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Rance P. L. Lee

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THE STRATIFICATION BETWEEN MODERN AND TRADITIONAL PROFESSIONS: A STUDY OF HEALTH SERVICES IN HONG KONG

By

Rance P.L. LEE

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The Stratification Between Modern & Traditional Professions: A Study of the Health Services in Hong Kong*

The process of modernization has been so pervasive in recent centuries that it can be taken as part of the universal experience. Societies in the course of modernization are characteristically changing at an accelerating rate from a technologically simple, structurally less differentiated, and sacred or traditional oriented pattern of social action toward a technologically complex, structurally more differentiated, and secular or utility-rational oriented pattern. Many nations in the West have been undergoing this complex process of "total mobilization" for several centuries. Because of the impressive social-economic and political successes of these Western nations, most countries in Africa, Asia and Latin America have also begun to struggle for modernity in recent decades. For most of these "new comers", modernization in effect means Westernization.

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It is the process of importing the technological, social-organizational, and ideological systems from advanced Western nations. The introduction of foreign products, however, cannot displace the existing indigenous elements within a relatively short period of time. The consequence is the coexistence of two sociocultural systems in a modernizing society; they are the traditional and the modern sectors.

In the modern sector, we usually find an increasingly large number of professional roles whose occupants have received "a prolonged specialized training in a body of abstract knowledge" and have developed "a collectivity or service orientation".[1] There are, for instance, physicians, nurses, social workers, lawyers, scientists, professors, and engineers. Although professionals are increasingly numerous and important in the modern sector, their counter-parts (such as the medical healers and religious "specialists") have existed in the premodern or traditional sector for a long time before the modern sector was imported. The specialized occupational roles in traditional sector may not be as professionalized as those in the modern sector, but to a significant extent their occupants also possess the two core elements of a profession, i.e., the prolonged specialized training in a body of abstract knowledge and the collectivity orientation. We may hence postulate that in a modernizing society, there <u>coexist</u> two distinct and specialized occupational roles, one in the traditional sector and another in the modern sector,

which claim to have a legitimate right to perform similar functions for the society. The coexistence of these two professions represent alternative response to particular social needs.

Although the traditional and the modern professions coexist, they tend to obtain different amount of social, political, and economic resources from the society. There emerges a stratificational order between the two professions. In the very early stage of modernization, the traditional profession may remain to occupy a higher stratificational position. The process of modernization, however, leads to a reversal of the stratificational ranking between the two professions. Compared with the traditional profession, the modern profession commands a higher prestige in the social order, greater power in the political realm, and more wealth in the economic order.

The stratificational ranking of modern profession is higher than that of traditional profession, because it is able to acquire a greater support from salient segments of the society. Its specialized knowledge is legitimized by the dominant social values and the academic authority in the modernizing society, and its members are delegated by the political authority to have a greater, or the sole,responsibility to provide and to control over the services.[2]

The traditional profession is not entirely passive. In order to struggle for survival and to compete for more social-economic and political resources, the traditional profession may strive for a rationalistic revivalism, i.e., to promote its stratificational ranking by rationalizing (in Weber's sense) its technical knowledge and social organization.[3]

The major objective of this paper is to elaborate and illustrate the above general statements concerning the dynamic process of interaction between the traditional and the modern professional groups in a modernizing society by analyzing the structure and functioning of the health services systems in Hong Kong. I shall begin with a brief description of some features of Hong Kong as a modernizing society, and then discuss (1) the extent to which the traditional and the modern medical professions are coexisting, (2) the stratificational order between the two medical professions, (3) the differential social support to the two professions, and (4) the revival of traditional medicine.

HONG KONG: A MODERNIZING SOCIETY

Hong Kong is situated in the southern coast of Mainland China. It became a Colony under the British Crown in January 1843. Presently it has a total area of about 1,045 square kilometers. Ever since the mainland was taken over by the Communist regime in 1949, Hong Kong has been undergoing rapid demographic, social, and economic transformations.[4]

Because of the great influx of refugees from China, the population has grown from an estimated size of 600,000 in 1945 to 3.95 million in 1971, an increase of nearly seven fold over one quarter of a century. A very great majority of the local residents are Chinese. According to the census in March, 1971, about 98.3 per cent of the total population can be classified as Chinese in place of origin.

Concommitant to population growth is the rapid modernization of technological and institutional systems. Let me list a few indicators. The proportion of working population engaged in manufacturing has increased from less than 10 per cent in 1948 to about 50 per cent in 1972. Over the last five years, the electricity consumption has risen from 3,449 to 5,412 million Kilowatt-hours, and the gas consumption from 7,252 to 10,759 thousand Therms. It was estimated that the per capita income rose from HK$1,738 in 1960 to HK$3,506 in 1968. In the communication system, the number of private motor cars increased from 9,764 in 1951 to 120,725 in 1972, while the number of telephones rose from 20,426 in 1947 to 353,912 in 1967. The Government expenditure on social security and welfare services was HK$32,320 thousand in 1967/68 and HK$74,140 thousand in 1971/72. With regard to educational standards, the proportion of population with no schooling was reduced from 24.4 per cent in 1966 to 17.2 per cent in 1971.

The realm of medical and health services has also been modernized. Over the last several decades, there have been downward trends in the incidence of various kinds of infectious diseases including, for instance, typhoid, bacillary dysentery, tuberculosis, chickenpox, diptheria, and whooping cough. Infectious diseases have been replaced by chronic illnesses, such as malignant neoplasms and heart diseases, as major causes of death. Infant and maternal mortality rates have also been substantially reduced.[5] These changes in disease-patterns might be partly due to social and economic progress. However, the contribution of the advancement in medical technology cannot be overstated. A striking phemonenon in the modernizing society of Hong Kong is the increasing utilization and expansion of the medical science and technology developed in advanced Western nations. The Government expenditure on the medical and health services increased from 15 million Hong Kong dollars (about 6.2 per cent of the total expenditure) in 1951 to 304 million dollars (about 10.5 per cent of the total expenditure) in 1972.[6]

PROFESSIONAL COEXISTENCE

There exist a wide spectrum of Chinese and Western medical and health services in Hong Kong. In the Western medical sector, for instance, there are general and psychiatric hospitals, out-patient clinics for general and specialty services,

maternity and child health care, nursing homes, immunization services, medical laboratories, and rehabilitation centres. There are also different kinds of personnel in the Western medical system, such as medical practitioners of various specialties, dentists, pharmacists, midwives, general and psychiatric nurses, medical social workers, etc. In this paper I shall focus on the profession of Western-trained doctors, which has been the most dominant profession in the realm of Western medical services.

Chinese medical services can be classified into three types: (1) the classical or great tradition of medicine, which is based on the cosmological conception of Yin-Yang and Five Elements and has been developed and accumulated for over three thousand years; (2) the folk remedies or small traditions of medicine, which are shared and practised by the indigenous populations in various localities of China;[7] and (3) the religious-medical practices, which is based on the belief in supernatural determination of illness and in the application of magical procedures to the treatment of diseases.[8]

The classical tradition of Chinese medicine emerged in China about 800 B.C. and had increasingly dominated the entire sector of medical and health care. It was well-documented by medical scholars and supported by governing regimes throughout the history of China. The Classic of Internal Medicine (Nei

Ching 內經), Treatise of Fevers (Shang-han Lun 傷寒論), General Compendium of Materia Medica (Pen-Ts'ao Kang-mu 本草綱目), and The Pulse Classic (Mo-Ching 脉經) represent some of the major literature in classical medicine. Each of these documents is typically consisted of an abstract theoretical framework and a detailed classification of diseases and medicaments.[9] The classical tradition is not formulated through the use of scientific procedures, but it is based on the naturalistic and rationalistic principles.[10] It is a product of conceptualization (primarily in terms of Yin-Yang and Five Elements) and empirical observations for several thousand years.

Practitioners in the classical tradition of medicine have played the most distinctive role in the history of Chinese medical care. They strongly claimed to be service-oriented. A central ethic of this specialized occupational group is to care for people. Moreover, in order to become practitioners, they normally have to spend several years, usually through apprenticeship, in studying the literature and learning clinical experience. These practitioners, therefore, possess at least two core attributes of a profession; namely, the collectivity orientation and the prolonged specialized training in a body of abstract knowledge. They commanded the most legitimate right to practise medicine, and gained a great deal of support from political authorities in traditional China. The profession of Chinese medicine, i.e., the practitioners in classical medicine, has been the most

dominant type of medical healers in the realm of Chinese medical care. In the following pages I shall focus on this dominant profession of classical medical practitioners in Chinese medical system, and compare it with the dominant profession of Western-trained doctors in the system of Western medical care.

Within the profession of Chinese medicine in Hong Kong, there are three special types: (1) herbalists, specializing in the use of herbs for internal medical care, (2) acupuncturists, treating illness by inserting needles into certain points of the body, and (3) bone-setters, specializing in the treatment of sprains and contusion. According to the survey in 1969 by the Hong Kong Medical Association in cooperation with the Government's Census and Statistics Department, there were then 4,506 Chinese practitioners of various kinds. The Chinese medical practitioners to population ratio was about 1 to 1,161. It was estimated that in the same year there were a total of 2,317 Western-trained doctors.[11] The ratio of Western-trained doctors to the total population was about 1 to 1,720. There were thus considerably more Chinese than Western-trained medical practitioners in Hong Kong. A great majority of the Chinese practitioners are herbalists (about 70%), followed by bone-setters (about 20%) and acupuncturists (about 10%).

The above statistics indicate that both the profession of Western medicine (i.e., Western-trained doctors) and the profession of Chinese medicine (i.e., the practitioners in the

classical tradition of Chinese medicine) coexist in the modernizing society of Hong Kong. Instead of coexisting in a coordinated fashion, however, these two systems of professional services are competitive on an unequal basis.

PROFESSIONAL INEQUALITY

Although the role of Government in the provision and subvention of medical and health care services has been increasingly important, the center of gravity of medical care in Hong Kong remains in private practice. Unlike Britain, there is no national health scheme in Hong Kong, though the Government has been financing a comprehensive School Medical Service to a small fraction of the student population.[12] The Government employs about one-fourth of all the Western-trained doctors,[13] and none of the Chinese medical practitioners. In other words, all the Chinese medical practitioners and three-fourth of the Western-trained doctors are in private practice. Furthermore, there are slightly over ten thousand general beds in Hong Kong, of which over 60 per cent are provided by non-Governmental hospitals.[14] The medical and health sector in Hong Kong can thus be characterized as pluralistic and entrepreneurial. The emphasis of the entire sector is on "individual, fee-for-service" mode of compensation and "free choice" of medical practitioners.

In such a pluralistic health context, Western-trained physicians are relatively more dominating than are Chinese medical practitioners. Although both professions claim to perform the same functions (i.e., the maintenance of health and the treatment of diseases) for the society, there exists a stratificational order between them. The profession of Western medicine is superior to that of Chinese medicine in respect to the three major dimensions of social stratification: power, prestige, and wealth.

(1) Power. The profession of Western medicine has obtained a greater power to control not only over the social organization of medical care in Hong Kong but also over the technical content of medical work.[15] The dual systems of medical care in Hong Kong can be characterized as "Western medical dominance."

The Medical Council of Hong Kong, established by the Government, plays the most crucial role in the legitimization and supervision of medical practice. The Council, chaired by the Director of Government's Department of Medical and Health Services, consists of representatives from the armed forces, Government health services, University medical school and two major medical professional associations in Hong Kong.[16] All the Council members, however, have to be qualified Western-trained doctors.

The Council has been granted by the Government a mandate to register medical practitioners, and to regulate their medical practices through the setting of minimum and uniform standards. Only those Western-trained doctors holding a diploma granted by the Hong Kong University or any other diploma which is recognized by the General Medical Council of the United Kingdom are registrable with the Council, and are then recognized by law as qualified medical doctors. Chinese medical practitioners are hence excluded from the Council, and their services are thus not recognized by the legal authority as duly qualified. They are deprived of certain privileges which are granted to the registered Western-trained doctors. For instance, Chinese practitioners are not permitted to issue death certificates.

With expert authority granted by the Government in the realm of health and medicine, the profession of Western medicine has the greatest influence on the social organization of medical care in the Colony as a whole. In the formulation of major policies dealing with medicine and health, the Government normally consults with representatives from two major medical professional associations; they are the Hong Kong Medical Association and the Hong Kong Branch of the British Medical Association. Both associations are oriented to Western medicine. The Government rarely seeks any advice from Chinese practitioners. Furthermore, there is no Chinese practitioner working in Government's Department of Medical and Health Services. All doctors in public

service were trained in Western medicine. It is thus not surprising to see that though the Government has provided and subvented an increasing volume of different kinds of medical and health programs, none of them is involved with Chinese medicine. With regard to the future development of health care services, the Governor, in early 1973, appointed a Medical Development Advisory Committee to make recommendations appropriate over the next ten years. Four of the eleven Committee members are Western-trained doctors, but none is a Chinese medical practitioner. The plans recommended by the Committee are primarily concerned with the provision of hospital beds and the increased supply of doctors and nurses in Western medicine.[17] There is no discussion about the development of Chinese medicine. Apparently the social organization of medical care in Hong Kong has been under the influence of the Western profession, rather than the Chinese medical practitioners.

The profession of Western medicine controls not only the social organization of medical care in Hong Kong, but also its own technical content of work. It has a greater degree of technical autonomy than the profession of Chinese medicine. As suggested by the previous discussion concerning the structure and functioning of the Medical Council of Hong Kong, the profession has acquired an officially approved monopoly of the right to determine how and by whom the work of healing should be done and evaluated. Members of the profession are free to

practise with very few formal constraints which are not made by their own professional colleagues. Relative to the profession of Western medicine, Chinese medical practitioners have a lower degree of technical autonomy. Their practices are constrained by the legal authority in many ways. For example, Chinese medical practitioners are not permitted to practise surgery, to undertake the treatment of eye-diseases, to possess antibiotics and dangerous drugs, or to make use of certain Western medical equipments such as X-ray and innoculation.

In addition to the above-mentioned technical constraints imposed by "outsiders", the profession of Chinese medicine is also prohibited by law from using any name or title which may induce anyone to believe that he is qualified to practise according to modern scientific method. These legal constraints serve to prevent traditional practitioners from misusing Western techniques, but also serve to protect the economic interest and medical dominance of the Western medical profession.

In sum, the profession of Western medicine and that of Chinese medicine in the modernizing society of Hong Kong are stratified in the dimension of political power. The profession of Western medicine has obtained a greater degree of control over the social organization of health care services and the technical content of medical work.

(2) Prestige. Status honors are not evenly distributed between the two professions. The profession of Chinese medicine carries a high prestige in traditional China, but its prestige has been declining in the modernizing society of Hong Kong. It is the profession of Western medicine, rather than that of Chinese medicine, which is greatly respected and honored by the local population. The uneven distribution of status honors can be reflected by the ways in which the technical competency of the two professions are evaluated and by the extent to which services of the two professions are utilized. To shed light on these points, let me use part of the empirical data I gathered in 1971-72 about medical organizations and health behavior in the district of Kwun Tong, Hong Kong.

The district of Kwun Tong is located on the east coast of Kowloon peninsula of Hong Kong, covering about 32 aeres. 13 square kilometers. Over the last two decades, it has developed into one of the largest industrial and residential satellite town in Hong Kong. There are currently about two thousand industrial undertakings, and about half a million Chinese residents in the community. Most people are residing in public housings of various kinds. About 14 per cent are living in private apartments and tenement buildings. Residents are therefore largely in middle or lower income groups.[18] Kwun Tong is by no means a self-contained community. As a colleague of mine has empirically demonstrated, the social, economic and political life in the community is to

a large extent connected with, and thus in many ways similar to, the Hong Kong society as a whole.[19]

I undertook three health surveys in Kwun Tong in 1971-72. The first one was a complete enumeration of the medical and health care units in various subdistricts of Kwun Tong. The second survey focused on the organizational structures of all the Western general out-patient clinics as well as the Chinese herbalist services.[20] Health-related attitudes of their medical practitioners were also assessed. In the third survey, I studied a random sample of 702 household heads for the purpose of understanding their health concepts and utilization. The data collected in these three surveys will be used in the following discussions.[21] Since, as mentioned, Kwun Tong is an integral part of, rather than separated from, the larger society, the survey findings, I believe, can be reasonably generalizable to the Colony as a whole.

There were a total of 174 Chinese and 101 Western health care units in the entire district of Kwun Tong in 1971-72. The distributions of both types of services in the eleven administrative subdistricts of Kwun Tong were found to be strongly associated with each other. The correlation coefficient is .55, indicating that the larger the number of Chinese services in a particular area, the larger would be the number of Western services; or vice versa.

Both the distribution of Chinese services and that of Western services, however, were greatly dependent upon the social-economic status of particular subdistricts. The correlation coefficient between the distribution of Chinese medical services and socioeconomic status is .54, while that between Western medical services and socio-economic status is .68. Hence, the higher the socio-economic status of a particular area, the more would be the Chinese as well as the Western medical services in that area.[22] Comparing the two correlation coefficients, we observe that the availability of Chinese services has relatively weaker association with socio-economic status than that of Western services. In other words, Western-trained doctors were more likely than Chinese medical practitioners to concentrate in economically wealthier areas.[23] This pattern of spatial distributions suggest that the profession of Western medicine is more likely than the profession of Chinese medicine to have closer ties with wealthier segments of the population, and may hence be more likely to carry a higher prestige in the community.

According to my sample survey of 702 adults in Kwun Tong, most people (67%) perceive that Western-trained doctors are <u>in general</u> technically more competent than Chinese practitioners. However, they seem to have differential evaluation of different aspects of medical practice.

Most people (84%) believe that Western medicine is more effective than Chinese medicine in the prevention of infectious diseases. With regard to tonic care, i.e., the promotion and maintenance of good health, most people believe in Chinese herbs (70%) rather than Western drugs (12%).

For the treatment of illnesses, a greater number of people are more confident in Western medicine (65%) than in Chinese medicine (10%). To be more specific, most people (about 60% to 80%) suggest that in the treatment of most diseases (1) Western medical care works faster than Chinese medicine, but (2) Chinese herbs are less likely to produce side-effects, and (3) Western medicine is good for the treatment of "symptoms" while Chinese medicine is more effective in the curing of "disease".

The evaluation of the effectiveness of medical treatment may be dependent upon the specific types of diseases in question. Respondents were given a list of illnesses and were asked to make comparison between the two medical approaches. The responses are percentaged in Table 1.

The data suggest that most people prefer Western to Chinese services for the treatment of most diseases, especially tuberculosis and fever. Opinions are evenly split in respect to measles. Chinese medicine is considered to be more effective than Western approach in dealing with rheumatism, sprains and fractures.

Table 1. Evaluation by the Lay Population of the Effectiveness of Treating Specific Types of Diseases (N = 702)

	Diseases	Western Better	Chinese Better	About the Same
(1)	Tuberculosis	91.2%	1.4%	7.4%
(2)	Fever	90.5	5.7	3.8
(3)	Heart diseases	84.9	0.9	14.2
(4)	Stomachache	84.3	3.4	12.3
(5)	Mental illness	84.0	0.4	15.5
(6)	Skin diseases	83.6	6.6	10.4
(7)	Throbbing and diarrhea	78.3	13.4	8.3
(8)	Whooping cough	76.9	14.0	9.1
(9)	Dysmenorrhea	65.0	17.5	17.4
(10)	Anaemia	55.0	29.1	16.0
(11)	Measles	47.9	47.0	9.1
(12)	Rheumatism	24.2	54.1	21.7
(13)	Sprains and fractures	8.2	86.5	5.3

All the above findings suggest that in general the lay population are more trustful of Western than Chinese medical care. Nevertheless Chinese medicine remains to be trusted in some specific ways such as tonic care, less side-effects, curing of diseases rather than symptoms, and treatment of certain illnesses such as measles, rheumatism, sprains and fractures. Then, to what extent are the two types of professional services utilized by the populations?

Among the various types of Western services, private physicians are most often visited by the people (70%). Among the three major kinds of Chinese services, herbalists are most often consulted by the people (36%), while acupuncturists have been visited by a very small fraction of the population (2%).

Concerning the relative utilization of Chinese versus Western services, I note that (1) among those respondents who have consulted doctors during the past three years, 83 per cent reported that they have visited Western-trained doctors more often, while 11 per cent have consulted Chinese practitioners more often; (2) among those whose parents have used medical services during the last three years, 68 per cent reported that their parents visited the Western-trained doctors more often, while 20 per cent were in favor of Chinese practitioners; (3) among those whose children have used medical services during the past three years, 92 per cent reported that their children consulted Western-trained doctors more often, while 5 per cent

preferred Chinese services. These findings suggest that Western services are more widely utilized by the people than Chinese services. Moreover, it seems that the younger the generation, the more extensive would be the use of Western medical care in comparison to that of Chinese services.

Table 2 presents the data about the process of seeking medical help. In the initial stage, people were most likely to be self-medicated (58%), rather than to seek help from Western-trained doctors (38%) or Chinese medical practitioners (4%). When this first move did not work, most of those who initially rely on self-medication or Chinese medical practitioners would shift to the use of Western-trained doctors, while most of those who consulted the Western-trained doctors in the initial stage would continue to use it. This process of seeking medical help reconfirms that most people prefer to make use of Western services, rather than the Chinese medical care.

I have presented some findings about the evaluation of medical quality and the utilization of services by the lay population. How are the two types of professional services evaluated and utilized by medical professionals themselves?

According to the survey of medical practitioners (174 Chinese medical practitioners and 101 Western-trained doctors) in Kwun Tong, most Western-trained doctors (84%) believe that their own colleagues are medically more competent than those in

Table 2. The Process of Seeking Medical Help

Later Stage	Initial Stage		
	Self-medicated %	Western %	Chinese %
Self-medicated	14.5	8.1	4.0
Western	76.7	79.3	52.0
Chinese	8.8	12.6	44.0
Total	100.0	100.0	100.0
(N)	(407)	(270)	(25)

Chinese medicine, while most Chinese practitioners (73%) feel that there is no significant difference in competence between the two groups. Western-trained doctors are hence more distrustful of their counterparts, than are Chinese practitioners.

Since there are three major types of Chinese practitioners (i.e., herbalists, acupuncturists, and bone-setters) in Hong Kong, which type do Western-trained doctors trust the most? The data show that about 16 per cent of the Western-trained doctors trust herbalists, 23 per cent trust bone-setters, and 30 per cent trust acupuncturists. Thus, Western-trained doctors tend to trust acupuncturists the most, relatively speaking, and are most skeptical of herablists.

As reported, Chinese practitioners are quite receptive of the Western medical practice, while Western-trained doctors are skeptical of the technical competence of Chinese medical practitioners. Then, how are the services utilized by medical practitioners themselves?

I found that over three-fourths of the Western-trained doctors have referred patients to their own professional colleagues, while under one-fourth of the Chinese practitioners have done so. Unlike the Western doctors, the network of patient-referrals among Chinese practitioners is rather weak. The question arises, do Chinese and Western-trained medical practitioners refer patients to each other? Over one-half of the Chinese practitioners

have referred patients to Western-trained doctors, especially those working in hospitals. The referral of patients from Western doctors to Chinese practitioners is a rarity: only two per cent of the Western-trained doctors have done so. Apparently there exists an asymmetric process of patient-referral between Western-trained and Chinese practitioners. It is likely to go from Chinese to Western-trained practitioners, but not the other way round. The above data also suggest that Chinese practitioners are even more likely to refer patients to Western-trained doctors than to colleagues of their own profession.

We have hence seen that the services of the profession of Western medicine are more favorably evaluated and more extensively utilized by both the lay population and the medical professionals themselves. This pattern of differential evaluation and utilization suggest that the two professions of medicine command different degrees of honor and respect in the modernizing society of Hong Kong. In terms of social prestige, the profession of Western medicine is superior to that of Chinese medicine.

(3) Wealth. The profession of Western medicine is economically much better off than the profession of Chinese medicine. I have no statistical data to show the actual income, but from the survey of medical practitioners in Kwun Tong, I found that (a) of the Western-trained doctors, 58 per cent felt that Western-trained doctors earn more income while only 5 per

cent felt that Chinese medical practitioners earn more, and (b) of the Chinese practitioners, 87 per cent felt that Western-trained doctors make more money while none of them felt that Western-trained doctors make less.

Moreover, I observed that on the average, the total number of service hours provided by Western-trained doctors is about 31 hours per week while that by Chinese practitioners is about 37. However, the average number of patient contacts among Western-trained doctors is about 244 contacts per week, while that among Chinese practitioners is about 100. Hence, as compared to the profession of Chinese medicine, the profession of Western medicine provides a smaller number of service hours but have a larger number of patient contacts.

Another indicator of the uneven distribution of wealth between the two professions is the financial support from Government. The Government has subvented an increasing volume of different kinds of medical and health programs, but none of them is involved with Chinese medicine. All the Government-subvented medical projects are Western-medical oriented.

The above findings suggest that as compared to the profession of Chinese medicine, the profession of Western medicine commands more economic resources.

In conclusion, there exists a stratificational ranking between the profession of medicine in the modern sector and that in the traditional sector. The former is superior to the latter in all the major dimensions of stratification; namely, power, prestige, and wealth. The question arises, why is this so?

DIFFERENTIAL SUPPORT

The stratification between the two professions may be due to the differential support from the community. The establishment and functioning of a profession have to be legitimized by the society. What it does must be considered as necessary and desirable. A profession would enjoy a high degree of legitimacy if its knowledge and role-performance are (a) congruent with the dominant values of the society, (b) conferred by the academic authority such as the University, and (c) supported by the political authority such as the Government.

Scientific principles are originally secular and utilitarian in nature. The application of these scientific norms has been so powerful and successful in solving many of the problems that science has gradually become a dominating "sacred" value in most, if not all, modernizing and modernized societies. Anything that is in connection with science would be accepted with little resistance.

The "good results" of Western medicine may be an important source of its dominance over Chinese medicine in Hong Kong. But it may also result from its association with science. It has been widely perceived by local population that the knowledge and skills of Western medicine were developed through the use of scientific procedures, while Chinese medicine is unscientific and is therefore less reliable. Being supported and justified by the dominant value of science, the profession of Western medicine enjoys a higher degree of legitimacy than the profession of Chinese medicine in Hong Kong.

The educational authority in Hong Kong also contributes to the legitimization of Western medicine, rather than that of Chinese medicine. Hong Kong has only one University medical school, producing about 100 graduates each year. These graduates are entitled to be registered with the Medical Council of Hong Kong. The training programs, however, entirely concentrate in Western medical science, giving no attention to Chinese medicine. If one wished to learn Chinese medicine, he may do it either by becoming a disciple of a Chinese medical practitioner or by enrolling in one of the thirty and some training schools in Chinese medicine. Up to the present, there is no way for any person to receive a University diploma in Chinese medicine. With its academic authority, the University has hence conferred the technical competence of Western medical science but not that of traditional Chinese medicine.

With its political and financial resources, the Government has been playing a major role in the modernization of medical services in Hong Kong. Its efforts, however, have led to a "partial" rather than "total" modernization in medicine. The Government concentrates in the development of Western medical science at the expenses of Chinese medicine. It has provided and subvented an increasing volume of Western medical services. It has granted the profession of Western medicine, rather than that of Chinese medicine, a mandate to monopolize and to control over the medical care services in Hong Kong.

The Government's attitude toward Western medicine is supportive. Its attitude toward Chinese medicine, however, can be described as "conditional tolerance." Because of its Colonial policy of minimizing interference with local customs, the Government has been tolerant with, though not supportive to, the existence of Chinese medical practice. The Medical Ordinance in Hong Kong primarily regulates Western medical practice. The Government has set up no standard examination nor licencing procedures for qualifying the practitioners in Chinese medicine. In fact, anyone can practise Chinese medicine without any interference from the legal authority. What is required is a payment of 25 Hong Kong dollars for commercial registration. It should, however, be noted that the Government's tolerance of Chinese medical practice is not unconditional. As mentioned, a person practising in Chinese medicine is subject to certain social and technical constraints.

In short, as compared to the profession of Chinese medicine, the profession of Western medicine is more closely associated with the dominant value of science, and it also receives greater support from both the academic and political authorities. As a result, the profession of Western medicine obtains a higher degree of legitimacy and hence a higher stratificational ranking than its counterpart. It commands greater power, higher prestige, and more economic resources.

PROFESSIONAL REVIVALISM

The profession of Chinese medicine is not entirely passive. There has recently emerged a revivalistic movement in Hong Kong. An increasing number of medical elites have publicly advocated for the improvement of the social organizational and technical content of Chinese medical practice. These elites include not only leaders of some major professional associations in Chinese medicine, but also some renowned Western-trained doctors such as the medical director of one of the largest welfare programs and the medical superintendent of a large community hospital.

The most serious problem faced by Chinese medicine in Hong Kong today is the lack of minimum and uniform control over education, licensing and practice. Some practitioners may be

well-qualified, while others may be real quacks. The public is much less certain about the possible results of seeking help from a Chinese practitioner than from a Western-trained doctor. In view of such a serious problem, revivalists have been strongly argued for introducing into the profession of Chinese medicine minimum and uniform standards for training and practice. It is also asserted that the University should establish a Chinese medical school so that medical knowledge can be systematically researched and it can be taught in classrooms with standard textbooks. With its rich amount of financial and technological resources and with its great variety of patients and disease-patterns, the hospital should include the Chinese medical practice into its research and service programs. The Government and voluntary agencies are urged to provide accessible, low-cost, high quality Chinese services to the public. These advocations indicate the concern of the revivalistic movement with the rationalization of the organization of Chinese medical care.

In regard to the technical content of work, many revivalists have argued for the use of scientific methods. Traditional treatments should be re-examined and refined through the use of scientific experiment. In fact, some faculty members in Physiology and Anatomy at the Hong Kong University Medical School have already begun to undertake scientific research on the medical effects of acupuncture. A group of practitioners in Chinese and Western medicine also established a so-called The

Chinese Medical Research Center to carry out scientific research and training in Chinese medicine.

Two of the major barriers against the use of Chinese medicine in Hong Kong today are the rising cost of medicinal herbs and the amount of time and effort required for preparing medical herbs and roots for consumption. Revivalists have asserted that Chinese medical herbs should be transformed into patent medicines by means of scientific procedures of extraction. In recent years, a great variety of Chinese patent medicines are already available in the local market. Most of these patent medicines are imported from the People's Republic of China, and have been increasingly utilized by the local population. These patent medicines include, for examples, those used in treating schistosomiasis, tumour and fulminating epidemic cerebrospinal meningitis, in dealing with snake poison, and in curing septic shock resulting from toxic dysentery.[24]

Apparently the revivalists are pushing toward an increased rationalization of not only the social organization of medical services, but also the technical content of medical work. The emergence of revivalistic movement may be a reaction to the state of "relative deprivation." Being confronted with the rising status of Western medical profession, the profession of Chinese medicine has to struggle for existence. In order to survive and to compete for more social-political and economic resources, the

profession of Chinese medicine considers it not only a matter of desirability, but also a matter of necessity, to rationalize its social organizational as well as technical content of work.[25]

SUMMARY AND CONCLUSION

A characteristic of modernizing societies is the coexistence of the modern and the traditional professions which claim to perform the same functions for the society. As a result of the differential support by the dominant social values, and by the academic and the political authorities, the modern profession occupies a higher stratificational ranking than the traditional profession. In order to struggle for survival and to compete for more social-political and economic resources, the traditional profession would advocate for a rationalistic revivalism, i.e., to rationalize its social organizational and technical content of work.

In this paper, I have illustrated the above generalized statements by analyzing and comparing the profession of Western medicine with that of Chinese medicine in the modernizing society of Hong Kong. These two types of professional services are coexisting in the pluralistic health context of Hong Kong, but the former enjoys greater power, higher prestige, and more economic resources. The state of Western medical dominance may be

due to the connection of modern Western medicine to the dominant social value of science and to its support by the University and the Government in Hong Kong. In recent years, however, there has emerged a revivalistic movement in the realm of Chinese medical care. The intention is to push toward an increased rationalization of the organization of medical services as well as the technical efficacy of medical knowledge and skills.

FOOTNOTES

1. As Goode has argued, other characteristics of a profession can be derived from these two "core" characteristics. See William J. Goode, "Encroachment, Charlatanism, and the Emerging Profession: Psychology, Medicine, and Sociology," American Sociological Review, 25 (1960), 902-914.

2. As Barber has postulated that the greater the amount of knowledge and/or responsibility required for performance in a given social role, the higher the stratificational position of the incumbent of that position. See Bernard Barber, Social Stratification: A Comparative Analysis of Structure and Process, N.Y.: Harcourt, Brace & World, Inc., 1957, pp. 24-30.

3. Rationalization refers to "the methodical attainment of a definitely given and practical end by means of an increasingly precise calculation of adequate means." See H.H. Gerth and C. Wright Mills, eds., From Max Weber: Essays in Sociology, Fair Lawn, N.J.: Oxford University Press, 1958, p.293.

4. See Hong Kong Social and Economic Trends 1968-72, and Hong Kong Statistics 1947-67, published by Census and Statistics Department, Hong Kong Government. For some discussions, see David Podmore, "The Population of Hong Kong", pp. 21-54, and E.E. Phelps Brown, "The Hong Kong Economy: Achievements and Prospects," pp. 1-20, in Keith Hopkins, ed., Hong Kong: The Industrial Colony, London: Oxford University Press, 1971.

5. Director of Medical and Health Service, Annual Departmental Report 1971-72, published by Hong Kong Government, 1972, and also R.K. Bowman, F.I. Forbes and J.D.F. Lockart, "Trends in notifiable infectious diseases in Hong Kong Island 1961-1965" Far East Medical Journal, Vol. 6 (August 1970), pp. 223-229.

6. See Director of Medical and Health Services, op. cit., p.70.

7. See Chung Yung Folk Medicine, Hong Kong: Tak Lee Book Co., 1972; Gerald Choa, "Some Ideas Concerning Food and Diet Among Hong Kong Chinese: The Constitution and Food Therapy," Brochure of the Hong Kong Branch of the Royal Asiatic Society, October, 1966; and E.N. Anderson, The Floating World of Castle Peak Bay, Washington: American Anthropological Association, 1970; Y. Chung, Food Therapy, Vol. 1-4, Hong Kong Tak Lee Book Co., 1973.

8. See Francis L.K. Hsu, "A Cholera Epidemic in a Chinese Town," pp. 135-154, in Benjamin D. Paul, ed., Health, Culture, and Community, N.Y.: Russell Sage Foundation, 1955; and Katherine Gould Martin, "Ong-Ia-Kong: The Plague God as Modern Physician," presented to the Conference on the Comparative Study of Traditional and Modern Medicine in Chinese Societies, Seattle, Washington, February 4-6, 1974. Hsu's study was conducted in a southwestern town in mainland China in 1942, while Martin's field work was carried out in Taiwan in 1972-73. John Myers is presently exploring the structure and functioning of religious-medical practices in urban Hong Kong. For some of his findings, see John Myers (in collaboration with Davy H.K. Leung) "An Urban Chinese Spirit-medium Cult," Social Research Centre Paper , The Chinese University of Hong Kong, 1974.

9. For more discussion on the historical development of medical theories and practices in China, see Stephan Palos, The Chinese Art of Healing, N.Y.: Herder & Herder, Inc., 1971; and Pierre Huard and Ming Wong, Chinese Medicine, N.Y.: McGraw-Hill Book Co., 1968.

10. For a fuller discussion on this point, see Ralph C. Croizier, Traditional Medicine in Modern China: Science, Nationalism and The Tensions of Cultural Change, Harvard University Press, 1968, pp. 14-19.

11. See the brochure "Hong Kong's Medical & Health Services," issued by Hong Kong Information Services in July 1970.

12. It was reported by the School Medical Service Board that a total of 70,758 students took part in the Scheme during the academic year 1972-73, constituting less than ten per cent of those eligible. These students were attended by 181 Western-trained doctors in private practice.

13. The total number is approximately 2,800, including doctors registered with the Medical Council of Hong Kong, and unregistrable doctors who are permitted to work in Government institutions or charity clinics.

14. Report of the Medical Development by the Advisory Committee 1973, published by Hong Kong Government, 1973.

15. For an elaborated discussion on the professional control over social and technical terms of work, see Eliot Fridson, Profession of Medicine, N.Y.: Dodd, Mead and Co., 1972; and also Professional Dominance: The Social Structure of Medical Care, Chicago: Aldine Publishing Co., 1970.

16. See Harry S.Y. Fang, ed., Medical Directory of Hong Kong, The Federation of Medical Societies of Hong Kong, 1970.

17. Report of the Medical Development by the Advisory Committee 1973, op. cit.

18. For a more comprehensive description of the Kwun Tong community, see "A Preliminary Ecological Analysis of the Development of Kwun Tong, 1954-70", by Sidney Wong, the Social Research Centre, The Chinese University of Hong Kong, December 1970.

19. Ambrose King, "A Theoretical and Operational Definition of Community: The Case of Kwun Tong", Social Research Centre Paper, The Chinese University of Hong Kong, 1973.

20. These two specific types of services were chosen for the study on the basis of the consideration that both of them constitute the majority of medical practitioners and that their services are most widely utilized by the public.

21. For a comprehensive description of the research procedures and statistical findings of the three health surveys, see my research reports and papers published by the Social Research Centre, The Chinese University of Hong Kong in 1972; they are "Spatial Distributions of Modern Western and Traditional Chinese Medical Practitioners in An Industrializing Chinese Town", "Study of Health Systems in Kwun Tong: Health Attitudes and Behavior of Chinese Residents," and "Study of Health Systems in Kwun Tong: Organizations and Attitudes of the Western-trained and the Traditional Chinese Personnel in an Industrial Community of Hong Kong."

22. The socioeconomic status of a subdistrict is measured in terms of the quality of residential housing. For a fuller discussion and more elaborated analysis of the relationships between socioeconomic status and distributions of various types of health services in Kwun Tong, see Rance P.L. LEE, "Population, Housing and the Availability of Medical & Health Services in an Industrializing Chinese Community," Journal of The Chinese University of Hong Kong, Vol. 1 (1973), pp. 191-208.

23. The reason may be that the number of Chinese practitioners is much larger than that of Western-trained doctors, but as will be reported later in this paper Western services are more likely to be utilized by the public than are Chinese services. To avoid competition, Chinese practitioners have to move into poorer areas, and can not afford to be as choosy as Western-trained doctors. It is noted that according to the estimation by the Medical Development Advisory Committee in 1973, Hong Kong will have a shortage of about 100 Western-trained doctors in the next ten years.

24. See the bulletin Chinese Patent Medicine, published by Chinese Patent Medicine and Medicated Liquor Exhibition in Hong Kong, June 1972. For a brief report of the development of pharmaceutical industry in China, see The Revolutionary Committee of the Chinese Academy of Medical Science, "Developing China's Medical Science Independently and Self-Reliantly", Peking Review, Vol. 13, No.1 (January 1970), pp. 24-30.

25. In this paper, I focus on the "internal" sources of change in the realm of Chinese medicine in Hong Kong. However, it should be recognized that some "external" factors, such as the revival of traditional medicine in the People's Republic of China, may also expedite the emergence of the revivalistic movement in Hong Kong.