ‘wasters’ who required extended assistance as a bad investment; chronic cases such as these strained the resources of the institution.36 In the process of distributing assistance, social workers imposed certain expectations (about self-disclosure, honesty, or the dangers of dependence, for example) shaping the ways that patients interacted with hospital staff.37 The following instance of a social work relationship gone wrong reveals conflicting sensibilities about truthfulness and self-presentation in the role of the modern patient.

34 Medical social service at PUMC was never entirely secure. Early on questions arose about Pruitt’s organisational skills, and later the China Medical Board asked whether social service was serving purposes of general charity that should not be associated with a hospital. Pruitt 1930, p. 3.

35 ‘The one class for whom we make no effort to do any thing because there are no agencies to handle them, nor are we equipped for the long and probably hopeless task of caring for them, are the character insufficients, the drifters and the wasters. They seem to be and rightly [are], the last class to which the public turns in its care of others,’ Pruitt wrote. Ida Pruitt, ‘Annual Report from 1928’: (record group IV, series 2 B 9 box 142, folder 1032, medical social service at PUMC).

36 American institutions in China accepted patients with venereal diseases and opium addiction, categories of patients who were, for moral reasons, routinely excluded by hospitals in the United States, along with those who had contagious diseases. Renshaw 2005, pp. 148–9.

37 Social workers’ control over medical resources offered patients a powerful incentive to defer, or to try not to offend the sensibilities of social workers. By appearing to accept the hospital’s authority a patient could remain worthy of assistance and retain access to hospital resources.
Truthfulness and trust: Wang Feng-ling, strategic story-telling and the expectation of self-disclosure

Wang Feng-ling, a 55 year old woman who arrived at PUMC in October of 1937, narrated her circumstances in a way that galvanised social workers’ sense of mission (and desire to win her trust); yet she ultimately failed to make her case for assistance. As the social worker began to take her history, Wang immediately confessed that she had heard rumours (from people ‘outside the hospital’, the disconcerted worker noted) that the hospital ‘takes out people’s eyes or heart’. Beginning her interview in this unlikely manner seems to have briefly reversed the usual power dynamic, putting the social worker, as the institution’s representative, at something of a disadvantage. Wang had implied the foreign hospital’s reputation was suspect, suggesting it was they who would have to win her trust, rather than she who would have to prove her worthiness to receive assistance. The worker reported: ‘She hesitated about admission at first. Yet she is so frank. She told worker that she is willing to try any treatment.’ Here, surely, was a perfect opportunity to convert a worthy patient to a subject of scientific medicine.

Patients narrating their histories to social workers and doctors—not unlike parties to bargaining—presented themselves in ways they hoped might make a useful impression. Although the social worker

38 PUMC patient # 46715.
39 Regarding such perceptions of missionaries in the mid nineteenth century, Paul Cohen wrote, ‘while all other heterodox sects made use of their religions in order to acquire wealth, the barbarians alone used wealth in order to spread their religion. . . . How did the Catholics get their seemingly unlimited supply of money? . . . In part they made it by means of an alchemical process which was to achieve farflung notoriety in later anti-Christian writings. The procedure was as follows. When a Chinese convert was on the verge of death, the Catholic priest came and, covering the convert’s head with a piece of cloth, pretended to pronounce the absolution. In reality, however, he secretly made off with the eyes of the dying man. These were then mixed with lead and mercury to create silver, none of the original quantity of lead being depleted. The eyes of the barbarians of course were useless in this technique—hence the motive for seducing so many Chinese into the foreign religion.’ Cohen 1963, p. 31. Such rumours of organ removal might have been sparked by the practice of dissection, which was widely disapproved of as desecration of the body given by one’s parents.
40 At PUMC, men’s and women’s strategies differed for narrating their life stories as part of the case history, reflecting differing expectations about what hospital staff might feel toward them. While women frequently emphasised need to arouse sympathy, men often narrated their stories in ways that emphasised their social value to others, in order to present themselves as worthy.
who took her history considered Wang Feng-ling ‘illiterate’, Wang had told her she ‘kept books’ for her husband’s restaurant in the bustling commercial district just outside Qian Gate. Simultaneously stoic and pitiful, Wang informed the worker that before she’d left, she put their affairs in order so her husband could manage without her, since she wasn’t certain when, or if, she would return.

As the social worker asked Mrs Wang questions about her past, an extraordinary story, consisting of a string of adversities and abrupt reversals of fortune unfolded. Wang Feng-ling, the social worker learned, had been married three times. At sixteen, she had been married to a farmer she described as ‘lazy and fond of gambling’. He sold her at age 33 to another man for $40. Of eleven pregnancies she had not one living child, as he’d sold their only son at the same time, and she did not know where to find him. She lived happily with her second husband, she reported, but after thirteen years together, he passed away. Having never regarded their marriage as a proper one, after his death, the family divorced her, leaving her a widow at age forty-six with no means of support. Determined to save herself from this fate, she brought a lawsuit against her in-laws, asserting her right of dependence and protesting their attempts ‘to compel her out’ of the family. Predictably, the judge sided with the man’s family against the isolated woman’s claim. When this happened, she left her home in Shandong province in the company of a friend. In Beijing she was introduced to her present husband. ‘She therefore married again’, the social worker reported matter-of-factly. ‘She states that her husband is very nice and good to her.’ It had been a long road, and Wang Feng-ling, it seems, considered her present situation very satisfactory.

Wang had, essentially, experienced abandonment by two families in succession, a terrible misfortune at a time when there were few ways for single women to survive outside of families. Such events throw one on the mercy of others. Over the course of her life, Wang no doubt had experience telling her story in different situations, with the hope

41 PUMC patient #46715.
42 The social worker was quite impressed, recording that Mrs Wang had put their affairs in order so that ‘in case she will die in hospital there won’t be anything not clear (to) cause her husband trouble’.
43 Chinese family law permitted the family of a deceased man to divorce his wife, thus ending all obligations to support her.
of arousing sympathy or outrage to inspire assistance. Recounting her dramatic life took some time and certainly made Wang a memorable individual in the eyes of the social worker, who seemed determined to help her. Wang Feng-ling’s account of her life appealed to cosmopolitan critiques of the position of women in Confucian society.

Although its association with modernity and power attracted some patients to scientific medicine, heroic measures and contact with foreigners frightened others off. What was it like for a patient like Wang Feng-ling who had never been to a hospital and was accustomed to individual relationships with a particular doctor, to be treated by a rotating team of people in white coats? How readily did such patients distinguish doctors, nurses and social workers? On most counts, the records don’t tell. We know that at PUMC, patients accustomed to having traditional doctors read their pulses and examine their tongues, submitted to verbal interrogation, prodding and poking, and exposed body parts usually hidden for the Western-trained doctors’ head-to-toe physical examination. Female patients consenting to a gynaecological exam by a male doctor, a foreigner at that, did something with little precedent in China. American medicine demanded self-exposure and was physically intrusive in ways that Chinese medicine was not.

Medical practice at PUMC prioritised the sense of vision as a way of knowing the world, in a manner calling to mind the American idiom, ‘seeing is believing’. In contrast to nineteenth-century humoral medicine’s methods of conjecture about the body’s inner states, scientific medicine plumbed and probed the body with an array of ‘scopes’ and needles. These technologies in various ways exposed the body’s interior to view, such as biopsies, an assorted variety of endoscopies, and pelvic exams using the speculum. Moreover, PUMC doctors opened the body’s interior directly to view with sharp blades, and saturated it with invisible rays. Radiation was simultaneously a

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44 Beginning with the 4 May era, nationalist reformers associated Chinese women with ‘backwardness’, ‘ignorance’ and ‘superstition’—forces thought to account for China’s weakness in the face of imperialist threats, while at the same time women also represented aspirations for modernity in a protest literature that figured them as tragic victims of oppressive traditions. From anti-footbinding, to education for girls and frustration about arranged marriages, narratives portraying women suffering cruel fates at the hands of Confucian families were ubiquitous in the new vernacular literature. By the 1930s, the irresponsible, gambling husband who sold wife and child was a well-established trope for invoking moral corruption, to illustrate the evils of opium and imperialism and inspire outrage, both moral and patriotic, against ‘backward’ old ways.
type of therapy, and a tool that rendered the body partly ‘transparent’, making inner structures visible. Even palpation and the stethoscope magnified the physician’s senses, enabling perception to penetrate the body. Treatment likewise routinely necessitated penetrating and puncturing the outer boundary of bodies (often involving displacement of fluids), from injections, to IV drips, blood transfusions, catheterisation, enemas and douches. Early twentieth-century scientific medicine was heroic and hands-on, and patients were expected to cooperate by exposing themselves in a variety of ways. Clinicians’ probing and social workers’ investigations exposed patients’ bodies, organs, finances and family affairs to view.

PUMC doctors produced evidence from the patient’s own body, through a complex interaction of people and technology that could make the body ‘speak’ independently of a person’s own account of her condition. Routine syphilis testing, for example, might mean a patient’s spinal fluid contradicted his words, as if testifying against him, even jeopardising personal relationships. Extracting material evidence from the body was one technique through which doctors translated patients’ accounts of illness into the technical, highly specific, seemingly ‘objective’ language of scientific medicine. Diagnostic acts of reinterpreting the body, imagining its mechanisms according to highly specialised, abstract anatomical ‘maps’ were inseparable from scientific medicine’s practical power, its ability to effect results. In Chinese medicine, as in scientific medicine, such intellectual ‘maps’ both reflect and create the territory they describe and, in so doing, generate a field of choices that would—in the most literal sense—be impossible if viewed differently, say, through the lens of another vision. Not unlike scientific medicine, Confucian physicians (nu yi) used such maps or modes of analysis to ‘read’ inside the body, enabling them to intervene in ways that produced predictable patterns of results. But achieving practical benefits evidently mattered more than vying to establish the ultimate accuracy or ‘truth’ of a medical portrait analysing the inner happenings of the body.

Wang Feng-ling agreed to allow the foreign doctor in a white coat to perform a pelvic exam. A nurse helped her onto a long table covered with white cloth, where they trained bright steel lamps on her. During the exam, the doctor poked and prodded her abdomen, finding her uterus swollen.45 Peering through the speculum, he observed

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45 Photos of hospital beds and examination tables and notations in case records.
that the cervix had been 'replaced' by an ulcerated growth that which bled easily. Dr McKelvey advised immediate admission to the hospital, since the bed that was currently available might be filled by evening.

After a course of radiation treatment in the hospital, which proved a painful ordeal, Wang was discharged to recover before surgery.46 When she returned to the hospital, she still wanted surgery but told them flatly she could not afford further radiation treatments. Social workers consequently initiated an investigation into her finances.

In January, a social worker paid a surprise visit to her home. Before knocking on any doors, she asked a couple of restaurant employees a few questions. They answered that Mrs Wang's husband was the owner, and that he had no partners. Looking around, the social worker noted 'eight bags of good quality flour and about two tons of hard coal in store for future use'. Crossing the street, she found the patient and her husband both at home. She wrote: '[B]oth at once start[ed] to beg for reduction of full course of x-ray treatment.' On the kang (platform bed), where Mrs Wang insisted she have a seat, the social worker noted 'two nice fur gowns'. In response to questioning, Mrs Wang discounted the pile of coal, saying she '... does not burn (the) coal balls for it is not the best quality'. Ignoring the husband and wife's entreaties, the social worker quickly concluded: 'Although pt's home is not good, but it shows that she is well provided (for) and has no financial difficulties.'47

Mrs Wang began hastily to explain: they had arranged to sell the shop on the first day of Chinese New Year, she claimed, 'to another person who does not wish to let outsiders know for fear of losing business'. 'This last statement is not true', the social worker confided in the chart, 'for pt and husband do not know that worker has had information in the shop from the workmen before seeing them'.48

46 In the 1930s, standard protocol at PUMC for operable cancers involved a course of radiation to shrink the tumor, surgery and a second course of radiation. Physicians at that time had not determined a minimum effective dose of radiation, so they applied X-rays until lacerations appeared on the skin's surface.

47 PUMC patient #46715.

48 Although small shopkeepers sometimes denied ownership or shifted responsibility to their tenants to avoid taxation, lies about property sales were easy enough to discover in cities where both owners and tenants were required to register their property with the government or police in order to gain legal protections.
The social gap between Wang and her social workers had motivated their ambition to win her trust and educate her; but this gap also (partly) accounts for their failure of empathy when it came to Wang’s reluctance to disclose her finances.

If social workers’ job was to facilitate treatment for those who needed it, Wang Feng-ling’s case is an example of a social work relationship gone seriously awry. By January, when Dr McKelvey realised she had not returned for surgery as expected, he asked social workers to send a follow up letter requesting her return for treatment. She reappeared in February, insisting on a price of $5 per x-ray treatment, not $10. The social worker dismissed her offer, noting in her chart: ‘According to SSD [Social Service Department] finding she should pay more, so she is told to get some more money and to come back later.’ On 5 March, with evident disappointment, her doctor recorded, ‘SS reports patient can pay for x-ray but will not . . . Patient states that she does not wish further treatment. There seems to be no use attempting further persuasion.’ Dr McKelvey was very reluctant to give up on this patient.49 The institution’s negotiating tactics, particularly its insistence on trusting, open, financial self-disclosure combined with a certain confrontational attitude toward establishing truth, seem to have alienated the couple, failing to convince them of the hospital’s good will.

Chinese social workers had the upper hand in such conflicts with American doctors. McKelvey’s insistence on follow up resulted in a second home visit by a social worker who had already once decided the case closed.50 When Mrs Wang finally did return for an examination in May, McKelvey recorded sadly, ‘Have been chasing her since February. She looks very badly. Her whole pelvis is a tumor mass . . . hopeless. Husband notified as to reasons involved.’

49 At this point, there appeared to be a conflict between social workers and the doctor, one left unstated in the patient’s chart. McKelvey may not have realised the bilingual social worker was working against him. When social workers’ views conflicted with those of foreign doctors, their crucial role in communication seems to have given them the upper hand. When told Wang Feng-ling did not want to seek treatment, McKelvey had no means to know otherwise, and no knowledge of the origins of her alienation.

50 This time the social worker found her bed-ridden, being tended by an ‘old style’ Chinese practitioner. She was not looking well. But she and her husband both declared coldly to their uninvited visitor they would not ‘waste’ their money on X-ray treatment, remarking that they could not possibly pay for her to travel by rickshaw to the hospital each time.
months after her final trip to the hospital, a social worker noted in her chart that Mrs Wang had died.\textsuperscript{51}

By refusing even a symbolic compromise on price, social workers sent a message that the hospital did not want to establish a personal relationship with her through an exchange of give-and-take. Small business people like the Wangs would have been accustomed to seeing high prices as an initial bargaining ploy, rather than an inflexible fact. In a business context, someone who started high and refused to lower their price communicated an unwillingness to sell; such inflexibility was a clear rebuff to a potential customer. Perhaps the outcome of this case reflects a failed encounter between different sensibilities toward the value of truthfulness in establishing relationships of trust. Correctly sensing their circumstances did not meet social workers’ expectations of legitimate ‘need’, the Wangs had compensated with a quick lie, denying their effective ownership of the restaurant. Nothing else recorded in the chart appears to explain the sudden negative turn their relationship with the hospital had taken.

Highly educated and well paid professionals, social workers may have viewed Wang Feng-ling’s attempt to conceal property as dishonesty. But in a business exchange, where prices reflected impressions and feelings between buyer and seller, such dissimulations would hardly have been surprising. That someone had fudged the truth in order to present themselves in an advantageous light might not have been admirable to some, yet entirely understandable to others. In some bargaining situations, people drew on stereotypic narratives (‘poor student’ or ‘oppressed woman’) that were transparently manipulative. To insist on exposing social fictions directly to a person’s face would appear an act of hostility intended to humiliate and disrespect.\textsuperscript{52}

\textsuperscript{51} Social workers almost certainly overestimated Wang Feng-ling’s inclination or ability to trust the hospital. Although she frankly had confessed some of her apprehensions, it seems that Wang never assumed her own welfare was the institution’s main priority, or that anyone there would care about her suffering. In fact, she may have perceived exorbitant prices as an insistence on profiting from her misfortune. The Wangs were not rich, but they were far from destitute; had they perceived the hospital’s treatment as their only option, most likely they could have found some way to afford the payments.

\textsuperscript{52} Getting caught strategically manipulating one’s appearance would hardly justify confrontation, which meant public humiliation and permanent enmity. On the other hand, to participate in such fictions, without taking them too seriously, while responding with similar tactics, might provide an enjoyable form of banter, and a way of really getting to know a person through back and forth exchanges. There
Let us return, briefly, to the start of this paper, when Zheng Bi-wu refused to pay for radiation fees. Her case illustrates how patients could employ bargaining for purposes beyond getting a reduced price, including as a way of avoiding direct disputes over therapy itself. It also brings us back to the difficulties attendant on American efforts to create a modern patient of scientific medicine in China.

'Still arguing over cost.' Mrs Zheng gracefully resists institutional authority

Like the two other women, Zheng Bi-wu, who was diagnosed with cervical cancer in March 1934, refused to pay for radiation treatment and resisted pressure to continue with it after surgery. Dr McKelvey referred her to the Social Service Department, where social workers took note of her elegant garments and jewelry, demanding to know how she had been able to pay her bills up to that point. Portraying herself as an isolated woman without means of support, Mrs Zheng explained her husband lived in Canton, and her children all had families to support. Home investigation, and interviews with neighbors revealed Zheng had concocted elaborate stories to conceal the fact that one of her sons, a newspaper editor, supported her leisurely lifestyle in Beijing. Still, she refused further treatment by insisting on getting a 'bargain'.

was not necessarily a widespread expectation that one has a moral obligation to report one's circumstances truthfully to outsiders, or more generally, a widely appreciated value to revealing truths to one's own disadvantage (whereas trust based on such "transparency" was considered necessary for making contracts in the United States). Still, somehow social workers found financial dissimulation by the resourceful and hardworking Wangs less forgivable than similar deceptions by wealthier, elite patients trying to get reduced prices. During the social worker's second visit, the Wangs' responses to her inquiry suggested they likewise had taken offense from their previous interactions.

53 Name changed.
54 Tien, 27 January 1936.
55 PUMC patient #15518.

Whereas social workers seem at first to have set great store on Wang Feng-ling's words, Mrs Zheng's stories did not quite pan out from the start. When she claimed she had paid for treatment by borrowing from friends, social workers sent her home to borrow more. She returned holding three dollars, also reportedly contributed by friends in the Sun Yat-sen Association. The worker inquired skeptically how she was able to maintain her membership in the Hui Guan. Zheng replied that she was 'eating with Mrs Cheng (Zheng), a relative of her(s)'. When asked specifics
Finally intuiting Mrs Zheng’s real meaning, perhaps, one of the social workers asked Dr McKelvey ‘if the X-ray therapy is absolutely needed’. The doctor responded that Zheng was at a critical juncture—without further radiation, her cancer might recur. ‘He considers this a hopeful case,’ the social worker noted.\textsuperscript{56} In the medical portion of her chart, Dr McKelvey responded tersely: ‘She is not to return until she has had X-ray. Still arguing over cost. Do not see again unless has X-ray.’ Despite this, they never actually turned her away.\textsuperscript{57}

It seems quite likely that Mrs Zheng protested the price simply in order to justify her selective approach to the hospital’s scientific therapies. She had already had one bad experience with radiation therapy and did not want more. By refusing treatment she claimed she could not afford, Mrs Zheng effectively limited doctors’ authority without directly confronting it. Bargaining may have appeared less controversial to her than open defiance of a recommended course of action. Quite possibly she felt debating price was more natural

about the relative, it seems Mrs Zheng concocted an elaborate story, claiming that the imagined relative’s son was also a patient at PUMC. A search to locate his patient record revealed no one with that name. In the chart, the social worker commented mildly, ‘From all what pt states, it doesn’t seem true to worker’.

Home visits to bring her back for radiation treatment following surgery confirmed that Mrs Zheng was indeed ‘all alone by herself in Beiping’, as she had declared. But she was quite evidently not ‘sewing for a living’ as she’d claimed. Rather, the social worker felt she was overly carefree, playing mahjong and gadding about town with friends. A second home visit found Mrs Zheng away. One of Mrs Zheng’s neighbours revealed she had a son who was a newspaper editor and a bachelor. It was he who supported her independent lifestyle in the city. Although they had caught her lying about her means of support, hospital staff did not for that reason stop attempting to persuade her to return for further radiation treatment. But Mrs Zheng refused, insisting on a reduction in cost ‘to get a good bargain’. Tien, 27 January 1936.

\textsuperscript{56} 24 September 1934.

\textsuperscript{57} Though her deceptive approach to bargaining and apparent selectivity about treatment did not make her an ideal patient in the eyes of her social workers or her American doctor, they remained solicitous of her well-being. In her chart, they did not condemn her in any direct manner for attempting to deceive them. Mrs Zheng was a woman of the social worker’s own class. She had received some education as a girl in the 1880s and her family had not neglected to bind her feet (which doctors described as ‘tender’). Her elegant glasses, earrings and gold teeth testified to her privileged lifestyle. Social workers recognised her capacity to pay, and that she was not fully honest about her resources. Maybe it was habitual deference toward women of her class, or perhaps social workers were aware that things they wrote in her chart might have untoward consequences, given her social status. Either way, it appears they dared not openly criticise her, or refuse her access to whatever care she would accept. Evidently the ideal, impersonal etiquette implicit in bureaucratic standards was, in practice, compromised by habits of deferring to elites.
and tactful than directly contesting a doctor’s orders. Mrs Zheng thereby circumvented institutional and scientific authority with grace.

Although Dr McKelvey threatened to deny services if she did not comply, there was little he could do if his orders were not respected. His (attempted) strict response may have reflected a perception that there was something incongruous about a wealthy person bargaining for reduced prices, or about the notion of a marketplace ethos like bargaining in a hospital setting.\(^{58}\)

From an American point of view, the marketplace and the scientific hospital operated on different principles. PUMC doctors offered patients a scientific, presumably ‘true’ diagnosis, based on evidence obtained by microscopic analysis of body fluids or tissues, x-rays or fluoroscopy. Accepting this as objective truth left little room for bargaining. But Chinese patients such as Mrs Zheng behaved like consumers who assumed they had choices and a right to be selective about treatment. At least implicitly, this raised questions about doctors’ authority, about the truth of their diagnoses and prognoses, and the benefits of hospital treatments. By bringing bargaining into the hospital setting, Chinese patients implicitly questioned the extent to which doctors might profit by patients’ misfortunes. Debating the price of medical treatment pointed to this conflict of interest, rather than fostering trust. At such moments, bargaining behaviour was inconsistent with the truthful and trusting relationship hospital staff expected from patients.

\(^{58}\) Or perhaps it reflected American assumptions that doctors were not sellers of items or services to be purchased at a discount, and that hospitals offered financial assistance to those in need for the serious purpose of saving lives. The social status, authority and trust accorded doctors in the United States had risen considerably by their association with the ideals of altruism and the scientific pursuit of truth. Rosenberg 1987, Stevens 1989.

In contrast, Chinese doctors had enjoyed less authority over patients and less of a monopoly over medical resources. Patients sought treatment as outpatients at clinics and herb shops. Those who could afford it might invite a physician into their homes, where doctors were subject to family decisions and obligated to work alongside competing healers. In wealthy families, male members of the household who’d had a traditional education often had a gentlemanly familiarity with classic texts of medicine, and might venture their own opinions about the situation, making the job of a visiting doctor who disagreed, difficult (Furth 1999, Unschuld 1979). In a city such as Beijing, the great diversity of local practices combined with limited practical capacity for government regulation such that Chinese patients retained a habit of greater authority over medical decision-making for themselves and their kin. Within the limits of their means, people could shop around, trying different therapies, and practising a degree of autonomy and choice their American counterparts were gradually ceding to institutionalised medicine.
The contrast between the bargaining behaviour of patients at PUMC and patterns of therapy-seeking and consumer behaviour in the United States during the same period is revealing. In the US, modernisation of consumption practices had meant standardisation of products and prices. Buying in chain stores and department stores was an increasingly common, if increasingly impersonal, form of exchange. Professional rhetoric emphasising objectivity and efficiency since the Progressive Era lent credence to the impression that a standard, non-negotiable price, the same for all buyers, was a just price. In a society that remained ill-at-ease about economic inequality and conflicted by tension between the capitalist profit motive and Christian altruism, fixed prices helped evade awkward issues. They masked the consciously calculated profit ratio claimed by the seller, while deflecting Americans’ attention away from the uncomfortable fact that exchanges between buyers and sellers necessarily involve one person’s profit at another’s expense. (This sensibility might be contrasted with the frank acceptance of conflicts of interest and tactics for approaching them implied by bargaining.) In the United States, hospitals were, if anything, less likely than department stores to become sites for haggling. Decades of idealistic rhetoric that emphasised scientific progress and altruistic motives—not profitability—had elevated the moral stature, respectability and incomes of American physicians considerably. Such images seemed incompatible with bargain hunting and cost-cutting.59

Compelling self-disclosure, institutional scrutiny and surveillance

PUMC represented a missionary style of cultural diplomacy promoted by Americans who hoped to help Chinese reformers establish a ‘new’, modern, more governable China—in Western terms. The hospital offered a model of how organisational technologies for generating and managing information could extend a modern style of administrative authority over citizens. By training doctors and through interactions with patients, the hospital encouraged the ‘right’ habits and attitudes (truthful, trusting self-disclosure, and deference) toward a new type of bureaucracy. A number of patients, however, brought

a marketplace negotiating style—as well as marketplace assumptions about the value of truthfulness—to their consumption of healthcare. This paper has attempted to explore how a broader context of lop-sided cultural and economic exchanges shaped the dynamics of the clinical encounter at PUMC, where scientific medicine as a global commodity became a site for encounters between local and imported rules of exchange, as well as ideas about health, sickness and therapy.

Differing rules of exchange, implied by bargaining on the one hand and standardised pricing on the other, suggest opposing cultural strategies for distributive justice. Americans employed standardised prices to achieve an appearance of social equality, reflecting a notion of justice as treating different people identically. A different approach to distributive justice animated the act of bargaining. The assumption of flexible or negotiable prices started from the premise of social inequality as a fact. In that context, flexible or 'personalised' pricing gave people with scarce resources other tools for negotiating, turning relationships and social skills into an alternative type of currency. The chance to bargain down a price offered possibilities of agency for people with less money. Flexible prices likewise implied that it was just (and face giving, perhaps) to expect the wealthy to pay more for an item that would cost a friend or a poor person less. Perhaps for this reason, relatively well-to-do women appear to have been among the most inveterate bargainers.60

When social workers doubted the truth of patients' statements, their challenge appeared to be to pry through Chinese social defenses, subjecting patients to new forms of bureaucratic scrutiny and surveillance. Patients admitted to the hospital quickly found themselves at a unique disadvantage, however, as they were surrounded by staff who shared their observations about the patient, as well as conversations, through the chart. Any doctor, nurse or social worker could

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60 Social work records suggest that women bargained more often than men, and that—perhaps surprisingly—wealthier ones often bargained with greater impunity than the poor. Women, it appears, were free to haggle openly without a loss of face to an extent men were not, while men were often more concerned with demonstrating their worthiness. Bargaining by women could be seen as a sign of duty and loyalty to the household; a responsible act, rather than a selfish one. In their accounts of their lives, women were occasionally transparently manipulative, just as in an outdoor market. Both parties might recognise as such the fiction that made their encounter tolerable. Face involved not exposing people, especially in direct confrontations. Still, Mrs Zheng's style of negotiating reflects a different perception of the importance of truthfulness in relationships as opposed to preserving 'face' or dignity.
know about a patient’s encounters with other hospital staff up to that moment. The collective memory of the hospital as recorded in the chart thus rivalled the memory of the patient in its totality regarding that person’s experience at the institution. Although it could not succeed, the hospital attempted to surround its patients in a total system.

PUMC embodied a scientific epistemology and administrative technologies that implied a social etiquette at odds with local practice. A method of challenging hypotheses with evidence seems to reflect a belief that truth emerges from the confrontation of facts or ideas in public. While patients tried to present themselves in an advantageous light, social workers investigated and sometimes confronted them with evidence to the contrary. In this regard, collecting and deploying ‘facts’ was a mode of exercising power over patients, of compelling truthfulness, as part of an institutionally assigned patient role. Social workers’ use of facts to contradict patients’ accounts reflected an imported bureaucratic etiquette, one more concerned with the process of ascertaining truth and less concerned with social consequences, preserving relationships, or ‘face’. Contested aspects of the modern patient role in early twentieth-century China suggest that scientific institutions, contrary to rhetoric, were not objective and culture-free, and point to practical limits on the extension of administrative authority in early twentieth-century Beijing.

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