Three Studies on Stigmatization:
The Emergence, Maintenance, and Removal of Stigma

by

Shaoqing Wang

A thesis submitted in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

in

Strategic Management and Organization

Faculty of Business
University of Alberta

© Shaoqing Wang, 2021

ABSTRACT

The stigma literature is burgeoning in the field of management and organization studies. While much of the existing work has sought to unpack the sources and characteristics of stigma or the varied counter-responses by which individual organizations manage their stigma, stigma scholars only recently started to explore broader processes of stigmatization—the social process by which stigma emerges, is maintained, or is removed. In this thesis, I will present three empirical studies that investigate the emergence, maintenance, and removal of stigmatization, respectively, and then discuss their contributions to the stigma literature and their implications for the literatures on professions and institutional theory.

The first study examines the process by which stigma emerges and attaches to a profession. Through a longitudinal case study, I explore how continuous professional misconduct led to the stigmatization of the prestigious medical profession in China, stimulating a remarkable amount of violence against physicians. The study highlights the dynamics between different stakeholders. In particular, primary and secondary stakeholders had divergent responses to the strategy used by the regulator to stem professional wrongdoing, which unintendedly propelled further movement towards stigmatization and especially harsh punishments by primary stakeholders. In a process model, I specify the distinctive momentum and the particular mechanisms that move a profession towards stigmatization.

The second study unpacks the mystery of stigma maintenance by exploring how stigmatized practices become and remain rationalized in a profession. Through a two-phase qualitative study, I investigate three interrelated questions: how individual professionals rationalize bribery in their practice of medicine; how professional organizations respond when the regulator heightens the stigmatization of bribery; and why the corrective actions adopted by professional organizations

fail to stem the rationalization of bribery among individual professionals. This study highlights the role of status and ownership in shaping organizational strategies to impede the rationalization of stigmatized practices and the distinctive mechanisms that maintain the rationalization even though the stigmatization of such practices persists.

The third study investigates the process by which categorical stigma becomes removed. To explore this question, I study the destigmatization of private business as a category in China. Given the initial intensity of stigma and the enduring efforts of the Chinese state, this is an extreme case that offers an unusual opportunity to uncover the variety of strategic repertoires that may be available to state actors. This study highlights the dynamic relationship between the regulator and category members. Specifically, the regulator adopted five distinct strategies at different stages of destigmatization based on how both category incumbents and new entrants responded to its previous strategies, and category members became more proactive as the state widened the entrepreneurial space for them.

My primary contribution is a comprehensive analysis and theorization of the stigmatization processes. Through three complementary empirical studies, I zoom in on three distinct processes of stigmatization. In particular, I emphasize that such processes are shaped by the interactive relationships between the stigmatized and its various stakeholders, ranging from the regulator and the media to customers and employers. Not only may different stakeholders respond to stigma management strategies differently, their reactions may also affect the processes of stigmatization. Moreover, all three studies highlight that stigmatization can be a cross-level process such that the reactions and interaction at one level may affect the dynamics at a different level.

Furthermore, my thesis also has important implications for the literatures on professions and

institutional theory. Given that professions typically enjoy high social regard, relatively little is known about their stigmatization. The first two empirical studies fill this lacuna by investigating how stigma attaches to and becomes rationalized within a profession. In particular, I show how professional characteristics may escalate the emergence of stigma and shape the ways by which professionals justify stigmatized practices. More broadly, stigmatization can be seen as a distinct type of institutional change. All three studies are set in the context of a market transition, during which the market logic encroached upon other societal institutions. In the third study, the destigmatization of private business was initiated by the government as a program of institutional transformation, which in turn contributed to a vibrant category of private entrepreneurship. In sum, the stigmatization processes may shape or be shaped by broader institutional changes.

PREFACE

The studies presented in this thesis received research ethics approval from the University of Alberta Research Ethics Board, Project Name "An Institutional Perspective on the Marketization of Chinese Economy" (ID: Pro00065495), June 13, 2016.

Chapter 2 of this thesis is collaborative work with Mia Raynard (WU Vienna) and Royston Greenwood (University of Alberta). I was responsible for the research design, concept formation, data collection and analysis, and manuscript composition. Mia Raynard and Royston Greenwood contributed to concept formation and manuscript edits. This study has been published as M.S. Wang, M. Raynard, and R. Greenwood, "From Grace to Violence: Stigmatizing the Medical Profession in China," *Academy of Management Journal,* In-Press.

For Fay

ACKNOWLEDGMENTS

I have had a wonderful journey in the doctoral program. Thanks to people whom I acknowledge below, my years in Alberta have been and will remain a memorable period of my life. First, I am deeply indebted to my supervisor, Mike Lounsbury, for his generosity academically and financially. He has always been responsive, prompt, and incisive. Thanks to his advice and encouragement, I learned the importance of being an independent scholar, thinking about grand challenges, and collaborating with different colleagues. I am also greatly indebted to Royston Greenwood, who was practically a co-supervisor to me. It was through our countless tea chats at local cafes that I learned the process of crafting good qualitative research. As a warm landlord, he also eased my early years in the program.

In the Alberta School, I have benefited from an intellectual and collegial environment. I am thankful to my supervisory committee members—Dev Jennings and Joel Gehman—who have helped me to keep on track, offered me pertinent advice on my career, and provided useful comments on early versions of my thesis. Conversations with Chris Steele have been particularly useful for the development of my theorization of orchestrated improvisation in this thesis. Others whose comments and suggestions in class or during chats have been helpful include Bob Hinings, Emily Block (both my arm's length readers), David Deephouse, Vern Glaser, Tim Hannigan, Jennifer Jennings, Trish Reay, Angelique Slade Shantz, and Madeline Toubiana. In addition, I am thankful to my peers in the PhD program, of whom Jingxuan Zheng, Rongrong Zhang, Mia Raynard, Paola Ometto, Chang Lu, and Maggie Cascadden deserve special mention.

Outside of Alberta, I have benefited from conversations with scholars from different milieux. Yifan Wei introduced me to the field of institutional theory before I learned of Alberta and has been a companion in academia. My brief research experience with Wen Guang Qu and

Xiaowei Rose Luo during 2014–2015 helped me open the door to pursuing a PhD program. When I visited the Cambridge Judge Business School in 2018, Paul Tracey was particularly welcoming; I really enjoyed the chats and beers we had together. In other milieux, Chris Marquis, Eric Zhao, Nan Jia, Pat Thornton, and Laura Claus shared with me their valuable insights into an academic career. Two visiting buddies, Richard Haans and Jan Lodge, who have also become my wonderful co-authors, deserve special thanks for their companionship.

Earlier drafts of the three empirical chapters in this thesis have been presented in various workshops and conferences. I wish to thank organizers and listeners at the following institutions: Arizona State University, Boston College, HEC Montréal, Hong Kong University of Science and Technology, Queen's University, University of British Columbia, University of Edinburgh, WU Vienna University of Economics and Business, as well as the Academy of Management Annual Meeting in Atlanta. I am also thankful to numerous anonymous interviewees who shared with me their valuable insights regarding the medical profession and the market transition in China.

Finally, I want to thank my family for their unreserved support. My mother, Dr. Chen Hui, introduced me to the world of medicine and has always been a complete supporter of my career. My in-laws, Zhai Guoqing and Tu Caihong, have offered their help and confidence when I needed them the most. My grandparents, Chen Xueqi and Li Meichun, have always been role models for me in life and in work. My uncle, Chen Xiaoyang, a fellow professor of management, introduced me to business research and helped me enter a doctoral program in business. My sons, Marc Wang and Leo Zhai, respectively marked the exciting beginning and happy ending of my PhD journey and constantly remind me of the goals of my life. I reserve my last thanks to my wife, Dr. Fay Yi Zhai, who has been my most loyal, humorous, and intellectual companion in exploring the meaning of life.

CONTENTS

Abstract ii

Preface v

Dedication vi

Acknowledgments vii

Contents ix

List of Tables xi

List of Figures xi

Chapter 1 **Introduction** 1
- Stigma and Stigma Management 2
- The Processes of Stigmatization 8
- Methods 12
- Implications for the Literatures 17

Chapter 2 **From Grace to Violence: Stigmatizing the Medical Profession** 19
- Introduction 20
- Theoretical Orientation 22
- Methods 28
- Findings 41
- Discussion 59
- Conclusion 71

Chapter 3 **Why Is Bribing Doctors an Excusable Crime? The Normalization of Stigmatized Practices** 81
- Introduction 82
- Theoretical Orientation 86
- Methods 94
- Findings 101
- Discussion 122
- Conclusion 132

Chapter 4 **From Foe to Friend: Destigmatizing Private Entrepreneurship** 133
- Introduction 134
- Theoretical Orientation 137
- Methods 143
- Findings 151
- Discussion 177
- Conclusion 190

Chapter 5 **Implications and Concluding Remarks** 191
Implications for Research on Stigmatization 192
Implications for Research on Professions 202
Implications for Research on Institutional Change 209
Concluding Remarks 215

Bibliography 216

LIST OF TABLES

Table 2–1: Media Coding and Illustrations 35
Table 2–2: Core Concepts, Data Sources and Illustrations 38
Table 3–1: Data Collection and Analysis 97
Table 3–2: Representative Quotes Supporting Rationalizing Practices 98
Table 3–3: Core Mechanisms and Data Illustrations 100
Table 4–1: Qualitative Illustration of Destigmatization 160

LIST OF FIGURES

Figure 1–1: A Conceptual Model of Current Stigma Literature and Missing Links 3
Figure 2–1: Media Depiction of Professional Ethics, by Year 41
Figure 2–2: Number of Reports of Disputes between Physicians and Patients, by Year 42
Figure 2–3: A Process Model of Professional Stigmatization 60
Figure 3–1: A Multi-level Model of Normalization in a Professional Context 123
Figure 4–1: A Process Model of Interactive Categorical Destigmatization 178
Figure 5–1: A Conceptual Model for Studying the Processes of Stigmatization 193

Chapter 1

Introduction

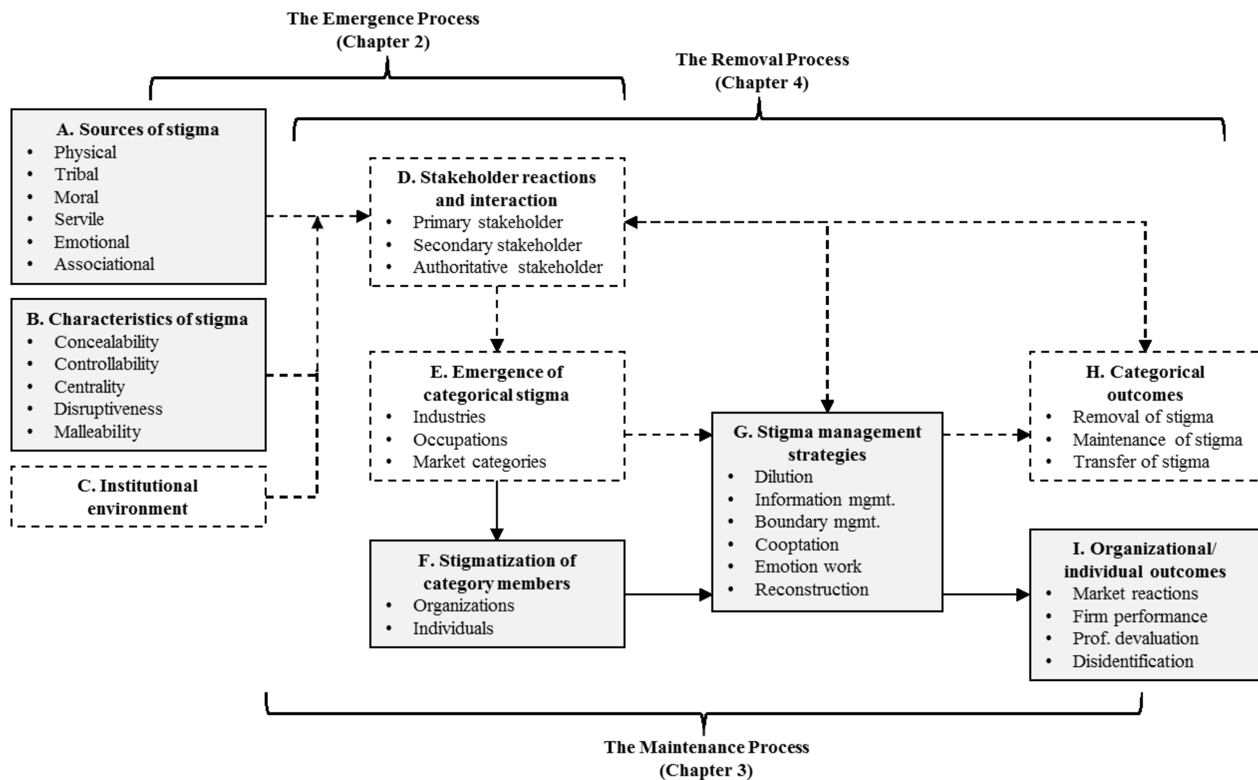
The stigma literature is burgeoning in the field of management and organization studies. While much of the existing work has sought to unpack the sources and characteristics of stigma or the varied counter-responses by which individual organizations manage their stigma, only recently have stigma scholars started to explore broader processes of stigmatization. This thesis investigates such processes through three self-contained yet interrelated empirical studies, each having its own literature review, findings, and discussion. In this chapter, I will broadly review the existing literature on stigma and stigma management, which is followed by an agenda for studying the processes of stigmatization. I will then briefly introduce three key sub-processes of stigmatization—emergence, maintenance, and removal—which will be empirically examined in Chapters 2–4, respectively. Next, a description of the empirical contexts and research methods will be provided. Finally, I will foreshadow how my thesis contributes to the stigma literature as well as its implications for the literatures on professions and institutional theory—which will be further developed in Chapter 5.

STIGMA AND STIGMA MANAGEMENT

The existing literature on stigma can be traced back to Goffman's (1963) ground-breaking work, which originally refers to stigma as a negative discrepancy between a target's actual social identity and its virtual identity—i.e., between perceptions of what a target is and expectations of what the target ought to be. Put another way, "stigma represents an attribute that produces a social identity that is devalued or derogated by persons within a particular culture at a particular point in time" (Paetzold, Dipboye, & Elsbach, 2008: 186). Early studies of sigma have focused on the stigma facing individuals (e.g., deformity, criminal, or racial minority) or members of "dirty" occupations (e.g., butcher, chauffer, or exotic dancer) (Ashforth & Kreiner, 1999; Kleck, 1968; Jones et al., 1984). More recently, the concept of stigma has been increasingly applied to

organizations (e.g., corporate failure) or members of industries characterized by stigma (e.g., arms, medical cannabis) (Hudson, 2008; Lashley & Pollock, 2020; Vergne, 2012; Wiesenfeld, Wurthmann, & Hambrick, 2008). Commenting upon this application, Devers, Dewett, Mishina, and Belsito (2009: 155) provide a useful definition of "organizational stigma" as a "label that evokes a collective perception that the organization is deeply flawed and discredited." Further, Hudson (2008: 252) makes a useful distinction between "event" and "core" stigma—the former of which results from "discrete, anomalous, episodic events" (e.g., bankruptcies), whereas the latter is associated with the "nature of an organization's core attributes—who it is, what it does, and whom it serves."

Figure 1–1: A Conceptual Model of Current Stigma Literature and Missing Links



Note: Solid lines capture key concepts in the existing literature. Dashed lines map under-examined links and concepts onto the existing literature.

Extant research has provided valuable insights into the sources and characteristics of stigma, how "preexisting stigmas" (Devers et al., 2009) are combated, deflected, and even co-opted, as well as the consequences of stigma management (Anteby, 2010; Ashforth, Kreiner, Clark, & Fugate, 2007; Helms & Patterson, 2014; Lashley & Pollock, 2020; Tilcsik, Anteby, & Knight, 2015) (see solid-line boxes and arrows in Figure 1–1). A recent comprehensive review by Zhang, Wang, Toubiana, and Greenwood (2021) puts forward a common language that integrates insights across different levels of analysis, proposing six sources, five characteristics, and six strategies for managing stigma (boxes A, B, and G), which I explain in detail below. I will then point out the missing links in the literature (see dash-line boxes and arrows).

To begin, the six distinct sources of stigma include physical, tribal, moral, servile, emotional, and associational (Zhang et al., 2021). *Physical* stigma refers to a discrediting mark that is often related to physical appearance such as facial deformities and obesity (Shapiro, King, & Quinones, 2007), but can also refer to associations with dirt, effluent, or death (Grandey, Gabriel, & King, 2019). *Tribal* stigma arises from membership in a group that is considered inferior or vilified such as race, gender, and sexuality (Stewart & Shapiro, 2000; Tilcsik et al., 2015). *Moral* stigma reflects a blemish of character or conduct, involving activities that are deemed morally dubious, including fraud and other criminal activities (Piazza & Jourdan, 2018; Roulet, 2019). *Servile* stigma refers to subservient activities or relationships that are considered degrading such as taxi drivers and cleaners (Ashforth & Kreiner, 1999; Phung, Buchanan, Toubiana, Ruebottom, & Turchick-Hakak, 2020). *Emotional* stigma results from activities that are emotionally exhausting and threatening such as distress-line workers who regularly work with upset, suicidal, or abusive people (McMurray & Ward, 2014; Zilber, 2002). *Associational* stigma arises from proximity or mere contact with those who are stigmatized—i.e., an unwanted

“courtesy” (Goffman, 1963).

In addition, five distinct characteristics are summarized in Zhang et al.’s (2021) framework: concealability, controllability, centrality, disruptiveness, and malleability. *Concealability* captures the extent to which a stigma can be hidden or disguised from others (Clair, Beatty, & Maclean, 2005; Jones et al., 1984). For example, compared to race, sexual orientation can be easily hidden. *Controllability* refers to the degree to which stigmatized actors are perceived to be responsible for having the stigma (Crocker, Major, & Steele, 1998; Ragins, 2008). Typically, dishonest wrongdoing is regarded as more controllable than accidental errors. *Centrality* refers to the relative proximity of the discredited activities or attributes to the core identity of the stigmatized actors (Hudson, 2008; Lyons et al., 2018). For example, the stigma of death is more central to a coroner than a trauma surgeon. *Disruptiveness* captures the extent to which a stigma disrupts social orders or interactions with others in society (Douglas, 1966; Kleck, 1968). People with criminal records, for example, are seen as more disruptive than domestic workers. *Malleability* refers to the degree to which the stigmatizing attributes or conditions change over time (Link & Phelan, 2001; Paetzold et al., 2008). Intuitively, those stigmas that arise from obesity or the gender composition of a company board may be relatively easier to change than those related to sexuality or the nature of dirty work.

Moreover, six types of stigma management strategies are proposed in Zhang et al.’s (2021) framework: dilution, information management, boundary management, cooptation, emotion work, and reconstruction. These six strategies can be grouped into three approaches: lose it, hide it, or embrace it (cf. Greenwood, Oliver, Lawrence, & Meyer, 2017). The first strategy, *dilution*, entails severing or reducing ties to the source of stigma. While individuals might reduce physical stigma by cosmetic surgery, managers of a misbehaving firm might jump ship to avoid public

stigmatization (Levine & Schweitzer, 2015; Semadeni, Cannella, Fraser, & Lee, 2008). In other words, dilution represents the “lose it” approach.

The second strategy, *information management*, manages the information disclosed or shared about one’s stigmatized activities or attributes. For example, racial minorities might “whiten” their resumes in order to get a job interview, and stigmatized organizations, such as a men’s bathhouse, might pretend to be something more acceptable, like a gym (Hudson & Okhuysen, 2009; Kang, DeCelles, Tilcsik, & Jun, 2016). Thus, information management embodies the “conceal it” approach to stigma management.

In contrast, the “embrace it” approach is more diverse, with four different identifiable strategies that each denote a different way of managing stigma. *Boundary management* involves establishment or maintenance of a boundary between those who are stigmatized (i.e., insiders) and those who are not (i.e., outsiders). Using the stigma as a means of differentiation, the stigmatized actors construct a “safe haven” in order to defend “us” from “them” (Moon, 2012). *Cooptation* entails strategic manipulation of stigma to generate benefits for the stigmatized. Instead of separating us from them, actors who use cooptation attempt to attract and even elicit support from neutral and potentially friendly stakeholders by celebrating the distinctiveness brought by the stigma (Helms & Patterson, 2014; Roulet, 2020). *Emotion work* is particularly targeted at the negative effects of stigmatization by manipulating emotions. Actors might strategically express and attach certain emotions to their stigmatized attributes in order to acquire social acceptance or enhance their own sense of self (Hamilton & McCabe, 2016; Levine & Schweitzer, 2015). However, the most radical strategy among all is *reconstruction*, which is used to reshape the values and meanings of stigma in order to rationalize the stigma *among* the stigmatized actors (Ashforth & Kreiner, 1999) and/or change the *broad* social evaluation of the

stigma (Tracey & Phillips, 2016).

In sum, the literature has focused on examining different sources (A) and characteristics (B) of stigma, why the stigmatized individuals or organizations adopt certain strategies (F to G), and the impact of each strategy on the individuals and organizations (G to I). However, as suggested by Zhang et al. (2021) and others, there are several missing links in the literature, which hinder us from developing a processual view of stigma and stigmatization (Pescosolido & Martin, 2015). First, the *emergence*, *maintenance*, or *removal* (E, H) of categorical stigma [1] (e.g., occupational or industrial) is still somewhat of a mystery (exceptions include Hsu & Grodal, 2020; Lashley & Pollock, 2020; Siltaoja, Lähdesmaki, Granqvist, Kurki, Puska, & Luomala, 2020). In particular, little attention has been paid to how the use of different strategies might shape or be shaped by the dynamics of categorical stigmatization (the links between E, G, and H). Second, the role of *different stakeholders* (D) in the stigmatization processes remains underexamined (Hampel & Tracey, 2019; Helms & Patterson, 2014). Specifically, we do not know much about how they interact with each other in response to different sources, characteristics, and strategies for managing stigma (from A, B, G to D); and, how the reactions and interaction of stakeholders in turn shape the dynamics of stigmatization (from D to E, G, H). Third, the role of *institutional environment* (C) is still largely in the background, but needs further development as it can shape the trajectory of stigmatization as well as the ways by which stakeholders interact and respond to stigma (Hudson & Okhuysen, 2009; Lashley & Pollock, 2020; Piazza & Perretti, 2015). Investigating these missing links will help us develop a more interactive, dynamic, and processual view of stigma and stigmatization.

[1] Categorical stigma is defined as "a negative evaluation arising from a social actor's association with a group that is recognized as engaging in contested practices" (Piazza & Perretti, 2015; see also Vergne, 2012). As indicated by Zhang et al. (2021), stigma can apply to individuals, organizations, or categories of similar peers such as industries, occupations, and market categories. In this thesis, I focus on the emergence, maintenance, and removal of stigmatization at the categorical level.

THE PROCESSES OF STIGMATIZATION

Following Pescosolido and Martin (2015) and Zhang et al. (2021), I define stigmatization as the social process by which stigma affects the lives of all those touched by it. Specifically, the process of stigmatization involve three key sub-processes—emergence, maintenance, and removal of stigma—that can take place across and between multiple levels of analysis. Stigmatization is often perceived as an important consequence of crisis, which can range from financial recession and political conflict to social upheaval and the ongoing pandemic. In this thesis, I strive to fill the missing links highlighted above (dashed-line boxes and arrows in Figure 1–1) by examining the three key sub-processes in the next three chapters, respectively.

The Emergence of Stigmatization (Chapter 2)

Much of the management and organization literature does not explore the question of how and where stigma arises. It is not surprising that the management scholarship has focused on the strategic responses to stigma and typically treated stigma as "preexisting" (Devers et al., 2009). However, as Pescosolido and Martin (2015: 91) rightly point out, "stigmas reflect the fault lines in a society at any one point and are as artificial and subject to change as national boundaries on a world map." Two pioneering studies theorize the emergence of stigma at the individual or organizational level as a socially constructed process of "collective labeling" (Devers et al., 2009; Wiesenfeld et al., 2008). As yet, however, we lack empirical accounts of the emergence of stigmatization—in particular, at the categorical (e.g., occupational or industrial) level.

Chapter 2 examines the process by which stigma emerges and attaches to a profession. Through a longitudinal case study, I explore how continuous professional misconduct led to the stigmatization of the prestigious medical profession in China, stimulating a remarkable amount of violence against physicians. To do so, I employed an inductive, exploratory research design,

drawing upon archival documents, media articles, multiple rounds of interviews, and secondary materials. This study highlights the dynamics between different stakeholders. To begin, primary and secondary stakeholders may learn how others are expressing their dissatisfaction through a "spiral of voice," which amplifies tensions and encourages similar expressions of discontent. But primary and secondary stakeholders may also diverge in response to the strategies used by the regulator to stem professional wrongdoing, which may unintendedly propel further movement towards stigmatization and especially harsh punishments of physicians by primary stakeholders (in this case, patients). Moreover, this study brings the role of the institutional environment to the fore: I show how a regulatory change may trigger a rise in morally deviant behavior and heighten the disruptiveness of the behavior—thereby precipitating the emergence of stigmatization. In an empirically derived process model, I elaborate on the distinctive momentum and the particular mechanisms that move a profession towards stigmatization. It is collaborative work and has been published as M.S. Wang, M. Raynard, and R. Greenwood, "From grace to violence: Stigmatizing the medical profession in China," *Academy of Management Journal*, in-press.

The Maintenance of Stigmatization (Chapter 3)

Stigma is typically seen as sticky and "persistent" (Link & Phelan, 2001: 379). In many cases, such as physical deformity, race, and dirty work, stigmatization may be taken for granted and institutionally embedded in social structures (Lempert & Monsma, 1994; Loyd & Bonds, 2018). While the existing literature highlights the strategies by which to cope with stigma, it often overlooks the potential causal links between such strategies and the maintenance of the stigma (Mikolon, Alavi, & Reynders, 2020; Phung et al., 2020). Indeed, as Zhang et al. (2021: 209) state, "five of the six management strategies in our framework (i.e., boundary management, dilution, information management, cooptation, and emotion work) could potentially contribute to

the maintenance of stigmatization." Yet, little has been done to understand the actual mechanisms underlying the process of maintenance.

Chapter 3 investigates the mystery of stigma maintenance by exploring how stigmatized behavior becomes and remains justifiable in a profession. Through an inductive qualitative study, I examine three interrelated questions: How do individual professionals rationalize bribery (i.e., an extreme form of stigmatized behavior) in their practice? How do professional organizations respond to the heightening stigmatization of bribery induced by the regulator? And why does the rationalization of bribery persist among the professionals despite the corrective actions adopted by professional organizations? Unlike the previous studies that take a relatively static approach to the rationalization of stigma, I used a more dynamic and processual approach to the question of how stigma is maintained by leveraging a national regulatory change in China as a natural experiment and conducting two rounds of interviews before and after the change. Chapter 3 highlights the dynamics between individual members of a stigmatized profession (in this case, physicians) and a particular type of primary stakeholder, the employers (in this case, hospital leadership). In particular, while the corrective actions adopted by professional organizations may affect the specific rationalizing practices by which individual professionals justify stigmatized behavior, the actions may also contribute to the sustained rationalization. Moreover, the study emphasizes the importance of institutional change, which can heighten the stigmatization of deviant behavior and in turn shape how professional organizations respond to the stigma.

The Removal of Stigmatization (Chapter 4)

The process of removing stigma, or destigmatization, is defined as a process by which the stigmatized group of individuals or organizations become "normal" and "legitimate in the eyes of those who originally stigmatized them" (Hampel & Tracey, 2017: 2175) and "gain recognition

and worth in society" (Lamont, 2018: 420). The removal of stigma has become an increasingly intractable problem in this "age of disruption" (Bridoux et al., 2021). For example, the religious and geopolitical conflict between the declining liberal world society and the rising alternative world orders underpins both ethnic and religious stigma in our society (Lounsbury & Wang, 2020). In addition, the increasing scandals of professional misconduct suggest that occupational stigma is becoming a more widespread issue (Bevan & Wilson, 2013; Brooks, 2018). However, studies of categorical destigmatization remain rare (exceptions include Lashley & Pollock, 2020; Siltaoja et al., 2020).

Chapter 4 unpacks the process by which categorical stigma becomes removed. To build theory on this question, I study the destigmatization of private business as a category in China. Given the initial intensity of stigma and the enduring efforts of the Chinese government, this is an extreme case that provides an unusual opportunity to uncover the process of stigma removal. Using a longitudinal case design, I analyzed an extensive body of data sources including archival documents, newspaper articles, interviews, oral history, and statistics. Chapter 4 highlights the dynamic relationship between members of a stigmatized category and authoritative stakeholders (in this case, state actors). In particular, authoritative stakeholders may adopt distinct strategies at different stages of destigmatization based on how category incumbents and new entrants respond to their previous strategies; moreover, the role of category members may become increasingly proactive as the authoritative stakeholders widen the political and entrepreneurial space for the improvisation of category members. Further, this study also highlights the change of institutional environments, which may not only shape the strategic responses of category members but also create schism among authoritative stakeholders, affecting the trajectory of stigma removal.

METHODS

Empirical Contexts and Research Design

The three empirical chapters each have their own empirical focus, but share an overarching empirical context: the market transition of China from "a state socialist redistributive economy to a market-like economy" (Nee, 1989: 663). Before the market transition, or marketization, was initiated in the late 1970s, the Chinese society was dominated by a planned economic system such that plans of social and economic development were shaped every five years by the Central Committee of the Chinese Communist Party and carried out through the state bureaucracy and public sector. Specifically, the private sector was systematically eradicated and replaced by the public sector—as part of the Socialist Transformation in the 1950s—and became publicly vilified for its ideological association with capitalism (Solinger, 1984). Moreover, the professional sector also became nationalized and controlled by the government to the extent that "all independent professional associations were disbanded" (Yao, 2016: 6). In health care, for example, medical professionals were forbidden from practicing private medicine, but were given tenured positions in public hospitals instead. Using theoretical terms, the state logic encroached upon the market and professional logics before the market transition, and rendered a particular instantiation of the market logic (i.e., characterized by private ownership and market economy) highly stigmatized.

It was in the aftermath of the Cultural Revolution when institutions began to dramatically change. In the late 1970s, the Chinese state faced a devastated economy—with more than twenty million people unemployed. This problem was further reinforced by soaring fiscal deficits, such that the state could no longer secure enough jobs in the public sector; nor could they provide full financial support for the professional sector including public health care (Su, 2016; Zhu, 2007). It was under these situations that the state decided to re-introduce market mechanisms into the

planned economic system. In doing so, the state gradually re-constructed the public image of private business—which had been discredited for decades—and encouraged people to join the private sector to ameliorate the devastated economy (Tsai, 2007). In health care, moreover, the government substantially cut public funding, compelling hospitals to seek alternative sources of financing via market practices (Sun, Santoro, Meng, Liu, & Eggleston, 2008). In other words, the state attempted to revive and integrate the market logic into the state and professional logics; in order to do so, it had to remove the stigma of private ownership and market economy.

However, the revival of the market in a society where the market had been denounced for decades was not an effortless project: it was expected to, and indeed did, induce backlash (Walder, 2017). It took almost three decades for private business and entrepreneurship to become publicly and legally recognized. During this time, the schism within the state regarding the legitimacy of market practices rendered their restoration particularly intractable and full of tension (Ang, 2016; Nee & Opper, 2012). Yet, interestingly, while market practices in the private sector eventually become acceptable and even appreciated by the general public, the medical profession becomes discredited for embracing market practices in the health care sector (Yao, 2016). Further, while the general public, along with the government and media, increasingly denounced market practices in health care, such practices remained acceptable among medical professionals (Zhu, Wang, & Yang, 2018). Put another way, while the market logic became resuscitated and destigmatized in China, its integration with the professional logic somewhat led to the medical profession's stigmatization—even though such integration was accepted by professionals themselves.

This historical, societal-level change portrayed above is an ideal context for my investigation into the processes of stigmatization. First, this context covers all three sub-

processes of stigmatization, including the *emergence* and attachment of stigma to the medical profession, the *maintenance* and sustained acceptance of stigmatized practices among medical professionals, and the *removal* of stigma from private entrepreneurship. Moreover, the sub-processes in this context are shaped by the multiplicity of relevant stakeholders, including category members (e.g., private entrepreneurs and physicians), primary stakeholders (e.g., customers and patients), secondary stakeholders (e.g., the media), and authoritative stakeholders (e.g., the regulator). Furthermore, all three sub-processes are largely shaped by the broad institutional change. These features make it possible for me to develop a more interactive, dynamic, and processual approach to stigma and stigmatization.

Given the underexamined status of my research questions, all three empirical studies share an exploratory, qualitative approach. Extreme cases are helpful for building theory on understudied topics as they provide 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). All three empirical cases certainly meet this criterion. In addition, inductive theory building is aided by rich qualitative data, from which underexplored and unexpected insights may emerge (Corbin & Strauss, 2008; Eisenhardt, 1989). Since the market transition in China is a recent, well-documented historical event, I was able to collect and use a wide variety of data sources for each empirical study.

Data Collection and Usage

Though the data sources and analysis for each empirical study will be explained in detail in each empirical chapter, it is useful to provide an overview here to highlight the diversity and complementarity of the data I collected and how it was used to examine of the processes of stigmatization. In total, I collected three primary data sources and three secondary data sources,

each with its own characteristics and distinctive use that cannot be completely replaced by another source. The three primary sources include archival documents, media articles, and interviews, and the three secondary sources are public statistics, oral histories, and relevant scholarly work done by others.

Archival documents were a particularly important data source, as they were typically my primary source for creating a contextual backdrop and chronological narrative in which the empirical case was situated. I collected government documents at both national and local levels to understand the change of regulatory institutions that were relevant to my empirical settings, such as the policy regarding public health care budget cuts for or the constitutional amendment for private ownership. I also used government documents to understand the role of authoritative stakeholders in shaping the process of stigmatization, as the rationales underlying their actions and strategies are typically explained in these documents. Additionally, I collected organizational documents from stigmatized category members in order to understand their responses to the stigmatization processes.

Media articles were collected from both government-controlled and private news outlets. The *People's Daily*, one of China's most influential media outlets and the Communist Party's official newspaper, was particularly important because it was one of the few news outlets that covered the entire period of market transition, thereby making a systematic analysis of public discourses possible. Though the media is relatively more censored and less independent in China compared to the West, it is still an indispensable means of mass communication by which public opinion is shaped. Thus, I used media articles to understand the role of secondary stakeholders in shaping the processes of stigmatization. Importantly, given the documentary function of news outlets, I also used media articles to track the frequency of stigmatizing events (especially in

Chapter 2).

The third primary source, *interviews*, provided important insights into the lived experience of the stigmatized and other stakeholders. Interviews complemented archival documents and news articles by providing vivid illustrations of the processes of stigmatization from different perspectives. I started with a round of pilot interviews with the stigmatized actors to explore their experiences and their views on their relationships with other stakeholders. Then, multiple rounds of semi-structured, formal interviews were conducted with members of different stakeholder groups—including employers, regulators, and clients. I paid particular attention to those "elite interviewees" (Marshall & Rossman, 1999) who held ideal positions to experience the stigmatization processes. Given that interviews may have the flaw of being retrospective, I used triangulation of multiple data sources whenever possible to improve the reliability of my interpretations.

The three secondary sources further enriched my data collection. *Statistics* can be used to resolve the issue of small sample, a common limitation of qualitative studies. Data from several large-scale surveys were collected, such as Chinese Medical Doctor Association Survey, which covered thousands of physicians across China, and the Chinese Private Enterprise Survey, which is the largest longitudinal survey with a representative sample of private enterprise owners. In addition, *oral histories*, which were documented by scholars during (rather than after) the market transition, provided contemporary accounts of the stigmatization processes, thereby supplementing the retrospective interviews. Lastly, *existing scholarly work*, including academic journal articles and monographs pertaining to market transition, were collected and used in order to gain a general understanding of the empirical settings and to corroborate my findings.

IMPLICATIONS FOR THE LITERATURES

In Chapter 5, I will discuss how all three empirical chapters contribute to the stigma literature as well as implications for the literatures on professions and institutional theory. My primary contribution is a comprehensive analysis and theorization of the stigmatization processes. Through three complementary empirical studies, I zoom in on three distinct sub-processes of stigmatization. In particular, I emphasize that these processes are shaped by the interactive relationships between the stigmatized and its various stakeholders including primary stakeholders (e.g., clients, employers), secondary stakeholders (e.g., the media), and what I call "authoritative" stakeholders (e.g., the regulator). Not only may different stakeholders respond to stigmatization differently, their action, inaction, and interaction may also shape the processes of stigmatization. Moreover, all three studies show that stigmatization can be a cross-level process such that the reactions and interaction at one level may affect the dynamics at a different level.

Second, my thesis has important implications for the literature on professions, as two of the three studies examine professional contexts. Given that professions typically enjoy high social regard for their command of a specialized body of knowledge and their commitment to a code of ethics, it is not surprising that the literature on stigma has said little about them. Even the literature on occupational stigma rarely connects professions to the taints that define "dirty work." These taints may be "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). I fill this lacuna in Chapters 2 and 3 by exploring how stigma becomes attached to and maintained in a profession. In particular, I highlight how professional characteristics may shape the emergence of stigma as well as the ways by which professionals rationalize stigmatized behavior.

Lastly, this thesis contributes to the literature on institutional change and complexity. The

processes of stigmatization can be seen as a distinct type of institutional change. All three studies are set in the context of market transition, during which the market logic encroached upon other societal institutions, including the state and professional logics. Yet, how these broader institutions' changes shape and are shaped by the trajectory of stigmatization at the categorical level (e.g., industrial or occupational) remains a largely underexamined research question. As mentioned earlier, stigmatization is becoming an increasingly visible and intractable problem in this new age of institutional disruption. The religious and geopolitical conflict between the liberal world society and the rising alternative world orders underpins not only populism and nationalism but also various stigmatizations in our global society. I care about this grand challenge, so have explored it in my thesis.

The next three chapters will empirically investigate three sub-processes of stigmatization—i.e., emergence, maintenance, and removal of stigma—respectively. Each chapter contains its own literature review, findings, and discussion. These empirical chapters are followed by a final chapter that discusses the overall contributions of these studies to the stigma literature as well as the broad literatures on professions and institutional change.

Chapter 2

From Grace to Violence: Stigmatizing the Medical Profession

INTRODUCTION

In 2015, media outlets across China reported twelve major incidents of physical violence committed against medical professionals in a span of just twenty days. One incident involved a physician being beaten by relatives of a critically ill patient; another involved a patient lacerating an otolaryngologist's left eye; and a third reported an oncologist being doused with gasoline and burned by a patient (*China News Service*, June 18, 2015). This spate of incidents reflects an alarming trend: the frequency of physicians being assaulted by patients increased dramatically from the early 2000s to the 2010s—to the point that, in 2012, 64% of hospitals reported physical attacks on physicians (Chinese Hospital Association, 2014). Moreover, the implications 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 to understand how and why this dramatic fall from grace happened. In theoretical terms, we ask: *What is the process by which stigma emerges and attaches to a profession?*

Deepening understanding of the stigmatization of *professions* is particularly timely given increasing reports of professional misbehavior—such as the role of non-disclosure agreement lawyers in 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 becoming a more widespread phenomenon (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.

However, despite the growing interest in stigma among management and organizational

scholars (Pollock, Lashley, Rindova, & Jung-Hoon, 2019), relatively little is known about the stigmatization of professions—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 towards stigmatization. Whereas prior research suggests that ethical transgressions alone can touch off 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 of how others are expressing their dissatisfaction—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 lower the perceived pervasiveness and severity of transgressions. In this way, authoritative stakeholders may unwittingly propel further movement towards stigmatization—generating a momentum that can become difficult to contain or reverse. Importantly, our model highlights that primary

stakeholders will 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 typically assume stigma to be a binary state (c.f. Hampel & Tracey, 2019), our case emphasizes that the process towards 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 to 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—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 towards stigmatization is likely to be a non-linear and oscillating process.

THEORETICAL ORIENTATION

Stigma and the 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 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 be 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 with 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) 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; Pollock et al., 2019). Within the field of management and organization studies, two conceptual models have offered potential insights. The first, by Wiesenfeld, Wurthmann, and Hambrick (2008), suggests 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. explain how stigma becomes attributed and focused on the organization's leadership (the CEO)—and how this narrowing 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" amongst 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)—highlights 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" (2009: 160). If this perceived incongruence is seen not just as 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, 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."

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—with the scope and form dependent on the perceived severity, salaciousness, and/or malice associated with the negative behaviors (e.g., ethical misdeeds as opposed to incompetence). As Kitsuse (1962: 248) puts 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 the 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 by a 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 rarely connects professions to the taints that define "dirty work"—i.e., "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) warn that the service orientation of professionals makes them especially vulnerable to public misperceptions and to the evaluations of "primary stakeholders" (Freeman, Harrison, & Zyglidopolous, 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 (Abbott, 1988; Muzio et al., 2019). Physicians treat patients, accounting and law firms deal with clients, and so on. This personal relationship stands in stark contrast to the impersonal distance between, on the one hand, a stigmatized organization that makes cigarettes or that manufactures weapons, and, on the other, the purchaser of those products.

At the same time, professions are subject to the evaluations of "secondary stakeholders" (Freeman et al., 2018) that do not directly receive 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 the profession: 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 public respect 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, shows that Italian bankers “who used to be seen as pillars of the community” are no longer praised and 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, 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 UK 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.

In approaching our case, we were also 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) remind us, 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 cut-throat 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 label 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[2]). Importantly, they were forbidden from practicing private medicine; and, in return, they were given tenured 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 mark-ups 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] In the following text, all references to interviews are noted using the format (IDX) to refer to the particular interviewee. For example, ID02 means interviewee number two.

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* social approval of the medical profession. It denounced professional misconduct and urged the public to cease aggressive behavior towards 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 were not typical (UNODC, 2018; WHO, 2002a).

This dramatic change in attitudes towards 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.

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 first-hand 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 where 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, 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 (职业道德)" with "physicians (医生)" or with "hospitals (医院)," and "medical professional ethics (医德/医风)"—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 by patients of physicians—including "medical dispute" (医疗纠纷), "doctor-patient dispute" (医患纠纷), "doctor-patient conflict" (医患冲突), and "medical disruption" (医闹, also translated as medical profiteer).

Applying this list, we identified 756 articles—which we later separated into those involving verbal or physical violence, and those that did not.

To corroborate data collected from the *People's Daily*, we conducted similar article searches in the *Guangming Daily* and the *Economic Daily,* which target professionals and business people. Although these articles only cover 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 that 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 understandings of relationships with patients. In the second wave, we spoke with 28 medical professionals to better understand their perspective. Last, 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

experiences before and after the reforms; and 5 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 in ideal positions 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 on-site in two major municipalities in two province-level regions where 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 other province level regions (e.g., Shanghai, Guangdong, Fujian, Tianjin, Liaoning, Qinghai). These discussions reinforced the perception that the move towards stigmatization was a national rather than regional phenomenon—even though its intensity might be lower in less marketized provinces. All interviews were conducted in Mandarin Chinese and lasted between 40 and 90 minutes—except for four of the "elite" interviews, which each lasted for two hours. 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 of physicians' experiences, we collected statistics from secondary sources: the National Bureau of Statistics' *Health Yearbooks*; and surveys by the Ministry of Health, the Chinese Hospital Association (CHA), and the Chinese Medical Doctor Association (CMDA). These sources

[3] All five elite interviewees had been hospital presidents in their career. Four had also served as health department officers in the Government. Three of them had presided at regional branches of professional associations. As such, their career paths represent those of elite members of the medical profession.

provided data on patients as well as physicians—e.g., personal non-reimbursable 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 CHA survey, for example, received responses from 8,388 physicians in 316 hospitals across thirty 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 role 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 process and mechanisms of professional stigmatization that unfolded in our case.

Identifying and mapping shifting stakeholder evaluations. We began by identifying public statements by the Government, which 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—focusing,

in particular, 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" (if it reported ethics-related facts that do not have immediate connotations or presented an impartial view). Table 2–1 provides details on how the articles were coded and 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 it to the profession. To verify the reliability of our coding we asked a Chinese physician to reclassify a random subsample of 100 articles. The Cohen's kappa 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 by patients. We captured changes in their evaluations by, first, examining media articles that reported disputes between physicians and patients; and, second, 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, 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 which163 involved physical violence.

Table 2–1: 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 bath them…so that the patients feel like they are at home. The medical staff strongly adheres to professional ethics, insist 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 has unified their thoughts, 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." (Jan10, 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 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 medical professionals. But this severely tainted the image of 'angels in white'…People hate these serious violations of 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)

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 violence (as defined by WHO). 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, first, to *why* their evaluations moved from collective approval through ambivalence (a mixture of negative and positive evaluations) towards stigmatization. We then addressed *why* primary stakeholders prescribed harsher 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 suggests that ethical violations would 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 followed, others' evaluations and behaviors—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 towards

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 triangulation of multiple data sources (Guba & Lincoln, 2005). Table 2–2 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 has intimate knowledge of the setting on account of having several generations of family members 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 sounding board for both sides.

Table 2–2: Core Concepts, Data Sources and Illustrations

Core Concepts	Data Sources	Data Illustrations
Pervasive transgressions by the professionals	Media articles	• “The issue in 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 being 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)
	Statistics	• Annual growth of prescribed drug expenses (MOH)
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)
	Statistics	• Annual growth of non-reimbursable health expenses (MOH)
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)
	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 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." (State Council, 2006)
	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)
	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 towards physicians." (ID07)
Collective labeling by primary and secondary stakeholders	Archival documents	• "The significant doctor-patient contradiction… is due to prescription mark-ups… and revenue generation among hospitals and physicians." (MOH, 2006)
	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)

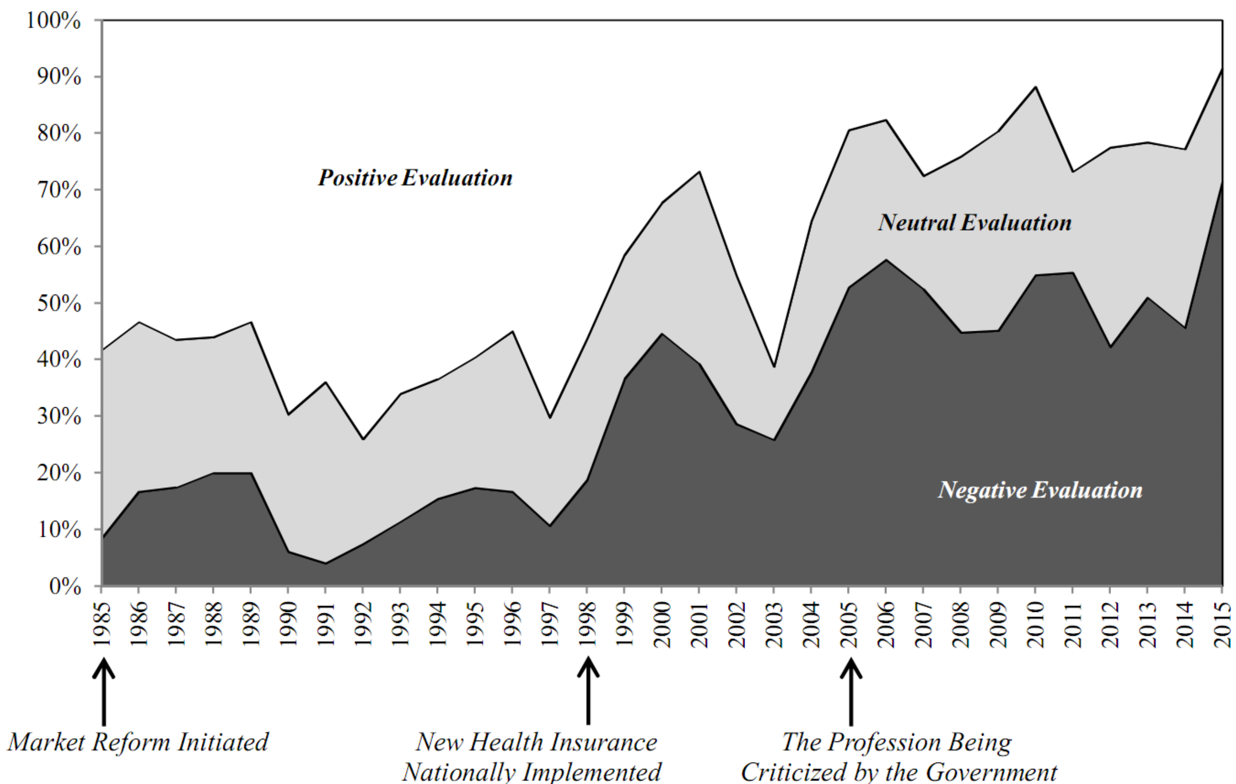
Divergent punishments by primary and secondary stakeholders	Archival documents	• "The general public shall respect physicians, constructing a nice atmosphere of respecting medicine in the society… improve the professional environment for physicians." (State Council, 2009) • "The rights of medical professionals shall be protected… Anyone who interferes with the work and life of medical professionals shall bear legal responsibility." (State Council, 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)
	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 disadvantageous and powerless." (ID14) • "Patients are stuck with doctors. Whichever hospitals 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) • "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)

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

FINDINGS

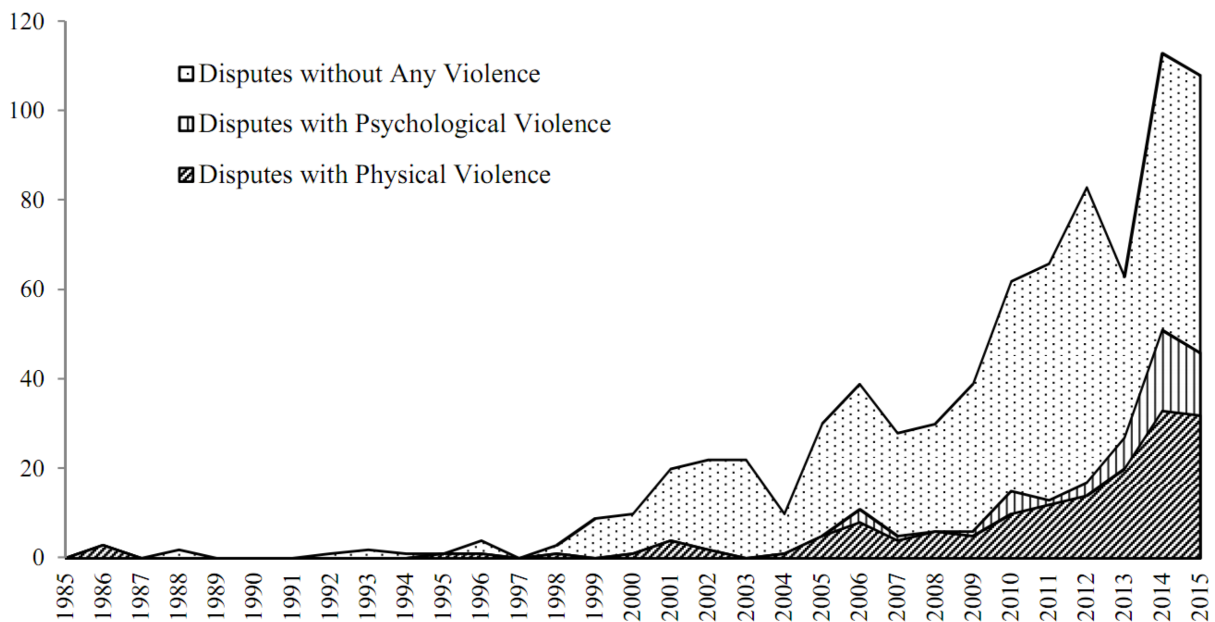
Our analysis surfaced three phases, each defined by movement along the continuum from collective approval *through* ambivalence *towards* stigmatization. In the first phase, beginning in 1985, physicians began engaging in practices of questionable ethical appropriateness, and, surprisingly, did so without incurring social disapproval. Beginning in 1998, however, the situation changed. Unethical practices became more pervasive and attitudes towards the profession shifted from collective approval to one of 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 towards one of stigmatization. Strikingly, in this phase, violence against physicians rose sharply.

Figure 2–1: Media Depiction of Professional Ethics, by Year



The overarching story is visualized in Figures 2–1 and 2–2. While the former shows the increasingly negative media attitudes towards professional ethics, 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 towards stigmatization. After presenting our findings, we detail the full model, situating it within extant stigma research.

Figure 2–2: Number of Reports of Disputes between Physicians and Patients, by Year



Source: *People's Daily*

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

The starting point of the story is 1985 when new regulations stipulated that while regular medical services would continue to be fully reimbursed, “special-demand” (特需) services and drugs would not.[4] Hospitals began charging patients a 15% mark-up for all drugs, and

[4] Whereas the regular health care includes regular clinical consultation, regular prescriptions, and necessary

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:

> 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)

Transgressions of physicians. The seeming compromising of professional behavior triggered a sense of unease amongst 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 *over*prescribing—as seen in the increasingly "standard" practice of prescribing the "three-element soup" (三素一汤) (i.e., a glucose injection of antibiotics, hormones, and vitamins) for various types of 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

---

surgeries, special-demand services typically include customized clinical consultation, imported drugs, plastic surgeries (e.g., laser hair removal, rouge removal), luxury delivery room services, etc.

association in this phase.[5]

Despite the growing pervasiveness of overprescribing, the media in general did not criticize the profession. As shown in Figure 2–1, from 1985 to 1997, of the 469 articles in the *People's Daily* that referred to professional ethics only 64 (14%) did so in a critical way. In contrast, 291 (62%) were highly positive, praising 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, a pattern confirmed by older physicians: "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 elder interviewees: "the media did not become hostile to physicians because people did not condemn overprescribing" (ID45). As shown in Figure 2–2, 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 elder 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" and self-regulation was assumed by the Government (Yao, 2016: 8; Davis, 2000). In this phase there was no equivalent to Western associations.

Thus, although this phase saw a rise of 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. Primary (patients) and secondary (the media) stakeholders, in other words, 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 towards 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 were now responsible for paying approximately 30% of their clinical bills. From 1998 to 2003, non-reimbursable medical expenses increased annually by 13%—making health care the third largest personal expense after food and education by the end of this phase (Ministry of Health, 1999, 2004). Hence, the perception that health care was a public welfare service was compromised, an outcome the media blamed upon 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 the 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 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 similar vein, the *Guangming Daily* 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 ten times that in

America… Physicians are incentivized by profits in [overprescribing] drugs—which has become an *unspoken rule* in the profession" (Oct 19, 2011, emphasis added).

It was 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 2–2 shows, doctor-patient disputes increased noticeably. From 1998 to 2004, the *People's Daily* published 101 articles reporting disputes, substantially exceeding the 14 of the previous phase. Likewise, between 2000 and 2004, the *Guangming Daily* and the *Economic Daily* published 106 articles describing patients confronting physicians. An elder 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 disputes increased, the tone of media articles became more critical. As shown in Figure 2–1, 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 attitude was 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" (白狼), 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 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 in 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). 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* its highlighting of 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 the 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 an elder 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 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., hospitals 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 forty or fifty 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, after 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 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

of questionable ethical conduct continued. As Yao, 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" (2016: 14). 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 were seen by their colleagues as "Don Quixote type of heroes" who were doomed to fail. An elder 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 towards stigmatization could be partially attributed to the absence of a powerful professional association—which might have provided a collective and authoritative voice. Indeed, the Chinese Medical Doctor Association was only established in 2002, and so 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 reached a point that was now 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 hospitals 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 an average employee (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* (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% mark-up on drugs. Yet, while doing so, the Government did not compensate hospitals for the resulting loss in revenues. 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—followed 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 proclaimed that 94% of the 17,638 respondents agreed that respect for the medical profession had collapsed (Sept 28, 2005). 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* succinctly summarized the situation: "The media have collectively fallen into

[6] In addition, we examined different unethical issues—"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.

stigmatizing doctors" (Oct 30, 2013). 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 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 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% to 11.4% from 2005 to 2013 (*Health Yearbooks*).

Sharing in this 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)

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 in aggressive ways. Between 2005 and 2015, not only did reports of doctor-patient disputes increase six-fold, incidents of violence rose sharply (see Figure 2–2). 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% 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 26, 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 upholders of socialism (e.g., State Council, 2009): "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, emphasis for secondary stakeholders 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" and harming doctors "is a societal shame" (*People's Daily*, Dec 21, 2006). The *Guangming Daily*, similarly, underscored "the importance and urgency of building a harmonious doctor-patient relationship" (Dec 23, 2005).

Nevertheless, patients continued to express their 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, 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 received less than 10 minutes (Wu et al., 2014; see also Chinese Hospital Association,

2014). They felt rushed through the system—in part because the daily number of patients seen by a physician rose from 5.5 in 1990 to 7.3 in 2015 (*Health Yearbooks*). 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, failure to live up to this representation was highly consequential. This expectation weighed 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 the 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 a president of a regional branch of the professional association despairingly complained:

> The associations and their websites might seem fancy and classy (高大上), but in fact their statements are just fake and empty (假大空)… 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 are mostly 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

At the end 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 towards stigmatization remains to be seen. Indeed, the current COVID-19 pandemic in 2020 has seemingly given the medical profession some temporary respite from stigmatization—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 medical professionals who came from outside 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

[7] A prominent example was Dr. Yu Ying, a surgeon in the prestigious Peking Union Hospital, who opened her Weibo (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 drew much attention (Zhao, 2016).

"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 the pandemic. Through such public acclamations, the Government has helped push for a restoration of the public's respect for the profession.

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 experienced verbal abuse or physical violence—down only 7% from 2015. Moreover, reports of aggressive behavior towards 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": "We should put a bullet in the heads of corrupt physicians, upholding the professional ethics"; "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" towards 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 towards medical professionals. The stigmatization of the medical profession has not, in other words, "stabilized" (Mair, Wolf, & Seelos, 2016).

DISCUSSION

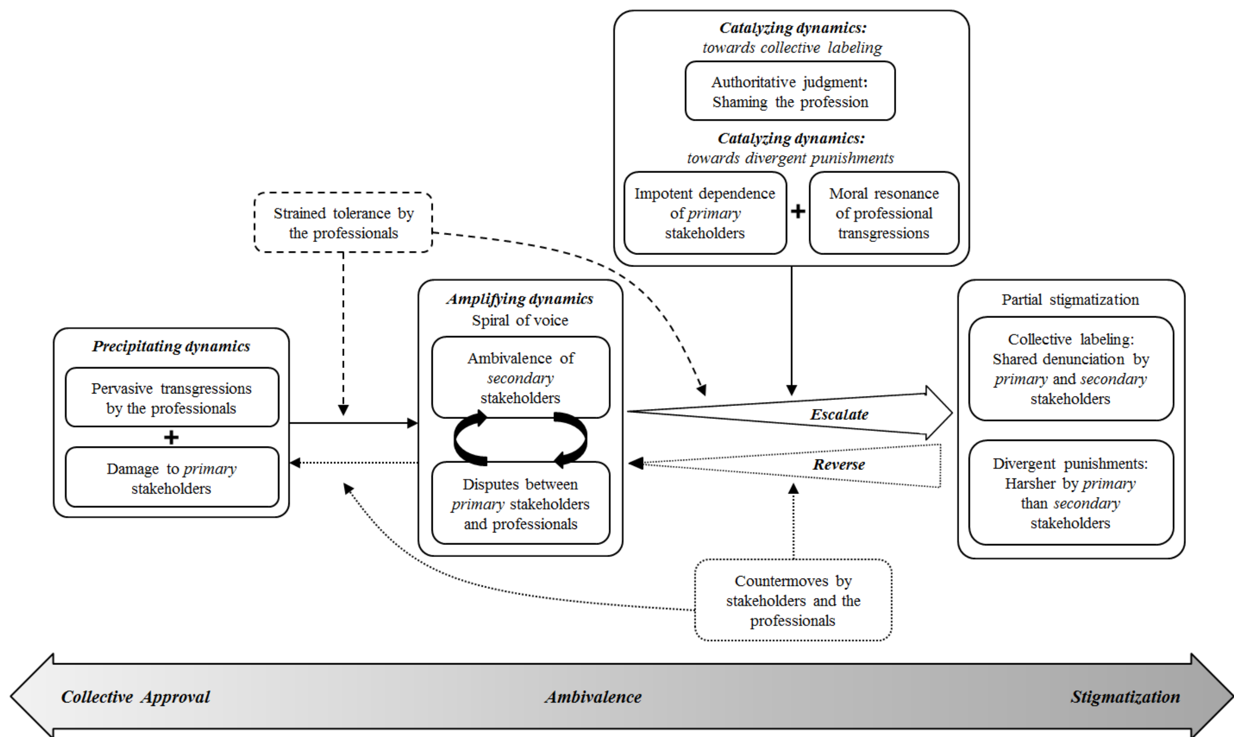
Despite growing interest among management and organizational scholars in uncovering how organizations manage the consequences of being stigmatized, there is still much to learn about the processes by which stigmatization emerges and unfolds. Our primary contribution is the development of a process model 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 2–3, 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 towards ambivalence, followed by catalyzing dynamics that escalate even further the momentum towards 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 prescriptions of

appropriate punishment because of their respective relationships with 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 towards stigmatization (as illustrated by the dotted lines and arrows in Figure 2–3). 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.

Figure 2–3: A Process Model of Professional Stigmatization



Precipitating dynamics. Unlike prior studies that point to ethical breaches as the starting point of a move towards stigmatization (Devers et al., 2008; Hudson, 2008; Wiesenfeld et al., 2008), ethical transgressions alone had little effect on the widespread social approval of the

Chinese medical profession. One possible explanation is that 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 loss of approval strengthens the possibility that misconducts *alone* need not trigger the process towards professional stigmatization.

Instead, for social approval to be undermined, it seems that unethical behaviors 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 towards ambivalence.

Amplifying dynamics. Once initiated, the momentum towards 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 towards 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 social 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 towards stigmatization, it is worth noting an unusual feature of our case: "strained tolerance"—i.e., the absence of any systematic pushback by the profession (as illustrated by the dashed lines in Figure 2–3). 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 of providing a defense is particularly acute if a profession lacks an effective collective voice—as in China, where the 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 and/or counter the narrative in the media.

Catalyzing dynamics: towards collective labeling. Prior studies suggest 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 English NHS, for example, details how the government stepped in to effect institutional repair by explicitly highlighting the harm inflicted by severe breaches to 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 public shaming in the 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. This broadening of the target of stigma contrasts with prior models that depict 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 towards stigmatization by catalyzing 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—triggering a chorus of criticism that quickens the move from ambivalence towards stigmatization.

Catalyzing dynamics: towards divergent punishments. The momentum unleashed by an

authoritative judgment moves the evaluations of primary *and* secondary stakeholders towards 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, there is typically a strong dependence of primary stakeholders upon the profession. This dependence runs counter to most portrayals of stigmatization situations which implicitly assume that "exit" (Hirschman, 1977) is an option—i.e., that those affected can "shun" (Adut, 2008; Hampel & Tracey, 2017) or limit 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 especially in professions such as medicine and 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 towards 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 towards stigmatization. While ethical transgressions often trigger emotional responses (Pollock et al., 2019), 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 towards ambivalence, suggesting that countermoves may disturb the momentum towards stigmatization.

Unfolding events also influence the move and momentum towards 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 towards 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 Helms et al. (2019) who advocate that audiences may stigmatize particular aspects of an organization's practices, yet 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 (or roots) of stigmatization.

To further develop understanding of the stigmatization process also requires giving 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 (Wiesenfeld et al., 2008; Devers et al., 2009), 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. But, whereas primary stakeholders persisted in advocating aggressive punishment of the professionals, 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 (Wiesenfeld et al., 2008; Devers et al., 2009). 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—slowing, containing, and perhaps even reversing the movement towards 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 social 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 suggests 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 towards stigmatization; and perhaps even reverse that process.

However, even in Western countries, including the UK, Australia and Canada, professional associations have shown relative weakness in addressing pervasive transgressions (Leslie et al., 2018; Marriage, 2019). In the UK, for example, the General Medical Council, established in 1858, consistently failed to prevent transgressions—to the point 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 UK 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 towards stigmatization. Comparisons across countries would be especially informative about the generalizability of our model. A related line of research could inquire whether, and in what contexts, other actors—prestigious professional firms, judges, media celebrities, political parties, and the Church—might have sufficient "discursive legitimacy" (Phillips, Lawrence, & Hardy, 2004) to influence the momentum towards 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 is 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 social respect would not be that easy. Alternatively, would strict punishment of 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 pervasive 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? And, would the restoration of professional respect be more likely during and after a health crisis, which seemed to occur during the 2002–2003 SARS epidemic and is now occurring during the current COVID-19 pandemic? While a crisis could immediately highlight the importance and devotion of medical professionals, the evidence from the SARS epidemic is that the 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 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 towards 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 and thus whose actions have a 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 been the fuse of riots and upheaval (Obrador & Uhlmann, 2018). Such comparisons could probe not only whether particular professions are held to a higher code 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 growing problem. Given that the growing incidence of violence against physicians has 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 for understanding 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.

REFERENCES

Abbott, A. 1988. ***The system of professions: An essay on the division of expert labor.*** Chicago: University of Chicago Press.

Adut, A. 2008. ***On scandal: Moral disturbances in society, politics and art.*** Cambridge: Cambridge University Press.

Allison, K. W. 1998. Stress and oppressed category membership. In J. K. Swim & C. Stangor (Eds.), ***Prejudice: The target's perspective:*** 145–170. San Diego, CA: Academic Press.

Anteby, M. 2010. Markets, morals, and practices of trade: Jurisdictional disputes in the U.S. commerce in cadavers. ***Administrative Science Quarterly,*** 55: 606–638.

Anteby, M., Chan, C. K., & DiBenigno, J. 2016. Three lenses on occupations and professions in organizations: Becoming, doing, and relating. ***Academy of Management Annals,*** 10: 183–244.

Ashforth, B. E. 2019. Stigma and legitimacy: Two ends of a single continuum or different continua altogether. ***Journal of Management Inquiry,*** 28: 22–30.

Ashforth, B. E., & Kreiner, G. E. 1999. "How can you do it?": Dirty work and the challenge of constructing a positive identity. ***Academy of Management Review,*** 24: 413–434.

Ashforth, B. E., Kreiner, G. E., Clark, M. A., & Fugate, M. 2007. Normalizing dirty work: Managerial tactics for countering occupational taint. ***Academy of Management Journal,*** 50: 149–174.

Bevan, G., & Wilson, D. 2013. Does 'naming and shaming' work for schools and hospitals? Lessons from natural experiments following devolution in England and Wales. ***Public Money & Management,*** 33: 245–252.

Boxenbaum, E., & Jonsson, S. 2017. Isomorphism, diffusion and decoupling: Concept evolution and theoretical challenges. In R. Greenwood, C. Oliver, T. B. Lawrence, & R. E. Meyer (Eds.), ***The SAGE handbook of organizational institutionalism,*** 2nd edition: 77–101. London: Sage.

Brint, S. 1994. ***In an age of experts: The changing roles of professionals in politics and public life.*** Princeton, NJ: Princeton University Press.

Brooks, R. 2018. ***Bean counters: The triumph of the accountants and how they broke capitalism***. London: Atlantic Books.

Carberry, E. J., & King, B. G. 2012. Defensive practice adoption in the face of organizational stigma: Impression management and the diffusion of stock option expensing. ***Journal of Management Studies,*** 49: 1137–1167.

Carmi-Iluz, T., Peleg, R., Freud, T., & Shvartzman, P. 2005. Verbal and physical violence towards hospital- and community-based physicians in the Negev: an observational study. ***BMC Health Services Research,*** 5: 54.

Chinese Hospital Association. 2014. ***Investigation on hospital violence in China (2003–2012).***

Chinese Medical Doctor Association. 2004. ***Investigation on physician practice.***

Chinese Medical Doctor Association. 2015. ***Chinese physicians' practice status white paper.***

Clemente, M., & Roulet, T. J. 2014. Public opinion as a source of deinstitutionalization: A "spiral of silence" approach. ***Academy of Management Review,*** 40: 96–114.

Creed, W. E. D., DeJordy, R., & Lok, J. 2010. Being the change: Resolving institutional contradiction through identity work. ***Academy of Management Journal,*** 53: 1336–1364.

Creed, D. W. E., Hudson, B. A., Okhuysen, G. A., & Smith-Crowe, K. 2014. Swimming in a sea of shame: Incorporating emotion into explanations of institutional reproduction and change. ***Academy of Management Review,*** 39: 275–301.

Currie, G., Lockett, A., Finn, R., Martin, G., & Waring, J. 2012. Institutional work to maintain professional power: Recreating the model of medical professionalism. ***Organization Studies,*** 33(7): 937–962.

Dacin, M. T., Dacin, P. A., & Kent, D. 2019. Tradition in organizations: A custodianship framework. ***Academy of Management Annals,*** 13: 342–373.

Davis, D. 2000. Social class transformation in urban China: Training, hiring, and promoting urban professionals and managers after 1949. ***Modern China,*** 26: 251–275.

Deephouse, D. L., Bundy, J., Tost, L. P., & Suchman, M. C. 2017. Organizational legitimacy. In R. Greenwood, C. Oliver, T. B. Lawrence, & R. E. Meyer (Eds.), ***The SAGE handbook of organizational institutionalism,*** 2nd edition: 27–54. London: Sage.

Devers, C. E., Dewett, T., Mishina, Y., & Belsito, C. A. 2009. A general theory of organizational stigma. ***Organization Science,*** 20: 154–171.

Dixon-Woods, M., Yeung, K., & Bosk, C. L. 2011. Why is UK medicine no longer a self-regulating profession? The role of scandals involving "bad apple" doctors. ***Social Science & Medicine,*** 73: 1452–1459.

Eisenhardt, K. M. 1989. Building theories from case-study research. ***Academy of Management Review,*** 14: 532–550.

Eley, J. & Kinder, T. 2019. MPs criticise "catalogue of failures" in Thomas Cook auditing. ***Financial Times,*** November 5, 2019.

Flack, J. M., Amaro, H., Jenkins, W., Kunitz, S., Levy, J., Mixon, M., & Yu, E. 1995. Panel I: Epidemiology of minority health. ***Health Psychology,*** 14: 592–600.

Fleiss, J. L. 1981. ***Statistical methods for rates and proportions.*** New York: John Wiley & Sons.

Freeman, R. E., Harrison, J. S., & Zyglidopoulos, S. 2018. ***Stakeholder theory: Concepts and strategies.*** Cambridge: Cambridge University Press.

Gabbioneta, C., Greenwood, R., Mazzola, P., & Minoja, M. 2013. The influence of the institutional

context on corporate illegality. ***Accounting, Organizations and Society,*** 38(6–7): 484–504.

Gabbioneta, C., Prakash, R., & Greenwood, R. 2014. Sustained corporate corruption and processes of institutional ascription within professional networks. ***Journal of Professions and Organization,*** 1: 16–32.

Galvin, T. L., Ventresca, M. J., & Hudson, B. A. 2004. Contested industry dynamics. ***International Studies of Management & Organization,*** 34: 56–82.

George, G., Howard-Grenville, J., Joshi, A., & Tihanyi, L. 2016. Understanding and tackling societal grand challenges through management research. ***Academy of Management Journal,*** 59: 1880–1895.

Gioia, D. A., Corley, K. G., & Hamilton, A. L. 2012. Seeking qualitative rigor in inductive research. ***Organizational Research Methods,*** 16(1): 15–31.

Gioia, D. A., Price, K., Hamilton, A. L., & Thomas, J. B. 2010. Forging an identity: An insider-outsider study of processes involved in the formation of organizational identity. ***Administrative Science Quarterly,*** 55: 1–46.

Goffman, E. 1963. ***Stigma: Notes on the management of spoiled identity.*** New York: Simon & Schuster.

Guba, E. G., & Lincoln, Y. S. 2005. Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), ***The SAGE handbook of qualitative research,*** 3rd edition: 191–215. London: Sage.

Gutierrez, B., Howard-Grenville, J., & Scully, M. A. 2010. The faithful rise up: Split identification and an unlikely change effort. ***Academy of Management Journal,*** 53: 673–699.

Hampel, C. E., & Tracey, P. 2017. How organizations move from stigma to legitimacy: The case of Cook's travel agency in Victorian Britain. ***Academy of Management Journal,*** 60: 2175–2207.

Hampel, C. E., & Tracey, P. 2019. Introducing a spectrum of moral evaluation: Integrating organizational stigmatization and moral legitimacy. ***Journal of Management Inquiry,*** 28: 11–15.

Helfen, M., & Sydow, J. 2013. Negotiating as institutional work: The case of labour standards and international framework agreements. ***Organization Studies,*** 34(8): 1073–1098.

Helms, W. S., Oliver, C., & Webb, K. 2012. Antecedents of settlement on a new institutional practice: Negotiation of the ISO 26000 standard on social responsibility. ***Academy of Management Journal,*** 55: 1120–1145.

Helms, W. S., & Patterson, K. D. W. 2014. Eliciting acceptance for "illicit" organizations: The positive implications of stigma for MMA organizations. ***Academy of Management Journal,*** 57: 1453–1484.

Helms, W. S., & Patterson, K. D. W., Hudson, B. A. 2019. Let's not "taint" stigma research with legitimacy, please. ***Journal of Management Inquiry,*** 28: 5–10.

Herepath, A., & Kitchener, M. 2016. When small bandages fail: The field-level repair of severe and protracted institutional breaches. ***Organization Studies,*** 37(8): 1113–1139.

Hirschman, A. O. 1977. ***Exit, voice, and loyalty: Responses to decline in firms, organizations, and states.*** Cambridge: Harvard University Press.

Hudson, B. A. 2008. Against all odds: A consideration of core-stigmatized organizations. ***Academy of Management Review,*** 33: 252–266.

Hudson, B. A., & Okhuysen, G. A. 2009. Not with a ten-foot pole: Core stigma, stigma transfer, and improbable persistence of men's bathhouses. ***Organization Science,*** 20: 134–153.

Hudson, B. A., & Okhuysen, G. A. 2014. Taboo topics: Structural barriers to the study of organizational stigma. ***Journal of Management Inquiry,*** 23: 242–253.

Jepperson, R. L., & Swidler, A. 1994. What properties of culture should we measure? ***Poetics,*** 22: 359–371.

Kitsuse, J. I. 1962. Societal reaction to deviant behavior: Problems of theory and method. ***Social Problem,*** 9: 247–256.

Kreiner, G. E., Ashforth, B. E., & Sluss, D. M. 2006. Identity dynamics in occupational dirty work: Integrating social identity and system justification perspectives. ***Organization Science,*** 17: 619–636.

Kurzban, R., & Leary, M R. 2001. Evolutionary origins of stigmatization: The functions of social exclusion. ***Psychological Bulletin,*** 127: 187–208.

Langley, A., & Abdallah, C. 2011. Templates and turns in qualitative studies of strategy and management. In D. D. Bergh & D. J. Ketchen (Eds.), ***Research Methodology in Strategy and Management,*** 6: 201–235.

Lashley, K., & Pollock, T.G. 2020. Waiting to inhale: Reducing stigma in the medical cannabis industry. ***Administrative Science Quarterly,*** 65: 434–482.

Leicht, K. T., & Fennell, M. L. 2008. Institutionalism and professions. In R. Greenwood, C. Oliver, K. Sahlin, & R. Suddaby (Eds.), ***The SAGE handbook of organizational institutionalism***: 449–472. London: Sage.

Leslie, K., Nelson, S., Deber, R., & Gilmour, J. 2018. Policy tensions in regulatory reform: Changes to regulation of health professions in Australia, the United Kingdom, and Ontario, Canada. ***Journal of Nursing Regulation,*** 8: 32–42.

Lin, N., & Xie, W. 1988. Occupational prestige in urban China. ***American Journal of Sociology,*** 93: 793–832.

Link, B. G., & Phelan, J. C. 2001. Conceptualizing stigma. ***Annual Review of Sociology,*** 27: 363–385.

Louis, M. R., & Bartunek, J. M. 1992. Insider/outsider research teams: Collaboration across diverse

perspectives. ***Journal of Management Inquiry,*** 1: 101–110.

Mair, J., Wolf, M., & Seelos, C. 2016. Scaffolding: A process of transforming patterns of inequality in small-scale societies. ***Academy of Management Journal,*** 59: 2021–2044

Marriage, M. 2019. UK accounting watchdog to be replaced by stronger regulator. ***Financial Times,*** March 11, 2019.

Marshall, C., & Rossman, G. B. 1999. ***Designing qualitative research.*** London: Sage.

McMurray, R. 2011. The struggle to professionalize: An ethnographic account of the occupational position of Advanced Nurse Practitioners. ***Human Relations,*** 64(6): 801–822.

Micelotta, E. R., & Washington, M. 2013. Institutions and maintenance: The repair work of Italian professions. ***Organization Studies,*** 34(8): 1137–1170.

Ministry of Health. 1992. ***A few opinions on deepening the health care reform.***

Ministry of Health. 1999. ***Research on national health services—an analysis report of the second national health services survey in 1998.***

Ministry of Health. 2004. ***Research on national health services—an analysis report of the third national health services survey in 2003.***

Ministry of Health. 2005. ***Developing the medical and health enterprise, and constructing a socialist harmonious society.***

Ministry of Health. 2007. ***Measures for the management of physicians' regular assessment.***

Montgomery, A. W., & Dacin, M. T. 2019. Water Wars in Detroit: Custodianship and the Work of Institutional Renewal. ***Academy of Management Journal,*** doi.org/10.5465/amj.2017.1098.

Muzio, D., Aulakh, S., & Kirkpatrick, I. 2019. ***Professional occupations and organizations.*** Cambridge University Press.

National Research Center. 2005. ***Evaluation and suggestions on China's health system reform.***

Nee, V. 1989. A theory of market transition: From redistribution to markets in state socialism. ***American Sociological Review,*** 54: 663–681.

Obrador, A. M. L., & Uhlmann, N. 2018. ***A new hope for Mexico: Saying no to corruption, violence and Trump's wall.*** OR Books.

Paetzold, R. L., Dipboye, R. L., & Elsbach, K. D. 2008. A new look at stigmatization in and of organizations. ***Academy of Management Review,*** 33: 186–193.

Palmer, D., & Feldman, V. 2018. ***Comprehending the incomprehensible: Organization theory and child sex abuse in organizations.*** Cambridge: Cambridge University Press.

Patton, M. Q. 2002. ***Qualitative research & evaluation methods,*** 3rd edition. Sage Publications.

Pescosolido, B. A., & Martin, J. K. 2015. The stigma complex. ***Annual Review of Sociology,*** 41: 87–116.

Phillips, N., Lawrence, T. B., & Hardy, C. 2004. Discourse and institutions. ***Academy of Management***

Review, 29: 635–652.

Piazza, A., & Perretti, F. 2015. Categorical stigma and firm disengagement: Nuclear power generation in the United States, 1970–2000. ***Organization Science,*** 26: 724–742.

Pollock, T.G., Lashley, K., Rindova, V.P., & Jung-Hoon, H. 2019. Which of these things are not like the others? Comparing the rational, emotional, and moral aspects of reputation, status, celebrity, and stigma. ***Academy of Management Annals,*** 13: 444–478.

Pontikes, E., Negro, G., & Rao, H. 2010. Stained red: A study of stigma by association to blacklisted artists during the "red scare" in Hollywood, 1945 to 1960. ***American Sociological Review,*** 75: 456–478.

Pratt, M. 2000. The good, the bad, and the ambivalent: Managing identification among Amway distributors. ***Administrative Science Quarterly,*** 45: 456–493.

Ramirez, C. 2013. "We are being pilloried for something, we did not even know we had done wrong": Quality control and orders of worth in the British audit profession. ***Journal of Management Studies,*** 50: 845–869.

Raynard, M., Lu, F., & Jing, R. 2020. Reinventing the state-owned enterprise? Negotiating change during profound environmental upheaval. ***Academy of Management Journal,*** 63: 1–36.

Roulet, T. 2015. "What good is Wall Street?" institutional contradiction and the diffusion of the stigma over the finance industry. ***Journal of Business Ethics,*** 130: 389–402.

Roulet, T. 2019. Sins for some, virtues for others: Media coverage of investment banks' misconduct and adherence to professional norms during the financial crisis. ***Human Relations,*** 72: 1436–1463.

Ruebottom, T., & Toubiana, M. 2017. Biographical opportunities: How entrepreneurship creates pride in alterity in stigmatized fields. ***Academy of Management Proceedings,*** 2017: 12168.

Sauder, M. 2008. Interlopers and field change: The entry of U.S. News into the field of legal education. ***Administrative Science Quarterly,*** 53(2): 209–234.

Sidel, V. W., & Sidel, R. 1973. ***Serve the people: Observations on medicine in the People's Republic of China.*** Boston, MA: Beacon Press.

Smets, M., Jarzabkowski, P., Burke, G. T., & Spee, P. 2015. Reinsurance trading in Lloyd's of London: Balancing conflicting-yet-complementary logics in practice. ***Academy of Management Journal,*** 58: 932–970.

Smets, M., Morris, T., & Greenwood, R. 2012. From practice to field: A multilevel model of practice-driven institutional change. ***Academy of Management Journal,*** 55: 877–904.

Smith, J. 2004. ***The shipman inquiry fifth report.*** London: Stationery Office.

State Council. 1989. ***Opinions on issues regarding the expansion of health services.***

State Council. 2009. ***Opinions on deepening the reform of the medical and health care system.***

Sun, Q., Santoro, M. A., Meng, Q., Liu, C., & Eggleston, K. 2008. Pharmaceutical policy in China. ***Health Affairs,*** 27: 1042–1050.

Supreme People's Court. 2014. ***Opinions of punishing illegal acts and crimes against medical professionals in accordance with law and maintaining the normal medical order.***

Swan, J. A., & Newell, S. 1995. The role of professional associations in technology diffusion. ***Organization studies,*** 16(5), 847–874.

The Economist. 2019. Italy's banks: The reckoning continues. ***The Economist,*** November 16, 2019.

Tilcsik, A., Anteby, M., & Knight, C. R. 2015. Concealable stigma and occupational segregation: Toward a theory of gay and lesbian occupations. ***Administrative Science Quarterly,*** 60(3): 446–481.

United Nations Office on Drugs and Crime. 2018. ***UNODC statistics online.*** https://dataunodc.un.org/crime/intentional-homicide-victims.

Vergne, J. P. 2012. Stigmatized categories and public disapproval of organizations: A mixed-methods study of the global arms industry, 1996–2007. ***Academy of Management Journal,*** 55: 1027–1052.

Vough, H. C., Cardador, M. T., Bednar, J. S., Dane, E., & Pratt, M. G. 2013. What clients don't get about my profession: A model of perceived role-based image discrepancies. ***Academy of Management Journal,*** 56: 1050–1080.

Wiesenfeld, B. M., Wurthmann, K. A., & Hambrick, D. C. 2008. The stigmatization and devaluation of elites associated with corporate failures: A process model. ***Academy of Management Review,*** 33: 231–251.

World Health Organization. 2002a. ***World report on violence and health.*** E.G. Krug et al. (Eds.). Geneva.

World Health Organization. 2002b. ***New Research shows workplace violence threatens health services***.

World Medical Association. 2015. ***Growing violence against doctors alarms medical profession.***

Wu, D., Wang, Y., Lam, K. F., & Hesketh, T. 2014. Health system reforms, violence against doctors and job satisfaction in the medical profession: A cross-sectional survey in Zhejiang Province, Eastern China. ***BMJ Open,*** 4: 1–10.

Yao, Z. 2016. The changing relationship between the Chinese urban medical profession and the state since the republican period: The perspective of the sociology of professions. ***The Journal of Chinese Sociology,*** 3(1): 1–17.

Yao, Z. 2017. Right-protection by violence in healthcare service and its governance: Based on content analysis of news reports from 2002 to 2015. ***Social Construction,*** 14: 49–63.

Zhang, N., & Zhao, J. 2014. Statistical analysis of medical dispute cases based on related literatures from 2009 to 2013. ***Medicine and Society,*** 27(6): 55–58.

Zhao, P. 2016. ***Physicians' self-empowerment and physician-patient communication in the perspective of new media.*** PhD dissertation. Beijing: Tsinghua University.

Zhu, H. 2007. Abuses in the health care system and distortions in pharmaceutical pricing. ***Social Sciences in China,*** (4): 89–103.

Zietsma, C., Groenewegen, P., Logue, D. M., Hinings, C. R. 2017. Field or fields? Building the scaffolding for cumulation of research on institutional fields. ***Academy of Management Annals,*** 11(1): 391–450.

Zuckerman, E. W. 1999. The categorical imperative: Securities analysts and the illegitimacy discount. ***American Journal of Sociology,*** 104: 1398–1438.

Chapter 3

Why Is Bribing Doctors an Excusable Crime? The Normalization of Stigmatized Behavior

INTRODUCTION

To battle health inequalities across societies, the World Health Organization (WHO) has made universal health coverage its top priority—i.e., accessible and affordable essential quality health services to all individuals and communities (WHO, 2017). Achieving this ambitious goal will require considerable resources, and efforts to achieve it are being undermined by widespread corruption in health care. Corruption in the health sector is a “dirty open secret” that kills 140,000 children each year, fuels the global rise in anti-microbial resistance, and hinders the fight against HIV/AIDS among other diseases (García, 2019; Jain, Nundy, & Abbasi, 2014; Transparency International, 2019). Globally, more than US$7.5 trillion is spent on health care annually and approximately 10–25% of that is lost to corruption (García, 2019; WHO, 2018). If even half of the lost expenditure could be recovered and re-invested in health care, WHO’s universal health coverage goal could be achieved by 2030. Corruption in health care has already been dubbed a “pandemic” that should be no longer ignored (Transparency International, 2019).

Researchers in medicine and public health are now producing an increasing number of articles on the problem of corruption. A search for the term “corruption” in combination with “health care” (or “healthcare”) in PubMed—a comprehensive search engine accessing academic journals in medicine and public health—yields 345 articles published from 2011 to 2020. In contrast, the same search in the management category of the Social Sciences Citation Index returns only 6 articles, while the same search in the public administration category returns merely 7 articles. Management theory has had little to say about corruption in health care.

Undoubtedly, corruption in health care is a grand societal challenge that is understudied by management scholars, but can management and organization studies further our understanding of this challenge and how to address it? Motivated by this question, I draw upon two literatures: one

on how stigmatized behavior may be "normalized"—i.e., rendered "permissible and even desirable" (Ashforth & Anand, 2003: 3; Palmer, Smith-Crowe, & Greenwood, 2016)—and one on corrective actions against such behavior (Hersel, Helmuth, Zorn, Shropshire, & Ridge, 2019). Based on the idea that corruption is an extreme example of a morally stigmatized practice, I explore three interrelated questions: How do morally stigmatized practices become normalized by professionals, who are supposed to uphold a code of ethics? What strategies do professional organizations (in this case, hospitals) adopt to correct such practices? And why do the stigmatized practices persist despite these strategies? Whereas prior work has taken a static approach to normalization and neglected context, I adopt a process-oriented view in this study and examine how stigmatized behavior is normalized both before and after a broad institutional change by exploring the three questions. These questions matter because research from various countries indicates that physicians consistently regard corruption as excusable even though such deviance is publicly discredited and prohibited (García, 2019; Jain et al., 2014; Zhang & Grouse, 2013). This means that any anti-corruption strategies that do not address the normalization of stigma may be ineffective.

Corruption can take many forms—such as bribery, embezzlement, extortion, and favoritism (Heath, Richards, & de Graaf, 2016). This study adopts a two-phase, mixed method approach to study a particular form of corruption—bribery—in the context of the health care industry in China. It began with a qualitative exploration of the context in 2016–2017, where I investigated how bribery was normalized by members of professional organizations (in this case, physicians in hospitals), even though the accepting and soliciting of bribes was stigmatized and formally prohibited by the professional regulators. In this first phase, I generated the "rationalizing practices" that were widely adopted among different organizations to justify bribery. I went into

the field again after a regulatory change in 2018, during which the Chinese government established new supervisory agencies charged with monitoring and removing professional misconduct—in particular, bribery. In this second phase, I leveraged the regulatory change as a natural experiment to explore what strategies different organizations used in response to the heightening stigmatization of bribery, and whether and how these strategies affected the rationalization of bribery and the persistence of such stigmatized behavior.

This study makes three contributions. First, it conceptualizes three complementary types of rationalizing practices that may be used by professionals to justify stigmatized behavior (in this case, bribery). Though the prior literature has provided a list of rationalizing practices that are used in corporate contexts or dirty work occupations, much less is known about whether these practices can be applied to prestigious professions, which are expected to be distinct (Muzio et al., 2019; Palmer et al., 2016). In the first type of rationalizing practice uncovered in this study, professionals insist that bribery is acceptable because it does not compromise "professional competence" or "expert professionalism" (Brint, 1994). The second type entails "professional confirmation;" here, professionals resort to both professional and socio-cultural norms in order to rationalize bribery. The third type portrays bribery as a form of "professional appreciation"—both socially and economically. While some of the specific practices in these three types are similar to those in the literature (Ashforth & Anand, 2003), others are distinct to professional contexts.

Moreover, the study identifies two important organizational characteristics—i.e., status and ownership—that may shape the ways by which organizations strategically respond to stigmatized behavior when challenged by important stakeholders. Particularly, high-status or publicly-owned organizations are more responsive to regulatory efforts to stem the stigmatized behavior to the

extent that they are inclined to adopt a larger variety of corrective actions as well as more substantial actions. This suggests that a “status hazard” (Graffin, Bundy, Porac, Wade, & Quinn, 2013) rather than a “status shield” (Montauti & Wezel, 2016) is activated, as high-status organizations tend to not only receive greater stakeholder attention but also become suspected as they have more opportunities to exploit their advantage. Further, it is suggested that public organizations are more responsive because they are highly dependent on the resources provided by regulators. In other words, when “stakeholder power” (Hersel et al., 2019; Mitchell, Agle, & Wood, 1997) is high, organizations are likely to take greater actions.

Finally, the study shows that the rationalization of stigmatized behavior might carry on despite corrective actions. This is an unexpected finding that runs counter to the existing literature, which has largely focused on the positive effect of corrective actions on firm performance and market reactions (Gabbioneta, Greenwood, Mazzola, & Minoja, 2013; Hersel et al., 2019). Instead, this study suggests that corrective actions might not eradicate the embeddedness and rationalization of stigmatized behavior within an organization for two reasons. First, given the obscure nature of bribery, professionals may perceive low risks of being caught, leading to an “optimism bias.” Even though certain corrective actions can substantially damage a physician’s professional career, the optimism bias contributes to continued rationalization of bribery. Moreover, the corrective actions might even exacerbate the embeddedness of bribery, as such actions may be perceived as imposing additional “injustice” on professionals and make some physicians feel “morally indignant” and even more inclined to rationalize bribery by resorting to the lack of professional appreciation. Together, the two perceptions facilitate the persistence and maintenance of stigmatized behavior.

THEORETICAL ORIENTATION

Research into "conduct stigma," that originating from individuals' or organizations' deviant behavior (Devers, Dewett, Mishina, & Belsito, 2009), often overlaps with the literature on organizational wrongdoing and misconduct (Greve, Palmer, & Pozner, 2010). However, organizational misconduct may include a wide range of "violations of criminal, civil, and administrative law; transgressions of explicit industry and professional codes; and contraventions of less codified organizational rules, social norms, and ethical principles" (Palmer et al., 2016: 1; Hersel et al., 2019). In this paper, I do not look at how morally contested yet legally permitted behaviors (e.g., industrial emission, exotic dancing, animal experiment) may be managed, which is widely studied in impression management and the dirty work literatures (Ashforth, Kreiner, Clark, & Fugate, 2007; Elsbach & Sutton, 1992). Instead, I focus on an extreme type of stigmatized behavior, corruption, which is defined as "the misuse of authority for personal, subunit and/or organizational gain" (Ashforth & Anand, 2003: 2). In the context of health care, corruption not only transgresses professional codes, but also violates criminal, civil, or administrative laws. Using Clair, Daniel, and Lamont's (2016) terms, corruption in health care is not only "publicly stigmatized" (for it deviates from professional and social norms) but also "structurally stigmatized" (for it violates laws and regulations).

While the previous literature has often focused on the sources and consequences of conduct stigma, we know less about how stigmatized behavior becomes maintained and normalized—in particular in professional contexts (Palmer, 2017; Zhang, Wang, Toubiana, & Greenwood, 2021). Nor do we know much about how professional organizations respond if the stigmatized behavior is challenged and further discredited by important stakeholders (Gabbioneta et al., 2013; Piazza & Perretti, 2015). Finally, we know little about how professionals within an organization react to

that organization's attempts to stem the stigmatized behavior.

The Normalization of Stigmatized Behavior

The burgeoning literature on stigma management—in particular, management of stigma that originates from behavioral deviance—may be summarized by three general approaches: lose it, conceal it, or embrace it (Greenwood, Oliver, Lawrence, & Meyer, 2017; Zhang et al., 2021). The "losing" approach entails temporary distancing from or total elimination of stigmatized practices (Courpasson & Monties, 2017; Piazza & Perretti, 2015). For example, members of a stigmatized occupation might withdraw from "dirty work" through absenteeism or resignation (Gonzalez & Pérez-Floriano, 2015). In contrast, the "concealing" approach does not pause or stop the stigmatized behavior; instead, it manages the information that is shared or disclosed about such behavior (Ashforth et al., 2007; Sutton & Callahan, 1987). In the case of men's bathhouses, organizations may pretend to be something more acceptable, like gyms, especially when the institutional environment is more "condemning"—e.g., with the presence of laws against same-sex marriage (Hudson & Okhuysen, 2009). The "embracing" approach also sustains the stigmatized behavior. Instead of hiding the tainted behavior, this approach is to reconstruct the meanings or interpretations of such behavior. However, there are two variants of embracing—the first of which is to reshape the *broad* social evaluation of the stigmatized behavior such that the behavior is no long stigmatized. For example, organic farming was once discredited in Finland in the late 1970s but became accepted by the general public once its environmental benefits were reframed by organic farmers as a core value of modern farming. In other words, the stigmatized practice is maintained but its stigma is removed. In contrast, the second variant, on which I focus in this paper, is to normalize the stigmatized behavior *among* those who conduct such behavior. In other words, the stigmatized practice is maintained and its

stigma still exists, but only to external audiences.

I adopt Ashforth and Anand's (2003: 3) definition of normalization as a process through which stigmatized behavior becomes "embedded in organizational structures and processes, internalized by organizational members as permissible and even desirable behavior, and passed on to successive generations of members."[8] The authors propose three "pillars" that contribute to the normalization process within an organization. First, individuals who engage in stigmatized behavior may use socially constructed justifications to legitimate the behavior in their own minds, which the authors refer to as "rationalization." Second, as newcomers enter an organization, they may be taught to perform and accept such behavior via "socialization." Third, an organization, especially its leaders, may enact the stigmatized behavior as a matter of routine to the extent that it becomes taken for granted; hence, "institutionalization" within the organization. As Greve and Teh (2016: 393) later summarize, the research into normalization focuses on how stigmatized practices become "entrenched in organizational processes as individuals engage in sense-making to rationalize deviant practices, and as new individuals entering the system become socialized to adopt these assumptions and norms" (see also Palmer, 2008; Treviño & Weaver, 2003). An important insight of the Ashforth and Anand (2003) framework is that it highlights the social interaction and processual character of collective wrongdoing, thus going beyond a static and individualistic view of stigmatized behavior.

In particular, Ashforth and Anand (2003) specify eight types of rationalizing practices (or, using their own term, "rationalizing ideologies") that allow organizational members to distance themselves from the aberrant moral position implied by stigmatized behavior. Specifically, the

[8] Though Ashforth and Anand's (2003) model focuses on organizational corruption, it provides insights into the normalization of various stigmatized behavior. As indicated above, corruption in health care is an extreme form of stigmatized behavior (since it is both publicly and structurally stigmatized), so it is reasonable to infer that the model of normalizing corruption may be applicable to the normalization of other forms of stigmatized behavior (e.g., publicly stigmatized yet structurally permitted).

first rationalizing practice, “legality,” is used to justify the stigmatized behavior on the ground that such behavior is not entirely illegal, as organizations may utilize institutional loopholes to commit the behavior. Second, “denial of responsibility” is adopted to emphasize that individuals have no choice due to the pressures they receive from organizational leaders or peers to engage in deviant practices. Third, “denial of injury” justifies stigmatized behavior by pointing to the minimal damage that is actually caused. Fourth, “denial of victim” denies the status of the victim, often emphasizing that “the victim” volunteered to participate in the deviant behavior. The fifth practice, “social weighting,” involves selective comparisons with others who have done worse to make one feel better about their own behavioral deviance. While the sixth practice, “appeal to higher loyalties,” rationalizes stigmatized behavior by highlighting the benefits of such behavior to one’s own group, the seventh, “metaphor of the ledger,” argues that the good works done by the deviant actors can be used to offset their deviant behavior. The last practice, “refocusing attention,” helps individuals to shift attention away from their stigmatized behavior in favor of more respectable aspects of their work.

This rationalization aspect has subsequently become the main focus of empirical studies of the normalization of stigmatized behavior (Ashforth et al., 2007). In their exploration of public servants in Indonesia, for example, Budiman, Roan, and Callan (2013) found that civil servants with a “collegial” identity, who promoted a positive sense of in-group distinctiveness, tended to rationalize corrupt behavior by maintaining that their motivation was to achieve organizational objectives (e.g., benefits for their department), whereas those with a “corrupt” identity, who basically degraded any personal values, were more inclined to use “a metaphor of the ledger” and argue that their good deeds could offset their deviant behavior. Further, in their examination of the 2008 financial crisis in Iceland, Kvalnes and Nordal (2019) went through the report

published by the Special Investigation Commission to show that bank employees often expressed a strong feeling of loyalty to their employers and leaders (i.e., appeal to higher loyalty) to justify their unethical behavior, whereas the bankers (i.e., decision makers) were more likely to adopt the "loophole ethics" (Kvalnes, 2015) and claim that they had not breached any rules.

Despite these insights, important questions of "rationalization"—i.e., the socially constructed justifications—remain underexplored. Particularly, existing studies have primarily explored stigmatized behavior in corporate or low-status occupational contexts (e.g., corporate corruption, dirty work), but much less attention has been paid to professional contexts. Specifically, we know relatively little about whether the rationalizing practices identified from corporate or dirty work contexts can be applied to prestigious professions, given that professional contexts are expected to be rather different (Gabbioneta et al., 2013).

Moreover, while scholars have mainly focused on the "rationalization" aspect, the other two aspects of normalization—i.e., "socialization" and "institutionalization"—are underexamined. For example, much less attention has been given to understanding whether organizations will "de-institutionalize" or maintain the institutionalization of stigmatized behavior when such behavior is exposed and even challenged by important stakeholders.

The Corrective Actions Organizations Pursue When Stigmatized Behavior Is Challenged

After an event of exposure or challenge, stakeholders may pressure organizations to address their stigmatized behavior. Organizations may choose not to respond, or "forbear" (Andrevski & Miller, 2020), but can also pursue a range of corrective actions, which are defined as "behaviors performed by an organization intended to mitigate the negative effects of misconduct on the firm and its stakeholders and generate positive outcomes for the firm" (Hersel et al., 2019: 554). In

their integrative review, Hersel et al. (2019) propose a typology of corrective actions[9]: executive dismissal, product recalls, organizational accounts (i.e., corporate communication to manage strategic relationships), and policy changes (i.e., internal strategic and organizational changes). Moreover, for each type of corrective actions, organizations can adopt either accommodative or defensive strategies. Specifically, for executive dismissal, an accommodative strategy is meant to correct leadership deviance, signaling substantive change, whereas a defensive strategy is used to scapegoat an organizational leader (Gomulya & Boeker, 2014). In the case of product recalls, an accommodative strategy is adopted voluntarily as firms initiate proactive recalls, whereas a defensive strategy entails involuntary recalls that are oftentimes mandated by the government (Haunschild & Rhee, 2004). For organizational accounts, an accommodative strategy may be either a symbolic apology or a material repentance, in order to rebuild the organization's image, whereas a defensive strategy can deny the stigmatized behavior and even attack the accuser (Coombs, 2007; Elsbach, 1994). Regarding policy changes, an accommodative strategy is to make substantive changes to the internal strategies or structures, signaling actual change, whereas a defensive strategy may be symbolic and easily decoupled as the organization sends "false signals" (Harris & Bromiley, 2007; Weaver, Treviño, & Cochran, 1999).

In their conceptual model, Hersel et al. (2019) suggest that the existing accounts have focused on the consequences of stigmatized deviance on focal firms and their stakeholders, and the impacts of corrective actions on the change of firm performances, corporate image, and organizational development. However, the authors also indicate some major shortcomings of the literature. In particular, we know relatively little about why certain corrective actions are chosen (e.g., either in an accommodative or defensive manner). To unpack this puzzle, two theoretical

[9] Hersel et al. (2019) list four major types of misconduct: fraud, product safety issues, employee mistreatment, and environmental violations. However, their framework may be applicable to a broader range of deviant and stigmatized behavior.

tenets are recommended. The first tenet is stakeholder salience, defined as the degree to which organizations are attentive and prioritize certain stakeholders (Mitchell et al., 1997). In general, stakeholder salience increases with critical attributes that are perceived by managers—in particular, the *legitimacy* of the stakeholder's claim on the organization, the stakeholder's *power* to force the organization to comply with their claim, and the *urgency* of the stakeholder's claim (Mitchell et al., 1997; see also Connelly, Tihanyi, Ketchen, Carnes, & Ferrier, 2017; Murphy, Shrieves, & Tibbs, 2009). In a nutshell, stakeholder theory suggests that when the affected stakeholders possess high levels of all three attributes, organizations tend to be more responsive correcting the stigmatized behavior.

The second tenet is strategic cognition, defined as the cognitive structures that influence an organization's assessment and interpretation of stakeholder claims (Bundy, Shropshire, & Buchholtz, 2013; Durand, Hawn, & Ioannou, 2019). Specifically, strategic cognition includes the cognitive structures of organizational identity and strategic frames, which is related to how the organization defines and displays conceptions of *the self* as well as its *goals and interests* (Bundy et al., 2013). Accordingly, when interpreting a stakeholder claim, an organization may evaluate whether the claim is consistent or conflicting with its core values (i.e., identity) and/or with its pursuit of organizational goals (i.e., frames). Unlike stakeholder salience, which may largely shape *whether* an organization is responsive, strategic cognition is likely to affect *the type* of response the organization adopts—e.g., substantive *or* symbolic (Bundy et al., 2013)—to correct the stigmatized behavior.

In addition to the differences in organizational selection of corrective actions, there are important questions that warrant further exploration. First, whereas the prior studies of corrective actions mainly investigate stigmatized behavior in corporate contexts, we know relatively little

about whether such actions may be applicable to highly professional contexts, and whether there are distinct corrective actions used by professional organizations. Moreover, little is known about how different corrective actions—and the extent to which such actions are used—may affect the ways by which stigmatized behavior is normalized within the organization (Hersel et al., 2019).

The Effects and Effectiveness of Corrective Actions

Much of the existing literature on the effectiveness of corrective actions examines their effects on firm performance and market reactions (Chakravarthy, Dehaan, & Rajgopal, 2014; Saeidi, Sofian, Saeidi, Saeidi, & Saaeidi, 2015). Though some studies also explore other effects, such as corporate reputation (Gillespie & Dietz, 2009), legitimacy (Arvidsson, 2010), and organizational trust (Smith, 2012), little is known about whether the attitudes of organizational members towards stigmatized behavior will be changed if such behavior is deeply embedded and normalized (Hersel et al., 2019: 573). In a professional context, there is little exploration of whether and how corrective actions, which are supposed to uphold professional ethics, may change the attitudes of potential perpetrators towards unethical behavior.

Moreover, we know little about how different professional members (e.g., low status versus high status members) respond to the corrective actions adopted by their employers. It is possible that some employees may be more likely than others to follow the organizational efforts to cease stigmatized behavior (Bundy et al. 2017). In other words, the effectiveness of corrective actions might be moderated by the individual characteristics of professional members. This could be a productive direction for exploring the effectiveness of corrective actions on the normalization of stigmatized behavior (Hersel et al., 2019).

METHODS

Empirical Context and Research Design

Before the 1980s, hospitals in China were fully owned and funded by the state. The health care industry was shaped by a social welfare ideology led by the state. In particular, hospitals were not allowed to make profits as their goal was to "serve the people" and fairly allocate scarce medical resources (Sidel & Sidel, 1973). However, as the government initiated a national project of market transition, it had substantially shrunk its annual funds to hospitals since the mid-1980s. Instead, the state began to encourage hospitals to pursue alternative sources of funds by allowing them to make profits. For example, a new regulation passed in 1985 permitted hospitals to offer customized services that were expensive but not covered by public health insurance schemes. The state further prompted hospitals to seek profits by allowing them to establish a performance-based compensation system (Ministry of Health, 1992). More recently, the state even permitted private businesspeople to enter the health care industry and found privately-owned hospitals (Ministry of Health, 2009).

As the government started to push hospitals to seek profits, hospitals began to incentivize and even pressure physicians to generate revenues. The greater majority of hospitals had set up incentive plans during the 1990s, which typically divided a physician's compensation into two components—a relatively low and fixed base salary and a variable performance-based salary (or bonuses) depending on how much money one could generate. The low base salary created incentives for physicians to solicit and accept informal payments—i.e., bribes, or "red packets" as they called it—from patients, which has become widespread since the 1990s (Sun, Santoro, Meng, Liu, & Eggleston, 2008; Yao, 2016, 2017; Zhu, 2007). For example, a survey in 2009 of 4,000 hospitalized patients across ten different provinces shows that more than half of them

made an informal payment; of those who received surgery, almost all paid bribes (Kong, Du, Zhao, Yang, & Qin, 2011; Meng, Meng, & Liu, 2001). This widespread corruption, in turn, led to public stigmatization of the profession (Wang, Raynard, & Greenwood, 2020).

In response to a growing number of complaints from patients and the general public about corruption in the health care industry, the professional regulator has been trying to curb the widespread bribery, especially in the recent years. The radical regulatory change I am interested in was initiated as part of the Chinese government's national anti-corruption movement. In March 2018, the National People's Congress passed an *Institutional Reform Plan*, which included the establishment of a National Supervisory Commission as the highest anti-corruption agency of the country and a parallel institution to the central government. In the following year, this new Commission set up stationed agencies within the National Health Commission (i.e., Ministry of Health) and its local branches. The Supervisory Commission is legally empowered to supervise any public employees directly (including physicians employed by public hospitals). Moreover, it is empowered to directly punish corrupt professional behavior including the accepting and soliciting of red packets. Individual hospitals have varied in their response (e.g., adopted different corrective actions to address bribery) to the institutional pressure.

To better understand the normalization of stigmatized behavior (of which bribery is an extreme example) and the corrective actions adopted by organizations, I engaged in a *two-phase* qualitative study of the health care industry in China. I used this empirical context for two reasons. First, bribery in health care has become widespread and publicly stigmatized in China. While the diffusion of bribery is triggered and facilitated by the organizational incentives indicated above, it is also attributable to a high level of acceptance of bribery *among professionals*, which makes the setting suitable for studying normalization. Second, the

professional regulator initiated a radical regulatory change in 2018 in response to widespread bribery and a series of scandals in the Chinese health care industry (Huang, 2019; Parry, 2013). New supervisory agencies were established across the country to monitor and stem bribery, which makes this an ideal setting for studying how different organizations respond to change in the institutional context and how organizations' adoption of different corrective actions may subsequently affect professionals' normalization. Given that these topics are under-theorized in the literature, I adopted an inductive, exploratory approach (Eisenhardt, 1989; Pratt, 2000), which is aided by rich qualitative data.

Data Collection

The main data source of this study is interviews. I conducted a total of 83 interviews in two phases. In the first phase, I collected 38 interviews with physicians in 2016–2017 to explore their experience and understandings of bribery in the health care industry. 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). All interviews were conducted on-site in 16 hospitals in two major municipalities where the accepting of bribes by physicians was both widespread and discredited. All interviews lasted between 40 minutes and two hours.

In the second phase, I went back into the industry in 2019, 12 months after the professional regulator initiated a radical change by establishing new supervisory agencies to monitor and stem bribery. In this phase, I conducted 15 in-depth follow-up interviews and 30 new interviews, all with physicians (again covering a range of professional ranks and leadership positions) of 20 hospitals in one major municipality. All interviews lasted between 40 minutes and one hour. I used these interviews to examine how different hospitals responded to the regulatory change and

how professionals reacted to the organizational attempts to impede bribery. All interviews were conducted in Mandarin Chinese. In order to minimize interviewer bias, I conducted 25 of the interviews with a research assistant (Patton, 2002).

Data Analysis

Following my three research questions, I analyzed the data in three steps. The two-phase data collection and three-step analytical procedure are summarized in Table 3–1.

Table 3–1: Data Collection and Analysis

Phase/Year	Data Collection	Data Analysis
Phase 1 (2016–2017)	Interviews with physicians (38) *Hospital presidents* *Department heads* *Chief physicians* *Resident physicians*	**Step 1:** Examine the practices adopted by physicians to rationalize and justify stigmatized behavior (in this case, bribery) (RQ1)
Phase 2 (2019)	Interviews with physicians (15 follow-ups; 30 new) *Hospital presidents* *Department heads* *Chief physicians* *Resident physicians*	**Step 2:** Investigate the corrective actions adopted by different hospitals in response to the regulatory change, and why certain hospitals were more responsive than others (RQ2) **Step 3:** Investigate the effects of corrective actions on the rationalization of the stigmatized behavior (i.e., bribery), particularly why the rationalization persisted (RQ3)

In the first step, I focused on exploring the practices adopted by physicians to rationalize and justify stigmatized behavior by investigating whether they regarded the soliciting or accepting of bribes as acceptable (or even appropriate) and, if yes, why. I began my analysis with an “open coding” process—“breaking data apart and delineating concepts to stand for blocks of raw data” (Corbin & Strauss, 2008: 195)—until I hit theoretical saturation (Glaser & Strauss, 1967). In doing so, I identified a list of *six* rationalizing practices that remain at the first-order level, labeled in ways that stay close to the language used by interviewees (Van Maanen, 1979).

For example, when several physicians justified bribery by contending that it did not affect the patients' health or that it was voluntarily offered by patients, I labeled them "denial of physical injury" and "attribution to volunteers," respectively. I then began "axial coding" to reduce the array of practices by placing them into *three* second-order themes based on common properties (Corbin & Strauss, 2008) and connecting the data with language similar to the literature. For example, as I found that both "denial of physical injury" and "attribution to volunteers" emphasized that physicians did not violate "expert professionalism" (Brint, 1994), I clustered the two practices into a theme, which I labeled "professional competence." While the identification of rationalizing practices was largely grounded in the data, I also iterated frequently between theory and data, comparing the practices I identified with those already covered in the literature (Ashforth & Anand, 2003; Ashforth et al., 2007; Gioia, Corley, & Hamilton, 2013). Table 3–2 shows representative quotes for each practice.

Table 3–2: Representative Quotes Supporting Rationalizing Practices

Theme 1: Professional Competence	
Denial of physical injury	"The bottom line is that patients are cured. As long as physicians treat their patients properly, it is okay to accept red packets occasionally." (ID#9)
	"No matter if I accept a red packet or not, I will treat my patients with the best care I can provide. Physicians shouldn't accept red packets unless the medical service is well executed." (ID#34)
Attribution to volunteers	"Many of us don't ask for red packets. It is only when patients voluntarily offer that we accept. It usually means we did a good job." (ID#10)
	"As long as we don't solicit it's acceptable. We can't impose it on patients. But if they offer… There is no harm." (ID#14)
Theme 2: Professional Confirmation	
Colleague comparison	"Many doctors accept red packets. The laws won't punish the majority. If your peers or even department heads are doing it [accepting red packets], you'll probably be fine as well." (ID#4)
	"We learn from our senior colleagues and peers. When they accept red packets, it sends a signal to us that it's okay to do the same." (ID#23)
Invocation of culture	"Receiving red packets is almost a cultural custom. Sometimes if you don't accept a patient's red packet, they might feel embarrassed." (ID#16)

	"This is normal because our society is based on reciprocity. Patients often use red packets to maintain a good relationship with physicians." (ID#34)
Theme 3: Professional Appreciation	
Emphasis on economic recognition	"I think this is just how medicine works in China. The government is paying a relatively low salary officially while patients are paying the invisible part of our salary under the table." (ID#12)
	"Physicians typically receive five to ten years of professional training. It is not fair for us to have such an undesirable salary. Red packets are merely a way to compensate for that." (ID#33)
Emphasis on social recognition	"Physicians have been losing societal respect in recent decades. Red packets are one of the few ways left for them to feel it." (ID#2)
	"For some physicians it's not for the material rewards that come from red packets but the mental rewards—the feeling of being respected." (ID#22)

In the second step, I then focused on examining how hospitals strategically responded to the regulatory pressure. In the 20 hospitals I investigated in 2019, I asked the hospital leaderships about the corrective actions they adopted in response to the regulatory change against bribery. In doing so, I identified a list of six main types of actions, ranging from a mandatory "no-red packet agreement" to the dismissal of physicians who accepted a large bribe. Following Bundy et al.' (2013) differentiation between "symbolic" and "substantive" responses, I paid particular attention to two dimensions of the correction actions adopted by each hospital: the number of actions adopted and whether the adopted actions substantially affected the career path of individual professionals. Next, I examined the relationship between whether a hospital adopted substantive responses (i.e., a larger number of actions and/or actions that greatly harmed a physician's professional career) and the hospital's organizational characteristics—in particular, ownership, status, and size (Bundy et al., 2013; Goodrick & Salancik, 1996; Graffin et al., 2013). As I dug into the data, it became clear that public and high-status hospitals tended to adopt more substantive actions. Further, I investigated the underlying mechanisms that could render these hospitals more responsive than others. For example, I discerned from multiple interviews the influence of "stakeholder power"—it was apparent that the government's control of resources

made public hospitals more inclined to substantively respond to the regulatory pressure.

In the third step, I turned to how individual physicians reacted to the actions adopted by their hospitals—particularly, whether a physician's perception and rationalization of bribery was affected by such actions. My preliminary analysis suggested that the corrective actions did not mitigate the rationalization of corruption. This is a strikingly unexpected finding that runs counter to the existing literature, which has largely focused on the positive effect of corrective actions (Hersel et al., 2019). Therefore, I redirected my analysis to explore why the physician's rationalization of bribery was *not* affected by corrective actions. I found statements such as: "It is not fair to punish the physicians for accepting red packets since we remain underpaid… Besides, many doctors take red packets and are never caught" (ID#55[10]). Two mechanisms surfaced: "moral indignation"—i.e., the perception of unfairness that one should be punished for accepting bribes; and "optimism bias"—i.e., the perception of low risks of being caught for accepting red packets. Table 3–3 provides illustrative examples for each mechanism I identified in the second and third steps of my analysis.

Table 3–3: Core Mechanisms and Data Illustrations

Core Mechanisms	Data Illustrations
Stakeholder power	"Public hospitals of course have to listen to the government. The government can fire public hospital presidents directly, who are basically semi-officials. After all, the government controls a large share of funding and resources that are going into public hospitals." (ID#43)
	"Although we try to maintain a good relationship with the government, it's the boss [in private hospitals] who makes important decisions in terms of bonus, HR, etc. We do whatever pleases our boss." (ID#52)
Organizational identity	"People expect public hospitals to serve the public even though the health care system has been marketized to some extent. But still, in many people's eyes, public hospitals should first provide social welfare." (ID#53)
	"I might be an old school, but for me, public hospitals are for public welfare and the people's interests." (ID#46)

[10] The ID# indicates the number of interviews.

Stakeholder scrutiny	"The media loves sensational stories, such a famous chief physician in a major hospital being super greedy and immoral, in order to catch the readers' attention. Who cares about a physician who is unheard of in a community hospital?" (ID#68)
	"People always think major hospitals have more problems because we perform more complicated surgeries… But do we really have more issues? Maybe. But we definitely are under the spotlight more than anyone else." (ID#74)
Optimism bias	"We are very familiar with some patients, especially those with chronic diseases. It's almost certain that they won't report on us. We won't ask for red packets. If they gave me, it'd be a gesture of appreciation. Why would they report on me afterwards?" (ID#70)
	"How can we capture those physicians who solicit bribes? Do you think patients will expose their physicians? In most cases, there is no hard evidence. Moreover, as long as the physician delivers the service, most patients don't have the incentive to make trouble." (ID#71)
Moral indignation	"We spent years of training only to be underpaid, while our college friends are making real money. Do you think it's fair that we should be punished for accepting some red packets? It's not even a lot of money." (ID#76)
	"The administration should raise our salary instead of punishing us for taking red packets. Otherwise, there will only be more physicians who want to quit the profession. There is no pride in being a physician." (ID#83)

Establishing trustworthiness. In order to ensure the trustworthiness of my interpretations and findings, I triangulated multiple interviews across different locations, hospitals, and professional ranks throughout the two phases of my study (Guba & Lincoln, 2005). In addition, I engaged in "member checks" (Langley & Abdallah, 2011) by presenting preliminary findings to leading members of a professional association that had been charged with monitoring corruption in hospitals by the municipal government. Moreover, I conducted 30 interviews with patients in order to understand their experience and attitudes towards bribery. This was used as a counter case to reflect upon the physicians' rationalization practices—in particular, whether such practices matched patients' perceptions of what is morally acceptable physician behavior.

FINDINGS

The Rationalization of Bribery within Hospitals before the Regulatory Change

I found six rationalizing practices that were widely adopted by physicians, across different

hospital types and professional ranks, to defend and justify their accepting or soliciting of bribes: denial of physical injury, attribution to volunteers, colleague comparison, invocation of culture, and emphasis on either economic recognition or social recognition. While some of these practices are close to what previous studies have identified (Ashforth & Anand, 2003; Ashforth et al., 2007), others are distinct to professional contexts. I then clustered these six practices (comparative to first-order concepts) into three types (comparative to second-order themes), connected to professional characteristics: professional competence, professional confirmation, and professional appreciation. Below I present how each of the six practices was applied and connects to professional characteristics. Table 3–2 above shows additional interview quotes that demonstrate each rationalizing practice.

Professional competence. The first two rationalizing practices, which make up the first practice type, suggest that the professional pledge to exercise judgment based on the application of expertise is not breached by engaging in stigmatized behavior (i.e., by accepting bribes). In other words, accepting bribes is not a violation of professional competence or "expert professionalism" (Brint, 1994). My first identified rationalizing practice highlights that the act of bribery does not physically harm patients. One quarter of interviewees adopted this practice to rationalize both accepting *as well as* soliciting of bribes; they emphasized that doing so does not hurt patients. This is close to Ashforth and Anand's (2003) conception of "denial of injury" by which actors construe that no one was really harmed, even in cases with slight actual damage. When using this practice, physicians emphasized that no health damage was actually done: "Medicine is still medicine, with or without red packets. What we do is to cure rather than cause disease" (ID#38).

In particular, my interviewees illustrated two types of bribery that "do no harm." First,

physicians were often bribed to expedite the procedure so that patients received more prompt health services. For instance, "when a patient has a cataract, they might need to wait for a couple of months to get scheduled. But physicians often perform priority surgeries on those who have offered red packets" (ID#11). The physicians would claim that "no matter whether or not the patient offers bribes the quality of the services they receive will be the same" (ID#28). Second, senior and more skillful surgeons were often bribed to perform surgeries that others could have equally performed. Expert surgeons are almost always overbooked, given their scarcity in the health care industry. A chief-surgeon in a major hospital remarked:

> It can be very hard for a patient to get health services delivered by the top experts in the field because everyone wants the best doctor. If the patient wants the most skillful doctor to perform the surgery, they had better make the connection. However, if the patient doesn't offer red packets, they will still receive the service, probably delivered by a less experienced doctor, but it is not like the less experienced doctor will harm them for not offering red packets. (ID#19)

But, interestingly, none of the interviewees who adopted denial of physical injury mentioned the potential inequality that might result from the priority services for those who paid bribes.

The second practice I identified, "attribution to volunteers," maintains that patients voluntarily bribe doctors: they are not forced to do so. This practice is close to Ashforth and Anand's (2003: 19) conception of "denial of victims," which refutes "the status of the victim qua victim." In my case, more than a third of the physicians rationalized "red packet" bribes by emphasizing the voluntary, unsolicited nature of patients' bribes. Physicians indicated that if a patient willingly offers a red packet, it means that their physician "did nothing wrong. We either just delivered or are expected to deliver quality professional service" (ID#32).

Interestingly, in some accounts, physicians depicted certain patients as "insistent" or even "adamant" on giving red packets "as if this is exactly the way of seeing a doctor" (ID#22). An associate chief physician explained to me with a personal story:

> Once I was going to perform a surgery on a patient. The day before the surgeon when I

> admitted the patient, he passed a red packet to me. I refused it, and then he got anxious, insisting that I should accept it. As I told him it was not necessary, he and his family tried to persuade me that he would be reassured only if I accepted it. It made me feel as if I would be sloppy and less skillful if I did not accept their red packet. (ID#16)

Physicians claimed that it is fine to accept bribes in this kind of situation because it might mentally ease the patients. One of my interviewees even said: "I would accept the red packet, and then give it back once the surgery is done well" (ID#34).

However, those who adopted attribution to volunteers drew a clear line between accepting and actively soliciting informal payments. As an experienced physician remarked: "If a red packet is solicited by a physician before it is offered by a patient, it is not appropriate as the patient might be pressured into giving money even if they appeared willing and amenable in response to the doctor's soliciting" (ID#7). Another physician more succinctly stated: "Voluntary red packets means nothing went wrong, but solicited one might not" (ID#25).

In a nutshell, the two practices of this type both emphasize that "professional competence" will not be compromised even if one accepts bribes. While both resonate with the rationalizing practices covered by previous studies, they seem particularly salient in professional contexts as they connect to the professional value of expertise (Currie, Lockett, Finn, Martin, & Waring, 2012; Vough, Cardador, Bednar, Dane, & Pratt, 2013).

Professional confirmation. The next two practices, comprising the second practice type, are built upon professional identity and confirm that the stigmatized behavior has become part of the professional norm. The first practice attributes bribery to "colleague comparison"—i.e., colleague-oriented learning and peer pressure. Several interviewees adopted this practice to rationalize the accepting *or* soliciting of bribes, and they emphasized that their colleagues did the same thing or even worse. This is close to Ashforth and Anand's (2003: 18) conception of "selective social comparisons," by which actors find examples of others who are even more

deviant and thereby demonstrate that "we're not so bad." However, my case suggests that in addition to "we're not so bad if we do," physicians might also argue that "we're stupid if we do not" (ID#4).

Specifically, I identified two rationales for using this practice. First, physicians frequently pointed out that "the law does not punish the majority," a Chinese idiom meaning that when too many people break the same law, the regulator cannot punish everyone; this idiom often implies that the law may be unreasonable. Many physicians tried to defend bribery by using this logic:

> Many of us tend to consider ourselves not unethical since it is the current institution that makes good people do bad things. The government neglects the welfare of doctors. That's why so many doctors are earning money through red packets. If so many of us are doing this, one cannot and should not harshly criticize any of us. (ID#19)

In other words, the doctors justified the practice of bribery as the consequence of an impersonal systematic failure rather than a personal choice of deviance. The bottom line was "if most of us in the profession are doing this, it is probably right" (ID#27).

In addition, physicians also emphasized that "if my colleagues accept red packets but I do not, I may be left behind and even mocked by them as stupid" (ID#23). A physician's "financial situation can be largely improved given that the amount of red packets can be rather substantial compared to a physician's fixed base salaries" (ID#14). Interestingly, a few hospitals tried to incentivize physicians to refuse bribes by providing financial rewards, but such rewards were "inconsiderable compared to the red packets offered by patients" (ID#8).

Those enacting the second practice I identified, "invocation of culture," framed the offering and accepting of bribes as a cultural tradition. Instead of comparing with professional colleagues within and outside of their organization, physicians using this practice resort to the broader socio-cultural norm. Those who adopted this practice refused to call the informal payments they received bribes; instead, they only used the term "red packets." Historically, red packets played

an important role between doctors and patients in China. As early as in the Qing Dynasty (1636-1912), red packets were already evident in medical practice: patients offered them in an attempt not only to ensure high-quality health care but also to maintain a good relationship with their doctors (ref. Zhou & Zhang, 2004). Moreover, the offering and accepting of red packets is an important, general cultural practice in developing and maintaining social relations among Chinese—i.e., a social practice of reciprocal relationships and friendship.

Rather than admitting that accepting red packets was bribery, the doctors who adopted this practice considered red packets a gift. A chief physician claimed: “The Chinese society is one of gifts—a society of connections (*guanxi*) and face (*mianzi*). The red packets offered by patients to doctors are widely accepted as a symbol of gratitude and good will” (ID#38). Similarly, an elder physician further added:

> The offering of red packets is an expression of being close. We also give red packets to friends when they got married or have a baby, or when somebody gave you a favor. China is a society of reciprocal relationships. Giving and accepting red packets is a cultural custom and tradition to express emotions. If I turn down a patient’s red packet, it would make them lose face and hurt the social relationship. (ID#1)

Indeed, several doctors pointed out that the refusing of red packets would sometimes be seen as a rude cultural practice and by doing so “patients might lose face” (ID#11). Notably, about half of those who adopted this practice also emphasized that patients volunteered to offer red packets (i.e., “attribution to volunteers”), suggesting that various practices may be complementary.

In sum, physicians may adopt this type of practices to achieve “professional confirmation” by referencing their professional colleagues, both within and outside of their organization, and the broader socio-cultural norms, which in turn reinforce the physicians’ attitude towards the stigmatized behavior. In doing so, professionals might no longer regard the accepting of bribes as a form of corruption, but instead a part of their collective norm and practice. While the practice of colleague comparison is similar to what has been covered in the literature, invocation of

culture is distinctive of professional contexts as it connects to the historical norm and identity of the profession (Zhou & Zhang, 2004; Zhu, Wang, & Yang, 2018).

Professional appreciation. The third type of practices, which includes the final two practices, is the most radical, as it contends that the stigmatized behavior (i.e., the accepting of red packets) recognizes the professional respect and appreciation that physicians deserve. Instead of focusing on whether the professional expertise is properly delivered, this practice type emphasizes that expertise should be properly recognized and either economically or socially rewarded. The first practice of this type emphasizes that physicians deserve, but can rarely achieve, "economic recognition" if they are not accepting bribes. Physicians who adopted this practice tended to maintain that they are substantially underpaid. Many interviewees complained that their "salaries do not match the many years of education and training" they had received (ID#33). Indeed, a recent survey by Zhu et al. (2018) stated that 91% of doctors were "not satisfied with their income" and 23% of those who declined to take up this profession chose "low income" as the main reason.

Physicians who engaged in this practice regarded bribery as a way of being justly compensated for their professional expertise. In other words, bribery is "not an issue of violating the professional ethics, but one of doing justice to the professional expertise" (ID#3). A middle-aged associate physician in a municipal hospital bemoaned:

> A doctor's consultation fee for one patient visit is barely several yuan. How can it be reasonable? The worth of physicians is seriously underestimated. With such a salary, we can barely raise our family with dignity… If one's salary cannot even satisfy their basic needs, why would they care about noble aspirations, or serving the people? (ID#29)

Some interviewees further justified the act of bribery by comparing the medical profession in China with that in the U.S. They indicated that "American doctors earn at least ten times more than Chinese doctors for the same expertise and skills. Of course they refuse bribes. They don't

need the extra money. If they were underpaid as we are, they would accept bribes as well" (ID#22). As an elder physician sarcastically summarized, "after all, earning money is preferable than serving the people with no money" (ID#6).

Not only did doctors prioritize economic recognition, the second practice of this type also emphasizes the "social recognition" brought by bribery. According to Zhu et al.'s (2018) fieldwork, 17% of medical professionals believed that red packets were mainly an expression of gratitude by patients. Several interviewees explained that the bribes they accepted compensated for their vulnerable self-esteem and lack of respect. In fact, Zhu et al. (2018) also showed that of those doctors who would decline to take up the profession, 20% gave "low public recognition" as the main reason. To those physicians who prioritized social recognition, receiving patients' informal payments was "a symbol of entering the high-status category of physicians" (ID#3). An associate chief physician remarked:

> Not every doctor has the opportunity to receive red packets. Patients typically offer only to senior doctors who are in charge of surgeries or who are renowned for their unique skills. Put another way, the receiving of red packets evidences that a doctor is recognized for having certain professional expertise. (ID#22)

Similarly, an experienced surgeon stated: "For some chief physicians, it is not out of greed that they accept informal payments from patients. It is a way for them to feel respected—that their, professional skills and worth are appreciated. [It is] a higher-level mental satisfaction" (ID#10).

Compared to prioritization of economic recognition, which was adopted to rationalize both the soliciting *and* accepting of bribery, prioritization of social recognition was used *mainly* to rationalize the accepting of briberies. An elder physician explained to me: "You can't ask for respect. If you received a red packet without soliciting, it means that you are a well-recognized doctor. But if you asked for it, patients might give you simply out of fear that you might mistreat them otherwise. This is not respect" (ID#2). It is noteworthy that almost all the interviewees who

adopted this practice also emphasized that patients volunteered to offer bribes (i.e., "attribution to volunteers"). This seems to suggest that the two types of practices can be complementary in rationalizing bribery.

In sum, the third type of practices emphasized that the stigmatized behavior may compensate for the lack of "professional appreciation." Unlike the first type, which significantly downplayed or entirely denied the negative effects of bribery on the professional value of expertise, the third type stressed the positive effects of bribery. By connecting bribery with professional recognition and respect, physicians who adopted practices of this type often appeared indignant about the lack of appreciation they otherwise received. Given that the indignation is based on the traditionally high social distance between professionals and clients, I argue that the two practices of this type are distinct to professional contexts (Kadushin, 1962; Muzio, Aulakh, & Kirkpatrick, 2019).

Importantly, the three types of rationalizing practices specified above—i.e., professional competence, confirmation, and appreciation—are not mutually exclusive. While professional competence and appreciation focus on whether the professional value of expertise is violated or should be recognized more substantively, professional confirmation defends the stigmatized behavior by connecting it to professional norm and identity. Instead of competing with each other, these three types of practices are more likely to complement and reinforce each other. In fact, more than half of my interviewees who rationalized the act of bribery adopted multiple practices.

However, the widespread rationalization of bribery has become a fundamental challenge for the profession and professional regulators. A "critical mass" (Devers et al., 2009) of professional members (about two thirds of the 38 interviews I conducted in the first phase) saw bribery as

permissible or even appropriate. Thus, the recent regulatory change—a "jolt" (Meyer, Brook, & Goes, 1990) initiated by the government, a particularly powerful stakeholder in China—became an importantly opportunity for observing how different professional organizations (i.e., hospitals) might respond to the heightening stigmatization of bribery by important stakeholders.

The Corrective Actions Pursued by Hospitals in Response to the Regulatory Change

In the second phase of my study, I started with examining the differences between different hospitals in regard to their reactions to the government's new anti-bribery efforts. To begin, I identified six specific types of corrective actions: whether physicians are 1) required to sign a No-Red Packets Agreement before any clinical treatment, or are 2) publicly criticized within the hospital (i.e., public naming and shaming), 3) fined, 4) suspended from promotion, 5) demoted, or even 6) dismissed, for accepting informal payments from patients. According to the great majority of my interviews in this phase, the first three types of actions were widely regarded by medical professionals as inconsiderable or symbolic, whereas the last three were seen as substantial as they directly and negatively affect one's professional career. In particular, I paid attention to two dimensions of each hospital's responses: the number of corrective actions it adopted and whether it adopted the three more substantial actions. Building upon Bundy et al.'s (2013) differentiation of "symbolic" and "substantive" responses, I investigated what kind of hospitals were more likely to adopt substantive actions (i.e., adopting a larger number of corrective actions and/or adopting more substantial actions); *and* why. Table 3–3 above provides additional illustrative examples for each mechanism I identified in this phase.

Public hospitals vs. private hospitals. The first major distinction I identified is based on organizational ownership—i.e., between public and private hospitals. Many of my interviewees indicated that publicly-owned hospitals were more responsive than privately-owned hospitals to

the heightening stigmatization of bribery brought by the state's anti-corruption movement.

In general, all the public hospitals I explored adopted certain corrective practices that prohibited the act of bribery. For instance, a major public hospital set up organizational guidelines that encouraged physicians and patients to "report any doctors who solicited or accepted red packets; and those who are reported will be publicly criticized, required to return the red packets, and even suspended from practice for a certain period of time depending on the amount of money they accepted" (ID#71). Compared to public hospitals, private hospitals might have lacked any formal organizational actions against the soliciting and accepting of bribes. As a young surgeon in a private hospital bemoaned, "accepting red packets is prevalent in my department, and since there is no rules against it doctors who accepted red packets will not face penalty" (ID#52).

Specifically, a typical corrective action adopted by public hospitals is a No-Red Packets Agreement, which each doctor in charge and their inpatients were required to sign when the patients were admitted. Another common corrective action that was often used by public hospitals was naming and shaming. Many of my interviewees mentioned that some public hospitals would "stick an announcement in the hallways naming and shaming those who accepted red packets" (ID#63). An elder physician further added: "During internal meetings our department heads or presidents sometimes publicly criticize those physicians who solicited red packets and call this misbehavior an illness of our hospitals" (ID#46). In a rare case, a large public hospital even used the media to criticize their employees who accepted bribes—as an associate physician stated: "Through the media our hospital basically tried to show that the accepting of red packets is not tolerated in our hospital" (ID#47). In contrast, private hospitals seemed relatively less active in response to the government's anti-bribery regulations and

increasing stigmatization of bribery.

Not only did public hospitals appear more willing to adopt corrective actions, they also seemed more likely to use substantial actions than private hospitals. As mentioned above, formal rules were established by some hospitals to punish the soliciting or accepting of bribes. According to my interviews, the most common penalties included intra-organizational shaming or moderate fines. However, to many physicians, such penalties were seen as "too weak" and even "lenient" because they do not impose a substantial cost on the physicians who accepted or solicited bribes. As some interviewees worried, such a weak penalty might even "send an encouraging signal that red packets are acceptable" (ID#45). Yet, I identified several hospitals that imposed more substantial penalties such that "those who accepted red packets will be demoted. A few physicians who frequently solicited red packets were even fired" (ID#41). All of these hospitals are owned by the government. But, why do such differences between public and private hospitals exist?

Stakeholder power. For the differences between public and private hospitals, two plausible mechanisms emerged from my interviewees. First, public hospitals are more strictly constrained by government regulations than private hospitals because the former is owned by the government whereas the latter by private businesspeople. In other words, the government has more power over public hospitals than over private hospitals. For example, the new Supervisory Commission is legally empowered to directly supervise only those physicians who are employed by public hospitals. A former public hospital president, who later became a private hospital president, remarked: "When the government set up new policies against red packets, public hospitals would have to respond quickly as their leaders are directly supervised by the government, but in private hospitals the owners are the boss and care much less about the government" (ID#55).

In particular, the importance of "political achievements" was highlighted by many of my interviewees. In China, leaders of public hospital are semi-governmental officials, whose career promotion is largely decided by the local government. This means that public hospital presidents have to "achieve great accomplishments not only professionally but also politically" (ID#69). A former public hospital president, who later worked in the government, elaborated:

> In order to make political achievements, leaders of public hospitals are expected to accomplish whatever the government prescribes. When the government prioritizes something, you as a public hospital president should also prioritize it no matter if it is the most professionally important thing. Thus, when the government prioritizes anti-bribery campaigns, public hospital leaders have to respond fast and substantively. (ID#51)

In contrast, in private hospitals, presidents are professional practitioners whose career promotion and rewards are decided by private owners, who typically care much more about profits than political achievements or political correctness.

Moreover, public hospitals in China are partially funded by the government. Even though the government substantially shrunk its annual funds to public hospitals since the mid-1980s, public funds remain a large source of revenues for public hospitals. "If a public hospital failed to satisfy the local government, it might have difficulties acquiring public funds. Especially when a public hospital needed extra funding—for example, for expansion or renovation—it would be really important for it to accomplish whatever the government wanted" (ID#44). In comparison, private hospitals do not rely on governmental funds and thus "have much less incentive to follow the government's project if it does not directly generate profits" (ID#39).

This resonates with Hersel et al.'s (2019) proposition that stakeholder salience may shape the corrective actions pursued by organizations in this way: when the affected stakeholders possess high levels of power, legitimacy, and urgency, organizations tend to be more responsive (Mitchell et al., 1997). In my case, although the government was a legitimate stakeholder to all hospitals, it had much more power over public than private hospitals because it possessed the

critical resources for the former (Wry, Cobb, & Aldrich, 2013; Zhu & Westphal, 2020).

Organizational identity. Second, the idea of anti-bribery is fundamentally consistent with the organizational identity of public hospitals, but less so with that of private hospitals. Although public hospitals also sought revenues as the government reduced public funds, they were still expected to embody core values that represented the principles of social welfare, which "call on professional devotion to the people" (ID#50). In other words, public hospitals, by their nature, should refuse any types of corruption that might hurt the people's interests. For example, one of the public hospitals in my sample explicitly stated on its website as well as in an official hospital introduction set up in its hallway that "our tenet and promise is to serve patients" (ID#49). In contrast, private hospitals are for-profit businesses and "care more about their revenues than patients' best interests" (ID#75).

Therefore, the government's anti-bribery campaign brought about a greater identity crisis for public hospitals than for private hospitals as it directly challenged the social welfare identity of public hospitals. A senior physician of a public hospital remarked: "the anti-corruption campaign explicitly criticizes the unethical behavior that is prevalent in public hospitals, which violates the core principles of public health care" (ID#80). In response, as another physician added, "public hospitals have to react not only promptly but also substantially in order to show that they still uphold the socialist welfare values," (ID#66). One of my interviewees further explained:

> Public hospitals need to set up strict rules and measures to stop and punish the soliciting and accepting of red packets because their value of existence is being questioned… In contrast, private hospitals are less responsive to the anti-bribery campaign since they are less concern with social welfare than market competition. (ID#72)

However, even though private hospitals did not adopt substantial actions in response to the state's call for upholding the socialist welfare values, they did not explicitly go against the state's

anti-bribery campaign either. For example, none of the private hospitals in my sample openly attacked the government for its criticism of physicians' accepting of red packets—which is a typical strategy identified in the dirty work literature (c.f. Ashforth et al., 2007).

This resonates with the existing theory that organizational identity may shape the corrective actions pursued by organizations such that when the affected stakeholder's claims challenge the identity of an organization, it tends to adopt more substantive responses (Bundy et al., 2013; Hersel et al., 2019). In my case, the state's anti-bribery campaign induced an identity crisis for public hospitals, whereas for private hospitals the campaign seemed much less relevant.

High-status hospitals vs. low-status hospitals. The second major distinction I identified is based on organizational status—i.e., between the high-status and low-status hospitals. In China's hierarchical health care system, hospitals are formally categorized into three hierarchical tiers. While the third-tier (highest) hospitals typically offer a comprehensive range of medical services and have a large proportion of chief physicians (highest rank), the second- and first-tier (lowest) hospitals offer a limited range of services and have much fewer chief physicians. Therefore, the third-tier hospitals are usually seen as superior to lower-tier hospitals. But, not all third-tier hospitals were regarded as high-status in my case. According to my interviewees, a high-status hospital had two other characteristics: a long organizational history and an academic affiliation to the most prestigious universities in the region. As a chief physician illustrated:

> The most prestigious hospital in our city was established in the 19th century and has been one of the most prestigious hospitals in the country since then. It is recently ranked top ten in China, and is affiliated with the medical school of a top university in the country. This means it trains and always attracts the best physicians, and provides the most comprehensive surgeries and cutting-edge treatments. Frankly, if I'm sick, I would want to be treated there. (ID#40)

Many interviewees indicated that high-status hospitals were more responsive than low-level hospitals to the government's anti-corruption measures. Specifically, high-status hospitals seem more willing than low-status hospitals to adopt corrective actions in response to the heightening

stigmatization of bribery. For example, the "No-Red Packets Agreement" mentioned above were widely adopted by all the high-status hospitals I investigated. Similarly, the strategy of naming and shaming was often used by high-status hospitals to criticize those physicians who violated the no-red packets policy. In contrast, low-status hospitals appeared less responsive. A physician in a low-status hospital told me: "Dr. H once reported his colleagues who accepted red packets, but the hospital did not react. Instead, his colleagues marginalized him" (ID#48).

Moreover, high-status hospitals seem to be more inclined than low-status hospitals to adopt substantial corrective actions. For example, in the low-status hospitals I explored, none of their employees were dismissed for the act of bribery. In contrast, several high-status hospitals had dismissed their employees for accepting bribes. A chief physician from a high-status hospital disclosed to me: "a department head in our hospital was fired last year for frequently soliciting red packets" (ID#74). This was confirmed by another physician from a third-tier hospital: "a senior surgeon in our hospital was pressured by the hospital leadership to resign for accepting red packets even though the surgeon was one of the most skillful in the city" (ID#82). But, why do such differences between high-status and low-status hospitals exist?

Stakeholder scrutiny. For the differences between high-status and low-status hospitals, I identified two plausible rationales—*stakeholder suspicion* and *stakeholder curiosity*—that both contributed to a mechanism that is documented in the literature: stakeholder scrutiny (Graffin et al., 2013). First, by stakeholder suspicion, I mean that high-status organizations were more likely to be scrutinized than low-status organizations because they aroused more suspicion from stakeholders; and, in response, high-status organizations were more likely to adopt corrective actions. In my case, high-status hospitals were under more scrutiny than low-status hospitals because the former was perceived to be more contaminated than the latter with the problem of

bribery. Compared to their low-status competitors, high-status hospitals were the most advanced hospitals in the province: "they not only employ the best physicians in a region, but also perform more complex procedures and surgeries than lower-tier hospitals do" (ID#81). In other words, as a chief physician remarked, "physicians in high-status hospitals have much more opportunities to accept or solicit red packets, and therefore arouse more suspicion from both the government and the general public that they are tainted with corruption" (ID#67).

In contrast, stakeholder curiosity suggests that high-status organizations tend to be more scrutinized than low-status organizations because stakeholders were generally more interested in the former than the latter; and, in response, high-status organizations are more likely to be more responsive. A hospital president of a high-status hospital caustically commented: "The public and the media are simply more interested in a story of the fall of professional elites rather than some mediocre hospitals" (ID#73). This was confirmed by the personal experience of another associate physician in one of the most prestigious hospitals in the city:

> After graduation I entered Hospital Z, but my college buddy went to a second-tier hospital. We chatted about the issue of red packets. Honestly, we think both hospitals have this problem, but the media often focus on my hospital than his. You know, people talk about the "value of news" which basically means that the media and the public are more interested in reading scandals of famous hospitals than of some lower-tier hospitals. (ID#42)

Because of stakeholder suspicion and stakeholder curiosity, high-status hospitals were under much more scrutiny than low-status hospitals. As a result, leaders of high-status hospitals tended to take greater actions in response to the government's anti-bribery movement. A senior physician in a high-status hospital further remarked: "prestigious hospitals cannot simply pretend to change now that they are under the spotlight; instead, they need to set up stricter rules to stop and punish the accepting of red packets" (ID#40).

The above two rationales resonate with and extend the extant debate about status as a shield or hazard. Some studies in the prior literature suggest that high status is a hazard since it attracts

attention and heightens the likelihood of being punished (Adut, 2005, 2008; Graffin et al. 2013; Wiesenfeld, Wurthmann, & Hambrick, 2008). My case shows that such stakeholder scrutiny can be attributed to not only the stakeholders' general curiosity—but also their suspicion—about high-status actors; *regardless* of whether or not high-status actors actually conduct more stigmatized practices than low-status actors.

The Persistence of the Rationalization of Corruption after the Regulatory Change

Surprisingly, the rationalizing practices identified in the first phase of this study (2016–2017) remained widely adopted by medical professionals in the second phase (2019). Comparing the 15 follow-up interviews I conducted in the second phase with their counterparts in the first phase, similar rationalizing practices were used to justify bribery. The 30 new interviews in the second phase also showed that similar practices were adopted to rationalize the accepting of red packets. Admittedly, the corrective actions adopted by hospitals seemed to suppress the act of bribery to some extent, but the accepting of red packets remained widely seen as permissible *among* the professionals even though the regulators explicitly prohibited it and heighted its stigmatization. As a chief physician remarked:

> The new measures and actions, such as a fine, organizational criticism, or even demotion, set up by hospitals are supposed to act as a deterrent to the corrupt behavior. And they do have some positive effects, making some doctors too frightened to accept red packets. However, the behavior itself [accepting red packets] remains largely acceptable among physicians. (ID#49)

Moreover, my interviews suggest that the rationalizing practices remained pervasively used by physicians in both public and private hospitals, and both high-status and low-status hospitals. In fact, about two thirds of my interviewees in the second phase still regarded the accepting of red packets as "reasonable." Further, even though no new rationalizing practices were identified in this phase, the practices used in this phase covered those identified in the previous phase. Yet, the relative frequency of the adopted practices changed such that professional appreciation was

used more often in this phase. So, why did the corrective actions used by hospitals *not* impede the rationalization of bribery?

Optimism bias. Two plausible mechanisms emerged from my interviewees. First, the hidden nature of bribery contributes to a perception of "optimism bias" among physicians that the risk of being caught is low, which in turn facilitates the sustained rationalization of bribery. As a chief physician and department head explained, "it is not that the hospital does not want to implement its anti-corruption policies, but the accepting of red packets is often an invisible behavior. It is hard to catch if patients do not report. But if a patient offered a red packet without being solicited, why would they report on doctors?" (ID#44). Another senior surgeon added: "it is difficult for hospitals to get hard evidence on the soliciting and accepting of red packets. They cannot punish some physicians simply based on hearsay and anecdotes" (ID#80). Consequently, whereas two thirds of my interviewees believed that hospitals had adopted much stricter actions punishing bribery after the regulatory change, most of the interviewees also believed that only a small proportion of those physicians who accepted bribes were actually caught and punished. Indeed, only 30 percent of my interviewees believed that the majority of "bad apples" were punished by the hospital's corrective actions.

The collective perception of optimism bias among physicians (i.e., their *perceived risk* of being caught is low regardless of the actual risk) in turn facilitated the continuous rationalization of bribery. As an associate chief physician in a provincial hospital explained to me, "while we saw some unethical physicians being punished and even demoted, many others who take red packets are still out there without punishment. People begin to wonder if the accepting of red packets is still acceptable or at least tolerated" (ID#58). For many, the insufficient capture of perpetrators sends "a signal that physicians can keep doing what they did before the regulatory

change [accepting red packets]" (ID#51).

Interestingly, the perception of optimism bias also contributed to the emergence of a new variant of colleague comparison in this phase. While in the first phase the physicians who used colleague comparison to rationalize bribery tended to assert "others did it, so I can do it," those who adopted colleague comparison in this phase tended to argue "others did not get caught, so I should not be caught either" (ID#61). Moreover, several physicians indicated that they would use those who were actually punished as "benchmark" such that "as long as you do not behave too obviously and too greedily as those who were demoted or fired did, you should be fine" (ID#77). As an associate chief physician bemoaned, "the anti-corruption measures adopted by hospitals are supposed to dissuade physicians from accepting red packets, but now basically invite them to be more cautious about accepting red packets" (ID#64).

Thus, in a nutshell, the perception of optimism bias in my case led to a widespread sense among physicians of low risk of being caught and improbable personal accountability—which in turn contributed to the sustained rationalization of bribery—in particular, the continuous use of colleague comparison.

Moral indignation. The second mechanism suggested by my interviewees is the "moral indignation" perceived by physicians over the increasing corrective actions against bribery. To many physicians, the corrective actions set up by hospitals after the regulatory change failed to address a root cause of the stigmatized behavior (i.e., accepting red packets): the relatively low base salaries of physicians. Several interviewees indicated: "These new anti-corruption measures treat only the symptom but not the cause of red packets. If physicians remain underpaid, the accepting of red packets will never be stopped" (ID#77). An associate chief physician in a major hospital further added, "the hospital's measures only increase the cost of accepting red packets,

which might discourage some physicians from accepting red packets, but it does not mean that the physicians' demand for a better compensation and social respect is no longer reasonable" (ID#60). Put another way, the corrective actions did not address the fact that physicians felt significantly under-appreciated both economically and socially.

Therefore, several interviewees expressed "indignation" over the corrective actions because they believed that "punishing the accepting of red packets without fixing the real problem does physicians an additional injustice" (ID#59). An elder physician complained:

> The administration only imposes pressure on physicians—fines, suspension, or even dismissal. But why only physicians are punished? Oftentimes patients voluntarily offer red packets to appreciate our expertise and the good service we provide. Punishing physicians is not fair. And it won't help hospitals to function more effectively… Instead, the administration should try to increase the physicians' compensation and restore the image of the profession. (ID#78)

A physician in a public hospital further pointed out: "I am not convinced that physicians should be the only party that is subject to punishment. In the political arena, both politicians who accept bribes and those who offer bribes are subject to punishment. Why is it different in the health care sector?" (ID#43).

This perception of moral indignation also contributed to a change of the relative frequency of the rationalizing practices that were adopted in this phase. Specifically, physicians became more inclined to use "professional appreciation" to justify the accepting of red packets. There were about one fourth of my interviewees adopted professional appreciation in the first phase, but the proportion went up to two fifths in the second phase. One of my 15 follow-up interviews highlighted: "the government's anti-corruption measures not only heighten the stigmatization of the medical profession, but also stimulate our perception of being under-appreciated. Physicians seem to be only party that loses in all aspects" (ID#41). Several other follow-up interviewees also expressed that while the government and patients might have benefited from the hospitals' corrective actions physicians gained nothing. Notably, those who expressed moral indignation

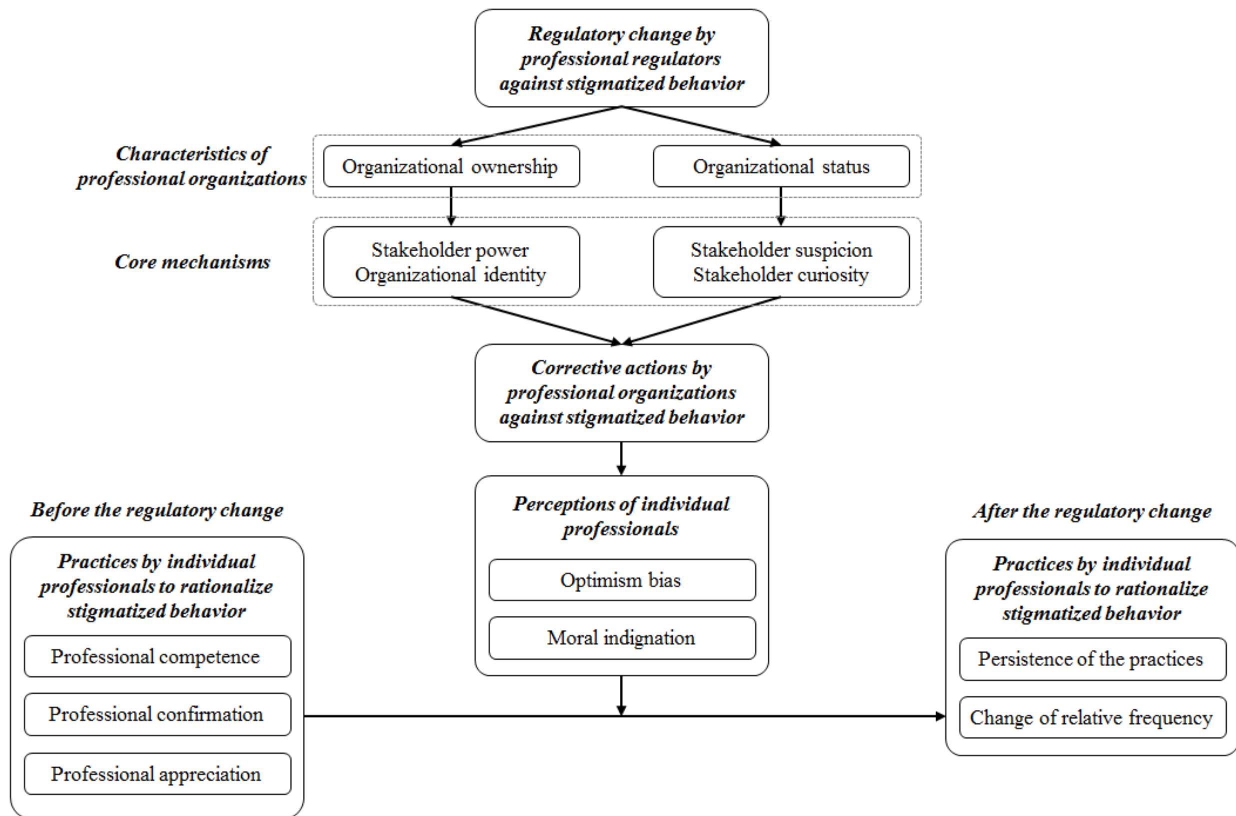
and subsequently adopted professional appreciation in this phase mainly came from public or high-status hospitals where corrective actions against corruption were more substantive—i.e., where physicians were likely to perceive a higher level of unfairness.

In sum, due to the perception of moral indignation, along with optimism bias, the corrective actions used by hospitals to prevent bribery not only did not reverse, but even exacerbated, the rationalization of bribery among physicians. In particular, professional appreciation seemed to become a more popular choice of rationalization for physicians—particularly those worked in public or high-status hospitals.

DISCUSSION

Despite growing interest among management and organizational scholars in uncovering the sources and consequences of stigma, there is still much to learn about how stigmatized behavior may be rationalized and maintained. Through a case study of bribery in the health care industry in China, this study has examined the normalization of stigmatized behavior through a sequence of three questions: How does stigmatized behavior become normalized by professionals? What corrective actions do professional organizations adopt in response to a regulatory change against the stigmatized behavior? And why does such behavior persist despite these corrective actions? In contrast to previous work, which used a static approach to normalization, this study presents a dynamic, process-oriented approach that focuses not only on the practices by which stigmatized behavior is rationalized but also how the use of these practices may be affected by the change in the degree of institutionalization at the field level (i.e., regulatory change) as well as at the organizational level (i.e., corrective actions).

Figure 3–1: A Multi-level Model of Normalization in a Professional Context



Specifically, as illustrated in Figure 3–1, this study makes three theoretical contributions. First, it conceptualizes three types of rationalizing practices that may be used by professionals to justify stigmatized behavior, and connects these practices to distinctive features of professions. Second, this study identifies two important organizational characteristics—i.e., ownership and status—that may filter the regulatory change against the stigmatized behavior through two sets of core mechanisms and in turn shape the corrective actions adopted by professional organizations. Finally, the study explains why the stigmatized behavior may persist despite corrective actions.

Practices Used by Individual Professionals to Rationalize Stigmatized Behavior

In this study, I found that individual professionals can adopt six distinct practices—denial of physical injury, attribution to volunteers, colleague comparison, invocation of culture, emphasis

on economic recognition, and emphasis on social recognition—in order to rationalize stigmatized behavior. Moreover, I found that professionals often use multiple practices to rationalize the same deviance, suggesting that those practices are not mutually exclusive but likely complementary. While some of the rationalizing practices identified in my case are similar to those proposed in the literature, others are distinct to professional contexts. Below, I categorize the six practices into three types and connect the adoption of each type to professional characteristics.

Professional competence. The first type of practices emphasizes that the professional pledge to exercise judgment based on the application of expertise will not be breached even if one engages in stigmatized behavior (in my case, bribery). It insists that the stigmatized behavior is acceptable as long as it does not compromise "professional competence." Specifically, *denial of physical injury* maintains that no physical harm is actually done so that the professional value of expertise (e.g., treatment of disease) is upheld. In contrast, *attribution of volunteers* emphasizes that no harm is done since the informal payment is offered by patients rather solicited. The two practices of this type are widely adopted by physicians across professional ranks as well as in public and private hospitals. In other words, the use of practices of this type is least affected by individual and organizational characteristics. Practices of this type are similar to those identified in the literature (Ashforth & Anand, 2003), but are highly salient in professional contexts because they connect to "expert professionalism" (Brint, 1994; Vough et al., 2013).

Professional confirmation. The second practice type is built upon professional identity, confirming that the stigmatized behavior has become part of the professional norm. Using "professional confirmation," professionals resort to both their professional colleagues and the broader socio-cultural norms in order to rationalize their deviant behavior. While *colleague*

comparison is similar to what has been covered in the literature (Ashforth et al., 2007), *invocation of culture* is a unique practice applied to my context. Compared to the previous type, which denies the negative effect of the deviant behavior, invocation of culture emphasizes the positive and claims that the behavior is culturally appropriate. This is a radical practice as it works to redefine the appropriateness of stigmatized behavior. In other words, professionals who use invocation of culture justify stigmatized behavior by connecting the behavior to "bad values" (Milo, 1984) in the society. Specifically, in my case physicians contend that the accepting of red packets is a cultural, traditional practice of building friendship and reciprocal relationships.

While other practices may be applied to a broader cultural-geographical context, invocation of culture heavily relies on the local cultural resources. In my case, it is only because personal patronage and relationship between physicians and patients—built through the use of red packets—is rooted in the Confucian tradition of reciprocity in China (Smart & Hsu, 2007; Zhu et al., 2018) that doctors can adopt this practice to effectively rationalize their accepting of red packets. This supports a "warm nature" of conduct stigma, which suggests that broader societal culture, in addition to "cold rationality" (Torsello & Vernard, 2016; Visvanhatan, 2008), can be invoked to normalize stigmatized behavior. I suspect that this practice might not be applicable to countries that do not have a Confucian tradition. However, it is likely to be applied to other East Asian countries, like Japan and South Korean, that share a similar cultural tradition.

Professional appreciation. In the third practice type, physicians argue that the stigmatized behavior grants the economic reward and social respect that these professionals deserve. It portrays the tainted behavior as a form of "professional appreciation"—both socially and economically. Unlike "professional competence" which denies the negative effect of the stigmatized behavior, this type emphasizes the positive effects of the behavior. Professionals who

adopt this type of practices tend to admit that they intentionally perform stigmatized behavior because they prefer the positive effects over the negative consequences of such behavior. Specifically, by *emphasis on economic recognition*, physicians stress that their undervalued expertise should be rewarded by the patients' informal payments. Moreover, *emphasis on social recognition* even somewhat transforms the accepting of red packets into a badge of honor (i.e., entry into the high-status group). In short, professionals who use this type of practice rationalize stigmatized behavior by emphasizing their "bad preferences" (Milo, 1984). Indeed, they highlight their "preference" for the economic reward and social respect over the formal code of ethics and regulations.

This type of rationalizing practices is distinct to professional contexts because it is built upon the assumption that prestigious professions should be highly rewarded and respected (Kadushin, 1962; Muzio et al., 2019; Vough et al., 2013). In my case, physicians who adopt this type of practice often appear indignant at the lack of appreciation they otherwise receive. They also emphasize that, by accepting red packets, they uphold the professional value of expertise. Thus, I suspect that this type of practices might be applicable to other prestigious professions such as lawyers and engineers, but not (or less so) to low-prestige occupations. This suspicion is corroborated by the fact that practices of this type have not yet been uncovered by the dirty work literature.

In sum, all three types of rationalizing practices deny that professional values are violated. While professional competence emphasizes that the value of professional expertise will not be affected by the stigmatized deviant behavior, professional appreciation veers further from the negative connotations by framing bribery behavior as upholding professionals' values. While these two types are relatively calculative, weighing justice against evil, professional confirmation

(in particular, invocation of culture) shows the warm nature of rationalization, using cultural tradition to justify the deviant behavior as part of professionalism. All these practices contribute to the persistent rationalization of stigmatized behavior as well as the maintenance of the behavior itself.

Corrective Actions Adopted by Different Professional Organizations

Importantly, this study also contributes to the literature on the corrective actions organizations pursue following misconduct (in my case, bribery). I leveraged the regulatory change in China as an exogenous "jolt" (Meyer et al., 1990), which makes the context suitable for exploring how comparable organizations respond differently when stigmatized behavior is challenged by important stakeholders. In particular, the study identifies two important organizational characteristics—i.e., status and ownership—that may shape the ways in which organizations adopt corrective actions. Specifically, high-status or publicly-owned organizations are more responsive to the regulatory challenge, to the extent that they might adopt a larger variety of corrective actions as well as substantially more punitive actions.

First, the differences between high-status and low-status organizations suggest that a "status hazard" (Graffin et al., 2013) rather than a "status shield" (Montauti & Wezel, 2016) is activated when professional organizations are under scrutiny. To begin, high-status organizations seem to be perceived as more deviant and stigmatized as they have more opportunities to exploit their advantage. In my case, high-status hospitals typically employ a much larger percentage of highly skillful physicians and offer a much wider variety of surgeries than low-status hospitals do. This makes high-status hospitals more likely than low-status hospitals to be *suspected* by stakeholders. Moreover, my case supports the existing insights of the literature that high-status organizations generally receive greater attention since the media and other stakeholders are more

curious about the fall of professional elites than that of mediocre professionals (Rhee & Haunschild, 2006). Here I highlight an interesting nuance that extends the literature: while previous studies show that high-status actors are not more deviant than low-status actors (Graffin et al., 2013), my case suggests that the former will nonetheless undergo more suspicion and scrutiny merely because it has more opportunity to deviate *regardless* of whether it actually deviates more than the latter.

Second, the differences between public and private organizations highlight two different mechanisms. To begin with, it is suggested that public organizations are more responsive because they are more reliant on the resources provided by the regulator who heightens the stigmatization of the deviant behavior. In my case, private hospitals are less controlled by the government and therefore more likely to defy the regulations against bribery. In other words, when stakeholder salience—in particular, "stakeholder power" (Hersel et al., 2019; Mitchell et al., 1997)—is high, organizations are more responsive. Moreover, compared to private hospitals, public hospitals are, by nature, more inclined to stop bribery which harms the interests of the general public. This demonstrates that an organization is likely to respond more substantively when its identity is in conflict with the deviant behavior; it will likely adopt a greater number of corrective actions as well as more substantial actions (Bundy et al., 2013).

The differences between public and private hospitals also explain the mixed and sometimes contradictory attitudes of the Chinese government towards private hospitals. On the one hand, private hospitals provide an alternative path to health services, encouraged by the government. On the other, the overly profit-seeking behavior in private hospitals further contributes to the stigmatization of the medical profession (Wang et al., 2020). In the case of bribery, even though neither public nor private hospitals have any incentive to support bribery, private hospitals are

less willing than public hospitals to punish senior physicians, as they are a valuable resource for generating revenue for the hospital.

The Persistent Rationalization by Professionals of Stigmatized Behavior

A strikingly unexpected finding of this study is that the rationalization of stigmatized behavior might not be impeded by corrective actions. This runs counter to the existing literature, which has largely focused on the positive effect of corrective actions on firm performance and market reactions (Gabbioneta et al., 2013; Hersel et al., 2019). This study suggests that professionals might not cease their rationalization of deviant behavior for two reasons. To begin, they may have an *optimism bias*, so perceive a low risk of being caught, given the obscure nature of bribery. While the majority of physicians in my case acknowledged that the corrective actions adopted by hospitals were severe, they also believed that only a minority of those who committed bribery were actually caught and punished. This belief of "I should be fine because my colleagues did not get caught" contributes to the persistent rationalization of the stigmatized behavior—in particular, the continuous adoption of colleague comparison.

More interestingly, my case suggests that corrective actions—especially the more punitive ones—might even exacerbate the persistent rationalization of deviant behavior as such actions can be seen as imposing additional "injustice" on professionals, making some of them "morally indignant" and even more likely to adopt professional appreciation to rationalize the stigmatized behavior. Here, I distinguish two dimensions for measuring the effectiveness of corrective actions. The first dimension, which is often the focus of the existing literature, looks at the direct effect of corrective actions on the behavioral deviance. Put another ways, it examines whether the actions actually reduced the *frequency* of the deviance. In my case, in response to the escalating punishments inflicted on bribery perpetrators, physicians become more reluctant to

accept red packets, or at least more cautious about the behavior. However, the second dimension, which seems to have been largely overlooked, investigates whether or not the corrective actions eradicated the *embeddedness* of the deviant behavior. In my case, the rationalization of bribery remains widespread despite certain corrective actions having been deemed severe.

As my interviewees suggest, an important explanation for the ineffectiveness (in terms of the second dimension) of the corrective actions is that the actions fail to resolve the root cause of the stigmatized behavior. According to Hersel et al.'s review of corrective actions (2019: 565), there are three objectives that "seek to address stakeholder claims and alleviate their concerns"—i.e., atone, resolve, and signal. In my case, while some of the actions taken by hospitals (e.g., no-red packets agreement) attempted to *signal* intentions for positive changes, the more punitive actions (e.g., demotion, dismissal) sought to *atone* by offering penance for the harm caused by the deviant behavior. However, none of the major corrective actions I identified attempted to *resolve* the root internal problem responsible for the stigmatized behavior. This seems to suggest that if corrective actions only signal and/or atone, but not resolve, they might not be able to effectively eradicate the embeddedness of stigmatized behavior.

This speaks to a separate yet interrelated issue: the relationship between *rationalization* and *institutionalization* in the process of normalizing stigmatized behavior. In Ashforth and Anand's (2003) original framework, an organization, especially its leaders, may enact the stigmatized behavior as a matter of routine or institution to the extent that it becomes taken for granted. Such institutionalization may give individuals' rationalizations "a weight and permanence that render[s] them all the more credible" (Ashforth & Anand, 2003: 36). However, my case suggests that the formal corrective actions taken by organizations, which are a form of de-institutionalization, may not impede rationalization—at least, not immediately. Is the persistence

of rationalization less reliant on institutionalization because the stigmatized behavior is more for oneself than for the organization? Is it because the rationalization of embedded deviance decays rather slowly? Or, is it because de-institutionalization via atonement is less effective than that via resolution? These questions warrant future research for a better understanding of normalizing stigmatized behavior.

Scope Conditions and Future Research

I developed these insights about the rationalizing practices used by individual professionals and the corrective actions adopted by different organizations from the details of my qualitative case, which imposes certain limitations. While there are major advantages to using a revelatory single case for theory-building (Creed, DeJordy, & Lok, 2010; Eisenhardt, 1989), this design does impose limits to generalizability. Theory derived from my case should be further examined and tested in future research. I note two research directions that could be especially interesting.

First, my case suggests that stakeholder suspicion—one of the two rationales that underlie the mechanism of stakeholder scrutiny—is attributed to high status. However, in my sample of analysis, all high-status hospitals are large and publicly-owned. Even though several low-status or privately-owned hospitals are also large, future research is needed to parse out the independent and/or interactive effects of the mechanisms that may be implicated. Specifically, does size alone also lead to stakeholder suspicion to the extent that larger organizations are perceived to be more deviant and stigmatized? Is the positive effect of stakeholder suspicion on the use of substantive corrective actions independent or conditional on stakeholder power and organizational identity? These are important questions that are worth further investigation.

Second, my case suggests that de-institutionalization—via formal organizational corrective actions—may not impede rationalization among organizational members. However, the second

phase of my study (when I examined the effects of corrective actions) was taken only 12 months after the regulatory change. Although the actions did not significantly impede the rationalization of bribery in the span of one year, they did begin to impede the act of bribery itself to some extent. Will continuous corrective actions gradually impede bribery, which in turn stems its rationalization in the long term? Further, will continuous and even more diligent execution of corrective actions mitigate the optimism bias and eventually impede the rationalization of bribery? Or will the continuous and more diligent execution further amplify the moral indignation and thus fail to impede the rationalization? These questions warrant future research for a better understanding of the relationship between the institutionalization and rationalization pillars of normalization.

CONCLUSION

Despite growing interest among medical and public health scholars in uncovering corrupt behavior in health care, there is still room for the management scholarship perspective to contribute to this conversation. In particular, the persistent rationalization among professionals of bribery has become a severe problem that renders corruption in health an "ignored pandemic" (Transparency International, 2019). Moreover, this problem speaks to a broader yet underexamined issue: the maintenance of stigmatization. Therefore, I have two hopes for this study. Practically, I hope it can translate to policy solutions that can potentially mitigate the problem of corruption. Theoretically, I hope it sheds light on the processes and mechanisms that can explain why stigmatized behavior persists in many contexts despite efforts to stem it.

Chapter 4

From Foe to Friend: Destigmatizing Private Entrepreneurship

INTRODUCTION

The market transition in China has not passed unremarked by scholars. In fact, of this profound societal change, two competing theories have dominated the field of Chinese studies. A bottom-up view of market transition portrays private businesspeople as entrepreneurial heroes who champion the state's formalization of informal institutions (e.g., Huang, 2008; Nee & Opper, 2012), whereas a state corporatist view depicts local governments as powerful institutional entrepreneurs, promoting and constructing a socialist market economy (Oi, 1999; Walder, 1995). While these two streams of work have provided important insights into the socio-economic consequences of the shifting regulations and norms during marketization, less is known about *how* the previously stigmatized capitalist market categories—in particular, private business and entrepreneurship—became socially and culturally accepted. To tackle this puzzle, I turn to the burgeoning literature on categorical stigma.

While the stigma literature has had promising growth in the field of organization studies, much of the existing work has sought to unpack the varied counter-responses by which individual organizations manage their stigma (Paetzold, Dipboye, & Elsbach, 2008; Pollock, Lashley, Rindova, & Han, 2019). Only recently have stigma scholars started to explore when and how categorical destigmatization takes place and uncovered the ways that stigmatized organizations can work to reshape the public associations of their defining categories (Adams, 2012; Lashley & Pollock, 2020; Siltaoja, Lähdesmaki, Granqvist, Kurki, Puska, & Luomala, 2020). Work in this area has done much to cast light on the destigmatization efforts of category members and their collective actors (such as trade associations), but our understanding of categorical destigmatization remains limited. In particular, less attention has been directed towards the state as an important stakeholder in categorical destigmatization—though policy and

legislation often form an important backdrop to the focal efforts of category members (Lashley & Pollock, 2020).

Lack of attention to the role of the state in (de)stigmatization is problematic for several reasons. From a theoretical standpoint, states can be almost uniquely powerful actors (Scott, J., 1998; Scott, W., 2014) and are likely to have distinctive strategic repertoires available when they choose to engage in efforts at destigmatization. Theories built on the strategies and impacts of other actors may thus be misleading when applied to the state, which is troubling given that state actors are likely to have disproportional influence once engaged (Lamont, 2018). The state apparatus can also be a particularly important site of political and policy struggle (Anderson, 2018; Glaeser, 2011). Related theory-building is thus needed to unpack the political struggles that may arise from, fuel, and dampen any substantive attempts at categorical destigmatization. Such questions increasingly gain practical importance given the emergence of disruptive and contested ways of doing business—such as recreational use of cannabis and human genetic engineering—and highlight the need to better understand the challenges and strategies available to states to control such categories, and the dynamics behind their relationships with both the incumbent and prospective category members. All this is particularly critical in settings where members of a stigmatized category are too weak to form effective alliances or external actors are strong enough to quash any bottom-up efforts at change (Haggard, 2018; Vasavakul, 2019).

In this paper, I ask: *How does the state, along with category members, shape the process of destigmatizing a category?* To build theory on this question, I empirically study the rise of private business as a category in China. This is an extreme case of state involvement in categorical destigmatization, given the initial intensity of stigma and the enduring and multi-faceted efforts of the state over a lengthy period, and thus offers an unusual opportunity to

uncover the variety of strategic repertoires that may be available to state actors and the dynamics that can underlie their relationships with category members. As I sought to build theory rather than test established theory, I adopted a qualitative case design and used multiple data sources—including archival documents, newspaper articles, oral histories, and interviews. I also used the extensive secondary literature on China's market transition as a check on my findings and emergent theorization.

My contribution is to the nascent literature on the processes of stigmatization. Specifically, I flesh out an empirically derived process model of categorical destigmatization that centers on the state and its interaction with category members. The model is made up of four phases: a "local experimentation" phase driven by the state's limited regulatory approval of a previously stigmatized category, which attracts a small yet growing number of new entrants; a "cautious expansion" phase made up of broader state approval, which accelerates the growth of the category, but also incentivizes certain members to breach state restrictions; an "internal conflict" phase that follows as the breaches unintendedly stimulate institutional custodians to restigmatize the category; and an "institutional settlement" phase in which the state and category members together stabilize the social approval of the category.

Throughout the process, I highlight the dynamic relationship between the state and category members, which I conceptualize as "orchestrated improvisation"—that is, strategic arrangements made by the state to stimulate changes of social evaluations and category dynamics on the ground (i.e., orchestration), and, responses adopted by category members based on the evolving institutions in order to survive and succeed (i.e., improvisation). I suggest that the process of categorical destigmatization is shaped by broader institutions—in particular, category members tend to be more proactive and enterprising as the state widens the political and entrepreneurial

space for them (cf. Lashley & Pollock, 2020).

Furthermore, my study has practical implications for understanding the grand challenge of balancing social welfare and economic value. The story of private entrepreneurship in China is not a distant and trivial history, but a recent and profound societal change that may shed light on our understanding of how organizations deal with social impact and responsibility. While much of the social innovation and entrepreneurship literature has focused on how organizations manage the tension between the social welfare logic and the market logic, or the "hybrid" social-business forms (Battilana & Dorado, 2010; Dacin, Dacin, & Tracey, 2011), my case opens up a new pathway to exploring how the two logics may be recombined at the field or even societal level.

THEORETICAL ORIENTATION

The Management and Removal of Categorical Stigma

Stigmas are discrediting marks, attributes, or labels that trigger a wide variety of negative attitudes and beliefs—many of which have important social and economic consequences such as devaluation, exclusion, discrimination, victimization, and even vilification (Devers, Dewett, Mishina, & Belsito, 2009; Paetzold et al., 2008). Social research was not slow to pick up on the importance of stigma. Since Goffman's (1963) canonical work, the challenges of coping with stigma have continued as a major theme in sociology and social psychology, with an empirical focus on marginalized or disadvantaged populations (Lamont, 2018). Within organization studies, the concept of stigma has been extended to organizations, industries, and categories (for a review, see Zhang, Wang, Toubiana, & Greenwood, 2021; see also Devers et al., 2009; Grougiou, Dedoulis, & Leventis, 2016; Pollock et al., 2019; Vergne, 2012). Hudson (2008) made a useful distinction between two types of organizational stigma: "event" and "core" stigma—the

former of which results from "discrete, anomalous, episodic events" (e.g., bankruptcies, industrial accidents), whereas the latter is associated with the "nature of an organization's core attributes—who it is, what it does, and whom it serves" (Hudson, 2008: 252). Core stigma is typically shared among a category of organizations "that [are] recognized as engaging in contested practices" (Piazza & Perretti, 2015: 726)—"such as arms, pornography, or tobacco" (Vergne, 2012: 1030; Galvin, Ventresca, & Hudson, 2004; Voss, 2015). Such core stigma is a noteworthy phenomenon, given that it can pre-empt or suppress large categories of social and economic activity. It is this form of stigma that I address in this chapter: specifically, I explore the core-stigmatized category of private business in China and its unfolding destigmatization during the country's market transition.

The preexisting literature has mostly treated categorical stigma as a background to organizational stigma management, focusing on unpacking the different strategies by which category members manage their association with the stigmatized category, in order to avoid negative consequences such as public derogation and market devaluation (Barlow, Verhaal, & Hoskins, 2016; Pollock et al., 2019). Organizations commonly manage this kind of stigma by distracting audience attention from their association with the stigmatized category. In core-stigmatized industries, such as global arms and nuclear power generation, organizations try to straddle multiple market categories to shift stakeholders' attention to their non-stigmatized practices (Vergne, 2012) or temporally terminate their association with the stigmatized category entirely (Piazza & Perretti, 2015). A second approach is to consciously hide category membership by trying to "pass as a member of the non-stigmatized majority" (Clair, Beatty, & Maclean, 2005: 90; Wolfe & Blithe, 2015). In Hudson and Okhuesen's (2009) study of men's bathhouses, organizations attempted to conceal their true identity by using discrete locations,

adopting target advertising, and mimicking gyms. A third common approach is for organizations to explicitly co-opt their association with the stigmatized category to solicit social approval. For example, Helms and Patterson (2014) showed that mixed martial arts organizations strategically used their stigma of violence to attract attention from supportive stakeholders. This literature has done much to show how individual organizations lose, conceal, or use categorical stigma. Attention to the dynamics of the stigmatized category *per se*, such as the growth and decline of the category, however, remains sparse.

The under-examined dynamics of categorical stigma is important, as categories are a key context for organizational struggle and responses. In particular, the rise and fall of categorical stigma may influence the ways in which incumbent members manage stigma and whether new members enter the category. For example, Vergne (2012) suggests that when a stigmatized category becomes more salient, straddling multiple industry categories will become an increasingly favorable strategy for individual firms. Similarly, Piazza and Perretti (2015) show that when the level of disapproval of a category—using their terms, "stigma intensity"—decreases, member organizations are less likely to terminate their involvement in that category. Though we still lack a comprehensive understanding of how categorical stigma may be intensified or reduced (Zhang et al., 2021; Wang, Raynard, & Greenwood, 2020), two pioneering studies offer particular insights. The first, put forward by Adams (2012), suggests that in a stigmatized industry, asserting greater control and increasing standardization among its members through professional associations' collective actions may be critical to categorical stigma reduction. By comparing two stigmatized categories that both specialize in the modification of the body—i.e., cosmetic surgery and tattoo artistry—Adams shows that plastic surgeons have achieved a higher degree of social approval by establishing professional associations that affiliate

with the mainstream American Medical Association and disowning disqualified members, whereas tattoo artists' lack of self-regulatory bodies had led to much lower public acceptance.

Complementing these insights, a second path-breaking study—provided by Lashley and Pollock (2020)—delved further into the process of reducing a categorical stigma. Through a rare empirical case of destigmatizing a nascent category, in the context of medical cannabis, Lashley and Pollock showed that categorical stigma reduction can be a multi-phase process, driven by collective actions of multiple actors in distinct relational spaces. Specifically, in the first phase, exogenous events (in their case, the AIDS crisis) triggered the initiating of a new moral agenda (cannabis as medicine), which differentiated the category from its previous tainted incarnation (as a black market). In the second phase, category members (medical cannabis entrepreneurs and industry group advocates) collectively established a moral prototype (a public image based on healing and patients' rights) that facilitated the legalization of the category (of medical cannabis). Finally, in the third phase, trade associations and lobbying groups were formed that help category members collectively disseminate and infuse the new morality (the medical use of cannabis is normal) to the general public. Via this dynamic model of stigma reduction, the authors cautioned us to recognize the complex relationships between individual organizations and the category as a collective—they showed that cannabis entrepreneurs sometimes had to engage in stigmatized activities to survive, but would hide those practices on the backstage away from what they collectively propounded for the category on the front stage.

Both of the above studies cast light on a previously neglected topic: the complexities of the destigmatization *of a category*. This nascent conversation has highlighted the role of internal actors such as member organizations and trade associations in categorical destigmatization—in particular, the importance of their collective actions. However, this body of work remains

underdeveloped. Notably, the role of critically important external stakeholders—in particular, governments—has remained largely backgrounded. This is a major theoretical limitation given that external stakeholders are often key to categorical destigmatization, especially in cases where internal category members are too weak to form effective alliances or external stakeholders can easily quash any bottom-up efforts.

The Puzzle of How the State Destigmatizes a Category

The role of the state, an often-critical actor in the dynamics of categorical stigma, is in need of elaborated theorization. Prior literature on stigma acknowledges the significance of the state to some extent, including recognition of state legislation as an institutional backdrop or an indicator of stigma reduction (Clair, Daniel, & Lamont, 2016; Hudson & Okhuysen, 2009). In prior empirical studies of medical cannibals and mixed martial arts, for example, the state was seen either as a source of exogenous events that triggered category members' collective actions or as an endorser of effective collective efforts (Helms & Patterson, 2014; Lashley & Pollock, 2020). Yet, while this work acknowledges the state's general significance, it does not directly attend to the state as a driving and ongoing influence in the destigmatization process. This is problematic because the state "exercise[s] legitimate control over specified areas under a rule of law and backed by the power of coercive sanctions" (Scott, Ruef, Mendel, & Caronna, 2000: 173). Such a power to deploy legitimate coercion can be a strong means of destigmatizing a category, and is likely to make the state remarkably influential in any destigmatizing efforts in which it interests itself. As Lamont (2018: 429) reminds us, "to fully understand destigmatization processes, one should consider the state in its capacity to legitimize, stigmatize, and control populations."

Though the role of the state in destigmatizing categories of organizations is understudied, there are resources in the existing literature on the destigmatization of categories of persons. This

work has shown that the state is highly motivated to reduce the stigma of certain populations when stigmatization occurs to impede policy objectives (Clair et al., 2016; Winter, 2014). For example, the U.S. government became increasingly interested in reducing the stigma of LBGTQ people after it learned that same-sex marriage laws would contribute to all federal tax purposes (Fisher, Gee, & Looney, 2018). Similarly, while promoting multiculturalism in Canada in the 1970s, Pierre Trudeau and his government mobilized various tools of ideological apparatus such as public television and national celebrations to destigmatize immigrants and their cultures and integrate them into the core of Canadian society (Tierney, 2007; Winter, 2014). The media and other means of image production have been emphasized as tools that the state can use to suppress alternative narratives and framings of the stigmatized (Rivera, 2008). Other work on the state as a powerful stakeholder has illuminated that the state is often not a unanimous collective of actors but may suffer from "internal pressures within the regulatory body such as turnover in agency leadership or internal agency politics" (Cavazos & Rutherford, 2012).

Intuitively, some of the insights and mechanisms highlighted above may be applicable to the destigmatization of categories *of organizations*, but we lack such empirical studies. Empirical work is important for highlighting potential differences between categories of persons and those of organizations. When considering the state's role in categorical destigmatization, we may find that the state focuses on universal values and morality (e.g., human rights) in seeking to destigmatize categories of persons, but on social and economic considerations for categories of organizations. These differences may in turn affect the process and dynamics of destigmatization. Moreover, whereas many categories of persons are relatively difficult to join or leave freely[11],

[11] Although the state' policy changes can directly affect whether LBGTQ people are more likely to identify themselves publicly or whether more immigrants are allowed to enter a country, the growth of LBGTQ or of minority populations is still relatively stable as most individuals cannot choose which category they can enter or be classified into.

the membership of many organizational categories can fluctuate rather dramatically, depending on the state's (in)actions—which, again, may shape the unfolding dynamics of destigmatization. Beyond this, as Lashley and Pollock (2020) suggest, whereas prior studies often focus on categories that are *partially* destigmatized in the eyes of some of their stakeholders (e.g., core customers), research is needed on how a category of organizations may become more broadly destigmatized in the eyes of different stakeholder groups.

Although the existing literature does not explicate the role of the state in destigmatizing a category of organizations, it provides some useful starting points which I summarize into several guiding principles for my study. First, given that the state possesses extraordinary coercive powers (Scott et al., 2000), it may adopt different, and potentially more assertive, destigmatizing approaches from those by internal actors. Second, as categorical destigmatization is likely to be a multi-phase process (Lashley & Pollock, 2020) the approaches adopted by the state may evolve over time. Third, since the state and its agencies can be bifurcated or even fragmented (Cavazos & Rutherford, 2012) their strategic decisions may be affected by their internal dynamics. Last but not least, as the state's approaches may change over time or contradict internally, social evaluation by other stakeholders, including incumbent category members, potential new entrants, and the general public may also shift and in turn shape the process. With these guiding points in mind, I explore the process of destigmatizing a category of organizations, with a focus on the role of the state and its dynamic interaction with other stakeholders.

METHODS

Research Design and Empirical Context

To explore my research question, I selected a historical qualitative case of the destigmatization of the "private business" category in China, from 1978 to 2004. This case is

particularly well suited to my topic. To build theory on understudied topics, such as the influence of the state in categorical destigmatization, it is often helpful to focus on extreme cases, in which the topic is especially salient. Such cases are particularly suitable for building new theory as they provide 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). The case of destigmatizing private business in China certainly meets this criterion. Indeed, destigmatization in this case was largely led by the state as the category was so discredited that members of the category lacked the power, influence, or felt security to contest their own stigmatization—as evidenced by the lack of mobilization in the suppressed, and almost non-existent, private sector for more than two decades before the market transition (Tsai, 2007). Theory building is also aided by rich qualitative data, from which unexpected insights can emerge (Eisenhardt, 1989; Pratt, 2000)—and the social significance and impact of marketization gave rise to an extensive and varied body of qualitative data sources that fueled my analysis, which I discuss below.

In the aftermath of the Cultural Revolution, the Chinese state[12] faced a devastated economy: more than twenty million people were unemployed—including more than ten million "sent-down youth" (知识青年)[13] who had been permitted to return from state-mandated labor in rural areas to the cities in the late 1970s. Rarely able to acquire a position in the already bloated public sector, these people were officially dubbed "idle labor forces" (闲散劳动力). The sheer volume of the idle labor forces was deemed a social problem, and a source of malcontent and criminality—in Qiqihar, a major city in Northeast China, for example, two thirds of crimes were listed as

[12] In China, the state is so closely connected to the Communist Party that "there is no independent judiciary system: the parliament, executive branch, and courts are all under the control of the Party" (Che & Qian, 1998: 9). For this reason, I use "state" and "Party" interchangeably in this article.

[13] It refers to the young urban students who had been sent away by the government or willingly migrated from the urban to the rural since 1955 (Bonnin, 2004). It is also translated as "educated youth" or "rusticated."

committed by the unemployed (Su, 2016). This problem was only reinforced by soaring fiscal deficits, which impeded the state from creating new jobs in the public sector or providing associated social benefit. Concerns about escalating social upheaval propelled the state to consider the illegal and stigmatized category of private business as a potential solution; setting in motion a complex process of destigmatization.

To destigmatize the category of private business was not an effortless project. Ever since the Socialist Transformation in the 1950s, private businesses had been systematically eradicated and replaced by state-owned enterprises and collective enterprises. For example, in Shanghai, a city with the most developed private sector in the early 1950s, about 26,000 private businesses disappeared during the Transformation. For more than two decades, private business had been discredited and denounced for their inseparable association with capitalism (Solinger, 1984). During the Cultural Revolution, in particular, purging remnants of capitalism and privatization became a major theme in people's everyday life; any attempt at private businesses would be condemned as part of the "tail of capitalism" and punished (Tsai, 2007: 48; Walder, 2017). Destigmatization of private business in such a context was highly contentious. On the one hand, the state tried to re-construct the social approval of private business and encourage people to join the private sector in order to ameliorate the national economy; on the other, it had to carefully disassociate private business from capitalism so that the socialist regime and values would not be undermined.

Data Collection

To study the role of the state in categorical destigmatization through an extreme, longitudinal case, I conducted a comprehensive search for multiple forms of data (Lawrence, 2017; Quattrone, 2015). In so doing, I began with collecting and reading academic monographs

about China's market transition in order to gain a general understanding of the empirical context. I then collected archival documents, newspaper articles, and statistics to build a comprehensive array of data on the state-led destigmatization. I also conducted interviews and collected oral histories to gain nuanced insights into how the state impacted the lives of those stigmatized and other stakeholders. Together, these rich sources of data provided a means for cross-validation of my emerging interpretations.

Archival documents. To map out a chronology of major events in the destigmatization of private business, I collected more than 200 government documents relevant to market transition and particularly private businesses, including laws, regulations, party decisions, public statements and guideline files, which enabled me to examine the role of the state. Among the various documents those passed by the National Congress of the Communist Party of China (the Party Congress, thereafter) and the plenary sessions of the Central Committee of the Party (the Central Committee, thereafter) are particularly important since they represent "the ultimate authority in the entire political system" in China (Wu, 2015: 2).

The Party Congress is held once every five years, during which the Party's Constitution will be revised, if necessary, and the Central Committee—the Party's highest organ of state—is elected. The Central Committee convenes at least once a year at a plenary session, which functions as a top-level venue for the discussion, refinement, and public release of important policies (i.e., "resolutions" or "decisions"). Given the Party's supreme political authority, those decisions are then legalized by the National People's Congress (i.e., the highest legislature) and executed by the State Council (i.e., the central government) and local governments.

Newspaper articles. In addition, I collected newspaper articles from the *People's Daily*, the largest and most influential and authoritative newspaper in China. As the official newspaper of

the Central Committee, the *People's Daily* not only provides latest news dispatches of the Party's political resolutions and policy information, but also expounds to the general public what should be praised or discredited. Therefore, I used these data to investigate how the state, through the media, strategically approved or disapproved of private business. In so doing, I gathered a comprehensive set of more than 40,000 articles by searching keywords or their synonyms that are related to private businesses, such as "individual business" (个体户), "individual economy" (个体经济), "private enterprise" (私营企业), and "private economy" (私营经济). While government documents are supposed to tackle broad, societal issues with a decisive tone, newspaper articles often comment on specific incidents in people's everyday life with a more suggestive tone. With this rich collection of newspaper articles, I was better able to examine the various tools used by the state to destigmatize the category of private business.

Interviews and oral histories. While further investigating the state's strategies and their effects, I conducted 46 interviews including 29 private businesspeople and 17 government officials during 2013 to 2017, to capture the "situated lens of the participants" (Hudson & Okhuysen, 2014: 244). These interviews were identified through snowball sampling: 39 of them were conducted in the eastern coastal area (e.g., Guangdong, Shanghai, and Zhejiang) where private businesses were relatively more active, while 7 in an inland province (i.e., Anhui) where the private sector was less developed. 19 of the 29 private businesspeople joined the private sector in the 1990s while the other 10 in the 1980s. All of the 17 government officials have worked in regional Bureaus of Medium and Small Enterprises. To complement this retrospective sample with a focus on the coastal area, I then collected 73 oral histories which were documented by the People's Political Consultative Conference, and its regional branches, *during* rather than *after* the destigmatization of private business. These oral histories consist of 44

private businesspeople who entered the private sector before the early 1990s (from across the country) and 29 government officials who were directly involved in the state's destigmatization of private business. With these interviews and oral histories as comparison I was able to validate and develop a more nuanced understanding of the destigmatization process.

Statistics. To further triangulate and develop a more accurate depiction of the effects of the state's destigmatizing efforts, I collected statistics from the National Bureau of Statistics of China (NBS) as well as the Chinese Private Enterprise Survey (CPES). In particular, I acquired longitudinal statistics regarding "how many people" *and* "what kinds of people" have joined the private sector—to help index whether *and* to what extent private business was destigmatized. Specifically, I collected data from the NBS on the growth of the private sector (e.g., the number of employees by private businesses) and from the CPES data on the changing demographic profile (e.g., education levels) of private businesspeople. The CPES provides the largest longitudinal survey with a representative sample of private enterprise owners. It has been conducted biannually since 1993, thereby covering only the later stage of my study.

Data Analysis

After assembling the data, I first established a chronology of major events that occurred to the category of private business—including the state's introduction of small sole proprietorship and legalization of large private enterprise. In so doing, I mapped out key events during which the state adopted a distinct stance to evaluate private business. Once I had developed this chronology, I then turned my attention to unpacking the process and mechanisms of categorical destigmatization, with a focus on the role of the state, and, its dynamic relationships with other stakeholders—in particular, the existing and future category members.

Identifying shifting stakeholder evaluations. I first delved into archival materials, which

documented the state's attitudes towards the private business category. Whenever I identified a clear pattern of activities adopted by the state to (re-)evaluate private business, I aggregated such data and inductively coded them as a strategic practice. For instance, when I found in multiple documents that the government tried to explicitly sever prior ideological associations between private business and capitalism, I conceptualized it as "symbolic reframing." Once the shifts in the state's evaluations and the ways by which such evaluations were rendered were identified, I assessed the media's evaluation. Given that the media in my case were highly controlled by the government, I compared how their evaluations mapped onto those by the government. Using the same coding scheme, I analyzed 800 newspaper articles randomly selected from those I collected from the *People's Daily*.[14] I stopped my analysis of articles when the point of theoretical saturation was reached (Corbin & Strauss, 2008). To gain a better understanding of the implications for the private business category, I interrogated the oral histories and interviews with private businesspeople to discern if and how the state's evaluations affected their decision to enter or leave the private sector.

Once I had adequately captured the state's evaluations, I turned my attention to the shifts in the evaluations by private businesspeople themselves. As it is "difficult to quantify stigma and hence the extent to which it is removed" (Lashley & Pollock, 2019: 32), I used three complementary indicators to capture the attitudes of existing category members and of potential new entrants. First, I sought to capture the "lived experience" (Smets, Jarzabkowski, Burke, & Spee, 2015) of private businesspeople—i.e., *how they perceived* the degree of destigmatization. I thus asked interviewees to describe how their perceptions of being private businesspeople or employed by private businesses were changed by the state's destigmatizing efforts over time.

[14] While I collected more than 40,000 articles from the *People's Daily*, I first randomly selected 100 articles from the pool for close reading and coding. After eight rounds of random selecting and reading, I no long found any new patterns and thus stopped further analysis.

Second, I captured *how many people* participated in the private sector, on the basis that reduction in category stigma is likely to be reflected in greater willingness to enter the category in question. Specifically, I used the annul number of employees by private businesses as well as the percentage of employees in the private sector relative to the public sector. Third, I captured *what kind of people* joined the private sector, on the basis that a less stigmatized category is likely to attract people with greater status or resources (i.e. those who would have a broader range of alternatives to category participation). Thus, I examined shifts in private enterprise owners' education level, social and political status, and prior employment. Together, I believe these three indicators constitute a sophisticated and reliable depiction of destigmatization for the category of private business.

Developing core concepts and relationships. After mapping out the changes in how the state and other stakeholders evaluated the private business category, I looked for "critical junctures" (Sewell, 1996: 843) when previous evaluations of private businesses were significantly changed. I identified four such junctures and thus divided the time frame of my study into four phases (Langley, 1999; Lashley & Pollock, 2019). I then used these phases as embedded units of analysis (Eisenhardt, 1989) to examine why various stakeholders' evaluations moved from collective disapproval towards destigmatization.

First, I tried to understand whether *and* to what extent the existing members and prospective entrants of the private business category were actually affected by the state's destigmatizing efforts. As I dug into the data, it became clear that it was the state's regulatory approval of private business within a limited scale and scope—along with its symbolic reframing of the category to fit socialism, and, selective praising of exemplary private businesspeople—that initially encouraged a small but growing number of new entrants. I label this initial phase one of

"local experimentation." With the same analytical process, I looked into the other three phases and conceptualized the state's approaches to destigmatization. I then looked into *why* the state's approaches evolved as they did. In so doing, I closely examined archival documents, looking in particular for how the state explained its strategic moves. Notably, I delved into the resolutions and decisions passed by the Party Congress, which provide explicit justifications for any changes in state policy. Further, I returned to interviews and oral histories—particularly, those with government officials—to develop a better understanding of why the state decided to change its course of action regarding the destigmatization of private businesses.

Establishing trustworthiness. Throughout, I sought to ensure the trustworthiness of my interpretations and findings through triangulation of multiple data sources (Guba & Lincoln, 2005). To make sure that my interpretation of the state's role in destigmatization is reliable, I also engaged in "member checks" (Langley & Abdallah, 2011), presenting preliminary findings to several "elite interviewees" (Marshall & Rossman, 1999) who founded their private businesses in the 1980s and were elected as the People's Congress representatives for their success in business. I also discussed my findings with a historian of contemporary China who worked in a prestigious university in China to confirm that I did not misinterpret the data.

FINDINGS

Private business had been denounced as capitalistic for decades: merely talking about "private business" or "private ownership" was regarded as a betrayal of socialism in the 1970s. As such, revitalizing private business represented a profound cultural challenge for the state. Even though the reintroduction of private business seemed a potentially viable solution to unemployment, the perceived moral toxicity of capitalism made it difficult to go about this change, in general, and to do so quickly. As a result, the state efforts at destigmatization evolved

over a lengthy period. Such efforts began with small trials that destigmatized private business at a certain scope and scale. Preliminary success and growth of the private business category then permitted expansion of destigmatization to a broader context. Surprisingly, the inevitable consequences of a burgeoning private sector, in turn, aroused tension and a backlash within the Party—though, ultimately, the opposing factions of the Party reached a settlement, further expanding destigmatization. As this process developed, distinct approaches to destigmatization by the state took form and effect, which both shaped and were shaped by the responses of existing category members and prospective new entrants. In this section, I identify the approaches adopted by the state in each phase, and explore how they evolved with the responses of category members.

Local Experimentation (1978–1983)

The state: limited regulatory approval of the category. The first phase of the process that I identified in the data was characterized by "local experimentation": state-promoted pilot experiments destigmatized the category of private business locally while setting limits on *where* and *in which industries* one could establish a private business, *who* could do so, and *what size* such a business could reach. This purposefully experimental and localized approach was explicitly articulated by Deng Xiaoping in his keynote speech at the Third Plenary Session of the Eleventh Party Congress in December 1978: "Before a national overall plan is made, we can start locally, with a region or an industry, and then gradually expand [the experiments]. The central ministries and departments shall allow and encourage such pilot projects" (ND781222)[15]. As a former government officer explained:

> What we criticized during the Cultural Revolution might be correct now, but the Party was concerned that a complete approval of private business all of sudden would be dangerous.

[15] I use ND to refer to government documents; and PD to refer to the *People's Daily*. The number after ND or PD, such as "781222", indicates the year (1978), month (December), and date (22nd).

> Instead, experiments were much controllable. If some experiments slipped into capitalism, we could figure out how to bring them back to socialism. (IDG03)[16]

Local pilot projects began in February 1979, when the state approved a proposal submitted by the State Administration for Industry and Commerce that "local governments can approve some officially registered 'idle labor forces' engaging in individual businesses in household goods repair, service, and handicrafts, based on local market demands. But they are not allowed to hire employees" (ND790201). Here, the local nature of early destigmatization efforts is clearly illustrated: this project imposed strong restrictions on *who* can found a private business (i.e., only "idle labor forces," or temporarily unemployed individuals), *the size* of such a business (i.e., "individual business," or sole proprietorship), and in *which industries* it can operate (i.e., three tertiary industries). The state slightly revised the restriction on size in July 1981 when the State Council established the first regulation that allowed private businesses to hire employees: "Individual businesses are generally operated by one person or one family; if necessary, upon approval by the Administrations for Industry and Commerce, an individual business can hire one to two helpers; if a business is fairly technical or involves special skills, it can hire up to five apprentices" (ND810707). This facilitated the emergence of small-size private businesses.

The state: symbolic reframing of the category to fit the existing institutions. While establishing new regulations for the category, the state also began to reframe the meaning of private business as compatible with the socialist planned economy. Specifically, there was a sustained effort to detach the category from the toxic capitalist associations that underpinned its stigmatization, and attach it to socialist meanings, enhancing its positive connotations. This "symbolic reframing" was performed through explicit public statements *and* implicit censoring.

First, the state tried to explicitly detach private business from its capitalistic associations

---

[16] I use IDP to refer to my interviews with private businesspeople, and IDG to those with government officials. IDG03 means the third interview with a government official.

and attach it to socialist labels through its official voice, the *People's Daily*. The first article I found in favor of private business was published in July 1979:

> Doing individual business is not going down the capitalist road. As long as it is self-reliant and does not exploit wage labor, it will *never produce new exploiters*… Self-employed individuals (such as peddlers who sharpen kitchen knives or repair shoes) should not be completely eliminated. This is not only *conducive to employment expansion*, but *also convenient to residents*. (PD790720, emphasis added)

Later, when the restriction on size was slightly loosened in 1981, the *People's Daily* published a series of articles reframing the act of employing—for example: "employment is just a special form of labor organization and compensation methods… which should not be attached to the scary label of 'exploitation'…" (PD810830). Sometimes the state's reframing could be somewhat more enthused. Another article stated that individual businesspeople were "absolutely necessary" for "development of productive forces and improvement of people's life" (PD800620). The private business category was thus repeatedly detached from capitalist "exploitation of labor" and attached to positive socialist meanings—particularly, "employment expansion" and "people's convenience."

Moreover, the state reframed private businesses in its political decisions, regulations and laws. During the Sixth Plenary Session of the Eleventh Party Congress in June 1981, the state officially redefined the relationship between private business and the socialist public economy (公有制经济) for the first time:

> The state-run economy and collective economy are the basic economic forms in our state. The individual economy within a certain scope is *a necessary supplement to the public economy*… market adjustment should play a supporting role. (Emphasis added, ND810627)

Thus, in a core document of the Party, it was explicitly spelled out that private business (labeled as "individual business" or "individual economy") was a "supplement" to the socialist economy. Just one month later, the State Council further entangled private business with positive socialist associations in its statement of national policy: "restoring and developing individual economy is

of great significance for developing productivity, activating the market, meeting the needs of people's lives, and expanding employment" (ND810707; see also ND811017).

In addition to these explicit expressions, reframing sometimes occurred more implicitly by avoidance of negatively value-laden labels and phrases. For example, the phrase "privately-owned" had strong capitalist denotation, so the state avoided using this phrase positively in its official documents throughout this phase, whilst practically permitting individuals to establish privately-owned businesses. Instead, state communications adopted less value-laden terms such as "individual business" or "individual economy." As a retired government official remarked, "given that we just walked out of the Cultural Revolution, using words such as privately-owned (私有) or hiring (雇工) would easily get on people's nerves… Although individual businesses were de facto privately owned, we did not call them 'private businesses' because 'private' meant capitalist" (IDG14).

In essence, symbolic reframing was used to make private business resonate with the interests and meanings of socialism. In this phase, the government documents that mentioned "individual businesses" largely emphasized their positive meanings (e.g., employment expansion) and that they "should not be seen as capitalist tails" (ND790929). However, the state's symbolic reframing alone was "not convincing enough for people to join the once condemned private sector" (IDP01). As one businessman put it:

> The government's talks and claims seemed supportive, but we had no idea if it would retaliate against us once we actually became businesspeople. Whereas some people took the risk, many of us waited and observed what would happen to them before we made a move. (IDP15)

The state: selective rehabilitating of exemplary category members. To destigmatize the private business category, the state selectively praised *members* of the category. A complement to symbolic reframing, rehabilitating showcased the plaudits that could accrue to exemplary category members and the protection of the category from mistaken public animus; this

showcased practical improvements in private businesspeople's situations. Rehabilitating efforts were thus "meant to show that doing private business was a politically safe pathway" for people (IDG03).

First, the state rehabilitated individual businesspeople through the provision of rewards and plaudits. A new regulation in October 1981 permitted businesspeople to join the Communist Party, which was seen as a sacred indication of moral consonance with socialism:

> Individual businesspeople are a socialist labor force of our country. Their work, just as that of state-owned and collective enterprise workers, is *necessary for building socialism* and *glorious*. As to their *social and political status*, they should be *treated equally* as state-owned and collective enterprise employees. (Emphasis added, ND811017)

Following this new regulation, the *People's Daily* repeatedly publicized, sometimes even on its front page, that individual businesspeople could become members of the Party, and earn other forms of state recognition through their activities. For example, one front page trumpeted that an individual businessperson, Jin Hongye, was elected as a representative of the Eleventh National Congress of the Communist Youth League (PD820704). Similarly, for "their good service attitudes and skills have won praise from the broad masses of the people", two individual businesspeople, Gan Jing and Ye Liguang, were nominated by the local government and elected into the Committee of the Provincial Communist Youth League (PD830205; see also PD811102).

Second, the state highlighted its protection of individual businesspeople and its disapproval of now-misguided public animus. On the front page for August 17 1980, for example, the *People's Daily* reported a physical altercation between an individual businessman who owned a food stall and a few employees of a state-owned restaurant, who "smashed bowls at the food stall" because they believed that the private owner "committed capitalist activities." Below this article was an editorial supporting the businessperson: "Some of our comrades still have some wrong views on the individual economy. They mistake the individual economy for capitalism,

and mistake going against individual businesses for fighting against capitalism" (PD800817). Similarly, upon a fight between an employee of a state-owned photo gallery and a self-employed photographer in Hangzhou, the *People's Daily* reported that "the Zhejiang Provincial leaderships have given serious attention to the incident, after which the Party secretary of the state-owned gallery, along with its employee, has made a formal apology to the individual businessperson." It added that "individual businesspeople should not be bullied" (PD821117).

Category members: the emergence of private entrepreneurs. While the state orchestrated a combination of limited regulatory approval, symbolic reframing, and selective rehabilitating to shape political and entrepreneurial opportunity for the private business category, a small yet growing number of people began to enter the category as they perceived a changing degree of stigmatization. Here, I make use of the three indicators of destigmatization discussed above, and examine how category members reacted to the state's destigmatization and how the changing dynamics of the category further impacted the evolution of state-led destigmatization.

Following the state's efforts, the number of category members grew to approximately 676,000 by the end of 1979 and then increased by 145 percent in the next year.[17] The private sector continued to grow as individual businesses were allowed to hire up to seven employees in mid-1981. By the end of 1982, the number of individual businesspeople and their employees increased to 3.2 million: an almost nine-fold increase over three years. Nevertheless, the partial and localized nature of destigmatization was also clear: state-owned enterprises remained generally dominant in urban areas, where individual business accounted for barely one percent of total employment.

The growth of private business provides only a partial story. Those who entered the private

[17] Although individual business was officially permitted in early 1979, it was estimated that there were approximately 150,000 individuals across the country operating illegal individual businesses before 1978.

sector in this phase were often "necessity entrepreneurs"—i.e., under-educated and unemployed before they founded or joined a private business. "They included the unemployed, the sent-down youth and the marginalized in society who could hardly find a job in the public sector. They became individual businesspeople often out of necessity instead of seeking for social recognition or a better career" (IDG11). One of the older generation individual businesspeople remarked: "Even though the state seemed to try to elevate the social status of individual business, most of us came from a lower class. If one had a job in state-owned enterprises, they would not quit for individual businesses" (IDP02). Indeed, early entrants to the private business category were often under-empowered and lacked the resources to fight again stigmatization on their own.

Category members: operating under the radar. Despite the state's efforts, individual businesspeople still faced strong social disapproval from the general public. The pervasive social discrimination against individual businesspeople was well captured by some interviewees' recollections: "We were discriminated against everywhere. People still believed that being an individual businessperson was to go down the capitalist path" (IDP14); "The public looked down upon us" (IDP08). One of the interviewees commented with unpleasant memories: "I became a self-employed bicycle repairer in 1980, and because of that my son could not get a job. When his girlfriend found out that I was an individual businessman, she even dumped him" (IDP05). One of the earliest individual businesspeople at the Yiwu Small Commodity Market also bemoaned: "People often treated individual businesspeople badly. Prejudice was still firmly engraved in people's minds…" (OHP07)[18]. Similarly, another individual businessperson said, "even though individual and private economy began to emerge, the jobs in state-owned enterprises, the so-called 'iron rice bowl', were still the envy of one's family and friends" (OHP28).

[18] I use OHP to refer to the oral histories of private businesspeople, and OHG to those of government officials. OHP07 means the oral history of the seventh private businessman.

It was under such social discrimination and political uncertainty that private businesspeople in this phase felt "ashamed and even frightened that the 'capitalist tails' might be cut again" (IDP07). Rather than proactively destigmatizing themselves, individual businesspeople in this period mainly lived with the stigma by *operating under the radar*. Many kept a low profile about their revenue in order to avoid others' attention:

> In 1982, when most of my family and friends earned no more than hundreds of *yuan*, I earned 370,000 *yuan*… Many individual businesspeople earned a lot of money. At that time, none of us dare disclose our wealth; we were not sure if bragging about it would make our business illegal. Out of fear, I hid my 370,000 *yuan* under the floor… (OHP15)

To businesspeople at this time, a misstep could seem a matter of life and death: "We wondered how long we could survive. Would we be treated as 'capitalist tails' again under another social movement? We contained our ambition, treading lightly so as not to incite others" (OHP11). In other words, private businesspeople in this phase did not have much leeway to expand or improvise outside the limited opportunity space demarcated by the state regulations.

From the category to the state: positive feedback. In sum, destigmatization had begun, but remained limited. The category of private business grew from practical non-existence to more than seven million members from 1978 to 1983, as the state sought to destigmatize a restricted form of private business ("individual business"). This growth of private business contributed not only to unemployment alleviation, but also economic revitalization—evidenced by an increase in the GDP growth rates from an average of 3.7 percent during 1972–1977 to 9.0 percent in this phase. Moreover, private business made people's daily life more convenient with 21 percent of nation-wide employees in the retail, catering, and service industries based in the private sector. Despite private businesspeople's continued perception of stigmatization, the benefits brought by the emergence of private business sent *positive feedback*, which became increasingly recognized by the state. As a former government official commented, "Upon the initial success from

restoring individual businesses, the government became more willing and even bolder in conducting more experiments of private economy" (IDG02). Similarly, as another interviewee remarked, "the benefits of individual business were visible and encouraging" (IDG09). (See qualitative details regarding destigmatization in this phase in Table 4–1).

Table 4–1: Qualitative Illustration of Destigmatization

	Local Experimentation (1978-1983)	**Cautious Expansion & Internal Conflict (1983-1992)**	**Institutional Settlement (1992-2004)**
The State			
Private business category	Individual business (IB) only	IB and private enterprise (PE)	PE and IB
Size control	From 0 to 7 employees	0 to 7 employees for IB, 8 and above for PE	0 to 7 employees for IB, 8 and above for PE
Industry control	Strictly limited industries in the tertiary sector	Permitted to more industries but primarily in the tertiary sector	Permitted to various industries across different sectors
Constitutional role of the private sector	IB is a supplement to the socialist public economy (1982)	IB and PE are supplements to the socialist public economy (1988)	IB and PE are important components of socialist market economy (1999)
Eligibility for Party membership	Individual businesspeople	Individual businesspeople, but not private enterprise owners	Individual businesspeople and private enterprise owners
Private Businesspeople			
Perceived public disapproval	High	Moderate to high	Moderate to low/none
Employment before becoming an entrepreneur	Typically unemployed or employed in a low status occupation (e.g., farmers, unskilled workers)	Typically employed in a low-status occupation (61% in 1992 used to be employed in a low-status occupation / unemployed)	Typically employed in a middle-status occupation (29% in 2003 used to be employed in a low status occupation / unemployed)
Education level	Low	Low to moderate (17% received post-secondary education in 1992)	Moderate to high (51% received post-secondary education in 2003)
Political status	Few party and/or governmental affiliations	Low proportion of party members (7% in 1990)	High proportion of party members (34% in 2003)

Sources: National Bureau of Statistics of China, Chinese Private Enterprise Survey, and documents.

Cautious Expansion (1983–1987)

The state: amplification of previous efforts of destigmatization. Following the momentum gathered during the previous "local experimentation" phase, the state began to amplify its destigmatization efforts—they loosened or removed restrictions on the scope and the size of private businesses. Starting in 1983, the state allowed individual businesses to operate and even become dominant in more tertiary industries: "Retail commerce and service sectors currently include more than one hundred natural industries, some of which, such as food, sewing, bathing, hairdressing, repair, dyeing, and photography, mainly rely on labor services; basically, we shall let the collective or individual [businesses] run those industries" (ND830305). In the next two years, the state further expanded the industrial scope of private businesses to secondary industries such as manufacturing and construction (ND851231). I also identified that symbolic reframing and selective rehabilitating continued to take form in this phase, which, for brevity, will not be described in details here.

The state: quiet acceptance of breaches of regulations by category members. While the state explicitly expanded regulatory approval of private business, it also systematically turned a blind eye to violations of regulatory restrictions on the ground, a practice that I label quiet acceptance. In fact, before the restrictions on the size of private businesses were abolished in 1988, local governments were instructed by the Party leadership not to strictly execute such restrictions. In January 1983, during an internal conference, the state, for the first time, quietly accepted the existence of larger private businesses that hired more than seven employees: "For [individual businesspeople] who hire more employees that exceed the previous regulations (i.e., one to two helpers, and up to five apprentices), we *do not* promote, *do not* publicize, and *do not* promptly ban it" (ND830102, emphasis added). Unlike public statements or regulations, this

internal document, informally dubbed "three don'ts policy," was circulated only within the government. It was explicitly intended to expand destigmatization to larger private businesses by giving more leeway to local governments, which could in turn create more space for improvisation while monitoring and regulating such larger businesses.

Not surprisingly, this practice was not publicized by the media. Indeed, I did not find any published documents between 1983 and 1987 that explicitly approved large-size private enterprises, but this practice is well-evidenced by oral histories and interviews. As an official in Hainan Province remarked, the local government had "implicitly permitted privately owned enterprises" since the mid-1980s (OHG06). Similarly, "the procedures of opening a private enterprise became flexible around that time" in Hunan Province; as some private businesspeople approached the provincial government officials about expanding their businesses, "the guiding policy was: do not publicize, but try it" (OHP05). When Mr. Liu, an individual businessperson, attempted to expand his business in 1985, "the local government officials turned a blind eye and did not prevent our expansion. Even though there were no public policy that allowed larger private enterprises, the regulatory effort on the ground became loose" (OHP15).

The state: reshaping of institutional values. In addition to quiet acceptance, I identified another strategic practice in this phase: an effort to reshape the existing institutional values to be less hostile to the stigmatized category. In contrast to symbolic reframing, which associated the private business category with *extant* socialist values (e.g., employment expansion), "reshaping" revised the values to be more compatible with the implications of burgeoning private businesses. To begin, the state redefined the socialist economic system as "a commodity economy with plans" (有计划的商品经济) in place of "a planned economy" in the Third Plenary Session of the Twelfth Party Congress in October 1984: "The difference between capitalist economy and

socialist economy *does not lie in the existence of the commodity economy*, but lies *in the different goals of production*" (emphasis added, ND841020). The state then proposed "common prosperity" (共同富裕) as the ultimate *goal* of this redefined socialist economic system:

> A socialist society must guarantee that the people's living standards will be gradually raised in order to achieve the goal of common prosperity. But common prosperity does not equate, and cannot possibly be, complete equality. It definitely does not mean, and cannot possibly be, that all members of the society become rich at the same speed, at the same time… The difference induced by *some people getting rich first is a difference of speed and order in sequence* as *all members of society are on the path toward common prosperity*. (Emphasis added, ND841020)

While articulating the meaning of "common prosperity," the state for the first time implied that income gaps—an emerging and inevitable outcome of the burgeoning private sector—might be acceptable. Rather, private businesspeople now seemed to be helping realize the reshaped values of socialism—e.g., common prosperity—since they were just "getting rich first." A private businessman explained: "Common prosperity means not only that all the people should become wealthy, but also that everyone has the right to pursue wealth. This is clearly distinct from previous socialist doctrines" (IDP08).

Category members: the growth of private entrepreneurs. In this second phase, the state orchestrated a distinct combination of practices to further expand political and entrepreneurial opportunity for the private business category, which facilitated the growth of the category and also encouraged more improvisations by category members. Here, I return to my three indicators of destigmatization, and explore how category members responded to the state's efforts and how the changing dynamics of the category—in particular, the consequence of category members' breaches of regulations—further impacted the process of destigmatization.

Not surprisingly, in the light of the state's ongoing expansion of regulatory approval, employment in the private sector kept growing fast from 3.2 million in 1983 to 21.5 million in 1987. Private businesses even became predominant in the tertiary sector, including more than

half of employment in retail, catering, and service industries. This meant that "while the majority of people were still employed in state-owned enterprises, collective factories, and public institutes—such as schools, hospitals, and government agencies—they enjoyed all sorts of services in their daily life provided mostly by private businesses" (IDP25).

Further, private businesses became increasingly attractive to high-status groups. Skilled younger people grew more interested in private business: about 13 percent of newly graduated students from colleges or vocational schools in the mid-1980s decided to join the private sector, compared to a mere three percent in the previous phase. Even state employees began to quit their jobs and join the more profitable private sector: "The high revenue of private businesses had attracted state-employed workers and government officials to join the army of private businesspeople. The public impression was that private businesses could easily lead to a wealthier life" (IDG07). Overall, the category seems to have expanded significantly and attracted relatively high-status and well-resourced new entrants—who began to improvise differently than those less resourceful category members.

Category members: operating under the radar and exploiting regulatory loopholes. In general, private businesspeople in this phase still perceived a general risk of stigmatization. An individual businessperson remarked: "When I proposed the idea of resigning from a state-owned enterprise and starting a business in 1986, my parents opposed, my friends tried to persuade me not to, and my former colleagues taunted me. They said that I was stupid… looking for bitterness" (OHP38). As in the previous phase, many private businesspeople in this phase continued to keep a low profile and *operate under the radar*—often "with no intention to stimulate people's envy or criticism" (IDP10).

In contrast, however, capable members in this phase—especially those who had government

connections—began to exploit regulatory loopholes on the size and organizational structure of private businesses. Notably, with "quiet acceptance," a growing number of private businesses "illegally" expanded. It was estimated that about 115,000 registered individual businesses hired more than seven employees *before* the regulatory restrictions on the size of private businesses were legally lifted in 1988 (Young, 1995: 112). It is important to note, as a former governmental official who became a private businessman in this phase told me, "not every private businessperson dared exceed the maximum limit of seven employees, nor were all of them capable of doing so. It was often those who were able to work around the government that learned and took advantage of the loopholes and the state's ambiguous regulations" (IDP07).

While some category members boldly expanded their registered "individual businesses," some others exploited the regulatory loopholes in a different way. They masked their status by either registering under or collaborating with collective enterprises.[19] In the mid-1980s, "those savvy businesspeople already began to wear a 'hat' of 'village-run enterprises' or 'township enterprise' even though their firms were operated as profit-seeking, private businesses" (OHP02). A founder of a chemical company commented: "Private businesses would wear a 'red hat'. For example, the factory I founded at that time was affiliated to the County Labor Service Enterprise because private enterprises were still disapproved of and despised as 'bastards'…" (OHP23). These "red hat enterprises" were often registered as township and village enterprises (TVEs). From 1983 to 1987, the number of TVEs grew from 1.35 million to 2.77 million, of which approximately 43 percent were de facto private businesses (Huang, 2008). In certain places, it was commonly known that 90 percent of registered collective enterprises wore red hats (Parris,

[19] I recognize that private businesses pretended to be collective enterprises partially for material advantages, such as favorable tax treatment and preferential access to bank credit; however, the fact that private businesses were discriminated in terms of tax and financial access manifested ongoing categorical stigmatization (Naughton, 1995).

1993).

From the category to the state: negative feedback and the split. In this phase, destigmatization expanded and public evaluation of the private business category seemed to become "ambivalent": the category attracted a growing number of well-resourced members, but, during the same period, tension accumulated. As a significant number of private businesses started to breach regulations in order to seek profit and further expand, *income gaps and inequality* became increasingly visible. By the end of this phase, private businesspeople already began to stand out as "parvenus" (暴发户), as recorded by a contemporary historian of China:

> Many of these individuals became millionaires. A farmer in Shen-yang, Liaoning Province organized a transport team and made ¥1 million in 1987. Another entrepreneur maintained 100 workers on her payroll. A 31-year-old owner…controlled assets of $539,000… On a lesser scale, many individual entrepreneurs of little education—owners of small appliance shops, tea farmers, owner-drivers of taxis—were making ¥30,000 to ¥100,000 a year, 10 to 30 times the salaries of professors and surgeons… (Hsu, 2000: 900-901)

In the face of growing income inequality, the general public started to question the morality of private business, which sent *negative feedback* and stimulated tension and conflict within the state. As one individual businessperson remarked, "the voice opposing private businesses became really loud and sharp in the mid- and late 1980s when more and more people joined the private sector and became much richer than people expected" (IDP14). Another added: "When our socialist state began to show a huge gap between the rich and the poor, people started to question societal morality… Did the rise of private business lead to profanation of the sacred socialism?" (IDG04). As indicated previously, the state was not a unanimous collective. In response to the public questioning, the state gradually split into two factions that were polarized around contradictory evaluations of private business. The more liberal, reformist faction embraced the reshaped values (i.e., common prosperity) to justify the emergence of income gaps, whereas the conservative faction saw income inequality as challenging the very essence of

original socialist values.

Eventually, the split of the Party leadership became explicit: with a more liberal faction (e.g., Hu Yaobang and Zhao Ziyang) that tried to reshape the very meaning of socialism and a more conservative one (e.g., Hu Qiaomu and Deng Liqun) that attempted to curb and even reverse the expanding destigmatization of private business. This split generated the defining dynamic of the third phase.

Internal Conflict (1987–1992)

This phase was generally characterized by two opposing approaches of state orchestration. The liberal reformists attempted to further expand previous efforts of destigmatization, whereas the conservatives tried to restrict or even reverse the process.[20]

The reformists: amplification of previous efforts of destigmatization. In this phase, the government lifted restrictions on the size of private businesses and formally legalized "private enterprise" (私营企业) or "private economy" (私营经济), which were then permitted to hire more than seven employees. In the previous phase, while individual businesses which could hire up to seven employees were permitted, larger private enterprises remained illegal. On October 25 1987, however, President Zhao Ziyang announced the Party's decision to restore private enterprises in his keynote during the Thirteenth Party Congress:

> With public ownership as the mainstay, [we shall] develop economy with diverse forms of ownership, and even *allow the existence and development of private economy*… We shall continue to encourage urban and rural cooperative economy, individual economy, and private economy to develop… (Emphasis added, ND871025)

Following the Party's decision, the highest legislature soon formalized the legal status of private

[20] Whereas the state was relatively more inclined to expand destigmatization before 1986, a strong reverse movement began to rise after 1988 (lasting until 1992). The shift did not happen overnight, as the backlash emerged gradually in response to the expansion of destigmatization. Thus, I use 1987 as a cut-off point. I acknowledge that the conservatives' restigmatization of private business can be dated back to the Anti-Spiritual Pollution Campaign in 1983. However, this campaign was rather short-lived and did not really cause reverse process directly (cf. Hsu, 2000). Therefore, I think it is reasonable to periodize 1987-1992 as a distinct phase.

enterprises in the Constitution, according to which "the state protects the legitimate rights and interests of private enterprises" (ND880412). Further, the State Council established the first comprehensive regulation for private enterprises in 1988 which specified how they should be structured, operated, supervised, and protected (ND880625).

Furthermore, the reformists continued to reshape the institutional values of socialism and officially destigmatized the role of private enterprises in this re-conceptualized socialism—building upon common prosperity and market efficiency—during the Thirteenth Party Congress:

> Private enterprises that hire certain number of labors may gain non-labor income, which shall be permitted. We should help those individuals and enterprises that are good at business and honest in work to get rich first… adhere to the direction of common prosperity, and embody social equity *under the premise of promoting efficiency*. (ND871025, emphasis added)

Since efficiency was explicitly prioritized over social equity, the destigmatization of private business seemed to become more justifiable, as it was positioned as an important drive for economic and market efficiency.

In addition to the expanding of regulatory approval and reshaping of institutional values, my analysis also identified that symbolic reframing and selective rehabilitating continued to take place in this phase, which, for brevity, will not be described in details here.

The conservatives: re-stigmatization of the category. In 1989, after the liberal President, Zhao Ziyang resign, the conservative leadership strived to reverse the reformists' destigmatizing efforts. Specifically, they adopted a set of *counter practices* that focused on limiting the regulatory approval of private enterprises, re-emphasizing original socialist values, and re-stigmatizing the private business category. In other words, they became the "custodians" of original socialist institutions. To begin with, the conservative faction in this phase put restrictions on the industries in which private businesses could participate: "Individuals are strictly forbidden to conduct private business activities in long-distance wholesale trade. Privately-owned banks

are banned. Individuals are forbidden to conduct international trade" (ND891109).

Moreover, the conservatives tried to reconnect private business with capitalistic values and polarized them against socialist ones. These practices were pursued through both public discourse and political decisions. To begin, the conservatives took over several important leadership positions that controlled the media and other means of image production: Head of the Publicity Department of the Party (Wang Renzhi), Minister of Culture (He Jingzhi), and President of the *People's Daily* (Gao Di). With such conservative leadership, the *People's Daily* often criticized private business during this phase. For example, in November 1989 it remarked: "the high incomes of individual businesspeople have brought economic, psychological, and moral impacts as well as corruption to the whole society" (PD891102). As recalled by a private enterprise owner who had experienced this turbulent period:

> The state publicly stated in the media that if private and individual economy were left unchecked, they would confront the socialist economy. Some newspapers directly pointed out that in places such as Wenzhou and Shishi cities private economy had already surpassed the state-owned economy, and questioned if they were socialist or capitalist. It was under such a situation that rumors—such as "individual businesses will be expelled", "*economic inequality is not socialist*", and "the rich should be investigated"—began to make us extremely anxious. (OHP02)

Not only did the conservatives attempt to counter the pro-market discourse encouraged by the liberal reformists, they also tried to counter the political decisions and regulatory policies that supported private business. Since the Sixth Plenary Session of the Twelfth Party Congress, the conservative faction began to emphasize that "Capitalist Liberalization" (资产阶级自由化) would inevitably lead to "obsession with self-interest" and "money worship," which were against socialist morality and thus "shall be firmly opposed by the people" (ND860928). This so-called Anti-Capitalist Liberalization campaign implicated private businesses; and its obvious criticism of excessive profit-seeking sent a strong signal against private businesspeople. Further, in August 1989, the conservative government declared: "in the development of individual economy and

private economy, certain notable problems have emerged… resulting in an excessive income gap between members of society, causing dissatisfaction among the people" (ND890830). One month later, during the Fortieth National Day speech, President Jiang Zemin stated:

> There exists unjust social distribution with excessive income disparity. This situation is mainly manifested in the huge income gap between the majority of [state] employees, cadres and intellectuals on the one hand, and private enterprise owners and certain individual businessmen on the other. This has caused a widespread concern of the whole society and strong dissatisfaction of the working people…disruption to the economic order and corruption of the societal morality. (ND890929)

Furthermore, the conservative-influenced state selectively lowered the socio-political status of certain category members, countering the reformists' rehabilitating practice. In particular, the state shamed and blamed private enterprise owners for causing economic inequality. In August 1989, for example, the conservative leadership stipulated: "There actually exists an exploitative relationship between private enterprise owners and workers; thus, we shall not absorb any private enterprises owners into the Party" (ND890828).

In a nutshell, by re-emphasizing prior associations between private business and capitalist ill (e.g., exploitation and profiteering), the conservatives strived to re-stigmatize the category of private business with the moral toxicity of capitalism. The private business category was once again being cast as a pathway away from socialism to capitalism, and worthy of stigmatization.

In sum, in this phase, the state split into two polarized factions, with opposing orchestration: while the reformists continued to use their previous approaches to destigmatization, the conservatives attempted to reverse the process. The competitive dynamics between the two factions in the state created uncertainty and ambivalence over the political and entrepreneurial opportunity for the private business category, leaving little room for improvisation.

Category members: the stagnancy of private entrepreneurship. I will now return to my three indicators of destigmatization. Below, I examine how category members responded to the

state's split and how the evolving dynamics of the category—particularly, the consequence of category members' retreat—further affected the process of destigmatization.

To begin, not surprisingly, the private sector experienced a stagnant period. In 1989, when the conservatives took over the Party leadership, the annual growth rate of employment by the private sector became negative for the first time (since the start of market transition): it decreased by 16 percent. Even in tertiary industries, where private businesses were dominant, the percentage of people employed in private business dropped by four percent. The average annual growth rate of the total employment by the private sector from 1987 to 1992 was merely five percent, clearly showing stagnancy compared to the 53 percent growth rate from 1983 to 1987.

Moreover, relatively well-resourced category members were particularly inclined to retreat. There were approximately 225,000 registered private enterprises (i.e., private business with more than seven employees) in 1988, but the number dropped dramatically to 90,581 in 1989 (Malik, 1997). Typically, private businesspeople in this phase worked in a low-status occupation or were unemployed before they entered the category (61 percent in 1992). Only a small proportion of them received post-secondary education (17 percent in 1992) or acquired a Party membership (7 percent in 1990).

Category members: operating under the radar. In general, private businesspeople in this phase expressed "fear" as they perceived the risk of being punished for "exploitation" by the conservative faction. Several interviewees expressed that they were affected by the state's split: "Influenced by the Party and the official media, public opinion after 1989 started to target us [private businesspeople] as the source of inequality and the dangerous foundation of capitalism and liberalism" (IDP20). In response, many private businesses decided to *operate under the radar* again—some of which even retreated, converting themselves into state-owned or

collective enterprises. This response became particularly widespread after the conservatives dominated the Party leadership in 1989 (Whiting, 1995). A private enterprise owner in Wenzhou confirmed: "The political changes exerted psychological pressure on us. Many private enterprise owners sought protection by converting into collective enterprises after 1989" (IDP09).

From the category to the state: negative feedback. Since category members retreated, however, the economy also suffered an immediate decline. For instance, after five years of two-digit growth rates, the annual GDP growth rate dropped to merely four percent in 1989 and 1990. Interestingly, this seemingly evitable consequence of a stagnant private sector, in turn, became an important reason for the opposing factions within the state to settle and unify once again. According to my interviews and oral histories, "the majority of general public did not want to return to the old [pre-marketization] days. Once exposed to some material comforts such as television and refrigerators, people could no longer bear the thought of going back to the widespread poverty and scant resources" (IDP17). As private businesses closed down in this phase, public discontent with economic slowdown began to rise, as did the unemployment rate. Further, the urgency of reversing the slowdown was enhanced by the collapse of Soviet Union at the end of 1991; "a sobering experience for the Party leadership that economic development must continue," in the words of one former government official (IDG15).

Institutional Settlement (1992–2004)

The state: stabilization of regulatory approval and of reshaped institutional values. Compared to previous phases, the state's destigmatizing approach in this phase did not include new practices. While the split factions were becoming unified again, the state resumed expansion of its destigmatization efforts—stabilizing regulatory approval of the category and strengthening the reshaped institutional values. These efforts began with Deng Xiaoping's highly publicized

January 1992 tour of the southern coastal cities, where the market transition had been most successful. His public speeches during this Southern Tour marked the settlement between the two factions (Vogel, 2011). Importantly, Deng redefined the criteria of "being socialist":

> In the economic reform, we should be bold and encourage experiments. After all, those who are afraid of the reform are afraid of being capitalist. But being capitalist or socialist depends on whether it *benefits* the development of productive forces, whether it *benefits* the overall strength of our socialist country, and whether it *benefits* people's living standards" (ND920118).

This so-called "three benefits" criterion soon became officially accepted as a means of testing and capturing the values of socialism—helping destigmatize private business insofar as it "benefited the development of productive forces" and "benefited people's living standards." In the same year, President Jiang Zemin's keynote speech at the Fourteenth Party Congress began by expressing full support for Deng's speeches; officially using the term "socialist market economy" (社会主义市场经济) in a core document of the Party, for the first time:

> Market economy is not equal to capitalism; socialism also has market… We must clearly state that the goal of China's economic system reform is to establish a *socialist market economic system*…The public economy is the mainstay, and *the individual economy, private economy, and foreign economy are supplements*… develop together in the long run… (Emphasis added, ND921012)

Meanwhile, the reformists re-gained leadership positions over state media and other means of image production (including Head of the Publicity Department of the Party, Minister of Culture, and President of the *People's Daily*), and redirected public opinion towards the approval of private business. Thus, only five days after the 1992 Party Congress, the front page of the *People's Daily* voiced full support for President Jiang's keynote speech (PD921017).

As the state continued to promote the reshaped socialist value of "common prosperity" and encouraged "some people to become rich first" (ND931114), the private business category became positioned as a key drive for the socialist market economy. Gradually, the regulatory approval of the category became stabilized. To begin, the Company Law of 1993 legalized joint-

stock and limited liability companies as organizational forms (ND931229). Two years later, private enterprises were granted equal market status with state-owned and collective enterprises such that "the state treats enterprises of different ownerships equally, constructing an equal competition environment" (ND950928). Further, private businesspeople were permitted to enter more industries such as infrastructure and public utilities which used to be monopolized by state-owned enterprises (ND031014). The process of destigmatization was thus broadened significantly, through an essentially consistent program of state orchestration.

Category members: the development of private entrepreneurship. As the state orchestrated a consistent set of practices to widen political and entrepreneurial opportunity for private business, a continuously growing number of people began to enter the category as they perceived a reducing degree of stigmatization. Again, I make use of my three indicators of destigmatization and examine how category members responded to the state's destigmatization and further impacted the dynamics of the category.

First, prompted by a more predictable and stable institutional environment for the private sector, a fast and steadily growing number of new entrants appeared in this phase (Ang, 2016; Tsai, 2007). From 1992 to 2004, employment by the private sector increased from 27 million to about 96 million. In 2004, for the first time, urban employment in the non-public sector (i.e., combining private businesses, foreign firms, and joint ventures) exceeded that in the public sector (state-owned enterprises and collective enterprise). In addition, while private businesses remained dominant in the tertiary industries, they also became increasingly visible in secondary industries (e.g., construction) contributing almost two-thirds of total industrial output.

Further evidence of consolidated destigmatization is that the people who founded or joined private businesses were more educated and more professional than their predecessors were in

previous phases. Specifically, at the beginning of this phase, 61 percent of private enterprise owners used to work in low status occupations before they founded their firms and only 17 percent received post-secondary education; but by the end of this period only 29 percent of private enterprise owners used to work in low status occupations and more than half received post-secondary education. Once again, the category had become increasingly attractive to those with high status and alternative options.

Moreover, according to interviews and oral histories, "public opinion was changing to the extent that private businesses were no longer seen as a despicable occupation" (OHP08) or "a stigmatized occupation" (OHP23). In response, many private enterprise owners began to reveal their true identity rather than pretending to be collective enterprises—that is, they were operating *back on the grid* rather than under the radar. From 1994 to 1998, it is estimated that 570,000 TVEs shifted their registration from collective enterprises to private enterprises, contributing to a rapid increase of about 19 million employees by the private sector (Huang, 2008).

Category members: elevating socio-political status. Whereas private businesspeople mainly resorted to passive stigma coping strategies in the previous periods, they became more *proactive* in destigmatizing themselves in this phase. The practice of "elevating" is characterized as an effort to acquire and maintain social approval through political connections and networking. Specifically, private enterprise owners would try to associate themselves with the government by becoming the People's Congress representatives or the Political Consultative Conference members—at various administrative levels. By gaining a position in an important political organ, private businesspeople "have been proactively seeking political protections as well as social status, which those prestigious political positions symbolize to Chinese people. When people know that I am a People's Congress representative, they would show respect"

(IDP07). In 1994, when the first national survey of private enterprise owners inquired about their political affiliations, only 13 percent were the People's Congress representatives. Just five years later, the number more than doubled to 28 percent. A private businessman in Zhejiang Province remarked:

> For some people, those political positions provide a platform to participate in politics. But for many of us, having a foot in the government shows a *political protection* such that our businesses are officially approved of. Even though the situation became much friendly in the 1990s, we still try to make an effort to show our legitimacy. (Emphasis added, IDP02)

Of course, not all businesspeople were qualified for a prestigious government position. Those who were not would pursue a Party membership, especially after private enterprise owners were officially permitted to apply for it (ND021114). In this phase, the percentage of private businesspeople who joined the Party significantly increased from 7 to 34 percent. However, seeking political protection in the government did not mean that businesspeople endeavored to become politicians: "Indeed, we participate but never interfere in politics. Politics can be unpredictable and precarious. By participating in politics, we try to maintain a stable and predictable environment for private business, and sometimes for an industry" (IDP01).

Category members: publicizing contributions to reshaped institutional values. In addition, private businesspeople in this phase pursued actions that exemplified how their businesses embodied socialism in practice. Although it was widely recognized that private enterprises contributed to employment expansion and the improved people's lives via convenience, how they helped realize "common prosperity"—i.e., the reshaped institutional values of socialism—became an important task. A first thing private businesspeople did was to provide better social welfare to their employees. According to the bi-annual national surveys of private enterprise owners, from 1992 to 2003, the percentage of private enterprises that provided pension to their employees increased from 25 percent to 61 percent, and the amount they invested in each

employee's pension fund per year from 39 *yuan* to 222 *yuan*. Moreover, the percentage that offered employee housing went up from 29 percent to 65 percent. Many private businesspeople sought to provide social benefits that were comparable to what state-owned enterprises offered. As a private businessman in Hangzhou City remarked:

> Some of our early employees came from state-owned enterprises, and they told me that the state-owned enterprises would offer free lunch to the workers, so we built our own canteen right away. Ever since then, we have been providing free and delicious lunch to our employees. Further, we give holiday gifts to them and organize two annual trips to hot tourist spots for them. We want to show them that we are also socialist; we do provide good social benefits, sometimes even better than state-owned enterprises. (IDP07)

Moreover, private businesspeople took social action by publicizing their contribution to common prosperity. From 1994 to 2003, the average annual donation by a private enterprise to private or public foundations grew from 125,000 to 238,000 *yuan*. When private businesspeople were asked about why they donated in national anonymous surveys, "elevating the social prestige of their enterprises" was one of the three top reasons, along with "contributing to the society" and "strengthen local and political connections." A private businesswoman who opened her private firm in the mid-1990s in Jinhua City commented on her own and her fellow business owners' actions:

> It is all about "face." The more we give back to the society, the more face everybody gets. Local government officials get the face because we contribute to the local economy. We also get the face as we gain the social approval and the government's favor. Isn't socialism about everybody getting rich? Isn't that common prosperity? It is a win-win-win. (IDP14)

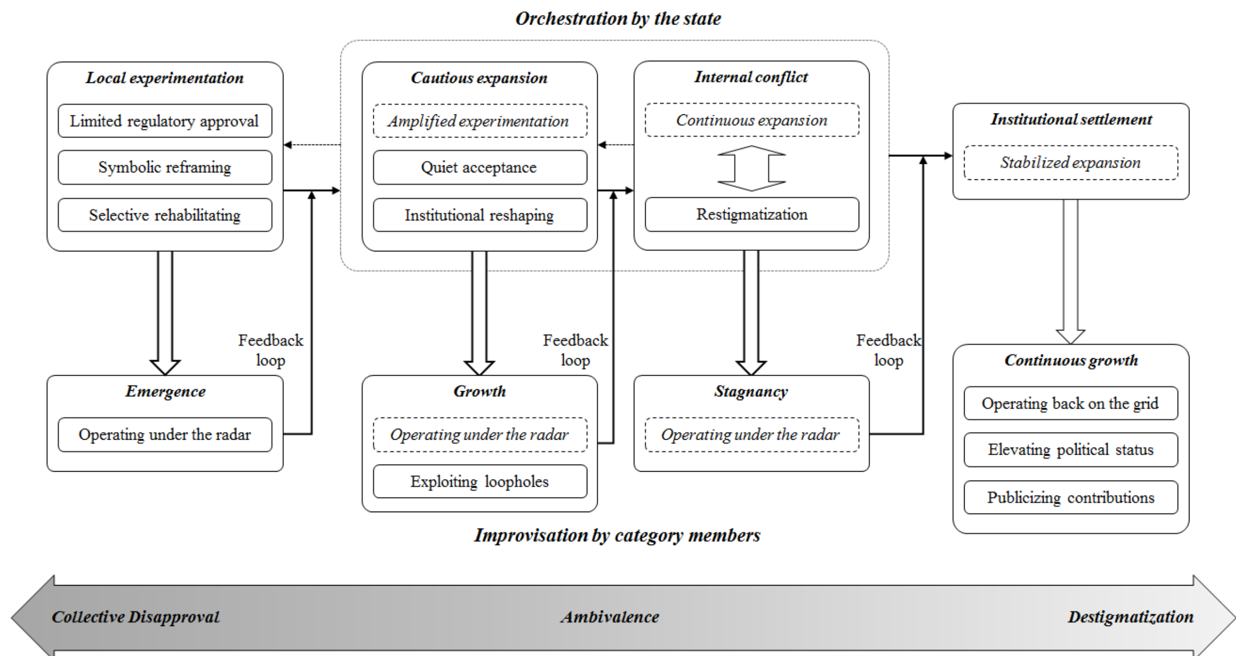
In sum, in this last phase, the state's approach to destigmatization was to orchestrate a rather consistent set of practices in order to construct a stable institutional environment for the private business category, which further widened the political and entrepreneurial space for private entrepreneurs to improvise and adopt more proactive practices to further destigmatization.

DISCUSSION

Categorical stigma affects whole populations of organizations, as members find themselves

discounted, discredited, or censured in ways that shape their prospects for success or survival. Although categorical stigma and the process of destigmatization have both garnered increasing attention in recent years, the literature on this topic is still young and our understanding of these complex processes remains inchoate. I contribute to this emerging literature by exploring the role of the state as a disproportionately influential actor and the state's dynamic interaction with both existing and prospective category members as the category undergoes destigmatization. Using an extreme and revelatory case, I build a theoretical model of categorical destigmatization. Below, I elaborate on my contributions in more detail, explore the practical implications of this study for research on grand challenge, and address the limitations of the case.

Figure 4–1: A Process Model of Interactive Categorical Destigmatization



Note: Upper boxes capture the orchestration by the state, while the lower ones the improvisation by category members. Dashed boxes capture old strategies and practices in previous phases.

The Interactive Process of Categorical Destigmatization

Based on the case of private business, I propose a process model of interactive categorical

destigmatization made up of four phases: a "local experimentation" phase driven by the state's initial, limited approval of a previously stigmatized category, which attracts a small yet growing number of new entrants; a "cautious expansion" phase made up of further state approval of the category, its accelerated growth, and certain members' breaches of state restrictions; a subsequent "internal conflict" phase, as breaches stimulate institutional custodians to restigmatize the category; and an "institutional settlement" phase in which the state and category members together stabilize the approval of the category. Throughout the process, I focus on the interactive relationships between the state and category members. I conceptualize this relationship as "orchestrated improvisation"—that is, dynamic interaction between *orchestration* by the state and *improvisation* by both the incumbent and prospective category members. Specifically, I define "orchestration" as strategic arrangements made by the state to stimulate changes of social evaluation and category dynamics on the ground, and "improvisation" as strategic responses and practices performed by category members based on the evolving institutional environments in order to survive and succeed (see Figure 4–1).

Local experimentation. In the first phase of categorical destigmatization suggested by my study, there is an initial opportunity and space for the destigmatization to commence by experimenting on the category. The state's core activities that make up this phase are limited regulatory approval, symbolic reframing of the category's meanings, and selective rehabilitating of category members. Such activities encourage and motivate a small yet growing number of new entries into the category. A main outcome of this phase is an emergent category that seems to be compatible with, rather than challenge, the existing institutions—which in turn sends positive feedback to the state. This opens up the possibility of further destigmatization.

The activities by the state demonstrate a distinctive toolkit of orchestration. First, via

symbolic reframing, the state systematically distances a category from its previously stigmatized associations and craft newly positive ones. The importance of framing broadly and particularly in destigmatization is, of course, already recognized by prior studies (Cornelissen & Werner, 2014; Lashley & Pollock, 2020; Rivera, 2008; Vergne, 2012). However, the state' reframing approach appears far more comprehensive, multi-channel, and emphatic in nature than would be feasible for most non-state actors. It involves a reformation of language and imagery in mainstream state-controlled media outlets, and in official documentation; making use of the state's distinctive authority and influence as a shaper of public opinion. Such an approach can be particularly comprehensive when undertaken by an authoritarian state; however, it does seem broadly generalizable to other states where close relationships with official broadcasters, newspapers, or other media outlets permit comprehensive framing efforts that would be beyond the reach of most non-state organizations (Glaeser, 2011).

Second, the state employs *selective rehabilitating* to highlight the capability of stigmatized organizations, their owners, and their employees to create value and positive effects that resonate with the existing institution. This makes it harder for audiences to stigmatize them as faceless villains, and creates and reinforces positive associations. It thus forms a complementary trajectory to symbolic reframing. The state in my case strategically singled out several individual businesses at the early stage of destigmatization and publicly praised their achievement. In so doing, the state created some "positive deviants" or "deviant celebrities" (Lundahl, 2018) for the public and potential future entrants to the category. Once again, rehabilitating seems a strategy primarily available to state actors and regulators, as they possess the power to impose and withhold major coercive sanctions (Scott et al., 2000). Such powers permit states to usher the stigmatized out from the shadows without fear of an immediate regulative crackdown by other

arbiters of public opinion. Moreover, they allow the state to punish those who insist upon the stigmatization, or even seek to impose it by the use of violence (Wang et al., 2020).

However, it is important to note that the state's orchestration via reframing and rehabilitating in this phase is coupled with limited regulatory approval, which is supposed to prevent the category and its members from expanding too fast or too widely. In other words, the space and opportunity for category members to engage in entrepreneurial improvisation—or, using Lounsbury and Glynn's (2019) term, "entrepreneurial possibility"—is very limited. Thus, the category dynamics in this phase is characterized by two distinct features. First, new entrants mostly came from low-status groups such as the unemployed—partially because the scope and scale of private businesses were strictly constrained and thus did not appear to be an attractive alternative to the more skillful and endowed population who tended to have a respectable job in state-owned enterprises. Second, given that new entrants were often less endowed and lacked the social skills, networks, and resources to collectively destigmatize the category, they mainly operated "under the radar," in order to avoid public attention and criticism. This contradicts a more active image of category members portrayed in other studies (Lashley & Pollock, 2020). A seemingly unthreatening category that resonates with, instead of challenges, existing institutions, sends back positive feedback to the state and encourages further orchestration for larger and wider experiments (cf. Plowman, Baker, Beck, Kulkarni, Solansky, & Travis, 2007).

Cautious expansion. The second phase is "cautious expansion": the state gradually loosens regulatory restrictions on the category, widening the space for category members' improvisation. In the case of private business in China, the state adopted two new practices—the "quiet acceptance" of the members' breaches of regulations and the "reshaping of institutional values"—in addition to symbolic reframing and selective rehabilitating. Though the outcomes of

a burgeoning category were justified by the reshaped values, they also sent negative feedback to institutional custodians that held the old socialist values dear. During this phase, the category began to show incompatibility with the existing institutions, which in turn endangered the possibility of further destigmatization.

The two activities of state orchestration in this phase are distinctive. First, *quiet acceptance* refers to deliberately turning a blind eye to violations of the restrictions on the stigmatized category. In my case, local administrations were instructed by the central government to not strictly execute the punishments on oversized private businesses, which encouraged potential future members to enter the stigmatized category and incumbent members to further expand. Anticipating that explicit approval of expansion would arouse backlash from disapproving audiences, the state used quiet acceptance to postpone and/or weaken this backlash by letting the stigmatized category grow under the radar of potential opponents. Once again, this practice seems most viable for actors, such as states, that have substantial capacity for (non-)coercion. Put another way, while expanding destigmatization of a category, the state may decouple (Bromley & Powell, 2012; Fiss & Zajac, 2006) its reactions to the stigmatized category on the ground from its formal discourse to the public; however, for the category to be destigmatized eventually, reactions and discourse may need to be recoupled again, in a shift away from more passive quiet acceptance to more active reshaping.

Institutional reshaping seeks to render the surrounding institutions less hostile to the stigmatized category. In the case of private business, the state revised the values and meanings of socialism in order to make it more compatible with the outcomes of a burgeoning private sector. In contrast to symbolic reframing, which attempts to change what a stigmatized category means to its audiences, institutional reshaping focuses on changing the audiences' meaning system so

that the meanings and values associated with the institutions may no longer be incompatible with those associated with the category. In my case, the state tried to justify income inequality and profit-seeking, which used to be associated with capitalism and vilified, as an inevitable step towards "common prosperity," which the state proposed and promoted as an essential value of socialism. The state seems uniquely positioned for this practice, particularly in an authoritarian state, given its ability to control and orchestrate mass media to constantly reshape the public meaning system (Rivera, 2008). More broadly speaking, my findings strongly suggest that the process of categorical destigmatization cannot and should not be understood independently of broader institutions, which furnish categories with defining associations (see also Ansari, Fiss, & Zajac, 2010; Loewenstein, Ocasio, & Jones, 2012).

With widened space and opportunity for category members to engage in entrepreneurial improvisation, the category dynamics in this phase evolved with two distinct features. First, though the majority of category members still came from low-status groups, there were a growing number of new entrants from relatively high-status groups such as skilled workers, professionals, and those who previously held a position in state-owned enterprises. Second, those more endowed members began to *exploit* regulatory loopholes—thanks to the state's quiet acceptance—in their quest for profit and expansion. In particular, as my case suggests, the members who exploited regulatory loopholes were often those who possessed government connections. When the state creates institutional ambiguity around the category, it also creates uneven entrepreneurial possibilities that favor those who have the socio-political skills, networks, and resources to work around the state. As the category expands and members accumulate wealth, there is pushback from disapproving audiences, or "institutional custodians," who strive to maintain the prior values and meaning system (Dacin, Davin, & Kent, 2019) during

this phase. This may, ultimately, lead to a split in the state.

Internal conflict. The third phase of categorical destigmatization captures the volatility and potential reverse movement brought by internal competition and "recalibration" within the state. While the destigmatization of the category is effectively expanded in the last phase, the burgeoning category also triggers moral reverberation as institutional custodians start to cast it as a troubling "Trojan horse" (Pache & Santos, 2013) that endangers the old institutions. In my case, the tension within the state, between the reformists, who attempted to reshape institutional values, and the conservatives, who meant to maintain old institutional values, mounted and eventually caused a split—which sent mixed signals about destigmatization to category members. In response, the category may contract as its members fear retaliation by the custodians, which further affects destigmatization (or lack thereof).

While the faction that supports institutional change and destigmatization continues to use its existing toolkit of orchestration, the other faction adopts a series of opposing practices in their call for institutional maintenance and restigmatization. For example, the latter faction—i.e., a group of "institutional custodians" (Dacin et al., 2019)—uses *discrimination* to reverse rehabilitation of the members of a stigmatized category by excluding them from certain rights and status—such as, in my case, Party membership—thereby encouraging alienation and segregation. Moreover, the custodians may use symbolic reframing, but in an opposite direction, to reconnect the category to its previous, stigmatized associations. Given that contestation within the state may arise as one faction's orchestration begins to harm the interests of opposing faction(s), I propose that the state should be seen as an endogenous actor in the process of destigmatization, rather than a source of exogenous shocks or an ultimate arbiter (Cavazos & Rutherford, 2012; Clair, Daniel, & Lamont, 2016). Changes or reversals in state orchestration

over time, depending on the effects of its previous orchestration and its internal dynamics (e.g., which faction becomes dominant), strongly support Lashley and Pollock's (2020) suggestion that categorical stigma reduction is a multi-phase, recursive, and complex process.

While institutional custodians squeeze the space for the category members' entrepreneurial improvisation, category dynamics further evolve. In my case, when the conservatives became dominant in the political arena, category incumbents immediately retreated out of fear that they might be vilified and punished. Surprisingly, even those who came from relatively high-status groups and were empowered with certain socio-political skills and resources to work around the government chose to retreat or operate under the radar instead of collectively mobilizing to more actively destigmatize themselves. This is in contrast to the portrayal of organizations as active and resourceful in the previous studies of destigmatization (Hampel & Tracey, 2017; Lashley & Pollock, 2020), but echoes Wang et al.'s (2020) recent suggestion that, in case of authoritarian states, the state likely drives the process of (de)stigmatization. This also further supports my earlier suggestion that the process of categorical destigmatization may be shaped by broader institutions. Interestingly, however, while incumbent members rush out of the category or conceal their identity, their retreat can induce a further twist in the process of destigmatization.

Institutional settlement. The fourth and final phase of categorical destigmatization focuses on "stabilizing" a compromise between the opposing factions of the state. One transformation is characteristic of this phase: category members become significantly more active and visible than they were during the previous phases, as they and the category become destigmatized. Not only do they begin to operate *back on the grid*, they also adopt two active practices: elevating their socio-political status and publicizing their contributions to the reshaped institutional values. Moreover, a steadily and fast growing number of new entrants come from high-status groups,

who are more capable than their predecessors of destigmatizing themselves and the category, both independently and collectively.

This phase begins with a settlement between the two opposing factions of the state, whose unification is triggered by the consequences of the category members' retreat in the last phase. In my case, the stagnancy of private businesses immediately caused economic recession that likely triggered collective memory of the widespread poverty and unemployment that existed before the market transition; this sent negative feedback to the state and changed its factional dynamics. Though institutional custodians can be very insistent when category members appear to violate old institutional values (social equity, in my case), they become more willing to negotiate and compromise if the reverse stigmatization of the category may bring about a comparable—or even more substantial—violation of their values (i.e., risk of full employment and economic development).

While the state re-engages in its previous approaches to orchestration, the practices of category members in this phase demonstrate a distinctive toolkit of improvisation. First, by *elevating status*, category members can obtain the same socio-political status as non-members can. In my case, Party membership, as a morally sacred status, became a popular target in this phase for private businesspeople. By acquiring such a status, category members not only signaled their compatibility with the institutions, but also broke their prior segregation with non-members. Notably, compared to previous studies, which typically highlight how stigmatized members accommodate or "ingratiate" stigmatizers (Hampel & Tracey, 2017) in order to obtain their approval, my case suggests that the stigmatized might fight off the stigmatizers by becoming one of them or acquiring a status that they look up to. By elevating status, the members of a stigmatized category attach themselves to a highly respected social category in the

broader institutional environment, thereby diluting or even eliminating their stigma. This also supports the idea of stigma being multi-dimensional such that a category may be stigmatized in some aspects, but legitimate or even praised in others (Helms, Patterson, & Hudson, 2019).

The second practice by category members, *publicizing contributions*, refers to the self-promotion of their substantive contributions to the reconstruction and reinforcement of institutional values, in a way that is coordinated with the state's institutional reshaping. In other words, the members begin to demonstrate their "service to society" (Hampel & Tracey, 2017). Specifically, private businesspeople, in my case, showcased the social welfare benefits they provided to their employees and the donations they made to public and private foundations—both in the name of "common prosperity," the core value of socialism that the state had been reshaping. Not only did category members become as active as is typically portrayed in previous studies of destigmatization (Aranda, Conti, & Wezel, 2020; Hampel & Tracey, 2017; Lashley & Pollock, 2020), they also coordinated with the state to redefine and stabilize the institutional environment.

The Grand Challenge of Balancing Social Welfare and Economic Value

The practical implications of this study stem primarily from its most fundamental finding: how a society that has long idealized social welfare and denounced the pursuit of economic value for decades was able to destigmatize market practices. The story of private business in China is not a distant, trivial history, but a recent and profound societal change that sheds light on our understanding of organizations' grand challenge of dealing with social responsibility and innovation whilst balancing between social welfare and economic value.

The first practical implication is that commercialization of the nonprofit sector may be a multi-phase process that involves dynamic interaction between social entrepreneurs and

regulators (and/or other influential actors). While most of social innovation and social entrepreneurship scholars have focused on how organizations manage the tension between the social welfare (community) logic and the market logic, or the so-called "hybrid" social-business forms (Battilana & Dorado, 2010; Litrico & Besharov, 2019), less is known about how the two logics themselves are recombined at the field and even societal level (Lounsbury, Steele, Wang, & Toubiana, 2021). Before its market transition, all organizations in China were social welfare-oriented, but most of them were gradually commercialized during the transition. Thus, the practical lesson for people wanting to import the market practices to a welfare-centered institutional environment—or, the social welfare practices to a liberal market environment—is to engage in both symbolic reframing of the imported practices and reshaping of the existing institutions, while maintaining a dynamic relationship with influential external actors.

A second practical implication that arises from the institutionally embedded nature of category dynamics and categorical destigmatization is that the meanings of social responsibility may vary for different stakeholders and evolve as the process of institutional change unfolds. Social responsibility was a norm for all organizations in China before its market transition, but increasingly became an impression management strategy as private businesspeople began to destigmatize themselves and the category. Moreover, whereas private businesspeople consciously publicized its social responsibility, state-owned enterprises and other institutional custodians still regarded it as a socialist legacy and performed it more intuitively and substantively (cf. Raynard, Lounsbury, & Greenwood, 2013). Thus, from a practical perspective, when organizations perform their social responsibility, they should pay attention to not only the institutional environment in which it is performed, but also the audiences to whom it is performed (cf. Marquis & Qian, 2014; Zhang & Luo, 2013).

Scope Conditions and Future Research

I drew these insights about the role of the state in categorical destigmatization from the details of my specific empirical case, and this imposes certain limitations. While there are major advantages to using rich and revelatory case studies for theory-building (Creed et al., 2010; Eisenhardt, 1989), this design does impose limits to empirical generalizability based on context specificity. Theory derived from my case should be further elaborated and tested in future research. I note two research directions that could be especially valuable.

First, because my analysis does not parse out independent effects of each state practice, I encourage future work to unpack the dynamics of each practice and explore when these efforts are more likely to succeed or backfire. Moreover, future research could explore how each practice used by the state might intersect with individual category members' efforts at stigma management (e.g. efforts to "pass" as non-members might undermine efforts at rehabilitation by making it harder to highlight positive exemplars). Cross-level studies of categorical stigma management could help us better explore the complexity of (de)stigmatization. Further, while my case addresses the efforts of a particularly powerful state, further work could explore whether the same strategies can be effectively deployed and executed by weaker or more vulnerable states, or by less powerful, non-state actors (e.g., industry associations or watchdog groups).

Second, while my study shows the role of an authoritarian state in destigmatization, future research could explore more liberal-democratic states that have plural political parties and less controlled media and civil society. A comparative institutional analysis is especially suitable for testing and elaborating whether the state can orchestrate categorical destigmatization effectively across diverse contexts. In particular, I wonder if the internal dynamics of a democratic state with multiple parties would render the process of destigmatization less stable. For example, the

categorical stigma of cell therapy in the U.S. has waxed and waned in the past three decades: it was supported when the Democratic Party was elected but was re-stigmatized or even illegalized under Republican leadership (Huang & Jong, 2019; Vakili, McGahan, Rezaie, Mitchell, & Daar, 2015).

CONCLUSION

While my primary focus is building theory on categorical destigmatization, and the role of the state in this process, my study has implications for broader debates on the market transition of China. First, it points to the critical cultural dimension of marketization, which entails and requires destigmatization of whole categories of organizations and activities. In addition, this study supplements existing accounts of marketization by highlighting *orchestration*. On the one hand, my theorization elaborates on a bottom-up view of market transition (Huang, 2008; Nee & Opper, 2012): the efforts of individual businesspeople to gain state and public acceptance were certainly critical, but my analysis suggests that these endeavors were culturally and practically facilitated by state efforts at destigmatization. On the other hand, my analysis also elaborates on more top-down theories of state marketization (Oi, 1999; Walder, 1995): for while state orchestration facilitated the growth of private business, it was shaped by the unexpected effects of its previous efforts, including the bubbling up of bottom-up concerns and successes. In this sense, my work supports and extends Ang's (2016) recent work in political sciences, which highlights the co-evolution of state and market over time—in a form of "directed improvisation."

Chapter 5

Implications and Concluding Remarks

In this chapter, I discuss the contributions of all three empirical chapters to the stigma literature as well as their implications for the literatures on professions and institutional theory. First, my primary contribution is to research on stigmatization. Through three complementary studies, I zoom in on three distinct sub-processes of stigmatization (see dotted lines in Figure 5–1). In particular, I emphasize that these processes can be oscillating and iterative, and depend upon the interactive relationships between the stigmatized and their various stakeholders. Those stakeholders may respond to stigmatization differently: their action, inaction, and interaction in turn shape the pace, momentum, and directions of stigmatization. Second, my thesis has important implications for the literature on professions. Though professions are rarely connected to stigma, I show how professional prestige may be a burden rather than a benefit in the process of social evaluation. Last but not least, my thesis also contributes to the literature on institutional theory by theorizing an alternative pathway of institutional change based on the study of stigmatization.

IMPLICATIONS FOR RESEARCH ON STIGMATIZATION

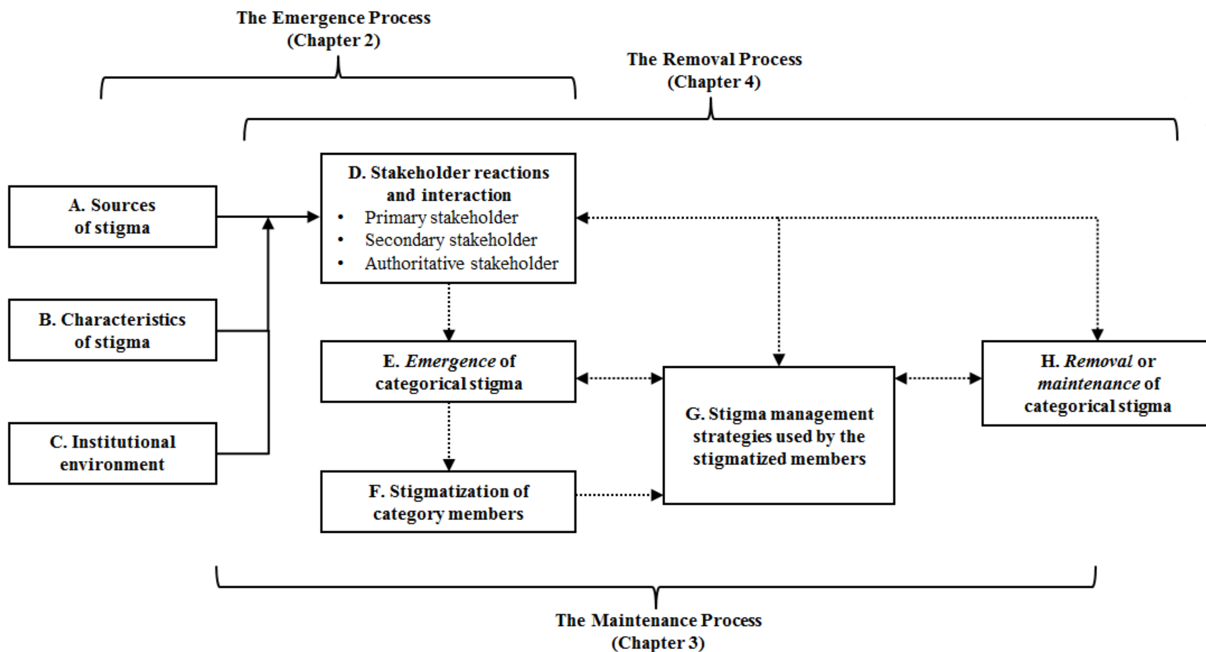
Key Characteristics of the Processes of Stigmatization

Though each empirical chapter has discussed its contribution to a distinct sub-process of stigmatization—i.e., emergence, maintenance, and removal, respectively—I focus here on the general features and mechanisms that cut across all three sub-processes. In particular, I highlight three interrelated characteristics of stigmatization: oscillating movement, an ambivalent middle range, and partial to full coverage. I discuss each of these characteristics below.

To begin, the movement of stigmatization may be more *oscillating* than unidirectional (see dotted arrows in Figure 5–1). In the case of emergence (in Chapter 2), the rise of stigmatization in the health care sector was shown to be resultant from an ongoing struggle between competing

stakeholder reactions. The emerging momentum may be precipitated or contained depending upon whether or not influential stakeholders are in agreement. Similarly, in the case of removal (in Chapter 4), the decline of stigmatization in the private sector was not a smooth, progressive movement. Even within the same influential group of stakeholders, schisms may occur due to the unexpected consequences of their interactions with other stakeholders as well as the stigmatized, which can induce backward movement or even radical reversal. However, the processes in these two cases eventually gravitated towards one end of the stigmatization continuum. In contrast, in the case of maintenance (in Chapter 3), the degree of stigmatization continued to oscillate as important stakeholders failed to reach a consensus, creating a temporal stalemate.

Figure 5–1: A Conceptual Model for Studying the Processes of Stigmatization



Note: This is an adapted version of the model proposed in Chapter 1. Dotted lines capture key interactions between the stigmatized and various stakeholders and the potential outcomes of such interactions.

Once the oscillating nature of stigmatization is recognized, it becomes obvious that stigma is not a "binary" evaluation—but, instead, a continuum which has *a middle range* between two

extremes (Hampel & Tracey, 2019). All three studies demonstrate a stage of "ambivalence" (Ashforth, 2019) during the processes of stigmatization. This middle stage is characterized by a mixture of negative and positive evaluations within and/or across different stakeholder groups. In Chapter 2, the emergence of stigmatization in the health care sector unfolded through a period of ambivalence when secondary stakeholders (in this case, the media) presented mixed views of the medical profession. Similarly, in Chapter 4, the removal of stigmatization in the private sector experienced an ambivalent stage when private business became increasingly acceptable to many residents, but remained disdained by many others.

Notably, this middle range of ambivalence entails both competition and tolerance. In the case of emergence (Chapter 2), before secondary stakeholders (the media in this case) reached a collective labeling, they expressed competing views of the medical profession. Similarly, in the case of removal (Chapter 4), authoritative stakeholders (state actors) voiced conflicting views of private business before achieving collective approval. In other words, the processes unfolded through competition before its resolution—or, "settlement" (Litrico & David, 2017)—among key stakeholders. In addition, as shown in the case of maintenance (Chapter 3), such competition might persist if stakeholders fail to build a consensus. In contrast, whereas competition may manifest through conflicts between those who express different views of the target, it may also induce tolerance by those who choose to not express their dissent, hence a "spiral of silence" (Clemente & Roulet, 2014).

The state of ambivalence is attributable to the multidimensional nature of stigmatization. Put another way, a target is often *partially* rather than entirely (de)stigmatized (Helms, Patterson, & Hudson, 2019). In Chapters 2 and 3, the medical profession was stigmatized primarily for its violation of professional ethics rather than its knowledge base of expertise, contributing to a

defensive view that as long as the expert professionalism is upheld the profession should not be discredited. Similarly, in Chapter 4, while private business remained publicly stigmatized for its association with capitalism, some of its aspects, such as unemployment alleviation, became positively viewed by certain stakeholders. Using Zhang, Wang, Toubiana, and Greenwood's (2021) terms, the target may have multiple sources of stigma, each having a different degree of centrality to the target's identity. Moreover, the degree of centrality is a perception that depends on how stakeholders view and frame each source. For example, whereas the conservatives framed the capitalist association as core to the identity of private business, the reformists emphasized unemployment alleviation and wealth creation as the core, marginalizing the capitalist association.

In sum, the processes of stigmatization are characterized by oscillating movement within or across a middle range of ambivalence that covers the wide extent between two extremes of the stigmatization continuum. The ambivalence is attributable to the fact that stigmatization can have multiple aspects, each of which has a different degree of perceived centrality depending upon the values and interests of different stakeholders.

The Reactions and Interaction of Stakeholders

Here I emphasize the importance of different stakeholders—in particular, their (in)action and interaction—in the processes of stigmatization. Earlier studies of stigma management have often focused on the responses of stigmatized actors, while treating the actions of stakeholders as either an antecedent or outcome of the responses (Zhang et al., 2021). However, in order to develop a more dynamic and interactive view of stigmatization, more attention should be paid to the variegated reactions of different stakeholders and their interaction with each other and with the stigmatized (Helms et al., 2019; see the dotted arrows connected to box D in Figure 5–1).

However, the influence of different stakeholders may vary substantially. Building on Freeman, Harrison, and Zyglidopolous's (2018) theorization of stakeholders, I discuss three distinct groups of stakeholders below.

Primary stakeholders are those who are "directly involved in the value-creating processes" of the target (Freeman et al., 2018: 16). Typical primary stakeholders include customers, partners, suppliers, employers, and employees, all of who contribute to the creation of value, giving them an economic stake. Using Wiesenfeld, Wurthmann, and Hambrick's (2008) term, they are "economic arbiters." Thus, primary stakeholders may react more negatively to the forms of transgression that harm the value creation process than to those forms that do not. In other words, as long as the target can deliver the value pursued by primary stakeholders, they tend to tolerate or even approve of the target, even if the ways by which to achieve such value might be transgressive (Ruebottom, Buchanan, Voronov, & Toubiana, 2020). In the case of health care, for example, even though overprescribing violated the professional code of ethics, it did not elicit disapproval from patients until it began to harm them financially. That said, when the pursued value is violated, primary stakeholders are more inclined to adopt radical punishment than other stakeholders, given their more substantial loss of value. This sends particularly negative feedback to the processes of stigmatization.

In turn, the target depends on primary stakeholders, rendering them salient evaluators. As the value-creating process is directly affected by primary stakeholders, members of a stigmatized category will typically accommodate—or "ingratiate"—such stakeholders (Hampel & Tracey, 2017). In the case of private business, private entrepreneurs had operated under the radar for more than a decade in order not to provoke local community members. However, in other cases in my thesis, members of the stigmatized group (i.e., physicians) chose to not ingratiate primary

stakeholders (i.e., patients). I suggest that it may be attributed to “impotent dependence” (Wang, Raynard, & Greenwood, 2020)—i.e., a strong dependence of patients upon the medical profession. In other words, whereas primary stakeholders can substitute state-owned enterprises for private business, “exit” (Hirschman, 1977) is not an option in the context of health care. This contrasts with the previous view that the stigmatized is in a disadvantageous position and devalued (Wiesenfeld et al., 2008). When the stigmatized can exclusively provide certain value that is necessary for its primary stakeholders, it may obtain an advantageous position and the power to fend off devaluation.

Secondary stakeholders are not directly engaged in the value-creating processes, but have “a legitimate interest” in what the target does (Harrison et al., 2018: 17). Typically, secondary stakeholders include the media, advocacy groups, and NGOs, which may serve as “watch dog” reflecting societal interests and defending social values. They possess legitimate and influential platforms for making social judgments, making them close to Wiesenfeld et al.’s (2008) “social arbiters.” Thus, compared to primary stakeholders, secondary stakeholders may respond more negatively to the forms of transgression that violate societal norms regardless of whether such violation harms the value creation processes. For example, in the case of health care, the media began to criticize overprescription much earlier than when such transgression started to harm patients financially. Moreover, if the interests of primary stakeholders are deemed legitimate and coherent with societal values, secondary stakeholders will react critically when such interests are under attack by transgression. This is further evidenced in the case of health care as the media scaled up its criticism of overprescribing after such transgression began to cause damage to patients.

The target regards secondary stakeholders as salient evaluators as well, even though they

typically do not have the means to directly apply economic sanctions that can disrupt the value creation process. However, they possess legitimate and influential platforms for making social assessments, which can amplify or dampen the evaluations rendered by primary stakeholders. Put another way, compared to primary stakeholders, secondary stakeholders have a lower degree of "stakeholder power" to directly punish the target and force it to comply with their claim, but may have a stronger *influence* so as to moderate the "urgency" of the claim and in turn affect the reactions of primary stakeholders, thereby eliciting responses from the target (Hersel, Helmuth, Zorn, Shropshire, & Ridge, 2020). In Chapter 2, the media is shown to generate awareness and legitimation of the negative stances and reactions of patients, creating a "spiral of voice." Further, it is noteworthy that within the secondary stakeholder group different stakeholders may have substantially different levels of influence. For example, the *People's Daily* is much more influential than a local media in China.

Authoritative stakeholders are a distinct group in that they are responsible for monitoring and governing the stigmatized category. They can be both primary and secondary stakeholders to the extent that they sometimes directly fund or partner with the stigmatized and also possess an influential platform for making judgments about the transgression of the stigmatized. Typical authoritative stakeholders include governments, regulators, and industrial, trade, or professional associations. In the health care case, the Chinese government directly funded public hospitals, but was also the sole regulator for decades, responsible for supervising professional misconduct. Authoritative stakeholders can be either institutional "custodians" (Dacin, Dacin, & Kent, 2019) defending pre-existing societal norms and values or "cultural entrepreneurs" (Lounsbury & Glynn, 2019) initiating institutional change and innovation. In other words, authoritative stakeholders may or may not respond to the transgression of the stigmatized, depending upon

whether they decide to uphold or update the existing societal norms and processes of value creation. For example, in Chapter 4, the reformists within the government systematically turned a blind eye to the illegal expansion of private business as they attempted to legitimate market practices.

Authoritative stakeholders may be the most salient evaluators, given the power and influence they possess over the target and other stakeholders. When authoritative stakeholders proclaim and attribute a judgment of blame, other stakeholders may follow suit—as evidenced in all three empirical chapters. By synergizing with other stakeholders, authoritative stakeholders can propel movement along the stigmatization continuum and generate momentum. Moreover, authoritative stakeholders may direct the movement of stigmatization within or across levels by "scapegoating" individual perpetrators (Wiesenfeld et al., 2008) or generalizing the stigma to a broader category (as in Chapter 2). Further, the judgments by authoritative stakeholders may be an indispensable catalyst for breaching certain social shields or protection that surrounds a particular category (e.g., a prestigious profession). However, even as powerful as authoritative stakeholders, their specific prescriptions of behavior might not be followed by the stigmatized or other stakeholders. In the case of health care, the government's attempt to suppress professional transgression by shaming was not well received by physicians; nor was its call for less violence followed by patients. This seems to suggest that, whereas authoritative stakeholders can (re)construct the basis of social evaluation, it is more difficult for them to decide how other stakeholders actually respond to the stigmatized *if* their prescriptions are not aligned with the latter's own interests or emotions.

In sum, the three distinct stakeholder groups each have different stakes in the stigmatized category. Primary stakeholders may respond most promptly and negatively to transgression that

damages the value-creating processes, while secondary stakeholders to transgression that violate pre-existing societal norms and values. Although authoritative stakeholders are responsible for supervising the stigmatized, their responses are dependent on whether they decide to become a cultural entrepreneur or custodian. As the most salient evaluators, authoritative stakeholders can generate synergy with other stakeholders, inducing momentum towards (de)stigmatization. Primary stakeholders are salient too, as they can impose economic sanctions on the stigmatized, but the stigmatized may or may not accommodate primary stakeholders, depending upon whether or not the value created by the stigmatized is rare and substitutable. Though secondary stakeholders do not have the power to apply economic sanctions, their prominent members can largely amplify the responses of other stakeholders, increasing the pace and momentum of (de)stigmatization.

Boundary Conditions

Though the three studies in this thesis involve different empirical contexts (i.e., health care and private entrepreneurship), they share certain commonalities. To begin, all three studies focus on the moral source of stigmatization. Both the unethical behavior of medical professionals and the market practices of private entrepreneurs are and/or were regarded as morally questionable in the Chinese context during the period of my research. Put another way, my thesis tackles only the processes of *moral* stigmatization. Whether or not these processes are significantly different from those of other sources (e.g., physical, servile, or tribal) exceeds the boundary of this thesis and warrants future research.

In addition, the stigmas in all three studies are widely perceived by the broad audiences as controllable in that the adoption of unethical professional behavior or market practices are seen as behavioral choice rather than predetermined conditions or accidental events. The stigmas are

also perceived as disruptive in that both activities violate social orders in the Chinese society. However, whereas the unethical behavior by physicians are fairly concealable as it is typically delivered in an interpersonal manner instead of being publicly observable, market practices by private entrepreneurs are less likely to be concealed given their distinct ways of doing business that are significantly different from those of state-owned enterprises. Further, whereas market practices are central to the identity of private entrepreneurs, professional misconduct is less central to professional identity, at least as long as the professionals do not violate their knowledge base of expertise. In other words, my thesis highlights the processes of stigmatization that are more *controllable* and *disruptive*. Future research can investigate if a lower degree of controllability/disruptiveness or other characteristics (e.g., malleability) may induce different processes of stigmatization.[21]

Furthermore, an authoritative stakeholder in this thesis—i.e., the Chinese government—is particularly powerful given the authoritarian regime in China. For the same reason, a different authoritative stakeholder, professional associations, is particularly weak, as they were granted a certain degree of independence only in the 2000s. Thus, whereas the Chinese government was able to elicit prompt responses from other stakeholders and the stigmatized actors, professional associations did not initiate any significant change. Further research is warranted for examining whether the government may be as powerful during the processes of stigmatization in a more democratic regime; and, whether other potentially authoritative stakeholders such as judges, the Church, and industrial/trade associations may significantly shape the processes of stigmatization in such a democratic state.

[21] For a more detailed agenda for future studies of how the sources and characteristics of stigma may shape the processes of stigmatization, see an integrative review by Zhang et al. (2021). In this review, my coauthors and I have proposed and elaborated on several new directions.

IMPLICATIONS FOR RESEARCH ON PROFESSIONS

Whereas the prior studies of categorical stigma mainly investigate corporate contexts, we know little about the processes of stigmatization in professional contexts. Chapters 2 and 3 both investigate the medical profession in China, involving individual professionals and professional organizations. Below, I discuss the implications of my thesis for the literature on professions. In particular, I elaborate on the role of professional prestige in the process of social evaluation and how the meanings of professionalism (especially, of the medical profession) shape the ways by which professions are socially assessed.

Professional Prestige as a Benefit or a Burden

As mentioned earlier, the professional case in my thesis is of a high prestige profession that suffers a falling from grace. Despite growing interest in stigma research, however, relatively little is known about whether or not all occupations (high prestige vs. low prestige occupations) or all members of a same profession (high status vs. low status members) are equally vulnerable to the risk of being stigmatized—even though some scholars suggest that professional elites "seem to be singled out and penalized far out of proportion to their culpability" (Wiesenfeld et al., 2008: 231; see also Vergne, 2012: 1027).

However, in the broader literature on social evaluation, empirical evidence on pre-existing positive evaluations[22] (e.g., prestige) as a benefit or as a burden remains equivocal (for a review, see Bundy, Pfarrer, Short, & Coombs, 2017). Some studies suggest that prestige and status buffer elite members from social assaults. Phillips and Zuckerman (2001), for example, note that high status law firms can diversify into lower status market categories without suffering the same

[22] Following previous studies, I regard occupational prestige as a complex of positive social evaluations that are "enduring and deeply embedded" (Ashforth & Kreiner, 1999: 415). As Deephouse and Suchman (2008: 66) formulate, "Prestige = Legitimacy + Legitimacy * (Status + Reputation + [Status * Reputation])." Therefore, I do not distinguish whether the effects of prestige originate from status or reputation or a mix of both, which is an interesting research question but beyond the scope of my discussion here.

adverse consequences as middle status law firms. Looking across (rather than within) categories, Sharkey (2014) discovered that the misconduct of firms from high status industries induced less negative reactions from investors than did similar behaviors practiced by organizations in low status industries (see also McDonnell & Werner, 2016; Montauti & Wezel, 2016). Prestige, in other words, can serve as a "shield" against the risk and consequences of being stigmatized.

Other studies, however, show the opposite result—that prestige or status is a burden because it attracts attention and heightens the likelihood of being stigmatized. Rhee and Haunschild (2006), for example, found that high-status and highly reputed firms in the automobile industry suffered market penalties for product defects because they attracted more media attention and their reputation had raised expectations of product quality (see also Barlow, Verhaal, & Hoskins, 2016). In a non-commercial context, Graffin, Bundy, Porac, Wade, and Quinn (2013) reported that high status Members of the British Parliament were more likely to be excoriated by the media for their dubious expense claims. Again, the explanation offered is that high prestige draws media attention. Taken together, these studies show the reverse of the shield effect—i.e., that prestige can be a distinct hazard. In sum, the role of prestige in the processes of professional stigmatization remains unclear.

I investigated the effects of prestige both *within* a profession and *across* professions. First, in Chapter 3, I examined the *intra*-professional effects of prestige. It is shown that high status hospitals reacted more promptly and more substantively than low status hospitals to the rising pressure of stigmatization because the former perceived a higher extent of scrutiny, from both primary and secondary stakeholders, than the latter. Moreover, such stakeholder scrutiny was attributed to two distinct mechanisms: curiosity—i.e., stakeholders are generally more interested in high status members of a profession, especially their transgression and decline; and

suspicion—i.e., stakeholders are generally more suspicious of high status professional members. Notably, while prior work suggests that high status members of a profession are not more transgressive than low status members (Graffin et al., 2013), which my case does not refute, Chapter 3 shows that high status members may nonetheless perceive a higher level of stakeholder suspicion.

My thesis also sheds light on the *cross*-professional effects of prestige. Though Chapters 2 and 3 focus on a single prestigious profession, supplementary analysis was conducted on other professions including university professors and elementary school teachers in China.[23] The former is regarded as high status, the latter middle status. It was discovered that professors and school teachers were engaging in ethical transgressions similar to those of physicians—such as overcharging students and embezzling public funds—but neither of these professions suffered physical violence from primary stakeholders. However, university professors received a large amount of media criticism similarly, whereas school teachers received a much less attention. This suggests that the prestige as a burden argument partially applies to cross-professional comparison such that *secondary* stakeholders might respond more substantially to the violations of societal norms by high prestige professions than those by low prestige professions—potentially because secondary stakeholders are generally more interested in and/or hold a higher moral standard for professions with a higher prestige. Moreover, the fact that university professors did not receive physical violence might be attributed to a lower level of "impotent dependence" in that high school students in China increasingly went abroad to receive higher education—i.e., "exit" is available, but no such alternatives are available in medicine.

In sum, professional prestige generally serves as a burden *within* a profession because it can

[23] Additional analysis was done and shown in an early version of Chapter 2. Though the analysis was taken out of the paper during the review process, it is worth discussing here for its implications for the debate about the effects of prestige as a burden or as a benefit.

raise stakeholder scrutiny by eliciting both curiosity and suspicion from various stakeholders. Yet, professional prestige only partially serves as a burden *across* professions. It may induce more scrutiny by secondary stakeholders by raising their attention and expectation of a higher moral standard. However, primary stakeholders are more likely to respond harshly only when the value created by the stigmatized profession is rare and unsubstitutable—regardless of its prestige.

Two Types of Professionalism and Seven Roles of the Medical Profession

The social prestige of professions provides professionals with a privileged position higher up on the occupational division of labor (Anteby, Chan, & DiBenigno, 2016; McMurray, 2011). As Brint (1994) pointed out, professions justify the privileges associated with their social prestige with a commitment to observe and prioritize societal values (i.e., "social trusteeship professionalism") combined with a pledge to exercise judgment based on the application of expertise (i.e., "expert professionalism"). In other words, the prestige of professions is based on their widely recognized authority over a particular domain of knowledge and their proclaimed adherence to a code of ethics. However, the role of social trusteeship professionalism seems distinct from that of expert professionalism in the processes of stigmatization. Chapter 2 shows that a profession might be stigmatized for its violation of the code of ethics even if the knowledge base was upheld. Chapter 3 further adds that, as long as the standards of expertise are maintained, individual professionals might rationalize their ethical misconduct even if such misbehavior was stigmatized. Put another way, a profession may be morally stigmatized for violating social trusteeship professionalism, but remain pragmatically legitimate for upholding expert professionalism.

However, what if a profession violates expert professionalism instead of social trusteeship professionalism, or both types of professionalism? To begin, it may seem unlikely for an entire

profession—or, at least a critical mass of it—to violate expert professionalism, but not social trusteeship professionalism, which would entail a systematic failure in training and credentialing the profession. In contrast, it is likely for individual members of a profession to violate expert professionalism but not social trusteeship professionalism. For example, a study of the health care sector in the U.S. showed that the annual number of deaths that were a result of medical error (i.e., an inaccurate or incomplete diagnosis or treatment that does not entail unethical behavior) exceeded 250,000, placing medical error the third leading cause of death in the U.S. (Makary & Daniel, 2016). Obviously, such a scale of failure in expert professionalism alone did not lead to the stigmatization of the medical profession in the U.S. As Zhang et al.'s (2021) framework on stigma suggests, unintentional violation of expert professionalism alone does not constitute any of the six sources of stigma, but might instead damage the reputation of individual professionals (Deephouse & Suchman, 2008; Mishina & Devers, 2012).

Moreover, it is likely for individual professionals to violate both expert professionalism and social trusteeship professionalism. Though the violation of expert professionalism alone may not induce the processes of stigmatization, as suggested in Chapter 2, it may amplify such processes. In Chapter 3, as many physicians pointed out, unethical behavior might be justifiable only when it did not compromise the professional standards of expertise. In addition, in the recent cases of accountants in the failures of Enron and Thomas Cook, and of financial analysts in the subprime crisis, it seems that professionals might become stigmatized and particularly devalued when both types of professionalism are violated (Bevan & Wilson, 2013; Brooks, 2018; Roulet, 2020).

While the two types of professionalism may broadly apply to all professions ranging from medicine and law to business and education, each profession may have more nuanced standards that prescribe specific professional roles. Below I will use the medical profession, which I

focused on in this thesis, as an example to elaborate on how the meanings of a profession can shape the ways by which it is socially evaluated. According to CanMEDS, a framework developed by the Royal College of Physicians and Surgeons of Canada that identifies the required capabilities for physicians to effectively meet the health care needs of the people they serve, all physicians have seven roles: medical experts, communicators, collaborators, leaders, health advocates, scholars, and professionals. Yet, how do these roles shape social evaluation such as stigmatization?

Medical expert is the central professional role that integrates all other six roles. It requires physicians to apply both medical and clinical knowledge and professional values in the provision of high-quality and patient-oriented care. It basically includes both expert and social trusteeship professionalism. *Professional* requires physicians to be committed to the health of patients by maintaining high standards of ethical behavior, which is perfectly aligned with social trusteeship professionalism. *Health advocate* more specifically prescribes that physicians should use their authority and expertise to improve public health, serving patients populations and communities. *Scholar*, in contrast, demands that physicians keep a permanent commitment to excellence in medical practice, contributing to the development of expert professionalism. The rest of the roles, *collaborators*, *leaders*, and *communicators*, basically require physicians to work effectively with colleagues and form effective relationships with patients and their families in order to provide higher-quality and more patient-centered care. It is evidenced in Chapter 2 that first of all the role of professional might be key to whether a profession will be stigmatized. In addition, violation of the scholar role may lead to bad reputation but not stigma. Moreover, a survey of the patients' negative evaluations (not necessarily stigma) of physicians in China showed that the roles of medical expert, communicator, and professional are the three most important factors—

yet other roles are not highlighted (Wang et al., 2014).

In sum, violation of either type of professionalism—expert or social trusteeship—can lead to negative social evaluations of a profession. The violation of social trusteeship professionalism alone can induce the emergence of stigmatization, whereas the breach of expert professionalism is more likely to result in bad reputation than stigmatization. However, stakeholders may respond particularly harshly if both types of professionalism are infringed. Importantly, in the health care sector, the role of communicator is essential to social evaluation. If physicians failed to share essential information regarding their professional decisions and values with their patients, they might become negatively assessed—which might be attributed to the interpersonal relationships between the professionals and their clients.

Boundary Conditions

Both Chapters 2 and 3 in this thesis investigate the medical profession in China, which have certain distinct characteristics that may not apply to other professions or the medical profession in other societies. To begin, the medical profession was highly prestigious in China before the market transition for its values of "serving the people" (Davis, 2000; Sidel & Sidel, 1973). Put another way, the social trusteeship professionalism of the medical profession had a higher level of "moral resonance" (Wang et al., 2020) than the expert professionalism had with the socialist societal values in China, rendering the former a more salient type of professionalism during the processes of stigmatization. This may not apply to other societies where expert professionalism might be as valuable as, or even more valuable than, social trusteeship professionalism. In order to further investigate the relative importance of the two types of professionalism in the processes of stigmatization, it would be useful to conduct comparative analysis across multiple societies.

Second, while this thesis explores one of most prestigious professions, whether its insights

regarding occupational prestige as a benefit or as a burden can apply to less prestigious occupations warrants further research. Although some supplementary analysis has shown that less prestigious occupations are less likely to be vilified by either primary or secondary stakeholders if they breach social trusteeship professionalism, we still do not know much about the underlying mechanisms. Nor do we know whether or not less prestigious occupations will be vilified if they breach both types of professionalism. Moreover, the medical profession is highly hierarchical in that high status members of the profession are expected to provide a larger amount of services and more complicated services, which may not apply to less prestigious occupations either. Thus, future research is needed to examine the effects of prestige *within* a less prestigious occupation.

Lastly, it is noteworthy that communicator seems to be a salient role in the social evaluation of the medical profession. It may be because the medical profession is characterized by a highly esoteric domain of knowledge and an interpersonal relationship with patients. In a way, the role of communicator is an essential vehicle through which the professional values are conveyed. In contrast, for other professions and occupations that require less interpersonal relationships or involve less esoteric expertise, will the role of communicator be less important? Again, it may be useful to conduct comparative analysis across multiple professions.

IMPLICATIONS FOR RESEARCH ON INSTITUTIONAL CHANGE

In theorizing the processes of stigmatization, my thesis speaks to a broader understanding of institutional change. In particular, Chapter 4 suggests that fundamental institutional change is likely to be triggered and precipitated by the orchestration of influential stakeholders rather than locally emergent improvisations—complementing the rising "practice-driven institutionalism" (Lounsbury, Anderson, & Spee, 2021; Smets, Morris, & Greenwood, 2012). However, I do not

suggest that influential stakeholders should be seen as omnipotent “institutional entrepreneurs” as their orchestrational efforts may unintendedly induce extensive improvisations that go beyond their control and even contradict their original agenda. Instead, the top-down orchestration and the bottom-up improvisation are interactive and co-constitutive—which represents an alternative model for studying transformational institutional change such as the fight against racism (Rojas, 2017), the endeavor to combat climate change (Hoffman & Jennings, 2018), and the challenge facing the public health systems (Stoate & Jones, 2006). Below, I first elaborate on what I call “orchestrated improvisation” and then delve into the role of influential stakeholders in governing institutional logics and orders.

Orchestrated Improvisation: An Alternative Pathway to Institutional Change

The case of removing stigmatization in Chapter 4 highlights the “orchestrated improvisation” between “authoritative stakeholders” (state actors in this case) and members of the stigmatized category (private entrepreneurs). Such dynamics cut across phases—each associated with distinct (re)actions of and interaction between the two parties. I turn now to how this co-constitutive and co-evolving relationship between the top-down arrangements by authoritative stakeholders (i.e., orchestration) and the bottom-up practices by organizations on the ground (i.e., improvisation) contributes to the broader literature on institutional change.

In recent years, institutional theorists have been following a “practice turn” in contemporary social theory (Gehman, 2021; Lounsbury, Steele, Wang, & Toubiana, 2021; Smets et al., 2012). This burgeoning “practice-driven institutionalism” has emerged as a competing perspective to the “institutional entrepreneurship” and “institutional work” strand of the institutional analysis: Whereas the latter focuses on purposive action and planned change—i.e., “projective agency” (Hampel, Lawrence, & Tracey, 2017; Lawrence & Suddaby, 2006)—the former emphasizes how

improvisations at work and practices at the present—i.e., “practical-evaluative agency”—can generate change (Smets, Aristidou, & Whittington, 2017). While the practice-driven model is thought-provoking, I suspect that certain kind of change—in particular, fundamental institutional change—might not originate from mundane daily practices. Below I highlight three features of an alternative pathway to institutional change.

First, fundamental institutional change is more likely to be precipitated by the orchestration of influential stakeholders than by locally emergent improvisations, especially when local actors are too weak to effectively mobilize or the orchestrating stakeholders are strong enough to quash any bottom-up efforts (Claus & Tracey, 2020; Hardy & Maguire, 2017). In my case, the private business category had been suppressed for more than two decades before the market transition; neither private entrepreneurs nor grassroots activists became the driving force of institutional change in early phases. Indeed, it was the state’s orchestration that widened the entrepreneurial opportunity space for local actors to improvise and experiment. It was only after the institutional environment was rendered more stable that private entrepreneurs became more influential and proactive in the process of change. Thus, my study suggests that the pathway to fundamental institutional change is more likely to be initiated and precipitated by orchestrated agency than by distributed agency (for contrasting cases, see Lawrence, 2017; Smets et al., 2012).

Second, while I highlight the role of orchestrated agency, I do not suggest that the efforts of an influential stakeholder should be seen merely as an exogenous jolt. Instead, I propose that the top-down orchestration and the bottom-up improvisation are interactive and co-constitutive, but do not always align well with each other. Of this co-constitutive relationship, my case shows at least two distinctive characteristics. To begin with, the consequences of previous improvisations and experiments may be retrospectively clustered by influential stakeholders as wins or losses.

Prior work on “small wins” emphasizes the sharing of underlying agenda and future orientation between individuals and stakeholders (Reay, Golden-Biddle, & Germann, 2006; Tracey, Dalpiaz, & Phillips, 2018), but, in my case, individual entrepreneurs and the state had tangential agendas (personal wealth creation vs. employment expansion) such that the state retrospectively coupled individual accomplishments in earlier phases as small wins for its underlying agenda which was actually remote to individual entrepreneurs. Moreover, without the sharing of future plans, the present and future improvisations by entrepreneurs on the ground that are stimulated by the state might diverge from its agenda. Therefore, I propose that the pathway to fundamental institutional change is shaped by all three dimensions of agency (Emirbayer & Mische, 1998)—including an orientation to the past (iterational agency), the present (practical-evaluative agency), *and* the future (projective agency).

Lastly, the alternative pathway I propose may be shaped by the internal power dynamics of influential stakeholders. My case in Chapter 4 shows that the state may split with regard to the very processes of institutional change that it seeks to shape. Both the income gaps in phase two and the economic recession in phase three were induced by the state’s efforts, but provided fuel for internal power struggles and ultimately helped reshape future state orchestration. This competition between different factions within an influential stakeholder group has made the removal of stigmatization an oscillating rather than linear process. Instead of focusing on the heroic acts of institutional entrepreneurs, I suggest more attention be paid to the political conflicts and truces (Wang & Lounsbury, 2021) among influential stakeholders, which may be as important in shaping institutional change.

Governance of Institutional Logics

Through institutional change in each chapter, my thesis uncovers that various stakeholders

govern the orders of institutions—and, in doing so, provide "a frame of reference that preconditions actors' sensemaking choices" (Thornton, Ocasio, & Lounsbury, 2012: 54). While the institutional logics literature has become one of the most burgeoning fields in organization theory, there is little focus on the *governance* of institutional orders and logics in the literature. As Lounsbury et al. (2021) recently point out, focusing on governance may be especially useful as it will redirect attention towards "the broader scale study of how a diverse array of actors try to actively maintain the coherence and durability of various logics" associated with either same or different institutional orders[24] (see also Meyer & Vaara, 2020).

To begin, while prior work has focused on how different organizations cope with competing pressures associated with logics through a variety of governing mechanisms, such as blending or balancing (Battilana & Dorado, 2010; Smets, Jarzabkowski, Burke, & Spee, 2015), this thesis explored how such localized forms of governance are shaped by wider systems of governance associated with institutional orders. In Chapter 4, I demonstrate that the ways by which individual entrepreneurs managed the state-market tension (e.g., through pretending in an early phase or blending in a later phase) is largely dependent on the societal change of institutional orders (e.g., legalization of corporations). Moreover, in Chapter 2, In show that the extent to which market practices are integrated with professional practices of medicine is shaped by the encroachment of the market order on professions. It is evidenced that the change of governing mechanisms at the organizational level is related to the field-level or even societal-level dynamics where logic and order shift occurs.

Moreover, all three chapters showcase the role of influential stakeholders in governing the orders of institutions—rendering support for the call for more examinations of command posts

[24] Following Lounsbury et al. (2021), I define institutional orders as "governance systems that maintain and bridge different instantiations of logics in a regionalized zone, enabling the meanings and practices that are woven together in and across those instantiations to be perceived as coherent and durable."

(Lounsbury et al., 2021; Meyer & Vaara, 2020). Chapters 2 and 3 highlight how professional regulators and elites attempted to maintain the old professional logic and reproduce the values of social trusteeship professionalism. In addition, Chapter 4 shows the ways by which traditional centers of societal power (the government in this case) reshaped the order of market and in turn affected organizational life in the private sector (i.e., the births and deaths of private enterprises). However, the governing attempts of command posts to maintain the coherence and durability of various logics may not always succeed. When governing mechanisms fail to resolve the conflict between incompatible logics, individuals and organizations might deviate from rules and norms, inducing or sustaining stigmatization.

Finally, my thesis confirms that more historical research is needed for studying the change and governance of institutional logics and orders (Lounsbury et al., 2021). Admittedly, critical events such as "natural catastrophes, accidents, political reforms, economic and financial crises, military conflicts, and trade agreements" may "raise questions about the value or appropriateness of a logic" (Clemente, Durand, & Roulet, 2017: 24) provoking change of institutions, but in most cases the change of logics occurs in a longer duration (Wang, Steele, & Greenwood, 2019). In this thesis, the rise of market logics unfolded in decades, which shape and is shaped by the broad societal contexts.

Boundary Conditions

While I theorize the distinct characteristics of an alternative pathway, I do not argue that it replaces other models of institutional change. To what extent this pathway may be applicable is an empirical question to be tested in future studies. However, it is likely to be more useful under two empirical conditions. First, this pathway may be more relevant to studies of transformational than incremental institutional change. It is reasonable to expect that distributed agency alone may

be enough to trigger incremental change (e.g., Semper, 2019; see also Micelotta, Lounsbury & Greenwood, 2017). Second, the pathway may be more relevant in authoritarian states where the civil society is less developed, even though in Western societies we also learned the important role of the state in addressing fundamental societal change—such as the change of public health systems or education reforms (Raynard, Kodeih, & Greenwood, 2019; Stoate & Jones, 2006). Yet, how the role of the state in authoritarian regimes differs from its role in liberal-democratic regimes warrants further research.

In addition, the market transition in China is characterized by its preservation of a one-party state. In other words, the order and governing system of state institutions in China have persisted throughout the reintroduction of the market. This juxtaposes China with some East European states where the rise of market logics significantly intruded on the state order and rendered the governing system of the market much more liberal from the beginning (Róna-Tas, 1997; Stark, 1996). Future comparative analysis across multiple states is recommended.

CONCLUDING REMARKS

Through three interrelated empirical studies, I examined one of the most transformational institutional changes the world has seen in the past four decades: the market transition in China. Unlike many prior studies, which focus on the socio-economic aspects of the transition, I adopted a cultural approach, which helps readers to build up a more comprehensive understanding of why and how the processes of stigmatization—in particular, its emergence, maintenance, and removal—have unfolded during marketization.

Bibliography

Abbott, A. 1988. ***The system of professions: An essay on the division of expert labor.*** Chicago: University of Chicago Press.

Adams, J. 2012. Cleaning up the dirty work: Professionalization and the management of stigma in the cosmetic surgery and tattoo industries. ***Deviant Behavior,*** 33(3): 149-167.

Adut, A. 2005. A theory of scandal: Victorians, homosexuality, and the fall of Oscar Wilde. ***American Journal of Sociology,*** 111(1): 213-248.

Adut, A. 2008. ***On scandal: Moral disturbances in society, politics and art.*** Cambridge: Cambridge University Press.

Anderson, E. 2018. Policy entrepreneurs and the origins of the regulatory welfare state: Child labor reform in nineteenth-century Europe. ***American Sociological Review***, 83(1): 173-211.

Andrevski, G. & Miller, D. 2020. Forbearance: Strategic nonresponse to competitive attacks. ***Academy of Management Review,*** in press.

Ang, Y. Y. 2016. ***How China escaped the poverty trap.*** Ithaca: Cornell University Press.

Ansari, S. M., Fiss, P. C., & Zajac, E. J. 2010. Made to fit: How practices vary as they diffuse. ***Academy of Management Review,*** 35(1), 67-92.

Allison, K. W. 1998. Stress and oppressed category membership. In J. K. Swim & C. Stangor (Eds.), ***Prejudice: The target's perspective:*** 145–170. San Diego, CA: Academic Press.

Anteby, M. 2010. Markets, morals, and practices of trade: Jurisdictional disputes in the U.S. commerce in cadavers. ***Administrative Science Quarterly,*** 55: 606–638.

Anteby, M., Chan, C. K., & DiBenigno, J. 2016. Three lenses on occupations and professions in organizations: Becoming, doing, and relating. ***Academy of Management Annals,*** 10: 183–244.

Aranda, A. M., Conti, R., & Wezel, F. C. 2020. Distinct but not apart? Stigma reduction and cross-industry evaluative spillovers: The case of medical marijuana legalization. ***Academy of Management Journal.***

Arvidsson, S. 2010. Communication of corporate social responsibility: A study of the views of management teams in large companies. ***Journal of Business Ethics,*** 96(3): 339–354.

Ashforth, B. E. 2019. Stigma and legitimacy: Two ends of a single continuum or different continua altogether. ***Journal of Management Inquiry,*** 28: 22–30.

Ashforth, B. E., & Anand, V. 2003. The normalization of corruption in organizations. ***Research in Organizational Behavior***, 25: 1-52.

Ashforth, B. E., & Kreiner, G. E. 1999. "How can you do it?": Dirty work and the challenge of constructing a positive identity. ***Academy of Management Review,*** 24: 413–434.

Ashforth, B. E., Kreiner, G. E., Clark, M. A., & Fugate, M. 2007. Normalizing dirty work: Managerial tactics for countering occupational taint. ***Academy of Management Journal,*** 50: 149–174.

Barlow, M. A., Verhaal, J. C., Hoskins, J. D. 2018. Guilty by association: Product-level category stigma and audience expectations in the US craft beer industry. ***Journal of Management,*** 44(7): 2934-2960.

Battilana, J., & Dorado, S. 2010. Building sustainable hybrid organizations: The case of commercial microfinance organizations. ***Academy of Management Journal,*** 53(6), 1419-1440.

Bevan, G., & Wilson, D. 2013. Does 'naming and shaming' work for schools and hospitals? Lessons from natural experiments following devolution in England and Wales. ***Public Money & Management,*** 33: 245–252.

Bonnin, M. 2004. ***Génération perdue. Le mouvement d'envoi des jeunes instruits à la campagne en Chine, 1968-1980.*** Paris: Éditions de l'École des hautes études en sciences sociales.

Boxenbaum, E., & Jonsson, S. 2017. Isomorphism, diffusion and decoupling: Concept evolution and theoretical challenges. In R. Greenwood, C. Oliver, T. B. Lawrence, & R. E. Meyer (Eds.), ***The SAGE handbook of organizational institutionalism,*** 2nd edition: 77–101. London: Sage.

Bridoux, F., Bundy, J., Gond, J.-P., Haack, P., Petriglieri, J., Stephens, J. P., Suscliffe, K. 2021. The new normal: Positive organizational impact in an age of disruption. ***Academy of Management Review.***

Brint, S. 1994. ***In an age of experts: The changing roles of professionals in politics and public life.*** Princeton, NJ: Princeton University Press.

Bromley, P., & Powell, W. W. 2012. From smoke and mirrors to walking the talk: Decoupling in the contemporary world. ***Academy of Management Annals,*** 6(1): 483-530.

Brooks, R. 2018. ***Bean counters: The triumph of the accountants and how they broke capitalism***. London: Atlantic Books.

Budiman, A., Roan, A., & Callan, V. J. 2012. Rationalizing ideologies, social identities and

corruption among civil servants in Indonesia during the Suharto era. ***Journal of Business Ethics,*** 116(1): 139-149.

Bundy, J., Shropshire, C., & Buchholtz, A. K. 2013. Strategic cognition and issue salience: Toward an explanation of firm responsiveness to stakeholder concerns. ***Academy of Management Review,*** 38(3): 352–376.

Bundy, J., Pfarrer, M., Short, C. E., & Coombs, W. T. 2017. Crises and crisis management: Integration, interpretation, and research development. ***Journal of Management,*** 43(6): 1661-1692.

Carberry, E. J., & King, B. G. 2012. Defensive practice adoption in the face of organizational stigma: Impression management and the diffusion of stock option expensing. ***Journal of Management Studies,*** 49: 1137–1167.

Carmi-Iluz, T., Peleg, R., Freud, T., & Shvartzman, P. 2005. Verbal and physical violence towards hospital- and community-based physicians in the Negev: an observational study. ***BMC Health Services Research,*** 5: 54.

Cavazos, D. E., & Rutherford, M. A. 2012. Bringing regulatory agencies into organizational studies: Broadening the lens used to examine the state. ***Journal of Management Inquiry,*** 21(1): 4-12.

Chakravarthy, J., Dehaan, E., & Rajgopal, S. 2014. Reputation repair after a serious restatement. ***The Accounting Review,*** 89(4): 1329–1363.

Che, J., & Qian, Y. 1998. Institutional environment, community government, and corporate governance: Understanding China's township-village enterprises. ***Journal of Law, Economics, & Organization,*** 14(1): 1-23.

Chinese Hospital Association. 2014. ***Investigation on hospital violence in China (2003–2012).***

Chinese Medical Doctor Association. 2004. ***Investigation on physician practice.***

Chinese Medical Doctor Association. 2015. ***Chinese physicians' practice status white paper.***

Clair, J. A., Beatty, J. E., & Maclean, T. L. 2005. Out of sight but not out of mind: managing invisible social identities in the workplace. ***Academy of Management Review,*** 30(1): 78-95.

Clair, M., Daniel, C., & Lamont, M. 2016. Destigmatization and health: Cultural constructions and the long-term reduction of stigma. ***Social Science and Medicine,*** 165: 223-232.

Claus, L., & Tracey, P. 2020. Making change from behind a mask: How organizations challenge guarded institutions by sparking grassroots activism. ***Academy of Management Journal,***

63(4): 965-996.

Clemente, M., & Roulet, T. J. 2014. Public opinion as a source of deinstitutionalization: A "spiral of silence" approach. ***Academy of Management Review,*** 40: 96–114.
Clemente, M., & Roulet, T. J. 2014. Public opinion as a source of deinstitutionalization: A "spiral of silence" approach. ***Academy of Management Review,*** 40: 96–114.
Connelly, B. L., Tihanyi, L., Ketchen Jr, D. J., Carnes, C.M., & Ferrier, W. J. 2017. Competitive repertoire complexity: Governance antecedents and performance outcomes. ***Strategic Management Journal,*** 38(5): 1151–1173.

Coombs, W. T. 2007. Protecting organization reputations during a crisis: The development and application of situational crisis communication theory. ***Corporate Reputation Review,*** 10(3): 163–176.

Corbin, J., & A. Strauss. 2008. ***Basics of qualitative research: Techniques and procedures for developing grounded theory, 3rd ed.*** Los Angeles: Sage.

Cornelissen, J. P., & Werner, M. 2014. Putting framing in perspective: A review of framing and frame analysis across the management and organizational literature. ***Academy of Management Annals***, 8(1): 181-235.

Courpasson, D., & Monties, V. 2017. "I am my body." Physical selves of police officers in a changing institution. ***Journal of Management Studies,*** 54(1): 32–57.

Creed, W. E. D., DeJordy, R., & Lok, J. 2010. Being the change: Resolving institutional contradiction through identity work. ***Academy of Management Journal*****,** 53: 1336–1364.

Creed, D. W. E., Hudson, B. A., Okhuysen, G. A., & Smith-Crowe, K. 2014. Swimming in a sea of shame: Incorporating emotion into explanations of institutional reproduction and change. ***Academy of Management Review,*** 39: 275–301.

Crocker, J., Major, B., & Steele, C. 1998. Social stigma. In D. T. Gilbert, S. T. Fiske, & G. Lindzey (Eds.), ***The handbook of social psychology,*** vol. 2 (4th ed.): 504–553. Hoboken, NJ: Wiley.

Currie, G., Lockett, A., Finn, R., Martin, G., & Waring, J. 2012. Institutional work to maintain professional power: Recreating the model of medical professionalism. ***Organization Studies,*** 33(7): 937–962.

Dacin, M. T., Dacin, P. A., & Tracey, P. 2011. Social entrepreneurship: A critique and future directions. ***Organization Science,*** 22(5): 1203-1213.

Dacin, M. T., Dacin, P. A., & Kent, D. 2019. Tradition in organizations: A custodianship framework. ***Academy of Management Annals,*** 13: 342–373.

Davis, D. 2000. Social class transformation in urban China: Training, hiring, and promoting urban professionals and managers after 1949. ***Modern China,*** 26: 251–275.

Deephouse, D. L., Bundy, J., Tost, L. P., & Suchman, M. C. 2017. Organizational legitimacy. In R. Greenwood, C. Oliver, T. B. Lawrence, & R. E. Meyer (Eds.), ***The SAGE handbook of organizational institutionalism,*** 2nd edition: 27–54. London: Sage.

Deephouse, D. L., & Suchman, M. 2008. Legitimacy in organizational institutionalism. In R. Greenwood, C. Oliver, R. Suddaby, & K. Sahlin-Andersson (Eds.), ***The sage handbook of organizational institutionalism***: 49-77: SAGE.

Devers, C. E., Dewett, T., Mishina, Y., & Belsito, C. A. 2009. A general theory of organizational stigma. ***Organization Science,*** 20: 154–171.

Dixon-Woods, M., Yeung, K., & Bosk, C. L. 2011. Why is UK medicine no longer a self-regulating profession? The role of scandals involving “bad apple” doctors. ***Social Science & Medicine,*** 73: 1452–1459.

Douglas, M. 1966. ***Purity and danger: An analysis of concept of pollution and taboo.*** London: Routledge.

Durand, R., Hawn, O., & Ioannou, I. 2019.Willing and able: A general model of organizational responses to normative pressures. ***Academy of Management Review,*** 44(2): 299–320.

Eisenhardt, K. M. 1989. Building theories from case-study research. ***Academy of Management Review,*** 14: 532–550.

Eley, J. & Kinder, T. 2019. MPs criticise “catalogue of failures” in Thomas Cook auditing. ***Financial Times,*** November 5, 2019.

Elsbach, K. D. 1994. Managing organizational legitimacy in the California cattle industry: The construction and effectiveness of verbal accounts. ***Administrative Science Quarterly,*** 39(1): 57-88.

Elsbach, K.D., & Sutton, R.I. 1992. Acquiring organizational legitimacy through illegitimate actions: A marriage of institutional and impression management theories. ***Academy of Management Journal,*** 35(4), 699–738.

Emirbayer, M., & Mische, A. 1998. What Is Agency? ***American Journal of Sociology,*** 103(4): 962-1023.

Fisher, R., Gee, G., & Looney, A. 2018. Same-sex married tax filers after *Windsor* and *Obergefell*. ***Demography,*** 55(4): 1423-1446.

Fiss, P. C., & Zajac, E. J. 2006. The symbolic management of strategic change: Sensegiving via framing and decoupling. ***Academy of Management Journal,*** 49(6): 1173–1193.

Flack, J. M., Amaro, H., Jenkins, W., Kunitz, S., Levy, J., Mixon, M., & Yu, E. 1995. Panel I: Epidemiology of minority health. ***Health Psychology,*** 14: 592–600.

Fleiss, J. L. 1981. ***Statistical methods for rates and proportions.*** New York: John Wiley & Sons.

Freeman, R. E., Harrison, J. S., & Zyglidopoulos, S. 2018. ***Stakeholder theory: Concepts and strategies.*** Cambridge: Cambridge University Press.

Gabbioneta, C., Greenwood, R., Mazzola, P., & Minoja, M. 2013. The influence of the institutional context on corporate illegality. ***Accounting, Organizations and Society,*** 38(6–7): 484–504.

Gabbioneta, C., Prakash, R., & Greenwood, R. 2014. Sustained corporate corruption and processes of institutional ascription within professional networks. ***Journal of Professions and Organization,*** 1: 16–32.

Galvin, T. L., Ventresca, M. J., & Hudson, B. A. 2004. Contested industry dynamics. ***International Studies of Management & Organization,*** 34: 56–82.

García, P. J. 2019. Corruption in global health: The open secret. ***The Lancet,*** 394: 2119-2224.

Gehman, J. 2021. Searching for values in practice-driven institutionalism: practice theory, institutional logics, and values work. In D.A. Anderson, M. Lounsbury, & P. Spee (Eds.). On Practice and Institution: Theorizing the Interface. ***Research in the Sociology of Organizations,*** 70: 109–129.

George, G., Howard-Grenville, J., Joshi, A., & Tihanyi, L. 2016. Understanding and tackling societal grand challenges through management research. ***Academy of Management Journal,*** 59: 1880–1895.

Gillespie, N., & Dietz, G. 2009. Trust repair after an organization-level failure. ***Academy of Management Review,*** 34(1): 127–145.

Gioia, D. A., Corley, K. G., & Hamilton, A. L. 2013. Seeking qualitative rigor in inductive research. ***Organizational Research Methods,*** 16(1): 15–31.

Gioia, D. A., Price, K., Hamilton, A. L., & Thomas, J. B. 2010. Forging an identity: An insider-outsider study of processes involved in the formation of organizational identity.

Administrative Science Quarterly, 55: 1–46.

Glaeser, A. 2011. ***Political epistemics: The secret police, the opposition, and the end of East German socialism***. Chicago: Chicago University Press.

Glaser, B. G., & A. L. Strauss. 1967. ***The discovery of grounded theory: strategies for qualitative research.*** Chicago: Aldine.

Goffman, E. 1963. ***Stigma: Notes on the management of spoiled identity.*** New York: Simon & Schuster.

Gomulya, D., & Boeker, W. 2014. How firms respond to financial restatement: CEO successors and external reactions. ***Academy of Management Journal,*** 57(6): 1759–1785.

Gonzalez J. A., & Pérez-Floriano, L. R. 2015. If you can't take the heat: Cultural beliefs about questionable conduct, stigma, punishment, and withdrawal among Mexican police officers. ***Organization Studies,*** 36(5): 665–687.

Goodrick, E., & Salancik, G.R. 1996. Organizational discretion in responding to institutional practices: Hospitals and caesarean births. ***Administrative Science Quarterly,*** 41(1), 1–28.

Graffin, S. D., Bundy, J., Porac, J. F., Wade, J. B., & Quinn, D. P. 2013. Falls from grace and the hazards of high status: The 2009 British MP expense scandal and its impact on parliamentary elites. ***Administrative Science Quarterly,*** 58(3): 313–345.

Grandy, G., & Mavin, S. 2012. Occupational image, organizational image and identity in dirty work: Intersections of organizational efforts and media accounts. ***Organization,*** 19(6): 765–786.

Greenwood, R., Oliver, C., Lawrence, T. B., & Meyer, R. (Eds.). 2017. ***The SAGE handbook of organizational institutionalism*, **2nd edition. London: Sage.

Greve, H. R., Palmer, D., & Pozner, J. E. 2010. Organizations gone wild: The causes, processes, and consequences of organizational misconduct. ***Academy of Management Annals*, **4(1): 53-107.

Greve, H. R., & Teh, D. 2016. Consequences of organizational misconduct: Too much and too little punishment. In Palmer, D., Smith-Crowe, K., & Greenwood, R. (Eds.). 2016. ***Organizational wrongdoing.*** Cambridge: Cambridge University Press.

Grougiou, V., Dedoulis, E., & Leventis, S. 2016. Corporate social responsibility reporting and organizational stigma: The case of "sin" industries. ***Journal of Business Research,*** 69(2): 905-914.

Guba, E. G., & Lincoln, Y. S. 2005. Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), ***The SAGE handbook of qualitative research,*** 3rd edition: 191–215. London: Sage.

Gutierrez, B., Howard-Grenville, J., & Scully, M. A. 2010. The faithful rise up: Split identification and an unlikely change effort. ***Academy of Management Journal,*** 53: 673–699.

Haggard, S. 2018. ***Developmental states.*** Cambridge, UK: Cambridge University Press.

Hamilton, L., & McCabe, D. 2016. "It's just a job": Understanding emotion work, de-animalization and the compartmentalization of organized animal slaughter. ***Organization,*** 23(3): 330–350.

Hampel, C. E., & Tracey, P. 2017. How organizations move from stigma to legitimacy: The case of Cook's travel agency in Victorian Britain. ***Academy of Management Journal,*** 60: 2175–2207.

Hampel, C. E., & Tracey, P. 2019. Introducing a spectrum of moral evaluation: Integrating organizational stigmatization and moral legitimacy. ***Journal of Management Inquiry,*** 28: 11–15.

Hampel, C. E., Lawrence, T. B., & Tracy, P. 2017. Institutional work: Taking stock and making it matter. ***The Sage handbook of organizational institutionalism,*** 2nd ed. London: Sage.

Hardy, C., & Maguire, S. 2017. Organizations, risk translation, and the ecology of risks: The discursive construction of a novel risk. ***Academy of Management Journal,*** 63(3): 685-716.

Harris, J., & Bromiley, P. 2007. Incentives to cheat: The influence of executive compensation and firm performance on financial misrepresentation. ***Organization Science,*** 18(3): 350–367.

Haunschild, P. R., & Rhee, M. 2004. The role of volition in organizational learning: The case of automotive product recalls. ***Management Science,*** 50(11): 1545–1560.

Heath, A. F., Richards, L., & De Graaf, N. D. 2016. Explaining corruption in the developed world: The potential of sociological approaches. ***Annual Review of Sociology,*** 42, 51-79.

Helfen, M., & Sydow, J. 2013. Negotiating as institutional work: The case of labour standards and international framework agreements. ***Organization Studies,*** 34(8): 1073–1098.

Helms, W. S., Oliver, C., & Webb, K. 2012. Antecedents of settlement on a new institutional practice: Negotiation of the ISO 26000 standard on social responsibility. ***Academy of***

Management Journal, 55: 1120–1145.

Helms, W. S., & Patterson, K. D. W. 2014. Eliciting acceptance for “illicit” organizations: The positive implications of stigma for MMA organizations. ***Academy of Management Journal,*** 57: 1453–1484.

Helms, W. S., & Patterson, K. D. W., Hudson, B. A. 2019. Let’s not “taint” stigma research with legitimacy, please. ***Journal of Management Inquiry,*** 28: 5–10.

Herepath, A., & Kitchener, M. 2016. When small bandages fail: The field-level repair of severe and protracted institutional breaches. ***Organization Studies,*** 37(8): 1113–1139.

Hersel, M.C., Helmuth, C.A., Zorn, M., Shropshire, C., & Ridge, J.W. 2019. The corrective actions organizations pursue following misconduct: a review and research agenda. ***Academy of Management Annals,*** 13(2): 547–585.

Hirschman, A. O. 1977. ***Exit, voice, and loyalty: Responses to decline in firms, organizations, and states.*** Cambridge: Harvard University Press.

Hoffman, A. J., & Jennings, P. D. 2018. Re-engaging with sustainability in the Anthropocene Era: An institutional approach. Cambridge: Cambridge University Press.

Hsu, I. C. Y. 2000. ***The rise of modern China.*** (Sixth edition). New York, Oxford: Oxford University Press.

Hsu, G. T., & Grodal, S. 2020. The double-edged sword of oppositional category positioning: A study of the US e-cigarette category, 2007–2017. ***Administrative Science Quarterly.***

Huang, Y. 2008. ***Capitalism with Chinese characteristics: Entrepreneurship and the state.*** Cambridge: Cambridge University Press.

Huang, Y. 2019. If a government can’t deliver safe vaccines for children, is it fit to rule? ***New York Times*****,** Jan. 30, 2019. https://www.nytimes.com/2019/01/30/opinion/china-vaccine-scandal-legitimacy.html

Huang, H., & Jong, S. 2019. Public funding for science and the value of corporate R&D projects; Evidence from project initiation and termination decisions in cell therapy. ***Journal of Management Studies,*** 56(5): 1000-1039.

Hudson, B. A. 2008. Against all odds: A consideration of core-stigmatized organizations. ***Academy of Management Review,*** 33: 252–266.

Hudson, B. A., & Okhuysen, G. A. 2009. Not with a ten-foot pole: Core stigma, stigma transfer, and improbable persistence of men’s bathhouses. ***Organization Science,*** 20: 134–153.

Hudson, B. A., & Okhuysen, G. A. 2014. Taboo topics: Structural barriers to the study of organizational stigma. ***Journal of Management Inquiry,*** 23: 242–253.

Jain, A., Nundy, S., & Abbasi, K. 2014. Corruption: Medicine's dirty open secret. ***BMJ,*** 348: g4184.

Jepperson, R. L., & Swidler, A. 1994. What properties of culture should we measure? ***Poetics,*** 22: 359–371.

Jones, E. E., Farina, A., Hastorf, A. H., Markus, H., Miller, D., Scott, R., & French, R. d. S. 1984. ***Social stigma: The psychology of marked relationships.*** New York, NY: W. H. Freeman.

Kadushin, C. 1962. Social distance between client and professional. American Journal of Sociology, 67(5): 517-531.

Kang, S. K., DeCelles, K. A., Tilcsik, A., & Jun, S. 2016. Whitened resumes: Race and self-presentation in the labor market. ***Administrative Science Quarterly,*** 61(3): 469–502.

Kitsuse, J. I. 1962. Societal reaction to deviant behavior: Problems of theory and method. ***Social Problem,*** 9: 247–256.

Kleck, R. 1968. Physical stigma and nonverbal cues emitted in face-to-face interaction. ***Human Relations*****,** 21(1), 19-28.

Kong, X., Du, Z., Zhao, M., Yang, Y., & Qin, Y. 2011. Red envelope and doctor-patient trust: Report of research on national questionnaire survey of 4000 inpatients in 10 cities. ***Medicine and Philosophy (Humanistic &Social Medicine Edition)*****,** 32(5): 34-48.

Kreiner, G. E., Ashforth, B. E., & Sluss, D. M. 2006. Identity dynamics in occupational dirty work: Integrating social identity and system justification perspectives. ***Organization Science,*** 17: 619–636.

Kurzban, R., & Leary, M R. 2001. Evolutionary origins of stigmatization: The functions of social exclusion. ***Psychological Bulletin,*** 127: 187–208.

Kvalnes, Ø. 2015. ***Moral reasoning at work: Rethinking ethics in organizations.*** London: Palgrave MacMillan.

Kvalnes, Ø., & Nordal, S. 2019. Normalization of questionable behavior: An ethical root of the financial crisis in Iceland. ***Journal of Business Ethics*****,** 159(3): 761-775.

Lamont, M. 2018. Addressing recognition gaps: Destigmatization and the reduction of inequality. ***American Sociological Review,*** 83(3): 419-444.

Langley, A., & Abdallah, C. 2011. Templates and turns in qualitative studies of strategy and

management. In D. D. Bergh & D. J. Ketchen (Eds.), ***Research Methodology in Strategy and Management,*** 6: 201–235.

Langley, A. 1999. Strategies for theorizing from process data. ***Academy of Management Review,*** 24(4): 691-710.

Lashley, K., & Pollock, T.G. 2020. Waiting to inhale: Reducing stigma in the medical cannabis industry. ***Administrative Science Quarterly,*** 65: 434–482.

Lawrence, T. B. 2017. High stakes institutional translation: Establishing North America's first government-sanctioned supervised injection site. ***Academy of Management Journal,*** 60(5): 1771-1800.

Lawrence, T. B., & Suddaby, R. 2006. Institutions and institutional work. In S. R. Clegg, C. Hardy, T. B. Lawrence, & W. R. Nord (Eds.), ***Handbook of organization studies,*** 2nd edition: 215-254. London: Sage.

Leicht, K. T., & Fennell, M. L. 2008. Institutionalism and professions. In R. Greenwood, C. Oliver, K. Sahlin, & R. Suddaby (Eds.), ***The SAGE handbook of organizational institutionalism***: 449–472. London: Sage.

Lempert, R., & Monsma, K. 1994. Cultural-differences and discrimination: Samoans before a public-housing eviction board. ***American Sociological Review,*** 59(6): 890–910.

Leslie, K., Nelson, S., Deber, R., & Gilmour, J. 2018. Policy tensions in regulatory reform: Changes to regulation of health professions in Australia, the United Kingdom, and Ontario, Canada. ***Journal of Nursing Regulation,*** 8: 32–42.

Levine, E. E., & Schweitzer, M. E. 2015. The affective and interpersonal consequences of obesity. ***Organizational Behavior and Human Decision Processes,*** 127: 66–84.

Lin, N., & Xie, W. 1988. Occupational prestige in urban China. ***American Journal of Sociology,*** 93: 793–832.

Link, B. G., & Phelan, J. C. 2001. Conceptualizing stigma. ***Annual Review of Sociology,*** 27: 363–385.

Litrico, J.-B., & Besharov, M. L. 2019. Unpacking variation in hybrid organizational forms: Changing models of social enterprise among nonprofits, 2000–2013. ***Journal of Business Ethics,*** 159(2): 343-360.

Litrico, J.-B., & David, R. 2017. The evolution of issue interpretation within organizational fields: Actor positions, framing trajectories, and field settlement. ***Academy of Management***

Journal, 60(3): 986-1015

Loewenstein, J., Ocasio, W., & Jones, C. 2012. Vocabularies and vocabulary structure: A new approach linking categories, practices, and institutions. ***Academy of Management Annals***, *6*(1): 41-86.

Louis, M. R., & Bartunek, J. M. 1992. Insider/outsider research teams: Collaboration across diverse perspectives. ***Journal of Management Inquiry,*** 1: 101–110.

Lounsbury, M. & Glynn, M.A., 2019. ***Cultural entrepreneurship: A new agenda for the study of entrepreneurial processes and possibilities*.** Cambridge University Press.

Lounsbury, M. & Wang, M.S., 2020. Into the clearing: Back to the future of constitutive institutional analysis. *Organization Theory*, 1(1): 1-27.

Lounsbury, M., Anderson, D., & Spee, P. 2021. On practice and institution. ***Research in the Sociology of Organizations,*** 71: 1-18.

Lounsbury, M., Steele, C., Wang, M., & Toubiana, M. 2021. New directions in the study of institutional logics: From tools to phenomena. ***Annual Review of Sociology.***

Loyd, J.M., & Bonds, A. 2018.Where do Black lives matter? Race, stigma, and place in Milwaukee, Wisconsin. ***Sociological Review,*** 66(4): 898–918.

Lundahl, O. 2018. Dynamics of positive deviance in destigmatisation: Celebrities and the media in the rise of veganism. ***Consumption Markets & Culture.***

Lyons, B. J., Martinez, L. R., Ruggs, E.N., Hebl, M. R., Ryan, A. M., O'Brien, K. R., & Roebuck, A. 2018. To say or not to say: Different strategies of acknowledging a visible disability. ***Journal of Management,*** 44(5): 1980–2007.

Mair, J., Wolf, M., & Seelos, C. 2016. Scaffolding: A process of transforming patterns of inequality in small-scale societies. ***Academy of Management Journal,*** 59: 2021–2044

Makary, M.A., & Daniel, M., 2016. Medical error—the third leading cause of death in the US. ***BMJ,*** 353.

Malik, R. 1997. ***Chinese entrepreneurs in the economic development of China.*** Westport, Conn.: Praeger.

Marquis, C., & Qian, C. 2014. Corporate social responsibility reporting in China: Symbol or substance? ***Organization science,*** 25(1): 127-148.

Marriage, M. 2019. UK accounting watchdog to be replaced by stronger regulator. ***Financial Times,*** March 11, 2019.

Marshall, C., & Rossman, G. B. 1999. ***Designing qualitative research.*** London: Sage.

McDonnell, M.-H., & Werner, T. 2016. Blacklisted businesses: Social activists' challenges and the disruption of corporate political activity. ***Administrative Science Quarterly***, 61(4): 584–620.

McMurray, R., &Ward, J. 2014. "Why would you want to do that?": Defining emotional dirty work. ***Human Relations,*** 67(9): 1123–1143.

McMurray, R. 2011. The struggle to professionalize: An ethnographic account of the occupational position of Advanced Nurse Practitioners. ***Human Relations,*** 64(6): 801–822.

Meng, K., Meng, X., & Liu, J. 2001. Investigation and analysis of the "red packet" phenomenon in health institutes in Liaoning Province during 1999-2000. ***Chinese Hospital Management***, 21(9): 57.

Meyer, A., Brooks, G., & Goes, J. 1990. Environmental jolts and industry revolutions: Organizational responses to discontinuous change. ***Strategic Management Journal,*** 11, 93-110.

Meyer, R. E., & Vaara, E. 2020. Institutions and actorhood as co-constitutive and co-constructed: The argument and areas for future research. ***Journal of Management Studies***, 57(4): 898-910.

Micelotta, E., Lounsbury, M., & Greenwood, R. 2017. Pathways of institutional change: An integrative review and research agenda. ***Journal of Management,*** 43(6): 1885-1910.

Micelotta, E. R., & Washington, M. 2013. Institutions and maintenance: The repair work of Italian professions. ***Organization Studies,*** 34(8): 1137–1170.

Mikolon, S., Alavi, S., & Reynders, A. 2020. The Catch-22 of countering a moral occupational stigma in employee customer interactions. ***Academy of Management Journal.***

Milo, R. D. 1984. ***Immorality.*** Princeton: Princeton University Press.

Ministry of Health. 1992. ***A few opinions on deepening the health care reform.***

Ministry of Health. 1999. ***Research on national health services—an analysis report of the second national health services survey in 1998.***

Ministry of Health. 2004. ***Research on national health services—an analysis report of the third national health services survey in 2003.***

Ministry of Health. 2005. ***Developing the medical and health enterprise, and constructing a socialist harmonious society.***

Ministry of Health. 2007. ***Measures for the management of physicians' regular assessment.***

Ministry of Health. 2009. ***Opinions on the deepening the health care reform.***

Mishina, Y., & Devers, C. E. 2012. On being bad: Why stigma is not the same as a bad reputation.

Mitchell, R. K., Agle, B. R., & Wood, D. J. 1997. Toward a theory of stakeholder identification and salience: Defining the principle of who and what really counts. ***Academy of Management Review,*** 22(4): 853–886.

Montauti, M., & Wezel, F. C. 2016. Charting the territory: Recombination as a source of uncertainty for potential entrants. ***Organization Science,*** 27(4): 954-971.

Montgomery, A. W., & Dacin, M. T. 2019. Water Wars in Detroit: Custodianship and the Work of Institutional Renewal. ***Academy of Management Journal,*** doi.org/10.5465/amj.2017.1098.

Moon, D. 2012. Who am I and who are we? Conflicting narratives of collective selfhood in stigmatized groups. ***American Journal of Sociology,*** 117(5): 1336–1379.

Murphy, D. L., Shrieves, R. E., & Tibbs, S. L. 2009. Understanding the penalties associated with corporate misconduct: An empirical examination of earnings and risk. ***Journal of Financial and Quantitative Analysis,*** 44(1): 55–83.

Muzio, D., Aulakh, S., & Kirkpatrick, I. 2019. ***Professional occupations and organizations.*** Cambridge University Press.

National Research Center. 2005. ***Evaluation and suggestions on China's health system reform.***

Naughton, B. 1995. ***Growing out of the plan: Chinese economic reform, 1978–1993.*** Cambridge: Cambridge University Press.

Nee, V. 1989. A theory of market transition: From redistribution to markets in state socialism. ***American Sociological Review,*** 54: 663–681.

Nee, V., & Opper, S. 2012. ***Capitalism from below: Markets and institutional change in China.*** Cambridge: Harvard University Press.

Oi, J. C. 1999. ***Rural China takes off: Institutional foundations of economic reform.*** University of California Press.

Obrador, A. M. L., & Uhlmann, N. 2018. ***A new hope for Mexico: Saying no to corruption, violence and Trump's wall.*** OR Books.

Pache, A.-C., & Santos, F. 2013. Inside the hybrid organization: Selective coupling as a response

to competing institutional logics. ***Academy of Management Journal,*** 56(4): 972-1001.

Paetzold, R. L., Dipboye, R. L., & Elsbach, K. D. 2008. A new look at stigmatization in and of organizations. ***Academy of Management Review,*** 33: 186–193.

Palmer, D. 2008. Extending the process model of collective corruption. ***Research in Organizational Behavior*,** 28: 107-135.

Palmer, D. 2017. Institutions, institutional theory and organizational wrongdoing. In R. Greenwood, C. Oliver, T. B. Lawrence, & R. E. Meyer (Eds.), ***The SAGE handbook of organizational institutionalism*,** 2nd edition: 737–758. London: Sage.

Palmer, D., & Feldman, V. 2018. ***Comprehending the incomprehensible: Organization theory and child sex abuse in organizations.*** Cambridge: Cambridge University Press.

Palmer, D., Smith-Crowe, K., & Greenwood, R. (Eds.). 2016. ***Organizational wrongdoing.*** Cambridge: Cambridge University Press.

Parris, K. 1993. Local initiative and national reform: The Wenzhou model of development. ***China Quarterly,*** 134: 242–263.

Parry, J. 2013. Head of GSK in china is replaced as details of fraud scandal emerge. ***BMJ*,** 347: f4791.

Patton, M. Q. 2002. ***Qualitative research & evaluation methods,*** 3rd edition. Sage Publications.

Pescosolido, B. A., & Martin, J. K. 2015. The stigma complex. ***Annual Review of Sociology,*** 41: 87–116.

Phillips, N., Lawrence, T. B., & Hardy, C. 2004. Discourse and institutions. ***Academy of Management Review,*** 29: 635–652.

Phillips, D. J., & Zuckerman, E. W. 2001. Middle-status conformity: Theoretical restatement and empirical demonstration in two markets. ***American Journal of Sociology*,** 107(2): 379-429.

Phung, K., Buchanan, S., Toubiana, M., Ruebottom, T., & Turchick-Hakak, L. 2020. When stigma doesn’t transfer: Stigma deflection and occupational stratification in the sharing economy. ***Journal of Management Studies.***

Piazza, A., & Jourdan, J. 2018. When the dust settles: The consequences of scandals for organizational competition. ***Academy of Management Journal,*** 61(1):165–190.

Piazza, A., & Perretti, F. 2015. Categorical stigma and firm disengagement: Nuclear power generation in the United States, 1970–2000. ***Organization Science,*** 26: 724–742.

Plowman, D. A., Baker, L. T., Beck, T. E., Kulkarni, M., Solansky, S. T., & Travis, D. V. 2007.

Radical change accidentally: The emergence and amplification of small change. ***Academy of Management Journal***, 50(3): 515-543.

Pollock, T.G., Lashley, K., Rindova, V.P., & Jung-Hoon, H. 2019. Which of these things are not like the others? Comparing the rational, emotional, and moral aspects of reputation, status, celebrity, and stigma. ***Academy of Management Annals,*** 13: 444–478.

Pontikes, E., Negro, G., & Rao, H. 2010. Stained red: A study of stigma by association to blacklisted artists during the "red scare" in Hollywood, 1945 to 1960. ***American Sociological Review,*** 75: 456–478.

Pratt, M. 2000. The good, the bad, and the ambivalent: Managing identification among Amway distributors. ***Administrative Science Quarterly,*** 45: 456–493.

Quattrone, P. 2015. Governing social orders, unfolding rationality, and Jesuit accounting practices: A procedural approach to institutional logics. ***Administrative Science Quarterly,*** 60(3): 411-445.

Ragins, B. R. 2008. Disclosure disconnects: Antecedents and consequences of disclosing invisible stigmas across life domains. ***Academy of Management Review,*** 33(1): 194–215.

Ramirez, C. 2013. "We are being pilloried for something, we did not even know we had done wrong": Quality control and orders of worth in the British audit profession. ***Journal of Management Studies,*** 50: 845–869.

Raynard, M., Kodeih, F., & Greenwood, R., 2019. Proudly elitist and undemocratic? The distributed maintenance of contested practices. ***Organization Studies.***

Raynard, M., Lounsbury, M., & Greenwood, R. 2013. Legacies of logics: Sources of community variation in CSR implementation in China. ***Research in the Sociology of Organizations,*** 243-276.

Raynard, M., Lu, F., & Jing, R. 2020. Reinventing the state-owned enterprise? Negotiating change during profound environmental upheaval. ***Academy of Management Journal,*** 63: 1–36.

Reay, T., Golden-Biddle, K., & Germann, K. 2006. Legitimizing a new role: Small wins and microprocesses of change. ***Academy of Management Journal,*** 49(5): 977-998.

Rhee, M., & Haunschild, P. R. 2006. The liability of good reputation: A study of product recalls in the U.S. Automobile industry. ***Organization Science***, 17: 101-117.

Rivera, L. A. 2008. Managing "spoiled" national identity: War, tourism, and memory in Croatia.

American Sociological Review, 73(4): 613-634.

Rojas, F. 2017. Race and institutionalism. In R. Greenwood, C. Oliver, T. B. Lawrence & R. Meyer (Eds.), ***The Sage handbook of organizational institutionalism,*** 2nd ed. (pp. 786-807). London: Sage.

Róna-Tas, Á. 1997. ***The great surprise of the small transformation: The demise of communism and the rise of the private sector in Hungary.*** University of Michigan Press.

Roulet, T. 2015. "What good is Wall Street?" institutional contradiction and the diffusion of the stigma over the finance industry. ***Journal of Business Ethics,*** 130: 389–402.

Roulet, T. 2019. Sins for some, virtues for others: Media coverage of investment banks' misconduct and adherence to professional norms during the financial crisis. ***Human Relations,*** 72: 1436–1463.

Roulet, T. 2020. ***The power of being divisive: Understanding negative social evaluations.*** Stanford, CA: Stanford University Press.

Ruebottom, T., Buchanan, S., Voronov, M., & Toubiana, M. 2020. Commercializing the practice of voyeurism: How organizations leverage authenticity and transgression to create value. ***Academy of Management Review.***

Ruebottom, T., & Toubiana, M. 2017. Biographical opportunities: How entrepreneurship creates pride in alterity in stigmatized fields. ***Academy of Management Proceedings,*** 2017: 12168.

Saeidi, S. P., Sofian, S., Saeidi, P., Saeidi, S. P., & Saaeidi, S. A. 2015. How does corporate social responsibility contribute to firm financial performance? The mediating role of competitive advantage, reputation, and customer satisfaction. ***Journal of Business Research,*** 68(2): 341–350.

Sauder, M. 2008. Interlopers and field change: The entry of U.S. News into the field of legal education. ***Administrative Science Quarterly,*** 53(2): 209–234.

Scott, J., 1998. ***Seeing like a state: How certain schemes to improve the human condition have failed***. London: Yale University Press.

Scott, W. R. 2014. ***Institutions and organizations: Ideas, interests, and identities,*** *4th edition.* Thousand Oaks, CA: SAGE.

Scott, W. R., Ruef, M., Mendel, P. J., & Caronna, C. A. 2000. ***Institutional change and healthcare organizations: From professional dominance to managed care.*** Chicago: University of Chicago Press.

Semadeni, M., Cannella, A. A., Jr., Fraser, D. R., & Lee, D. S. 2008. Fight or flight: Managing stigma in executive careers. ***Strategic Management Journal,*** 29(5): 557–567.

Semper, D. 2019. Agents, actors, actorhood: Institutional perspectives on the nature of agency, action, and authority. ***Research in the Sociology of Organizations,*** 58: 187–208.

Sewell, W. H. 1996. Historical events as transformations of structures: Inventing revolution at the Bastille. ***Theory and Society,*** 25(6): 841-881.

Shapiro, J. R., King, E. B., & Quinones, M. A. 2007. Expectations of obese trainees: How stigmatized trainee characteristics influence training effectiveness. ***Journal of Applied Psychology,*** 92(1): 239–249.

Sharkey, A. J. 2014. Categories and organizational status: The role of industry status in the response to organizational deviance. ***American Journal of Sociology***, 119(5): 1380-1433.

Sidel, V. W., & Sidel, R. 1973. ***Serve the people: Observations on medicine in the People's Republic of China.*** Boston, MA: Beacon Press.

Siltaoja, M., Lähdesmaki, M., Granqvist, N., Kurki, S., Puska, P., & Luomala, H. 2020. The dynamics of (de) stigmatization: Boundary construction in the nascent category of organic farming. ***Organization Studies,*** 41(7): 993-1018.

Smart, A., & Hsu, C. L. 2007. Corruption or social capital? Tact and the performance of guanxi in market socialist China. ***Corruption and the secret of law: A legal anthropological perspective***, 167-190.

Smets, M., Aristidou, A., & Whittington, R. 2017. Towards a practice-driven institutionalism. In R. Greenwood, C. Oliver, T. B. Lawrence, & R. Meyer (Eds.), ***The sage handbook of organizational institutionalism, 2nd ed.***: 384-411. London: Sage.

Smets, M., Jarzabkowski, P., Burke, G. T., & Spee, P. 2015. Reinsurance trading in Lloyd's of London: Balancing conflicting-yet-complementary logics in practice. ***Academy of Management Journal,*** 58: 932–970.

Smets, M., Morris, T., & Greenwood, R. 2012. From practice to field: A multilevel model of practice-driven institutional change. ***Academy of Management Journal,*** 55: 877–904.

Smith, J. 2004. ***The shipman inquiry fifth report.*** London: Stationery Office.

Smith, B. G. 2012. Public relations identity and the stakeholder–organization relationship: A revised theoretical position for public relations scholarship. ***Public Relations Review,*** 38(5): 838–845.

Solinger, Dorothy J. 1984. ***Chinese business under socialism: The politics of domestic commerce in contemporary China.*** Berkeley: University of California Press.

Stark, D. 1996. Recombinant property in East European capitalism. ***American Journal of Sociology,*** 101(4): 993-1027.

State Council. 1989. ***Opinions on issues regarding the expansion of health services.***

State Council. 2009. ***Opinions on deepening the reform of the medical and health care system.***

Stewart, M. M., & Shapiro, D. L. 2000. Selection based on merit versus demography: Implications across race and gender lines. ***Journal of Applied Psychology,*** 85(2): 219–231.

Stoate, H., & Jones, B. 2006. ***Challenging the Citadel: Breaking the hospitals' grip on the NHS.*** Fabian Society.

Su, X. 2016. ***Bai nian jingji shi biji.*** Beijing: People's Oriental Publishing & Media Co., Ltd.

Sun, Q., Santoro, M. A., Meng, Q., Liu, C., & Eggleston, K. 2008. Pharmaceutical policy in China. ***Health Affairs,*** 27: 1042–1050.

Supreme People's Court. 2014. ***Opinions of punishing illegal acts and crimes against medical professionals in accordance with law and maintaining the normal medical order.***

Sutton, R. I., & Callahan, A. L. 1987. The stigma of bankruptcy: Spoiled organizational image and its management. ***Academy of Management Journal,*** 30(3): 405–436.

Swan, J. A., & Newell, S. 1995. The role of professional associations in technology diffusion. ***Organization studies,*** 16(5), 847–874.

The Economist. 2019. Italy's banks: The reckoning continues. ***The Economist,*** November 16, 2019.

Thornton, P. H., Ocasio, W., & Lounsbury, M. 2012. ***The institutional logics perspective: A new approach to culture, structure and process***. Oxford, UK: Oxford University Press.

Tierney, S. 2007. ***Multiculturalism and the Canadian constitution attribution.*** Vancouver: University of British Columbia Press.

Tilcsik, A., Anteby, M., & Knight, C. R. 2015. Concealable stigma and occupational segregation: Toward a theory of gay and lesbian occupations. ***Administrative Science Quarterly,*** 60(3): 446–481.

Torsello, D., & Venard, B. 2016. The anthropology of corruption. ***Journal of Management Inquiry,*** 25(1): 34-54.

Tracey, P.,& Phillips, N. 2016.Managing the consequences of organizational stigmatization:

Identity work in a social enterprise. ***Academy of Management Journal,*** 59(3): 740–765.

Tracey, P., Dalpiaz, E., & Phillips, N. 2018. Fish out of water: Translation, legitimation, and new venture creation. ***Academy of Management Journal.***

Transparency International. 2019. ***The ignored pandemic: How corruption in healthcare service delivery threatens Universal Health Coverage.***

Treviño, L. K., & Weaver, G. R. 2003. ***Managing ethics in business organizations: Social scientific perspective.*** Stanford: Stanford University Press.

Tsai, K. S. 2007. ***Capitalism without democracy: The private sector in contemporary China.*** New York: Cornell University Press.

United Nations Office on Drugs and Crime. 2018. ***UNODC statistics online.*** https://dataunodc.un.org/crime/intentional-homicide-victims.

Vakili, K., McGahan, A. M., Rezaie, R., Mitchell, W., & Daar, A. S. 2015. Progress in human embryonic stem cell research in the United States between 2001 and 2010. ***PLoS One,*** 10(3):

Van Maanen, J. 1979. The fact of fiction in organizational ethnography. ***Administrative Science Quarterly,*** 24: 539–550.

Vasavakul, T. 2019. ***Vietnam: A pathway from state socialism.*** Cambridge, UK: Cambridge University Press.

Vergne, J. P. 2012. Stigmatized categories and public disapproval of organizations: A mixed-methods study of the global arms industry, 1996–2007. ***Academy of Management Journal,*** 55: 1027–1052.

Visvanhatan, S. 2008. ***The necessity of corruption.*** Retrieved from http://www.india-seminar.com/2008/590/ 590_shiv_visvana-than.htm

Vogel, E. F. 2011. ***Deng Xiaoping and the transformation of China.*** Cambridge: Harvard University Press.

Voss, G. 2015. ***Stigma and the shaping of the pornography industry.*** Routledge.

Vough, H. C., Cardador, M. T., Bednar, J. S., Dane, E., & Pratt, M. G. 2013. What clients don't get about my profession: A model of perceived role-based image discrepancies. ***Academy of Management Journal,*** 56: 1050–1080.

Walder, A. G. 1995. Local governments as industrial firms: An organizational analysis of China's transitional economy. ***American Journal of Sociology,*** 101(2): 263-301.

Walder, A. G. 2017. ***China under Mao: A revolution derailed.*** Cambridge: Harvard University

Press.

Wang, C., Cao, Y., Zheng, X., Gao, S., Jia, X., & Cheng, Y. 2014. Awareness and attitude on hospital violence in view of hospital and patient. ***Chinese Hospitals,*** 18(3): 7-9

Wang, M. S., Raynard, M., & Greenwood, R. 2020. From grace to violence: Stigmatizing the medical profession in China. ***Academy of Management Journal.***

Wang, M. S., Steele, C. W. J., & Greenwood, R. 2019. Mentalités and events: Historicizing institutional logics. ***Academy of Management Review***, 44(2): 473-476.

Weaver, G. R., Treviño, L. K., & Cochran, P. L. 1999. Integrated and decoupled corporate social performance: Management commitments, external pressures, and corporate ethics practices. ***Academy of Management Journal,*** 42(5): 539–552.

Whiting, S. 1995. ***The micro-foundations of institutional change in reform China: Property rights and revenue extraction in the rural industrial sector.*** Ph.D. dissertation, University of Michigan.

Wiesenfeld, B. M., Wurthmann, K. A., & Hambrick, D. C. 2008. The stigmatization and devaluation of elites associated with corporate failures: A process model. ***Academy of Management Review,*** 33: 231–251.

Winter, E. 2014. Multiculturalism in the 1990s: The smallest common denominator in defining Canadian national identity. In J. Jedwab (Ed.), ***The multicultural question: Debating identity in 21st century Canada***: 53–72. Montreal, Canada: McGill-Queen's University Press.

Wolfe, A. W., & Blithe, S. J. 2015. Managing image in a core-stigmatized organization: Concealment and revelation in Nevada's legal brothels. ***Management Communication Quarterly,*** 29(4): 539–563.

World Health Organization. 2002a. ***World report on violence and health.*** E.G. Krug et al. (Eds.). Geneva.

World Health Organization. 2002b. ***New Research shows workplace violence threatens health services***.

World Health Organization. 2017. ***World health statistics: Monitoring health for the SDGs.***

World Health Organization. 2018. ***Public spending on health: A closer look at global trends.***

World Medical Association. 2015. ***Growing violence against doctors alarms medical profession.***

Wry, T., Cobb, J. A., & Aldrich, H. E. 2013. More than a metaphor: Assessing the historical

legacy of resource dependence and its contemporary promise as a theory of environmental complexity. ***Academy of Management Annals,*** 7(1): 441-488.

Wu, G. 2015. ***China's Party Congress: Power, legitimacy, and institutional manipulation.*** Cambridge: Cambridge University Press.

Wu, D., Wang, Y., Lam, K. F., & Hesketh, T. 2014. Health system reforms, violence against doctors and job satisfaction in the medical profession: A cross-sectional survey in Zhejiang Province, Eastern China. ***BMJ Open,*** 4: 1–10.

Yao, Z. 2016. The changing relationship between the Chinese urban medical profession and the state since the republican period: The perspective of the sociology of professions. ***The Journal of Chinese Sociology,*** 3(1): 1–17.

Yao, Z. 2017. Right-protection by violence in healthcare service and its governance: Based on content analysis of news reports from 2002 to 2015. ***Social Construction,*** 14: 49–63.

Young, S. 1995. ***Private business and economic reform in China.*** Armonk, N.Y.: M. E. Sharpe.

Zhang, N., & Zhao, J. 2014. Statistical analysis of medical dispute cases based on related literatures from 2009 to 2013. ***Medicine and Society,*** 27(6): 55–58.

Zhang, W., & Grouse, L. 2013. Physician bribes in the US and china. ***Journal of Thoracic Disease,*** 5(5): 711-715.

Zhang, J., & Luo, X. R. 2013. Dared to care: Organizational vulnerability, institutional logics, and MNCs' social responsiveness in emerging markets. ***Organization Science,*** 24(6): 1742-1764.

Zhang, R., Wang, M. S., Toubiana, M., & Greenwood, R. 2021. Stigma beyond levels: Advancing research on stigmatization. ***Academy of Management Annals,*** 15(1): 188-222.

Zhao, P. 2016. ***Physicians' self-empowerment and physician-patient communication in the perspective of new media.*** PhD dissertation. Beijing: Tsinghua University.

Zhou, H., & Zhang, J. 2004. A social historical analysis of "red packaging" in medical services in China. ***Chinese Journal of Population Studies,*** 2004(1): 23-31.

Zhu, D. H., & Westphal, J. D. 2020. Structural power, corporate strategy, and performance. ***Strategic Management Journal.***

Zhu, H. 2007. Abuses in the health care system and distortions in pharmaceutical pricing. ***Social Sciences in China,*** (4): 89–103.

Zhu, W., Wang, L., & Yang, C. 2018. Corruption or professional dignity: An ethical examination

of the phenomenon of “red envelopes” (monetary gifts) in medical practice in china. ***Developing World Bioethics***, 18(1): 37-44.

Zietsma, C., Groenewegen, P., Logue, D. M., Hinings, C. R. 2017. Field or fields? Building the scaffolding for cumulation of research on institutional fields. ***Academy of Management Annals,*** 11(1): 391–450.

Zilber, T. B. 2002. Institutionalization as an interplay between actions, meanings, and actors: The case of a rape crisis center in Israel. ***Academy of Management Journal,*** 45(1): 234–254.

Zuckerman, E. W. 1999. The categorical imperative: Securities analysts and the illegitimacy discount. ***American Journal of Sociology,*** 104: 1398–1438.