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Trading Legitimacy: Everyday Corruption and Its Consequences for Medical Regulation in Southern Vietnam

Government regulation of health professionals is believed to ensure the efficacy and expertise of practitioners for and on behalf of patients. Certification and licensing are two common means to do so, legalizing a physician to practice medicine. However, ethnography from Ho Chi Minh City (HCMC) suggests that in corrupt socioeconomic environments, certification and licensing can alternatively produce a trade in legitimacy. Drawing on participant observations during 15 months of fieldwork with 25 medical acupuncturists in private practice in HCMC, southern Vietnam, and their patients, I argue that everyday practices of corruption and the importance of personal networks meant that legality, efficacy, and expertise separated. Certificates and licenses did not unproblematically validate expertise and efficacy. Consequently, compliance and enforcement of regulations as solutions to inadequate medical care may not achieve the effects intended. [southern Vietnam, medical regulation, corruption]

Five months into fieldwork investigating knowledge construction among acupuncturists in Ho Chi Minh City (HCMC), I was confused about certificates and licenses.¹ Practising acupuncturists may or may not have attended a university or an institute to obtain a certificate in acupuncture. They may or may not have a license to practice acupuncture medicine. Indeed, these documents themselves seemed unreliable. My acupuncture master, teaching a course of private classes to paying students, claimed to provide expertise not paper certificates—as if the two were contraindicated. A respected teacher of bloodletting technique provided certificates to those who paid for his class—the cost of teaching included the certificate, he pointed out. An informant opening up a large, new traditional medicine clinic in the center of the city was reputed to be “renting” an acupuncture certificate to gain a license to practice. There was much speculation about the fee she was paying for this service.

These anecdotes conflicted with assumptions in academic and development donor literature. Certification and attendant licensing is one of the most frequently used means (Ensor and Weinzierl 2007) to regulate health professionals in order to ensure expert and efficacious medical practice for citizens of a country. But fieldwork called into question the implicit and assumed relationships between vocational specialization, teaching, certification, licensing, and professional practice. Informant reports of ongoing and seemingly trivial acts of bribery and misrepresentation were at the heart of such doubt.

Approaches to the study of corruption tend to problematize corruption, explore its impact, and identify solutions. Transparency International assesses the national and international scale of the problem in its annual perception of corruption index, recently rating Vietnam as 112th out of 182 countries (2011). Corruption is a negative activity: It prevents economic growth and development (Quinn 2006; Segon and Booth 2010; Templer 1998), increases out-of-pocket health expenditures for the poor, and reduces the efficiency of

already underfunded health systems (Ensor 2004; Nguyen and Tran 2005). However, as Anjaria (2011:61) notes, the problem with such framing is that “unofficial transactions ... are framed as deviations from the normal way states and citizens interact, or at least deviations from how they ought to interact,” where “normal” and “ought to” are often unexpressed.

Like Anjaria (2011) and Gupta (1995; 2005), I understand corruption to be productive practices. By following bribery and certificate rental, I explore taken-for-granted relationships in the regulation of medical professions as assumptions underpinning regulation are rendered more discernable. I will show that in HCMC, a collusion of practices produced a trade in legitimacy; consequently, our understanding of what certificates and licenses are able to do is changed.

Notwithstanding anthropological investigation into everyday corruption practices (e.g. Lomnitz 1988; Seyyed-Abdolhamid 2010; Yang Mayfair 1994), a persistent assumption in social science literature is that education certificates and government licenses to practice can provide a comprehensive division between medical experts and quacks. Medical practitioners holding appropriate documentation are assumed to be experts, practicing safe and efficacious medicine (Pfadenhauer 2006; Wahlberg 2006). In contrast, a medical practitioner without a certificate from an approved medical education provider and a government license is construed to be ignorant, ineffectual, and dangerous to a patient’s health. For this reason, Wahlberg (2006) called certificates and licenses dividing practices because they are productive in the Foucauldian sense. They produce categories (expert, quack) and a division between persons.

Certificates are linked to a specialized professional education through bureaucratic processes (Becker et al. 1961). A novice student attends a government-sponsored educational institution to train in medicine on a mass basis (Johnson 1972; Krause 1996). Curricula have quality standards built in. Education is understood to be transformative, so that on exit from an institution, a student becomes an expert and obtains a document (certificate) validating this change. Certificates from an approved education provider are necessary to obtain a practice license through a systematic and purposeful government application procedure (Friedson 1988). If successful, the receipt of a license allows the holder to participate in a quasi-monopoly (Welsh, et al. 2004) by legalizing his or her medical practice. Certificates and licenses that witness a named holder as a safe, competent, and efficacious medical practitioner are of utmost importance when public health is conceived as bio-politics that seeks to eliminate risks to the lives of a population who are ignorant and potentially irrational (Wahlberg 2006).

After progressing through a regulated education process and a statutory license application procedure, a graduate is assumed to have attained the required expertise to practice medicine (Friedson 1970). This assumption is based on government legitimating claims to knowledge under statutory legislation. Because I refer to a number of authors who use legitimacy in association with statutory legislation, the meaning of the word legitimacy in this article is restricted to legal matters only. Government renders a practitioner legal by means of his or her passage through government-sponsored education and licensing processes. For many writers, government therefore becomes the guarantor of a division between practitioners who are legal—and are therefore thought to possess special expertise and can act competently, effectively, and safely—and those who are not. Wahlberg (2006) argues that when medicine is regulated by government, the public can feel assured of the quality of medical care offered and be protected from dangerous medical practitioners. However, in southern Vietnam, bribery in medical education and misrepresentation in license

applications meant that the government could not ensure best practices through regulation as assumed above.

I argue that in HCMC, everyday corruption, processes of bureaucratization, and personal networking interacted to enable a trade in legitimacy to occur. First, I delve further into assumptions around certificates and licenses before describing local meanings of efficacy and expertise. Expertise was understood as a complete education, in the sense that nothing was missing, whereas efficacy was measured in the number of satisfied patients returning to a clinic. Documents, on the other hand, were unreliable in this regard.

After describing how informants experienced licensing procedures, I will argue that legitimacy came to be traded, making use of Fuller's (2001) argument that certificates have the ability to separate knowing from legality. This separation allowed a trade in legitimacy through the new educational and regulatory bureaucracies in operation in southern Vietnam since 1975. Consequently, certificates and licenses divided acupuncturists on grounds of legality only. Because legitimacy itself was traded, certificates and licenses could not be used to divide practitioners on the basis of expertise and efficacy, two key aspects of practice raised as important by informants.

Research Design and Methods

The content of this article is drawn from anthropological fieldwork with medical acupuncturists and their patients in southern Vietnam, conducted between January 2007 and August 2008. I worked with 25 practicing acupuncturists, 24 of whom worked solely in the private sector. The majority of this group were men, aged between 28 and 75. They included certified medical doctors, acupuncture diploma holders (awarded by the government's Traditional Medicine Institute [hereafter, the Institute]), uncertified practitioners who learned acupuncture formally with a private teacher, and certified practitioners who had also learned informally within their family and took part in other short informal courses. Only one informant had attended neither public nor private school and claimed supernatural authority for her practice. This group also included two Vietnamese doctors who had learned medicine (allopathic and traditional) overseas as well as in Vietnam and highlighted to me many unspoken assumptions at work in HCMC.

I spent time with practitioners at work in their clinical settings; attended charity acupuncture training and treatment events throughout Vietnam and Cambodia; and attended private acupuncture classes in HCMC. I also had conversations with practitioners during long-distance travel, overnight stays, and when socializing.

I informally interviewed acupuncture patients who I came into contact with through fieldwork activities. It is not possible to state the total number of informal interviews because many hundreds of patients attended charitable acupuncture events and clinical sessions. Patients were aged between 22 and 85 and worked in farming, home care, administration, business, and traditional medicine. The majority of patients were women—notably in HCMC, acupuncture was used by adult women more than by men and children. I sought verbal consent from patients after I explained my role and the research project. I conducted structured interviews with key practitioner informants in the last months of fieldwork to verify field notes and working ideas. I recorded field notes daily and fully coded them when I returned to the university.

Actor-network theoretical approaches were influential in the coding process. An actor-network approach (Latour and Woolgar 1979; Mol 2002) emphasizes the net of relationships between technologies, practices, and people collaborating to shape reality. This

approach assumes that the world is constructed in some way but is still very real and capable of affecting consequences (Haraway 1991). Like social constructionism, network theory usefully maintains a sense of constant productive action while extending the concept of action to more “actants” (Latour 2005), which are able to “relay” (Gomart and Hennion 1999) activity through numerous relationships. In this approach, things as well as people are capable of producing social action. The documents known as certificates and licenses are the central actants under discussion in this article.

I worked with practitioners active in the private sector at a time of burgeoning private medical practice in Vietnam. Since the 1986 government policy shifts called Renovation (*Doi Moi*), which sought to re-create Vietnam as a socialist-orientated market economy, medicine in Vietnam has often been characterized as being on a trajectory of privatization. Increased private (non-state) provision of clinical services has moved in tandem with reduced government subsidy for hospital services, increasing individual out-of-pocket expenditures and changing ways of paying for health services. There is concern that universal access to basic and specialized health care is threatened by increased private medical practice and reduced controls over treatment efficacy (Guldner 1995; Hien, et al. 1995; Lonroth et al 1998; Lonroth et al 2001). The net effect has been a flourishing private sector that “plays an increasing role in ambulatory services, covering some 32% of total patient visits in 2008,” but with an estimated 97.5 percent of traditional healers working solely in the private sector (Hanoi School of Public Health 2012:25).

All private practice (traditional and allopathic) is regulated through administrative and bureaucratic controls (Ensor and Weinzierl 2007) set out in the Ordinance on Private Practice dated 1993. This regulation designates rules for opening and registering clinical facilities and a process for license application. It also sets out sanctions for noncompliance (Government of Vietnam 2003). Despite the Ordinance on Private Practice, there are many unregistered facilities (Hanoi School of Public Health 2012). The government, though, continues to take the key leadership role by setting health policy and regulation for all public and private medical practice in the country (Adams 2005).

Objective Proof

Sociological studies on professions tend to assume that educational certificates can “warrant” (Svensson 2006) expertise. Certificates are thought to attest that an individual has consumed specialized expertise (Pavlin, et al. 2010). In medicine, they “convey a certain level of education or expertise to the public” (Abrams 2010:383). More widely, different authors have cast certificates (equally credentials /qualifications) as authenticators of identity within a bureaucratic system (Mitchell 1994; Morgan 2003; Schlecker 2007) with which to make claims on that system.

In Fassin and d’Hallusin (2005), medical certificates drawn up by doctors or psychologists were assumed to be higher proofs of truth than oral narratives of asylum seekers—in part because writing is assumed to be more trustworthy than speech. For Cody, researching the performativity of signatures and writing in rural Tamil India, a “rational-bureaucratic ideal” is that “writing is conceived of as a more transparent medium of representation than speech” (2009:356).

Likewise, printed licenses are taken to be trustworthy permissions assigned to a person to do something. When a license to perform medical procedures is legally tied to a particular certificate within a medical regulatory system, certificates and licenses are assumed

to be objective proofs of competency, in the sense of ability to perform certain acts. Pfadenhauer sums up this position, saying:

[T]he professional is awarded a license and has the permission/entitlement to perform certain tasks. This license is tied to certificates attesting the competence of the professional by certifying his or her willingness, ability and legitimacy to conduct certain activities ... the professional's claim to competence is coupled to certificates and thus to proof of specialised expertise. (2006:565-566)]

For the normative understanding of certificates and licenses to hold, we must make numerous assumptions about relationships between people, documents, and the educational and bureaucratic procedures that produce them. At the very least, we must assume that progress through an educational process is unimpeded and complete; that licensing procedures are enforceable and accountable; that citizens obey the law as stated in government statutes; and that both the education and licensing system in use can produce knowledgeable graduates and competent practitioners.

Delving further, we can see that there are other more fundamental assumptions at work. The accounts above create a connection between a person who did something (such as attend a training program), a piece of paper, a name, and a person who seeks to do something (e.g., practice medical acupuncture). For the normative sense of certificates to hold, the relationships between these parts of the assemblage must cohere and, indeed, are often assumed to cohere. The person who undertook training is assumed to be the person who seeks to practice medical acupuncture. The name of that person is assumed to accurately identify the person as one and the same throughout. The name on the certificate and license to practice is assumed to be the same as the name of the person undergoing training and seeking to practice medicine. I belabor this seemingly banal point because fieldwork showed that such assumptions cannot, in fact, be taken for granted.

Learning Acupuncture

In Vietnam, acupuncture education and treatment are publically and privately provided and regulated by statute. Private acupuncture education flourishes but cannot provide certificates that the government will recognize for license applications. During fieldwork, I encountered numerous sites of acupuncture learning in HCMC. Prospective students could participate in acupuncture classes at the Institute through either a degree program, an additional practice year for qualified medical doctors, or a two-year technician's program that leads to a diploma.

Degree courses in acupuncture were also available at the University of Pharmacy and Medicine. Alternatively, a potential student could study privately with a scholar-practitioner who was willing to take on students. In one known instance, such study entailed attending morning lectures and shadowing the teacher during clinical activities in the afternoon. Students could also learn within a household (*gia truyên*). My informants used *gia truyên* to talk about a place where parents taught sons and daughters their medical secrets as well as a place where people lived and learned together and were not necessarily biologically related. Finally, acupuncture teaching also took place in Buddhist pagodas by government certified as well as uncertified and experienced practitioners. Such teaching was often undertaken free of charge.

Bui (1999:34-36) suggests that traditional medicine practitioners in Vietnam can be put into three different groups. One group would consist of elder practitioners who had been trained in classical traditional medical techniques with a classical theoretical and philosophical base. The second group would be those who had received training at traditional medicine faculties of a medical college or a secondary school of traditional medicine. The last group would be those who had received no formal training but had acquired expertise and experience through apprenticeships.

However, acupuncturists working in HCMC during 2007/2008 could be classified more simply as those who were practicing legally and those who were not. Such a division is only possible because licenses exist as part of national statutory regulation of acupuncture and traditional medicine practice in both the public and private sectors (following Whalberg 2006). Students who attended courses at the Institute or the University of Pharmacy and Medicine became certificate holders and potentially legal—legitimacy being determined by a future, and successful, license application. The creation of credentialing and licensing procedures was productive in the Foucauldian sense because such procedures could produce a particular division between all the different persons who had studied and practiced acupuncture.

As noted, there are numerous sites of learning but students could proceed to legitimacy by being awarded a certificate only at certain places. Legitimacy was attached to a person, not to acupuncture techniques. After studying government-approved curricula at a university or an institute, certified students could take up nongovernment-approved acupuncture training elsewhere without endangering their right to practice. Although the government did not monopolize acupuncture education in HCMC, it did monopolize the production of certificates, linked to a specialized education, that were necessary for license applications to practice legally.

Efficacy and Expertise

In 1975, the new socialist government of a unified Vietnam instituted mass education of traditional medicine in the southern part of the country. The Institute, founded on December 24, 1975 in central HCMC, was envisaged as the key government instrument to do so. The continuing purpose of the Institute is to guide, develop, and promote traditional medicine in the south through teaching, training, and research and by standardizing such education for all who attend it (Traditional Medicine Institute n.d.).

Mass medical education conducted at the Institute is in marked contrast to other teaching and learning modalities at different sites in Vietnam. Class sizes at the Institute were typically large and classrooms crowded, with over 100 students in some classrooms. Through mass training programs, numerous students from many different backgrounds could be trained at the same time. Training at the Institute therefore enabled numerous citizens to sign up for classes, learn the same curricula, consult the same textbooks, learn a common acupuncture language, earn the same certificate, and be eligible to apply for the same license to legally practice medicine.

Schlecker (2007) argues that such “gathering practices,” bringing together a large group of diverse individuals and codifying them into one homogeneous group, is a hallmark of a modern bureaucratic state. Teaching at the Institute was therefore mass education: A mass of students was to be transformed into experts by the same method. An expressed pedagogical intent of such government-funded and -mandated education was the standardization of teaching for all attending students. However, the potential of these

relatively new education practices to produce knowledgeable and effective medical acupuncturists was disputed by practitioners and their patients during my fieldwork in 2008.

For acupuncturists and their patients in HCMC, therapeutic efficacy was an assessment made by patients not a verification made by certificates. Patient presence at a treatment room was taken as empirical evidence of efficacious treatment. “Look at Mr. Two,” pointed out an acupuncturist who had been running his own practice for five years. “He has between 40 and 50 patients a day. That proves his techniques. If methods work, the patient will tell you because they will always come back.”

Generating patient return through positive publicity was an ongoing concern for practitioners. Word of mouth was considered the most effective. How do you find your patients, I asked acupuncturists? Their replies included: “I don’t find patients, patients find me,” “For example, the way you found me; a mutual friend introduced us by email sharing our phone numbers and you called me—through friends and word of mouth,” “By referral, one person tells another that I did a good job. In Vietnam, patients find the doctor not like in foreign countries where the doctor finds the patient.” “Medicine moves by word of mouth,” summed up an informant, who has since retired from medicine. “People talk and *phát ra*” (radiate/send out, e.g., the sun *phát ra* light).

By word of mouth, patients could find a good practitioner. To this end, one experienced acupuncture master was friendly toward his patients and students. He prided himself on his approachability and placed great importance on developing empathy with his patients. Personal networks acted as a media form, moving the name of an efficacious practitioner independently of his or her own publicity efforts.

Patients who I came to know during fieldwork undertook acupuncture simultaneously with other treatments, mainly for muscular skeletal pain. These treatments could include prayer, pharmaceuticals, allopathic medicine, or other traditional medicines. A woman in her early fifties with persistent back pain, for instance, had been unsuccessfully treated at the Institute before being introduced to the licensed acupuncturist who cured her; a woman in her thirties with a cancer diagnosis was also undergoing surgery while being treated with acupuncture and other traditional medicine by an uncertified and unlicensed practitioner. But uppermost in patient choice was belief in the personal efficacy of a practitioner: A poor elderly woman declined to be treated for free by a certified and licensed acupuncturist because he was also blind.

Efficacy was defined by both patients and practitioners as removal of pain felt by the patient and it was measured by counting patient numbers. Hence, efficacy can be understood not as a trait of a medical treatment but an activity jointly worked at between practitioners and patients that had to be constantly proved. This could be described as a patient-centered approach—being concerned with how a patient experienced clinical activities and how such patients assessed results.

However, assessing efficacy according to patient volume is also free market logic: The customer is always right. Practitioners without certificates were as likely to be considered efficacious as certified colleagues because the most important indicator was the volume of patients attending a treatment room, attained through consistent patient-to-patient referrals that generated a durable reputation. As one doctor/acupuncturist put it: “It’s not polite to ask to see a doctor’s qualification in Vietnam ... that’s not our culture. ... If patients get a successful treatment from you, then they will believe in you and refer you to others. They do not look at your qualification.”

Medical practitioners sought to become famous in the sense that their patients talked about them to friends, family, and colleagues, spreading the word of an efficacious

practitioner. Patients were willing to travel widely to meet a famous practitioner undertaking charitable treatment—some informants had traveled from HCMC to Tay Ninh and An Giang provinces (around seventy-five–one hundred ninety kilometers respectively).

Certificates could not a priori validate therapeutic efficacy in part because doubt constantly circulated as to their authenticity. They were subjects of intense gossip and speculation. The presumed knowledge transfer during a professional training program; presumed relationships of honesty between teachers and students, and presumed equivalence in relationships between graduates' learning and their certificates were all questioned. Although no practitioners in my study said directly that they themselves had engaged in such activity, informants described how they had heard of other students offering cash to their teachers to “pass” exams regardless of performance and that it was easy to bribe a teacher to pass an exam. Students at any level could offer a bribe and therefore not attend classes and take an exam without being there. Informants claimed that it was easy to “rent” the name of a certified practitioner to apply to the Department of Health to open a private clinic—those who had no certificates could rent another's.

The certificate holder was paid to put his or her name on a license application but would not be the person carrying out treatment (discussed further in the next section). Because renting certificates for license application was reputed to be common, it was difficult for patients to know who was renting and who had legitimately completed their education. Doubt circulated. Whether these stories are true or not, informants constantly circulated doubt about certificate authenticity, thereby undermining any objective validity that certificates might otherwise have.

An additional worry among the acupuncturists I worked with was the thoroughness of their education from either a public or private provider. A common complaint was that teachers at the Institute taught “just a few acupuncture points” or that students might “just pay and learn a little but the teachers don't want to tell you everything because they might want to do ‘extra’ tuition, at additional cost.” One medical doctor complained about the perceived inadequacy of her teaching at the Institute: She felt she was taught “just a few meridian points” (also known as acupuncture points) and spent “about five hours” following acupuncture doctors from the Institute on ward rounds at the traditional medicine hospital because she had already gained her medical degree. She switched her study to a private teacher instead. The completeness of such teaching could not be assured at the time of learning and would only manifest itself in efficacious clinical outcomes measured, as noted above, in numbers of patients attending a practitioner's treatment room.

The fear of incomplete education was complicated by a repeated stereotype that traditional medicine practitioners kept secrets (see also Hsu [1999] and Scheid [2002] on secrets in Chinese medicine). “Practitioners didn't write their secrets down in a book,” explained an avid user of *materia medica*² and acupuncture, “all their effective cures were taught within the household (gia truyên) so a practitioner needs to be with a family or an acupuncture master, else how can they learn the techniques that really work?”

For the speaker, personalized learning was how true and complete understanding might be attained. Certificates and licenses did not stand in lieu of efficacy: Truly efficacious techniques were reserved for those within trusted personal relationships. All students had heard this. But secrets raise the possibility of more secrecy: No one knows what they could or should know. Because of this, an acupuncture master teaching a small class of private students that I attended during fieldwork sought to systematically demonstrate the completeness of his teaching in his private classroom. He did so to convince students that his

teaching was complete and assure them that his techniques would be clinically effective when they returned to their own practice settings.

I am not suggesting that each and every acupuncture student and teacher was engaged in averting the professionalized education of acupuncturists. Rather, there was sufficient evidence for patients and practitioners to be confident that bribery and incomplete teaching took place. Many stories circulated in the personal networks of informants. Such stories came from their own experience as well as that of friends, connections, newspaper articles, television reports, and the Internet. Bureaucratic procedures and informants' experiences of those procedures existed together with talk about those experiences. Stories became "part of the fabric of daily lives ... shaping fears and sensibilities ... (becoming) elements in each person's understanding" (Gammeltoft 2007). Claims and counterclaims circulated in person networks, which were active in the Latourian sense, escalating, translating, and transforming circulating content—generating suspicion and doubt. In the face of this, I suggest that in HCMC in 2008, the government was not able to generate assurance as suggested by Wahlberg (2006). Certificates could divide persons on legitimacy when engaging with bureaucratic procedures, but for practitioners and their patients in numerous small treatment rooms throughout the city, certificates could not guarantee expert and efficacious practice.

Informants suggested that the shift to a bureaucratic medical education model itself generated opportunities for distrust. This sounds contradictory to Weber's ideal type of bureaucracy, where professionals "operate in accordance with a system of formal regulations, within precisely fixed functions ... expected to devote their full energy to the fulfilment of their obligations" (Mommsen 1989:113). However, for some, it was the very insertion of certification via bureaucratic procedures that opened up these new opportunities for distrust.

Mass acupuncture education enabled mass certification. Students could now go to a college, university, or institute to learn acupuncture, whereas in the past a genealogy of masters had been more important. "In the past, the genealogy acted as a practitioner's credential" (in the popular sense described in the introduction), and was his or her authority to practice rather than a government license. "The more Western people in Vietnam become," this overseas Vietnamese speaker argued, "the more they like certificates—but this does not mean expertise." Certificates from such schools, where one pays to learn, were suspicious because teaching may be incomplete. Patients and prospective patients, she generalized, "would know the old masters. If a practitioner was from a household of practitioners or had been accepted into a household it means that complete expertise has been taught."

A committed Catholic acupuncturist went further, claiming that many students were uneducated, even after attending an institute or university. Students, he complained, no longer wanted to learn—they just wanted a diploma. They left the Institute but still knew nothing. For this speaker, diplomas took the place of learning: Learning was erased, it did not occur. Certificates appeared. These speakers compared past and present pedagogies and relayed suspicions about the nature of certificates, suggesting that the relatively new rationalized educational model implemented at the Institute was not working because complete teaching could not be guaranteed.

It is worth asking why students sought to study at a government school at all, given that certificates were not necessary for a successful private practice. Private practitioners who I worked with either rented premises and converted this into clinical space, used their homes as treatment rooms, or offered a mobile service.

Public schools like the Institute were important in creating access to an acupuncture education for students who did not have the necessary personal connections to active teacher-acupuncturists or to personal connections of such teachers who could teach privately or

through the household tradition. Additionally, lack of a license could potentially limit success. If a practitioner was mobile, meaning she or he had a treatment room with no fixed address, licenses were less important since a volume of patients were distributed—the volume of one’s success, which could be considerable, was dispersed. However, for a static private clinic address, success coalesced in one place.

A licensed practitioner explained that, at some point, a clinic’s success in attracting patients would irritate the neighbors. “If you keep a small treatment room, for example around ten patients a day, and don’t disturb the neighbors,” a practitioner did not have to worry. However, with too many patients, “they block the street with their motorbikes so the neighbours get annoyed.” Irritated neighbors may call the local branch of the Department of Health. An official could check the address and learn whether the individual had a current license and met other regulations. Such license checks were feared by practitioners as opportunities to levy bribes, making the need for personal connections in the local district health office significant to avoid such levies. If you were a practitioner without the appropriate personal connections, uncertainty could be mitigated (but not erased) by government schooling.

Trading Legitimacy

Regulation of health professionals around the world traditionally takes a bureaucratic approach. Governments use a legislative basis for administrative and bureaucratic controls that set out a seemingly transparent and rational process for all health professionals to follow. In Vietnam, the Department of Health has a license application process that is, likewise, intended to be homogeneous for all applicants. To register, an applicant is required to submit a file to the local office of the Department of Health in the district and ward in which they intend to open a treatment room. This file should include the following:

- the application form;
- valid copies of professional diploma certificates;
- a CV certified by the people’s committees of the ward where the applicant resided;
- certification of the applicant’s good health for professional practice;
- written certification of the applicant having practiced at a traditional medicine establishment;
- written commitment by the applicant to strictly observe the law and relevant professional regulations;
- a copy of the applicant’s personal identity card and right to reside in the city, as evidenced by a photocopy of their household registration book; and
- two facial photos.

The Ordinance on Private Practice also stipulates that applications will be processed within 30 days and cash fines of one–three million Vietnamese dong levied for the use of expired licenses and any hiring or leasing out of professional certificates (Government of Vietnam 2003). Licenses are valid for up to five years, after which the applicant should extend or renew. License numbers were often, but not always, printed on business cards if the acupuncturist used them and on outdoor signage above a static clinic entrance. The processing of license applications included a site visit by a Department of Health official to check that a site met regulations, for example, on sanitary space, signage, and advertisement of treatment costs. Applicants expected that if bribes were not offered, problems would be found even if there were none. However, bribes provided an opportunity for medical

practitioners not to have to deal with regulations, so they were simultaneously subsidies to entreat officials to obey the law and opportunities for citizens to avert it.

Applying for a medical license is obligatory for acupuncturists who wish to attain the status of a legal practitioner. Getting a license was set out in government regulations as a series of stages in a process: Gather this; obtain that; sign the other; take it here; and wait for a short time. Such regulations are set out as a consistent and systematic process with a start and end point, obligations and expectations, rewards and punishments. It should be noted that licensing was not obligatory, since as mentioned above, success in private practice did not depend on legitimacy. For those who did not have the appropriate certificates, were unable to rent a certificate, or did not wish to attend a training course at a government-sponsored medical school to obtain it, it was necessary to practice illegally.

When applying for a medical license, it was the certificate and not the person that must join with other documents to obtain an additional piece of paper known as an acupuncture license. This meant that an individual who had obtained the appropriate certificate could put his or her name and certificate forward, for a fee, for a license application on behalf of another practitioner who would undertake treatment. Informants called this renting a certificate.

The practice is specifically prohibited in the Ordinance on Private Practice. However, a traditional medicine clinic in central HCMC was opened and managed by an individual without “written certification of the applicant having practiced at a traditional medicine establishment” (Government of Vietnam 2003) as stated in the Ordinance on Private Practice. The person holding the appropriate certificate provided his name, certificate, and other details necessary to make the license application for a monthly fee. Persons, names, certificates, and training activities, then, did not necessarily cohere. When certificates were rented, the person who retrospectively experienced training was not the person who prospectively would practice acupuncture. Certificates were understood as alienable—they could be temporarily transferred to another’s ownership.

In contrast to thinking of certificates and licenses as either objective proofs of expertise or dividing practices on efficacy, in HCMC they can be understood as entitlements to legitimacy that were traded. Fuller (2001) argues that certificates split knowledge, which he figured as a freely circulating commodity, from either a person or a social network (i.e., knowledge can be disembodied). Fuller suggests that certificates erase a knowing human vessel (the expert), who would otherwise have held this portable knowledge, out of certain encounters.

Fuller’s argument is somewhat problematic because he fetishizes knowledge. For knowledge to be a fetish in this way, extensive networks of assurance are necessary but these were interrupted in HCMC by corruption. Certificates could not create a split between a person and his knowledge, embodied as expertise, because relationships of knowledge production were continual sources of speculation. But Fuller does point out that certificates have the ability to separate knowing from authority, in the sense of legitimacy, to do an act. I argue that this happened in southern Vietnam—certificates were enacted as alienable. And because only government-sponsored education certificates were accepted for license application—where licenses enable a health professional to treat legally—knowing and legitimacy separated. This separation allowed legitimacy to be traded.

Legitimacy in the form of medical licenses was traded in personal networks. “In Vietnam it can be difficult for a blind person to obtain a license to open a private clinic,” explained a blind acupuncturist, “because the blind are classified as invalids so people think we shouldn’t do acupuncture.”

In law, there is no injunction against blind people practicing acupuncture in Vietnam. However, bureaucratic process constituted an impenetrable barrier for her. She said: “If a blind friend opened a treatment room, then it might take one or two years to get permission.” She did not want to wait that long, so she operated a mobile clinic instead, visiting patients in their own homes rather than working out of a fixed address treatment room. If she wanted to open her own clinic, she could ask her doctor friend B to use his name, and, if he agreed to lend, or rent out, his doctor’s degree, she could open a treatment room in his name, for a fee. B’s name would be the name on the application, so responsibility would belong to B for problems that might arise, such as “the place turns out not to be a clinic but a karaoke joint ... so the room is not a place where patients get treated but where people sing karaoke.”

I asked what other kind of problems might arise. “Other problems might be that the patient gets a treatment and dies so it means that B takes responsibility” for the possible repercussions. However, the running of the business, including payment of any taxes, would be met by the tenant. If she opened her own clinic without a license but was unable to rent a certificate from a doctor, she was sure that she would have to offer cash bribes to the district Department of Health officials and she was opposed to doing that. Her thinking was informed by the experience of a colleague who had attended the Institute and had earned the appropriate certificate but had met such difficulties during licensing procedures that he retrained and worked for a time as a teacher of literature.

Expectation of a trade in legitimacy shaped how acupuncturists interacted with bureaucratic regulation. Many informants acted on expectation. They expected that bribes would be necessary when dealing with officials; the speaker above expected problems with the Department of Health so did not apply for a license. She felt afraid to approach the bureaucracy without personal connections, without friends and contacts on staff to help her out in such a jungle. Gainsborough (2005) likewise argues that government departments make “life difficult for (city) residents ... who had to run the gauntlet of numerous offices to complete simple procedures... it is nearly impossible to determine where bureaucratic interests end and business [personal] interests begin” (2005:375). McNally (2002) concludes in similar vein on his discussion of beer joints (*bia ôm*) in Hanoi.

My informant made use of a common idiom in HCMC—help. “Help” could mean that an official would accept an application without making life difficult. Being difficult could entail requesting additional paperwork or leaving an application at the bottom of pile that never got smaller. Help could mean not delaying an application because the file did not contain cash or not waiting for cash “tips” to grant a license. Some practitioners acted in accordance with expectation, rather than having experienced rejection or difficulties directly. Media circulation of stories, in printed press and gossip in personal networks, helped create these expectations. Although cash bribes were often seen by informants as a means to reduce presumed high uncertainty in dealing within a potentially irrational bureaucratic state, I suggest that offering cash to officials can also be considered as generating such uncertainty in the first place.

Discussion and Conclusion

A recent report by the Rockefeller Foundation identified the importance of public stewardship of the private health sector for achieving broad health objectives (Lagomarsino, et al. 2009). The report noted that many governments of lower- and middle-income countries are not performing that role particularly well at present. Analysts on Vietnam particularly have suggested that the government’s ability to regulate the flourishing private sector in a

now highly decentralized health system is in question (Bui and Le 2012). To remedy this, international donors assert that accreditation and licensing (World Health Organization 2007), together with increased monitoring (Lewis and Pettersson 2009), will lead to higher compliance with regulations and incentivize private providers to provide higher quality of care (HANSHEP Group 2011).³ However, in the context of everyday corruption, I believe that this is doubtful.

In southern Vietnam, the mass education of acupuncturists and a bureaucratic model of medical regulation colluded with bribery and misrepresentation so that education certificates and practice licenses divided acupuncturists on matters of legitimacy only. Medical efficacy and technical expertise was assessed through patient numbers and trusted personal relationships with teachers. The existence of documents called certificates and licenses that replaced persons in bureaucratic regulatory process enabled legality to be traded, a trade manipulated through person networks. In the absence of trustworthy structures to ensure veracity of mobile documentation, written documents were understood as being vulnerable to falsehood—and were not “the highest form of truth telling” (Fassin and D'Halluin 2005:606) that they were reported to be in Europe. Consequently, in acupuncture, expertise and legality detached from each other. Legitimacy was restricted to the letter of the law—measures of expertise and efficacy went elsewhere.

Because legitimacy can be traded, regulating a health system through certification of some kind may ultimately be ineffective in assuring medical care. The implications of this ethnography from HCMC suggests that a regulation can be complied with but still be ineffective at overcoming bribery and misrepresentation. Informants described in this article rented a certificate and, in doing so, fulfilled the letter of the law: They did not act outside the regulation so much as adapted their behavior to conform with it. The name above a private clinic or consulting room was the name of an individual who had obtained the appropriate education certificate. A license application had been made and approved according to the conditions set out in a regulatory process. However, as a piece of paper could replace a person in that process, conditions were complied with but untrained persons still practiced medicine.

Likewise, a regulation can be enforced—Does the individual practicing acupuncture have the appropriate certificate?—but still be ineffective if the objective of the regulation is to ensure that only experts practice acupuncture, being expert by dint of completing their education. Notwithstanding extortion by health inspectors reported by my informants or bribes to government officials to ignore compliance issues, enforcement of a regulation cannot assure expertise and efficacious medical practice when practitioners who hold the appropriate education certificates obtained proof of their training through bribery. Certificates as proof of training cannot be assumed to stand for genuine participation in that training. Enforcement as a remedy for poorly performing health professionals, then, is unlikely to result in a higher standard of medical care.

Notes

1. “Certificate” refers to a document obtained from an education provider; “license” refers to a document obtained by application to the Department of Health.
2. Plant, insect, and animal matter either fried, boiled, dried, shaved, shredded, or burned for use as medication.
3. HANSHEP, Harnessing Non-State Actors for Better Health Outcomes for the Poor, include AusAID, Bill & Melinda Gates Foundation, Government of Rwanda, International

Finance Corporation, KfW Entwicklungsbank (German Federal Ministry), Rockefeller Foundation, DFID, USAID, and the World Bank.

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