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## Utilizing the Moral Nobility of Older Chinese Women in Governance – the Uses of Humility, Empathy and an Ethics of Care in Moral Clinics in Huzhou City

### Abstract

This paper examines the emergence of the role of ‘moral doctors’ who volunteer in what are called ‘moral clinics’ in Huzhou City. In these Moral Clinics, the characteristics, experiences and attributes of older women, in particular, are highly valued and viewed as being essential to the role of the moral doctor. These moral doctors act as moral exemplars and conflict mediators in their local communities. Their moral capital and professionalism, combined with their gender, age, familial and neighbourhood attributes, contribute to the accumulation of an affective feminized labour which employs the techniques of care, reason and moral fortitude to govern the self and others. We unpack these ethical virtues exemplified by moral doctors and nurses in order to show how a female-centric ‘ethic of care’ can become a set of techniques in governing others. In this paper, we elaborate on the role that these moral doctors perform to support the aims of the moral clinics in terms of fostering pro-social behaviour and moral obligation in local communities. We argue that the performance of this type of ‘moral work’ is both a mechanism of discipline and a process of self-actualization. We contribute to the current literature on ‘therapeutic governance’ in China by showing how the non-expert medicalization of social ills by moral doctors is incorporated into the reproduction of social control.

*Keywords:* moral clinics, moral doctors, ethics of care, China, affective labour, affection and reason

## **Introduction**

From September 2010, volunteer organizations called ‘moral clinics’ started to be introduced in Wuxing district, Huzhou city, Zhejiang province in China. These moral clinics staffed mostly by female retirees who are called ‘moral doctors’ or ‘nurses’. According to the moral clinic publicity materials featured in this programme, moral doctors and nurses work together with local Party organizations in these clinics to ‘diagnose and cure moral diseases’ in communities, such as uncivilized/immoral behaviour of residents or they intervene to mediate quarrels between neighbours. In recent years, these moral clinics have not only tried to ameliorate these types of social problems, they have also the backing of local Party officials to influence public opinion in order to promote ‘healthy and civilized lifestyles’ and ‘harmonious relationships’ in local neighbourhoods.

Indeed, just like with the urbanisation of European societies centuries before, the unprecedented (in terms of scale) urbanisation of Chinese society in the late twentieth and the early twenty-first century is a cause of much concern. Since the 1980s, there is a widely shared perception of an impending moral crisis in China (Yan, 2011: 51), in which people tend to emphasise individual rights and personal interests over their obligation to the community and other individuals (Yan, 2003: 16). As Yan argues these interdependent factors have led to the emergence of community governance interventions in general in China:

Contextualising the changes in the private sphere in the larger social setting shows that the decline of public life, the near-absence of community power, the increasingly predatory local government, and the accelerating pressure of competition in a market-oriented economy all contributed to the rapid spread of egotism and the rise of the uncivil individual (2003: 16).

As such, rapid urbanisation through internal immigration has created a multitude of new challenges in China's urban communities. Within this context, the establishment of moral clinics also pays special attention to the new urban underclass who are recently urbanised rural Chinese migrants to cities. According to our participants, they are often characterised by local officials and moral doctors as uncivilised and unsophisticated and are seen as adversely affecting the social cohesion of neighbourhoods. Many of these challenges or social problems are often nuanced, trivial and varied, and therefore cannot be easily solved through the usual standardised formal methods of policing and social work. That is, these types of social problems, although trivial, can be more complex and intrusive than some of the problems that require state or policy attention. Therefore, finding alternative approaches becomes necessary in order to address community issues that are neither clearly defined nor straightforward. Thus, we argue here that the institutionalisation of moral work through the moral clinics aims at producing knowledge about 'social ills', developing bespoke ways in which these 'social ills' can be treated or cured. Furthermore, part of this moral work is the mobilisation of local residents to participate in moral and civilising campaigns in the context of what we call the institutionalisation of voluntary (rather than professional) social or community workers. We argue that the moral clinics are rendering explicit the often-implicit behavioural expectations of the 'urban' citizenry in China (Zhang & McGhee, forthcoming). In this initiative, rural-to-urban migrants' lifestyles are problematised in that aspects of rural lifestyles are presented as putting public health at risk in the urban context. Therefore, the moral clinics are presented as a locally delivered antidote to improve the deficiencies of 'the rural people'. This is pertinent to what Powell (2013: 2) calls the 'civilising offensive', through which a powerful group attempts to eradicate the supposedly "uncivilised" behaviours associated with another less powerful group.

In this paper, we further examine how these ‘uncivilised’ behaviours are to be corrected by moral doctors and nurses who employ a set of techniques ranging from Maoist ‘thought work’, traditional Chinese medicine and female-centric communication skills as an ‘ethic of care’. We show that the emergence of moral clinics in Huzhou is similar to what Yang (2017, 2018) and Zhang (2014) call therapeutic governance in China, through which the medical therapeutic ethos, techniques and care are adopted in the process of governing society (Yang 2018). In contrast to the Western emphasis of medical expertise, Chinese therapeutic governance often occurs without recourse to experts and always draws on social and cultural practices of healing, for which informal and non-expertise psychological diagnosis are often conducted by government agencies, media, and even the public (Yang 2018). Our study adds to this literature by demonstrating that the establishment of moral clinics, which are staffed by older female volunteers, represents a type of feminized, non-expert, traditionalized medical governance of communities, which is, in many aspects, is an alternative to modernized hegemonic expert therapeutic governance in the west.

Our contribution to sociological literature is that we show that moral doctors’ role in therapeutic governance through feminized affective labour is “a technology of the self that simultaneously verifies workers’ identities and contributes to their exploitation through self-governance and their sense of individual responsibility for providing good service” (Monrad 2017: 282). As such, moral doctoring is not based on active post-retirement leisure or on performing familial obligations; rather, it is a quasi-public role that provides status, purpose and respect at a time (retirement) when these are generally lost to a person (see also Zhang & McGhee, forthcoming). As we show in this paper, despite these retired older women being no longer economically productive, they have created a role for themselves in their neighbourhoods as respected moral exemplars. In the words of Gilligan (1982), their practice reframes ‘women’s alleged weakness’ and shows these actions to be human strengths. Their

‘toolkit’ includes a highly valorised set of skills, such as disarming humility, a willingness to collaborate, caring, loving and demonstrating ‘goodness’. We see parallels between the activities of these moral doctors and affective labour of, for example, aid workers (see Fechter 2016).

This particular ethics of care that the moral doctors exhibit and embody in their work is an example of a highly effective combination of skills built up over a lifetime. They are both the professional skills of effective leadership, emotional intelligence and ‘active listening’ skills, as well as what Gilligan would suggest are the skills mostly attributed to nurturers who exhibit care for and sensitivity to the needs of others (1982: 18). Their instruction style is at once affective, flexible, and performative (Yang 2017: 182), and this therapeutic ethos makes this exercise of power appear as therapy and as such, has hegemonic tendencies (Yang 2017: 189). That is, they serve government interests through what Yang calls virtuous power, which not only help[s] individuals cope with socioeconomic change, but also ‘constrain[s] direct opposition to the causes of those changes by translating structural inequalities into ethical and moral issues’ (Yang 2017).”

Empirical data for this study was collected through two focus group interviews and participant observation in local moral clinics in Bilanghu and Shangxiatang *shequ*, in Huzhou city, between October 2017 and March 2018. We also held eleven informal interviews and talks with local Party officials both in Resident Committee (RC) and Street Office (SO) and also with the propaganda officials responsible for supporting moral clinics of Wuxing district. We did not conduct interviews with the so-called ‘moral patients’ or beneficiaries of the clinics. This is because, unlike moral doctors and nurses who we were confident gave their genuine informed consent to participate in the study, we were less confident that their service users, who could have been compelled by local officials to participate in the study. Moreover, many of service users could be considered to be members of a vulnerable group (see

Schlosser 2008). Here, the data from interviews and participant observation are also supplemented with the analysis of publicity and informational materials produced by the moral clinics themselves, and articles published in the local media about the work of moral clinics. All the names of participants have been anonymised. We translated the data and following this analysed the data through employing a thematic analysis of data as advocated by Boyatzis (1998). Initially, an overview thematic grid was produced to identify and collate our participants' views on the topics discussed. Relevant sections of the transcripts of the focus groups and interviews were then assigned, appropriate thematic codes and refined sub-categories emerged.

### **Establishing Authority for Moral Doctors**

The practice in moral clinics implies both a moral and a physical commitment from the 'moral workforce' who must be active, motivated and in fairly good health (Audin 2017: 52). Not only must these moral doctors be morally committed and physically healthy, but they must also be both unburdened by excessive familial obligations and have the support of their family. A local official described the personal qualities that a moral doctor must have:

they should be willing to perform the role... Third, we prefer retirees. Those who are trapped by trivial family matters, including babysitting, are not suitable. They must ... [be] physically healthy and have family support. Because if you are occupied with your own family affairs, this work could be a burden.

Willingness, availability and the commitment of a critical mass of volunteers are crucial if a moral clinic is to be sustainable in local communities, as seen from the experiences of one of the very first moral clinics to be introduced, but through staffing issues it stopped operating:

When the moral clinic was just established, only a few retired senior female citizens were on duty every day. I was very happy to be part of this group. But

later, because my grandson was not in a good health, I had to quit and take care of him. At that time, Mrs W was the secretary of the Party general branch, and on behalf of the Party, she took the lead. Later on, Mrs W had to take care of her grandson, and another member was diagnosed with cancer. They had no time and energy to continue this job. Therefore, although we were one of the first to open a moral clinic, we were also the first to shut the clinic down.

Thus, family commitments or the ill-health of key clinic members can easily disturb the work of moral clinics. In order to keep the clinics running, clinic administrators must keep recruiting and training new retirees.

The recruiting and training of retirees brings challenges, we can see many parallels between the practices of the moral clinics and those of traditional Chinese medicine. Both require the active recruitment of willing ‘apprentices’ who can be enlisted for training on the job, which in both cases entails a long-term commitment to developing highly socially interactive diagnostic skills and techniques (Peng 2006: 35). Both ‘professions’ are also hierarchical with nurses, assistants and other staff at the bottom and well-trained doctors at the top. However, there is a permeable barrier between the hierarchies in both professions, just as in traditional Chinese medicine, in the context of moral clinics, moral nurses can, with experience and mentorship, eventually be promoted to become a moral doctor. Similarly, the moral nurses must willingly submit to doctors and do the work without being paid as volunteers. A moral doctor elaborated on the different levels of the hierarchy at a moral clinic:

We have different roles in the moral clinic. There are moral doctors and moral nurses. The number of doctors is about one-third of the total number of nurses. Technically, there isn’t that much difference between moral doctors and nurses in terms of their professional capability. The more experienced [individuals] get to

be doctors, and nurses are usually new recruits. Doctors issue prescriptions, and nurses follow up on case to see whether the problem is solved.

There is an explicit politics of gender in moral clinics. This moral work is very much a female-dominated sector. These retired women have been specially selected because of their professional skills and experiences, and also their moral capital as respected, long-term members of communities. Similar to social workers in England, moral doctors are able to engage in innovative practice that goes beyond prescriptive work around eliminating risk, their ability to be creative relies on levels of confidence and self-belief in interpreting, analysing and making decisions. Their communication skills and personal attributes as opposed to more formal qualifications, are all vital qualities required in moral doctors (Parr 2008: 1267). These moral doctors know how to use 'local', 'traditional' and also professional resources to manage communities with norms of common-sense everyday lives (Farquhar 2012: 160). This is articulated below by one of the moral doctors:

First, they should be morally noble themselves. If you are not noble morally, then it cannot be convincing. Second, moral doctors and nurses should possess strong abilities to persuade and educate. Most of them were the elites in their former organizations. Of course, some ordinary people can do it, but it's not common.

Thus, as elites in their former organizations, moral doctors have accumulated a reputation for professionalism and possess proven abilities as influencers of others through their moral capital. This is similar to the practice of traditional Chinese medicine, where medical ethics (*yide*) and medical skills (*yishu*) are indistinguishable. These two attributes of moral doctors are mutually reinforcing. That is, a doctor's skills demonstrate the strength of her ethics, and in turn her ethics guarantee her skills. Moreover, as the moral doctor further articulates,

Third, many of them are familiar with their communities. Moral doctors and nurses all live in the community in which the clinic operates. So, when they conduct moral work, the residents will be more cooperative. You see, China is a *guanxi* society. I'm old, so people are willing to listen to me. Fourth, moral doctors do not get paid. So, what do they work for? It is for the harmony and stability of our society. They all work for the sake of this society. They don't make a profit, and that makes them more persuasive. They are volunteers and engaged in charity work. Besides, those elderly moral doctors are very touching. They are all warm-hearted people; they are volunteers who make a contribution to our society out of their own pocket.

Thus, to be a moral doctor, the volunteers have to be morally noble, have the ability to persuade and educate residents, be familiar with the local community, be a senior citizen with professional experience and be eager to selflessly engage in unpaid volunteer activity that offers no economic gain. Perhaps most of all, they must have a warm-hearted disposition. A description of a warm-hearted personality includes a number of what Gilligan (1982) would suggest are female-centric communication skills, including empathy, compassion and relational interdependence, which she frames as the attributes of an 'ethic of care'. We will draw parallels between moral work and moral clinics, and the ethics of care. We suggest that these parallels are most readily observable through the productive combination of moral doctors' age, gender, moral capital, and professionalism. In other words, their cultivated morality, communication skills and professional experience and expertise (evident from previously holding prestigious organizational positions) are highly sought after and relatively rare. As a consequence of these desired characteristics, there are not many individuals in local communities who are capable of becoming moral doctors. Thus, local officials and moral doctors are constantly on the lookout for older women, whom they call 'aunts', with

high moral capital, community standing, professionalism and a warm-hearted personality in order to maintain a constant stream of volunteers to work in and for the moral clinics. A local official described the process of finding volunteers for this moral work:

We also use our 'moral clinic' as resources. During the process of visiting, several aunts will also hear about which aunts are more enthusiastic and warm-hearted. Then they will pay a visit. Just like why you are here today. Then, we will ask their neighbours about them, if everyone speaks highly of them, and then we absorb them as our members. Just like this, step by step.

Thus, moral clinics are not only for addressing moral issues in local communities (more on this below) but are also consistently vigilant in terms of identifying and recruiting potential doctors and nurses into their daily practices. In order for these clinics to perform their work well and to keep it going, there must also be a leader amongst moral doctors and nurses. In other words, there must be a core group of 'moral sages' with exemplary moral capital, experience and communication skills, who embody an 'ethic of care' and exude emotional intelligences (Goleman 2006).

### **Accumulating Moral Capital and Being Moral Exemplars**

It is evident that in large measure, the clinics' effectiveness comes from moral doctors and nurses delivering their services through highly effective communication techniques, as a moral doctor told us:

You must have the ability to persuade and assess the situation. You have to be patient when encountering conflicts, and you should have your own perspective, but you must avoid antagonizing both parties.

As noted above, this moral work is highly relational, non-adversarial and collaborative. Similar to what Nissen finds in the use of complementary and alternative medicine (CAM), moral work is also characterized by empathic interactions, where ‘experiences are contextualised, and health and illness are explored within networks of relationships and responsibilities’ (2011: 194). During consultations, narrative strategies are often employed by moral doctors and patients alike, ‘to forge a “partnership of healing” that facilitates knowledge sharing and the building of consensus’, and ‘also accommodates differences and disagreements about how to approach and understand “health problems”’ (Nissen 2011: 195). Thus, the moral clinic is a nurturing and supportive environment, in which moral doctors ‘do not antagonize’, ‘must be patient’ and ‘are able to communicate’.

This is a kind of skilled approach to communication that can also be learnt from the technique of ‘looking at the illnesses’ adopted by the practitioners of traditional Chinese medicine. As Farquhar suggests, ‘looking at the illness’ (*kanbing*) is a mundane practice that entails a sense of partnership between doctor and patient in perceiving and managing the symptoms of the illness and its potential course and prognosis (Farquhar 1994: 45). Similarly, in moral clinics, the moral doctors and moral patients talk with each other about the ‘illness’ in order to co-produce a potential ‘remedy’. Thus, the recognition of patients’ authority, as in the use of complementary and alternative medicine, becomes ‘a key element in patients’ empowerment’ (Nissen 2011: 195). Patients retain a sense of being the expert, the authority, and of having the last word on their own illness (Farquhar 1994: 45). In the process of sharing knowledge, patients feel that they are being listened to and emotionally supported by the moral practitioners (Nissen 2011: 194). In this sense, the ethics of care evident in moral doctors’ work is a practice of ‘listening and talking’. It is a relational technique that requires a genuine partnership between the governing and the governed, with the objective of building and maintaining public order, creating harmony and encouraging behavioural change and

ultimately the formation of ethical subjectivities amongst the members of local neighbourhoods.

This form of pastoral power is like what Rose calls the somatic ethics in *the politics of life itself* (2006), which is a kind of ethics that works through the relation between the affects and ethics of the guiders and the affects and ethics of the guided (2006: 74). As Rose describes,

These counselling encounters entail intense bidirectional affective entanglements between all the parties ... In these entanglements, the ethical relations of all the subjects to themselves and to one another are at stake, including the experts themselves. (2006: 74).

In short, there is a bidirectional affective relationship between moral doctors and their service users that works on the self and others. Below we attempt to draw parallels between this semantic ethics in the therapeutic encounter with the relationships evident in the ethics of care, through examining everyday acts of humility whereby the moral doctors earn their reputations as selfless moral exemplars. Although age, wisdom and accumulated life skills are prerequisites for doing moral work, the essential characteristics of being a moral doctor are more gauged against the doctors' own behaviour (Farquhar 1994: 227). Thus, simply being older or female is not enough. Performing the role of a moral doctor involves embracing a consistent moral-quality threshold driven by a sense of pride as progressive citizens (Wan 2016: 2342). In other words, they must be models of morality in order to gain their communities' respect, and it is this respect that gives them the authority to do their work. For example, a moral doctor explained to us the importance of the moral doctor having an upright character:

It is necessary to manage your own family relationship well. If you fail in doing this, then you are not convincing when trying to mediate in other family disputes. ‘Take care of yourself before meddling in our affairs’, they will say. What I mean by this is that, first of all, you should manage harmonious relationships in your own family.

As such, there is an expectation that moral doctors’ exemplary private lives enable their public mission. A pamphlet produced by the Bilanghu moral clinic explicitly characterizes the moral doctors’ role as that of moral exemplar for other residents of the community. In this pamphlet, the staff of the clinic praise the work of one of the few men allowed to be involved in the clinic:

Moral doctors want to influence others by their own behaviours. The 71-year-old Mr Y climbs up the balcony in order to clean the rubbish... He is enthusiastic about public welfare after his retirement. He still assists in babysitting his grandson, so he is very busy... The environment of our community has been improved greatly because of work done by people like Mr Y... Moral doctors are old but work very hard to clean up the environment. They show how to be moral and civilized through doing good with the hope that the residents will be encouraged to work with them and to put an end to uncivilized behaviour altogether.

Thus, for moral doctors, doing moral work not only presents an opportunity to be recognized as contributing individuals who are useful to society, but also, and more importantly, it gives them a chance to present themselves and to be seen to be morally elevated individuals who are more valuable to society than the average citizen. Their elevated status and good works have become a source of veneration and admiration in their neighbourhoods.

Moral clinics were established with the intention of rendering moral doctors' work redundant, as they hope to 'retire' fully once the need for this kind of work diminishes. That is, by doing moral work, it is hoped that, according to a moral doctor, in the future when 'there will be less demand for moral work, then the moral doctors can finally retire. We will have our second and last retirement'. In other words, there is a sense of offering moral salvation, utopia and the promise of helping to introduce new forms of sociality through the work of the moral clinics. In this setting, moral doctors are like a shepherd (Foucault 2007), in this case, the flock being the residents of their local community and the essential objective of their work being the salvation of the flock (Foucault 2007: 126). In this case, the flock is saved through becoming self-governing, civilized and harmonious.

In order to exercise this power, as we discussed above, moral doctors must teach through their own examples and actions as individuals who live a morally exemplary life. If they do not do this, then their teachings will be nullified by their practices (Foucault 2007: 180). Thus, their efficaciousness as a moral doctor depends upon their ability to govern the self. Furthermore, it is not just their moral 'purity' that renders them effective but also their usefulness and willingness to 'roll up their selves' and 'get their hands dirty' in the name of the community. The words of a moral doctor illustrate this willingness amongst moral doctors to be hands-on:

I pick up garbage every day. I always pick up garbage when I am out. I keep on doing so when I walk in the community. My behaviour makes people who throw garbage feel ashamed. Moral doctors are changing the people in the community.

More and more people begin to trust us and ask us for help.

Their willingness to perform menial and often dirty work could actually increase their moral purity. In this sense, the power of moral doctors is not manifested by their strength and moral superiority alone but also in their zeal, devotion and endless application (Foucault 2007:

127). Rather than shoring up their status and importance, their effectiveness comes from their humility, from their willingness to perform lowly work such as garbage collection – that is, through doing selfless acts for the good of the neighbourhood. By so doing, the affects of shame and guilt amongst people who do bad things are also invoked.

The authority of the moral doctors derives from a combination of elements. They often have considerable emotional intelligence and well-honed communication skills as retired professionals, and they can also draw on the authority of being a representative of the ‘masses’ and an arm of the Party in civil society (see below). There is a relationship between the effectiveness of a moral clinic and the extent local communities trust moral doctors. Trust in moral clinics from local residents is a consequence of moral clinics and their doctors and nurses being perceived as being useful and having a practice orientation dedicated to a willingness to help, even when this can put these elderly volunteers in dangerous and risky situations. A moral nurse clarified the risks they sometimes face:

Moral doctors and nurses often encounter people with lack of morality who are really difficult to communicate with. We may even be cursed and insulted by them. We suffer a lot mentally. For example, once our moral doctor was nearly hit when mediating a conflict caused by residents’ inconsiderate behaviour in lighting fireworks and firecrackers.

Given that many of the moral doctors are 70 plus years old, they would have lived through Mao Zedong’s Cultural Revolution of the 1970s and would have actively participated in the revolutionary activities dedicated to making China ‘better’. Yet, they have transformed this collective cause from the Maoist ethics of serving the people into an ethic of promoting harmony, civility and community in these fast-changing urban contexts. Furthermore, through becoming moral doctors, this older generation of political activists has created the possibility of a nostalgic sense of continuing to contribute to society. Although

the dominance of older women in moral clinics seems to be similar to previous mechanisms of political mobilisation in the 1950s, when ‘old ladies with red armbands’ served ‘as neighbourhood watchdogs and political organizers’ (Tomba, 2008: 52), the practices of these older female moral doctors are different to the red armband women who were disseminators of top-down party decrees. In many ways, these former political activists turned moral doctors have become important agents of the party’s social governing apparatus – and are seemingly less political and more social in their practices. Moral doctors are not formally organized political agents and more like informally self-organized social activists. While old ladies with red armbands in 1950s were political guardians of the Maoist doctrines backed up by the threat of political power, moral doctors are more like pastors in the urban context. They are less repressive and more nurturing, furthermore, they use their individual feminized capital as a governing technique, which we refer to as an example of ‘matriarchal power’ (see Zhang & McGhee, forthcoming). Gender played a less important role in the 1950s than in the case of moral doctors and nurses in contemporary China. Yet, as we show below, ‘thought work’ (*sixiang gongzuo*) conducted by political or moral superiors during Maoist era and moral work conducted by moral doctors and nurses use a similar range of affective techniques towards service users. In short, in the setting of the moral clinic, these elderly women have transformed themselves from Maoist political activists into social activists, from retired senior citizens into moral doctors, and from unproductive (retired) labourers into active socially productive moral exemplars.

### **Applying Affects and Reason and Practicing an Ethics of Care**

With their intimate knowledge of their local communities and the expertise they have accumulated in their professional (pre-retirement) roles, moral doctors’ comparative advantage is that they ‘align the self-governing capacities of subjects with the objectives of

political authorities by means of persuasion, education and seduction rather than coercion’ (Rose 1996, cited in Leung, Yip, Huang, & Wu, 2012: 1051). Many of the moral doctors told us that ‘we cure our patients following the principle of touching their hearts with love, instructing them with reason’ (*dongzhi yiqing xiaozhi yili*). As Yang argues, affect as a primary element in social relations needs to be contextualized and examined culturally, historically and politically (2014: 10). Indeed, In China, the heart (*xin*) is seen as the grounding space for cognition, emotion and morality, where the body and the mind become mutually embedded (Zhang 2014: 286). In the case of moral clinics, the ‘hearts’ of patients are to be rendered open and purified by moral doctors’ affect based on their virtuous personality. In so doing, patients will become virtuous by changing their habits and lifestyles. Thus, virtue becomes the cohesive force of the soul itself (Foucault 2005: 304). This is a kind of “virtuous power through which one’s inner moral core anchored in the heart directs and regulates spontaneous bodily responses to circumstance” (Yang 2017: 183). In our case, the personal virtue of moral doctors becomes a technology of governing others. This can also be clearly seen in the teachings of Confucius:

If one tries to guide the people by means of rules, and keep order by means of punishments, the people will merely seek to avoid the penalties without having any sense of moral obligation. But if one leads them with virtue (both by precept and by example), and depends upon *Li* to maintain order, the people will then feel their moral obligation to correct themselves. (Creel 1953: 40)

Thus, as Yang finds, the emphasis on virtue in China adds a new dimension to biopower and therapeutic governance, whereby the heart as the basis of emotion, virtue and bodily sensation becomes the linchpin uniting the psychological, the moral and the political (2017: 195). In the case of moral doctors and nurses, affect operates in concert with reason (Richard and Rudnyckyj, 2009: 74). As such, their ethic of care is a combination of what

Gilligan called the ‘expressive capacities of women’ with the ‘instrumental abilities’ of the ‘masculine domain’ (1982: 17). The words of a moral doctor reflect this approach of applying affect and reason to the situations these practitioners encounter:

In dealing with moral problems, you cannot just judge who is right or who is wrong. The working methods are very important. In dealing with a community’s conflicts, you should first chat with them, find out their concerns, which will generally make them believe in you and thus make it easier to accept your suggestions. That’s what we call ‘letting them understand by reasoning while moving them with emotion’. We want to create a relaxed working atmosphere. We are here to persuade, to negotiate, so we are welcomed.

Thus, moral doctors, who manage the everyday lives of the community through a form of ‘management by negotiation’, are also like ‘arbiters of lifestyles’ (Flint 2012: 824). The *modus operandi* of touching patients’ ‘hearts with love’ also involves a tactic of persuasion to build rapport between moral doctors and local communities for the purpose of solving problems. This tactic of persuasion is also a Maoist technique associated with ‘thought work’ (*sixiang gongzuo*) conducted by political or moral superiors (Zhang 2011: 16), through which to alter the way people think about themselves and their relationship to the party-state (Zhang 2014: 295). As a moral doctor told us, ‘Actually, the idea of moral clinic originates from Mao Zedong, that is, “caring about the lives of the masses and paying attention to the ways of interacting”. The ‘thought work’ conducted by moral doctors and nurses in our case aims at engendering ethical changes in a person. The skills that these moral doctors and nurses learned from previous ‘thought work’, which also has an affective dimension involving feelings, attitudes, and gestures of care (Zhang 2014: 295), are applied to their current treatment based on touching the hearts of their patients. In this affective regime, knowing, caring, and regulating are coalescing (Zhang 2017: 15).

There is also much in common here between the approach of traditional Chinese medicine and moral doctors' processes for reducing conflict in communities. What we mean by this is, whereas the clinical craft of traditional Chinese medicine is about framing the perfect balance between nature and human (non-)action, moral doctors also strive to forge a balance between conflicting parties. That is, for moral doctors it is not necessarily the idea of Western medical 'disease' (*jibing*) that is to be cured, but rather Chinese medicine's 'pattern of disorder' (*zhenghou*) that is to be addressed. As Farquhar (2012: 160) showed, the pattern defined by Chinese medicine is not a disease discovered in nature but a 'diagnostic outcome' (*jielun*, resolution) resulting from skilled and educated human activity (Farquhar 2012: 162–163). In other words, it is not to eradicate the root of a problem but to adjust the asymmetrical relationships that enable the problem to persist. The words of a moral doctor indicate how moral doctors seek to rebalance these irregular relationships in the context of the neighbourhood:

Through a moral doctor's constant persuasion, the problem of growing vegetables in public green areas is solved. Since moral doctors have no administrative power, how can they achieve this? Moral doctors patiently and consistently persuade each resident who grows vegetables to uproot their vegetables, explaining that growing vegetables in public green areas does affect the environment in the whole community. Later, moral doctors contacted the greening department to restore the lawn in the public green area. You see, our work is always about restoration.

Indeed, the restoration of local order (rather than constructing a new order) is a key to understanding therapeutic governance in China. This process simultaneously produces disciplining and nurturing, repressive and unfettering effects in everyday life (Zhang 2017: 6). Moreover, moral doctors do not impose their will on patients. Rather, they offer advice

and information according to their ongoing and developing understanding of the situation, rather than solely based on their own expertise, goals and beliefs (Peterson 2012: 4). Their approach proposes what Nissen refers to as ‘a ‘partnership’ model of interaction whereby patients collaborate with practitioners, and by so doing, they take an active role in the healing process (2011: 194). ‘In this way, patients are respected as experts and active partners ... with their . . . needs contextualised within their lives’ (ibid.). As a moral doctor told us:

When we are actually doing moral work, we do not present ourselves as, “we are doctors and we are here to treat you;” rather, we prefer to be partners together to build a good ethical environment for ourselves. Therefore, we are not forcibly intervening. We actually negotiate with people.

In this kind of clinical setting, there is no specific ‘drug’ (or herbal) to be used. Instead, the ‘medicine’ is the moral doctors and nurses themselves. They do not simply tell the patient what is right or wrong; rather, they take the time to identify the needs and feelings of the patient, and then offer the sort of help the patient requires, and because each patient will have different needs and experiences, he or she requires a unique plan of treatment (Peterson 2012: 4). As such, moral doctors are caseworkers who rely to a great extent on their personal skills in the context of face-to-face interactions (Read 2000: 817). Their way of working is to treat each case with ‘universalist caring’, with the ultimate aim of promoting ‘relations of empathy and mutual intersubjectivity’ (Held 1993, cited in Peterson 2012: 4). Thus, as Bond-Taylor (2017: 132) argues, these symbolically ‘feminine’ principles of ‘care’ rather than ‘masculine’ principles of ‘justice’ focus upon the importance of interconnectedness, the maintenance of relationships and harm avoidance, and emphasis is based on empathetic situated and contextual decision-making. In this sense, affect is both an analytical tool and a force for reconfiguring power (Yang 2014: 3).

As caseworkers, moral doctors and moral nurses are often seen as ‘miracle makers’ because of their effective handling of ‘difficult clinical cases’ (Zhan 2001: 453). That is, because moral doctors are affective and performative (as discussed above), they use their ‘miracle making’ abilities to craft a niche for the moral clinic both within the official governing mechanism (Zhan 2001: 454) and amongst community members. In turn, clinics also subject moral doctors to ‘a field of visibility in public’ where they are the bearers of the roles of both the governor and the governed (Chong 2011: 48) and exemplars of good citizenship. A local official spoke to us about the significance of using examples to support new governance approach, including the work of the moral doctors:

Presenting normal people with exemplars has created a positive atmosphere for promoting the new style of civilization. We strive to create a good civil and moral-production atmosphere, by emphasizing the fine practices of moral doctors, moral nurses and volunteers, and through promotional platforms like media resources, publicity lists and community websites in the district and the city.

In many ways, the aims of the moral clinics are to transform neighbourhoods through the power of the example of these elderly women who desire to effect social change through their pastoral ethic of care (Hoffman 2013: 852). In other words, moral doctors, as role models, act to induce others to change, through attempting to shape the behaviour of others directly and indirectly, especially through their humility, selfless acts, empathic relationships and collaborative problem-solving skills. As an elderly moral doctor told us, when people see ‘us doing hard work, they will in turn improve themselves gradually’. Thus, as these elderly women selflessly work hard to improve neighbourhoods, they are using the example of their labour, their age, their gender and their commitment to amplify and articulate their goodness – in order to encourage the rest of society to be ‘good’. As such, they are involved in a subtle programme of attempting to induce pro-social behaviour through being moral and social

exemplars through their behaviour and action (Hoffman 2013: 853). This is especially the case when the work of the moral clinics attracts media attention, as a moral doctor explained to us:

The moral clinic has received extensive attention since its birth. More than 20 news media, including the Xinhua News agency, *People's Daily Online*, *Zhejiang Daily* etc. covered the story of the moral clinic. In June 2017, the volunteer service working group of the Office of the Spiritual Civilization Development Steering Commission spoke highly of the moral clinics when they conducted field research in Huzhou. According to this group, as an innovative form of volunteer work, the moral clinic is highly practical, distinctive and effective, and therefore should be well promoted. Overall, this expanded the influence of the moral clinic and helped to gradually create a new trend of exemplary moral production in the whole society.

We must remember that, despite the organic, 'bottom-up' mobilization of the moral clinics – they are not independent of government – these clinics' methods might be distinct from government, yet they share a common vision with the state in terms of promoting greater self-control and social harmony in urban China. The 'bottom-up' 'grassroots-focused propaganda' processes conducted by moral doctors are also connected to the promotion of state-derived ideals of good behaviour and good citizenship of 'top-down' Chinese community-building process (Heberer & Göbel 2011: 8).

Furthermore, moral exemplars have been employed in various publicity materials aimed at making the public aware of the moral clinics. The moral doctors see facilitating theatrical performances for the purpose of generating publicity as a key part of their role – central to these initiatives is the use of exemplars and examples. Indeed, negative and positive examples are often used together in China for purposes of mass education,

mobilization, social control, and human development’ (Yang 2018: 1952). In these theatres and other artistic collaborations, the moral doctors use public education techniques to attempt to convert the ‘uncivilized’ into responsible, good citizenry. A local official described a related theatrical production depicting the worth of the moral hospitals, thus:

All three performers were doctors working at the moral hospital. They acted out examples of uncivilized phenomena that they have come across in the past in a witty and humorous way, such as growing vegetables in the green belt, dog owners who have little regard for public health and other examples were littering and airing quilts everywhere. It amused residents in the community, and they in turn welcomed moral baptism into their hearts.

As well as these practices of ‘moral baptism’, moral doctors are also involved in other practices such as public shaming and using negative examples to teach moral lessons to the public (Yang 2018: 1952) have also been adopted by moral doctors. For example, other publicity materials produced by the moral clinics include excerpts depicting the treatment of uncivilized actions, such as “the sketch ‘Mr Ye Grows Vegetables’ which is one of the classical plays the moral hospital performs in public”. Although these activities and performances are closely allied with the Chinese Communist Party’s agenda, what the moral doctors and their collaborators add is an element of entertainment to spice up ‘community education’ for the purpose of increasing the potential relevance to the audience and by so doing they hope that the pro-Social Education message they hope to convey resonates with the audience. In many ways, the use of gentle humour in these examples of publicity is a particular extension of their distinctive soft power approach for encouraging social change through the promotion and embodiment of moral nobility.

## Conclusion

In this paper, we explore the emergence, in recent years, of a particular network of moral clinics and moral hospitals in Huzhou city in China. In the context of therapeutic governance, we see the development of these clinics as offering for analysis a particular framing and valuing of the skills, attributes and characteristics of older, retired women at a time in their lives when they might otherwise be experiencing marginalization, invisibility and isolation. Far from being unproductive and disregarded by society, these women find themselves willingly called to ‘duty’. Moral clinics provide a context and a platform whereby these older women can exhibit, perform and embody a particular ethics for effectively interacting with the public.

That being said, there are some limitations associated with this paper. For example, in future studies, more could be done in terms of how these moral clinics relate to the social credit system in China. Could the clinics become potentially punitive if they are closely connected with the social credit system? As we have also indicated elsewhere, a weakness of this research is that we were unable to interview the ‘service users’ (moral patients) because of practical and ethical concerns. They are the other half of the highly uneven power relation embedded in the clinics. If this had been done, we would be able to draw a more complete picture of this form of power, where the ‘service users’ have neither the authority to refuse interventions by the moral clinic workers nor any rights in this relationship to secure their well-being in the clinics. This is where the potential violence of this seemingly benign form of ethics of care might be identified.

Nevertheless, the strength of this paper comes from our identification and framing of this particular ethic of care that these moral doctors exhibit and embody in their ethical work as being an example of a highly effective combination of skills built up over a lifetime. They are both the professional skills of effective leadership, emotional intelligence and ‘listening’

skills, as well as what Gilligan would suggest are the skills mostly attributed to nurturers who exhibit a care for and sensitivity to the needs of others (1982: 18). These professional and nurturing abilities in combination with other attributes such as humility and selflessness in their willingness to perform hard and dirty work – like picking up garbage and performing other environmental ‘cleaning’ jobs for the greater good of their communities – are both disarming and seemingly influential in terms of shaming and also encouraging others to join them in their labours – and for others to encourage them to refrain from ‘uncivilized’ behaviour.

Their social activism is not in opposition to the state. In many ways, the moral doctors are a highly conservative group who are supported and aligned with state agendas. Their distinctive and seemingly effective practices are thoroughly governmental in terms of what Foucault describes as governmentality, or the ‘conduct of the conduct’. Through their moral nobility and moral capital, they have been set up as moral exemplars of good citizenship. Moral doctors, as role models, act to induce others to change, through attempting to shape the behaviour of others directly and indirectly, especially through their humility, selfless acts, empathic relationships and collaborative problem-solving skills. In turn, they appear thoroughly to enjoy this status as moral paragons in their communities – it gives them a sense of purpose, that is, a zeal for promoting social change and bringing forth a desired state of ‘social harmony and social responsibility’. As such, the phenomena of the moral clinics which are organised by these elderly, female moral doctors and nurses – and in particular their distinctive moral ‘toolkit’ or *modus operandi*, replete with a sophisticated and explicit ethics of care – is an example of high-status ‘active ageing’ that is deserving of academic attention and analysis.

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