PERSONAL, PUBLIC, AND PROFESSIONAL IDENTITIES: CONFLICTS AND CONGRUENCES IN MEDICAL SCHOOL

by

BRENDA LORRAINE BEAGAN

B.A., Dalhousie University, 1987
M.A., Dalhousie University, 1988

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Department of **Sociology**

The University of British Columbia
Vancouver, Canada

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ABSTRACT

Most research on medical professional socialization was conducted when medical students were almost uniformly white, upper- to upper-middle class, young men. Today 50% of medical students in Canada are women, and significant numbers are members of racialized minority groups, come from working class backgrounds, identify as gay or lesbian, and/or are older. This research examined the impact of such social diversity on processes of coming to identify as a medical professional, drawing on a survey of medical students in one third-year class, interviews with 25 third-year students, and interviews with 23 medical school faculty members.

Almost all of the traits and processes noted by classic studies of medical professional socialization were found to still apply in the late 1990s. Students learn to negotiate complex hierarchies; develop greater self-confidence, but lowered idealism; learn a new language, but lose some of their communication skills with patients. They begin playing a role that becomes more real as responses from others confirm their new identity. Students going through this training process achieve varying degrees of integration between their medical-student selves and the other parts of themselves.

There is a strong impetus toward homogeneity in medical education. It emphasizes the production of neutral, undifferentiated physicians – physicians whose gender, ‘race,’ sexual orientation, and social class background do not make any difference. While there is some recognition that patients bring social baggage with them into doctor-patient encounters, there is very little recognition that doctors do too, and that this may affect the encounter.

Instances of blatant racism, sexism, and homophobia are not common. Nonetheless, students describe an overall climate in the medical school in which some women, students from racialized minority groups, gays and lesbians, and students from working class backgrounds seem to ‘fit’ less well. The subtlety of these micro-level experiences of gendering, racialization and so on allows them to co-exist with a
prevalent individual and institutional denial that social differences make any
difference. I critique this denial as (unintentionally) oppressive, rooted in a liberal
individualist notion of equality that demands assimilation or suppression of difference.
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Chapter I: Introduction

There is an assumption common among lay people and some researchers that women will practice medicine differently than men—and that women doctors will be better for women patients, if not for all patients (e.g., Lorber, 1985; Pizzini, 1991; Riska & Wegar, 1993; Roberts, 1981; Ulstad, 1993; Waller, 1988; West, 1990). Similarly, there is often an assumption that ethnocentrism in health care would be rectified by seeing a doctor of one’s own cultural/racial group (e.g., Curtis, 1970; Davis, 1990; Frideres, 1994; Gomez & Smith, 1990; Komaromy et al., 1996; Secundy, 1994; Weaver & Garrett, 1983), or that gay men and lesbians would be better served by gay and lesbian doctors (Auger, 1992; Barnett, 1985; Gentry, 1992; Gomez & Smith, 1990; Lucas, 1992; Robertson, 1992; Stevens, 1992; Trippet & Bain, 1992).

At the same time, there is an abundance of literature on the homogenizing influence of the intensive professional socialization processes undergone by medical students through their five to ten years of training (Becker, Geer, Hughes & Strauss, 1961; Coombs, 1978; Fox, 1979; Haas & Shaffir, 1987; Konner, 1987; Reilly, 1987; Shapiro, 1987). Virtually all of those studies and accounts were written about medical training as it existed twenty, thirty, even forty years ago. At that time medical students in Canada and the United States were a pretty homogeneous group, mostly middle- or upper-class, white, Protestant men, frequently the sons of doctors (Becker et al., 1961; Coombs, 1978). In Becker and colleagues’ classic American study, for example, only about 5% of the students in any class were women, 5-7% were non-white, and fewer than 15% of

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1 Merton, Reader and Kendall (1957: 287) state: “The technical term socialization designates the processes by which people selectively acquire the values and attitudes, the interests, skills and knowledge—in short, the culture—current in the groups of which they are, or seek to become, a member. It refers to the learning of social roles. In its application to the medical student, socialization refers to the processes through which he [sic] develops his [sic] professional self, with its characteristic values, attitudes, knowledge, and skills, fusing these into a more or less consistent set of dispositions which govern his [sic] behavior in a wide variety of professional (and extraprofessional) situations.”
students were non-Protestant (1961: 60)\(^2\). Even in the mid-1970s when Jane Leserman made gender central to her study of medical school, 74% of the students were male, 91% were white, and 75% appear to have been from middle- or upper-class backgrounds (Leserman, 1983: 81).

Today the profile of the typical medical school class in Canada and the United States has changed a great deal. In the United States women made up only 9.4% of all medical students in 1969; by 1979 that number had increased to 28.3%; and by 1993, 42% of medical students were women (Bickel & Kopriva, 1993). In Canada, women’s proportion of medical school classes increased from 8.5% in 1957-58, to 33.0% in 1977-78, to 52.2% in 1995-96 (Association of Canadian Medical Colleges [ACMC], 1996: 16). In francophone medical schools in Québec, women have made up more than 50% of all students since 1983, currently averaging about 60% (ACMC, 1995: 13; see also Dufort & Maheux, 1995). Schools in English Canada average 46% female enrollment; three of the four largest schools have classes that are 39%, 40% and 41% female (ACMC, 1996: 19-21).

Though statistics are hard to find on other forms of diversity among medical student populations, what little evidence is available indicates a slow rise in the representation of students from historically underrepresented racialized minority groups. For example, in the United States in 1991-92 African American, Native American, Mexican American, Puerto Rican, other Hispanic, and Asian or Pacific Islander students made up 26.8% of all medical students (Jonas, Etzel & Barzansky, 1992: 1088; c.f. Foster, 1996). However, it is noteworthy that more than half of those are Asian and Pacific Islander students, the only group whose representation has been

\(^2\) Calculated based on the rather sloppy descriptive statistics given by Becker et al. They say “each class contains a number of women, ordinarily around five... a few students from such faraway places as Central America or Africa, as well as a small number of American Negroes, possibly four or five” (1961: 60). However, they don’t give the class sizes for the time of their study. They do say, though, that in 1958, two years later, “94 new students entered the first year” at the medical school where they did their research (1961: 53). Assuming class sizes are fairly constant, I estimate the percentages above.
increasing significantly. In Canada, the only statistics available are for citizenship status of students. In 1994-95, non-Canadians, including landed immigrants and those with student visas, comprised 5.8% of all medical students in Canada (ACMC, 1995: 21)\(^3\). However, this number would not include students who are Aboriginal, nor those of Asian, African, Indian or South American heritage whose families have Canadian citizenship.

Statistics on diversity in religious backgrounds, class backgrounds, and sexual orientation are even less readily available. However, for the latter we may be able to infer from the recent emergence of gay and lesbian student caucuses in medical schools in Canada (e.g., at the University of Toronto; also a standing committee of the American Medical Student Association [Oriel, Madlon-Kay, Govaker & Mersey, 1996]), the development of a Canadian gay and lesbian medical student E-mail list, and recent journal articles devoted to the topic (Cook, Griffith, Cohen, Guyatt & O'Brien, 1995; Druzin, Shrier, Yacowar & Rossognol, 1998; Oriel et al., 1996; Rose, 1994; Wallick, Cambre & Townsend, 1992), that there are more publicly-identified gay and lesbian students than was the case historically. Canadian medical students are also somewhat older and better educated upon entry than they were in previous years, which may mean there are more parents in medical school (Gray & Reudy, 1998: 1047).

Finally, some medical schools have deliberately broadened their interpretations of the academic backgrounds expected of medical students. It is no longer the case that students must major in biology or chemistry in their undergraduate years; they can now gain admission to medical school in some places with a background in the arts, humanities or social sciences. Thus, the student population represents greater diversity in academic backgrounds.

\(^3\) Even that proportion is artificially inflated by the presence of 138 non-Canadian students at one medical school in Quebec, for a proportion of 25%. The proportion at other medical schools ranges from 1.5% to 7%. Furthermore, a little over half of these non-Canadian students are from the United States, Australia and Europe.
Not only has the composition of medical student populations changed a great deal in recent years, but also the content and form of medical training has been under continual revision. Many medical schools have recently increased their attention to – among other areas – ethics, dealing with death and dying, bedside manner, and communication. Some schools have been exploring the use of poetry, literature and art in medical education (see Wear, 1997), and most have been revising their curricula to better meet the needs of faculty, students, and community. Many schools have begun adopting some version of the McMaster Model, a curriculum based on self-directed learning and a case-study approach (Bloom, 1988; Haas & Shaffir, 1987).

1.1 Research Questions

Given that medical students in the late 1990s come from far more diverse backgrounds, are far less homogenous than they used to be, and experience a significantly altered curriculum, what does that mean for what we know about the professional socialization medical students go through during their intense training? To what extent was the homogeneity formerly found in medical graduates a product of the homogeneity of the group when they entered medical school, and to what extent was it a product of training? Is the process of coming to identify as a medical student, as a future physician, the same for students who are and are not middle-to-upper-class, white, Protestant men?

Grant (1988) argues that any school has its own latent culture, "the patterns of meanings, behaviors, and beliefs that students bring to medical school." That latent culture dictates the boundaries of appropriate behaviour.

When professional school members share a latent culture, elements of that culture will filter into the school’s informal environment. The gender,

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4 In fact, the only two Canadian medical schools that did not include some type of self-directed learning introduced new curricula in 1997 and 1998 to move toward that model.
race, and religion of faculty and students affect their relationships, even when these attributes are ostensibly irrelevant (Grant, 1988: 109).

Do certain background characteristics, and attendant forms of socialization, allow some individuals to ‘fit’ more easily within the dominant medical school culture while others fit less easily? Grant suggests that, “Those who share the latent culture have a sense of belonging; those who do not may feel alienated and marginal” (Grant, 1988: 109). Or is it possible that women, racialized minorities, working-class and gay and lesbian students, and students from a variety of academic backgrounds have reached a critical mass, such that they have begun to alter the culture within medical schools rather than being required to adapt themselves?

What I examined in this research was students’ experiences of coming to self-identify as student-physicians, and how membership in or prior identification with particular social groups affects the processes of professional identity formation. In particular I explored how the congruences and conflicts between students’ membership in disparate social groups and their emergent professional identities might affect their experiences of medical school. My central research questions, then, were:

- How are processes of professional identity formation experienced by undergraduate medical students in the late 1990s, in the context of a diverse student population?

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5 As one student put it as I was still conceptualizing the research, if you are other than a middle- to upper-class, white, Canadian, heterosexual man must you “forget where you come from” in order to successfully become a doctor?

6 Clearly the jury is still out. Compare: “Medical school is a systemically deforming milieu that nullifies ordinary social experience” (Gallagher & Searle, 1989: 441); “Medical training does not erase the specifically female ways of behaving from women doctors, as is sometimes feared” (Charon, Greene & Adelman, 1994: 216); and “Are women actually changing medicine, are they somehow different as doctors – or does the long and rigorous medical training produce doctors who are simply doctors, male or female?” (Klass, 1996: 83)

7 Medical undergraduate education refers to the training students experience in their first four years of medical school. In the school where I conducted my research the first two years consist of basic science courses, including anatomy, physiology, pharmacology, microbiology, biochemistry, pathology, neuroanatomy, and so on. The third year consists of a clinical clerkship during which most of students’ time is spent on the hospital wards or in clinics rotating through a range of medical departments. There may be lectures one morning a week. The fourth year is a student internship, similar to the third-year clerkship with more responsibility. At the end of the fourth year graduates are granted the Medical...
• How do students' membership in or prior identification with social groups based on such characteristics as gender, 'race,' social class, and sexual orientation affect their experiences of professional identity formation?
• How do students, faculty and administrators deal with the social differences represented among medical students in the late 1990s?

1.2 Theoretical Framework

The dominant theoretical approach to understanding socialization and identity development comes from the work of social psychologists, and symbolic interactionists in sociology. George Herbert Mead's (1934) theory of socialization provides important grounding. Mead explains how the individual is socialized, internalizing social norms and cultural patterns to become a functional member of a society or social group. The development of the self emerges solely from social experience. It relies upon the internalization of the attitudes of the social group of which one is a member, the "generalized other." This can also be a form of social control, as it is the manner in which the community enters as a determining factor into the individual's thinking. The individual then governs his or her own conduct accordingly.

It is the ability of the person to put himself in other people's places that gives him his cues as to what he is to do under a specific situation. It is this that gives to the man what we term his character as a member of the community; his citizenship, from a political standpoint; his membership from any one of the different standpoints in which he belongs to the community (Mead, 1934: 270).

Finally, Mead points out the unique socializing role of education: "Education is definitely the process of taking over a certain organized set of responses to one's stimulation; and until one can respond to himself as the community responds to him, he does not genuinely belong to the community" (1934: 265).

Doctor (M.D.) degree, though they must pass Federal qualifying exams and complete at least two years of post-graduate training (residency) to get a license to practice.
In the 1960s Peter Berger and Thomas Luckmann (1966) developed further on Mead's theory, and added specific details about processes of secondary socialization, which they saw as, "the internalization of institutional or institution-based 'subworlds'" (1966: 127). Secondary socialization though is always impeded by a fundamental problem; it must confront a preceding primary socialization which is particularly firm due to the individual's relationship with his or her very first significant others.

Secondary socialization has to deal with an already formed self.

This presents a problem because the already internalized reality has a tendency to persist. Whatever new contents are now to be internalized must somehow be superimposed upon this already present reality. There is, therefore, a problem of consistency between the original and the new internalizations (Berger & Luckmann, 1966: 129).

As I will discuss in more detail in Chapter 5, the range of possible outcomes to resolve conflicts in secondary socialization include: detaching role-specific parts of the self; total transformations, kind of switching worlds; and more moderate adjustments, building on the primary socialization rather than eradicating or negating it. In any case, a significant component of secondary socialization is the isolation of the individual within the new world he/she is adopting, such that most or all significant interaction takes place with other members of that new world (Berger & Luckmann, 1966: 145-146). As we will see in Chapters 4 and 5, this is highly pertinent to the situation faced by medical students, in which they are so pressed for time that they see almost no one outside the medical school and do almost nothing that is unrelated to their education.

That medical undergraduate training is in fact a secondary socialization process seems beyond doubt. In his overview of medical socialization Peter Conrad claims that:

Through the rigor and the tension of medical education, students' beliefs about medical care change as they increasingly adopt the dominant clinical perspective that pervades medicine. Most adopt it readily, while others must be converted; some accept it only uncomfortably; a few resist it actively (1988: 329).
Conrad argues that a change in identification is one of the most profound transformations medical students experience. Students begin identifying with the patients and end up identifying with the doctors and other health care personnel on the medical ‘team’ (Konner, 1987: 365). Some have used the metaphor of initiation into a priesthood to describe professional socialization in medical school (Haas & Shaffir, 1987: 70; Klass, 1987: 41). Similarly, Haas and Shaffir define professionalization as “a process of differentiation and alienation from lay society and of the elevation of the professional” (1987: 6).

What Mead, Berger and Luckmann, and other interactionists tend to leave out of their theories of socialization is the existence of competing socializations or “ways of being” in any given society or social group, and the factors that determine which one will predominate. They leave out the fact that some members in a society or social setting hold more power than others, and that this power difference affects whose ways of being will come to be seen as normal. The Gramscian notion of hegemony is valuable in understanding how such dominant practices, values or worldviews can come to dominate without blatant imposition. Hegemony refers to rule without coercion; rather the worldviews and interests of one social group eventually achieve consensus such that they dominate political, economic and cultural life with the active consent of most members of a society (Bocock, 1986). One of the key processes in establishing hegemony is naturalization, whereby particular practices and ways of being come to be seen as natural; thus countering these ways of being, or posing alternatives, is paramount to challenging nature. This notion of hegemony, and the difficulty of countering hegemonic practices, is central to understanding how socially structured power relations operate within the micro-level, social-psychological processes of socialization.

As we will see in Chapters 4 and 5, medical students are quickly drawn into specific worldviews that hold hegemonic status within medicine. That is a key aspect of their professional socialization.
1.2.1 Identity and professional identity

Identity is simultaneously individual and social, internal and external. Identity is socially constructed, meaningful only in relation to other people; at the same time, though, identity is unimaginable in isolation from embodied individuals (Jenkins, 1996: 20-21). It is, simply stated, our answer(s) to the question ‘Who am I?’ (Yuval-Davis, 1994: 409). But that implies the corollary, ‘Who am I not?’ We identify ourselves in relation to social groups; groups constitute the individual as well as the reverse (Young, 1990). Social categories, or aggregates, are external classifications of people according to some attribute (Jenkins, 1996; Young, 1990). Defined and identified by others, they lack the social salience that social groups have.

Group identifications, in contrast, are not mere combinations of people, they are defined as a group by a sense of shared identity – they are largely self-defining. That identification may be associated with objective attributes, but the attributes alone do not constitute the group. More pointedly, collective or group identities are usually asserted in political contexts (Jenkins, 1996; Yuval-Davis, 1994). But the process of identification is never unilateral. It is not enough to assert an identity; that identity must be confirmed by others. Similarly, it is not enough to categorize another as a member of a specific group; he or she must affirm that categorization, and must be accepted as a member of that collectivity before it approaches a social identity. Broadhead defines an identity as being “socially situated and assigned membership by self and others in a particular reference group, organization, social world, or ‘scene’” (1983: 38).

Identity, then, is an accomplishment, a non-static outcome of the dialectical interplay between internal and external processes of definition.

Self-identification involves the ongoing to-and-fro of the internal-external dialectic. The individual presents herself to others in a particular way. That presentation is accepted (or not), becoming part of her identity in the eyes of others (or not). The responses of others to her presentation feed...
back to her. Reflexively, they become incorporated into her self-identity (or not). Which may modify the way she presents herself to others. And so on (Jenkins, 1996: 50).

Processes of identity-construction are not infinitely flexible, though. At least in some instances they are constrained by the materialities of embodiment: skin colour, secondary sex characteristics, physical disability, for example. Claiming some collective identities implies the ability to meet the relevant standards, being able to successfully perform or actualize the identity.

Recent postmodern theorizing has emphasized that identities are multiple and fragmented, constantly shifting, and internally contradictory (e.g., Haraway, 1990). But the concept of multiplicity within identities is not completely new. Freud’s Id, Ego and Super-Ego, as well as Mead’s I and Me were early conceptualizations of multiple selves. Jenkins (1996) critiques characterizations such as these as depicting a self made up of component “bits” that converse with one another. This, he argues, is not how most of us experience ourselves most of the time. We experience more consistency than that. In contrast, a unitary model of identity,

allows us to recognise the self as a rich repository of cultural resources: organised biographically as memory, experientially as knowledge; some conscious, some not; some of them in contradiction, some in agreement; some of them imperative, some filed under ‘take it or leave it’; some of them pure in-flight entertainment; etc. The self is an umbrella under which this is organised (Jenkins, 1996: 46).

Jenkins stresses that the self, though unitary, is complex and multifaceted. Each of us, to maintain some sense of ourself as a relatively coherent person, finds some way(s) to articulate various facets of our identity to one another, sorting out the convergence and divergence of attitudes, assumptions, activities and perspectives (Broadhead, 1983).

One of the divergences that may exist is that between “nominal social identity” and “virtual social identity” (Jenkins, 1996). The former is how we are perceived, and therefore labelled, by others; the latter refers to what meaning that nominal identity comes to hold for us over time. For example, the nominal identity ‘medical student’
remains the same throughout four years of training, but the meaning of the term changes dramatically for the student.

Professional identity construction is about developing primary allegiance with others of that profession — in this case, physicians — rather than with lay persons. It means coming to see oneself as a member of that group, acting as a member of that group, being treated as a member of that group by others, and being accepted as a fellow group member by other physicians. Early sociological study of the professions focused on defining the essential traits of a profession. These include professional autonomy (setting standards of education, training, and licensing; being self-governing), exclusivity (rigorous standards for admission into training, rigorous socialization in training), and high power and prestige (including high income) (Goode, 1960; see also Weiss & Lonnquist, 1997: 149).

Later sociologists took these traits in a more critical direction, focusing on the power and control wielded by professionals. Eliot Freidson’s (1970a; 1970b) studies of professional dominance identified medicine as the epitome of professions, and examined the extent of influence physicians held over the terms of their own work. Professional power in the field of medicine includes more than the ability of medical professionals to control their own training and work, and the training and work of others — such as nurses, physiotherapists, occupational therapists, respiratory therapists and so on (Battershill, 1994; Wotherspoon, 1994). Professional dominance in medicine also includes considerable power over patients and over the broader conceptual or ideological sphere surrounding health and ill-health, through the power physicians hold more generally in society (e.g., Ehrenreich & Ehrenreich, 1978; Illich, 1976; Zola, 1978). The exclusive knowledge and technical competence of medical professionals, along with their social authority, gives them the power of definition, the power to define when illness exists (Friedson, 1970b). Medicalization, the defining of certain
states as pathological, at the same time constructs and reinforces social norms by defining what is ‘normal’ or non-pathological (Riessman, 1983; Zola, 1976).

Thus, it becomes particularly important to understand how individuals are socialized into the profession of medicine. This has resulted in a series of studies of professional identity formation, particularly in medicine (see Chapter 2 for a detailed discussion). The degree to which these studies have been critical of the power and control held by physicians has varied. What remains constant, though, is the awareness that professional socialization is training for power.

The processes of professional identity formation follow the framework of identity formation more generally, as sketched above. In particular, a professional identity is the non-static outcome of dialectical processes of self-definition and definition by others. Furthermore, the individual’s historical particularities and his or her embodiment of particular subjectivities, may have a greater or lesser degree of ‘fit’ with dominant discourses about what it means to be a physician. Different students, then, will face greater or lesser convergence among the subjectivities they embody and the subject positions they take up through their training to become doctors.

1.2.2 Social construction of social differences

With respect to the social differences that are increasingly represented among medical students, and that are a key focus of this research, I follow the theoretical approach of social constructionism. Increasingly theorists are focusing on social relations and social processes, rather than employing identity categories as if they existed independent of people’s actions and reactions. There is a move away from studying categories of ‘race’ for example, as if they existed in biology rather than as social constructions which make use of physiological features for social and political
purposes. Instead the focus is shifting to processes of ‘racialization,’ in which the center of analysis is how a particular social group is constructed as a distinct ‘Other’ (e.g., Anderson, 1991; Miles, 1989). ‘Race,’ gender, sexuality are increasingly understood as social accomplishments, outcomes of social relations and social processes (Connell, 1995; Katz, 1995; Seidman, 1994; West & Zimmerman, 1987). We do a specific gender, rather than we are a specific gender.

Social relations, then, are constantly produced and reproduced through human agency and interaction. Yet these practices are not random nor individual. They are institutionalized and coordinated, not contained in the local interaction but determined by extra-local social relations (Smith, 1987), relations that bear the weight of history. Identity is not only about what you do, it is also about what others do, and have done (Jenkins, 1996). It is a socially organized way of knowing yourself in relation to others, in terms of group social relations that carry historical salience.

In this study, I assume those historical relations. I do not attempt to prove that there is social inequality in Canadian society, in which people’s experiences and life-chances differ by gender, age, sexual orientation, ‘race,’ class, culture, and so on. I take it as a given that there are particular relations of dominance and subordination that privilege some social groups and disadvantage others. This has been thoroughly established in the literature.

Like many others, I am in the problematic position of needing to use a term that I deny the validity of, except as a social construct. To continue to use the word ‘race’ as if it were unproblematic reifies it and solidifies it as if it were a biological reality. Nonetheless, that which is perceived to be real is real in its consequences, and in the late 1990s Canadians still operate as if ‘race’ were a biological reality. That makes it real in its social consequences. I think it is irresponsible to move too quickly away from the use of categorizing terms because their use may be implicated in the maintenance of oppressive dichotomies (or pluralities), if that leaves us no way to recognize, analyze or talk about the patterned and structured differences that affect people’s lives. In other words, to abandon use of the term ‘race’ while the reality of racism continues unabated is not acceptable (see Henry et al., 1995; Kitzinger, Wilkinson & Perkins, 1992).

The conflict between insisting on the constructedness of ‘race’ and insisting on the reality of its social consequences is an ongoing tension in my writing, reflected in my use of quotation marks around the term ‘race.’ Where possible I try to use some variant of the term ‘racialized minority groups’ to focus on the social process of racialization and destabilize the presumed biological grounding of the term ‘race.’ But stylistically, this is not always possible.

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Furthermore, it is important to note that the processes I am examining here are not unique to the profession of medicine. Many fields of work that were previously male-dominated have been regendered in the past two decades. In an era of heightened litigation regarding employment discrimination based on gender, 'race,' sexual orientation, and age (among other factors), and in a era of heightened awareness of and aversion to such discriminatory practices, many occupations are experiencing increased diversity in their workforces (Reskin & Roos, 1990). In many professions, manual trades, factory jobs, skilled trades, unions and so on, employers and trainers are seeking to "diversify" their workforces, for a variety of reasons and with varying degrees of success (Cockburn, 1983, 1985, 1991; Reskin & Roos, 1990). The particular importance of these processes in professions such as medicine is heightened by the traditional exclusivity and social desirability of these professions (Tang & Smith, 1996).

1.3 Organization of the Thesis

The next chapter, Chapter Two, provides a detailed review of the literature on medical professional socialization. Though dated, the earliest classic studies are still surprisingly relevant. The processes of medical education have changed very little, despite revisions to curricula and content. Virtually none of the large-scale analyses of how students come to take on a medical professional identity paid any attention to issues of social differences. Even when there were substantial numbers of women and racialized minorities among the students the ways their experiences may have differed were not examined. However, more recent research has specifically studied the effects of gender, 'race' and other 'differences' on medical practice and education. In general, these studies have found that there is substantial overt discrimination, as well as a more-micro-level latent culture that lets certain students know they simply do not quite belong.
Chapter Three details the research methods employed in this study, a three-part design including a survey of students, interviews with students, and interviews with medical school faculty. It also describes the resultant samples upon which the results and analysis are based. Finally it offers brief reflections on the research process itself.

The next chapter begins the analysis of the research data. In Chapter Four I clarify the elements that make up a professional identity, as depicted by the research participants. I also outline the changes students go through during their training, and identify some of the processes through which students become medical professionals. In short, almost all of the traits and processes noted by classic studies of medical professional socialization still hold true in the late 1990s, as much as forty years later. Students learn to negotiate complex hierarchies; develop greater self-confidence, but lowered idealism; learn a new language, but lose some of their communication skills with patients. They begin by playing a role that gradually becomes more real as responses from those around them confirm this new identity, and increasing responsibilities demand that they take up this identity.

In Chapter Five I examine the aspects of medical education that lead toward homogeneity among the students. In particular I focus on their struggles to find balance and degrees of integration between their medical-student selves and the other parts of themselves. Students illustrate many modes of articulating aspects of their identities to one another, with varying degrees of success. I argue that there is a strong impetus in medical training to erase the social particularities students bring with them into medicine, as social beings. Building on a predominant social philosophy of liberal individualism that pervades Canadian society, medicine seeks to produce neutral, undifferentiated physicians – physicians whose gender, 'race,' sexual orientation, social class background, religion, age, parental status does not make any difference. While there is some recognition that patients bring social baggage with them into doctor-patient encounters, there is very little recognition that doctors do too, and that this may
affect the encounter. I argue that students are learning to see 'difference' only where it
contests the ideologies and standards of dominant social groups.

Chapter Six extends this understanding of the impact of social difference, by
examining how students experience gendered, racialized, and other such aspects of
their training. While students tended to say gender (or 'race,' sexual orientation, class)
did not matter, they usually then went on to detail how exactly it has made a difference
in their lives as medical students. I also explore how students and the medical school
itself deal with these social differences. Not surprisingly, the predominant approach
seems to be denial that 'difference' makes any difference. From a stance rooted in the
politics of difference, I critique this position of denial as (unintentionally) oppressive,
demanding as it does assimilation or suppression of self.

The concluding chapter, Chapter Seven, continues this emphasis on a politics of
difference, outlining in more detail how a commitment to formal equality and
nondiscrimination based in liberal individualism is insufficient. I point to the ways
individualism is built into our concepts of both science and professionalism, intensifying
the pressure on students to learn blindness to their own social particularities, as well as
to the social situatedness of the identity they are taking up. I contrast this with a politics
that allows for and celebrates the embodiedness of identities and insists on the benefits
of retaining social differences and challenging the prevalent belief in impartial,
objective individuals as the basis of (medical) professionalism.
Chapter II: Review of the Literature

2.1 Prior Research on Medical Socialization

In recent years there has been a proliferation of literature on medical education. Many of these accounts are "insider accounts" (Conrad, 1988), written by men and women who have been through medical school themselves (e.g., Gamble, 1990; Harrison, 1982; Klass, 1987; Klitzman, 1989; Konner, 1987; Mizrahi, 1986; Nolen, 1968; Reilly, 1987; Shapiro, 1987). These accounts provide rich descriptions of the direct experiences of medical students in their preclinical, clinical, internship, and residency years. Many of these authors kept journals in which they regularly recorded the events of their days. Konner (1987) and Shapiro (1987) wrote their accounts after the fact, and bring to them a particular interpretive distance. Melvin Konner taught Anthropology for several years before entering medical school. He brings that training to bear in his account. Martin Shapiro took a year off after his internship to reflect on his experiences. He interprets them through a Marxist framework of alienation. Most insider accounts, though, are simply "tales from the field" (Van Maanen, 1988) stories about experiences shared by a select group of people.

The overwhelming commonality in all of these personal accounts is that medical school is an incredibly intense experience in many ways: in terms of the time and energy demanded, the intellectual demands, the emotional demands, and the immersion into medical and medical-student cultures. These authors write about finding tricks to learn everything they have to learn in the pre-clinical years, about coping with cadaver dissections, about the first autopsy. They write about learning to accept the impossibility of learning everything, yet having to act with confidence when faced with patients. They write about learning the hierarchy of medicine, often quite brutally. Medical students – who were previously esteemed top students, often pre-medical students – are at the very bottom of the heap. They write about the frustration...
of doing endless "scut-work" from which they feel they learn very little. They write about learning the language of medicine, but also the informal language of medical students, interns and residents used to express their unique concerns and responsibilities (Konner provides an 11-page glossary of slang). They write about sleeplessness, year after year of never-enough sleep. They write about having no time for friends, families, and outside interests. They write about their fears, frustrations, anxieties, and discomforts, as well as their pleasures, their feelings of pride and satisfaction, the rewards and excitement of their work. They also write about the beauty of human anatomy, the beauty of diagnosis, the beauty of relieving pain, illness and suffering. And they write about their developing sense of competence, their growing self-confidence, their growing sense of themselves as almost-doctors.

"Outsider accounts" of medical education by sociologists and anthropologists are less common. Two classic studies – *The Student-Physician* (1957) by Robert K. Merton and his colleagues, and *Boys in White* (1961) by Howard Becker and his colleagues – are still the groundwork for sociologists in this field. Though subsequent studies have been conducted, most recently by Simon Sinclair in England (1997), recent work still tends to build on the interpretive frameworks of the early works. Even more tellingly, the fact that Becker's (1961) and Merton’s (1957) studies from almost 40 years ago are still highly relevant indicates the lack of significant changes in processes of medical education in the interim.

Sociological and anthropological studies of medical education have focused on professional socialization and professional identity formation. This focus is driven by an assumption that how students are socialized, how they learn to *be* as professionals, will affect their behaviour with patients (Bloom, 1979). One of the more significant aspects of medical school socialization that has been identified is the development of emotional control. Reneé Fox (1957) found that students are encouraged to control their emotions and adopt a position of "detached concern" with regard to patients.

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Emotional involvement and over-identification are seen as dangerous; students must strike a balance between empathy and objectivity. There is no room for feelings in medical training (Conrad, 1988; Haas & Shaffir, 1987), and students “are taught to overcome or master their emotions rather than talk about or examine them in detail” (Baker, Yoels & Clair, 1998: 298).

Students develop specific techniques to facilitate this position of detached concern. They learn “gallows humour” (Coombs, 1978; Shapiro, 1987; Weiss & Lonnquist, 1997) and use extensive irony (Sinclair, 1997). They learn to depersonalize patients (Cockerham, 1995; Conrad, 1988; Coombs, 1978; Konner, 1987) and even more specifically, they learn to ‘scientize’ patients. By adopting a scientific gaze they reduce patients to their bodies, separated from their “socio-emotional selves” (Baker, Yoels & Clair, 1998: 299). This allows students to concentrate on learning what is medically important, and to focus on disease, procedures, and techniques (Haas & Shaffir, 1987) rather than emotions – their own or their patients’. While the short-term benefits for stress management are clear, later in their clinical years some students recognize that they have mastered “detachment at the expense of genuine concern” (Weiss & Lonnquist, 1997: 183); it is not uncommon during postgraduate training to develop outright hostility toward patients (Mizrahi, 1986; Reilly, 1987). Eventually students come to accept emotional detachment as the proper professional stance, believing it is in patients’ best interests because doctors cannot practice effectively without it (Haas & Shaffir, 1987).

A second aspect of medical student socialization is what Reneé Fox (1957) called “training for uncertainty.” She identified three main types of uncertainty: 1) that arising from the inability to learn everything; 2) that arising from the realization that medical knowledge itself is incomplete, limited, filled with gaps; and 3) that arising from

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1 This appears to begin in preclinical years with cadaver dissection. Some analysts consider this early training for emotional coping mechanisms that students will need later when they work with patients (Charlton, Dovers, Jones & Blunt, 1994; Hafferty, 1988).
difficulties distinguishing between personal lack of knowledge and the limitations of medical knowledge and technology. The personal accounts of medical school are filled with examples of students' feeling anxious because they do not know enough (e.g. Klass, 1987: 57; Konner, 1987: 129). Fox argued that not only did students gather knowledge and experience to gradually reduce these feelings of uncertainty, but they also grew to simply tolerate high levels of uncertainty.

In contrast, Weiss and Lonnquist (1997) suggest that medical students learn to resolve, control or disregard uncertainty, rather than tolerate it. They suggest that students quickly discern it is risky to display lack of knowledge or certainty in front of their instructors (and possibly in front of patients), and often present themselves as more certain about a matter than they are. Impression management becomes a central feature of clinical years (Conrad, 1988). Haas and Shaffir title their study of one Canadian medical school Becoming Doctors: The Adoption of a Cloak of Competence (1987). They argue that clinical students face routine expectations of competence – from patients who expect them “to know it all” and faculty who often expect them to know far more than they do and who will evaluate the students on the basis of their competence. Students exhibit a common response:

When individuals are uncertain about what they should know or how they should apply it, they ‘cover’ themselves by deflecting others from probing their ignorance. . . This ‘cloaking’ behaviour is often accompanied by initiative-taking behaviour intended to impress others with their competence (Haas & Shaffir, 1987: 59).

They go so far as to conclude that the process of professionalization involves above all the successful adoption of a cloak of competence such that audiences are convinced of the legitimacy of claims to competence (Haas & Shaffir, 1987: 110). Like Weiss and Lonnquist then, Haas and Shaffir believe medical students learn not to tolerate uncertainty but to resolve or deny it.
A third aspect of the socialization process experienced by medical students is the acquisition of a new language and particular communication skills. Good and Good (1993: 97) claim that a central metaphor for medical education is "learning a foreign language." Coombs et al. (1993) point out that there are really two languages students must learn, a formal language and an informal one. In their study of medical slang they state that the informal language that spontaneously arises among participants in a formal system expresses the shared values and conduct norms that exist among those participants. They categorize more than 300 medical slang terms used by medical personnel across the U.S. These terms serve five functions: "Slang: (1) creates a sense of belonging to a select inside group, (2) establishes a unique identity, (3) provides a private means of communication, (4) is an exercise in creativity, humor and wit, and (5) softens tragedy and discharges strong emotions" (Coombs et al., 1993: 992-993). This medical slang is a central feature of medical novels, personal accounts of medical training (see especially Konner, 1987), ethnographers' reflections on their research (Becker, 1993), and ethnographic accounts (e.g., Sinclair, 1997).

In terms of formal medical language, acquisition of a huge vocabulary of new words and old words with new meanings, both in written form and orally, is one of the most crucial tasks facing medical students, and one of the central bases for examining them (Sinclair, 1997). Sinclair emphasizes that it is not just any technical jargon or language specific to a profession, but it is the language of science. It is formalized and concrete, unambiguous, and objective. Good and Good (1993: 98) suggest that it is the basis for constructing an entirely new world. They quote one student pointing out that once you learn names for every tree, they are no longer just generically 'trees.' In the same way students learn names for structures and processes they may not have even been aware of. Sinclair would support this view of the significance of medical language: "the language learned by student is . . . far better analysed along the lines that social identity is in large part established and maintained by language" (1997: 23). He also
states that "without this language, and its associated emotions of objectivity, detachment and judgment in such dramatic settings, it is difficult to see how some doctors could do the work they do" (Sinclair, 1997: 321).

The formal language of medicine is highly reductionistic. As students move from whole bodies to tissues to tissue types to cells, and from structures to functions to mechanisms and systems, a world view in which body systems are seen as isolated from the rest of the person becomes normal, natural, "the only reasonable way to think" (Good & Good, 1993: 98-99). Accompanying this is the development of a way of thinking that is geared to ‘case presentations’ on clinical rounds or case conferences. One of the first things a clinical student learns to do is to take a patient history and do a physical examination and translate this into the language of medicine, a highly formalized format. Sinclair notes that, “This marks another transition for the student, in that he would have described any previous episode of illness (his own or a member of his family’s, say) as patients do; he now develops the clinical narrative style" (1997: 201).

The case presentation is the major form of communication among medical staff, and is highly stylized (Atkinson, 1994). It uses depersonalizing language, separating biological processes from the patient; it uses the passive voice to omit agency, or at times attributes agency to a technology (e.g., ‘the EKG showed…. ‘); and it encodes skepticism about patients’ self-reports, using phrases such as ‘the patient reports’ or ‘the patient claims’ (Anspach, 1988). Anspach argues that the format of the case presentation “serves as an instrument for professional socialization” because so many of its underlying assumptions about what constitutes relevant knowledge are unexamined and unquestioned (1988: 372).

Klass (1994) provides a powerful example of the way a pediatrician constructs a formal medical narrative from the visit of a mother with a 6 month-old baby who will not stop crying. The questions she asks are guided by the process of making a

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differential diagnosis; she is mentally filling out a check-list in her head of attributes that rule out one disease and strengthen the probability of another. Fisher (1991), though, shows how that limits and constrains physicians’ ability to communicate effectively with patients. In transcripts of doctor-patient interactions she shows how doctors may follow the path of their diagnostic detective-work, probing when a symptom started, how it is experienced, how related biological systems are functioning and so on, while missing direct cues as to the real psycho-social reasons for the patient’s office visit. Again, learning to do a patient history and physical is a key task of students’ early clinical education. Not surprisingly some argue that students lose the natural abilities to communicate that they had upon entry to medical school, as they learn the formalized technique of medical interviewing (Baker, Yoels & Clair, 1998).

A fourth aspect of medical student socialization that research has indicated is a growing tendency toward apathy, “an attitude of ‘let’s not take any risks’” (Rosenberg, 1979: 90). It seems to arise from a series of structured conflicts faced by medical students, such as that between a need for cooperation and an impetus toward competition; a need to be a team player and a need to be an authority figure; a need to learn techniques and language and a need to serve patients. It also arises from a pedagogical approach common in medical education, “teaching by humiliation” (Sinclair, 1997).

Becker et al. (1961) argue that the students develop an approach geared to getting along with faculty. Faculty can prevent students from getting through, or can make it more difficult. They can humiliate and degrade students. It is necessary to make a good impression on them – but it is not always clear what will impress them positively. Therefore, it is it is necessary to attend to faculty demands and behave accordingly even when those demands seem foolish or wrong. As Becker and colleagues comment, “One must please the faculty in order to finish school or avoid the
delay of repeating a course or a whole year, no matter what is required to please them” (1961: 281). Sinclair calls this “appeasement” of the faculty (1997: 29).

Students experience medical school as a trial by ordeal and develop a sense of themselves as occupying a distinctly subordinate status in which it is best to play it safe (Bloom, 1973; Gallagher & Searle, 1989; Weiss & Lonnquist, 1997). According to Bloom, “the typical response of the student is to concentrate on the difficult problem of how to survive [italics in original] . . . in general adhering to a policy expressed in the phrase ‘Don’t make waves’” (1973: 20). A related response is the desire for anonymity, to simply get out. As one student in Becker et al.’s study said he didn’t want to make an impression on anyone, positive or negative: “I don’t want anybody to know who I am. Dr. Lackluster – that’s who I want to be. Just so long as I get out of here” (1961: 284).

At the same time, students may experience tremendous pressure to fit in with the team (St. Onge, 1997). Perhaps consequently, many students, and later residents and physicians, learn not to say anything even when they see colleagues and superiors violating the codes and norms of the profession (Light, 1988). Such violations are frequently disregarded as matters of personal style.

A fifth aspect of medical student socialization that seems to be firmly established is the loss of initial idealism and increase in cynicism. First noted in the mid 1950s, it was solidly grounded in Becker and colleagues’ study (1961) and confirmed in subsequent studies (e.g., Broadhead, 1983; Coombs, 1978; Haas & Shaffir, 1987; Rosenberg, 1979). Though medical students tend to begin with higher levels of humanitarianism, or idealism, than do other professional students such as law students, their idealism wanes more rapidly such that upon graduation levels of cynicism are equally high (Bloom, 1988). Students move from wanting to help people to wanting to learn what they need to learn to get by and pass exams. There is little doubt then, that medical students’ initial idealism gives way to pragmatism and cynicism. But the
question of whether this loss of idealism is temporary or permanent remains an unresolved debate.

Becker and colleagues (1961), as well as Coombs (1978) later, argued that changes in students during medical school were situational, adaptations to the specific circumstances of school life. Idealism returned as graduation approached. The return of idealism may be partial, though, tempered by a stronger desire for remuneration and social status, and lower desire to work with indigent populations (Broadhead, 1983).

Haas and Shaffir (1987), on the other hand, follow in the tradition of Merton et al. (1957) arguing that the waning of idealism has greater permanence. They believe students construct an absence of idealism as inherently part of medical professionalism:

Rather than salvaging their ideals by postponing their application to a future time, they became increasingly convinced that the demands of professionalization, which do not lend themselves to an idealistic approach, are unlikely to change or be successfully challenged. If they are to complete the passage to professionalism, idealistic attitudes must go (Haas & Shaffir, 1987: 86-87).

The differences of opinion about the permanence of medical student attitudinal changes reflect a broader debate about the status of medical students. As Bloom characterizes it, "Are they most essentially students, required to prove themselves in a rite of passage that emphasizes trial by ordeal? Or are they physicians-in-training, junior colleagues to the medical professional...?" (1979:18). The study by Merton and his colleagues (1957) assumes the latter, and depicts the changes students go through as part of the development of the values, standards, and norms they will need as full-fledged physicians. Becker and colleagues (1961), in contrast, depict students as students first and foremost. They learn to see the faculty as the enemy, not as their colleagues, and student culture is quite distinct from medical culture, being situationally exclusive to medical school as a distinct institution. Students' increased cynicism then, can be either an adoption of values that will be professionally valuable, or a situational response to feeling oppressed by faculty.
It seems highly probable that the medical school experience contains elements of both (Conrad, 1988). In fact this inherent demand on students to be simultaneously an autonomous professional and a subordinate underling seems to me to be the overall tension that structures the conflicts Rosenberg (1979) describes as the “Catch 22” of medical education. For example, the need to learn versus the need to serve; the need to be self-sufficient versus the need to follow authority; the need to take responsibility versus the need to check everything with superiors (Rosenberg, 1979: 84-88).

Even if we grant, though, that medical students experience both student-oriented demands and professionally-oriented demands, that leaves unresolved the question of the extent to which changes in medical school are internalized. Bloom (1979) argues that a distinction must be made between changes that are more superficial – learning to meet role expectations, for example – and changes that are more deeply internalized, that become part of who someone is. Simon Sinclair (1997) in his recent medical school ethnography argues that Becker et al. (1961) were too modest in their analyses. By only studying students, and not including interns, residents and physicians, Becker et al. failed to see how the perspectives they discerned among medical students were not limited to students but reflected a more general medical culture. He employs Bourdieu’s notions of ‘disposition’ and ‘habitus’ to rework Becker’s analysis in his own research.

According to Becker and his colleagues (1961) medical students develop a student culture, based in collective negotiation and norm-setting about the amount and direction of effort students should expend. They adopt the perspective and urgencies of medical students: exam anxieties, having too much to learn, being at the bottom of a hierarchy, and so on. In the preclinical years they move through an idealism in which they want to learn it all, to a provisional perspective in which they try to identify only the most important things to learn, to a final perspective in which what they learn is determined by what they think the faculty want them to know. They also adopt a
perspective on how to get by the faculty, on co-operation with other students, on the desirability of gaining clinical experience and on the value of increased responsibility. But again, these are transient perspectives, situationally specific.

In contrast, Sinclair (1997: Chapter 2) argues that there is a particular medical 'habitus,' a way of being that is collectively created but individually embodied. It is the sum of "dispositions" which are akin to, but more fundamental than Becker's perspectives. Sinclair sees dispositions as similar to individual psychological schema that we learn as children to make sense of the world. Such schema have cognitive, emotional, behavioural and embodied aspects; they are relational in that as a child encompasses what it is to be 'child' he or she also takes in what it is to be 'adult' or 'parent.' Similarly, dispositions are schema on a social scale. According to Bourdieu, they are regular without being regulated; they are socially organized and structured even as they socially organize and structure; they bear the weight of history; they are "collectively orchestrated without being the product of the orchestrating action of a conductor" (Bourdieu, 1977: 72). Dispositions are durable and habitual patterned ways of being acquired through social experience (Bourdieu, 1990). Habitus is a system of dispositions, both structured and structuring. It is a product of history that perpetuates itself though making possible particular sets of individual and collective practices – and not others (Bourdieu, 1990: 54-55).

Sinclair argues that in medical school particular medical dispositions are conveyed to students through formal instruction, through language, through silences, and through bodily movements. They are enacted by students, embodied by students, in the same ways. The general professional dispositions that constitute a medical habitus are cooperation, competition, idealism, status, knowledge, experience, responsibility, and economy.\(^2\) I will discuss Sinclair's theory in more depth in

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\(^2\) Cooperation is concretized in the emphasis placed on team work in medical school and medical practice. Competition is the integral inverse of cooperation; teams imply rivalry. Sinclair suggests both competition against a common adversary, and competition for individual gain. Idealism starts as a
subsequent chapters. What matters here is that these qualities, collectively held as desirable in medicine, and shared by students and practitioners, are embodied — therefore are accorded much greater permanence than Becker and colleagues imagined when attributing them to mere perspectives (Sinclair, 1997).

So, what do we know from past research about medical student socialization? We know that they develop emotional control, 'detached concern' for their patients. They learn to master their emotions. They learn to deal with uncertainty, tolerating or disregarding it. More concretely, they learn to present themselves to patients and to physicians as competent, whether or not they are. They learn new languages, an informal one of humour and disparagement, and a formal, technical, reductionistic one that eliminates emotions — even people — from the standard forms of medical communication. They learn to desire anonymity, learn to not make waves. They learn to abandon idealism for cynicism and pragmatism, either temporarily or permanently. And they learn to balance an ambiguous status as lowly student and elevated medical professional, at the same time. These teachings, conveyed overtly and covertly to medical students, may be discarded upon graduation, but alternatively may be adopted as inherent to professionalism, or less intentionally, may be internalized, encompassed and embodied — not so easily discarded.

What do we not know from prior research on medical socialization? We know very little about how these processes of professional socialization3 may be experienced personal disposition, but develops as a professional one focused on the notion of professional service. Status stresses the importance of social status while knowledge focuses on the emphasis on 'book-learning.' Experience and responsibility are akin to Becker's perspectives, pointing to the value medical students and professionals place on these qualities. Finally, economy is the disposition that allows for and arises from the resolution of conflicts between dispositions. When students face conflicts between their idealism and their need to acquire knowledge, their ability to compromise care or sacrifice studying displays the economic disposition.

3 I do not wish to overstate the homogeneity of these processes. As social processes, they are interactive and therefore include some diversity. I do not mean to imply that a group of socially diverse students are put through exactly identical socialization processes, in a factory model. It does make a difference what individual clinicians the students encounter, who they model themselves after, and so on. Different clinicians practice medicine differently and have vastly different pedagogical philosophies — as will become more apparent in subsequent chapters. Nonetheless, to the extent that sociologists can generalize ... 28 ...
differently by students who are significantly different from one another upon entry to medical school. None of these studies paid significant attention to gender, ‘race,’ culture, ethnicity, age, sexual orientation, and so on.

2.2 Accounting for ‘Difference’

Obviously the main reason most existing analyses of medical professional socialization ignore issues of social difference is that for most of history medical students have been middle-class white men. However, there is also a measure of oblivion operating in some accounts. For example, comparing Melvin Konner’s (1987) account of his experiences in medical school in the 1970’s with Michelle Harrison’s (1982) personal account of her experiences in a residency program around the same time is eye-opening. Like Harrison, Konner was older than the average medical student and was a parent of a young child. Yet unlike Harrison, childcare never enters into his story of medical school experiences. Only the fun parts of his parenting experience, such as picnicking with his daughter on weekends, enter into the account, as something he missed when working inhumane hours at the hospital.

Harrison’s (1982) account is strikingly different. She entered an obstetrics and gynecology residency part-time after several years as a general practitioner. She had a great deal of experience working with midwives at home births, and worked from a feminist critical perspective. In the end she was not able to complete the residency program. Partly this was because of the constantly competing demands she faced as a medical resident and a single mother of a young child. Partly it was because she could not bear to participate in a medical model that she believes relies on the dehumanization of patients. In her case the patients were women, and her identification with the women patients, as a feminist, was impossible to reconcile with any attempt to

socialization processes at all, I do assume some degree of (institutionalized) similarity in students’ experiences in medical school.

... 29 ...
identify with the physicians, residents, interns, and medical students around her. In the end she felt she had to choose between identifying as a woman and identifying as a physician.

The same type of oblivion displayed in Konner’s account is apparent in the most recent full-scale outsider study of medical education. Simon Sinclair’s (1997) ethnography of a British medical school was conducted in the mid-1990s, when 52% of medical school entrants in Britain were female (Allen, 1994: 3) and at least a third were Asian or ‘black’ (Sinclair, 1997: 76). Yet he tells his readers almost nothing about how these students may have experienced school differently than the white men. He simply remarks on more than one occasion that his own sex and colour prevented him from being able to fully investigate the experiences of less-dominant groups of medical students (e.g. 1997: 9, 127), and that ideally he would have had a woman of colour as a co-researcher.

While I agree that this could have improved his study, I also believe that he could have deliberately chosen to attend to issues of ‘race’ and gender (among others) more than he did. He failed to interrogate the co-construction of whiteness and masculinity accompanying the constructions of medical student identity he attended to. He ignored how women and students of colour reacted to the frontstage and backstage activities he describes. He did not seek out the reactions of those students. He simply failed to problematize social differences, and even in the 1990s evoked an image of the generic medical student (read upper class, white, heterosexual male).

In all of the earlier research on professional socialization in medical schools, women were present only in token numbers. In most of the studies women and other ‘minorities’ made up such a small portion of the student population that they were not even considered in analyses. For example in the research by Merton and colleagues (1957) the gender and ‘race’ of students is not even described. Presumably all, or nearly

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4 My research, too, could have benefitted from the additional perspective of a co-researcher.
all, were white men. More recently, in the study Coombs conducted in 1967-71, fully 98.4% of the students were white, and 96% were male; most had relatively well-educated parents (Coombs, 1978: 23-25). Haas and Shaffir’s Canadian study, though not published until 1987 was conducted shortly after McMaster University’s new medical school had opened, in 1965 (1987: 115). Again they do not describe their sample with regard to demographics, but women constituted less than a third of the graduates from that school until 1977 (ACMC, 1995: 35-39).

Howard Becker and his colleagues did their research in 1956-57, at a time when the medical student population was very homogeneous. Almost the entire class in each year was “young, white, male, Protestant, small-town native Kansans who are married” (1961: 59). While they were clearly looking for generalizations, shared perspectives among students, they nonetheless failed to explore the few cases that fell outside of the generalizations they made. Nor did they systematically separate out the experiences of the students who were atypical, who did not fit the norm in terms of gender, race/culture, religion or age, for exploration. While they found remarkable consistencies in students’ concerns, experiences and actions, they did not examine who the students were that experienced things differently.

Furthermore, Becker and his colleagues deny the significance of sociodemographic differences. They emphasize that medical student culture is the dominant influence on students, eliminating other differences and becoming a sort of “master status” (Schur, 1971).  

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5 I assume this based on the preponderence of white male students in medicine at the time, but also I assume that had Merton and colleagues’ (1957) sample not been homogeneous, that would have been noteworthy enough to mention.

6 While Becker and colleagues are exploring what they call the process of medical school turning “boys into men” (hence the title, Boys in White) they nonetheless use quite different language for male and female students throughout the book. While male students are usually referred to as “men,” in the few places where female students are discussed at all they are called “girls” (e.g., pages 98-100). In a similar lack of parallel construction, Sinclair (1997) tends to refer to “students” and “female students.”

7 As defined by Schur (1971), master status is part of the social construction of deviant identities. But more broadly, it refers to the way one aspect of identity becomes exceptionally important for an
Elements in the students' background do not exert any decisive influence on how students behave in medical school. Such background factors may have indirect influence in many ways, but the problems of the student role are so pressing and the students' initial perspectives so similar that the perspectives developed are much more apt to reflect the pressures of the immediate school situation than of ideas associated with prior roles and experiences (Becker et al., 1961: 47).

In other words, gender, race/culture, social class, sexual orientation, religion and so on are mere background variables that have little or no impact compared with the impact of student culture. Though this is not stated so explicitly in the 1997 study conducted 40 years later (Sinclair, 1997), the same attitude is apparent in the lack of attention to social differences among students.

2.2.1 Gender and medical socialization

In more recent years there has begun to be a considerable amount of research specifically on gender differences within medicine. Much of that work has been done by people within the field, and a substantial amount has focused on differences in practice styles between male and female physicians. In general, the research indicates that women tend to be more humane, warmer, more empathic, communicate better with patients of both sexes, are more egalitarian with patients, achieve better patient compliance, and are more interested in the psychosocial and preventive aspects of medicine (Charon, Greene & Adelman, 1994; Ducker, 1988; Hall, Irish, Roter, Ehrlich & Miller, 1994; Hojat, Gonnella & Xu, 1995; Kutner & Brigan, 1990; Lorber, 1985; Pizzini, 1991; Ulstad, 1993; West, 1984, 1990). A frequent implication is that women will change the practice of medicine.

As a consequence of being socialized toward caring roles, women physicians may be more willing to 'go the extra mile' for patients, but that may also cause them greater difficulty setting personal boundaries around their work, and consequently individual, overshadowing other aspects of self. The classic example is disability, but Becker's description of the dominance of student identity closely paralells this.
cause greater difficulty balancing work and family (Alexander, 1996; Klass, 1996). They may have more trouble negotiating working relationships with (predominantly female) nurses (Cassell, 1996; Klass, 1996; Pringle, 1996) but on the other hand they make take up the reins of authority much the way men have and may be equally hard on junior women (Candib, 1996).

A few studies have directly examined discrimination against women in medicine. Stephen Cole (1986) showed quite conclusively that there has been little or no active discrimination against admitting women to medical school since the late 1920s. When women applied they were as likely as men to be admitted. The gendering of medicine as a profession is more subtle and complex, including the bases upon which men and women decide to apply to medicine (or not), their experiences in medical school, the range of factors that influence specialty choices, and their access to residencies and professional circles (Fiorentine & Cole, 1989; Gross, 1989).

Judith Lorber’s classic study (1984) documents discrimination against women students in the selection of postgraduate residencies, exclusion of women physicians from the inner circles of referrals and professional networks, and blocking of academic women from positions of authority in medical education. More recently, in a survey of all Canadian women surgeons 49% reported that they did not feel discrimination had hindered their careers in any way and a further 29% said discrimination had had little effect. Yet, 51% reported having experienced discrimination from male attending staff during their training, and 41% experienced nursing staff as discriminatory (Ferris, Mackinnon, Mizgala & McNeill; 1996). Finally, women residents seem more likely to experience or witness sexual harassment: 39% of women residents and 25% of men, in one study (Farley & Kozarsky, 1993). Harassment was usually initiated by a faculty member or administrator.

Most of the literature on gender differences in medical education has focused on experiences and perceptions of gender discrimination and sexual harassment. Routinely
women students experience and perceive more of both (Bergen, Guarino & Jacobs, 1996; Bickel, 1994; Bickel & Ruffin, 1995; Dickstein, 1993; Grant, 1988; Hostler & Gressard, 1993; Komaromy, Bindman, Haber & Sande, 1993; Moscarello, Margittai & Rissi, 1994; Schulte & Kay, 1994). In one American study 73% of women and 22% of men reported having been sexually harassed at least once during medical training (Komaromy et al., 1993). Women's harassers were almost exclusively male and were almost always faculty, staff, interns or residents. Male students were harassed mostly by nurses, and their harassers were equally likely to be male or female. A recent study at the University of Toronto found 70% of women and 66% of men reported verbal or emotional abuse during medical school, while 46% of women and 19% of men reported sexual harassment (Moscarello et al., 1994). Again, perpetrators of sexual harassment against women were significantly more likely to be clinicians and faculty, persons with substantial authority. Finally, an American study found 71% of women students and 29% of male students had experienced at least one incident of patient-initiated inappropriate sexual behaviour (Schulte & Kay, 1994).

Differing experiences and perceptions of harassment seem to lead to differing perceptions about the "general school climate" among medical students. Among both male and female students, having experienced or witnessed harassment is associated with a more negative perception of the overall climate (Bergen, Guarino & Jacobs, 1996). American studies found that though women experience relatively little overt discrimination from patients, nonphysician staff or students, they still perceive more discrimination (emanating primarily from faculty) and more subtle forms of discrimination than do men (Grant, 1988; Hostler & Gressard, 1993). In short, women still perceive medical school as a less hospitable environment than do men.

8 Perhaps not surprisingly, both of these studies set off flurries of letters to the editors of the peer-reviewed journals in which they were published. The letters almost invariably contested the validity of the findings, or even the premises of the research, and challenged what appeared to be quite solid research methods.
This evidence is bolstered by a few studies that have examined ‘microinequities’ such as male students being called doctor while women are not, use of gender-exclusive language, absence of parental leave policies, gender-biased illustrations in medical texts, sexist questions and comments in admissions interviews, sexist jokes in class, and so on (Bickel, 1994; Dickstein, 1993; Guyatt, Cook, Giffith, Walter, Risdon & Liutkus, 1997; Kirk, 1994; Lenhart, 1993; Mendelsohn, Neiman, Isaacs, Lee & Levison, 1994). A Canadian study found women felt marginalized in many subtle and not-so-subtle ways: being mistaken for nurses, being called ‘girls,’ being ignored by instructors, being faced with sexist, misogynist and pornographic humour in ‘skits nights’ and other informal social events (Kirk, 1994: 175). Again, all of these lead to a gendered climate in medical school that may cause women to feel less welcome and more marginal.

The impact of these differences in terms of stress levels has been examined but results are not conclusive. Two studies found women and men experience medical school as equally stressful, though women express their stress more through anxiety, and men more through heavy drinking (Richman & Flaherty, 1990; Stern, Norman & Komm, 1993). There is also some indication that male and female students are stressed by different things, with men most stressed by academic demands while women are most stressed simply by being women, in medicine (Bernstein & Carmel, 1991). Another study found women were more stressed than men by sexual harassment and conflicts between career and personal life (Firth-Cozens, 1990).

Like the research on women physicians, there has also been some attention paid to gender differences in emotion, humanitarianism, and communication among medical students. See also Sinclair (1997) for detailed descriptions of sexist, misogynist humour as a basis of medical student culture in the British school he studied. Though he does not examine the impact on women students, one can imagine the feelings of marginality that might arise. There is some indication that the climate varies from department to department. One study found the use of gender-exclusive language by male and female residents was significantly higher in surgery and lower in psychiatry and obstetrics/gynecology than in other departments (Guyatt, et al., 1997). This may be because surgeons are still disproportionately male, or it may be that a ‘macho’ climate in surgery fosters sexist language.
students. There is some evidence that women medical students are more sensitive to emotions than are men (Bickel, 1994), or enter medical school with more humanistic and holistic orientations, though usually gender differences disappear by final year (Dufort & Maheux, 1995; Leserman, 1981). A survey of graduating students conducted by the American Association of Medical Colleges found that among 1994 graduates women were less likely than men to have been involved in research and to have published papers, and more likely to have worked in providing medical services to underserved areas, inner city communities and public health clinics (Bickel & Ruffin, 1995).

It does not seem, though, that these gender differences are the result of greater resistance to loss of idealism during medical school socialization. In one of the few large-scale studies of professional socialization of medical students that has systematically studied gender differences, Jane Leserman examined changes in "professional orientation" over time in medical school. She found that women students were more humanitarian and liberal in orientation upon entering medical school (1983: 141), and she expected the gap between women and men to widen over time. She predicted less conformity with the medical professional model from women by their senior year, assuming frequent encounters with gender-bias would politicize women students toward alternative ways of practicing medicine. In fact both men and women became slightly more conservative. In their senior year women were still more liberal and humanitarian than men were, but the margin stayed the same, with both groups less liberal and less humanitarian than they had been. Leserman concludes that socialization works the same way for men and women in medical school (1983: 163).

There is some support for these findings in Martin Shapiro's analysis of medical training. He claims that in his experience the women medical students were even more eager than the men to "assume the mantle of physician" in order to distinguish themselves from the nurses (1987: 70). It may also be that women in medicine identify more closely with men whose social class background they share, rather than with other...
women of lower class backgrounds or other ethnicities; certainly in the past class-
loyalties were stronger than gender ties among women in medicine (Leserman, 1983:
33). In Leserman’s study the only significant difference in patterns between men and
women was that women started out believing in discrimination against women more
than men did, and by their senior year men and women had polarized on that issue.
Differences in degree of belief in discrimination against women were explained most by
degree of familiarity with and support for the women’s movement, rather than by

Martin, Arnold and Parker (1988) argue that for women medical socialization
involves a dynamic balancing act between prior gender socialization and the
professional socialization they encounter in medical school. Women have to seize every
opportunity to prove they are “tough enough” to be a doctor (Klass, 1987) and women
who communicate in ways considered gender-appropriate are seen as not assertive
enough (Dickstein, 1993).

Toward the end of their undergraduate training, medical students narrow the
scope of their future careers by selecting residencies for which they will apply. The
gendered climate of different departments, as mentioned above, may influence
students’ decisions (Guyatt et al., 1997). In addition, a substantial body of research on
gender differences in specialty choices has found that women students are more
influenced by personal values, family demands and negative experiences in specific
clerkship rotations, leading to residency choices that result in a sustained gender
segregation within medicine (Bickel, 1994; Calkins, Willoughby & Arnold, 1992; Lorber,
1987, 1984; Redman, Saltmans, Straton, Young & Paul, 1994; Riska & Wegar, 1993; Xu,
Rattner, Veloski, Hojat, Fields & Barzansky, 1995).11 Some observers predict increased

11 Of all medical residents in Canada in 1994-95, the specialties with the lowest proportions of women
were urology (2.4%), cardiovascular/ thoracic surgery (3.8%), and orthopedic surgery (9.5%). Two-thirds
of all women residents are concentrated in five specialties: family practice, internal medicine, psychiatry,
paediatrics, and obstetrics/gynecology (ACMC, 1995: 82-83; see also Bickel & Kopriva, 1993, for
comparable American statistics). Not too surprisingly, the latter five specialties have long been among the
internal stratification within medicine, with women concentrated in relatively low-prestige, low-paid specialties and general practice (Light, 1988).

So, we know from existing research that women may be more empathic and humanitarian, both as medical students and as medical practitioners. However, it also appears that these gender differences are the result of gender socialization prior to medical school, and while in training male and female students are similarly affected by their socializing influences such that both end their training with reduced humanitarianism and decreased idealism. While in school, and later in practice, women are more likely to face direct discrimination and harassment, from faculty, clinicians, peers, and patients. Perhaps consequently, women students perceive the overall climate of medical school more negatively than do male students. Though reported levels of stress are similar, the sources of stress differ for men and women – gender is only a significant stressor for women students. Finally, women seem to be ‘turned off’ some specialties because their climates are unwelcoming for women, and they tend toward some specialties because they are more welcoming and have a better fit with family demands. The long-term result may be heightened internal gender segregation within medicine.

2.2.2 ‘Race’ and medical socialization

There is considerably less information available about the experiences of physicians and medical students who come from racialized minority groups, than there is about women. As we saw with respect to gender, students who were not of Caucasian/European origins were simply not represented in most medical schools at the time the bulk of the professional socialization research was conducted. And again, 

lowest paid in medicine, while cardiothoracic surgery and orthopedic surgery are two of the top three specialties in earnings as well as public prestige (Gellman, 1992; Pope & Schneider, 1992; Rosoff & Leone, 1991).

12 Until the late 1960s virtually all African-American medical students enrolled in one of two “medical schools for Negroes” established in the 1860s, or one of six other such schools open from the 1880s till ... 38 ...
even when non-white students may have been present, student experiences were not analyzed on the basis of racial or cultural differences.

The greatest research attention has been given to practice patterns of racialized minority physicians, particularly studying where they practice, who their patients are, and what specialties they choose. In the United States, the research shows quite clearly that African American and Hispanic physicians are more likely to practice in “underserved communities,” communities where the patient populations are predominantly Black and Hispanic (Komaromy, Grumbach, Drake, Vranizan, Lurie, Keane & Bindman, 1996; Nickens, 1992; Steinbrook, 1996; Weiss & Lonqust, 1997). Even when the racial/ethnic make-up of the community is controlled for, racialized minority physicians care for 21-36% more African American and Hispanic patients than do white non-Hispanic physicians (Weiss & Lonqust, 1997: 165; Komaromy et al., 1996).

Like the discussions of gender differences in practice style, there is also anecdotal evidence that suggests at least some racialized minority physicians practice medicine differently than do physicians from the white-dominant majority population. One clinician argues that compared with white women, African-American women physicians use a more holistic approach, are more empathic, less detached, more sensitive to patients’ cultural needs, and identify more with their patients (Secundy, 1994).

Finally, as with women physicians, racialized minority doctors tend to concentrate in particular medical specialties. One American study found that underrepresented minorities tend to cluster in the same lower-paid, primary care specialties that women concentrate in, though there are differences among ethnocultural groups. Aboriginal and Mexican men were almost twice as likely to choose

1910 (Curtis, 1971). While other schools did not formally exclude African-American applicants, an understanding that African-Americans would go to ‘their own’ schools led to de facto segregation.
family practice as nonminority men (Colquitt, Smith & Killian, 1992). Another study found these students disproportionately entered family practice, internal medicine and pediatrics, and were significantly underrepresented in surgical subspecialties (Pamies, Lawrence, Helm & Strayhorn, 1994). There is some reason to wonder what racialized minority students experience in their medical training, especially their postgraduate residencies. A recent U.S. study found that three years after graduation African-American and other underrepresented minority students were significantly more likely than white students to have switched specialties, or dropped out of residency programs – both highly unusual moves (Babbott, Weaver & Baldwin, 1994). Furthermore, significantly higher proportions of racialized minority students are not matched to residency spots in the National Residency Matching Program (Lee, 1992).

As medical students, there is also some indication that racialized minorities may have higher attrition rates and take longer to complete their undergraduate training (Lee, 1992). Considerable attention has also been paid to the academic performance of underrepresented minority students. An American study found their academic performance was significantly lower than that of white students, but clinical scores during clerkship were comparable (Campos-Outcalt, Rutala, Witzke & Fulginiti, 1994). In the United Kingdom, “ethnic minority” students were found to be 2.09 times as likely to fail one or more exams as were white students (McManus, Richards, Winder & Sproston, 1996). The authors argue that this cannot be due to racism because the students did poorly on multiple choice and computer graded exams, and because “ethnic students” not from the U.K. performed better than did white students. This is a very narrow understanding of how racism operates, viewing it exclusively as active discrimination. It overlooks the possibility that students may have very different daily experiences in medical school, such that the learning environment differs for white students and students from racialized minority groups.
Those daily experiences of racialized minority students in medical school remains an under explored area, about which little is known. One study found that 19.7% of students at ten U.S. medical schools reported experiencing racial or ethnic harassment (Baldwin, Daugherty & Eckenfels, 1991). Examining a later stage of training, a national survey of medical residents found 23% had experienced at least one incident of racial or ethnic discrimination in the previous year (Baldwin, Daugherty & Rowley, 1994). About 10% (31% of the 'minority' students) had experienced such discrimination “sometimes” or “often” — 5% of the white residents, 18% of Hispanic residents, 29% of Asian/Pacific Islanders, 45% of Indian residents, 39% of African-Americans, 48% of Middle Eastern residents. The most serious types of discrimination (being denied opportunities, being given poor evaluations) occurred most to Middle Eastern, African-American, Hispanic and Native American residents. Patients were the most common source of racial/ethnic discrimination, but almost as many incidents came from attending clinicians, other residents, and nurses. (Baldwin, Daugherty & Rowley, 1994).

The consequences of this fairly high level of racial discrimination on medical students has not been conclusively demonstrated. But there are some indications. One interesting study examined students’ ‘need for power’ in first and third year. The researcher found that during this time white students’ need for power decreased and non-white students’ increased (Kressin, 1996). She suggests that all students experience being at the bottom of a status hierarchy and have a desire to compensate by expressing power. White students get satisfaction from respectful interactions with patients, interactions which allow them to feel powerful. In contrast, at least some non-white students experienced interactions with patients as reinforcing their powerlessness and marginality.

This study is bolstered by the growing body of personal accounts of medical school written by members of racialized minority groups. Some African-American
physicians write of their medical school years as extraordinary ordeals (Blackstock, 1996; Gamble, 1990; Rucker, 1992). They faced racist comments and stereotypes from doctors, patients, nurses, and fellow students. They were occasionally mistaken not for nurses – as white women students have been – but for cleaning staff, cooks and clerks. Those students who also came from backgrounds of poverty felt particularly marginalized and torn between worlds; minority students from upper-middle class families seemed better able to assimilate (Blackstock, 1996; Gamble, 1990). But all of these students had to find ways to cope with membership in institutions they perceived as racist:

During medical school I also got to see firsthand that medicine did reflect the views of a racist American society. I saw black people ridiculed because of their dialect. One hospital even kept a list in its emergency room of ‘humorous’ examples of black dialect and folk medicine knowledge (Gamble, 1990: 60).

Surviving in such environments seems to have demanded non-response to such incidents. Gamble (1990: 61) describes learning to be silent rather than risk her status in the medical school. The one example she gives of having spoken up was to distinguish herself from the Black patient being disparaged, to make her fellow medical students realize African-Americans are not homogeneous – in a sense saying that she was not one of ‘them.’

Not surprisingly, the stress on medical students from racialized minority groups is high. In addition to experiences of racial and ethnic discrimination, they may face increased financial concerns (Sullivan, 1977), as well as pressures to be role models for their entire racial group, and to return to their home communities to work (Robb, 1997). A recent US study found average stress levels were higher for “minority” medical students (Calkins, Arnold & Willoughby, 1994). Fully 82% of those “minority” students were Asian.\textsuperscript{13} The factors that caused higher stress were not race-related, but were

\textsuperscript{13} Asian is left undefined in the study.
about academic aspects of the program. The authors suggest Asian students have higher need to achieve in medical school, due to cultural or familial pressures. Unfortunately they did not report what factors were most stressful for non-Asian minority students.

There is very little evidence about more subtle issues of 'race' and culture, issues that nonetheless might construct a 'racialized' medical school climate. There are some signs in the personal accounts above, though those authors tend to focus on instances of outright racism. Simon Sinclair's (1997) recent ethnography of medical school, though, contains a few hints that that particular school at least might be a place where students of colour would feel marginalized – though this is not his focus. He describes a few incidents of students' being subjected to racist comments, especially from patients. But more compellingly, his description of the medical student informal culture – the team sports and variety shows, as well as beer drinking at the medical student pub – are populated almost exclusively with white students. He mentions that Asian students tend not to participate, and tend to hang out together at another pub. He depicts a fairly high degree of racial segregation.

So what do we know about 'race' /ethnicity and medical school socialization? Considerably less than we do about gender. Nonetheless, it does appear that medical students from racialized minority groups are disproportionately likely to want to work in primary care and in underserved communities, and that physicians from these groups are in fact disproportionately serving minority patients, and are concentrated in lower-status, lower-paid specialties. These students have less success in the residency matching program, and higher attrition rates there and in medical school itself. They may perform less well than students from dominant cultural/racial groups, though the reasons for that are not clear – it could be due to less adequate early education, greater financial struggles, experiences of racism in school, feelings of marginality, or any number of other factors. We do know that minority students experience a considerable
amount of racial and ethnic discrimination and deal with somewhat higher levels of stress while in school. Finally, it is worthy of note that almost all of the available research, and even the personal accounts, of medical school as experienced by students from racialized minority groups come from the United States. There is almost nothing in the literature examining these issues in Canada.

2.2.3 Social class, sexual orientation, and medical school socialization

Very little research has examined the impact of social class on physicians’ practice styles, or on students’ experiences in medical school. In an overview of the topic Roter and Hall (1992: 64-65) cite two studies that suggest a poorer quality of communication is demonstrated by doctors of working-class origins; they spend less time with patients and give fewer explanations. Roter and Hall argue that medical education can be a vehicle for social mobility but only for students who have already demonstrated mastery of middle-class values. It has been suggested that medical students are homogeneous in their class affiliations, regardless of origins; that by the time they gain admittance to medical school students of lower-class origins will have “assimilated middle-class norms and values” through their undergraduate educations (Cockerham, 1995:195).

In contrast to this supposition, though, in a Canadian study where only two of the 80 medical students studied were working-class,14 both reported that they felt marginalized by the interests and values of their middle-class fellow students. One working-class student joked that the hardest thing for him to learn at medical school was “the wine and cheeses” (Haas & Shaffir, 1987: 23). This illustrates a sense of ‘outsider-ness’ that is complex, involving a subtle sense of belonging rather than

14 It is not clear how class was measured in the study; it may have been self-report (Haas & Shaffir, 1987).
outright dismmination. Similarly, Dale Blackstock felt marginalized in medical school not just because she is African-American, but because of her working-class background:

I was also somewhat intimidated by the backgrounds of many of my peers. Most of the students came from well-to-do families, including many of my African-American classmates. In my class alone there was a student who was a relative of Jackie Onassis, several students whose parents had written textbooks that we would be using in class, several students who had parents on the faculty, a student whose father would win the Nobel Prize in Medicine... My claim to fame was my mother who received her LPN degree after raising six children, and I was very proud of her. She had attended school full-time, worked full-time, taken care of the family and gotten off welfare (Blackstock, 1996: 77).

It is difficult, especially in the American literature, to separate the impact of racism and the impact of poverty on students’ experiences, since ‘race’ and class are more thoroughly conflated there than in some parts of Canada. That having been said though, one of the few studies on the impact of family incomes and medical school performance found that regardless of racial category, students from lower income families tend to perform somewhat less well academically (Fadem, Schuchman & Simring, 1995). The authors cannot really explain this finding.

There is little evidence about the impact of students’ sexual orientation on their experiences of medical training. While there are indications that some students are affected by homophobia (as prevalent in medical schools as it is elsewhere) others report having been ‘out’ all the way through school with no particular negative encounters. However, the ability to ‘pass’ as heterosexual, and the familiarity with a heterosexual culture one has been immersed in from birth make this slightly different than issues of gender and race/culture.

15 By “homophobia” I mean the irrational fear and hatred of, or more mildly, hostility and condemnation directed toward people known or believed to be gay, lesbian or bisexual. I will distinguish it from “heterosexism” by which I mean the overwhelming assumption that the world is and must be heterosexual, and the systemic display of power and privilege that establish heterosexuality as the irrefutable norm – and by extension establish homosexuality as deviance. Heterosexism centres on oblivion about the very existence of gays and lesbians.
A very recent Canadian study found that of a random population sample in a large urban centre, 11.8% said they would refuse to see a gay, lesbian or bisexual physician (Druzin, Shrier, Yacowar & Rossognol, 1998). The authors suggest that rate may be even higher among those who refused to respond to the telephone survey, assuming at least some were unwilling to discuss the topic. The main reasons given were fear that the physician would be incompetent and patient discomfort. A small proportion of respondents expressed outright hostility toward gay, lesbian, and bisexual physicians.

A small-scale British study found that doctors perceived a fairly high degree of homophobia within the medical profession (Rose, 1994). A recent Canadian study found about 40% of general internists experienced homophobic remarks from fellow physicians, nurses, other health care workers, and patients (Cook et al., 1996: 570). The authors conclude that, "Homophobia among physicians is common, negatively affecting the care of lesbian patients, gay men, and patients with HIV and AIDS, and the careers of gay, lesbian, and bisexual physicians" (1996: 570). In the United States Wallick, Cambre & Townsend (1992) found that on average 3 hours 26 minutes of curriculum time were devoted to teaching about homosexuality, out of a four year curriculum. The vast majority of that time was in first-year lectures on human sexuality.16

Finally, an American study examined attitudes of family practice residency program directors to determine how a medical student’s disclosure of homosexuality might affect an application for residency (Oriel et al., 1996). They also examined third- and fourth-year students’ perceptions of the impact of disclosure about homosexuality on their residency application process. They found that although 67% of residency directors showed “homophilic attitudes” (supportive to gay men and lesbians) 25%

16 The authors give no comparative data on how much time is spent, on average, addressing issues of gender or racial/cultural differences.
would rank applicants lower if they were known to be gay or lesbian. Homophobic attitudes were expressed by 8% of residency directors, and another five surveys were returned uncompleted with homophobic remarks written on them. The authors suggest negative attitudes may be more prevalent among non-respondents. Finally, 46% of students had experienced discrimination based on sexual discrimination during medical school, and 71% considered their sexual orientation as a factor in choosing specialties. Most hid or planned to hide their homosexuality during their residency application process, even if it meant omitting leadership roles in gay and lesbian organizations.

Oriel et al. (1996:720) quote a popular guide to getting onto medical residencies as warning gay and lesbian students that disclosure of their sexual orientation may "doom" their applications. They state that overall:

Gay and lesbian medical students learn medicine and care for patients in an environment that often assumes heterosexuality and, at times, is actively hostile to gays and lesbians. . . Disclosure of homosexual orientation by medical students or physicians has generally been regarded as having dire professional consequences (1996: 720).

In short, it seems reasonable to assume that the prevalence of homophobic attitudes are no higher or lower among medical students and faculty members than in the general population, and that students who identify as gay, lesbian or bisexual might feel more marginalized in medical school than do heterosexually-identified students.

2.3 Conclusions

The professional socialization experienced by medical students is an intense and effective process. For ‘typical’ students – read: white, male, heterosexual, upper- or upper-middle class, young, Judeo-Christian, unmarried, no children – the experience seems to be transformative.

Through the rigor and the tension of medical education, students' beliefs about medical care change as they increasingly adopt the dominant
clinical perspective that pervades medicine. Most adopt it readily, while others must be converted; some accept it only uncomfortably; a few resist it actively... By the final year of medical school... they have learned how to think like doctors... Medical school fundamentally affects one's world view (Conrad, 1988: 329).

They learn to control their emotions, to present themselves as competent, to use new languages, to not buck the system. They learn to become professionals.

For less typical students – women; those from working class backgrounds, racialized minorities and/or minority cultures and religions; those who identify as gay or lesbian; those who are older, married or parents – the processes of professional socialization may be less straightforward. They simply don’t ‘fit’ as easily. As Jane Leserman says,

Professional socialization in medical school may be less orderly and more problematic for such minorities as women due to some of the difficulties that they face in a predominantly male profession. Therefore a description of the socialization process should take into account how this process may vary for minorities such as women (1983: 39).

When gender and racial/cultural differences have been studied in medical education, it has usually been in a ‘deficit model’ in which the central question is why women or racialized minority students do less well in medical school and how they could be more like white men. Alternatively, we see a ‘glorification model’ in which it is assumed that women will practice medicine more humanely than men do, and that minority physicians will practice medicine in ‘their own’ ways and ‘their own’ locations. Apart from experiences of open discrimination and harassment, which are decreasingly common, we still know surprisingly little about how these less-typical students experience socialization processes in medical school, and how effective that professional socialization is. The research methods through which I sought to address these questions are detailed in the next chapter.
Chapter III: Research Methodology and Design

3.1 Standpoint Methodology

All research is done from a standpoint — not just the researcher’s own personal background, but also the researcher’s choices concerning whose concepts and categories to use, whose experience to start from, in whose interests to frame research questions, and to whom research is accountable (Harding, 1993; Smith, 1987). It is like shifting a kaleidoscope — if you shift the standpoint from which you begin, the whole pattern changes. The standpoint a researcher employs, then, becomes largely a matter of choice. It may be the standpoint of the student, the teacher, the principal, the parent, or the school board. Or it could be the standpoint of a subgroup of students, or a subgroup of teachers. Or the standpoint of academic discourses entrenched in traditional sociological concepts and methods.

Dorothy Smith (1987) has most fully developed the notion of standpoint in research methodology. She argues that research must begin from the relevances of individuals in their everyday lives which set the problematic of the research inquiry. Research should help people understand what social relations determine the particular aspects of their lives that they identify as problematic.

While I draw on Smith’s methodology, this research did not employ it in its purest form. I did not begin inquiry directly from the experiences of medical students, adopting their collective relevances as the standpoint of my inquiry. If I had done that, concerns about exams and grades and money would undoubtedly have come to the forefront. Rather, I started from the standpoint of some students, the standpoint of the students who are in specific ways different from the historical norm in medical schools.

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1 Smith understands the concept of social relations to mean concerted sequences of action, performed by more than one and perhaps sometimes by a multiplicity of individuals not necessarily known to one another. These coordinated practices happen outside the realm of the everyday experience of individuals, and organize and articulate the activities of people in widely dispersed settings (Smith, 1987: 183).
To some extent I am privileging the standpoint epistemology developed by Patricia Hill Collins (1990; 1991) over that of Smith. Collins argues that "personal and cultural biographies [are] significant sources of knowledge" for "outsiders within" in the academy (1991: 53). She believes that Black women, especially those from the working class, are likely to be struck by the "mismatch" of their experiences and the paradigms of the academic relevances around them; they are thus more likely to identify anomalies than would true "insiders" (1991: 50).

I would argue that my research began from the relevances I found in the talk of some medical students – the students who are "outsiders within," who have found it difficult to identify as student-physicians. Some of this talk is documented in the form of autobiographical accounts of medical school. Some of this talk was relayed to me by people I met at conferences, email connections, and chance encounters as I have worked in the area of health and illness for several years. Some of this talk occurred informally with friends who were medical students and are now doctors.

What I have heard from lay people over the years – and from students in sociology of health and illness classes I have taught – is their high expectations of ‘minority’ and women doctors to do things differently. What I have heard from women and minority medical students is the conflict they experience between the expectations of those they are connected to outside of medical school and the expectations they face inside medical school – and an accompanying feeling of being split, or divided. These are the relevances that structured my inquiry.

3.2 Research Design and Implementation

A key way to improve any research is to use multiple methods of data collection and analysis – to "triangulate" the methods (Creswell, 1994: 174-178). This research employed three complementary research strategies: A survey of an entire third-year

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2 See Naples (1996) for an excellent analysis of the differences between these two standpoint theories.
class (124 students) at one medical school; in-depth semi-structured interviews with 25 students from that class; and in-depth semi-structured interviews with 23 faculty members from the same medical school.³

The survey was intended to provide a broad, population-based picture of the experiences of the class as a whole. It was not meant to test hypotheses so much as to explore whether my guiding assumptions were reasonable, and to guide the in-depth interviews. In addition, it allowed meaningful comparisons among groups, and enabled me to study patterns of association. Finally, it permitted me to interpret the interviews within the context of the responses of the whole class.

The qualitative components of the design allowed me to explore the central aspects of the inquiry at greater depth. They allowed me to ask ‘how’ and ‘why’ questions; and to discover how students create meaning of their own lives, expressed in their own words. Interviews with faculty provided a different perspective on the same issues discussed with students – a longer-term, more historical perspective. These interviews allowed me to explore the meanings faculty attach to the changes they see in the student population over time, and how they understand the changes individual students go through during their training. I was slightly surprised to find the faculty also used the opportunity to reflect on their own experiences of medical school, and draw comparisons.

One of the weaknesses of the research design is that it was retrospective, relying on respondents’ ability to remember accurately what they were like a few years ago and what changes they have undergone since, or how the student body has changed over time. Students may have been unaware of or unable to articulate clearly how they

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³ I do not identify the medical school where the research was conducted. This was an agreement I made with the administration of the school in order to gain access to the research site. While that decontextualizes the research in some ways, nonetheless I believe the main findings have some degree of generalizability to other Canadian medical schools. The school in question was located in a large city with a racially and ethnically diverse population, and the school followed a traditional undergraduate curriculum.
changed over time. Any cross-sectional design would be limited in this way; only a longitudinal design following a single group of students from first year through their undergraduate education would have been completely adequate. The time and money required for such a study were prohibitive for a dissertation.

In addition, in surveying and interviewing students who were already in their third year, I studied people who were already 'acclimatized' to the culture of medical school. Things that took them aback at first may have become commonplace after three years. The impact of socialization and peer pressure may have already reduced their consciousness of the details of the world into which they are being socialized.

Nonetheless, there is some basis in the literature for choosing third year students as an appropriate study population. Third year is clearly a key point for medical students; it marks an important transition point as students move out of the classrooms to spend the vast majority of their time on the hospital wards and in clinics working with patients. Becker et al. (1961: 185-187) found that while the first year of medical school brought significant changes for students, the second year was much the same as the first. At the other end, both Konner (1987) and Reilly (1987) claim that the fourth year is an anticlimax after the grueling transitions of the third year. Broadhead (1983) concludes that during the first two years the primary identity is that of medical student; in the third and fourth years the primary identity shifts to that of student-physician (see also Coombs, 1978: 217). Similarly, Haas and Shaffir argue that the third year intensifies the symbolic manipulation and impression management that are formative processes for professional identity development (1987: 55, 106).

Additionally, in terms of the more specific questions I am asking in this research, interactions with patients and other health care personnel – which really begin in the third year – are an important part of how medical students put together their student-physician identity with other identities that are important to them. Several authors argue that a major factor in students' coming to see themselves as doctors is being
called doctor and treated as a doctor by others (Klass, 1987; Konner, 1987; Reilly, 1987; Shapiro, 1987). Coombs states that "being called 'doctor' by patients and staff helps students view themselves as physicians. Such a social looking-glass enhances the development of a professional self-image" (1978: 227).

Thus, the third year is a key point for medical students' transitions to a future-physician identity, due to the increased interactions with staff and patients. Furthermore, these interpersonal encounters may also be a forum in which students are reminded of their other salient identities, and in which those other identities are enforced. Interactions with patients and other hospital workers can enforce gendered and racialized notions of what is appropriate behaviour and position/status for whom. For example, as we saw in Chapter 2, women and racialized minorities are less likely to be called doctor, and more likely to be called nurse or maid. Thus the third-year clerkship, when students begin to spend most of their time in the hospital, is an appropriate point in their education to ask them about the complex mixes of identities they experience, and how those identities are enacted and enforced by others' actions.

### 3.2.1 Student survey

The survey was pre-tested on a convenience sample of 10 graduate students, revised several times, and pre-tested with 12 medical students and faculty I was in contact with through E-mail. In response to their feedback the survey was revised again, and the final version was printed (see survey instructions Appendix I). I used a saddle-stitched booklet format. Enclosed with the survey were a letter of introduction explaining the purpose of the research, emphasizing the voluntary nature of their participation, and clarifying issues of confidentiality; a stamped addressed return envelope; and a separate card agreeing to be interviewed, on which students wrote their first names and phone numbers (see Appendix II). A second stamped addressed return envelope was enclosed to return the interview card separately from the survey.
Each survey was numbered to enable record-keeping. The return address for surveys and interview cards was a rented post-office, partly to accommodate the potential volume of mail and partly to protect my own privacy and safety.

The survey was administered through the students' mailboxes at the hospital; 124 survey packages were distributed on January 29, 1997. I followed the protocol outlined by Mangione (1995) to maximize response rate, with two follow-up notices and one follow-up survey package. Two weeks after the initial distribution of the survey, on February 13, 1997, a reminder notice was distributed to all student mailboxes. On February 26, 1997, a second survey package was distributed to all students who had not yet responded. A final reminder notice was placed in the mailboxes of those who had not responded by March 13. (See Appendix II for follow-up letters and notices.)

Mangione (1995: 67) claims that a follow-up protocol such as this should provide approximately a 75% response rate. My final response rate was 58% (N=72). While this is lower than I would have liked, given the extreme time commitments faced by medical students, it may be as good as can be expected. Faculty members in this medical school and others thought it was a high rate of return. Similar surveys, when conducted with non-captive populations of students or recent graduates, achieved response rates from 51% (Hostler & Gressard, 1993) to 62% (Hojat, Gonnella & Xu, 1995).

I took two steps mid-way through the process that increased my responses, that - had I taken them from the first - might have improved the overall response. I should have arranged to speak to the class when I distributed the initial survey package in January. The face-to-face contact and the chance to 'pitch' the importance of the survey would undoubtedly have improved the initial response. Instead, when I realized the response was low I arranged to meet with the class on February 26, the day I
distributed the second survey package to students who had not yet responded. Some students told me in later interviews that this contact made a difference.

Secondly, before I started the survey I debated the pros and cons of offering monetary or other compensation for students who completed the survey. Mangione (1995) suggests this can significantly improve response rates. I decided against this for three reasons: my limited resources would not permit compensation of any significance to 124 students, and a lottery for all respondents would still be costly and produce less substantial improvement in response rates. Secondly, I assumed that medical students would be more likely to come from affluent families and might have less concern about money than most other students have, thus would be less motivated by a draw for a relatively small amount of money. Lastly, I was concerned that offering money would cheapen the research, decreasing the internal motivation to participate while not significantly increasing external motivators.

Several of the first surveys that were returned mentioned financial issues as a major concern that I had neglected to ask about. I started to realize my assumptions about the affluence of medical students might be in error! So when I arranged to meet with the class to pitch the survey, I also added an external motivation: I announced that I would enter the identification numbers of all surveys returned by March 21 into a draw for $200, including those surveys that had already been returned. I believe this, along with the personal contact, increased my response rate markedly.

Mangione demonstrates that with the follow-up protocol I used one can expect each wave of mail-outs to return half as many surveys as the previous wave. Thus, if 40% were returned after the initial survey distribution, the first reminder should bring in another 20%, the second survey package another 10% and the final reminder another 5% for a 75% total. In contrast I had a 17% (N=21) response to the first survey package; 12% (N=15) after the first reminder; 20% (N=25) after the second survey package and
class visit plus the announcement of the $200 draw; and a final 9% (N=11) after the final reminder, for a total 58% response (N=72).

Though the responses picked up in March, after I visited the class and instituted the draw, there is no way of knowing what the total response would have been had I met with the class and offered the lottery from the outset. By March students were already panicking about the intense examinations they would face at the beginning of April, and would have been less likely to spend time on the survey than they might have been in February.

Finally, I made some decisions on the survey content that I knew might result in lower responses but that I believed were necessary, both politically and sociologically. In several series of questions about the impact of age, religion, ‘race,’ gender, social class and so on, I included sexual orientation. I knew that some students might be offended by these questions and refuse to answer the survey – which would lower my response rate. However, after years of critiquing surveys for totally excluding the realities of gay men and lesbians, I could not myself construct a survey that did the same thing. It was a difficult decision; I knew I might lose several respondents in order to capture one or two gay or lesbian respondents. At the same time I believe deliberately excluding specific social groups through exclusionary question wording is simply bad sociology.

From some comments on the survey, and others by students I interviewed, it is clear that my inclusion of questions about sexual orientation did in fact offend some students. One man raised this issue after our interview was concluded. He said the talk around the school, around his class, was that the gay and lesbian questions were asked too many times and some people found them offensive. I pointed out that questions about sexual orientation came up no more and no less than religion, ‘race,’ culture, ethnicity, language, gender, age, and so on. He said he realized that, but that the perception was that I was asking too much about it. So again, I can assume that my
decision to be inclusive of gay and lesbian students (and to name heterosexual orientation as a social factor) cost me in terms of response rate, but I do not know how much.

The survey results were analyzed using SPSS for Windows. It is worth noting at this point that the statistics that appear throughout this dissertation, based on the survey results, are primarily at the level of description, with some sub-group comparisons and analysis of variance. I have deliberately not included more advanced statistical analysis here, because I do not believe the sample size (N=72) warrants it. It is also important to comment here on how statistics are reported. In the social sciences a level of significance of 0.05 is conventionally used, though 0.10 is also seen with less frequency. Given the small sample size, the exploratory nature of the research, and the fact that the survey data are supplemented with two types of interview data, statistical significance is sometimes of less concern to me than would otherwise be the case. Thus, at times I indicate patterns in the data whether or not statistical significance was reached. Generally, I simply provide the probability levels and readers can decide for themselves what to make of them. If, for example, I report a trend in the data with a probability level p=0.08, readers may note that there is an 8% chance this trend is due to chance and interpret the evidence accordingly. Finally, where quotes from open-ended survey responses are used in the text, they are indented and set off with a bullet but are not attributed to anyone, since the only identification I have is the survey number.

3.2.2 Student interviews

Interestingly, the pattern of returned interview cards suggest early respondents were probably more motivated by internal factors such as interest in the topic, while later respondents may have been more motivated by the potential of winning money. Of the first 21 surveys returned 10 (48%) were accompanied by cards agreeing to
interviews at a later date. In subsequent waves of returns, the proportion volunteering for interviews dropped to 26%, 16% and 18%.

Upon completion of the survey I had first names and phone numbers of 20 students who were willing to be interviewed.\textsuperscript{4} To increase participation, I distributed a notice to all student mailboxes a few weeks after the survey deadline announcing the winner of the $200 draw (with her permission) and announcing a second draw for $100 from among the names of all those who completed an interview with me. That brought two more students willing to be interviewed. Finally, as I conducted interviews I asked students if they would be willing to tell me the names of a few classmates they thought it would be useful for me to interview, or who might provide a perspective very unlike their own.

Many students named classmates who had already been interviewed or agreed to an interview. Nonetheless, this snowball sampling also generated an additional 35 names. In each case I wrote the student a brief letter indicating that someone had suggested they would be a valuable person for me to interview, and asking them to call me if they were willing to be interviewed. I contacted the students only once to avoid harassing them. This process brought an additional 4 interviews. My final total of student interviews was 25.

The interviews were conducted between April 27, 1997 and July 27, 1997. At that time students were on a two-week break just after third-year final exam, or had just begun their fourth year rotations. Most interviews were held in students' homes, though two were held in my home, one in a research lab I had access to on campus, and two were held near the hospital during breaks – one at a park and one at the student alumni centre. Each interview was tape-recorded with the written consent of the participant (see Appendix III). Each tape was identified with a number and a pseudonym. I also completed a one-page demographic questionnaire for each student during the

\textsuperscript{4} One student later cancelled due to time pressures.
interview (see Appendix III). The interviews were usually 60 to 90 minutes long, though three went to 115 minutes and one woman was enjoying the interview so much she wanted to meet a second time to continue! That interview totalled almost 3 hours.

In each case I followed an interview guide (see Appendix III), though it was revised continually as I went, in response to how well particular questions seemed to be working and to query students' thoughts on issues emerging from previous interviews. Furthermore, I did not ask all questions in every interview, but rather allowed the interview to be guided by what I was hearing from each participant, and his or her particular interests. Interviews were transcribed verbatim, and coded inductively.

The final number of interviews was determined by the number of volunteers and by ‘saturation’ of the data. In qualitative research saturation is reached when the researcher no longer seems to be finding out much that is new from continued interviews. At that point there is diminishing return from subsequent interviews. They may be confirmatory but they supply little insight the researcher does not already have. I expected with the diversity I was seeking in the interview sample that I would not reach saturation quickly. But by the 23rd and 24th interviews I was starting to feel I was hearing the same thing over and over. I believe I saturated the data.

Lengthy quotes from the interviews that are used in the rest of this text are identified with the pseudonym of the student. The quotes have been ‘cleaned’ of the usual grammatical errors, false starts, phrases like “um” and “y’know,” and pauses that all of us use in everyday speech. This is a controversial move, since many qualitative researchers believe in 100% authenticity when using quotations. My position is that cleaning the quotes simply avoids making my research participants look stupid and inarticulate, as they might if their unedited speech were portrayed next to my edited and re-edited writing. In no case have I altered the meaning or content of any passage. My editing has simply tidied their speech.5

5 For example, the first student quote I use in Chapter 4 is:

... 59 ...
3.2.3 Faculty interviews

The final stage of the research was interviews with 23 faculty members. I was startled by the level of response and interest from faculty. Students were asked on the survey to identify faculty members who have substantial contact with students during their clinical years and who are especially interested in medical education. About half (N=37) of the completed surveys identified 1 to 6 faculty members; some names were raised by as many as 13 students. A total of 34 faculty were identified; 4 of those were not listed in any department within the Faculty of Medicine and I had no addresses, or even first names for them. I added 3 names to the list to increase the representation of women, and to add one gay male physician who is involved with support services for a particular sub-group of medical students. In total, then, I sent out 33 letters to faculty requesting interviews. Of those, 24 agreed to be interviewed – most were very eager. One interview with a family physician was rescheduled three times and we finally abandoned the attempt. Thus, in total I conducted 23 interviews with physicians/faculty members.

These interviews were conducted between July 11, 1997 and October 10, 1997. One was held at the physician’s home, and one in a hospital cafeteria, while the rest took place in the participants’ offices. Each interview was tape-recorded with the faculty member’s written consent, and the interviews followed an interview guide (see Appendix IV). Again the guide changed over time as the interviews followed the

Valerie: I would have to balance family and practice, and I wouldn’t want to let my practice overrun, or take over family time. The odd occasion I guess you’re on call and you have to go, but I’d want to keep a good balance.

In the original transcript, it looked like this:

Valerie: I would (pause) I mean I would have to balance family and practice, um, and I wouldn’t want to let my practice overrun, or take over family time. You know the odd occasion I guess you’re not, you’re on call and you have to go, but I’d want to keep a good balance. Um...

6 This one physician is not actually a faculty member; he does invited lectures regularly, and works with students on placements in his practice. For simplicity, though, I will usually refer to this group as faculty, since all physicians but this one were on faculty, while not all faculty were physicians – some had PhDs in academic subjects.

...60...
relevances of each participant, but also as the interviews became more focused around themes that were emerging from previous interviews and from the transcripts of student interviews. These interviews were usually 60 minutes long, though 2 were slightly shorter, and 6 were 70 to 90 minutes. Tapes were identified with a number and pseudonym. Interviews were transcribed verbatim and coded inductively.

The pseudonyms are simply Dr. A, Dr. B, Dr. C and so on. This does not tell the reader anything about the person, whereas the student pseudonyms (Valerie, Mark, Bruce) at least indicate gender. I decided against indicating the demographics of each faculty member I quote in the text, because I am afraid that would make some of them, especially the small number of women, overly-identifiable. Even just noting age and gender, it would be easy for a reader who knows this relatively small community to put together, ‘Hm, Dr. A is female, mid-40s, appears to be a surgeon – must be so-and-so.’ Where I think the demographic background of the interviewee is pertinent, I bring it up in the text surrounding the particular quote.

3.3 Description of the Samples

3.3.1 Survey sample

The sample of students who completed the survey were split exactly between women and men (N=36 each) – the class itself was 48% female. Just less than half (44%) of all respondents were 25 years old (N=31), and 82% of respondents were under 30 (see Table 3.2). The average age was 27 years. The majority of the students named their social class background as upper middle class or lower middle class (see Table 3.3). I did not allow a “middle middle class” category to try to force some clearer categorization. I did not want to overburden respondents with demographic questions, so chose not to ask about what occupations or education levels their parents had. Therefore, I have only their self-reports about social class background. Perhaps most significant here is that only nine students (15.3%) claimed a poor or working class
background while fully half the respondents claimed a upper class or upper middle class background (50%, N=36).

<table>
<thead>
<tr>
<th>TABLE 3.1</th>
<th>TABLE 3.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey – Student Gender</td>
<td>Survey – Student Age</td>
</tr>
<tr>
<td>Sex</td>
<td>Age</td>
</tr>
<tr>
<td>Male</td>
<td>#</td>
</tr>
<tr>
<td>Male</td>
<td>36</td>
</tr>
<tr>
<td>Female</td>
<td>36</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TABLE 3.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey – Student Class Background</td>
</tr>
<tr>
<td>Class</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Upper</td>
</tr>
<tr>
<td>Upper Middle</td>
</tr>
<tr>
<td>Lower Middle</td>
</tr>
<tr>
<td>Working</td>
</tr>
<tr>
<td>Poor</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Almost exactly half of the respondents had no religious affiliation, while the majority of the rest were Christians (see Table 3.4). A small number named Sikh or Hindu religions and two students were Jewish. A third of the respondents were married or living with a partner while just over a third were in serious dating relationships. Just under a third were single or dating casually (see Table 3.5). All but one of the students identified as heterosexual, and only one student was a parent.

Twenty (18%) respondents considered themselves members of minority groups, though three of those did not say on what basis. The 17 who identified the minority group they are part of all referred to racialized minorities such as Asian, Chinese, Indo-Canadian, South Asian and so on. About 30% of students in every medical school class for the past decade or so have been 'visible minorities.'

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7 I could not get official statistics on the class and age distributions among the third year students, nor their academic backgrounds or religions.
TABLE 3.4
Survey – Student Religion

<table>
<thead>
<tr>
<th>Religion</th>
<th>#</th>
<th>Valid %</th>
<th>Cum %</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>37</td>
<td>51.4</td>
<td>51.4</td>
</tr>
<tr>
<td>Protestant</td>
<td>17</td>
<td>23.6</td>
<td>75.0</td>
</tr>
<tr>
<td>Catholic</td>
<td>9</td>
<td>12.5</td>
<td>87.5</td>
</tr>
<tr>
<td>Sikh</td>
<td>4</td>
<td>5.6</td>
<td>93.1</td>
</tr>
<tr>
<td>Hindu</td>
<td>2</td>
<td>2.8</td>
<td>95.8</td>
</tr>
<tr>
<td>Jewish</td>
<td>2</td>
<td>2.8</td>
<td>98.6</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>72</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Finally, there was some diversity in students’ undergraduate academic backgrounds, though biological and health sciences still dominated (see Table 3.6). Most students named only one discipline in which they did undergraduate studies, though a few named as many as 4 disciplines. In total then, the 72 students named 115 academic backgrounds; of these 61% were in the biological and health sciences. A substantial number had some background in arts, humanities, social and political sciences, though these were still a minority (21%). Twenty-five students (35%) considered themselves “pre-med” while they were doing undergraduate studies. Of the 14 graduate degrees students held, 12 were in biological and health sciences (86%), and 2 were in physical and applied sciences (see Table 3.7).

TABLE 3.6
Undergraduate Backgrounds

<table>
<thead>
<tr>
<th>Discipline</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological, agricultural</td>
<td>46</td>
<td>40.0</td>
</tr>
<tr>
<td>Health sciences</td>
<td>24</td>
<td>20.9</td>
</tr>
<tr>
<td>Arts, Humanities</td>
<td>15</td>
<td>13.0</td>
</tr>
<tr>
<td>Math, computers, physical sciences</td>
<td>15</td>
<td>13.0</td>
</tr>
<tr>
<td>Political and social sciences</td>
<td>9</td>
<td>7.8</td>
</tr>
<tr>
<td>Interdisciplinary</td>
<td>3</td>
<td>2.6</td>
</tr>
<tr>
<td>Engineering and applied sciences</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Total</td>
<td>115</td>
<td>99.9</td>
</tr>
</tbody>
</table>

TABLE 3.5
Survey – Student Relationship Status

<table>
<thead>
<tr>
<th>Relationship</th>
<th>#</th>
<th>Valid %</th>
<th>Cum %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single, dating</td>
<td>21</td>
<td>29.2</td>
<td>29.2</td>
</tr>
<tr>
<td>Serious relationship</td>
<td>27</td>
<td>37.5</td>
<td>66.7</td>
</tr>
<tr>
<td>Married, living</td>
<td>24</td>
<td>33.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>72</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

TABLE 3.7
Graduate Backgrounds

<table>
<thead>
<tr>
<th>Discipline</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological, agricultural</td>
<td>5</td>
<td>35.7</td>
</tr>
<tr>
<td>Health sciences</td>
<td>7</td>
<td>50.0</td>
</tr>
<tr>
<td>Math, computers, physical sciences</td>
<td>1</td>
<td>7.1</td>
</tr>
<tr>
<td>Engineering and applied sciences</td>
<td>1</td>
<td>7.1</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>99.9</td>
</tr>
</tbody>
</table>
Sixty-three of the 72 students were Canadian citizens and the other nine had dual citizenship. When asked an open-ended question about how they identified their ethnic origins, other than as Canadian, a significant number (18) did not answer the question or insisted they were simply “Canadian.” Apart from these, the greatest number were of British, Scottish or Irish origin (N=19, 31%). An additional 13 (21%) were of Chinese, Hong Kong Chinese, Japanese, Korean or Taiwanese heritage, and 6 (10%) were of Indian, Punjabi, or Pakistani heritage (see Table 3.8). Most respondents (N=59, 82%) were born in Canada, though only 26 (36%) had both parents also born in Canada.

<table>
<thead>
<tr>
<th>Heritage</th>
<th>#</th>
<th>Valid %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canadian</td>
<td>8</td>
<td>12.9</td>
</tr>
<tr>
<td>British, Scottish, Irish</td>
<td>19</td>
<td>30.6</td>
</tr>
<tr>
<td>American</td>
<td>1</td>
<td>1.6</td>
</tr>
<tr>
<td>Chinese, including Hong Kong</td>
<td>10</td>
<td>16.1</td>
</tr>
<tr>
<td>Korean, Taiwanese</td>
<td>2</td>
<td>3.2</td>
</tr>
<tr>
<td>Japanese</td>
<td>1</td>
<td>1.6</td>
</tr>
<tr>
<td>Indian, Punjabi, Pakistani</td>
<td>6</td>
<td>9.7</td>
</tr>
<tr>
<td>German</td>
<td>4</td>
<td>6.5</td>
</tr>
<tr>
<td>Indonesian, Malaysian</td>
<td>2</td>
<td>3.2</td>
</tr>
<tr>
<td>Scandinavian</td>
<td>2</td>
<td>3.2</td>
</tr>
<tr>
<td>Romanian, Hungarian, Polish</td>
<td>2</td>
<td>3.2</td>
</tr>
<tr>
<td>Italian, Portuguese</td>
<td>2</td>
<td>3.2</td>
</tr>
<tr>
<td>Jewish</td>
<td>2</td>
<td>3.2</td>
</tr>
<tr>
<td>First Nations</td>
<td>1</td>
<td>1.6</td>
</tr>
<tr>
<td>No answer</td>
<td>10</td>
<td>missing</td>
</tr>
<tr>
<td>Total</td>
<td>72</td>
<td>99.8</td>
</tr>
</tbody>
</table>

The majority of their parents had come to Canada from the U.K., Hong Kong and China, though substantial numbers also came from other parts of Asia. Nineteen students (26%) did not have English as a first language; of these the greatest number spoke Chinese languages, while the next most common was Punjabi (see Table 3.9).

<table>
<thead>
<tr>
<th>Language</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>52</td>
<td>72.2</td>
</tr>
<tr>
<td>Chinese, Sino-Tibetan</td>
<td>5</td>
<td>6.9</td>
</tr>
<tr>
<td>Korean</td>
<td>2</td>
<td>2.8</td>
</tr>
<tr>
<td>Japanese</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>Punjabi</td>
<td>4</td>
<td>5.6</td>
</tr>
<tr>
<td>Hindi, Tamil</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>Germanic</td>
<td>2</td>
<td>2.8</td>
</tr>
<tr>
<td>Romance languages(^8)</td>
<td>2</td>
<td>2.8</td>
</tr>
<tr>
<td>Not English</td>
<td>3</td>
<td>4.2</td>
</tr>
<tr>
<td>Total</td>
<td>72</td>
<td>100.0</td>
</tr>
</tbody>
</table>

\(^8\) Following Statistics Canada census categories, this includes Italian, Portuguese, Romanian and Spanish.
TABLE 3.10
Country of Birth – Students and Their Parents

<table>
<thead>
<tr>
<th>Country of birth</th>
<th>Respondent #</th>
<th>%</th>
<th>Father #</th>
<th>%</th>
<th>Mother #</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>59</td>
<td>81.9</td>
<td>28</td>
<td>38.9</td>
<td>26</td>
<td>36.1</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>2</td>
<td>2.8</td>
<td>11</td>
<td>15.3</td>
<td>11</td>
<td>15.3</td>
</tr>
<tr>
<td>Western Europe</td>
<td>1</td>
<td>1.4</td>
<td>2</td>
<td>2.8</td>
<td>6</td>
<td>8.3</td>
</tr>
<tr>
<td>Southern Europe</td>
<td>1</td>
<td>1.4</td>
<td>2</td>
<td>2.8</td>
<td>2</td>
<td>2.8</td>
</tr>
<tr>
<td>Eastern Europe</td>
<td>0</td>
<td>0.0</td>
<td>4</td>
<td>5.6</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Hong Kong, China</td>
<td>4</td>
<td>5.6</td>
<td>9</td>
<td>12.5</td>
<td>11</td>
<td>15.3</td>
</tr>
<tr>
<td>Other Eastern Asia</td>
<td>1</td>
<td>1.4</td>
<td>5</td>
<td>6.9</td>
<td>3</td>
<td>4.2</td>
</tr>
<tr>
<td>South East Asia</td>
<td>2</td>
<td>2.8</td>
<td>3</td>
<td>4.2</td>
<td>3</td>
<td>4.2</td>
</tr>
<tr>
<td>Southern Asia</td>
<td>0</td>
<td>0.0</td>
<td>6</td>
<td>8.3</td>
<td>5</td>
<td>6.9</td>
</tr>
<tr>
<td>Africa</td>
<td>1</td>
<td>1.4</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
<td>2.8</td>
</tr>
<tr>
<td>United States</td>
<td>1</td>
<td>1.4</td>
<td>1</td>
<td>1.4</td>
<td>2</td>
<td>2.8</td>
</tr>
<tr>
<td>Oceania</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>Missing data</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
<td>1.4</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>72</strong></td>
<td><strong>100.0</strong></td>
<td><strong>72</strong></td>
<td><strong>100.0</strong></td>
<td><strong>72</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

3.3.2 Student interview sample

The students I interviewed were a fairly equal mix of men and women and ranged in age from 23 to 40 years old (see Table 3.11 and 3.12). They tended to be slightly older than the survey respondents, with an average age of 28. As in the survey sample, few self-reported as being from an upper-class background; collapsing upper and upper-middle class, though, more than half the sample falls into this category (see Table 3.13). The interview sample slightly over-represents students from working class and poor backgrounds, students who are married or living together, and students with previous Masters degrees. These three factors may be related to the older average age of these students. On the other hand there was only one student who was a parent.

These students were similar to the survey sample in that just over half (N=14) reported no religious affiliation. Of those who did say they had a religious affiliation (N=11), all were Christian denominations except for one Jewish student. Similarly this group reflected the survey sample in that virtually all identified as heterosexual; only one student interviewed identified as gay/lesbian. And the majority of the interview

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9 Compared with an average of 27 years for survey respondents.
sample had academic backgrounds in the sciences, including biology, biochemistry, biopsychology, and so on. One student came from nursing and one had a previous degree in an applied science. Only three had backgrounds in social and political science.

<table>
<thead>
<tr>
<th>TABLE 3.11</th>
<th>TABLE 3.12</th>
<th>TABLE 3.13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Age</td>
<td>Student Gender</td>
<td>Student Class Background</td>
</tr>
<tr>
<td>Age</td>
<td>Gender</td>
<td>#</td>
</tr>
<tr>
<td>23-25yrs</td>
<td>Male</td>
<td>7</td>
</tr>
<tr>
<td>26-30yrs</td>
<td>Female</td>
<td>12</td>
</tr>
<tr>
<td>31-35yrs</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>36-40yrs</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

Most students identified their cultural heritage as being “Canadian” or “American,” which tended to mean their families were of European ancestry and came to North America some generations ago. I identify these as “old” European below (see Table 3.16). Those whose parents are of European descent (plus one student’s mother who was originally Australian) and moved to Canada, or students who immigrated here themselves, I call “new” European or commonwealth. One of these identified his/her cultural heritage as Jewish. Similarly, 6 students were of Asian heritage. Of these, one student’s family had lived in Canada at least two generations (“old” Asian) while 5 had immigrated here with their families or were first generation Canadian (“new” Asian). Only two did not have English as a first language, though one other student had two first languages.

<table>
<thead>
<tr>
<th>TABLE 3.14</th>
<th>TABLE 3.15</th>
<th>TABLE 3.16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship Status</td>
<td>Academic Background</td>
<td>Cultural Heritage</td>
</tr>
<tr>
<td>Relationship</td>
<td>Discipline</td>
<td>#</td>
</tr>
<tr>
<td>Single, dating</td>
<td>Bioscience undergrad</td>
<td>8</td>
</tr>
<tr>
<td>Serious relationship</td>
<td>Masters in bioscience</td>
<td>3</td>
</tr>
<tr>
<td>Living together, married</td>
<td>Arts, social science undergrad</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Masters in arts, social science</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>2</td>
</tr>
</tbody>
</table>

...66...
The major differences between the interview sample and the entire class (as reflected in the survey demographics), apart from slightly older average age and slightly more working class students, is representation of racialized minorities. A substantial number of students who completed the survey identified as Indo-Canadians and Sikhs; none were interviewed. Additionally, some Chinese-Canadian students suggested there is a sub-group of “culturally Chinese” students in the class, who identify strongly with their cultural heritage, speak Mandarin, and stick together in school. As far as I know none of these students were represented in the interview sample, though I did identify some of them and specifically requested interviews.

3.3.3 Faculty sample

Unlike the student interviews, I did not systematically collect demographic information about each physician/faculty member I interviewed. I decided against this because these demographic questions are usually the ones that interview subjects take greatest offense to, especially about age, income and sexual orientation. I decided not to risk ruining rapport with these individuals to gather demographic information. Among the most relevant factors are gender and visible minority status, both of which I could see for myself. And I suspected that other pertinent information would come up during the interviews.10

In most cases, in response to the opening question asking them to tell me a bit about themselves they told me where they did their medical or academic training, when they finished it, how long they have been at this particular medical school and so on. Only two specifically stated their ages; the others I estimated from when they began or completed their training. Some mentioned relationship/marital and parental status, while others did not. In many cases I guessed from wedding rings and photos in their

10 In hindsight, I regret not collecting these data. I suspect my decision was partly influenced by my awareness that I was “interviewing up,” as I discuss below, in section 3.4.
offices, and/or things they said. Similarly, while most did not mention ethnic/racial/national origins, a few did and others I discerned from their stories about their lives, or from observation and listening to accents.

<table>
<thead>
<tr>
<th>TABLE 3.17</th>
<th>Faculty Ages (N=23)</th>
<th>TABLE 3.18</th>
<th>Time at This School (N=23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated age</td>
<td>#</td>
<td>Years at this school</td>
<td>#</td>
</tr>
<tr>
<td>36-45yrs</td>
<td>6</td>
<td>0-10yrs</td>
<td>7</td>
</tr>
<tr>
<td>46-55yrs</td>
<td>12</td>
<td>11-20yrs</td>
<td>9</td>
</tr>
<tr>
<td>56-65yrs</td>
<td>3</td>
<td>21-30yrs</td>
<td>7</td>
</tr>
<tr>
<td>66yrs +</td>
<td>2</td>
<td>mean time 15 years</td>
<td></td>
</tr>
<tr>
<td>mean age 51 years</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Five participants were academic faculty teaching the basic sciences; 18 were clinical faculty. Five were women, eighteen were men. All but two were white-skinned and were from the United States, Britain or New Zealand, or were Canadians of British or European origin. Twelve participants mentioned husbands, wives or partners; two women mentioned being divorced; I am unsure about the marital/relationship status of the other nine. Two participants identified themselves as gay men; none identified as lesbian; three identified as heterosexual. Several others I assume from their marital statuses are heterosexual; the rest (8) I do not know. Ten of the 23 faculty members had administrative positions ranging from heads of departments or divisions to Associate Deans.

The sample of faculty members and administrators I interviewed was not a representative sample of the Faculty of Medicine; rather it was a purposive sample, chosen for characteristics desirable to my research. Students directed me toward faculty who have a significant amount of contact with undergraduate students, and who are interested in medical education in general. The three names I added to the list are

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11 Obviously an imperfect method of data collection.
12 They represented anatomy, biochemistry, physiology, and pharmacology.
13 Their clinical areas included renal, pulmonary, pediatrics and pediatric oncology, medical genetics, family practice, surgery, neurology, ethics, internal medicine, infectious disease, endocrinology, anaesthesia, and psychiatry
physicians who have particular interest in the social impact of professional training on students.

3.4 Interviewing up

One of the three research components for this study involved ‘studying up.’ I think most sociologists – most Canadians – would agree that when I contacted and interviewed physicians and medical school faculty members, I was researching a group of people whose social status is greater than my own. Not only were they all doctors and or university professors while I was a graduate student, they were also all older than me, most were men, and undoubtedly all were wealthier than I. The usual concerns about the power of the researcher that have been so well examined by feminist and qualitative researchers in recent decades were reversed in this instance. In addition to awareness of my own power as researcher I had to contend with my awareness of the power of my interviewees.

Susan Ostrander (1995) argues that issues of access and interview techniques differ in situations of studying up. She suggests that access is not especially difficult, but it is also true that elites normally have the power to shield themselves from exposure. According to Ostrander it is important to do background work and be well-prepared before attempting to gain access; to make contacts in the right order; to expect ongoing processes of being “checked out”; and to maintain control over the research (1995:135).

I found myself in what I thought was a background preparatory meeting on the way toward seeking access to my research site when I discovered that the administrator with whom I was talking was the person who would decide whether or not to grant me access. And from the discussion it seemed unlikely. I had stumbled upon the right contact completely out of order. Fortunately, I was able to pull credentials and documentation together on short notice, and was ultimately granted access. When I
arranged interviews I usually had to explain the purpose of the research fairly extensively before faculty would agree to an interview. In one case a faculty member said he had called my department to check on me before he called me.14 Throughout the faculty interviews, unlike the interviews with students, I remained aware that a complaint from any of the doctors/faculty members could likely end the research.15

While I did not feel control over the research was threatened, I did find myself altering the ways I conceptualized and described the research to make it more acceptable to medical school administrators. I found myself emphasizing the survey component, countering the assumed biased nature of the qualitative components with the assumed objectivity of the survey. I found myself broadening the types of student 'diversity' I was interested in more in line with the way non-sociologists might conceive of the issue: 'race,' class and gender became just three of a range of variables on which individuals might vary. However not only did this re-framing of the issues early in the process allow me to gain access, I think it also helped me to genuinely re-frame my investigation to begin from the standpoint of my informants.

In terms of the interviews themselves, both Ostrander (1995) and Aldridge (1995) note that when interviewing elites status is continually being negotiated. Ostrander suggests that the interviewer must be appreciative but never deferential; must learn the language of the elites before interviewing them; and must maintain control of the interview itself. I think I may have crossed the boundary into deference when I failed to collect systematic demographic data on each faculty interviewee. More importantly though, in early faculty interviews I had a difficult time framing questions in terms of the language and relevances of the faculty without raising their ire. I tended to ask less challenging questions than I might have if I were not interviewing up. However, as the interviews progressed I learned to ask faculty to respond to things other faculty or

---

14 One medical student also called to question me about my stand on some political matters concerning the BCMA before he and his friends would complete the survey.
15 That may also have been true of complaints from students, but I did not perceive it to be so.
students had raised in prior interviews. That enabled me to frame challenging questions in their terms and even allowed me to distance myself somewhat from the question, constructing a situation where one physician or professor was responding to another.

Negotiating status showed mostly in maintaining control over the interview. Ostrander (1995: 145) notes that elites are often accustomed to deference, to being in charge, and to talking easily and at length. The task for the researcher is to try to keep elites speaking to the research issues. I found that in interviews with faculty, unlike any others I have done\textsuperscript{16}, my control over the interview was indeed challenged subtly. This started with scheduling the interviews, when I was usually contacted by a secretary or receptionist who told me when Dr. X would see me. Frequently I was kept waiting, and interruptions during interviews were common.

At the outset of the interview, faculty often commented on the consent form, dismissing its importance and indicating how many of these forms they themselves have composed over the years. In contrast, most others I have interviewed have taken consent forms quite seriously. One physician started right in discussing my topic without signing the form, which meant I could not record the conversation until I interrupted her to please read and sign the form. In a few other cases I was quizzed about my interest in the topic, and found myself establishing my credibility by explaining about having lived with a medical student. Lastly I did indeed find that some faculty spoke volubly and at length without ever really answering my questions. They were also unusually willing to dismiss the issues of interest to me as unimportant and tell me what the important issues were. Some clearly had their own agendas concerning medical education that they hoped to advance through my research.\textsuperscript{17} On

\textsuperscript{16} Not just the 25 student interviews, but also 45 interviews for a concurrent study on diet and breast cancer, and a few dozen for other projects in the past.

\textsuperscript{17} Which is fair enough. This is one of the few things a researcher can genuinely offer back to the people he/she interviews. My point is not that the faculty had strong interests, but rather that they felt more entitled to put them forward than has anyone else I have ever interviewed.

\ldots 71 \ldots
the other hand, some faculty allowed my questions and their own thoughtful insights to lead us both in challenging, thought-provoking directions.

3.5 Summary

All knowledge is socially located. Starting research from the vantage point of particular human participants allows you to see some things and not see others. The starting point determines which relevances structure the project. In this research I started primarily from the standpoint of students who have written and expressed their accounts of being on the margins in medical school. Those relevances meant starting from the assumption that medical students may have aspects of their identities that do not fit easily with the new medical-student identity they are taking on. The non-random sample from a survey of an entire class, at a key point in their professional socialization, allowed me to explore the extent to which students feel conflicts and congruences among their multiple identities. Interviews with 25 self-selected students, many of whom were particularly interested in the topic, allowed me to probe more deeply into issues of difference and conformity in medical school as they who discussed their thoughts, experiences and reflections. Finally, though interviews with faculty and physicians were subject to the particular constraints of ‘interviewing up’ they also provided yet another vantage point, one that has the disadvantages of distance and hierarchical relationship as well as the advantages of longevity and the opportunity to observe patterns over time.
Chapter IV: Becoming A Medical Student, Developing A Professional Identity

For most medical students, a remarkable and important transformation occurs from the time they enter medical school to the time they leave. . . . They become immersed in the culture, environment and lifestyle of the school. They slowly lose their initial identity and become redefined by the new situation. Medical students have to look for something to hang on to. And that something is provided: their new identity as 'doctor' (Shapiro, 1987: 27).

As was reviewed in Chapter Two, much of what we know about students' coming to identify as medical students, as future-physicians, is derived from research conducted when students were almost exclusively male, white, middle or upper class, young and single. When women and students of colour were present it was usually in token numbers. Even when their numbers were substantial, as in Sinclair's (1997) ethnography, the possibly distinct processes of professional identity formation for these students were largely unanalyzed; additionally, the potential impact of their presence on the professional socialization of the heterosexual, white, male students was also unanalyzed. So what does becoming a physician-to-be look like in a medical school of the late 1990s?

The students in this study clearly feel they are on their way to becoming doctors. In response to an open-ended survey question about what they enjoyed most about medical school, some wrote in the fact that they are beginning to become doctors, are starting to fit in with the profession, not just with their classmates.

- I feel my talents and strengths fit in with the medical profession.
- Turning slowly into a clinician.
- Most of the aspects of becoming a doctor – dealing with patients and other health care professionals, learning about the human body and diseases, doing procedures.

In his 1978 study, Robert Coombs found that when scoring themselves on a 7-point scale from layperson (1) to doctor (7), even first year students had a mean score of 3.4 out of 7. Each year the average score increased by 0.6 or 0.7, until in the third year
students averaged a score of 4.7 out of 7, and by senior year 5.4 out of 7. They saw themselves as ever-closer to being doctors, but not quite there yet (Coombs, 1978: 221). Even in their first year, though, students saw themselves as almost halfway to being doctors.

On a similar scale in this study students surveyed averaged 4.5 on a 7-point scale, ranging between 2.6 and 5.5. More than half the respondents (54.3%) placed themselves between 4.6 and 5.5 out of 7. Another 28.6% scored themselves between 3.6 and 4.5, while the remainder fell between 2.6 and 3.5 out of 7. I had anticipated that white, middle-to-upper class men, of average age, would feel most at home in the medical school and would be slightly more likely to see themselves as ‘almost a doctor.’ In fact the reverse was true.

The mean for women (4.6) was slightly higher than for men (4.4) though not significantly so. The mean for students who self-identified as ‘minorities’ (4.6) was slightly higher than for non-minority students (4.4) though again the differences did not reach significance. Upper class students thought of themselves as least far along the continuum toward becoming a doctor (mean 2.9), followed in order by upper middle class, lower middle class and working class students (mean 4.9) (F=3.3, d.f.=5, significant at p=0.01)\(^1\). The one pattern which matched what I expected was age: the youngest and oldest students saw themselves as having further to go toward becoming doctors than did the 25 to 30 year olds (difference not significant).

4.1 Professional Identity – What Is It?

It was not easy for most of the medical students and faculty I interviewed to articulate what the medical professional identity is that students are being socialized

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\(^{1}\) The means need to be interpreted with caution. The number of students who identified as “upper class” is very small, so the mean of 2.95 may be misleading. However, even without that group the overall pattern holds true, with students of lower social class background tending to see themselves as further along toward becoming doctors than students from higher social class backgrounds.
into. Nonetheless, some elements are discernible, including an approach to medicine that sees it as a vocation, a calling to service provision rather than a mere job. Other characteristics include being a ‘good team player,’ taking a particular position in the professional hierarchy – vis-à-vis other medical staff, other health care personnel, and patients; adopting some form of professional ethics; identifying with the concerns of the profession and with professional colleagues; and taking on a professional appearance. In some cases differences among the students – by gender, ‘race,’ class, and so on – were significant, in some they were not. Though I will allude to some of these differences here, I will not explore them fully in this chapter. The impact of social differences in medical education is a central theme in Chapters 5 and 6.

4.1.1 Medicine as a calling, a vocation

One hallmark of a profession is that it is expected to be a vocation, a calling, not just a job like any other job. I mean here vocation in the Weberian sense of passion, responsibility and devotion to a cause; the vocation should be one’s life, should nourish one’s inner being. Weber sees the ‘calling’ to science as a passion to the point of irrationality. The scientist should be devoted to the task of science for the sake of knowledge itself (Weber, 1958).

Similarly, some commentators describe medical professionals as a kind of science-based priesthood, and medical socialization as a kind of doctrinal conversion into a sacred identity (e.g., Haas & Shaffir, 1987). It involves selection and preparation, initiation, testing and ritual ordeals or rites of passage. “Symbolic changes in wardrobe of costume, props, script and demeanor both affirm the new role and identity and help to sustain it” (Haas & Shaffir, 1987: 4-5). Becoming a professional involves a series of ritual performances through which initiates learn to play the professional role. “The professionalization process... involves dramatic rituals which symbolize the transformation of the ‘called’ into ‘the chosen.’” (Haas & Shaffir, 1987: 36). This notion...
of "the chosen" and medicine as a "calling" are key – though contested – elements of a medical professional identity.

There were differences of opinion among medical faculty members in this study about whether medicine is appropriately thought of as a vocation, a calling, or whether it is better understood as simply a job. Two faculty members were particularly clear about the vocational aspect of medicine:

Dr. B.: Many people get into specialties they find themselves unhappy in. And they can't get out of it. And then they will be just doing medicine as a job, as opposed to a calling which we like to think it is.

Dr. T.: I happen to come from a tradition that believed that medicine is a calling and that it's a privilege to serve. And I actually get irritated with people who feel that they need to have a balanced life of kayaking every weekend and so on.

Two faculty members spoke about their concerns seeing older students admitted to medicine. Their understanding of medicine as akin to a calling is apparent in their notions that medical students have to "give back" to society through service: "your debt to society is a good forty years."

A related concern was shared by several faculty members – namely that students these days are less willing to put in the hours they should. Students treat medicine as a normal job, when it requires a much deeper commitment.

Dr. B.: I think it's a little disappointing, quite frankly, to hear things like, 'I prefer to take up this particular aspect of medicine because I'll always be off at five o'clock and to hell with...'. Medicine has suffused my life in every way. And I don't think that my patients were any the worse for that. In fact, in some ways, I think they were better for it... And I think it's a little disappointing to hear that sort of thing.

The notion of medicine as vocation was expressed most by students as fear that they were not as immersed in medical school as their classmates were. Several wrote in comments on the survey to the effect that, "I'm not as 'consumed' by medical school as some of my classmates are." A very few students who were interviewed described their ideal of 'a good doctor' as someone who approaches medicine as a calling, putting their
patients above all else. Cindy, for example, referred somewhat scathingly to some doctors' "just treating it as a job, rather than as, you know . . . a calling or helping those in need."

Most students, though, thought that the medicine-as-vocation approach led to an unbalanced lifestyle in which the doctor him/herself would not be a healthy person. They argued strongly that medicine should not take over your life, should remain "just a job."

Valerie: I would have to balance family and practice, and I wouldn't want to let my practice overrun, or take over family time. The odd occasion I guess you're on call and you have to go, but I'd want to keep a good balance. I really think that having a balance just mentally makes you more, a better person, I think.

Martin: [Medicine as a calling,] I don't agree with that at all. No. I don't think it's fair to do that to anyone. And I think if you talk to a physician who has that attitude they might be happy in their 30s and early 40s but it's going to tire them out into their 50s and 60s. It's gonna break up their family life, it's gonna break up their marriage, and they might think they're happy but they're just burying themselves in their work, I think. I don't think anyone should expect to have medicine as their life. And . . . I don't think they should expect other people to have that same attitude. . . . There's a lot more to life than medicine. I'll change careers before I let that happen.

Faculty saw this focus on 'a balanced lifestyle' as a change among medical students in recent years. Many faculty commented that students are placing more emphasis than ever before on the lifestyle, hours and call schedules attached to particular specialties when they are making decisions about residencies.

Dr. A.: A lot of them choose their careers around lifestyle, quality of life. So there's more consideration about that than I think there used to be. . . . They want a niche that is comfortable for them and one in which they can do their thing. Have their families if they want or not or do other things. This seems to counter the notion of medicine as a calling, as something a student would/should willingly allow to absorb his or her every waking hour.
Some faculty, though, expressly argued that this move toward greater balance is a positive trend, that physicians definitely should cultivate more balanced lifestyles than has traditionally been the standard.

Dr. N.: There are some wonderful physicians out there who have completely impoverished personal lives. They love what they do, and they've either never committed themselves to anyone or they couldn't find anyone, or they've had just a series of relationship failures because of their complete dedication to medicine. Some of them are exemplary teachers, researchers, clinicians and often loved and regarded because they're omni-available... I see [lots of] physicians whose personal relationships are unraveling. Good people, well meaning people but their spouses can't do it anymore. Or their spouses are okay but their kids are in all kinds of trouble.

Some also commented that this notion of balance is not taught particularly well in the medical school.

Dr. U.: We don't help them very much in terms of lifestyle. It's almost like we have this older view of, listen this is the torture chamber, this is a gauntlet of fire and you've gotta go through it, like we all did. The old story about when I was an intern we were on call one in two. And there's almost a badge of honour associated with it. So that the ones that are here at six in the morning and stay 'till late at night, 'Oh that student is such a great student,' you know. 'Works his tail off.' But that's not a good lifestyle. And I don't think we show the students that maybe some of us don't like to work so hard either. All the role models are the ones that are here 'till all hours and you know – 'the dedicated physicians.' And that's the physician that's usually divorced and doesn't even know his kids. Has got ulcers and heart disease and dies early when he retires.

One clinician suggested students today are asked to do two completely opposing things: devote their time to medicine as if it were a vocation permitted to suffuse their entire lives, and maintain balanced connections to their wider communities.

4.1.2 Becoming a ‘team player’

The concept of ‘team-player’ became a central metaphor in interviews with faculty as they talked about students learning to be medical professionals. Interestingly, it does not have such significance in most of the prior research on medical socialization.
In the most recent full-scale ethnography of medical school, though, by Simon Sinclair (1997), the concept of team is central to his understanding of the development of co-operation and competition among medical students. He extends Becker et al.'s (1961) observation of the development of student co-operation to set standards for their work, arguing that official and unofficial teams within the medical school are based on internal co-operation with one another in competition against other teams.

Sinclair focuses on the drama teams that put together plays and skits for public performances; the rugby team and other sports teams that represent the school and form the backbone of its unofficial social life, especially at the school bar; and the teams that organize and participate in “rag week” activities to raise money for charities (1997: 96-133). These he calls “representative teams.” In addition there are “official teams” such as small groups for dissection or clinical rotations, and “official-purpose teams” that students form themselves to work together to divide up their labour.

In my study, the sports teams were also important, though my research methods did not include observation of the students and therefore did not fully capture this aspect of their socialization as Sinclair’s study did. Nonetheless, well over half the students surveyed said they were involved with intramural hockey or other medical school team sports. Hockey players (male and female) were among the most frequently named ‘cliques’ on the survey, and a few students wrote that hockey had been one of the most enjoyable and important aspects of medical school for them.

The significance of this aspect of medical school socialization may be greater than first appears. The concept of the team extends beyond the ice, or playing field, to the classroom, the hospital, and eventually the clinic or operating room. Several faculty referred to the concept of team when talking about students’ becoming members of the medical profession. One clinician, who was trained in Britain, claimed the Dean of St.

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2 An alternative, and much less common, metaphor is that of family. Sinclair says students in his study were given an introductory lecture in which they were told, “You’ve become part of the family, a very
Mary’s Hospital, a teaching hospital in London, deliberately recruited rugby players as
medical students: “His claim, which was a bit exaggerated, was that if you work and
you get on with people, playing rugby and drinking beer and so forth helped you get
on well with patients.” This clinician believed, “Sports is a team game and medicine is a
team game.” He argued that, “one really doesn’t want loners in medicine.”

While others drew less direct links to sports teams, nonetheless the team concept
was pervasive. Usually it was simply the description of medical students as “good
team-players.” The term sometimes seemed to mean slightly different things, though.
Sometimes it was used to refer to the medical team, the clinicians, residents, student
interns and student clerks involved in the care of a patient.

Dr. T.: [Once] you’ve contributed you’re part of the team and then you
become ‘we.’

Dr. M.: That sense of belonging, I think, is a sense of belonging to the
profession as much as anything else. You feel you actually are now doing
what you wanted to be doing. What medicine’s all about... you’re part of
the process of health care... Even if it’s tenuous, even if it’s just at the
bottom end of the totem pole. I mean, you haven’t a lot of the
responsibility, but at least you’re connected with the team.

In other cases faculty made it explicit that they were talking about becoming members
of the broader health care team of medical staff, nursing staff, social workers and so on.

Dr. F.: They interact with the multidisciplinary team... When you come
in in fourth year, you’re still probing what does the social worker do?
What does the psychologist do in the clinic? What does the secretary do?
And all this is a team... So at the end you start figuring out what are
the interactions between different professionals and how they complement
each other... and where you fit in the team as a future physician.

Dr. U.: I think that the nurses here are... terrific at helping these students.
... My feeling is in general that they’re really a team, they have a real
team concept... Once they get on the unit then they find that the nurses
kind of depend on them and they depend on the nurses and there’s kind

large family, which will nurture you and look after you” (1997: 101). Similarly, one clinician I interviewed
told me his own class’s 25th reunion “was like my brothers and sisters came home.”

... 80 ...
of a, it reaches kind of, 'Hey we’re on the same team here we, we gotta help each other. ‘Cause the patients are most important.’

Students’ learning their place in this larger team, then, is seen as key to becoming a medical professional.

A few students also talked about the importance of being a good “team player.” In particular it came up when discussing the desire to present a united front for patients, to not display dissent among the ranks. It was sometimes discussed as not wanting to undermine the patient’s confidence in their doctor or doctors in general – a sort of generalized saving face for the profession.

Josh: You have to go along with some things and do them but this isn’t how you want to do it. But it’s not your place to say, ‘I’m not going to go along with this,’ you know? You just have to go along with it, like in front of the patient, you know? For teams it wouldn’t be good to have the ranks sort of arguing amongst themselves about the best approach for patient care at times. Or as to what to do at certain times. So in front of patients you have to sort of say, ‘Okay well everyone holds the same general ground,’ and then later on you’ll be able to discuss and decide whether it’s going to be different or not.

Interestingly, this form of face-saving may also contribute to a perception among patients of physicians’ closing ranks, protecting one another from scrutiny.

Josh’s description brings to mind Goffman’s notion of “performance teams,” “any set of individuals who co-operate in staging a single routine.” (1959: 79). As Goffman argues more generally, the members staging a medical performance have to display a substantial amount of agreement, or minimally roles that will fit together into a coherent whole. “Open disagreement in front of the audience creates, as we say, a false note” (1959: 87). In Goffman’s terms, such disagreements must be expressed “backstage,” just as Josh describes above.

Two underdeveloped elements of Goffman’s dramaturgical analysis (1959) are highly relevant here: conflicting roles, and the assumption of a consensual script. When Goffman talks about discrepant roles, he does not mean playing two roles that diverge widely, but rather having information that one shouldn’t have given one’s
position in relation to the performance. But from Sinclair’s (1997) description of medical school teams I get a clear impression of the exclusion of students whose roles might be discrepant with the mainstage performance. He states on several occasions that non-white students and women are largely absent from the teams he analyzes. The bar, a focal point for team-building and team-performances, is habituated by white students, mainly men, mainly rugby players. The Asian students, he remarks, frequent another bar entirely. The rugby team, Sinclair’s archetypal team, is exclusively white men from upper-class schools. The drama troupes are composed of men and women, but almost no non-white students, and then only in non-acting roles. In Chapter 6, I will discuss the extent to which ‘race’ and gender, among other social differences, affected the ability of students in my study to be fully members of both unofficial and official teams – and how they manage being member of multiple teams with multiple front and back stages.

The second underdeveloped aspect of Goffman’s framework that is immediately relevant is the absence of a director and assumption of a consensual script. While he does discuss the backstage negotiations that go on to produce the united front of any performance, he continues to stress that team performances rely on the “reciprocal dependencies,” of their members. This does not adequately address the power hierarchies entailed in a setting such as medicine in which reciprocity is rare. I wonder if the widespread adoption of the concept of team among medical school faculty members is a way of denying the hierarchy that exists in medicine while accepting the notion that people fill many different positions with distinct jobs. The team metaphor may illustrate a desire to level the hierarchy, or at least not acknowledge it as hierarchical.
4.1.3 Working out relationships with others / learning the hierarchies

One of the themes that came up consistently throughout the interviews was the need for medical students to learn their place in a complex hierarchy. Some saw this as an appropriate step in students' professional development; others saw it as a necessary evil; still others saw it as an abomination and fought hard against replicating hierarchical structures. Three somewhat separate themes emerged from the interviews: 1) the position of medical students within the medical hierarchy; 2) the relationship of medical students to the larger hierarchy of health care workers; and 3) the hierarchical or authoritative relationship of medical students and future-physicians to patients.

Hierarchies within medicine

Virtually everyone agreed that there is a clear hierarchical structure within medicine, and medical students are on the bottom. One of the key aspects of becoming a medical student is learning to negotiate this hierarchy. Dr. U. sees it as a fine and important tradition, facilitating the communication of knowledge, experience and skills to those following behind, and allowing more junior members of the profession to be protected somewhat by more senior members.

Dr. U.: You're always taught by the person above you. Third year medical students taught by the fourth medical student. . . . Fourth year student he depends on the resident to go over his stuff. Resident he depends on maybe the senior or the chief resident or the staff person. And so they all get this, this hierarchy which is wonderful for learning because the attendings can't deal with everybody. So the one above helps the one below. That's a very strong tradition in medicine.

He also thinks it important to help junior members learn to accept their changing position in the hierarchy as they move upward:

Dr. U.: I always tell the final year residents when they're going for their oral exam, I say the year before you go for your oral exam you start calling all the staff men by their first name because you have to get into the mode of I am no longer a resident, I am [a specialist], these are my colleagues and they are not my bosses anymore.

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Dr. J., too, referred to a "time at which [students] need to start clicking over to being part of the power structure" themselves.

The way most faculty talked about the hierarchy in medicine made it seem absolutely commonplace. They described the compliance it inculcates in students, who are afraid to question or critique their superiors.

Dr. T.: Because by and large medicine is a highly structured hierarchical kind of thing you tend not to question.

Dr. G.: Part of their concern is the fact that if they don’t appear compliant and so on that they will get evaluated poorly. And if you get evaluated poorly then you might not get a good residency position. And so there’s that sort of thing over their shoulders all of the time. I don’t think it’s necessarily true, but it’s the fear.

Students, understandably, were far less accepting of the hierarchy – and particularly of their place in it.

Peggy: There’s this whole staff/student sort of thing…. Oftentimes I feel like I’m being treated like I’m very, very low on the totem pole…. That’s a different experience to have people, you know, looking down. And having to be the proper little medical student and wear our white coats and be looking up to the staff person and pretending that it’s four o’clock in the morning and this is exactly where you want to be and you wouldn’t think of wanting to be anywhere else, you know? And sometimes I find myself getting caught up in that. I don’t like to think that I’m being dishonest but I do find myself talking to staff people, playing the game in a way… almost acting younger than I am…. I hate having to pretend that I’m somebody that I’m not, you know.

For the students, a central piece of learning to be a good medical student seems to be about learning not to challenge clinicians. Though virtually every student described seeing things on the wards that they disagreed with, as long as there is no direct harm to a patient the students usually stay silent and simply file away the incident in their collection of ‘things not to do when I am a doctor.’ Most students are very clear that this is their current student role: they are there to learn, not to criticize.

Mark: I remember seeing things that were wrong. I didn’t challenge. But thinking back, I kinda wish I did. Suppose it’s part of the learning
process. Next time I probably will challenge, but it's kind of a shame that I saw some things that might have made a patient feel uncomfortable. I don't think any harm was really done, but people were feeling a bit uncomfortable, which was unnecessary. But, at the time, this guy was way above me. He had an evaluation in his hands. He really had so much power over me. And in medical school we're always thinking about letters of reference etc, so you never want to step on too many people's toes. ... It's a really tough situation to be in, when you're there though, 'cause - just the power he has over you. And it's not even threatening grades or threatening evaluations or stuff like that, but just the power that he's someone who's teaching, and you're supposed to respect what he's doing. And you try, sometimes you go a bit too far and try and force yourself to respect what he's doing, when in a sense you shouldn't. You should be a bit more critical.

Lily: Lots of times there are, just the way people are treated sometimes I disagree with, just lack of basic human kindness, and it upsets me. And depending on, actually I don't know if I've ever called someone on it. I've called a couple people on it, like residents or something, just kind of mentioned it as a conversation, but as a student it's difficult to sort of question the authority of others.

A few students had more thoroughly internalized the notion of not criticizing a clinician. They saw it as part of being a good "team player." It is one thing to critique a superior or colleague behind closed doors, but never in front of a patient.

Denise: In an interaction between a doctor and patient, I've never seen a doctor criticize another doctor's work. The most that they'll ever do is say something like, 'Yes, well, I'm your doctor now,' or, 'I'm sorry, I can't comment because I don't know all the factors that went into that decision.' I haven't ever seen them say, 'You're kidding. He didn't see this?' or whatever. ... It's very true that you don't know all the factors that were presented to the other doctor, so I don't criticize other people's decisions. ... People have to trust their doctor to do something, and it doesn't help the therapeutic process if they don't feel they can trust it. ... I know how important it is for [patients] - they don't know all the facts, they don't know the anatomy, they don't know the problem - for them to feel like they're with somebody competent. So I would be quite reluctant to destroy that confidence they have.

Some students, then, had fairly entrenched understandings that you never criticize another doctor. To my mind this indicates an important component of becoming a professional.
Though the professions are self-policing, there is also often an unspoken “code of silence” as Janis put it. Speaking ill of a professional colleague may entail risk to yourself, may put your professional judgment on the line, and/or may weaken the shared understanding of professional autonomy.

Janis: That’s the first rule, never talk bad about other doctors. . . . It’s just something you don’t do. ‘Cause it can come back to you, you know. Especially as a student.

Valerie: I would hope that if I ever saw something blatantly sexist or racist or wrong I would hope that I would say something. But, you get so caught up in basically clamping up, shutting up, and just taking it. . . . Is it going to ruin my career, am I gonna end up known as the fink, am I gonna not get the [residency] spot that I want because I told. . .?

Mark: As students we all critique the professors and our attendings. . . . But, at the same time, I don’t think we’d ever do that in front of a patient. It’s never been told to us not to. But most of us get the feeling that we wouldn’t do that. Or even if a patient describes something their doctor has prescribed to them or a treatment they’ve recommended which you know is totally wrong, maybe even harmful, I think most of us just, unless it was really harmful, would tend to ignore it and just accept this is the doctor and his patient. What happens between them is okay. I think.

This seems to be a key aspect of developing a professional identity, a sense of self as aligned with the other members of the profession rather than with other laypeople and patients. To return to Goffman briefly, this may be the process of learning to maintain the performance of the team in front of an audience. He suggests (1959: 89) that when a team member makes a mistake, the other members of the team must suppress their desire to immediately correct until the audience is no longer present.

Finally, though the students indicated that the hierarchical structure affected all of them in the same ways, faculty suggested there may be some gender differences. In particular, though the men implied – by their silences as much as their comments – that when students reach full professional status the nature of the hierarchy levels off, two of the women indicated that their struggles with the hierarchy internal to medicine are ongoing. Both are well-established in their fields, known and respected by colleagues.
internationally. One talked about being dismissed at a conference because she identified too much with her women research “subjects,” despite her clear scientific credentials. The other woman described continually being treated differently from the men:

Dr. R.: I would go to these big symposiums and I was invited ‘cause I was this brilliant scientist. And [we’d be introduced as] Dr. John Smith, Dr. Joe Black, Sharon Rose, Dr. Frank Clark3— I kid you not! ... All the men got treated one way and I did not get treated the same way. So there is a gender issue.

Hierarchies among health care staff

In keeping with the team concept discussed earlier, students on their way to becoming full-fledged medical professionals need to learn where they fit in relation to other health care workers, including nurses, dietitians, pharmacists, technicians, physiotherapists, counsellors, receptionists, and so on. Dr. D. called hospitals “very complex social hierarchies,” where “subtleties are important.” Several faculty discussed the importance of medical students’ learning to get along in these complex hierarchies.

Dr. I.: I believe in medical school we should teach our students how to approach nurses, to watch from a distance, see if they have the time, be very polite, be very nice, be very receptive, be very conscious, you know, and, and see if they have time or something. Find the time when you can talk to them and so on and so forth. So it’s all part, probably, of that process.

Dr. I. suggested that all medical students should have to spend time in the role of social worker or nurse or pharmacist or mopping floors, to learn what the other essential hospital work entails.

Dr. I.: If you clean up an operating room once then you know what’s involved to clean up an operating room. You know what’s involved in taking a patient up there. Then you never scream at people, ‘Why does it take so long. . . ?’ You would know how long the elevator takes, you know how to clean, change the sheets and clean things— . . . All medical school students should have a summer job doing sanitation or whatever. . . . ‘Cause most of the time we don’t know what’s involved there. That’s why most of the time we don’t appreciate the work of other people because we

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3 None of these are actual names.
don’t know how much is involved in the work of other people. . . . It would solve a lot of interaction problems.

Students were clear that there were differences between their roles in the hospital and those of other health workers. But this was of less concern to them at this point in their training than was establishing their relationships to other medical staff and to patients. As Erin said, "We’re not expected to do nurse things" – but she connected this primarily to how students should relate to patients.

**Relationship to patients**

One of the most contested topics that came up in the faculty interviews was about the relationship medical students should strive toward vis-a-vis their patients. In particular there were widely diverging views on the degree of professional authority that physicians – and by extension student-physicians – should display.

Some faculty drew a very clear connection between professionalism and the "emotional distancing" that Reneé Fox documented in 1957. They believe it essential that students learn an appropriate distance from patients. The relationship between a physician and patient is different from the ones other health care staff have with patients, and is based on specific skills and knowledge.

Dr. E.: Unfortunately with professionalism also has to come a distancing. . . . I’m not my patients’ friend, I’m not their neighbour, I’m their doctor. Within the professional job that you have to do, one can be very nice to patients but there’s a distancing that says you’re not their friend and you’re their doctor. [. . . ] I mean nurses and doctors have an entirely different body of knowledge. . . . [Nurses] are not taught differential diagnostic skills. The patient develops chest pain they call the doctor. Meantime the nurses try to deal with the patient’s discomfort themselves, but the doctor has to come and deal with the chest pain. I think the medical students just can’t see through it. They just can’t see their eventual role will be appropriate.

Another clinician described this professional distancing as a “veneer,” a “hard shell” that is adopted by physicians and by students, “as a necessary way of dealing with feelings they don’t have other ways to deal with.” She does not advocate it, but does
understand it. Another female clinician recalled her first realization of a need for professional distancing. She felt herself being drawn into the hysteria of a parent of a very ill child, and realized, “I’m not gonna be any use whatsoever if I cry.” She described it as “a total click of I’m not of any use to this family if I get involved with them. I want to be sensitive... [but] I only become of use if I can put some distance so that I can function.”

Several faculty members rejected this approach to medicine in favour of one based in egalitarianism.

Dr. V.: That’s [professional-distancing’s] the easiest way to deal with it. But I reject that way of dealing with it. As much as possible the patient’s concerns are more important than my medical concerns, in other words when I’m seeing a patient I have to try to get into understanding what’s bothering them. And in fact it’s a harder job, I mean my concept is I need to understand well enough so I can help them to understand. ‘Cause that’s the process of healing is their self-understanding.

They raised the issue of power, talking about recognizing and leveling or sharing power with patients. They emphasized that clinicians need to be able to hand-hold, to care, to know their patients as something more than “The liver in Room 207.” They stressed the importance of communication skills, not as secondary to good clinical skills, but as “a matter of life and death.” Patients visit a doctor with one complaint as a way of feeling them out. If they feel comfortable, they may raise the more serious concerns they are afraid to mention. In short, these faculty members rejected the image of distant professional.

Dr. J.: [This university] is obsessed with prestige, this is the mark of our excellence is how prestigious we are. So we try to create medical students who look successful. Well for many patients that’s a problem. If you’re having to explain to your physician things that involve admitting you’ve really made a mess of your life, it’s very hard to do that to somebody who looks like they’d never make a mess of anything. It’s much easier to do that to someone who looks a little more relaxed who doesn’t look like they’re trying to impress you... The idea that the dress of the business community is somehow better than the dress of the labouring community [is] simply bigotry.

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The issue of power between doctors and patients is a crucial one, and one that came up surprisingly little in the interviews. Only five faculty members talked about such power, and none of the students did. As students are learning their place in a complex series of hierarchies, their focus is on the hierarchy within medicine, the hierarchy which will determine whether they pass or fail, whether they become doctors. In that hierarchy they are at the bottom. With all of their attention on their performance in front of their superiors, they lose sight of the fact that within another simultaneous hierarchical relationship, that between medical staff and patients, they already have considerable power. Students told me story after story of their own powerlessness, their inability to confront their own humiliation or the humiliation and ill-treatment of patients at the hands of clinicians. They told almost no stories of the powerlessness of patients.

As I said, only a handful of faculty talked about power in the physician-patient relationship. It is tempting to read more into an apparent gender difference than my sample size warrants. Four of the five women faculty mentioned power issues. But one woman undermined her comments about the need for mutual respect between a patient and doctor and the need to recognize that knowledge is power, by talking scathingly about some pregnant women as “real granolas who have no idea what’s good for them” and have ideas that “are frankly quite unsafe for both them and their babies.” Another woman was by far the most adamant person I interviewed in her belief in the need for clear professional distancing and an authoritative relationship to patients and other health care staff. So three of the five women had a sustained critique of power-over relationships to patients, compared with two of eighteen men; while not conclusive evidence of a gender difference, it is suggestive. I will look more at how gender affected students’ relationships to authority in Chapter 6.

What seems to make this issue complex is the interrelationships among power, prestige, elitism, authority, specialized knowledge, and responsibility. Students clearly
acquire increasing amounts of knowledge and responsibility, and that brings with it a certain degree of authority, at least in relation to laypeople. The line between that professional authority and elitism or power-over is less clear and seems to be drawn differently by different professionals.

Overall, the degree of authority, status, prestige and power a budding-physician adopts in his or her interactions with patients seems to be a complex decision. The standards are widely different from one practitioner to another, and even for one physician may vary according to the patient; it is little wonder students find this difficult. It seems likely there is no right answer for everyone. It may depend on individual personality. It may depend on gender, with men granted authority readily while women need to gain and secure it for themselves using white coats and titles alongside their specialized knowledge and skills.

Dr. R.: If you need a white coat to get respect then you’ve got some insecurities and some other problems. And I do believe if there were a bunch of women of my generation we really, they had to be really hard as nails to get respect. That was the way they learned to get it and I don’t particularly want to see us model for the future but that is how they functioned. And it’s hard for me to judge that.... Medical students need many different models.

What seems clear is that it is a difficult balance to strike. Clinicians may believe strongly in egalitarianism, but still find it painful to work that way – though differently damaging not to. Dr. R. confesses she doesn’t always know the answer, how to find a balance.

Dr. V.: It’s very hard though. To allow yourself to feel is to make yourself vulnerable. And that’s a hard way to be. Yeah.
I: Easier to learn the veneer?
Dr. V.: Oh yeah, yeah. And the veneer gets very thick. In fact it gets so thick that family and friends can’t break through it. You know and which is one of the reasons partners of physicians have a really rough time.

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4 I did not have a specific question on this in the interview guide. The theme emerged after about 5 faculty interview; after that I raised the issue of hierarchy when faculty members did not bring it up themselves.
Because they don’t really know who their partner is anymore if you don’t watch out. So veneer once it gets up is really, really hard to let go of.

Dr. R.: I think you’re most effective when you intuitively do understand where that person’s coming from. You have to somehow open yourself up enough but protect yourself from being overwhelmed. It’s a very fine balance. The reason so many doctors become callous is because it’s a very hard balance to find. . . . It’s really a fine balance. I don’t know the right answer.

Dr. W. argues that clinicians should dispense with professional distancing, but only when that is in the interest of the patient – which takes practice to determine.

4.1.4 Taking on professional ethics

Faculty had surprisingly little to say about the issue of professional ethics, given that a voluntary code of ethics seems to be a cornerstone of professionalism. Psychiatrists were most likely to discuss the struggles students have to learn professional boundaries. Students on the other hand, spoke of professional ethics when discussing what it means to be a professional. Some described explicit instruction about professional ethics, fairly straightforward lectures about standards of behaviour. Students seemed to have thought most about ethics when the standards of practice they are being taught contradict their own religious beliefs – in particular Christians who feel medical secularism contradicts their ethical beliefs as Christians. Some students said they would apply the guidelines they have been taught, almost in a formulaic way, while others spoke of needing to work out their own ethical stances, set limits for themselves, and recognize their own boundaries.

Cindy: Even though we may be Christians, we’re living in a secular world, and we’re professional, too. So you have to be careful not to – you’re in a position of power, so you know, you’re not supposed to, like, mislead or lead at all the patients under your care according to what you think is right, based on just your values or beliefs. It should be more of a medical direction. Like, give them the pros and cons and let them weigh them for themselves. If you want my personal opinion you can ask me.
I: So because you’re a professional, you aren’t free to express your moral convictions in the moment? Is that right?
C: Yeah. Like, if someone asks you to perform an abortion on her, you can say no, and refer her to another doctor.

Doug: In my last elective the doctor wanted me to do a lumbar puncture on a patient. And I’d seen it before, hadn’t done it before, and he said, ‘Well, if you’ve seen it, that’s all, you know, don’t worry. You go in and you’re gonna do it.’ He said, ‘I’ll be in the room, but I don’t even want the patient to know that I’m a doctor. You’re gonna be the doctor. You’re gonna do it.’ And I just said, ‘No. I’m not gonna do that,’ ‘cause I had seen it but I hadn’t seen it the day before. It had been several months before. And I wasn’t comfortable doing that. And I just said, ‘I wanna be able to talk to you during the procedure, if the patient consents, and say this is my landmark, this is what I feel, where should I go from there?’

The most direct connection to medical socialization was expressed by two women who spoke of situations in which they would normally give casual opinions to family or friends about health concerns, but no longer feel free to do so because they are ethically bound by their medical opinions now. The ‘ways of being’ they are learning within medical school are spilling over into the rest of their lives, affecting their interactions with friends and family. They are becoming doctors on more than one front.

4.1.5 Identifying with ‘the profession’

Another aspect of a professional identity is identifying yourself as having a primary affiliation with your professional colleagues, as opposed to identifying with patients or other lay people. An important shift occurs in the clinical years as students’ focus moves from exams and grades to practicing medicine: gradually the faculty and clinicians become role models to follow rather than adversaries (Coombs, 1978: 217). The students increasingly come to feel part of the medical profession. The transition from perceiving themselves as lay persons to perceiving themselves as doctors is gradual – and is central to developing a professional identity.
As noted in Chapter Two, the ongoing debate started by Becker (1961) and Merton (1957) has been over whether medical students are socialized into a *medical identity* or a *student identity*. As I said there, obviously elements of both are going on, and which one dominates may vary by school as well as by type of student. I will come back to this when I talk about processes of identifying, later in this chapter. Here, I simply wish to establish the presence of this element of professional identity, not to refute the presence of a student identity.

About a third of the students talked at some length about concerns they have that I would classify as being concerns of the profession as a whole. In that sense I see these students as identifying with other medical professionals, as sharing the concerns of their senior colleagues around job conditions, remuneration, restrictions on locations for practice, restrictions on services allowed, relationships between the profession and the general public, and relationships with the state.

As we have seen above, some students talked about not critiquing another physician because you do not know the full story, and because you would not want others to criticize your professional judgment. This notion of shared professional autonomy was extended further by some students to understandings about a shared position in the health care system. Some talked about the pressures put on physicians by drug companies. Several students discussed the unrealistic expectation by patients that they can be cured of everything, even when patients may be unwilling to tell you what you need to know to make an accurate diagnosis. Several students also expressed concern about the negative image of physicians in public perceptions, and the lack of effective representation of their interests by official professional organizations.

Bruce: There's a lot of negative public perception, talk, about physicians and about the stereotype of what they are and what they're not, and what they make and how financially well-off they are. And you know, about how they're not maybe as caring and – I feel very caught up in that, and, well, that doesn't describe me or any of my classmates. All these soft allegations about the negative parts of, of physicians. . . . And in a
different way altogether, I think... we feel shortchanged. In terms of this issue of billing and, and more restrictions as to where you can and can’t be and so on... The profession’s changing radically.

Martin: I think physicians are generally poorly organized. Nurses? They have a lot more time off, they’re unionized, they’re a lot more organized as a group of professionals it seems to me, and whenever they have an issue they attack it, and they get organized about it. Whereas physicians don’t—I mean we’ve got the BCMA which supposedly takes on that role, and the College of Physicians and Surgeons, but I just don’t think they’re as organized about things, and I wish we were. ‘Cause I think in this society, if you’re not unionized, you’re not organized, you’re underpaid and overworked in general.

Thus far we have seen that in the process of becoming a physician, medical students take a position on whether medicine is a vocation or a job for them, they learn to become team players, and they find their way in a series of hierarchies that include other medical personnel, other health care staff, and patients. They also learn to adopt a version of professional ethics and to identify at least to some extent with the profession. The last factor I will examine here is taking on appropriately professional appearances.

4.1.6 Constructing a professional appearance

Mark: As you’re becoming a doctor, you feel a bit more constrained. Constrained in time, and constrained in the appropriate way for you to be presenting yourself, and the appropriate way for you to be acting and thinking about things. You just feel a bit more constrained.

Another aspect of medical socialization, of becoming a medical professional, is taking on a professional appearance. Some students commented that a certain degree of concern about appearance and dress is mandated and expectations about professional appearance are conveyed to students very explicitly – “When people started to relax the dress code a letter was sent to everybody’s mailbox, commenting that we were not to show up in jeans, and a tie is appropriate for men.” It seems students are frequently reminded about what constitutes appropriate dress; according to one survey comment,
the Dean’s Office sends students a notice “at least every other week about us not dressing appropriately for clinic.” A few students also mentioned specific clinicians demanding a certain standard of dress on the wards, such as wearing a tie.

Most students, though, do not require such mandates. From comments written in on surveys, they seem to have internalized the required standards and seem to fully accept the rationale: that ‘professional’ attire is respectful to patients. They want to fit in with other medical staff, and they want to be taken seriously by patients. Wearing the required attire helps in taking on the image and role of physician. It helps to look the part. Some consciously take their cues for appropriate dress from the clinicians they are working with, deliberately mirroring the physicians around them.

- I feel students should dress conservatively. We must look competent and professional at all times.

- Dressing neatly and appropriately is important to convey respect to patients, other medical staff, and the profession. It probably also helps in patients taking students seriously.

- When you have less than a minute or so to establish rapport with a patient, it seems to help if you appear as ‘the generic doctor’ with short hair, collar and tie (male). I feel this is especially true with elderly patients – kind of what they expect.

When asked whether or not they ever worried about their appearance or dress at the hospital, 40.8% of the survey respondents said they did not, while 59.2% said they did. Those of working class or poor backgrounds were slightly less likely to worry (55.6% did compared with 61.1% of upper and upper middle class students), while “minority” students were slightly more likely to worry about appearance (65.0% compared with 56.9% of non-minority students). Neither of these differences reached statistical significance, and there were no statistical differences by gender.\(^5\)

\(^5\) Despite the lack of statistical significance I report these patterns because I think the open-ended questions discussed below suggest there may indeed be issues of gender and social class at work here, even though they do not show up in the closed-ended questions. Here, for class p=0.3 and for minority p=0.5. Thus there is a 30-50% chance the “pattern” is a product of random chance.
One concern about dressing and looking professional is cost. If students do not already have professional-looking clothes in their wardrobes, they may not have the money to purchase them. Yet the expectations about professional dress remain.

- I do ensure that I am dressed formally enough. Sometimes this is a problem, as in 1st term of this year I only had 2 pairs of pants I felt appropriate, and no comfortable shoes to go with skirts.

- We do have to look as professional as possible – this can be tough financially!

- I don't have a lot of money for clothes, and not a very good figure either. Also, I'm usually really tired in the mornings and don't have much time for make-up/hair.

I do not think it is a coincidence that all of these comments are from women. Women's clothing costs more, and more variety is expected. It goes out of fashion more quickly and the fashion standards are more rigid. Women have to buy more to keep up with social expectations, and those expectations include accessories and make-up. Lastly, women face more pervasive social messages about appearance and appropriate body type/size; a "good figure" is a mandated part of a professional image for women in a way that it is not for men.

Dressing 'professionally' also raises some concerns for students who are not used to dressing that way. This may be simply personal preference, or may reflect the fact that in student environments casual clothes are often the norm and budgets permit little else. But it may also reflect differences in social class background. If a certain 'up-scale' or professional style of dress was not taken for granted in students' homes when they were growing up, they may be less likely to feel comfortable dressing that way as young adults.

- I worry about not appearing 'formal' or 'professional' enough, as my background has never involved wearing dressy clothes.
There were important gender differences in students' concerns about appearance. Most of the men's concerns about professional appearance were satisfied by a shave and a shirt with a collar, perhaps adding a tie.

- I always wear a tie – keeps things simple, no worries about being underdressed.
- I do make sure that I am dressed appropriately when I see patients i.e. well-groomed, collared shirt (but no tie).

Women, on the other hand, struggled with the complex messages conveyed by their clothing. It is a challenge to look well-dressed, yet not convey sexual messages. For women, 'dressed up' normally means dressed feminine – and feminine means sexual, or sexy. But professional image is intended to convey competence, not sexuality. At the same time, clothing must be practical, suited to the work students will be doing on the wards. And as one woman commented on the survey, she is simultaneously trying to convey messages about age and status. Some women found striking this complex balance a struggle.

- Like to look nice, but don't want to appear too trendy or provocative.
- Is it professional enough? Competent looking? Will it be too hot on the wards? (I have fainted). I do not want to appear 'sexy' on the job.
- As a female I worry about whether or not something is 'too short' or 'too low' and as a young woman I try to look older to gain respect of my patients.

In one interview a student commented that both men and women sometimes violate standards of professional dress, but she finds it more problematic when done by women. Men's violations involve wearing their hair longer than average, or wearing hiking boots on the wards; women's usually involve dressing too provocatively. The former may be too informal, the latter sexualizes a doctor-patient encounter.
4.2 Changes Students Go Through

So how do students go from being a layperson to adopting the professional identity outlined above? What changes are apparent in students as they go through this process of medical professionalization? Faculty, with greater distance from the subject and ability to observe greater numbers of students over time, were better able than the students to articulate some of the changes students go through during their undergraduate training. These include developing an increased self-confidence, maturity and sense of responsibility; loss of idealism; narrowing of thought processes, loss of initial communication skills, and adoption of a medical language.

4.2.1 Increased self-confidence, maturity, responsibility

Faculty described many – if not most – students as ‘blossoming’ during their four years of undergraduate medical training. They described quiet, insecure students developing increased self-confidence. Most commonly they talked about students gaining in maturity as they take on increased and serious responsibilities.

Dr. N.: There is a heck of a maturity process that goes on over four years, for better or for worse.

Dr. B.: They gain in maturity, that comes very rapidly. It’s extraordinary how rapidly it comes. . . . They become focused on what in fact is to be their life’s work. And they realize it’s no game. It’s a serious matter.

In Boys in White Becker and colleagues argued that the idea of “medical responsibility” is one that predominates in medical culture. Students encounter this in their clinical years and construct their own student version of it (1961: 223). The notion has two sides: doctors can, through their power to act on patients, save lives; at the same time, doctors can, through failure to act or improper actions, cost patients their lives. The more serious a patient’s illness, the more substantial the weight of responsibility on the doctor – and the greater the glory should he or she pull the patient

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through (1961: 237-8). Students structured their clinical learning around seeking out opportunities to exercise responsibility.

This was less apparent in my study, probably partly because I did no observations of the students on wards. However, the pervasive belief in "medical responsibility" was clear in faculty interviews.

Dr. J.: They know they're being prepared for a role in which they have a great deal of responsibility... They're beginning to understand that in the very near future they would have to make some very serious decisions about people, that they're going to have to deal with very complex issues.

Dr. N.: [There's] a sense of assuming increasing responsibility for one's patients. And the strong mandate there of trust, you know the patients' trust and expectation of you as an emerging physician... Plus I think an associated kind of maturity in terms of willingness to increasingly accept that responsibility.

I heard little evidence in student interviews that they sought out opportunities to exercise responsibility, as Becker and colleagues (1961) report. In fact, whereas Becker tells of students doing complex procedures they were ill-prepared for (such as a lumbar tap) in order to gain responsibility, I had three students tell me of their own refusal to do procedures (including a lumbar tap) that they did not yet feel prepared to do on their own. Here emphasis on responsibility took a different form.

In my research, concern with medical responsibility was most apparent in students' concern about their own performance. Most may have been worried only about reference letters and passing grades, but a substantial number also commented in interviews and on surveys that their desire to learn it all for exams was motivated by fear that one day soon patients' lives will be in their hands.

- I always wonder if I am learning enough, if I will miss something crucial that hurts a patient. I feel a tremendous sense of responsibility toward people who will put themselves in my care, and I worry a lot that I won't be up to the responsibility, that I'll make a careless or flippant or ignorant mistake. Right now I don't have responsibility for patients and my self-doubt is expressed mostly over fears of failing exams, but I can see the day when I will lie awake wondering if I made the right decision.
4.2.2 Loss of initial idealism

About half the faculty I interviewed talked about students' losing the idealism they had upon entering medicine. For many, this was the biggest change they see in medical students as they go through their training.

Dr. P.: Well probably the biggest change is idealism gets trampled. That's probably the biggest thing. And enthusiasm... I think that students start off in the first year with idealist views about how they're going to be different.

Dr. A.: What I often see is a young person totally passionate about what they are doing, totally alive, totally excited about their four years of medicine. And they're gonna be doctors, they want to go out, they want to help the world, they want to cure illness, they want to do all these incredible things. . . . By the time they graduate, they're not quite as excited. . . . I see a lot of disenchantment. And by the time that I see them graduate, they've grown up, they've matured. Some of them are a little jaded perhaps. . . . Perhaps their initial ideas about why they went into medicine have changed, that really it's more about themselves rather than helping others.

One clinician described it more specifically as a loss of humanitarianism. He argued that "the medicalization of people" was a loss of the caring side as students begin to emulate medical role models who "are often very highly scientific people." Others suggested that students learn to adopt a mask or veneer of professionalism. Dr. V. made it clear that for her it is a position of superiority, an aloof distancing that protects students from their own feelings.

Dr. D.: What you see in year one, you see this extraordinary, talented, happy, unsophisticated bunch of young men and women, on the whole very enthusiastic, all ears, charming lay people. And then you see a gradual transformation and socialization of medicine. . . . They become professionals. You know, professionals means wearing a mask, the persona of professional. Which is not the totally happy-go-lucky sort of thing you see in year one.

Dr. V.: I see students change sometimes from being sensitive, well-rounded, caring people into being aloof, superior professionals. That's the typical trend. Get a hard shell, 'I represent wisdom, knowledge. I'm the gift of God to you the lowly patient.' That veneer, this protective thing is
too often adopted by both the professors and the students as a necessary way of dealing with feelings they don’t have other ways to deal with.

Another clinician took up this theme of superiority or power. He argued that the loss of idealism and innocence that he witnesses is not just about a necessary move toward a pragmatism. It is also about role-modeling on clinicians that embody power and enact superiority. It is about learning superiority.

Finally, it may be that students do not so much lose idealism, as that their idealism was exaggerated to start with. One clinician suggested the requirements to enter medicine have become so intense that the only things distinguishing among hundreds of brilliant applicants is volunteer work. Students ‘do idealism’ more to get into medicine than from an inherent desire to help people or improve the world. In fact their desire to enter medicine may be based on much more pragmatic and mundane factors, which come to the fore once they have been admitted.

While students did not normally talk about loss of idealism in those terms, their discussions did reflect this to some extent. One student said she had learned there was no room for naiveté in medical school, that patients rarely tell you up-front why they have come to see you and you have to tease it out of them. Her thinking about patients in general, and their relationships to care-providers, had changed with experience on the wards, and she spoke somewhat scornfully about drug-dependency and indigent patients.

Much more commonly, though, students’ loss of idealism was expressed in terms of the profession. Most of these students had thought they were entering a profession in which they would have a comfortable standard of living, a decent lifestyle, social respect, and the autonomy to decide where they want to work. In Canada in the late 1990s, instead they see physicians having to go on strike for what they consider decent remuneration, physicians working excessive hours and call-shifts, wide-spread public cynicism about doctors, and an erosion of professional autonomy.
such that if they set up practice in an area considered 'over-served' they will only be able to bill 50% of the going rate for their services. By far the greatest amount of cynicism expressed by students was in relation to these issues.

4.2.3 Changes in language, thinking, and communication skills

In their important work on the social construction of reality Peter Berger and Thomas Luckmann (1966) argued that a basic foundation of a shared or social reality is language. It allows typification or categorization of experiences and of people; this allows abstraction, in as much as the categories must be broad enough to hold more than one, they must potentially apply to the as yet unseen and unexperienced; this abstraction allows communication. At the same time though, "language builds up semantic fields or zones of meaning that are linguistically circumscribed" and those semantic fields determine "what will be retained and what 'forgotten' of the total experience of both the individual and the society" (Berger & Luckmann, 1966: 39). In other words, language helps establish particular relevances by allowing some things to matter, to register, and some not.

As we saw in Chapter Two, the socialization of medical students into their new professional role includes learning two new languages: an informal medical slang, and a formal scientific language of official communication. The methods of my study did not permit observation of the former. But students did talk about the latter.

Dawna: All of a sudden all I can think of is this lingo that people won't understand, but like my brother told me the other day, 'Sometimes I just don't understand what you are talking about anymore.' I don't realize it! I'll use technical terms that I didn't think that other people wouldn't know.

Learning the language of medicine – what one student called "medical-ese," may have been the most obvious sign of, or may have itself facilitated a larger change in thinking,
structuring a new reductionistic world-view (Good & Good, 1993) by establishing as valid specific relevances (Berger & Luckmann, 1966) – the relevances of medicine.

As we will see later in Chapter Five, some students were quite conscious about a movement toward standardized thought processes to achieve common clinical decision-making. However a few also alluded to more subtle processes of change in how they think. The most basic change is to process things in scientific or clinical terms.

Rina: My thinking sort of changed, I guess I think more in terms of science, just scientific kind of methods or something. And not even that formally, but um, I mean I was having this conversation with a friend of mine... and we were talking about HIV and she was asking me some questions and I realized, 'Oh wow! I guess I'm answering these questions in terms of sort of the pathogenesis of how this virus works in the body and replicating and stuff.'

In more complex terms, though, a few students described a sort of paring away of the 'extraneous' information about a patient's life, to focus on what is clinically relevant.

Though Becky believes that communicating with and relating to patients is crucial, she can also see how physicians develop a narrower focus.

Becky: I sorta see how it happens. . . . The first day of medicine we're just people. We relate by asking everything about a person. Just like you'd have a conversation with anybody. And then that sort of changes and you become focused on the disease. . . because right now there's just too much. It's overwhelming. I can't do everything.

I: So you don't want to know anything that is external to what you are focused on?

Becky: (overlapping) Well, it's not that I don't want to, but I don't know if I have the ability to take it all in. I'm hoping that as I learn more and become more comfortable with what I know and I can apply it without having to consciously go through every step in my mind, that I'll be able to focus on the person again. And come right back full circle.

Faculty members also described a kind of narrowing that occurs as medical students proceed through their training, a kind of new way of thinking that focuses on science, clinical diagnoses, and specific skills. One man called it "deindividualization."

Another told me a study of ethics among students at this medical school showed
significant differences between first and fourth year, differences that he thinks mark this narrowing of thinking.

Dr. G.: The first-year students’ minds were quite wide open and their approach to ethics was— it was less curtailed by the science that had been heaped on the students in those intervening years. The perspective of the fourth-year students was much more narrow. They were much more interested in the clinical aspects of things, the scientific aspects of things than the humanitarian aspects of things. There was quite a difference there.

Several students also spoke of their growing intolerance for others since they have been in medical school. They identified a general impatience with casual conversation, and some spoke of a more specific condescension about laypeople’s health knowledge and behaviours, as well as actions with physicians.

Doug: I don’t have any patience for the level of conversation that goes on [in a normal social setting]. You know, sort of that make-conversation kind of thing... I find myself really impatient with the level of conversation... I think three years ago I would have played my role.

Jason: My sister noted that I had become more (pause) condescending. And, in retrospect, I actually might have become, at the end of my second year... Maybe feeling that I knew a lot more than everyone else did in the lay public. And, God, if they only knew what was happening then maybe they wouldn’t smoke or blah, blah, blah, blah. And almost a kind of a moralistic attitude toward people. Thinking, ‘Oh, I know all this and you don’t.’

Whether the intolerance for small talk and impatience with laypeople’s health knowledge is a situational adaptation unique to students – a product of time pressures and pride in new knowledge – or is a more generalized aspect of socialization into medical ways-of-being is not certain.

One faculty member mentioned that a study in this school showed medical students’ communication skills improved significantly during their first term of first year, but “by the end of fourth year they were worse than they had been before they entered medical school.” Another clinician suggested the fault lies with the education
process itself, that communication abilities are sacrificed to learning the “medical interviewing” style.

Dr. W.: Their ability to talk to people became corrupted by the educational process. They learned the language of medicine but they gave up some of the knowledge that they had brought in. . . . The knowledge of how to listen to somebody, how to be humble, how to hear somebody else’s words that kind of stuff. It got overtaken by the agenda of medical interviewing.

She argues that students who enter medicine as empathic listeners, learn “that to do it right you have to jump in after six seconds.” This, she claims, is the average time a doctor waits before interrupting a patient. This suggests that students’ conversational impatience and intolerance are more than situational adaptations, that they are a (learned) part of medical culture.

4.3 Processes Of Becoming, Identifying

Lance: A lotta things seemed so mysterious and so, so difficult, you know. ‘Oh, man, you’d have to be a genius to know that!’ or something. But really it’s just a matter of sitting down and somebody explaining it to you, and then, gradually, all through the study the mysteries disappear.

When students enter medical school they are simply laypeople with some science background. When they leave four years later they have become physicians; they have experienced some or all of the changes discussed above, and have to some extent taken on a new identity of medical professional. What happens in those four years? What are the processes of socialization that help students make these transformations? Obviously a huge part is simply the acquisition of specialized knowledge, knowledge exclusive to the members of this profession. What other processes go into the making of a doctor?

Some faculty argued that an initial transformation occurs upon acceptance into medicine, that people develop an identity as medical students. Others thought students don’t start to feel like ‘real med students’ until they have begun passing their exams,
proving (to themselves not least of all) that they are in fact acquiring medical knowledge. Until then the sense of being an impostor lingers, at least for some students. Self-confidence begins to grow with passing grades.

While a couple of students said they felt like medical students as soon as they were accepted into the program, most others talked about not really feeling they were medical students until well into their second year, or even later. In particular, while they were engaged mainly in learning basic sciences, studying books and attending lectures in their first two years, they felt like they were simply extending their undergraduate science education.

Dawna: First and second year I was just like an undergrad, it wasn’t that different.

Interviewer: So in first year you weren’t doing the things that you thought a med student would do?
Cindy: At the beginning of first year it’s totally orientation, you’re having lots of parties, lots of fun, getting to know each other. Learning how to study and stuff. When exams come, you’re really, really busy trying to cram this material, and you don’t realize that what you’re doing is dissecting a human cadaver.

Whether it occurs earlier or later, there are some discernible elements that together compile the processes of ‘becoming a doctor.’ A significant one is experiencing a series of ‘first times’ which later become commonplace; getting used to violating personal boundaries is a major component here. Interactions with patients probably have the greatest impact on the development of a medical-student identity, but more generally the responses of others – friends, strangers, other staff, and patients – all help the student to construct a new sense of self as (almost) physician. Finally, the process clearly involves some degree of acting, role-playing. Students present themselves as if they were student-physicians, and before long they start to believe in that themselves. Finally, simply having a real job to do, having some responsibility seems to be a major part of beginning to live this identity.

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4.3.1 First experiences become more commonplace

Several students talked about 'first times' as key moments in their transformation toward becoming doctors. They described a process in which what felt artificial and unnatural initially, came to feel natural simply through repetition. Denise in particular thought that learning to identify herself as almost-a-doctor happened through a series of emotionally powerful first-experiences.

Denise: I think there are sort of seminal experiences. Like, the first cut in anatomy, the first time you see a patient die. First time you see a treatment that was really aggressive, and didn’t work and probably shouldn’t have been used. For me, that was a big day; when I saw something that I thought, 'This is not dignified.' First few procedures that I conducted myself. First time I realized that I really did have somebody’s life in my hands— not that they gave me a lot of power, but, for example, when a person is paralyzed before an operation and they are getting the breathing tube put in their throat, if you get it in the wrong place they don’t have a whole lotta time without oxygen. And that was, for me, the first time that I intubated somebody and had to check and make sure that I had it in the lungs instead of down the throat, that was a big day. Actually the first time I gave a shot to somebody with HIV was also a big day. And I had to actually leave afterwards and sit down 'cause I was shaking ‘cause I had internalized so many things about needles and HIV and the rest... It seems like a whole lot of first times. The first time you take a history, the first time you actually hear the murmur. There are a lot of ‘Ah-ha!’ sort of experiences.

Several students specifically named their first encounters with patients on their initial visit to a family practitioner’s office, in first year, as a turning point. One student described being emotionally overwhelmed by the confidences of patients, and his feeling of inclusion in medicine. Another suggested time and repetition makes these startling firsts become more commonplace.

Cheryl: I guess you kind of lose that sense of awe that you have with the patient. I don’t know if you’re socialized into it, but you just... I guess just being told and being taught about your role as a doctor. You kind of assume it more. Your relationship with patients and stuff becomes more familiar and you just become more and more accustomed to having a certain way with people.
One faculty member also pointed out the importance of 'first times,' in particular anatomy class being for most students, "the first time that they’ve ever seen a dead body, and for some of them this is not a minor experience. . . . I think there’s a growing experience there." A student echoed the importance of anatomy.

Brendan: At the end of [first] year I started studying for the anatomy final, and it just, it was another one of those steps. Because it made me look at that whole year and all the things that I’d been exposed to. It’s probably the closest I have come to crying. And not because I was sad, but just overwhelmed. I remembered that sort of wide-eyed awe that I had that first day in anatomy lab, and that sort led to the first day in the family practice office, and to the wonder of seeing some of the biology of the cadavers we’re dissecting, and just the awe of the human body. That all sorta came back, that first year of study.

Part of the novelty of the medical school experience is the new experience of being entitled – even required – to violate conventional social norms in terms of personal boundaries, both physically and conversationally. One of the things that clearly sets medical people apart from most lay people is being permitted to go far beyond the usual boundaries with their patients, touching their bodies, entering orifices, inquiring about bodily functions, probing emotional states, and so on. Several students found this set them apart in their own minds, distinguished them as something different from other people, something akin to a doctor.

Denise: You have to master a sense that you’re invading somebody. And to feel like it’s all right to do that, to invade their personal space.

Rina: In second year I remember we had these little clinical sessions . . . and we were all so shy! . . . And just feel like, ‘Why am I asking all these personal questions about someone’s bowel movements and their sexual history?’ Like you feel really weird, especially if the person’s like your mom’s age or something. I guess the more you do it you just get matter of fact about it.

Peggy: Putting your hands on patients. You know, listening to their heart and lungs and just, just touching people is, that’s a boundary, you know. And just the things that these people will tell you, just by virtue of the fact that you’re in the medical profession. Boy, they’ll just tell you everything. And it doesn’t have to be, you know, deep, dark, perverse secrets, or
anything like that, but just their medical background. Which is very
personal.

4.3.2 Responses from others

The more students are treated by others as if they really were doctors the more
they feel like (almost-)doctors. The response from family and friends, strangers, other
hospital staff, and patients, is key for many students in beginning to think of themselves
as doctors. In response to an open-ended survey question about the aspects of medical
school students most enjoy, two wrote in the social respect their new status is afforded:
"The practically automatic respect I get from strangers when they find out I'm in med
school." In the interviews, too, several students talked of feeling "put on a pedestal"
when people find out they are medical students.

Mark: I get more respect, generally, from friends, and family.

Martin: I think a lot of the friends of my parents in the neighbourhood
were kind of like, 'Wow! Martin got into medical school?!' I could really
sense a new respect from some of the people in the neighbourhood. Like
my parents' friends who thought I was just a trouble-maker and wasn't
going to go anywhere. . . . And I felt it from my friends too.

Interactions with other health care staff are another possible source of
confirmation of a medical self-identity. When nurses, for example, treat the students as
if they really were medical people, they feel more like they are.

Rina: The more the staff treats you as someone who actually belongs
there, that definitely adds to your feeling like you do belong there. . . . It's
like, "Wow! This nurse is paging me and wants to know my opinion on
why this patient has no urine output? You're kidding, you want my
opinion?!"

For many students though, contact with patients was the single most important
source of confirmation that they are in fact medical students, even junior physicians. It
is with patients that they feel most like doctors. As one survey respondent commented,
"I feel good when I feel that patients are putting their trust in me and it is gratifying to

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be able to help them.” Several students pointed out that when patients look to them as if they were physicians, and as if they know what they are doing, they realize they do know more than the average person. With doctors, students feel they can easily be caught out for what they don’t know; with patients they feel fairly certain they will know more.

Faculty, too, tend to believe patient contact is the single most important thing for helping students begin to see themselves as almost-doctors. As one man said, “First and second year I haven’t noticed much of a change, but once they get into the hospitals and start their clinical training then, yeah, there is a change.” That is when they truly alter their self-conceptions.

Dr. B.: You’re on the other side. You’re no longer a layperson. Once you’ve got a patient confiding in you and telling you things.

Dr. O.: Patients confide in them and maybe even call them ‘Doctor.’ . . . That sense of belonging, that sense of really being part of the profession and working with doctors, being treated, maybe not as equals, but as colleagues by their professors and being confided in by patients when you start taking histories. When you start sharing people’s life, when they start telling you their problems, that puts you in a certain position.

Students echoed this view, saying that the confidences patients entrusted in them that make the biggest difference.

Brendan: For me it’s not really been so much the learning of the individual skills that sort of defines my role as a physician, or as a medical student, but more the trust and the confidences that people relate to me.

Part of this transition seems to be an altered relationship to knowledge. Firstly, it involves students’ recognizing that they have indeed learned something. Secondly it involves recognizing that the knowledge that has seemed so abstract and possibly irrelevant has direct meaning and application.

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6 At the same time some of them sometimes feel uncomfortably aware that patients believe they know more than they may actually know.
Dr. U.: When they have to really start looking after sick people and making decisions for somebody other than themselves and then it really hits home, and they make this transition from being students to being doctors. . . . They start realizing that everything isn't so black and white and that yeah, you really have to know that; it's not just because you have to pass an exam, it's because there's a sick person there, and if you don't know it they may not do so well.

Thirdly, it involves making what has been very abstract knowledge much more concrete. They can no longer talk in the abstract about what they would do if, when they have real patients in front of them.

Dr. P.: Probably the biggest change I see in people is between the third and fourth year, because that's really when they start to see patients. . . . It's very easy for somebody to talk about what they would do in terms of abortion or in terms of talking about death and dying when they are doing it from an intellectual perspective, talking about a paper case. But when they're doing it from the perspective, actually knowing the person, having taken care of the person, having to deal with the emotional component, that they were never prepared for, that's the tough part.

The importance of responses from significant others, hospital staff, and especially patients is unsurprising. Symbolic interactionists and social psychologists have clearly established the importance to identity development of seeing yourself reflected back to yourself. The classic is Cooley's (1964) concept of the looking glass self, the idea that self is based on how others respond to us. And following Cooley, George Herbert Mead (1934) argued that the construction of the social self entails the internalization of “the generalized other,” the collective responses of the community of others to which one belongs. More specifically, in his study of medical socialization, Robert Coombs argues that part of the change in self-image is a matter of how medical students are viewed and treated by others (Coombs, 1978).

Thus interactions with others can help cement students' self-identities as budding-physicians7. One small component of such interactions that seems to have

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7 Of course interactions with others in which a student is not treated as a legitimate member of the medical community would help to destroy his or her self-identity as student-physician. I will discuss such instances more in subsequent chapters.

... 112 ...
tremendous impact is being called doctor by others. Despite the fact that legally medical students are not doctors and should not be referred to as doctors, it is nonetheless a reality that they are – either mistakenly by patients, or by hospital staff seeking to allay the concerns of patients who might be alarmed to be examined by a mere student. In virtually all of the first-hand personal accounts of medical training the authors discuss the first time they were called doctor as a highly transitional point (Klass, 1987; Konner, 1987; Reilly, 1987; Shapiro, 1987).

In my survey, 66.2% (n=47) of students had been called doctor at least occasionally, by people other than family or friends (see Table 4.1). Of the 66 students who had been called doctor, fully 64 recalled the situation and/or how they felt about it. This indicates that being called doctor for the first time in the context of medical school carried some significance for these students. Most students were first called doctor by patients, though a significant proportion were first called doctor by a clinical instructor or preceptor. The vast majority of students felt uncomfortable or uneasy when called doctor, knowing they do not yet warrant that title.

<table>
<thead>
<tr>
<th>Frequency (#)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>5</td>
</tr>
<tr>
<td>Once or twice</td>
<td>18</td>
</tr>
<tr>
<td>Occasionally</td>
<td>47</td>
</tr>
<tr>
<td>Regularly</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>71</td>
</tr>
</tbody>
</table>

Students expressed more mixed feelings when the label of doctor came from a patient than when it came from a physician. While several did talk of feeling uncomfortable, fraudulent, or anxious, some also added that they simultaneously felt proud or pleased.

- I felt that the expectations that this person had of a doctor could not be met by my present skill level so I was surprised, a little embarrassed and I corrected the patient. I must also admit that I was proud of myself for appearing professional.

... 113 ...
Students were more uniformly uncomfortable with the label doctor when it came from a physician, partly because they felt they were being misrepresented to patients, which raised ethical questions, and partly because they felt unable to cope with the accompanying expectations and responsibility. Those who had mixed feelings or felt good about being called doctor by a physician felt respected or included.

### TABLE 4.2
Feelings About Being Called Doctor by Various People

<table>
<thead>
<tr>
<th>Who called you Dr?</th>
<th>#</th>
<th>%</th>
<th>Good</th>
<th>Mixed/neutral</th>
<th>Uncomfortable/uneasy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>2</td>
<td>3.1</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Doctors</td>
<td>19</td>
<td>29.7</td>
<td>2</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Patients</td>
<td>31</td>
<td>48.5</td>
<td>2</td>
<td>9</td>
<td>20</td>
</tr>
<tr>
<td>Medical association</td>
<td>2</td>
<td>3.1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Friends/ family</td>
<td>5</td>
<td>7.8</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other/ don't know</td>
<td>5</td>
<td>7.8</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>64</td>
<td>100.0</td>
<td>7</td>
<td>15</td>
<td>42</td>
</tr>
</tbody>
</table>

(10.9%) (23.4%) (65.6%)

The personal accounts of medical education also mark the significance of not being called doctor, especially when your peers around you are. There have been many accounts of male students being called doctor while women were not (Bickel, 1994; Dickstein, 1993; Lenhart, 1993; Mendelsohn, Neiman, Isaacs, Lee & Levison, 1994; ), and of students of colour being taken for nurses, orderlies, maids or cooks, while their white peers are taken for doctors (Gamble, 1990; Rucker, 1992). Here survey results showed that social class background, age and having English as a first language make no difference to whether or not students have ever been called doctor, nor to how frequently that happens. But significantly more men than women are regularly called doctor, and significantly more women have never been called doctor.8

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8 Never been called doctor, 14% of women, 0% of men; occasionally or regularly 57% of women, 78% of men (Cramer's V=0.32, p=0.06; ANOVA F=6.6, p=0.01).

... 114 ...
4.3.3 Playing a role gradually becomes real

In his study of medical socialization, Robert Coombs argues that the change in self-image is partly a matter of playing the role of doctor, complete with white coat and stethoscope (1978: 222). Jack Haas and William Shaffir (1987) expand on this describing professional socialization as learning to manipulate symbols and manage impressions. They argue that medical students are given an “identity kit” consisting of the symbols that mark them off as distinct from lay persons and other hospital staff: a white jacket, a stethoscope, a name tag, a clipboard, and a language Haas and Shaffir term “med-speak” or “McBabble” (1987: 70). Thus begins the important differentiation between We and They. The symbols and props of doctors do not simply allow students to present a desired image to fool others; this manipulation of image gradually changes students’ perceptions of themselves. What begins as a kind of role-playing becomes a more thorough identification with the role (1987: 77-78).

This is exactly the way students described their experience of the process in interviews. They spoke of coming to feel like ‘real’ medical students as playing a role at first that gradually comes to feel more genuine.

Erin: In third year it was really role playing. You were doing all these examinations on these patients which were not going to go into their charts, were not going to ever be read by anybody who was treating the people so it really was just practice. Just play acting.

Cheryl: I remember the very first interview we had with a patient. . . . It was like a joke. ‘Cause I was asking this patient about blood pressures I knew nothing about, but I was just taking on this role. . . . It seemed like I was a total fraud. I can’t be doing this.

Rina: Our first real clinical exposure’s in second year and it’s not a lot. And I remember that was like, ‘Wowww! Okay, I’m wearing the white coat, this is weird but it’s cool, but what the hell am I doing wearing the white coat!’ Major impostor syndrome again! (laughter) And then third year, for sure by halfway through the year, sort of like, ‘Yeah, okay, I’m a med student, and I kinda belong here. Kind of.’ Definitely by this year.

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They even affirmed the importance of the "identity kit" (Haas & Shaffir, 1987) of white coat, stethoscope, clipboard and ID tag to successful accomplishment of their role-play — even as it enhanced the feeling that this is an act.

Maureen: Even last year I hated going in all those Staff Only places. . . . It’s a lot better this year because we have I.D. tags so we are somewhat legitimate.

Erin: The little white coat actually made a difference. The times that I went in third year without my little white coat I would always sort of feel a little bit nervous.

Peggy: We had to wear the little white coats. And the stethoscope, ‘Do I put it in my pocket or on my neck or—?’ It’s just comical. And then in second year when we first start going around in little groups of students, again, comical is the word. You’ve got these four medical students with their little white coats, their pockets are just stuffed with everything, and they’re following a staff person around in a little group up to the patient.

Martin: It was during third year when we got to put the little white coat on and carry some instruments around the hospital, have a name tag. . . . It definitely felt like role-playing.

As we saw in Chapter Two, a central part of the image projection engaged in by medical students is the donning of a "cloak of competence" (Haas & Shaffir, 1987). The daily lives of clinical students consist of proving to faculty, preceptors, clinical instructors, nurses and patients that they do know something and are competent. They quickly learn to at least look competent (Haas & Shaffir, 1987: 59).

Several students thought confidence was central to being a good medical student or physician.

Nancy: I think patients need to feel that you are confident. And that’s part of it, you know. One of the doctors said, ‘You can’t just know what you’re doing. You have to look good doing it.’ . . . You go in and see a doctor who could ask you all the right questions, but they ask you in such a way you think, ‘This person’s an idiot. They don’t know what they’re doing. I’m leaving.’ Where somebody who asks it in a confident way, they might not get everything but you feel comfortable.
But for the majority of the students their confidence in their own skills and knowledge was not as high as they felt they needed to portray to patients. They described pretending confidence while gradually their skills, experience and knowledge base caught up.

Nancy: Even if I don’t know what I’m doing I can make it look like I know what I’m doing. . . . It was my acting in high school. I don’t know what I’m doing but I can make it look like I do. So in a way I get the trust of the patient and I feel really good about it.

Maureen: I think [patients] actually assume that we know more and are able to do more than we really are in a lot of cases. I think we look a certain part and I’m not sure that we’re actually up to that part. . . . Like if I didn’t know any better, I could see myself and think well that person’s doing— they know a lot . . .

Martin: You try to look confident, and you try to feel confident, and I think I did that right off the bat, as soon as I got in the hospital. . . . Your knowledge base goes up and you actually do have some competence in assessing the patients and making the decisions that you do. But still, most of my cases I am not completely confident about and I have to play a bit of a role in looking confident. . . . I think it is important to look confident, and not have the patients doubt you or your abilities.

Most students assumed the role-play was temporary, giving way to a gradual sense of themselves as ‘the genuine article’ as they acquired more experience and knowledge. One suggested the role-play continues.

Martin: I think the role-playing goes on and on. I don’t know if the role-playing ever actually ends. (laughter)

Certainly during their training, the role-play continues, since the roles and settings are constantly changing. Just as students start to get over their initial discomfort and feel they belong in one part of the hospital in one capacity, they move on to a new rotation and start all over again feeling like they do not belong and are in everyone’s way. And as students progress through the program the expectations of them change, so that even in the same ward they may be in a new capacity, thus still feeling initially uncertain and out of place.
Finally, several faculty members pointed out that a major part of the process by which students become medical professionals is through role-modeling, fashioning themselves after other medical professionals. As an apprentice-type training, role modeling is a central aspect of training. Some of the modeling can be negative – faculty described other clinicians teaching students by example to be disrespectful to patients, and to enact an attitude of power-over in their interactions with patients. Others described clinicians modeling how to create positive interactions with patients and their families, as well as how to balance their own lives in terms of medicine and family life. And they model how to take on responsibility appropriately.

Dr. R.: What we’re talking about here is helping them learn the responsibility. I’m completely convinced that that is not head work it’s heart work. And you learn heart work by osmosis. You see people who are for real doing it. . . . It is not intellectually taught. . . . They will osmose from the people they’re working with. And of course you’d like to give them the best models (laughing sort of) but it isn’t always possible.

One student echoed the importance of role-modeling in helping students learn the roles they need to play.

Mark: I think a fair amount would probably be modeling after doctors that you know and respect or have spent time with in the clinics. And you sort of model yourself and your persona to be something like that. ’Cause you see it as being effective with the patients, so you kind of wanna have the same effect. . . . I think unconsciously you develop a tone of voice that asks the questions and gets the replies that you want. Or at least creates the effect that you want.

4.3.4 Being in the hospital, responsibility, having a job to do

While interacting with patients can be a huge affirmation of a students' developing self-identity as budding-physician, even more important is doing things that feel like medical things and taking on what feels like medical responsibility. Some faculty stressed that what matters most is not just patient contact, but making a difference to patients, taking responsibility for patient care.

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Dr. I.: When they come into contact with the patients then they feel like, 'Oh, I'm somebody. I'm doing something.' But that's a kind of a false feeling... you still do not feel comfortable examining that patient because you don't have enough skills to do that. ... The next level of maturity, the real maturity as a medical professional, thinking that you belong to the system, comes when... they are given some degree of freedom on examining the patient on their own. ... It's the independence, independent evaluation of patients.

The more responsibility students face the more they begin to identify as almost-doctors. Some students had begun fourth year by the time I interviewed them. They noted that having a job to do, specific responsibilities that are theirs, makes a big difference. In third year, as one student said, “We didn't know anything. We have nothing to contribute. Thoughts are grasping at anything medical, but it's like your mind's still on your science - all you have are basic sciences behind you. It's like you could be anybody in the hospital.” In fourth year, when they are medical student interns (MSIs) they are expected to accomplish specific tasks; it actually matters whether they do their jobs or not, and that gives them a sense of entitlement - they have a right to be there, they belong.

Rina: Since this MSI year's been going, it's like 3 months I guess, I am sort of developing like more of an identity of like, 'Okay, I am this professional.' ... I think part of it is just ‘Okay, this is my job and I have to get this information for the sake of hopefully helping the person, for their health and stuff.'

Erin: Now we are actually writing in the real charts. And people really read it and so you feel - it's not, they're not actually really relying on you to do it, somebody else could do it a lot faster probably [Laughter] But you feel like you're somehow playing some sort of important role in the system.

Rina: The more they let you do the more you feel like you belong there. So, I started with psychiatry, they let you book your own appointments with patients and see patients on your own. Like 'Whoa, these are my patients?! Really?' And you're writing progress reports in the charts, and you're doing dictations, you're writing into these cool dictation machines every day. So maybe a question of just the more you do, the more you really feel like you belong. In third year obstetrics [it was like] you have no place here. Whereas fourth year it's like, 'Yeah, we're gonna page you

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to come to the delivery and you’re gonna help out and help deliver babies.’ So then you just feel like ‘Well I must belong here, cause I work here. I actually write in the charts and everything.’

The notion of having “my patients” is a key transition pointed out by some of the faculty.

Students’ responsibility shifts in the clinical years from being responsible solely for themselves to taking responsibility for patients.

Dr. U.: [Before third year] I would say the majority are concerned about their own performance evaluated by the instructor. In other words, the patient is kind of an inanimate object. They’re polite and everything but they really aren’t thinking I’ve got to care for this patient or I can help this patient ‘cause they don’t feel they have the skills at that point. Even if they did feel the empathy. . . . They’re not indifferent, they’re very kind to the patients but it doesn’t mean the same thing. They don’t feel the responsibility. They have a responsibility for themselves and that’s, that’s pretty well it.

To come back full circle to the team concept discussed at the beginning of this chapter, some students feel that having real responsibility finally makes them full-fledged members of the health care team. The work they do matters, contributes.

Josh: Now you’re having more decision-making power and you’re getting to do things this time. . . . Only now we are starting to develop a professional identity, because before we were students. . . . Last year was more in hospitals, but we weren’t part of any kind of team at all . . . you never sort of actually were involved in patient care. . . . Now we’re part of teams. . . . Now you’re expected to do doctor kind of things. And so now you have to develop the professional identity. ‘Cause you couldn’t still walk around as a student and feel comfortable with what you were doing ‘cause there’s no one there to really spoonfeed you and pat you on the shoulder and now you have to take your own initiative and do the things that they taught you in the last three years.

4.4 Summary – Constructing a Medical-Student Identity

Thus far we have seen that a medical professional identity, at least as understood and articulated by the participants in this research, includes an understanding of medicine as a calling (though this conflicts with a growing orientation toward more
balanced lifestyles); being a 'good team player'; and taking up a prescribed position in
the medical hierarchy, the larger health care hierarchy, and an appropriate relationship
to patients (though the definition of appropriate is contested). In addition, medical
professionalism involves adopting some version of professional ethics, identifying with
the concerns of one's professional community, and fashioning and maintaining an
appearance that instills confidence in one's professional abilities.

On the way toward acquiring such a professional identity, students go through
many changes. These include developing an increased self-confidence, maturity and
sense of responsibility; loss of idealism; narrowing of thought processes; and loss of
their initial communication skills in favour of adopting a new medical language. The
process of medical socialization is one in which students encounter a series of
transformational 'first experiences' which help them realize an altered world view.
Their emerging sense of self as medical professionals is bolstered by interactions with
others in which they are treated as if they really were medical people. Interactions with
patients have a particular importance, as does being called 'doctor' in medical settings.
The label sets them on their way toward playing the role of medical-person, a role
which through repetition, suitable props, growing skills, and appropriate role models
gradually comes to feel more real. Finally, though I did not find responsibility had the
same significance in being a medical professional that Becker et al. (1961) and Sinclair
(1997) found it does, it certainly is a major factor in the process of becoming a doctor.
Being granted increasing responsibilities for patient care is a key aspect of developing a
sense of self as a medical professional.

Virtually all of the research findings reviewed in Chapter Two have been borne
out in this study. Medical students do learn a position of "detached concern" toward
their patients, though this position is not uniformly accepted by medical practitioners.
Some struggle against its dehumanizing effects; as we shall see in subsequent chapters,
so too do some students. Medical students do learn to present themselves to patients
and clinicians as competent, whether or not they are. They do learn a new language, one which scientizes and reduces their world to component objective factors, and one which may limit their communication abilities with patients, even as it facilitates communication with other medical people. They do seem to lose idealism, though that is clearer to faculty than to students, except in the arena of career prospects. Finally, they do learn, to some extent, to balance an ambiguous status as simultaneously lowly student and elevated medical professional. Part of that lesson is balancing different parts of one’s life, and learning not to make waves. I will explore those themes more in the next chapter.

The experiences of students in medical school are not unique, in that they reflect more generalized processes of social interaction, socialization and identity formation. As I have indicated above, the importance of role-playing as part of how we all function in our daily lives was thoroughly examined by Erving Goffman (1959). Identity, according to Goffman, is not so much a matter of being as of doing. “To be a given kind of person, then, is not merely to possess the required attributes, but also to sustain the standards of conduct and appearance that one’s social grouping attaches thereto” (1959: 75). We must enact “doctor” in order to be a doctor. “A status, a position, a social place is not a material thing, to be possessed and then displayed; it is a pattern of appropriate conduct, coherent, embellished, and well articulated. . . . [It] must be enacted and portrayed” (1959: 75). But in playing those roles, the self is also altered: “By playing roles, the individual participates in a social world. By internalizing these roles, the same world becomes subjectively real” (Berger & Luckmann, 1966: 69).

For Goffman identities are negotiated through interactions. Individuals present an image of self for acceptance (or not) by others. The interaction is dialectical, and requires the art of impression management – which as we have seen medical students are immersed in. The part of the performance intended to impress Goffman called the “front.” It includes the setting, the “personal front” (clothing, gender, appearance and
manner). And "when an actor takes on an established social role, usually he finds that a particular front has already been established for it" (1959: 27). Most roles also involve a larger performance team, as well as an audience. In medical settings, the health care team must maintain discipline and loyalty to the collective performance if they are not to give it away as performance to the audience – the patients. The team, and individual members of the team, must conceal actions or aspects of self that are incompatible with the performance and even cover evidence of the covering. "Audience segregation" facilitates this concealment. If the audience (patients) or any other non-team-members (such as family, friends) are allowed "backstage" they will see the work of producing the finished performance. I will explore in the next chapter how such segregation can make it easier for students to stay in role as medical professionals.

The other component of social identity formation that is apparent in the account of medical school above that fits well with existing theory is the importance of responses of others to an emerging self. First noted by social psychologists such as Cooley (1964) and Mead (1934), as mentioned above, it was later taken up by theorists such as Berger & Luckmann (1966). Mead (1934) argued that the development of the self is only possible through social interaction. Individuals learn to reflect on themselves by watching the reactions of others. They eventually absorb the responses of the community around them, allowing them to become functioning members of a society. If those around you fairly consistently respond to you as if you were a medical person, chances are you will come to see yourself as one. If those around you fairly consistently express the belief that to be a medical professional means to be X, Y and Z, chances are you too will come to believe medical professionalism consists of traits X, Y and Z.

Social psychology often implies that socialization ends in childhood. But of course social interactions continue, and consequently so do socialization processes. Because primary socialization is particularly entrenched, secondary socialization and re-socialization must always contend with an individual who has an already formed
self which has a tendency to persist (Berger & Luckmann, 1966). In other words, Rina was someone before she entered medical school. She was a woman, Jewish, daughter of a physician. She had a degree in anthropology, had worked in NGOs, and considered herself a “Lefty radical.” She had a boyfriend, and a community of friends. All of that was still there when she entered medical school. All of that was part of her prior self-identity.

As Berger and Luckmann (1966: 129) state, “Whatever new contents are now to be internalized must somehow be superimposed upon this already present reality. There is, therefore, a problem of consistency between the original and the new internalizations.” The process may be eased by the ability of the individual to view a part of the self as relevant only to a role-specific situation, to detach that part from his or her total self. Or such secondary socialization may entail a deeper transformation. Which occurs depends in part on the role of significant others. The ‘old’ others help the student retain connections to those parts of self; new ‘others’ help the student switch worlds, adopt a new identity. The latter requires “an intense concentration of all significant interaction within the [new social] group” (Berger & Luckmann, 1966: 145). It may also require minimal contradictions between the world of the ‘old self’ and the world of the ‘new self.’ Maintaining the plausibility structure requires ongoing contact with a community. The extent to which medical students manage to integrate differing aspects of self during their training will be taken up in the next chapter.
Chapter V: Producing Homogeneity and Neutrality

In his book *Getting Doctored*, Martin Shapiro (1987: 27-66) suggests that the medical school cultural norms of incredibly hard work, pressure to study at every available moment, and competition to work the longest hours, mean that students have no time left for extra-curricular activities and involvements. To the extent that your identity is connected to your activities and interpersonal interactions, if you are not doing anything but medical school and you are seeing no one but medical people, you are likely to see yourself as little other than a medical student. This is most intense during clinical years and internship when students spend the majority of their time in the hospital. Even the social lives of medical students tend to include only other medical students, nurses, physiotherapists and other health care workers (Shapiro, 1987: 61).

Not surprisingly, research has shown that the socialization of students in professional education programs such as medicine and law (Guinier, Fine & Balin, 1997; Kennedy, 1982) leads to a considerable degree of homogeneity among the students, as well as an increase in conservatism. Values, attitudes, beliefs tend to coalesce around a central norm. Students become more similar in their outlooks than they were before they began the intense training process. In law school, for example, women students seem to "become more 'like men'" particularly in terms of career aspirations as they lose initial interest in labour or public interest law (Guinier et al., 1997: 46).

In medicine there is a documented intensification of political conservatism among undergraduate students (Coombs, 1978). Jane Leserman found that women students were more humanitarian and liberal in their professional orientations upon entering medical school (1983: 141). While still more liberal than men by graduation,

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1 Kennedy argues that in law school "there is no purchase for left or even committed liberal thinking on the smooth surface of legal education. The issue in the classroom is not left against right but pedagogical conservatism against moderate, disintegrated liberalism" (Kennedy, 1982: 43).
both men and women had become more conservative in their attitudes. Shapiro argues that even students who enter with "progressive" politics are relentlessly socialized toward a common professional outlook.

Many do not even try to resist the gentle depoliticization (which is really politicization into a different ideology). For those who do make an effort to remain involved, the isolation from people of like mind and the lack of time to be politically active are obstacles that may prove impossible to overcome (Shapiro, 1987: 59).

In this chapter I show that the incredible time pressures on students restrict their lives to medical school activities and medical school people such that it becomes increasingly difficult to maintain those parts of their lives that are external to medicine. I argue that this time pressure, the structured lives of the students, and the tendency for the medical student identity to dominate self-identity combine to construct a certain degree of conformity or homogeneity among the students. I also argue that this tendency toward homogeneity is compounded by a predisposition in medical education toward a liberal individualism that encourages students to see themselves as neutral in terms of their social characteristics, and to see their patients as almost neutral. This, I conclude, elides recognition of the impact of membership in relevant social categories, particularly those categories which enjoy dominant or hegemonic status.

5.1 Time Pressures and Absence of Balance

Students who responded to the survey spent an average of 60 hours that week on activities related to medical school – studying, being in classes, being on the wards. There was a wide range, from as little as 25 hours to as much as 110 hours. Just under half the respondents (43%) fell within 10 hours of the mean, between 50 and 70 hours. School took more of their time than did anything else in their lives, by a wide margin. All other activities definitely took a back seat. While about half the students spent 60

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2 See Appendix V, Table A.1 for a complete breakdown of the activities and time spent on each.
hours or more that week on school, fully half the respondents spent 4 hours or less with friends, two-thirds spent 2 hours or less with family other than spouse or partner, and about three-quarters spent 2 hours or less on music/arts/movies, restaurants/bars, religion, housework, or reading for pleasure. About three-quarters spent 6 hours or less on sports or watching television – the two most common pastimes. Virtually no one spent more than 2 hours on racial/ethnic/cultural activities; volunteer activities; or social/political activism.

TABLE 5.1
Hours Spent on Medical School the Previous Week (N=70)

<table>
<thead>
<tr>
<th>Hours on school</th>
<th>Frequency</th>
<th>Valid %</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 hrs/wk and under</td>
<td>17</td>
<td>24.3</td>
<td>24.3</td>
</tr>
<tr>
<td>41-55 hrs/wk</td>
<td>11</td>
<td>15.7</td>
<td>40.0</td>
</tr>
<tr>
<td>56-65 hrs/wk</td>
<td>15</td>
<td>21.4</td>
<td>61.4</td>
</tr>
<tr>
<td>66-75 hrs/wk</td>
<td>16</td>
<td>22.9</td>
<td>84.3</td>
</tr>
<tr>
<td>76-90 hrs/wk</td>
<td>8</td>
<td>11.4</td>
<td>95.7</td>
</tr>
<tr>
<td>91-110 hrs/wk</td>
<td>3</td>
<td>4.3</td>
<td>100.0</td>
</tr>
</tbody>
</table>

So, students are spending their time on school, with brief episodes of TV and sports, occasional time out to read, visit friends or family, go out for a meal, a drink or a movie. Not surprisingly, the aspect survey respondents reported as most difficult about being in medical school was time pressures. The time pressures, of course, were connected to the amount of work students had to cover. The vast majority of students indicated they found the amount of work, and the consequent shortage of time, by far the most stressful (see Table 5.2).

TABLE 5.2
Degree of Stress Associated With Various Aspects of Students’ Lives (N=72)

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Fairly to very stressful</th>
<th>Neutral</th>
<th>Fairly unstressful to not at all stressful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount of work</td>
<td>84.7%</td>
<td>15.3%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Shortage of time</td>
<td>80.6%</td>
<td>13.9%</td>
<td>5.6</td>
</tr>
<tr>
<td>Balancing school and life</td>
<td>78.6%</td>
<td>12.5%</td>
<td>8.9</td>
</tr>
<tr>
<td>Dealing with patients</td>
<td>18.1%</td>
<td>34.7%</td>
<td>47.2</td>
</tr>
<tr>
<td>Family</td>
<td>17.4%</td>
<td>24.6%</td>
<td>58.0</td>
</tr>
<tr>
<td>Being a “minority”</td>
<td>7.1%</td>
<td>9.5%</td>
<td>83.3</td>
</tr>
<tr>
<td>Gender</td>
<td>4.2%</td>
<td>6.9%</td>
<td>88.9</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>4.3%</td>
<td>1.4%</td>
<td>94.2</td>
</tr>
</tbody>
</table>

...127...
As a result of the time pressure students have difficulty balancing school and the other parts of their lives – and as we have seen, most simply don’t balance their lives. Medicine takes over most of their time. This then negatively affects their relationships with friends, partners and family, which adds stress and guilt. Virtually all the students interviewed mentioned constant guilt, whether they are “sacrificing time with partner, friends and family for study,” or taking time from their studies and “worrying about the consequences.” In comments written on the survey, ten students mentioned strain on their relationships, eight students isolation from friends and family, and eleven students difficulty balancing school and personal lives. A few talked about their entire lives being overtaken by medical school, and some of putting the rest of their lives on hold.

• Medical school has swallowed me up and has not left any time for pursuing other interests and activities. I feel that medical school has made me more unidimensional. The stress of trying to balance school and everything else.

Most students clearly feel they are making considerable sacrifices to be in medical school. When asked what they would like to spend more time doing after medical school two-thirds or more of the survey respondents indicated they would like to develop other skills and interests, read more, build relationships and spend more time with loved ones, take better care of themselves and travel – among other things. Not surprisingly, students feel large parts of their lives are ‘on hold’ while they are in medical school. Relationships and marriage are the key things, cited by more than half the respondents. Second was travel, followed in order of frequency by creative and artistic interests, having children, spending more time with friends, and sports and outdoor leisure activities. Significant numbers of students mentioned the fact that major financial planning, and even the ability to be financially independent, are on hold. Some

3 See Appendix V, Table A.2 for the complete list and frequencies.

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felt that most big life plans, the ordinary aspects of adulthood, were held in abeyance at least until they knew where they would live. The lists of things they have put on hold indicate that these students had been incredibly well-rounded people, engaged in music, writing, art, sports, and so on — before they entered medical school. However, very few of them were still engaged in those activities.

5.2 Striving for Balance

Research has shown consistently that medical students have higher than average rates of depression and substance abuse, especially excessive drinking (Firth-Cozens, 1990; Sinclair, 1997). Not surprisingly, several students told me about episodes of serious depression during their years of undergraduate training. On the other hand, many students found concrete ways of building balance into their lives that helped stave off frustration, stress, guilt and anxiety. They scheduled their lives to allow activities other than school. They found stress releases that worked for them. They found sources of support for their values and interests within school. They carefully maintained outside contacts and interests. They changed their expectations of school and of themselves, and they clarified their own priorities to keep school in perspective.

One of the most common strategies for maintaining a balanced life was carefully scheduling time off. Students varied in the extent to which they did this consciously and deliberately.

Cheryl: You have to come to a point where you just decide to do other things, just block off time where you’re not thinking that this is medicine time. ’Cause if you don’t do that, then it just kind of permeates everything. . . . Like I didn’t really exercise in undergrad very much, and now I do quite regularly. And that’s something that I just do. . . . Even though I think, ‘That’s another hour I could be studying,’ but I just do it. . . . With my boyfriend, too, we have certain nights. Like, Tuesday night and

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4 Most of them were very reluctant to tell anyone at the medical school about their depressions. Though there are support services available, students tended to believe that if they sought help through those channels it would go on their records that they had had psychological difficulties; it would be a black mark against them and could hurt their future opportunities.
Friday night – sounds kind of rigid – but we just kind of blocked off time. And some of my friends thought, ‘Oh, that’s really spontaneous!’ (laughs)

Another thing students found central for maintaining balance was finding effective means for releasing stress. Several students run regularly, or do other physical activities. Many participate in medical intramural sports. Some talk things out with partners or spouses. Some alluded to a ‘work hard, party hard’ ethic. For a few students, just doing the necessary studying, getting it out of the way, was their best stress release. Finding the time for stress-releasing activities can be a challenge.

Becky: I’m a runner. I run five times a week. So that’s my survival. . . . Just even taking an hour and going for a run has caused me extraordinary agony many times. . . . To be honest I used to skip classes all the time and go running. In the winter when you’re sitting in lecture all day and I couldn’t go home and run because it would be dark. . . . That’s how I survived. I know my own balances and I know my own thresholds. . . . You just gotta know your own limits.

Finding people in medicine with whom they could be totally themselves was another important aspect of striving for balance. A handful of students talked about Bible study groups within the medical school as a place where they can discuss medical school experiences with others who will be able to relate to them but who will also respond from a common set of values and beliefs. Some students also mentioned the significance of finding even a few like-minded friends in medicine who shared their values and perspectives.

One of the most important sources of stability and balance for many students is their connections to people and activities that are completely unrelated to medical school. On the survey 89% of respondents agreed strongly or very strongly with a statement to that effect. Though most find it very difficult, they also find it essential to maintain these links.

Cheryl: I think the main way to prevent, like, losing parts of yourself is just having time and people who aren’t medicine. . . . If you don’t have other things or other people to help you keep an even keel and get perspective, it can be probably very deadly.

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Having roommates, partners, spouses who are not in medicine maximizes the potential for spending time with non-medical people – and for enabling reality checks with someone outside medicine. Of course maintaining outside connections may mean not making many school-based connections.

Doug: With some of my friendships, I made a conscious choice to not go to this barbecue and not go to that party and not hang out at Weepers on Friday night and drink with other medical students. . . . I made some choices about things that I wouldn’t get involved with in medical school because it has the potential to be so all-consuming.

In contrast, having primary relationships with other people in medicine may make dealing with time conflicts easier, but the cost may be the loss of stabilizing outside connections: “I’ve been able to maintain a good relationship with my girlfriend and even that’s been difficult at times. And my family. . . . Everybody beyond that who I was very close to . . . most of those people have fallen by the wayside.”

Many of the students I interviewed had learned that one way to hang on to what matters when school could easily engulf their entire lives was to scale down their expectations about what they could accomplish while in school. Their involvement in sports was reduced. Housecleaning standards slid a little. A few of the women had relinquished any unease they felt about hiring someone else to clean for them. The most common adjustment, though, was lowered self-expectations concerning grades. Students simply had to learn to accept lower marks than they were used to, if they were going to maintain any sort of balance in their lives: “Does it matter whether I get 80% or 85%? If it means that I get to do the things that I want to do as well?”

One student had devised a “70% solution” that allowed her to maintain a life outside of medicine.

Denise: You have to follow the policy of doing enough and not more. I think that’s what’s worked for me. Don’t try to be the best. . . . I decided that 70% was an acceptable mark. Called it ‘the 70% solution.’ Like if I got 70% at school I could probably still manage 70% at home. It wasn’t easy.
(laughs) I'd never before thought of 70% as an acceptable mark. . . . [But]
this is a practical field. I'm no longer an academic and 70% is enough.5
This is clearly the sort of “situational adaptation” the Becker et al. (1961) found medical
students engage in as a pragmatic response to the impossibility of ever learning it all.
Several students had gone through a difficult adjustment accepting that they will never
be able to learn everything.

5.3 A Push Toward Homogeneity

Answering open-ended survey questions, a few students expressed concern that
the intensity of their training and the lack of time for any interests or activities outside
of school resulted in a tendency toward a kind of homogeneity among the students.

• I’m not myself; I can’t be. The vigorous training forces all 120 of us,
regardless of age, ethnicity or other factors, to become essentially identical
people. So much of our time is spent in medicine that we don’t have a lot
of time to explore other interests.

About two-thirds of the students I interviewed agreed that there is a great deal of
pressure to think, act and be in certain ways. As Dawna said, “I think that you’re
expected to think a certain way, you’re expected to act a certain way, and it’s pretty
hard to be anything but that.” Faculty also indicated they see an increased uniformity
among the students as they proceed through the four years, especially in terms of
appearance and manner.

Dr. H.: They respond the way that you would expect them to respond.
You know what I mean? There’s almost a deindividualization of the
student.

5 To be clear, she qualified this by saying that her standards for emergency procedures, or any “drug that
has a very narrow therapeutic window, so that I could kill somebody” were 100%. She expects herself to
know those things perfectly. And in topics related to her chosen specialty she has higher expectations for
herself. However, she found her 70% solution helped her to accept the fact that you cannot learn
everything.

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Clinicians referred to students' becoming "almost like automatons," or "one of the rest of the cattle." Dr. Q. kept returning to the image of a cookie cutter, producing identical cookies.

Dr. Q.: I think the training tends to streamline and produce sort of a cookie cutter as you come out the end and basically you could be a lesbian feminist and come out as sort of a heterosexual white male in your attitudes (laughing). . . . You [are] being fit into a mold very much.

This type of language was echoed by some students. About a quarter of those interviewed compared medical students to robots: "You just become kinda like a robot, I think, kind of an automaton."

Part of this pressure toward homogeneity is the development of clinical diagnostic thinking. Students are expected to think in standardized ways, to follow the same thought processes to reach the same diagnosis. And most do not see this as problematic in any way.

Lance: Medical training trains you to think in a certain way. I mean, every doctor should think clinically and follow the same path. It's important, it's the best pathway.

But the pressure toward homogeneity is more than just clinical thought-processes. Some students identified a much broader homogenizing socialization that "forces you to kind of follow this pathway like sheep," including the way you dress, walk, speak and so on.

As indicated in the previous section, part of this homogenizing is simply lack of time for things outside of school. Sean eloquently described the intensity of the training and the homogenizing implications for both students and their loved ones.

Sean: I think there is a force in that direction, that we're pushed to be the same person. And I think that probably we're more alike now than when we started. Yeah. I think that we're all held to one standard, we're all after the same thing. And in the end you all have to get through the same hoops to get there, so you all study the same material and spend the same time in the same libraries, reading the same things. And then, at the same time, it does kind of take away the things that made you individual to
begin with, like your outside interests and stuff start to disappear. And your families and friends go through the same things in terms of you, so that kind of makes them the same. You know, the same issues crop up for everybody. So I think that by the end you've all had essentially the exact same experience for four years. In every aspect of your lives. Because most of your life outside of medical school is taken away, kind of. The things that made us real individuals when we started, like our outside interests and our outside experiences are removed, kind of. And you're given a substitute set of experiences that are all exactly the same.

A few faculty members described the intensity of medical training as analogous to military training and boot camp, with strict dress code, rigid learning style, and near-total isolation from people outside the institution. One clinician said it “is much the same process as any brainwashing.” At the same time some students described a tremendous pressure, especially in the first two years, to be involved with medical school activities and friends. This peer pressure further isolates them from the lives they led prior to and outside of medicine.

Some students argued passionately that while thought processes and some behaviours might tend toward conformity, fundamental values and personality would never change. However, fully 44% of survey respondents agreed that they sometimes feel they have lost touch with who they are during medical school, and 49% disagreed with the statement that “I am more or less the same person I was before I entered medical school.” Older students were most likely to think they are much the same as they were upon entry to medical school (the age difference is not significant, ANOVA F=1.48, p=0.2; T-test of the difference in means between 25-26 year olds and 36+ p=0.07).

Only a few students talked about their own values changing in significant ways. Janis spoke of having gone through an extended period of wanting to be like “them” – other medical students and doctors – of losing her own reasons for entering medicine, becoming “money-grubbing,” status oriented, image-conscious, competitive: “To stay

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6 There were no significant differences by gender, minority-status, age, class background, or having a religious affiliation.
in medical school... you have to be very focused on yourself. And that's not my nature. You have to say, ‘No, I have to study. Get lost.' You have to be very selfish about your time.” Rina felt she was becoming “way more conservative.”

Rina: Going from traveling around India working in NGOs worrying if you’re going to get funded, to having to shop at The Gap now for my little clinical outfits, ‘cause you don’t want to wear hippy-dippy dresses and stuff... It’s sort of vaguely disturbing. Like... I just bought a second-hand car, and I’ve never had a car before... I guess I have to face it: I’m just this bourgeoisie middle class person with liberal values. I don’t know. (laughs)

Her (ex)boyfriend first pointed out how she was changing, becoming more conservative. But then she too wondered, “Whoa, who am I? This is kind of strange.” She went on to say, “I know my— I mean I think my politics are still very Left... in theory anyway, but then I drive this nice car, and I want to go to Hawaii on holiday...”

Despite the fact that students tend not to think their own values have changed significantly during medical school, there is evidence of some convergence among students – whether it reflects permanent or situational attitude change. One clinician described what he called students’ “natural attitude,” the set of shared assumptions held in common so pervasively that to even question these assumptions disrupts everything. He argues that students who are new to medicine witness or participate in things they think are wrong and feel shocked. When no one around them seems shocked, they learn to let it go, and eventually to accept it as normal. If they question it, it is usually with their peers, other medical students who are witnessing similar things. This cements the notion that what they have witnessed is normal and not in need of questioning.

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7 Fully 38% of survey respondents agreed with the statement, “I feel my values have changed while I have been in medical school.” Another 46% disagreed. So there appears to be a split among the students on this.

8 I interpret his “natural attitude” as the establishment of a hegemonic social order (Bocock, 1986), a particular social arrangement or set of social rules that become naturalized, seen as ‘just the way it is,’ such that it becomes virtually impossible to question that order.

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Dr. P.: They share some of the stories, but... they share them in a kind of way that reinforces the behavior... [Builds on] the ‘natural attitude’ and sort of all the assumptions that we make about things so that we don’t question. And that people who question the natural attitude or the assumptions are actually shit disturbers and not liked.

This can occur around fairly minor things or more serious ones: not taking the time to treat a patient respectfully because you need to get a history quickly. Calling a patient ‘the liver in 207.’ Seeing a clinician not telling a patient the whole truth and saying nothing. Or as Dr. P. suggests, helping someone re-insert a needle into a bottle “to get more fluid after they’ve had the needle inside an HIV positive patient.”

One of the central natural attitudes seems to be the importance of conformity. Among the faculty, three people used the phrase “don’t rock the boat” when talking about undergraduate medical students: “I think that over a period of time students go from feeling uncomfortable with certain aspects of the culture, to not wanting to rock the boat, to identifying with it, to perpetuating it” (Dr. P.). One clinician described medical school as making sure students have “good blinders on,” staying focused on school unable to even see injustices going on around them. Students also described a desire not to rock the boat.

Robin: I would characterize probably about 75% of medical students, and that’s a conservative guess, as being afraid to stand out in any way. Except perhaps as a brilliant person in terms of knowledge. You know, no one’s afraid to be especially knowledgeable.

One faculty member suggested this desire to conform is strongest in the clinical years: “You want to be same, you don’t want to be ‘Other.’ And what we do is we justify and explain away a lot of stuff in order to be able to be part of the group right?”

Part of what gets justified and explained away in the face of what I am calling a pressure toward homogeneity or conformity is the conflicts students experience between what is expected of them as a good medical student and what they expect of themselves as “a decent human being.” Virtually every student told me stories about feeling compelled to ignore basic human needs that they would normally meet with
common courtesy or human kindness, in order to be a “good med student.” For example, one student told me about having to do a physical on an elderly woman: “I was trying to put her through the physical thinking, ‘Damn, I gotta present you tomorrow. Move it!’ You know?” Then, realizing what the woman really wanted was to have someone just listen to her, talk to her, be with her, the student decided to brush and braid the woman’s hair. “I’m thinking, what kind of medical student am I? You know? You’re supposed to be in and out, write it up, and present it. And here I was, like, braiding, you know, stuck!” It took this student much longer than it should have to do the physical, and she felt like a ‘bad med student.’

Another instance: A group of students is doing rounds with a resident. They all stop to feel an older woman’s enlarged abdomen. The woman starts crying and asking whether she will be okay, whether her husband is okay at home without her. The resident says, “Okay, let’s go. Next patient.” One student, frantically thinking, “I gotta go or else I’ll look bad,” stays behind anyway, risking the wrath of the resident to comfort the patient. Another instance: A group of students in a room with a young man their age who has a bowel problem. “And the surgeon just said, ‘Oh some of us are going to do a rectal exam on you,’ and didn’t really ask his permission and all of us were in the room.” This student felt very uncomfortable but said nothing.

My argument here is not that medical students are particularly heartless people, but rather that there is a ‘natural attitude,’ or hegemony, with which they learn to conform, and which dictates certain appropriate responses to situations like this. In part they are governed by a desire not to stand out in a highly hierarchical setting where shame-based teaching is still common. In part they are governed by a strong sense of their own powerlessness vis-à-vis clinicians, a powerlessness they confirm by talking with their classmates who feel equally powerless. They share with one another stories of ‘What could I do, I need a reference from him?’ together building a joint understanding that it is not safe or wise to confront things you see that may disturb
you. But in part they also come to believe that these responses to patients are appropriate, that this is what doctoring is. This is the process of building the natural attitude, or hegemony, which then provides guidelines for future behaviour.

What students described is the adoption of a new or altered social reality. (Most) students who enter medical school with typical social attitudes about human kindness and caring learn to see these automatic responses to pain and suffering as abnormal, unacceptable in medical professionals. They are resocialized. Berger and Luckmann (1966) explain that the internalization of social reality hinges on everyday conversations with the significant others in a person’s life; this is key to the ongoing maintenance, modification and reconstruction of the individual’s social reality (1966: 140). Casual conversation is the means by which people establish and share in a taken-for-granted world – or what Dr. P. calls a natural attitude.

Adoption of a new social reality requires adoption of a new set of significant others. Together with these new people the individual establishes a new “symbolic universe,” a way of understanding and making sense of the world (1966: 88). To maintain the new social reality, though, requires “an intense concentration of all significant interaction within the group that embodies” that symbolic universe, or “plausibility structure” (1966: 145).

The plausibility structure must become the individual’s world, displacing all other worlds, especially the world the individual ‘inhabited’ before his alternation [resocialization] This requires segregation of the individual from the ‘inhabitants’ of other worlds, especially his ‘cohabitants’ in the world he has left behind. . . . [O]ne must be very careful with whom one talks. People and ideas that are discrepant with the new definitions of reality are systematically avoided (Berger & Luckmann, 1966: 146, my emphasis).

Eventually the new plausibility structure takes on the weight of history and of the institution. It becomes ‘the way things are done’ and is no longer questioned.

Let me be clear what I am arguing here. As we saw in the previous section, the time pressures and intensity of medical training cause students considerable difficulty
balancing the demands of school with the rest of their lives. Many students let go of, or put on hold, aspects of their lives that were important to them before they entered medicine. Most of their time is spent with other medical people, largely segregated from non-medical-school friends and connections. Their community of significant others gradually becomes a narrower one; their “worlds” outside of medicine are gradually “displaced” and they seldom encounter views that are discrepant with the new definitions of reality they are adopting. As Dr. P. stressed, resisting conformity to “the natural attitude” requires external reality checks that time pressures make difficult.

Dr. P.: What I tell them is how important it is to compare their experience and talk to their friends – not their medical friends, ‘cause their medical friends are only going to reinforce the one perspective – but to talk to and to maintain friendships and relationships outside so that when you tell these stories you have an outsider’s perspective to remind us that our perspective is simply one perspective.

The extent to which students have access to such external reality checks depends in part on the extent to which their new medical student identity has displaced the rest of their lives – or, in contrast, the extent to which they have maintained outside connections. As I discuss below, students displayed a range of degrees of integration between their medical students selves and the rest of their lives.

5.4 Degrees of Separation / Integration

In Robert Broadhead’s (1983) study of how medical students put together their identities as spouses, parents, and so on with their developing identities as physicians, he insists that medical student identities do not totally displace all other identities such that individuals become nothing other than medical students. He stresses that identities are always multiple and always interacting. Individuals must find ways of “articulating” their various identities to one another, sorting out the convergences and divergences of attitudes, assumptions, activities and perspectives that accompany different subjectivities. Whether the development of a professional identity is
experienced as an unproblematic integration of the new identity with prior ones, or a drastic change that may entail negation of some former identity and may result in "a new or different person," the process inevitably requires students to find some way to "relate, integrate, and align their emergent professional identity with all others" (1983: 37).

In my research students displayed varying degrees of integration between their medical school selves and the rest of their lives. For a few students all aspects of their lives seem fully integrated, with friends, loved ones, school, and other activities fitting smoothly together. For most though, there were degrees to which they kept medicine separate from the rest of their lives. Or even more commonly, degrees to which medicine took over their lives, excluding other people and activities.

5.4.1 Good at medical school, bad at everything else

Perhaps the most common sign that students felt they had not fully integrated medical school with the rest of their lives was the pervasive sense that they were doing a fairly poor job of their other activities and responsibilities. A few students mentioned being a "bad spouse and family member," not keeping up with their share of household duties, not feeling able to reciprocate in important relationships. Several students talked about being "bad friends," "bad members" of sports teams, "bad volunteers." In fact, one of the few students who described themselves as having integrated medicine fully into their lives said that he had almost no commitments outside of medicine.

On the survey, 55% of students indicated that they thought they were doing a quite good job of being a medical student (see Table 5.3). Most students seem happy with their performance on this front, with no significant differences by sex, class

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9 Broadhead is drawing on the work of Richard Travisano (1970) who distinguishes between two types of identity change: "alternations" are logical extensions of or additions to prior identities, while "conversions" are monumental changes that require a reorganizaton of the individual's understanding of his/her life and biography.
background, age, or 'minority' status. On most other fronts, though, students tend to feel they are doing a fairly poor job. Of those to whom the categories applied a majority felt they were not doing a very good job of being a volunteer, being a social activist, being a member of a political party, or being a member of their religion.

### TABLE 5.3
Degree to Which Students Think They Are Doing a Good Job of Various Activities

<table>
<thead>
<tr>
<th>Being a...</th>
<th>Not a good job (%)</th>
<th>(%)</th>
<th>(%)</th>
<th>(%)</th>
<th>An excellent job (%)</th>
<th>Does not apply (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>medical student</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>0.0</td>
</tr>
<tr>
<td>spouse/partner</td>
<td>2.1</td>
<td>23.4</td>
<td>21.3</td>
<td>38.3</td>
<td>14.9</td>
<td>33.3</td>
</tr>
<tr>
<td>son/daughter</td>
<td>8.5</td>
<td>28.2</td>
<td>32.4</td>
<td>28.2</td>
<td>2.8</td>
<td>0.0</td>
</tr>
<tr>
<td>friend</td>
<td>12.7</td>
<td>33.8</td>
<td>31.0</td>
<td>18.3</td>
<td>4.2</td>
<td>0.0</td>
</tr>
<tr>
<td>informed citizen</td>
<td>25.4</td>
<td>26.8</td>
<td>29.6</td>
<td>18.3</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>member of your religion</td>
<td>17.1</td>
<td>40.0</td>
<td>25.7</td>
<td>11.4</td>
<td>5.7</td>
<td>50.0</td>
</tr>
<tr>
<td>social activist</td>
<td>71.1</td>
<td>23.7</td>
<td>2.6</td>
<td>2.6</td>
<td>0.0</td>
<td>45.8</td>
</tr>
<tr>
<td>member of a political party</td>
<td>64.3</td>
<td>21.4</td>
<td>0.0</td>
<td>7.1</td>
<td>7.1</td>
<td>79.2</td>
</tr>
<tr>
<td>volunteer</td>
<td>63.0</td>
<td>28.3</td>
<td>6.5</td>
<td>2.2</td>
<td>0.0</td>
<td>34.7</td>
</tr>
</tbody>
</table>

A third of the respondents did not think they were doing a very good job of being a son or daughter, and about half did not think they were doing a good job of being a friend, or being an informed citizen. Less than a quarter thought they were being a good friend to their friends. Clearly being a spouse or partner is a high priority for most people, and of those to whom that applied more than half thought they were doing a reasonably good job of that aspect of their lives.

Minority students were more likely to say they were not doing a good job of being a family member, though the difference did not quite reach significance (ANOVA p=0.1). Older students tended to feel they were doing a poor job of being “informed citizens” compared with younger students. In fact age had an inverse relationship with this variable: the younger the students the better they thought they were doing at being
informed citizens. Men were also slightly more likely to feel they were doing a good job of being informed citizens, though again the difference was not significant (p=0.1).

For the majority of students what emerged from the interviews and the survey was not a picture of integrated lives, but a picture of medical school dominating over all other aspects of daily life. Overwhelmingly, students talked about sacrifice.

Nancy: It can be overwhelming to know that you’ve got all this stuff to try and learn. And I don’t seem to have enough time to do it and still have a life. . . . You sacrifice your life to it.

Lew: You just sacrifice so much. I don’t know about people who don’t have children, but I value my family more than anything, and, and I cannot, I didn’t know you have to sacrifice that much.

What I heard in interviews was not stories of how students had managed to fit medical school in with the rest of their lives but stories of things given up – or, with any luck, put on hold temporarily. Five students had given up playing musical instruments; three had given up artistic pursuits and/or writing; several had given up sports activities they had once pursued competitively; a few had given up volunteer activities. A handful of students talked about feeling uncomfortably cut off from what was happening around them in the world. The clear message that comes through is that students believe there is more to themselves than just medicine, but there is no time or room to express that.

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10 This relationship did not reach statistical significance, though the pattern was clear and consistent (with 0=not doing a good job at all and 5=doing an excellent job). (N=72) (ANOVA F=1.1, p=0.3)

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Mean score for “informed citizen”</th>
<th>Age (years)</th>
<th>Mean score for “informed citizen”</th>
</tr>
</thead>
<tbody>
<tr>
<td>23-24</td>
<td>3.3</td>
<td>31-35</td>
<td>2.1</td>
</tr>
<tr>
<td>25-26</td>
<td>2.5</td>
<td>36+</td>
<td>2.0</td>
</tr>
<tr>
<td>27-30</td>
<td>2.2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5.4.2 Letting go of other identities, learning to wear blinders

While most students talked about letting go of specific activities they used to participate in, they did not think of themselves as having given up any aspects of who they are. A few students, though, described themselves as taking on a new medical-student identity by letting go of aspects of how they thought of themselves before. They did not integrate so much as displace identities. Sean switched from thinking of himself as a marine ecologist and athlete to thinking of himself as a medical student. Martin let go of an image of himself as “carefree, wants to just hang out with the boys, and go away for a long weekend, water-ski and drink beer.” In exchange he felt he was becoming a “model citizen, intellectual, responsible,” not drinking too much, not smoking pot. Rina let go of her self-concept as a Left-wing, political-type.

Rina: I almost feel it’s – not a change of identity but – well, sort of. I mean, when I first came in I felt I was a complete impostor, like, ‘Whoa! what am I doing, I’m supposed to be hanging out at some NGO, or writing an anthropology paper. What am I doing in this anatomy lab?’ And so, I guess slowly, I’m sort of understanding, ‘Okay you’re this, now.’ Now I really feel like I’m a medical student.

Two students mentioned how the medical student identity even started to predominate in some interactions with family members. One described her father talking to her about the health of his prostate, talking to her as a medical student, not as his daughter.

A few students felt they were losing their families, describing a growing distance from family since they entered medical school. This was largely due to time constraints, simply not having enough time to spend with people who matter. But for some there was also a growing social distance as they move into a social status and education level that separates them from their roots.

Lance: My family actually were very unsupportive. I mean, they didn’t even know what I was doing. And there’s still this huge gap between them and myself because they don’t want to understand what’s going on in my world, and their world seems quite simple simplistic to me. . . .

I: And the gap with your family, do you see that lessening over time?
Lance: No. No, I see it getting larger, really... No, I don’t see it getting less at all.

Relationships with old friends are also frequent casualties of medical school. Students had varying degrees of success hanging on to old friendships. Many felt growing distance with old friends, again partly due to time constraints, and partly due to growing social differences.

Josh: My friends now from [my hometown] – this might be medicine related or not – I find now I can’t talk to them as much about stuff... it’s always sort of this enigma, medicine is. So people would ask me about medicine and I could only present to them a tiny fraction of what I’d actually experienced. I’d talk to them about it a bit and then that’s all they’d really know about me. Whereas I could sort of know a lot about them and what they were doing, ’cause I’ve done some of that stuff... [medicine] is not something a lot of people have experienced. So in that way it is a division.

Several students described medical school as “taking over their lives” costing them friendships and intimate relationships. Old friends were displaced by medical friends.11

Valerie: If you let yourself get sucked in, it can control you 24 hours a day.

... For first year and second year I probably let it control too much of my life. My every weekend was spent with my new medical school friends, all the social activities I went to were with medical people. And just sort of forgetting – not forgetting, but like putting my family on the back burner, putting my highschool friends on the back burner.

Three women students had lost intimate relationships to medical school. The stress of keeping up with school and the stress of building a new relationship or

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11 Degrees of connectedness to others in medical school varied widely. On a scale designed to measure this, scores were fairly evenly distributed from 3 to 13 out of a possible 15. The scale was comprised of three items: “Few of my close friends are medical students,” “My connections to people outside of medical school provide an important balance for me,” and “Most of my social time is spent with other medical students.” On each item respondents indicated their disagreement (1) or agreement (5) on a 5-point scale. Reverse-scoring the first two items produced the 15 point scale, where 15 is “Very connected to others in medicine.” The scale reliability coefficient alpha= 0.62.

Neither gender nor minority status made any difference to the degree of connection experienced. Social class background made some difference with the mean for upper and upper middle class students (7.8) slightly higher than that of lower middle class students (7.0) which was slightly higher than that of working class and poor students (6.5). This did not reach statistical significance (p=0.3). There was also a fairly clear inverse relationship to age with the youngest students feeling most connected (mean =8.3) and the degree of connectedness lessening with age to the 31-35 year age group (mean 5.5). The age difference did not reach significance (p=0.2).
maintaining an ongoing relationship was just too much. One found herself unable to bridge the separation between her new life and the boyfriend she had prior to medical school. In contrast, students who were dating other students appeared to have more integrated lives, and to feel less torn between conflicting desires and demands.

For some students letting go of other identities is quite serious. As we will see in detail in the next chapter, there is a common assumption that students from racialized minorities – especially if their cultural background is non-Western, non-Caucasian – need to assimilate. As one faculty member said, “students from other cultures leave behind a lot of their culture in order to succeed. There’s a trade off.” Another clinician described a lesbian student just finishing her undergraduate training and suddenly becoming more conventional, conforming to expectations about professional appearance.

Dr. Q.: Now all of a sudden her hair’s cut sort of very business-like and the clothes are different. And I said, ‘Okay she’s fitting into medicine, medicine isn’t sort of becoming a component of her, she’s becoming a component of the machine.’

Some students, then, clearly do not integrate their medical student identities; rather they let go of parts of themselves, bury them, abandon them, or put them aside at least for a while.

Some of the faculty suggested women in medicine must to some extent let go of their identity as women in order to fit in as physicians. Several people alluded to women becoming more-or-less men during medical training, becoming “almost hyper-masculine in their interactions,” and adopting a “a way of thinking of men.”

Dr. Q.: Women were a very small minority for a long time in medicine. It’s hard to say this without sounding offensive, but the women I think who are in those positions are white men. You just have to look at the way they dress. They’re wearing power suits often with ties you know they’re really trying to fit the image. [One of the women here] recently retired and I was in the elevator in the hospital, and they talked about her as one of the boys. So that’s even the perception of the men is that this is not a woman, this is one of the boys.
These faculty members were speaking of their peers. Dr. V., however, argues that little has changed among the students. She still sees women transforming in the same ways they did when she was in training about 25 years ago.

Dr. V.: They [women students] become much more like men in terms of thought processes and interactions with people. . . . [They] learn to just dismiss a woman's concerns or blame her for them.

5.4.3 Maintaining a divided self

Another option for students who experience incongruities between their medical student identities and other aspects of themselves is to segregate different parts of their lives – and their selves. Berger and Luckmann (1966)\textsuperscript{12} argue that because human beings have the ability to reflect on our own actions, "it becomes possible to conceive of the self as having been only partially involved in [an] action. . . . [A] segment of the self is . . . subjectively experienced as distinct from and even confronting the self in its totality" (1966: 68). To generalize even further, they argue that it is possible to detach a part of the self and its concomitant reality as relevant only to the role-specific situation in question. The individual then establishes distance between his total self and its reality on the one hand, and the role-specific partial self and its reality on the other (Berger & Luckmann, 1966: 131).

In other words, we are capable of maintaining co-existing partial selves, with greater or lesser social distances separating them from one another.

Some of the medical students talked about feeling quite divided in themselves. They might be highly skilled in music, art or writing, but find no outlet for expressing that aspect of themselves in medical school. Those aspects of self remain separate. Others find their Christian values and beliefs do not always integrate easily with the secular world of medical school.

\textsuperscript{12} They are drawing on both Mead's (1934) distinction between the acting "I" and reflecting "Me," as well as on Alfred Schutz's (1962) "working self" that carries out actions and "reflective partial self" that can objectify those actions.
Cheryl: There's always jokes made about it in school. Or about religious beliefs, not necessarily Christian, but about believing in God. Values like premarital sex or certain values that religions will have are kind of laughed about. ... Sometimes it seems to me that it's religion versus science. It's like you have science or you have religion. Instead of both.

On the survey 31% of students agreed that they often feel they are one person at school and another with friends and family. And perhaps as a consequence, many students maintain quite separate groups of friends, their medical school friends and their outside friends and families.

While, as we saw above, many students lose old friends and relationships, others hang onto them to the exclusion of significant new connections within medicine. They keep their lives separate with their closest social relationships remaining unconnected to what they do all day everyday in school. It seems many students feel forced to choose between friendships inside and outside medical school; there isn't enough time for both.

Cheryl: My main circle of friends was not in medical school. So I guess I wasn't involved so much with medical school social activities.

Survey respondents were quite evenly split on this. While 43% agreed that they have few close friends in medical school, 42% disagreed with this. Only 15% were neutral on this question. In other words, students seem to have either mostly medical school friends, or non-medical school friends, rather than some combination of the two.

Some of the faculty, particularly those who identified as gay or lesbian, stressed the importance of maintaining strong connections outside of medicine if you want to make it through medical school without losing part of yourself. A gay male student also described himself as staying true to who he was by maintaining strong friendships in the gay community, despite the difficulties of making time for these commitments. While the physicians described themselves as well integrated now, as doctors whose patients and colleagues know they are gay, all of the gay/lesbian faculty and students

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described themselves as leading highly segregated lives during medical school. They kept their gay selves quite separate from the medical school.

Another physician who spoke of being isolated and different in medical school, came from a multi-cultural working-class/poor family background, and could not identify with others in medical school. While a student she did volunteer work that allowed her to connect with disadvantaged communities, communities she could identify with more than she did her classmates. Both she and another woman clinician said they had learned to simply enjoy living on the margins, never quite being mainstream. They became comfortable with the segregation in their lives. It seems likely that the greatest moment of dis-integration is during medical school. In contrast with the students, physicians seemed to experience much less conflict between different aspects of self. Many seemed to have integrated the parts of their lives that were problematic for them in school with their current medical practices.

5.4.4 Integrated identities

There were widely varying degrees to which students had managed to integrate medical school into the rest of their lives. It was obviously easier for some than others, and some did not seek greater integration as a way of articulating their multiple identities. I would categorize 6 students out of 25 as having managed to integrate medical school fairly smoothly with the rest of who they are. This categorization is inevitably subjective. Even if I shadowed these students through their daily lives I could not really know the degree to which they had integrated aspects of their identities. However, I base this categorization on specific statements made in the interviews, as well as the total picture I gained of each student from the interview as a whole. I am particularly basing it on considerations like: 1) the extent to which the students identified conflicts among different aspects of their lives – e.g. feeling pulled in two directions, doubting their ability to ‘do it all’; 2) the extent to which students
maintained very separate friendship groups, or seemed to blend their medicine and non-medicine significant others; 3) the extent to which students expressed doubts about being in medicine, especially sentiments such as ‘This is not how/who I want to be,’ or ‘I feel like I am not one of them’; 4) the extent to which students expressed sentiments of having found the right thing for them; and 5) the extent to which students managed to maintain non-medical activities and connections that are important to them, rather than abandoning them under the onslaught of medical school demands.

All but one of the students I would categorize as ‘most integrated’ are older than average, and all but one had other careers before medicine. One suggested that being older entering medicine meant she had her goals and self-identity more clearly set in her mind. Four of these students are in committed relationships with non-medical partners. Three do not seem particularly close to other medical students, maintaining their primary relationships outside of medicine and being relatively uninvolved with school social activities. In contrast, the other three have more fully blended their friendships networks than most and are among the very few whose old friends and family know their new friends from medical school.

All six students had clear priorities that allowed them to maintain the outside activities and connections that mattered most.

Robin: I resolved that I wouldn’t let my close friends go by the wayside. . . My partner is important to me, and [I resolved] that I wouldn’t always make him take a back seat to what I was doing. Also that I would ride my horse once a week. . . I guess it was like an ultimatum. Like, if this program won’t allow me to do those things, which I thought were reasonable things, then I just wasn’t willing to do it. . . I have to draw my boundaries now. Because otherwise you get sucked in and sucked in and I don’t believe that it’s gonna end in medical school. There’s a residency program, there are the pressures of practice, with people always wanting more and wanting more.

Part of what she is describing is the importance of deciding in advance “what’s important to you and what you can give up and what you can’t give up.” A balanced life may preclude high academic achievement – or vice versa.

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The students I would categorize as most integrated held two quite different perspectives on the centrality of medicine in their lives. Both of these perspectives seemed to help students integrate medicine into their lives, though in different ways. Some students saw medicine as one of a range of possible things they could be doing with their lives – important, but not overly so. Certainly not so important that they would sacrifice other things that matter, including their own moral and ethical principles. Robin is willing to risk the anger of those above her in the hierarchy, or the loss of reference letters, for what she believes is right.

Robin: There are other things that are more important to me than this [medicine], so if at any point this conflicted too much with those things, I would give it up.

In contrast, the other students saw medicine as a closer to a calling, the one thing they were meant to do with their lives. Lance, more than anyone else I interviewed, described his chosen career as a passion, a calling. His sacrifices while in school seem a small price to pay to do what he loves so much. He feels 100% a medical student.

Lance: Most people go through life working at their job and never loving it. It's something they do. But I've always had to love what I do and put my whole heart into it and, for me, medicine's everything I ever wanted. It's a connection with people, it's very scientific, it's technical. You feel that you're making a difference. And you get paid to do it, you know. You get everything. I go to work and, for me, it's fun. I just, I love going to work, because it's just like, wow! you know, I get a big bang out of it!

He has integrated his life but in a very different way than Robin has. His wife works full-time in a health care field and is very supportive of his work. His family is unsupportive, but he has almost no contact with them. He has only a few close friends, mostly classmates, and he and his wife spend time with them. He has streamlined his other activities to fit well with school. He describes his future patients as his top priority, and nothing can be allowed to interfere with that.
Like Lance, Brendan came to medicine after years of working as an engineer. He was unusually clear about the differences between living a life that feels integrated and living as 'split selves.' Medicine fits for him.

Brendan: I never thought of myself as an engineer . . . I really felt that there was a part of me who was playing the role of an engineer and there was a part of me who was getting on with his life. I didn't feel the two were the same person. Whereas now I may not be able to have as much of an outside life as I like, but I do feel very comfortable that it's the same person that's going to medical school . . . This is who I am.

As an engineer he had to "shut [his] brain off" at work and turn it back on again at home. In comparison, he feels fully himself in medical school.

I do not think it is a coincidence that the three women in this group of six 'most integrated' students all tended toward the perspective Robin illustrates above. All three women plan to have children; the fact that they seek a form of integration that centers on balancing the multiple aspects of their lives makes sense for them. Two of the three men, on the other hand, seem to be integrating their medical identity by making it the centre of their lives in the way some faculty described medicine as a vocation (Chapter 4). When women faculty talked about their lives as medical professionals, they too tended to focus on the need to strike a balance between competing expectations.

I also note that all six of the students I have categorized as 'most integrated' are white. I will look more in the next chapter at how issues of 'race' and racism, cultural and ethnic differences are dealt with in the medical school. Also none of the students who seem most integrated are parents. My sample does not permit definitive statements about the impact of parenting on tendencies to segregate parts of one's life, though the only parent I interviewed identified parenting as a source of tremendous conflict. He had serious concerns that he was being a 'bad father' because of his commitment to school. It seems likely that the more you can rid your life of external expectations and allow medicine to be a vocation, or the more you have a solidly grounded perspective in which medicine is just one part of who you are and what you

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do, the better able you are to integrate being a medical student with the whole of your identity.

5.4.5 Modes of identity articulation

To return to Robert Broadhead’s (1983) analysis, he saw four ways students articulate their emerging medical professional identities to their other social identities. I saw little evidence of what he called “blending,” coming to see two identities as the same, such as male students constructing their professional identity as fulfillment of their breadwinner role as fathers or husbands (Broadhead, 1983: 42-43). I suspect this may be due to the self-selection of my interview sample; quite possibly the students who were most interested in exploring these issues with me were those who had the greatest concerns about the ‘fit’ between the different aspects of their lives.

Broadhead’s (1983: 43) “instrumentalism” refers to articulating two identities in such a way that one becomes a means of expressing the other, though they remain quite separate. Again, his example was that an African-American student could come to see his medical student identity as a means toward Black pride, or eliminating racist stereotypes. I saw some evidence of this, though it never seemed to be a primary mode of identity articulation. Janis, for example, the daughter of post-World War Two German immigrants has an intense desire to be a physician to work with victims of torture. Nancy is from a working class family in the suburbs; she says her family and community there “kinda look at me like I’m the Great White Hope.” She implies that she feels some pressure to succeed, but other than that it is not apparent that she sees

13 The stereotype of Asian students going into medicine for the advancement and honour of their whole family was rampant, especially among faculty. But I never encountered this among the students I interviewed. This could be because I was not able to access the “culturally Chinese” students, or because of the self-selection of my sample, or because students did not tell me about this motivation. Or it may be that this particular instrumentalist identity articulation is less prevalent than many assume. However, students who identified as members of ‘minority’ groups were significantly more likely than others to agree that “Being a medical student has added an important dimension to my involvement with my cultural/ethnic community.” (ANOVA F=13.0, p=0.001).

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her professional identity as an instrument for upward class mobility – though this may well be the case. Finally, Lew and Cindy, both strong Christians, see medicine as in part a means to carry out a religious calling or mission.

Broadhead’s (1983: 46) “diversionary” identity articulation means one identity provides escape or respite from the other. For example a medical student may be a skier to get away from medical school concerns. Such identities are noted for their non-relation to the medical identity. There was abundant evidence of this in my research, particularly in how students thought about themselves: as writers, artists, musicians, competitive athletes, spouses/partners, parents, hikers, skiers, rock climbers, travelers, social activists, and so on. But to recall the ways students actually spend their time, very few of them are in fact drawing, painting, writing, playing their music, doing their sports, doing any social activism. Broadhead notes that identities entail not just symbolic, emotional or cognitive adoption, but also behavioural articulation. In other words, identity is also a matter of doing. In that regard, most of the potentially diversionary identities were not in fact articulated that way – they provided no diversion because they were largely on hold for the duration of medical school.

Finally, Broadhead’s (1983: 47) “problematic” articulation is one in which the relationship between two or more identities is at best partial, is never completely resolved and remains a constant struggle, “fundamentally unsatisfactory and disturbing” (1983: 47). Not surprisingly, Broadhead’s example is that of a woman medical student. This form of identity articulation was most apparent in my research.14 And I would add to Broadhead’s schema some subcategories under his category of “problematic” articulation.

One is “overriding.” By this I mean that the emerging professional identity may override or completely dominate another identity, or vise-versa. For example, Janis’s

14 Again, though, I am not suggesting it is most prevalent among all medical students. Sample bias, plus the fact that I was intentionally asking about sources of conflict may have over-emphasized this in my interviews.
insistence that she is not “one of them,” that she came from the other side of the tracks and still belongs there, that she could never fit in at medical school. This speaks of a personal identity rooted in social class background overriding her newer professional identity. I suspect this identity articulation is unusual among medical students who continue the training process. If a personal identity continued to override the medical professional identity the student would likely drop out. The reverse situation, in which professional identity overrides personal identity was common. It was clearest in Becky’s fears that she was siding with the doctors in relation to a family medical crisis. Several students said they could not relate to friends’ and families’ lay concerns about medical care or the medical system anymore, except as doctors.

I would also add the subcategory of “distortion” within the larger category of problematic identity articulation. By this I mean either the new professional identity is distorted to fit better, or the prior personal identity is distorted to accommodate the new identity – or both may be adjusted for better fit. The one gay student and the gay physicians talked about the need some students feel to go back into the closet during their medical training. I would call that a distortion of personal identity. Probably due to the overwhelming pressure toward compliance, I saw little evidence of students’ intentions to ‘do medical professional’ differently. I suspect that may come to the fore more when these students begin to practice on their own. But, for example, two of the students from working-class backgrounds were adamant that they will not adopt the professional dress that seems to be required in medical school, especially once they leave school. Some of the women insisted that they will make time for pregnancies and child-rearing, even if they have to force the hospitals where they do residencies to accommodate them. And several students, both women and men, said they intend to work hours that will allow them to have a balanced life; depending on the field of medicine they enter, this may well mean doing medicine differently.
Lastly, I think Broadhead’s “diversionary” articulation does not adequately capture the complexity of what students are doing. I would strengthen this type of identity articulation by calling it “segregation.” By this I mean that the relationship students articulate between their medical student identity and other identities is one of distance, even dissociation. Sometimes this is in the form of diversion – i.e., ‘my husband and old friends keep me grounded, so I don’t really mix with people at medical school.’ This was by far the most common, and was understood by the students less as a diversion than as a counter-balance to the inundation of medical school into all aspects of their lives.

Secondly, “segregation” as a form of identity articulation is not always unproblematic, as Broadhead (1983) indicates. Some students maintained very separate parts of their lives, and their selves, seeing no way to put them together. For example, Lilly could not handle being both a medical student and a woman in a relationship. Her ‘failure’ to do this led her into depression, and eventually into taking a year off school. She was back in school at the time of the interview but would not attempt a new relationship until school ended. Rina was troubled by seeing herself let go of her socialist and international-development politics; she still ‘visited’ that old life when she had holidays, but otherwise kept that self very separate from her medical school self. Finally, Janis kept the parts of herself that were working-class, wife, animal lover, humanitarian, and even “decent human being” totally separate from school, where she had accepted that she had to be someone she really didn’t like very much.
5.5 The Production Of ‘Neutral’ Physicians For ‘Neutral’ Patients

In 1971, African-American physician and faculty member at Cornell Medical College, James Curtis, wrote with great hope of,

a day when all physicians, irrespective of color, will be able to treat all patients, irrespective of color, with the same high standard of excellence and care. A single color-blind system and standard of health education and health care is a first step in the more difficult transition toward a system which will be blind to social class difference as well (1971: xi).

His wish for a colour-blind medical system occurred in the context of the American civil-rights movement and a growing militancy on the part of many white and black Americans. He describes a campus atmosphere in which African-American students were caught between competing pressures: forces of racist segregationism, and radical student activists who also supported racialized segregation for opposite reasons (1971: 136-138). Yet even in the context of multicultural Canada in the late 1990s I found similar imperatives toward neutrality, toward a medical system and medical education that is colour-blind, sex-blind, class-blind and so on.

A few medical faculty members were explicit that membership in social demographic categories does not, and should not, matter to medical students – nor to physicians. Dr. B. expressed this most directly and is worth quoting at length here:

Dr. B.: There’s a final common pathway we like to think. That you come out with the basic ethics of the medical profession wherever you started from. Now these people here are much more diverse, at least in terms of their ethnic origins, than we were... and I think this leveling down to a final common pathway is exceedingly valuable to society... They come out with a final common ethic, if I can use that word. So they’re all in a melting pot. And they melt very rapidly.

Later he went on to say:

Dr. B.: In the end we’re all human beings and I think that these social differences and cultural, ethnic differences fade away... You’re channeled into this one worldwide ethic – that is of medicine, the looking after of human beings... That final common pathway, whether you’re a Sikh or you’re from China or whether you come from darkest Africa it doesn’t matter... This question of identity... I don’t know why it is so

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important. We’re all stuck on this planet together... I would have thought that these edges would have got blunted, quite frankly, and blurred... Whether you’re a Sikh or whether you’re, whatever you are, I think it’s totally irrelevant to the final common pathway... [W]earing turbans or wearing kilts, doesn’t matter to me. Provided they’re doctors.

Dr. B. was mildly echoed by another physician who said, “The aim is to be able to treat anybody” and students should learn to adopt “almost a professional face” that would look more or less the same regardless of who was wearing it. Two others referred to the aim of producing “undifferentiated physicians.” While these were minority viewpoints, they were echoed in complex ways in many of the faculty interviews. One clinician referred to the “conventions of medical training” requiring students to leave behind any cultural distinctiveness, requiring women to become more like men. Students learn not to stand out in any way, to fade into the background. They construct themselves as neutral as much as possible.

When I surveyed and interviewed students it became apparent that most of them tended to deny the impact of social characteristics on their lives, the lives of physicians, and the experiences of patients. They stated that it shouldn’t and didn’t much matter whether the physician was male or female, Asian or Caucasian, gay or heterosexual. It mattered slightly more what ‘social baggage’ the patient brought to a doctor-patient interaction, but only inasmuch as the physician needs to take that into consideration in dealing with the particular patient. Students seemed quite unreflexive about the implications of their own membership in social categories and what impact this might have on their interactions with patients. I began to think of this as producing ‘neutral physicians for almost-neutral patients.’

When asked to rate the effects of various social and individual factors on their experiences of medical training, students overwhelmingly indicated that the more social or collective variables had little or no effect on their lives (see Table 5.4). Using a scale from 1 to 7 students almost uniformly rated the individual or personal variables as
having positive effects on their school experiences, while ‘race’, culture, religion, gender, sexual orientation were rated as having no impact.

**TABLE 5.4**

Effects of Various Attributes on Students' Medical School Experiences (N=72)

<table>
<thead>
<tr>
<th>Item</th>
<th>Negative (1-3)</th>
<th>Neutral (4)</th>
<th>Positive (5-7)</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic abilities</td>
<td>5.6%</td>
<td>14.5%</td>
<td>2.8%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Personality</td>
<td>14.5%</td>
<td>8.7%</td>
<td>9.9%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Interpersonal skills</td>
<td>2.8%</td>
<td>18.3%</td>
<td>7.3%</td>
<td>5.2</td>
</tr>
<tr>
<td>Skills, talents</td>
<td>2.8%</td>
<td>57.7%</td>
<td>76.8%</td>
<td>7.0</td>
</tr>
<tr>
<td>Appearance</td>
<td>7.0%</td>
<td>25.4%</td>
<td>35.3%</td>
<td>4.4</td>
</tr>
<tr>
<td>Academic background</td>
<td>9.9%</td>
<td>24.3%</td>
<td>34.3%</td>
<td>4.3</td>
</tr>
<tr>
<td>Relationship status</td>
<td>24.3%</td>
<td>41.4%</td>
<td>41.4%</td>
<td>4.3</td>
</tr>
<tr>
<td>Age</td>
<td>11.1%</td>
<td>42.3%</td>
<td>46.5%</td>
<td>4.7</td>
</tr>
<tr>
<td>Social class</td>
<td>14.1%</td>
<td>52.1%</td>
<td>33.7%</td>
<td>4.4</td>
</tr>
<tr>
<td>Parental status</td>
<td>2.8%</td>
<td>53.5%</td>
<td>33.7%</td>
<td>4.8</td>
</tr>
<tr>
<td>Race, culture</td>
<td>9.9%</td>
<td>74.6%</td>
<td>15.4%</td>
<td>9.9</td>
</tr>
<tr>
<td>Religion</td>
<td>2.8%</td>
<td>71.8%</td>
<td>25.4%</td>
<td>2.8</td>
</tr>
<tr>
<td>Gender</td>
<td>1.4%</td>
<td>80.3%</td>
<td>18.3%</td>
<td>1.4</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>1.4%</td>
<td>94.4%</td>
<td>4.2%</td>
<td>4.0</td>
</tr>
</tbody>
</table>

The oldest students were slightly more likely to think their age has had a positive effect, and the youngest students were slightly more likely to say their age has had a negative effect (Gamma=0.29, p=0.06). Women were slightly more likely to rate their parental status as having a positive effect on them (Lambda=0.10, p=0.03). Bearing in mind that virtually all respondents did not have children, this means being childfree is more beneficial for women than men; women imagine a greater negative impact had they had children during medical school.

Poor and working class students were somewhat more likely to say their class background had a slight negative impact during medical school (Gamma=-0.42, p=0.005). Similarly, 25% of 'minority' students said their racial or cultural background had a somewhat negative effect during medical school, compared to only 4% of non-minority students, though the difference was not significant (Lambda = 0.13, p=0.15).

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15 The mean score for working class and poor students was 3.9 compared to 4.1 for lower middle class students and 4.7 for upper and upper middle class students (ANOVA F=3.7, p=0.03).
What is most striking about the overall ratings of these factors is the extent to which social or collective variables are rated as neutral, having no effect on students' lives. For example, 87.3% of respondents said their interpersonal skills had a somewhat or very positive effect. In contrast 94.4% said their sexual orientation had no effect and 74.6% said their 'race,' ethnicity or cultural background had no effect.

As we will see more fully in the next chapter, social characteristics like class background, racial/cultural background, age and so on do make a difference to how students feel they fit in, and is one basis for social groupings or cliques within the class. Furthermore, sexual orientation was very stressful for the one gay/lesbian survey respondent, and judging from comments on and about the survey, gays and lesbians face a certain amount of homophobia in the medical school (though not necessarily more than in society at large). Thus, it seems likely that dominant social characteristics such as heterosexual orientation in fact have a positive effect on most students' lives, in that identifying as heterosexual frees them from stress and oppressive or discriminatory attitudes, words and actions. I believe the overwhelming neutrality attributed to social characteristics like sexual orientation, 'race,' and gender reflects a lack of examination of or reflexivity about the hegemonic status of privileged categories.

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16 One student wrote in beside a Likert scale question that included an item about involvement with gay or lesbian community work, “Damn I'm sick of this question! Not everyone is limp-wristed!” One student wrote, “A few less questions about gay/lesbian/bisexual etc etc would be nice. Who cares?”

Finally, as mentioned in Chapter 3, during the interview phase of the research one student told me that the buzz around class after I administered the survey was that it was filled with gay and lesbian questions. Apparently that turned some students off and led them not to complete the survey. To be clear, every question about gays and lesbians was part of a set of questions inquiring about the impact of social class, religion, culture, ‘race,’ age, academic background, relationship status and so on.

17 A few students were exceptions. The comments they wrote in the margins indicate their awareness of the positive impact of their membership in dominant social categories. For example, one young man rated gender as having a slight positive impact, and wrote in “male”; he also rated racial/cultural background as having a positive impact and wrote in “white”; finally, he scored social class background as having a strongly positive effect on his medical school experiences – he wrote in “upper class parents, Dad is an M.D.” Similarly, one student rated sexual orientation as 5 out of 7, having a slight positive effect, and wrote in “Easier to be straight.” She also wrote in response to another open-ended question, “Med school seems somewhat geared towards the white upper middle class – I am 'lucky' enough to be one of these people.” Both of these students show an unusual awareness of the ways being a member of the dominant social group can make daily life easier. As a whole though, the medical students who
For the most part students consider individual characteristics and abilities more important to how they think about themselves day-to-day than membership in social categories (see Table 5.5). Again, social characteristics such as sexual orientation, class background, racial background, religion and cultural heritage are unimportant to over half of respondents. Age and gender show more variance, being important to about a third, unimportant to a third and neutral to a third. The day-to-day importance of age has an inverse relationship to age. The older the students the more important their age is to how they think about themselves (Gamma=0.44, p=0.002). The day-to-day importance of gender was highest for women (Lambda= 0.21; p=0.02). Analysis of variance shows the mean for women (mean=3.3) to be significantly higher than the mean for men (mean =2.4; p=0.005). Similarly, the daily importance of cultural background and ‘race’ are highest for students who identify as members of ‘minority groups’ (Lambda=0.10, p=0.05; Lambda=0.22, p=0.001 respectively). 18

For the most part students consider individual characteristics and abilities more important to how they think about themselves day-to-day than membership in social categories (see Table 5.5). Again, social characteristics such as sexual orientation, class background, racial background, religion and cultural heritage are unimportant to over half of respondents. Age and gender show more variance, being important to about a third, unimportant to a third and neutral to a third. The day-to-day importance of age has an inverse relationship to age. The older the students the more important their age is to how they think about themselves (Gamma=0.44, p=0.002). The day-to-day importance of gender was highest for women (Lambda= 0.21; p=0.02). Analysis of variance shows the mean for women (mean=3.3) to be significantly higher than the mean for men (mean =2.4; p=0.005). Similarly, the daily importance of cultural background and ‘race’ are highest for students who identify as members of ‘minority groups’ (Lambda=0.10, p=0.05; Lambda=0.22, p=0.001 respectively).

18 Students also rated the importance of these factors before they entered medical school. (See Appendix V, Tables A.3 and A.4, for results) Volunteer work, academic performance, creative skills/talents, athletic skills/talents, and political affiliations have all decreased in their day to day importance for students. In

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Not only did survey respondents see themselves as unaffected in medical school by their membership in social categories, which they considered largely insignificant to their daily self-concepts, but they also see these social factors as having little impact on how physicians practice medicine (see Table 5.6). Again, personal skills, abilities and characteristics are seen as having tremendous impact on physicians' practice, while social characteristics such as sexual orientation and class background are seen as relatively insignificant.

**TABLE 5.6**

<table>
<thead>
<tr>
<th>The physician's...</th>
<th>Not at all (1-2)</th>
<th>Neutral (3)</th>
<th>Very much (4-5)</th>
<th>Item mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal skills</td>
<td>0.0%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>4.9</td>
</tr>
<tr>
<td>Personality</td>
<td>1.4</td>
<td>0.0</td>
<td>98.6</td>
<td>4.7</td>
</tr>
<tr>
<td>Clinical skills</td>
<td>0.0</td>
<td>2.8</td>
<td>97.2</td>
<td>4.6</td>
</tr>
<tr>
<td>Talents, abilities</td>
<td>8.6</td>
<td>18.6</td>
<td>72.9</td>
<td>4.0</td>
</tr>
<tr>
<td>Age</td>
<td>21.1</td>
<td>35.2</td>
<td>43.6</td>
<td>3.2</td>
</tr>
<tr>
<td>Parental status</td>
<td>36.6</td>
<td>28.2</td>
<td>35.2</td>
<td>3.0</td>
</tr>
<tr>
<td>Gender</td>
<td>35.2</td>
<td>31.0</td>
<td>33.8</td>
<td>2.9</td>
</tr>
<tr>
<td>Race, culture</td>
<td>34.3</td>
<td>34.3</td>
<td>31.4</td>
<td>2.9</td>
</tr>
<tr>
<td>Relationship status</td>
<td>50.7</td>
<td>23.9</td>
<td>25.3</td>
<td>2.6</td>
</tr>
<tr>
<td>Social class background</td>
<td>46.5</td>
<td>32.4</td>
<td>21.1</td>
<td>2.6</td>
</tr>
<tr>
<td>Religion or lack of religion</td>
<td>58.5</td>
<td>20.0</td>
<td>21.5</td>
<td>2.4</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>68.1</td>
<td>21.7</td>
<td>10.1</td>
<td>2.0</td>
</tr>
</tbody>
</table>

When it comes to patients' personal and social characteristics, and how those affect their care in the medical system, students attribute somewhat more impact to particular volunteer work and academic performance, both of which would have been important to get accepted to medical school, have significantly declined in importance. Presumably lack of discretionary time also diminishes students' ability to be involved in volunteer work. Being a partner or spouse, social class background and religion have varied in their importance, becoming slightly more important for some and slightly less important for others. Age and gender have become somewhat more important to substantial numbers of students, while cultural heritage and racial background have grown in importance for a smaller number. Sexual orientation has remained the same (not very important) for the vast majority of students. For younger students, the importance of age has declined slightly since entering medical school, while for older students (over 27) it has increased in importance slightly, especially for 31-35 years olds ($F=2.4$, $p=0.06$). The importance of gender has increased slightly more for women than for men, while the importance of cultural heritage has increased slightly for 'minority' students, and decreased slightly for non-minority students, though these differences are not statistically significant.
social characteristics (see Table 5.7). The characteristics having the most impact are still individual ones: personality, severity of illness, level of compliance, and prognosis.

<table>
<thead>
<tr>
<th>Item</th>
<th>Not at all (1-2)</th>
<th>Neutral (3)</th>
<th>Very much (4-5)</th>
<th>Item mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personality</td>
<td>5.6%</td>
<td>12.7%</td>
<td>87.7%</td>
<td>4.1</td>
</tr>
<tr>
<td>Severity of illness</td>
<td>7.0</td>
<td>9.9</td>
<td>84.5</td>
<td>4.3</td>
</tr>
<tr>
<td>Level of compliance</td>
<td>4.2</td>
<td>12.7</td>
<td>83.1</td>
<td>4.1</td>
</tr>
<tr>
<td>Prognosis</td>
<td>17.4</td>
<td>21.7</td>
<td>60.8</td>
<td>3.6</td>
</tr>
<tr>
<td>Age</td>
<td>12.7</td>
<td>32.4</td>
<td>54.9</td>
<td>3.5</td>
</tr>
<tr>
<td>English language ability</td>
<td>27.1</td>
<td>20.0</td>
<td>52.9</td>
<td>3.3</td>
</tr>
<tr>
<td>Appearance</td>
<td>28.2</td>
<td>32.4</td>
<td>39.4</td>
<td>3.1</td>
</tr>
<tr>
<td>Social class background</td>
<td>33.8</td>
<td>28.2</td>
<td>38.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Race</td>
<td>46.5</td>
<td>29.6</td>
<td>23.9</td>
<td>2.6</td>
</tr>
<tr>
<td>Culture, ethnicity</td>
<td>44.3</td>
<td>32.9</td>
<td>22.8</td>
<td>2.7</td>
</tr>
<tr>
<td>Gender</td>
<td>52.1</td>
<td>26.8</td>
<td>21.1</td>
<td>2.5</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>62.0</td>
<td>26.8</td>
<td>11.2</td>
<td>2.2</td>
</tr>
<tr>
<td>Religion or lack of religion</td>
<td>70.0</td>
<td>24.3</td>
<td>5.7</td>
<td>2.0</td>
</tr>
<tr>
<td>Marital/relationship status</td>
<td>84.5</td>
<td>12.7</td>
<td>2.8</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Nonetheless, over half the respondents thought a patient's age and ability to speak English affects his or her care; approximately a third of respondents thought a patient's social class background affects care; and about a quarter thought patients' 'race,' culture, and gender affect care. Sexual orientation is still not seen to be a very significant characteristic affecting care, but students are slightly more likely to see the patient's sexual orientation as having an impact than the physician's sexual orientation.19 This may be due to the association between sexual orientation and risk factors for particular health concerns such as HIV/AIDS. Two students wrote comments in the margins that clarify the role they see social class background playing in the care a patient receives. They suggest the cultural capital of higher social class status—articulateness, education, social connections with the 'right' people—ensure better quality medical care.

19 42% said doctors' sexual orientation has no impact at all; 33.8% said patients' sexual orientation has no impact at all.
Women were slightly more likely to think a doctor's gender and parental status would affect how he or she practiced medicine, but neither relationship reached statistical significance. Women were also slightly more likely to believe patients' physical appearance affects the care they receive (Lambda=0.20, p=0.06). Minority students were somewhat more likely to say a physician's 'race,' culture or ethnicity makes a difference to his/her practice of medicine, and that a patient's culture/ethnicity affects care received, but neither relationship reached significance. Similarly, students who identify as having a religious affiliation themselves are somewhat more likely to believe a doctor's religion affects his/her practice (Lambda=0.19, p=0.05) and a patient's religion affects his/her care (Lambda=0.22, p=0.07). And students from a working class background are most likely to agree that upper class background makes it easier to fit in at medical school (ANOVA F=2.7, p=0.08).20

The overall message, though – about the effect of personal and social attributes on students’ own experiences of medical school, the importance of those attributes to them day-to-day, the effect of those attributes on how physicians practice medicine, and the effect of those attributes on the care patients receive – is that we are all individuals largely unaffected by our membership in social groups. There is some acknowledgment that patients are a diverse lot, and bring some degree of social and cultural 'baggage' with them into doctor-patient encounters – baggage that can make a difference to patient care. But there is still a fairly clear message that patients are individuals first and foremost. Moreover, there is an overwhelming message that medical students and doctors are socially and culturally neutral; they are individuals, pure and simple, largely unaffected by their sex, age, 'race,' class, sexual orientation, religion and so on.

20 Keep in mind that, as indicated in Chapter 3, I am reporting patterns in the data even when they may not be statistically significant. There is a 7-8% probability that the impact of religion and class described here are products of chance.
They enter into interactions with patients devoid of, or at least unaffected by, any social or cultural baggage.

5.6 The Hegemonic Status of Privileged/Dominant Social Categories

This assumption of social and cultural neutrality is common in our society. Seeing oneself as an individual first and foremost, rather than a member of any social groups, is a central tenet of western capitalist societies’ liberal humanism.

The discourse of liberal individualism denies the realities of groups. According to liberal individualism, categorizing people in groups by race, gender, religion, and sexuality, and acting as though ascriptions say something significant about the person and his or her experience, capacities, and possibilities, is invidious and oppressive. The only liberatory approach is to think of people and treat them as individuals, variable, and unique (Young, 1997: 17).

Such individualism is paramount among members of privileged or dominant social groups – groups that in our society include men, white-skinned people, people who are able-bodied, people who identify as heterosexual, people who are highly educated, and those from the higher echelons of the social class hierarchy.21

Most sociologists would acknowledge that membership in social groups, by gender, ‘race,’ class and so on, makes a difference to a person’s experiences, life chances, and so on. In fact, as Young goes on to say,

Without conceptualizing women [or gays, or Aboriginal peoples . . . ] as a group in some sense, it is not possible to conceptualize oppression as a systematic, structured, institutional process. If we obey the injunction to think of people only as individuals . . . structural and political ways to address and rectify the disadvantage are written out of the discourse (1997: 17).

Individualism, then, obscures oppression.

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21 I am assuming here that the dominance of these social groups has been adequately demonstrated and documented over the past few decades, and that I do not need to replicate those extensive bodies of work here. I take the vast literature on the oppression and relative subordination of people of colour, women, gays and lesbians, people with disabilities, the under-educated, and the poor and working class as my starting point.
Individual experiences and individual knowledge are conditioned by the social location or position of the individual (e.g., Collins, 1990, 1991; Haraway, 1991; Smith, 1987, 1990). What an individual is likely to see about the world varies according to social location, since “personal and cultural biographies [are] significant sources of knowledge” (Collins, 1991: 53). We are most likely to see the social organization of the world around us at those points where it ‘fits’ least well for us. For example, Patricia Hill Collins argues that Black women in academia, especially those from the working class, are most likely to be struck by the “mismatch” of their experiences and the paradigms of the academic relevances around them; they are thus more likely to identify anomalies than would true “insiders” (1991: 50). At the same time, members of social groups who are marginalized or subordinated have to understand the relevances of the dominant group – it may be a matter of survival (Collins, 1990). In contrast, the members of dominant groups do not have to understand the way the world works for members of subordinate groups.

The relevances of dominant social groups take on hegemonic status. Hegemony, in the Gramscian sense, is leadership or rule that is so pervasive in its dominance and in the consensus built around it, that it appears natural and inevitable.

Hegemony, in its most complete form, is defined as occurring when the intellectual, moral and philosophic leadership provided by the class or alliance of classes and class fractions which is ruling, successfully achieves its objective of providing the fundamental outlook for the whole society (Bocock, 1986: 63).

Hegemony is effective because it is invisible, consensual, seen as normal and natural.22 Among the most difficult things for us to understand is phenomena which are very

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22 To cast it in the terms of Berger and Luckmann (1966), all human activity has the potential to become habitualized through repetition and patterning. In the course of a shared history such actions may become typified to the point of institutionalization. Subsequently, institutions “by the very fact of their existence, control human conduct by setting up predefined patterns of conduct, which channel it in one direction as against the many other directions that would theoretically be possible. It is important to stress that this controlling character is inherent in institutionalization as such, prior to or apart from any mechanisms of sanctions specifically set up to support an institution” (Berger & Luckmann, 1966: 52).
normal, which we “take for granted because we have no concept of any possible contrast” (Hunter, 1992: 367). We have a hard time naming, or even seeing the ‘normal’ (Katz, 1995: 16). Social relations like heterosexuality, whiteness, masculinity and ablebodiedness are “silent terms” (Kitzinger et al., 1992: 295). Privileged groups tend to ignore (or cannot see) their own specificity, so that their own views appear neutral, representative of “universal, undifferentiated humanity” (Gabriel & Scott, 1993: 35). The norms of dominant social groups come to constitute “the standard for legitimate and prescriptive [social] arrangements” (Ingraham, 1994: 204).

Writing about whiteness, Peggy McIntosh argues that hegemonic whiteness is locked into a taken-for-grantedness which is “blind to its own cultural specificity. It cannot see itself. It mistakes its ‘givens’ for neutral, preconceptual ground rather than for distinctive cultural grounding” (McIntosh, 1990: 1). Whites tend to see ourselves as individuals, not members of “a people” (Ayvazian & Tatum, 1994; McIntosh, 1988). We enjoy a “privileged incredulity” when we are faced with the fact that our lives, our experiences are shaped by ‘race,’ racism, and white dominance (Roman, 1993: 192).

For example, when Ruth Frankenberg (1993) interviewed American women about their whiteness, most of them were unable to see themselves as practicing ‘white culture.’ They defined whiteness as absence of culture, as sameness, emptiness, a ‘white-bread’ culture. Women were better able to name the parts of themselves that did not fit, the parts that stood out as Irish or German because of food they ate or holidays they celebrated. They had a much harder time seeing the parts that do fit. For example Thanksgiving was not seen as a cultural event, though Aboriginal people might disagree. Frankenberg argues that to understand whiteness as a culture, we need to think of culture as “constructing daily practices and worldviews in complex relations with material life” (1993: 228). In this sense white people are daily practitioners of white culture – though we tend not to be able to see it.

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other words, certain ways of being become consensual, such that sanctions are usually not neede to enforce them. This parallels hegemony.

23 For example Thanksgiving was not seen as a cultural event, though Aboriginal people might disagree.
Being white is not a biological condition. It is being a member of a particular social/political category. If one is white, one is a member of a continuously and politically constituted group, which holds itself together by rituals of unity and exclusion, which develops in its members certain styles and attitudes... which defines itself as the paradigm of humanity. If you were born to people who are members of that club, you are socialized and inducted into that club (Frye, 1992: 149-50).

Moreover, you may continue to replicate the practices that are expected of members of that club, practices that you are unaware are distinctive to a particular social group, practices you take as just 'normal,' the 'way things are."

Marilyn Frye (1992) argues that we need some new ways of thinking and talking about whiteness. In her terms to be "white-skinned" is something we are born with, a physical trait. "White privilege," according to Peggy McIntosh (1988), is the unseen, taken-for-granted conditions of daily experience that we could not count on if we were not white-skinned. These range from issues of personal safety, to seeing ourselves represented in the media and among authorities in most institutions, to being able to buy 'flesh-tone' bandaids, to knowing that in most places we will more-or-less fit in without having to brace ourselves against feeling isolated, out-of-place, distanced, feared (McIntosh, 1988). One of those privileges is "white solipsism": being free to "think, imagine, and speak as if whiteness described the world" (Rich, 1979: 299). Ignorance of other social groups, especially subordinate groups, is a mark of privilege, a positioning only available to members of dominant social groups.

But even beyond white privileges Frye argues that there are culturally distinct ways of being that are common to white-skinned people. She coins the term "whitely" to refer to ingrained ways of being in the world that are distinctively, culturally white, and which we are not born with but must be trained in. "One can be whitely even if one's beliefs and feelings are relatively informed, humane and good-willed." (Frye,

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24 I would argue that it is also socially constructed to some extent, since some social groups such as the Irish have moved in and out of the category 'white' over time (Miles, 1989). Furthermore, some individuals move in and out of the category over a lifetime. Nonetheless, her point remains.

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1992: 152) "Whiteliness," then, is a coordinated, coherent set of culturally approved standards of behaviour considered appropriate for those born with light skin. One of the things that is important about these terms is that they acknowledge that there are ways of being that are part of being considered a member of the social group 'whites.' They include but are not limited to privileges. Frye also makes clear that they may, for some people, be accompanied by racism or "race-hatred," deliberate, or conscious acts that subordinate and oppress other groups. But the fact that a white individual does not display race-hatred does not mean he or she is immune to whiteliness.25

Unfortunately the task of delineating what exactly whiteliness entails is less well-developed than expressions of the need for exploring the topic. Frye does, however, identify some white 'ways of being.' First, she says whitely people have an amazing faith in their own rightness and goodness, and that of other white people. We tend to have an ethics based on forms, procedures and due process. We emphasize good manners and abiding by the rules. She gives an example of how white people often affirm to each other that a disruption caused at a meeting or in a classroom when someone insists on raising an injustice could have been less uncomfortable for everyone had the disrupter addressed the problem following proper procedures: ‘She should have brought it up in the business meeting,’ ‘She should take this through the grievance procedure’ (Frye, 1992: 155). Frye (also Pratt, 1984) also argues that authority is central to whiteliness, since white people are raised to run things, or to expect to.

Another key feature of whiteliness is a sense of entitlement, an unquestioned assumption that you can have whatever you want, not even pausing to wonder if it is

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25 "Whiteliness," or the cultural aspects common to whiteness, is complex. In particular it is difficult to distinguish between the impact of social class and the impact of skin colour. But to the extent that we can argue that being black, or Indian, or Aboriginal makes a difference, regardless of the income or class status of the individual, to that same extent we can claim that whiteness makes a difference. Nonetheless, we must bear in mind that the social construction of a white man differs from that of a white woman, and that of a white upper class person differs from that of a white working class person.

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okay to do/take/ask/hear, watch something or someone, or be somewhere. It is assuming you are welcome in a space, perhaps not even noticing you are the only white person there. It is not even noticing that only the white students in a class are speaking – and if you notice constructing that as ‘They’ have cultural ways that encourage silence, rather than ‘We’ have cultural ways that encourage speech.

Like whiteness, identifying as heterosexual means being ordinary (Belhoff, 1992). It means easily entering into the culture around you. The world is designed to fit you (Crawford, 1992). Again, heterosexuality enjoys hegemonic status, and therefore is unquestionable, unnamed, unproblematic, naturalized. Those who consider themselves heterosexual almost never address the question of when and how they knew they were heterosexual, or what might have caused it. Heterosexuality is assumed to be natural, not in need of explanation (Bartky, 1992). It is surprising, really, when sociologists understand so many aspects of our world as socialized or socially constructed, that somehow we tend to think sexual desire is immune, is natural and immutable rather than socially produced.

Heterosexuality is not only a matter of sex or sexual desire (Kitzinger et al., 1992; Segal, 1994; Wilkinson & Kitzinger, 1994). It actually encompasses a whole range of other social practices. As Rich (1986) pointed out in naming heterosexuality as an institution, sexuality is thoroughly social, and therefore political (Seidman, 1994). Like whiteness, it brings with it a series of heterosexual privileges, such as having a category you fit into on census forms; having your relationship recognized by the law and your church, temple, synagogue, mosque; being able to buy His and Hers towels; being able to adopt a child; having your estate automatically go to your partner even if you die.

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26 Possibly a legacy of our colonial heritage, at least in North America. We have moved from appropriation of Aboriginal land to appropriation of Aboriginal art, spirituality and rituals.

27 The editors of a journal special issue on heterosexuality state that, “heterosexuals do not generally think of themselves as ‘heterosexual.’ Indeed, many... are reported not even to understand the meaning of the word: the privilege of incomprehension is, of course, a luxury afforded only to those with hegemonic identities” (Wilkinson & Kitzinger, 1994: 310).
without a will; not having to fight for a hotel room with one double bed; not having to carry guardian of health care forms to ensure your status in your partner’s health care; not having to explain your relationship to your child’s teachers, dentists, doctors or to neighbours, real estate agents, salespeople, and repair people; buying greeting cards that reflect your reality; holding hands in public without having to check to see where you are; chatting at work about your date/boyfriend/husband; putting your spouse on your medical plan; having a family photo on your desk; being able to immigrate based on partnership status; not fearing harassment at border crossings, at least not for your sexual orientation. These are profoundly political acts, and are among the (often unrecognized) privileges enjoyed by those who are identified as heterosexual.  

As with whiteness, identifying as heterosexual can afford an individual the luxury of ‘heterosexual solipsism’ in which he or she can be oblivious to the realities of gays, lesbians, bisexuals. And again, one can identify as heterosexual without necessarily participating fully in the cultural practices that accompany heterosexuality – though not participating does not make those practices, which are institutionalized, disappear. And again like whiteness and race-hatred, identifying as heterosexual may or may not be accompanied by fear or hatred of gays and lesbians.

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28 I do not want to push the similarities between whiteness and heterosexuality too far, and this point about “being identified as” marks one of the key differences. Gay men and lesbians are often able to pass as heterosexual in a way that most people of colour are not able to pass as white. And to reverse this, men and women who identify themselves as heterosexual may nonetheless be identified as gay or lesbian by others, costing them at least some of their heterosexual privileges.

29 As Marilyn Frye says with whiteness, I would say we need more comprehensive language to talk about heterosexuality. The state of being heterosexual encompasses being in an intimate (usually sexual) relationship with someone of the opposite sex. But it also encompasses identifying as heterosexual, based on presumed sexual attraction to the opposite sex, even if one is not and may never have been in an intimate sexual relationship with anyone. There is no accepted word that captures what gay men and lesbians mean when we refer to someone as “so het!” This phrase refers to the ways in which someone enacts heterosexual culture (as opposed to gay or lesbian culture); it is distinctive to those of us outside of it, but is difficult to articulate. It has mostly to do with oblivion to the fact that heterosexual ways of being and heterosexual relevances are not universal and shared by all. Akin to Frye’s (1992) “whiteliness” or the term ‘macho’ to describe particular ways of enacting masculinity, I would use the term “het-ness” to refer to enacting the cultural aspects of heterosexuality.
Like whiteness and heterosexuality, masculinity is also based in a set of social practices, socially organized and approved ways of being. And like the others, particular versions of masculinity have enjoyed the status of hegemony, though in recent years subject to growing counterhegemonic struggles waged by feminists, pro-feminist men, and gays and lesbians (Connell, 1995: 90). Nonetheless, the concept of male privilege still holds true, as evidenced by a continuing gender gap in wages and employment opportunities (see Creese & Beagan, 1998), gendered divisions of household labour (Luxton, 1998), gender differences in health care, and male violence against women (Armstrong, 1995; Duffy, 1995).

But again, it is important to examine what masculinity is over and above male privilege. What are masculine ‘ways of being’? Thomas Dunk’s research suggests that working-class masculinity is at least in part a celebration of “physical strength, practical skill, the willingness to withstand discomfort stoically, and being able to ‘drink like a man’” (1991: 56). For middle and upper class men it might emphasize rationality, logic, technical skill, objectivity, and non-emotionality (Connell, 1995: 90, 164). Authority seems to be a component, regardless of class (Connell, 1995). Michael Kimmel adds that masculinity centers in the devaluing of anything feminine, including parts of the self or other men. “Masculine identity is born in the renunciation of the feminine, not in the direct affirmation of the masculine” (Kimmel, 1994: 127). Masculinity, then, involves the enactment of non-femininity, or even anti-femininity.

Masculinity also intersects in complex ways with sexuality; the most common response to men who do not fit the norms of masculinity is the accusation of “fag” (Dunk, 1991). Men constantly police themselves and each other for signs of femininity, any sign of which is grounds for the assumption or accusation of homosexuality. Kimmel describes male adolescents as “a kind of gender police, constantly threatening to unmask [each other] as feminine, as sissies” (1994: 132). Even tiny insignificant things hold the potential for being unmasked. The ‘signs’ that a man must be gay...
include walk, speech, mannerisms, dress, emotionality – all of these are the sites in
which men daily enact heterosexual masculinity, to make sure no one mistakes them
for gay. Masculinity is constructed around a set of negative rules: never act that way,
never talk that way, never walk that way.

R.W. Connell’s (1995) work on gender and masculinity over the years has
contributed the important notion of hegemonic masculinity, “the configuration of
gender practice which embodies the currently accepted answer to the problem of the
legitimacy of patriarchy, which guarantees (or is taken to guarantee) the dominant
position of men and the subordination of women” (1995: 77). Though it may differ over
time and place, there is always a particular form of masculinity that “occupies the
hegemonic position in a given pattern of gender relations” (1995: 76). He argues that
hegemonic forms of masculinity are not only cultural ideals, but must also have some
support from institutional power structures, including top levels of business, military
and government.30 There will at the same time, however, be other subordinated and
marginalized (counter-hegemonic) versions of masculinity, which place some men in
positions where their interests may lie with contesting hegemonic masculinity.

Most recently Connell (1995) has coined the term “complicit masculinity,”
another extremely important insight. Complicit masculinity is practiced by the majority
of men who benefit from the subordination of women and concomitant male privilege
but do not necessarily enact hegemonic masculinity themselves. They are “complicit
with the hegemonic project” (1995: 79). Michael Kimmel (1994) begins to explicate
complicit masculinity when he suggests that fear of humiliation (by other men) leads to
silence in the face of violence against women, sexist comments, gay bashing, gay jokes
and so on. It leads to complicity.31

30 I would add to his list support of media institutions: television, magazines, books, ads, and
newspapers can subvert or sustain hegemonic ideals of masculinity.
31 This is a potentially fruitful direction for examination of other dominant social relations, including
heterosexuality and whiteness. In what ways do some people enact complicit whiteness rather than
hegemonic whiteness, or complicit ‘het-ness’ rather than hegemonic ‘het-ness’?

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When people in our society deny the relevance of membership in social groups they may be demonstrating belief in liberal individualism, as described at the outset of this section. They may also be demonstrating their desire to *not* have privileged statuses named. To name the unnamed, to problematize the hitherto unquestioned and unmarked weakens its hegemonic status – hegemony relies on the absence of alternative ways of thinking and being. Or, in Berger and Luckmann’s (1966: 100) terms, open legitimation of a symbolic universe or way of understanding the world posits the existence of alternative perspectives, which threaten the inevitability of the dominant symbolic universe. Pluralism is inherently subversive (1966: 115).

Yet multiple perspectives are also inevitable, in part because many people never completely ‘buy in’ to hegemonic forms of dominant identities.

Socialization is never completely successful. Some individuals ‘inhabit’ the transmitted universe more definitely than others. Even among the more or less accredited ‘inhabitants,’ there will always be idiosyncratic variations in the way they conceive of the universe (Berger & Luckmann, 1966: 100).

In addition, we all have multiple identities, we belong to multiple social collectivities. And different dimensions of our identities have higher or lower salience in different social contexts (Yuval-Davis, 1994). What determines the salience of particular aspects of identity is, largely, their political relevance. Thus I would argue that for most of the medical students in this research, and for some of the faculty, membership in social categories was not just unrecognized because of the hegemonic status of many of those identities, but it was also politically irrelevant in the face of an emerging allegiance to the category of ‘medical doctor.’ That is, for many students, becoming a doctor – with its high prestige and social value – supersedes their other identities (Broadhead, 1983).

32 Marilyn Frye argues that the most impressive aspect of deconstructing hegemony is revealing the “complex and intense interplay of construction of concepts and construction of concrete realities” (1992: 163), the social construction of reality.
I am arguing that medical training by intent as well as by effect builds on a social paradigm of liberal individualism to encourage medical students to see themselves as individuals and to deny their membership in social groups as relevant to their practice of medicine (or their lives). Their ability to do this is facilitated when they occupy social locations or identities that are hegemonic in stature, 'natural' and unproblematized – and therefore unrecognized. Hence we saw that men were more likely to see gender as irrelevant, non-minority students were more likely to see culture and 'race' as irrelevant and so on. To the extent that the doctor-status can be assumed to override other social identities, however, all students may be encouraged to deny the salience of membership in social groups. Constructing or adopting a unitary identity of 'doctor,' though, requires the exclusion or suppression of differences (Haraway, 1990), particularly those differences that cause their bearer to 'fit' least well with social expectations of what a doctor is. At the very least students must accomplish a complex articulation of their emergent professional identities to identities that do not match the expected neutrality.

Furthermore, I would argue that lack of recognition of one's own membership in social groups, and the salience that has in doctor-patient interactions, is an example of the type of oblivion I have described as characteristic of dominant social groups. When medical students say that their own gender ('race,' class, sexual orientation) has no impact on encounters with patients, even if they are willing to acknowledge that the patient's gender ('race,' class, sexual orientation) may have some slight impact, they lose the opportunity to examine how it affects the encounters. I would argue that it is not sufficient to be 'open to' the sociocultural baggage of your patients; it is also essential to be aware of and reflexive about your own baggage in order to achieve genuine connections. If during an encounter with a patient, a physician enacts whiteness, het-ness and hegemonic or complicit masculinity, that will have an impact on the interaction, whether or not the impact is recognized. I will return to this argument in Chapter 6.
5.7 Summary and Conclusions

Medical students are under great pressure concentrated around shortage of time. They find it extremely difficult not to let medicine totally inundate their lives, to the exclusion of everything else. Other interests, commitments and connections get pushed aside or put on hold by most students. They struggle to maintain balanced lives by creating tight schedules, finding stress releases, building support systems in school, maintaining outside contacts and interests, and clarifying their own priorities to keep school in perspective. Though the latter two strategies may be difficult in the short-run, these balancing skills may be essential to the long-term health and well-being of the medical professional.

Meantime, the time pressure and subsequent inundation of everyday life with the demands of medicine lead to a certain pressure toward conformity or homogeneity among the medical students. Though this is mostly in terms of thinking and decorum, both students and faculty indicate there are broader shifts toward a convergence in values. This value shift is intensified by lack of contact with external 'reality checks,' speeding the adoption of a medical student 'natural attitude.' As Berger and Luckmann (1966) argue, a process of resocialization is eased by segregation of the individual with members of the resocializing group.

Students display varying degrees of segregation and integration in terms of how their medical school self 'fits with' their other identities of social roles. Most seem to have grown more distant from family and old friends, usually in terms of time commitments, but also sometimes in terms of social distancing as they move higher on the social hierarchy. In many cases, old friends and intimate relationships are displaced both by the time commitments of medical school, and by the new friendships built there. Some students manage to hang on to old connections, but often by distancing themselves from their colleagues in medicine. In general, students tend to feel they are...
succeeding as students, but failing in most of their other social identities. Many students let go of prior conceptions of themselves that do not fit easily with the emergent medical professional identity. Others retain multiple aspects of self, but keep them carefully segregated. Finally, about a quarter of the students had integrated their new identities with the rest of their lives quite thoroughly.

I argue that among the ways students articulate their multiple identities to one another one of the dominant modes is “overriding.” The medical student identity excludes all else, at least temporarily. Much less commonly, personal identities may preclude full acceptance of the medical student identity. A few students “distort” either the medical identity or their personal identities to facilitate a better fit. Lastly, many students seem to keep their medical and other identities segregated, some in ways that indicate unresolved conflicts, and others in ways that strike a careful counter-balance.

Finally, I argue that medical education builds on a social predisposition toward liberal individualism such that by intent or effect students are encouraged to see themselves as neutral in terms of their social characteristics, and to see their patients as almost neutral. Students are somewhat ready to see the potential impact on doctor-patient interactions of patients’ social, cultural, racial, class backgrounds, as well as gender and sexual orientation. But they are unwilling or unable to see that their own membership in social groups, particularly those groups which enjoy dominant or hegemonic status in our society, can have any impact on how they practice medicine, or how they are experienced by their patients.

In the next chapter I will examine how membership in non-dominant social groups is experienced by those students, and how it is dealt with by students and by the medical school. In other words, in the pressure toward uniformity and neutrality (in terms of gender, ‘race,’ culture, class, sexuality and so on) what happens to those students who are visibly and/or performatively different from the norms that enjoy hegemonic status? What happens to women students whose gender remains a marked
status? To ‘minority’ students whose ‘race’ and/or culture remains a marked status? To openly gay or lesbian students whose sexual orientation sets them apart? To students from working class backgrounds, or who may be older than average?
Chapter VI: Dealing With Social Differences

We have seen in Chapter 4 that medical students go through an intense process of secondary socialization into an emergent medical professional identity. The process entails beginning to identify as and act as a member of the health care team, and taking up particular relationships to other health care workers and patients. It also entails constructing a presentation of self that is 'professional' in appearance and manner, most importantly that conveys competence. After going through a series of 'first experiences' that set medical students apart from lay people, and after beginning to play the role of medical professional – complete with costume, props and dialogue – students begin to identify as medical professionals. In particular as other people respond to them as if they were medical professionals, especially expecting them to fulfill specific medical roles and responsibilities, they begin to internalize that understanding of themselves.

In Chapter 5 we saw that these processes of 'becoming' contain within them tendencies toward homogeneity and neutrality. In essence, because the time pressures of medical school are so intense students have great difficulty maintaining any degree of balance in their lives. Lack of contact with 'the outside world,' displacement of students' usual activities with a set of very uniform ones, training in specific thought processes, and for some an incompatibility between prior values and current expectations, leads toward what one clinician called a "deindividuation of the students." A new social reality emerges among students that includes pressures to conform with others and standards of behaviour that differ from those of the lay world. Students integrate this emergent medical professional identity to varying degrees, in part depending on the extent to which they are able or willing to meet the underlying expectation of the 'neutral physician.'

The assumption that physicians can act from a position of classlessness, sexlessness, racelessness and so on is explicit in the approach of some faculty and
implicit in some ways in the school. This assumption feeds a prevalent liberal individualism such that students overwhelmingly believe the social location of the clinician does not affect the encounter with a patient. It also intensifies the hegemonic status of identities rooted in social dominance, allowing membership in dominant social groups to go unexamined – even in terms of how they impact on medical practice.

What I turn to in this chapter is examination of a specific incongruence: Given the tendencies toward homogeneity and neutrality discussed in Chapter 5, and given the diversity (lack of neutrality) among medical students in the 1990s, what happens to social differences during medical training? Is the medical school atmosphere a welcoming space for students who are non-white, non-Christian, older, parents, gay or lesbian, women, and so on? Or is it more of a melting pot, where those who are 'different' are expected to assimilate? Are social differences ignored, denied, acknowledged, resisted, accommodated? What impact do social differences have on the students, as well as on the institution?

Specifically, in this chapter I examine how being different from the historical and hegemonic norm for medical students is experienced by students and understood by faculty. I argue that such social 'differences' pose specific difficulties, even if students do not always perceive themselves to be in any way limited by their membership in non-dominant social categories. But I also argue that these social differences provide a site for resistance to the overwhelming pressures toward conformity. In addition, I examine how the medical school responds to social differences among the students, and the implications of various possible responses. Lastly, I argue that a response emerging out of a sustained 'politics of difference' is a fundamental challenge to liberal individualism and is an appropriate goal for a medical school.

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6.1 Diversity Among Medical Students

As indicated in the introduction, there have been significant differences in the student populations in Canadian medical schools in recent years. One faculty member summarized some of the differences in classes now compared with ten or twenty years ago.

Dr. A.: More women. . . . I see more ethnic diversity which is great. . . . There seem to be a whole lot of students from different parts of the world. Iran for example. When I first started there was no one from Iran. . . . Asians of course in Vancouver . . . East Indians, Sikhs . . . you know wonderful people. So yeah, incredible diversity of people from different parts of the world. . . . I think that the student population is a little older. In this past year's first year class we accepted the oldest student we've ever had. . . . I also see people feeling more comfortable about who they are and not having to toe the line and be so um so – there's um, there's a Gay Medical Student's Association for example and I don't know 10 - 15 years ago that was just unheard of. . . . Oft times you don't know who's working class anymore. I do have a sense that there are a lot of people from small communities. They sort of stick out you know there's an oft times a nice quality about people that come from a small island and the Gulf Islands for example or someone from up North. We have some First Nations Students that have been through the program and they've been terrific as well.

Another clinician added that students today come from a wider range of academic backgrounds, remarking that, "a year ago we graduated our first medical student with a Ph.D. in music." Generally, then, as perceived by faculty the student body today includes more women, "a bigger mix of racial cultural backgrounds" and ethnic differences, more students who identify as gay or lesbian, more diversity in academic backgrounds.

Admissions at this medical school have been approximately 40% female for about 15 years. The class I conducted my research with was 48% female. Other demographics are harder to get. Using my own subjective assessment of class photos, for the past 15 years about 30% of each class would be considered 'visible minority'
students.1 About a third of the survey respondents identified as visible minorities, and
about a third indicated their ethnic origins as Chinese, Japanese, South Asian, Korean,
Taiwanese, Indonesian or Malaysian, plus one student who is Aboriginal.

Two instructors indicated that increasing numbers of students have English as a
second language; a quarter of my survey sample indicated a first language other than or
additional to English. Another faculty member, though, insisted that, “you don’t get
into this school unless you’re very literate in English.” There were mixed perceptions
about age differences. Two faculty members thought there were more very young
students than there used to be: “There’s so many of these, you know, dynamite students
that’re finishing school very young with these gold medals and all that.” Another
argued that there are more older students in medicine, as the economy tightens and
people decide to change careers. National statistics show that in medical schools outside
Québec students are older and better educated upon entry “than those of the previous
generation” (Gray & Reudy, 1998: 1047).

One area where there may have been least change is in social class backgrounds
of students. Traditionally medical students have been from upper or upper-middle
class families, often children of doctors. Cockerham indicates that “although increasing
numbers of lower-middle- and lower-class students are entering medical school, most
medical students are homogenous in terms of social class affiliation” (1995: 195). Dr. F.
suggested that still today about 40% of students have at least one family member who is
a physician. Dr. A. talked about one student who came from Vancouver’s East Side and
grew up in poverty, as very different from the “typical medical student.” Finally Dr. J.
talked about most students doing volunteer work with people in less-developed
countries out of an upper-class ethic of noble charity work rather than a feeling of
resonance with the lives of those people. Nonetheless, proportions of students from
different social class backgrounds is speculative – statistics are not available.

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1 Thirty years ago the class was 16% female and 7% visible minorities.
Overall, though, it is clear that the medical student population is far less homogeneous than it was even 15 years ago.

6.2 The Impact of Social Differences: Perceptions and Experiences

As we saw in the last chapter, students tend to adhere to a liberal individual perspective in which they believe their membership in social groups is largely irrelevant to their experiences in medicine and elsewhere. There were some patterned differences though, in which students who are ‘Other’ in some way were more likely to believe their own category of ‘Otherness’ makes a difference.

One faculty member suggested that anything that makes a student somehow marginal might increase his or her difficulties fitting in, might make the student-physician identity fit less easily than it does for others. If they come from another country, or even province, if they fail a year, if they stand out in any way. For example, students with Arts backgrounds, students who had strong religious affiliations, students who were parents – all of these attributes increased the likelihood that students would feel they fit in less well in medicine. But the most significant attributes that seem to affect the processes of coming to see oneself as a medical professional are ‘race’ or cultural background, gender, sexual orientation, age, and social class background.

6.2.1 Racial and cultural differences / Racism

Interestingly, and perhaps tellingly, many people interpreted my questions about the impact of social differences to mean what problems are created, and responded by naming problems or denying that it causes any problems. Only a few students or

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2 This is what Peggy McIntosh (1990) calls “deficit identities.” She is talking about the ways ‘people of colour’ are portrayed only in the category of Problem, only as victims of racism, as if they have no identity or culture that exists apart from White people, as if they are defined by racism. McIntosh calls this a kind of inadvertent racism, since it is a cultural insult to any group to imply that its main feature is a “deficit identity” (1990).

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faculty members identified positive differences created by having a 'racially,' ethnically and culturally mixed student body. One faculty member and a couple of students talked about the range of cultural backgrounds bringing diverse perspectives to discussions of any issue. Through their classmates students gain exposure to different cultures before they encounter such differences in their patients. One faculty member said that with "white middle class males" becoming the minority, the increased presence of women and racialized minority students changes the overall atmosphere – the school has become a more comfortable place to raise issues of 'race' or gender.

In general the faculty did not believe racial differences or differences in ethnic origin were particularly significant. Five faculty members specifically stated that racism is not an issue in the medical school.

Dr. U.: I've never seen any, any indication of any kind of racist behaviour amongst the students.

Cultural differences were seen as having more impact. Several faculty members referred to a strong work ethic among Asian students, and suggested emphasis on the value of education is lower among Caucasians. There was also substantial agreement that Asian families put unusually strong pressure on their children to be successful, sometimes pressuring them into medicine against the students' own wishes.

Dr. E.: Some of the Asian families, if they themselves are professional, they put a lot of pressure on their kids to follow the path. I've had two or three recent experiences with the medical students who came from that background, who are clearly pressured into doing medicine and who have an awful struggle with it. . . . Some of the newer immigrant families, and especially some of the Asian Chinese families are very inclined to want to push. You know, very high achievers, success oriented.

The other issue most frequently raised about cultural differences is style of self-presentation. One faculty member suggested there is an unintended systemic bias in the admissions process whereby students whose cultures dictate that they be more humble, loathe to boast, meek or self-effacing do not present themselves in the ways expected in admissions interviews – ways based in Western cultures. He and three others argued...
that when these students (particularly Asian students) do get into medicine, they are at a disadvantage in the oral components of their training. One clinician described his difficulties evaluating the work of students who come from cultures very different from his own.

Dr. D.: I have a student now who's from [an Asian county]. . . . I find him very diffident, reticent. . . . Now he might look fine dealing with the Chinese population, but I don't know that. I find it hard to evaluate him on those kind of things. . . . I find it hard to know what to say about him that is not going to be damaging or inappropriate, you know. What, what can I really say, you know? . . . My cultural biases [favour] the kind of physician that I want for myself.

To some extent the clinical evaluation of a student measures that student against culturally-derived norms. But as several faculty pointed out, such students can always learn to assimilate, to behave in the ways dictated by white Canadian culture. After all, the student is being granted a Canadian medical degree and should be expected to meet Canadian standards and clinical practice norms. That begs the question: which Canadians? Who is a real Canadian? In practice that usually means the standards of the dominant culture, the culture established through colonial heritage. To excel, then, a student may need to abandon some elements of his or her culture, to assimilate to dominant cultural norms.

Dr. D.: There's two kinds of Asians. There's the new Asians, which probably we have half the time, and then there's the Canadian, beautifully assimilated Japanese or Chinese Canadians who, I think, have adopted the classic Canadian values, you know. So, they're not the issue for me.

From this perspective, racialized differences would no longer matter once cultural differences are outgrown.4

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3 It is interesting to imagine a medical school that evaluated its students based on the cultural norms and values of the first Canadians, Aboriginal peoples. What kind of medical professionals would it produce?
4 This is what Philomena Essed (1991) calls "ethnicization," turning racialized power struggles into issues of cultural difference. She argues that this is part of everyday racism as experienced in liberal democracies such as the Netherlands, where part of her research was conducted. The same approach is appropriate in Canada where we have a formal commitment to multiculturalism (see Henry et al., 1995).
Two white men raised the problem of racialized minority students' lacking role models. As one said, “It’s hard for me to identify with some of them. And identification is probably an important process, part of actually giving your all to an individual.” It may also be harder for racialized minority students to identify with him.

In keeping with the liberal individualism discussed in the last chapter, the majority of students indicated that ‘race’ and racism really are not an issue in medical school. When surveyed, 27% of respondents indicated that ‘race’ affects how students are treated by other medical staff, and 14% indicated that it affects the degree of respect from patients. Using these items to construct a scale measuring perceptions of racism in the school, the scores of students who identified as members of ‘minority groups’ were slightly higher than those of non-minority students (means of 5.4 and 4.5 out of 10, p=0.06). Similarly, 25% of ‘minority’ students said their racial or cultural background had a somewhat negative effect on their experiences of medical school, compared to only 4% of non-minority students, though the difference was not statistically significant. The day-to-day importance of cultural background and ‘race’ were also highest for this group (Lambda=0.10, p=0.05; Lambda=0.22, p=0.001 respectively), an importance that has increased slightly since entering medical school.

When interviewed, again the majority of students started out by saying ‘race’ is really not an issue in medical school. In particular they said racism is not an issue at their school. There seems to be a consensus that racism does not occur in large, multicultural cities. Many then went on to describe incidents at schools where they

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5 The scale was comprised of two items: “Interns and residents treat all medical students roughly the same regardless of race,” and “Patients have more respect for white students than for minority students.” Reverse-scoring the first item resulted in a 10 point scale in which 10 is “Yes, racism affects medical student’s experiences.” The inter-item covariance was 0.40, and inter-item correlation was 0.34. The scale reliability coefficient alpha = 0.51. Despite the fact that the scale is weak, it does show variation by ‘minority’ status.

6 Analysis of variance shows that 21% of variance in the daily importance of cultural background (p=0.0001) and 38% of the variance in daily importance of ‘race’ (p=0.001) are explained by the students’ ‘minority’ or non-minority status.

7 Again, see Appendix V Tables A.3 and A.4 for full details. Students rated the importance of various individual and collective factors to their day-to-day lives during medical school, and before school.
have done elective rotations for a few weeks, or while they were doing placements in rural practices.

Janis: When I was up in Dawson Creek, too, it was ‘fucking Indians’ this, ‘fucking Indians’ that.

Dawna: In terms of being Asian, I’ve never had a bad problem with it, except for one occasion where I was invited to have dinner with a preceptor in a small town. This was a rural practice, this was my ex-boyfriend’s preceptor, and the entire evening heard nothing but racist comments directed at Asians. But he’s of the old school, so in a way I can sort of, you know, I guess he’s really quite old, so I mean I’ve heard it before so it’s not that surprising.

Sean: This guy had gone through the windshield of his car and they made some comment about, ‘Oh, he was DWC.’ And I said, what’s DWC? And they said, ‘Driving While Chinese.’ And that was the first day I was there. And that’s on the wards, and walking along the halls, so anybody could hear it. One of the residents said that to a doctor and the doctor laughed and said, ‘Oh, that was a good one. I never heard that before.’ And I just thought, you would not get away with that at UBC.

The few who did talk about issues of race in the medical school itself almost invariably attributed derogatory comments to “dinosaurs” – older patients and/or faculty who are close to retirement and if you just wait it out they’ll be gone (c.f. Wear, 1997: 39).

Countering the belief that racist sentiments are only harboured by older about-to retire clinicians, though, a few students talked about racial stereotypes and sentiments expressed by classmates.

Jason: My ethnicity, I think the feeling that I got was in the context of my medical school class, is that Chinese people are seen as kind of brainoids. So there’s that sort of stereotype. And that they’re not really social and that sort of thing. And they stick together, which for a large part of the class they did. There was kind of the Chinese group and then scattered Chinese people around.

A few students said they thought they heard more racism because they were white. Patients and medical staff included them in racist jokes and asides, assuming they would share in the sentiments.
Janis: There was this one patient, we had a bedside teaching session, he commented he’s moving from Richmond because there’s too many yellow people there. And the doctor and the three other students in my group laughed. I mean, it’s kinda uncomfortable, you’re supposed to laugh at all the patient’s jokes to kind of make rapport. I didn’t laugh. But I’m thinking, ‘Man! How would I feel if I were Asian?’

Robin: There are people who are prejudiced . . . and they assume that just ‘cause you’re white you feel the same way they do . . . I had an unpleasant experience with a patient who assumed because I was white I was going to be racist like her.

Apart from outright racism, though, racialized differences may still affect the extent to which a student feels he or she fits in. One faculty member said she thought being strongly connected to a non-white cultural background, especially Aboriginal, would make it difficult to fully identify with other medical students. Survey results showed that students from racialized minority groups were slightly less likely to feel they fit in at medical school, but the difference was not statistically significant (ANOVA F=1.4, p=0.25). Nonetheless, when students identified the social subgroups or cliques they perceived in their class, several students named “Orientals,” a “group of Chinese students,” “the Chinese crowd,” or people of the “same ethnic background.” Furthermore, the most frequently identified type of offensive jokes noted in the medical school was those about “ethnicity or race.” This gives some reason to believe that racialized differences have some impact on students’ ability to fit in and fully identify as medical students. At the very least it may produce the sort of marginalization Sinclair (1997) (perhaps unwittingly) described when he said he could not comment on

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8 When asked to indicate what types of offensive jokes they heard around the medical school, about half the student respondents said none; the other half reported the following types of jokes:

<table>
<thead>
<tr>
<th>Jokes about:</th>
<th>#</th>
</tr>
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<tbody>
<tr>
<td>ethnic/racial groups</td>
<td>22</td>
</tr>
<tr>
<td>types of patients</td>
<td>19</td>
</tr>
<tr>
<td>gender</td>
<td>18</td>
</tr>
<tr>
<td>gays &amp; lesbians</td>
<td>14</td>
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<tr>
<td>height or weight</td>
<td>12</td>
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<tr>
<td>religious groups</td>
<td>12</td>
</tr>
<tr>
<td>cadavers</td>
<td>7</td>
</tr>
<tr>
<td>age</td>
<td>3</td>
</tr>
<tr>
<td>other (“crude”)</td>
<td>3</td>
</tr>
</tbody>
</table>

9 Again, see Essed (1991) for an excellent examination of the effects and processes of everyday racism.
the social lives of the Asian medical students in his study, because they frequented a
different bar.

My point here is not that students of colour are subject to extraordinary levels of
racism while in medical school, nor that white students and medical faculty exhibit
unusual levels of racism. My point is that processes of racialization are more subtle and
complex than straightforward acts such as refusing entry to an Indo-Canadian, or
calling someone a ‘Paki.’ Such overt individual racist acts are intricately linked to
supportive social, political and economic structures and arrangements as well as
specific ideologies that may perpetuate racism even while masking it.

In Canada the dominant ideology is one in which we verbalize tolerance while
holding at times conflicting attitudes, while tolerating institutional practices that
reinforce and perpetuate racialized inequalities, and while ourselves engaging in
practices that uphold the hegemonic status of whiteness as discussed in Chapter 5.
Frances Henry and her colleagues call this “democratic racism” (1995). Intolerance
toward racialized minority groups coexists with commitment to democratic principles
of justice, equality and fairness.

A central tenet of democratic racism is that racism only lingers on in the attitudes
and actions of a few aberrant individuals (left-over dinosaurs). In contrast Philomena
Essed demonstrates that “everyday racism” is distinctively structured in “practices that
infiltrate everyday life and become part of what is seen as ‘normal’ by the dominant
group” (1991: 288). Those practices range from laughing at a ‘Paki joke,’ to assuming all
Chinese people are super-smart, to shadowing Aboriginal shoppers in a store because
‘they tend to shoplift,’ to assuming an African-Canadian in a hospital wearing a white
coat must be cleaning staff, and so on. The power of these everyday acts lies in their
overwhelming repetition and their cumulative impact. In societies such as Canada
where the existence of such everyday racism is denied it becomes even more difficult to
challenge. The result is not exclusion, but marginalization of people of colour.
6.2.2 Gender differences / Sexism

Neither men nor women thought their gender had much impact on their experiences of medical school, but the day-to-day importance of gender was highest for women (Lambda= 0.21; p=0.02). The importance of gender increased slightly more for women than for men after entering medicine, but the difference is insignificant (F=3.1, p=0.08). When asked to indicate their agreement with the statement, “Interns and residents treat all medical students roughly the same regardless of gender,” 41% of survey respondents think gender does make a difference, 28% think it does not, and a sizable group remains neutral on the question. In most of the survey questions relating to gender women were more polarized than men were. For example, while virtually none of the men (3%) thought their gender would be a consideration in choosing residencies, 43% of the women rated it as important while 40% rated it as unimportant.

In the interviews, most students stated that gender is really not an issue in medical school. Their classes are almost exactly gender balanced and everyone gets treated pretty much the same. Having said this though, most women and some men went on to give examples of how gender does make a difference. These ranged from quite blatant sexism and sexual harassment to a more subtle climate of gendered expectations that may make things easier for male students in almost intangible ways.

A few faculty said expressly that they do not think sexual harassment or outright discrimination are serious problems in the school. And if they were, the school has an Associate Dean of Equity who handles complaint of that nature. A few men suggested blatant sexism is a thing of the past; though it may once have been the norm in medical

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10 Analysis of variance shows the mean for women (3.3) to be significantly higher than the mean for men (2.4; p=0.005).
11 The mean is 2.9 on a scale from 1 (disagree) to 5 (agree) with fairly even distribution around the mean.
schools, today the presence of large numbers of women constrains certain behaviours among male students and faculty.

Dr. U.: I would say because the number of women in the class now is at least 50% you don’t – my professors would crack jokes, occasionally throw up a Playboy picture. You’d never do that now. That would be unacceptable. . . . And there’s all kinds of formal restrictions on what’s appropriate now too.

Women students, though, described fairly clear instances of sexism and harassment. One woman spoke of a clinician greeting her small clinical group – three men and one woman – three mornings a week for a year with, “Good morning, gentlemen.” In another instance a male clinician who was using one student as a sample patient to demonstrate a technique inappropriately fondled and commented on her gluteus maximus. Other incidents were even more blatant.

Janis: I had one clinician . . . we were at a woman’s bedside, middle-aged woman, and he was trying to demonstrate how to palpate the spleen, and he goes, ‘See, just like making love to a woman.’ Totally inappropriate. The same clinician another time, we’re at the bedside of a middle-aged man, and he says to me, ‘What part of your hand do you use to palpate?’ And I hesitated before I answered, because I thought is this a trick question? ‘Cause it’s so obvious. And then he said to me, ‘Let me put it this way to you. When you make love to your husband, what part of your hand do you use?’

None of the women who told me stories such as these had reported the incidents to the Associate Dean of Equity; they may have internalized the desire not to ‘rock the boat,’ as outlined in previous chapters.

To be clear though, direct experiences of sexism and harassment were rare enough to stand out. Generally the impact of gender was more subtle.

Erin: I haven’t encountered a lot of overt sexism. There’s a lot of sort of low level (sigh) low level slightly irritating stuff . . . . I’m not quite sure even why it irritates me you know? Because it’s not out to get me or anything, but it just feels like it – it’s just somehow not inclusive or something? Or not valuing me? The way I would.
As we saw with racism, this is a sort of ‘everyday sexism.’ It is more covert than direct harassment, constructing an overall climate in which women fit less easily.

For example there were clear gender differences in the construction of a professional appearance – part of taking on a new professional identity as discussed in Chapter 4. While none of the men interviewed raised concerns about dress or appearance, the topic came up repeatedly among the women, discussing the need to dress professionally to earn respect. Though roughly equal numbers (just over half) of men and women surveyed reported having concerns about their dress and appearance, the types of concern differed. Men tended to report that they shave, wear a shirt with a collar, and perhaps add a tie. Women worried about being in style, about their accessories, their figures, their hair and make-up, and the complex messages their clothing conveyed.

For women it can be a challenge to look well-dressed yet not convey sexual messages. ‘Dressed up’ often means dressed feminine, or even sexy. But professional image is intended to convey competence, not sexuality – and sometimes not even femininity (Tannen, 1994). At the same time, clothing must be practical, suited to the work students will be doing on the wards. Judging from comments written on the surveys, some women find striking this complex balance a struggle.

- Like to look nice, but don’t want to appear too trendy or provocative.

- Is it professional enough? Competent looking? Will it be too hot on the wards? (I have fainted). I do not want to appear ‘sexy’ on the job.

One interviewee commented that when men dress unprofessionally it is not “as bad,” since it usually entails wearing their hair overly long or wearing hiking boots on the wards. She has “more of a problem with some of the women in the class. Because I truly think that some of the dresses are a little too short, and that’s really not professional.”

So, on a daily basis women need to be conscious of creating an impression lest they be
dismissed as too feminine or unprofessional. Women must work to fit in, while men do not seem to have to.

One of the surprising ways in which gender emerged as salient was that six out of fourteen women do not tell people they are medical students. They tell people they are in sciences. In fact, two women questioned whether they will even be able to have people call them Doctor when they have completed their training. In all six cases the women seemed uncomfortable with the automatic respect or social status that accompanies being in medical school. They disliked being “put on a pedestal,” or seeming “almost like you’re bragging.”

Becky: I don’t bring it up unless people specifically ask. And in fact, like if I meet somebody I won’t ask them what they do because then they might ask me what I do. . . . I guess maybe – maybe it’s arrogance! In that I believe being a medical student might be intimidating . . . like a status thing. So maybe I’m being, like, high on my horse by even thinking that that’s what people would assume by saying it. Do you know what I’m saying? But I do sort of make that assumption that it might be intimidating. It might sort of make people feel like, ‘Oh, well, she’s a med student, and I work at the Gap.’ You know?

I am left with the impression that the women worry about being perceived as aspiring beyond their ascribed status in life. As Roxanna Ng suggests, authority is seen as incompatible with femininity; to be a woman is to be denied authority, to take authority is to deny womanhood (1991: 103).

Alternatively, the women students may want to avoid being seen as immodest (and therefore unfeminine). Deference to men has traditionally been a part of femininity – a tricky accomplishment for women in training for a powerful position. In the same vein, four women mentioned fears that they have put themselves outside of the relationship/marriage market by entering medicine. “Women tend to marry up, as opposed to down,” as Lily said. Who is left for women physicians to marry above them? More to the point, if men tend to marry down (entrenching their own status as

12 And all of the students who said they do not tell people they are in medicine were women; in other words 6/14 women (43%) and 0/11 men (0%).

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the higher status one in the partnership) what men are going to feel unthreatened by a woman physician? This is a growing concern for some women students.

A few faculty members suggested there is a lingering societal assumption that the doctor is a man. This perception may even, paradoxically, be shared to some extent by the women medical students. It may be reinforced by the fact that they are less likely to be called doctor by other health care staff or by patients, as was discussed in Chapter 4. Again, this is an important aspect of coming to self-identify as a physician. In addition, women students and clinicians are still often mistaken for nurses.

Dr. O.: Some of the old folks still keep calling them nurse. 'I wanna see the doctor.' 'I am the doctor.' 'No, nurse, I want the doctor.' So the doctor has to be a male, of course.

Two of the male students suggested the dominant assumption that a doctor is a man facilitates their establishing rapport with patients and may ease their relationships with those above them in the medical hierarchy.

Mark: I'm white and male which is the stereotypical medical student for the last four hundred years really. And most of the professors that we have are white and male. But it's hard to tell how much that helps.... Perhaps I do bond better with the students and the residents and the staff members, just because I come from the same background as the other doctors do. That's a really tough one to tell. ... I've often felt, though, because I fit like a stereotype white male, that patients might see me as a bit more trustworthy. A bit more what they'd like to see. Who they want to see.

Perhaps as a consequence of this lingering societal assumption that the doctor is a man, women may feel a need to act more authoritatively or appear more professional in order to be taken seriously.

Dr. T.: The women in the group [of students] tended to feel that they had to be sort of hyper professional and so on in order to be taken seriously.... I think that probably female physicians in order to look like physicians – whether that's authority or whatever that looking like physicians or being like physicians is – I would suspect they do have to be a little more self-conscious of it in part because in our society it is a relatively growing role.
Certainly women in medicine appear to have a more problematic relationship to authority. One clinician suggested that women have a less authoritarian style, tending to use a more collaborative form of leadership that he thinks benefits all of medicine. When they talked about their own practice styles, the women physicians expressed considerable ambivalence about the issue of authority. They discussed the status or power associated with becoming a professional more than did men, and seemed to have more mixed feelings about it. One woman talked about a trend among GPs toward arranging office furniture in non-hierarchical, non-threatening ways. As a woman this conflicted with safety for her.

Dr. E.: You know those of us who were early lady doctors in general practice – there was an aspect of sitting behind a desk that deliberately placed a barrier with intent. And there were times when I was glad that I had a desk.

Others agreed that the growing trend toward non-hierarchical relationships with patients carries particular risks for women doctors who may be interpreted as ‘coming on’ to their patients. Whether or not to wear a white lab coat, whether to be on a first name basis with patients, whether to touch a patient in comfort, whether to mention one’s own children to the mother of a sick child, where to draw the line between caregiving and nursing duties, how much to ‘identify’ with the patient – all of these seemed to be more problematic for women than for male clinicians and students.

At the same time, it may not matter what approach to authority a woman medical student or clinician chooses to take; she still may not be seen as being as professional or authoritative as a male counterpart would. Authority is not chosen, it is granted by others. Men may be automatically granted authority and status – in part because they match the societal expectation of what a doctor should be, as well as because of their medical knowledge and skills – while women have to earn authority.

One of the most obvious effects of gender differences is in students’ choice of future career directions. At the point when I surveyed and interviewed students, late in
their third year and into their fourth year, they were making crucial decisions, choosing their electives for fourth year. They want rotations in any field they are considering for residencies as early as possible in fourth year, so they can make up their minds and get good references. So in late third year residencies and career directions were foremost in students’ minds.  

Two-thirds of the students were considering family medicine as one of their options (see Table 6.1). The other most common choices were internal medicine, paediatrics and “other surgical.” Relative to their proportions of all survey respondents (50%), women were under-represented among those who were considering entering anaesthesiology, all surgical fields, and internal medicine – all highly paid specialties. Women were over-represented among those considering obstetrics and gynecology, psychiatry, family medicine, paediatrics, some of which are the lowest paid fields of medicine.  

<table>
<thead>
<tr>
<th>Postgraduate field</th>
<th>% of all students considering as one of their options</th>
<th>Of those considering it:</th>
<th>% women</th>
<th>% ‘minority’</th>
</tr>
</thead>
<tbody>
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<td>40</td>
<td>20</td>
<td></td>
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<tr>
<td>Family medicine</td>
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<td>36</td>
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<tr>
<td>Paediatrics</td>
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<td>Psychiatry</td>
<td>19</td>
<td>57</td>
<td>21</td>
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<td>Of all respondents</td>
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<td>50%</td>
<td>29%</td>
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13 At the time of the survey, only 23% of respondents had narrowed their choices down to one field for their residencies; another 32% were considering 2 possible areas; and 19% had narrowed it down to three. However fully 25% listed 4 or 5 options they were still considering. Many students mentioned having to choose a specialty as the most stressful thing in their lives.

14 Students who identified as members of ‘minority’ groups were under-represented relative to their proportion of survey respondents (29%) among those considering entering anaesthesiology, psychiatry, family medicine, and paediatrics. They were strongly over-represented in the groups considering internal medicine, and somewhat so for obstetrics and gynecology. See Table 6.1.
Faculty speculated on why some fields might continue to disproportionately draw men. Some argued that gender is really not an issue any more.

Dr. M.: The opportunities are there. . . . The good student, whatever their sex, the really top student will get their choice. . . . I don’t think sex is an issue. . . . I’ve had students who’ve wanted to do something and will apply for it. You know, they want to do Plastic Surgery or Orthopedics or— . . . I see a change in the numbers, I mean, I think there’s much more equality in some of the specialties. I think that’s all going to be broken down over the next few years. I don’t think you’ll see a difference.

There was a belief shared by some faculty that if there are no active moves to keep women out of specific specialties, then there is no gender issue to discuss.

Other faculty members talked about a lack of female role models for women making it harder for women students to identify with specific fields. Some fields have relatively greater flexibility of hours, lighter call-schedules and possibilities for part-time work, facilitating women’s desires to practice medicine and raise children. Some residencies are more accommodating of pregnancy issues and family issues. One surgeon claimed, “There isn’t any social factor preventing [women] from being a surgeon.” However he then went on to detail the material factors identified to him by a female surgeon that make surgery more difficult for her than it is for many men.

Dr. I.: Because the image of a surgeon was a tall, big man, everything is designed to that proportion. Like the operating tables, even the clamps, the instruments, the things. Everything is for a man’s hand. And when a small woman, with small hands, is in the OR, it creates physical problems. She’ll say, ‘I need a stool to step on,’ so the nurse now has to do another thing, that she is not scheduled to do in a hectic situation. The surgeon is saying, ‘Take this clamp off.’ And she cannot – it’s too big for her hand. . . . Because she cannot take the clamp off the surgeons are screaming at her. . . . And then the nurses say, ‘Whoa, she’s scrubbing again,’ you know. Like it’s trouble.

Surgery was clearly identified as one of the remaining male-bastions. Dr. E. recalled from her student days a highly-gendered climate in surgery: “the men made it quite clear that it was a man’s world” quite apart from the struggles she had being
female and physically small. Several women students named surgery, particularly the surgical sub-specialty of orthopedics, as ‘no-woman’s’ land.

Becky: I do have some frustration with some of the specialties, mainly men wanting to go into them still. And men in them. It's still fairly intimidating for females to go into them. It's really sort of old-school, very male oriented, a boy's club. And I think that as a female I wouldn't cope well in that. I don't want to do surgery so it's not a deal for me, but I have a friend who's just started orthopedics in [another city] which was a real coup for her. But she's just different from me. For it even to bother her, which she's mentioned to me already, is something. Because she's fairly resistant. She can hold her own really, really well. . . . Lots of guys, if there's a woman there they won't do their usual jokes and banter between them. Or if they do do it, then you have to stand there and listen to it, which I wouldn't really want to either. The attitudes change when, you know, a woman walks in to the clinical setting, if it's been all males before that. . . . I would have been intimidated by it, it would affect me.

In addition, several women had ruled surgery out as a residency option because they could not see how it would fit with having a family. The long hours and intense call schedules do not easily mesh with being a primary family caregiver. Though one male surgeon described a woman surgical resident who had children during residency, he went on to suggest women either work incredibly hard, give up on family, or give up on careers such as surgery. Expecting to combine surgery and family, as men do, is unrealistic for women – sacrifices must be made.

Not surprisingly, then, men and women take into consideration somewhat different things in making their career decisions. For 89% of men, their gender was not an important consideration when choosing their future specialty; for 43% of women it

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No one seemed entirely clear on why surgery is organized such that it has unusually long hours and intense call schedules.

He was not necessarily advocating this, but seemed to readily accept it as the reality. "I think it's a question of whether, you know, what you want to do and what your priorities are. And if family life is something that's going to be really important to you, then you know that you may have to make the sacrifice of not doing something else that you also might wanna do. But if above everything else you really want to do Orthopedic Surgery, then your spouse is gonna help you, support you in that. Or you might, you know, you're not married. That's fine. . . . I don't think it should be a surprise that the female students are thinking twice about some of the disciplines that may restrict them in doing other things that they wanna do in their lives.

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was an important or very important factor.\textsuperscript{17} The relationship between gender and the impact of gender on specialty choice was strong and highly significant (Phi= 0.54, p=0.0003; Lambda=0.26, p=0.02). On average, the importance of gender to specialty choice was double for women (mean=2.9) compared with men (mean=1.5) (F=27.6, p=0.0001).

Women also rated “having or not having children” as a significantly more important factor in their choice of specialty than men did. The mean score for women was 4.1 compared with 3.2 for men (F=7.6, p=0.007).\textsuperscript{18} Women rated encouragement from others as more important (mean=3.7 compared with male mean=3.0, F=5.9, p=0.02) and potential financial rewards as less important (mean=2.3 compared with male mean=2.9, F=4.9, p=0.03). Lastly, marital or relationship status was a slightly more important consideration for women (mean=4.1) than for men (mean=3.4) (F=5.4, p=0.02).

In the interviews virtually every woman talked about trying to fit career and family life together, and how that guided them away from some specialties and toward others.

Nancy: I worry about balancing my family life. I worry about when I’m gonna have children. How I’m gonna put my children and my husband into a career which is a full-time career. With him having a full-time career. And I don’t wanna have children who know their nanny better than they know me. And I’m in that position that I think a lotta women are in, of wanting to be able to do it all and feeling inadequate when you can’t. Wanting to be a full-time mom and have a nice house and be able to keep it up and do the grocery shopping and do the laundry and still work full-time and be there for all your patients and also be a good wife to your

\textsuperscript{17} Students indicated the importance of a range of factors to their decision-making about residencies. The complete list with the rankings of importance is in Appendix V, Table A.5. Most important were individual traits and factors related to the job or its setting. The most important social characteristics were marital/relationship status, and parental status – whether or not the student has or plans to have children. Religion, social class, ‘race’ or culture, and sexual orientation were not important considerations for most students. In the middle though, are a series of factors that had mixed importance.

\textsuperscript{18} Women were also significantly more likely to indicate that they want to have children after they finish medical school (Phi = 0.5, p=.003; means 4.3 and 3.8, F=3.8 p=0.06).
husband. And I know something's gotta give there and I'm not sure where it's gonna be. And I hope it's not my children.

Women anticipate significantly more difficulty combining career and family. Women were almost twice as likely as men to strongly disagree with the statement: "If I choose to have children (or already have children) I do not anticipate many difficulties combining a medical career with a family." 19

Finally, as with racialized differences, any difficulties associated with gender differences were described by most as temporary. Whether choosing gendered specialties, or not being granted the authority due to male colleagues, or facing harassment – the final response seems to be, "that will change with time." One male clinician suggested that women are reaching a critical mass in medicine, and that soon "those who rise in the hierarchy will not necessarily have to be those who adopt the ways of thinking of men." But things aren't changing anywhere near fast enough for some women faculty.

Dr. V.: We've had 50% women since 1977 or something. And what's astonishing is that it's been that many women and yet the women haven't made as much impact as I would have thought on the culture of the class.

Again, as was the case with racism, I am not trying to claim that women face extreme sexism in medical school. A few women had been sexually harassed, but I am trying to highlight the more subtle gendering processes that construct the role of medical student or physician as more suited to a man than a woman. Women have to struggle to look competent yet feminine, have to temper their pride in being in medicine with feminine modesty, have to win authority granted readily to men – though that very authority may come at the expense of their femininity. The women students (and physicians) are expected to be feminine and expected to be competent

19 The mean for this variable was 2.0 out of 5, with men at 2.33 and women at 1.67. Women then were almost twice as worried about combining parenthood and career (F=7.0, p=0.01).

... 199 ...
professionals, when professionalism has traditionally been defined in terms of men and masculinity (Harris, 1995; Tang & Smith, 1996).

Inasmuch as fulfillment of the feminine role in our society means marriage and family, the women students are caught between being doctors or being women. Women today still do the majority of the housework and childcare (e.g., Lorber, 1994; Luxton, 1980; Luxton & Rosenberg, 1986). Whereas being a good husband and father can be achieved by working hard and bringing home a good paycheck, being a good wife and mother entails cooking, cleaning, and caring. While very few male students had even thought about how they will combine career and family, women students were very concerned about how a professional career would fit with expected feminine roles.

6.2.3 Sexual orientation / Homophobia

The experience of being identifiably gay or lesbian in medical school seems to depend a great deal on the dominant ‘tone’ of the class you are in. It varies from year to year. One clinician described a lesbian student being isolated and somewhat ostracized once she was ‘out’ to her classmates; the following year a gay student “came out to his whole class and ... felt very included in his class and finds that it’s an extremely supportive environment.” An out gay student the next year again felt isolated.

The two faculty who identified as gay said their sexual orientation had been a source of difficulty and marginalization for them in medical school. They had to decide how ‘out’ to be, and how much to suppress that part of their identities. They both see gay and lesbian students today facing similar struggles. The one gay student who responded to the survey noted that his sexual orientation is a source of great stress.

Survey respondents indicated their agreement or disagreement with the statement: “Students who are gay or lesbian face no distinct problems at medical school.” The mean was 2.5 out of 5; a quarter were neutral, and 23% thought being gay or lesbian at medical school would not be a problem, while 54% of respondents thought
gay and lesbian students face particular difficulties in school (survey N=72). At the same time, when students were asked whether gay and lesbian medical students should remain ‘closeted’ at school, 85% said no. So gay students do face difficulties, but nonetheless they should be ‘out.’ Students seem to be indicating that there is a fair amount of homophobia at medical school, such that it is not a safe place for gays and lesbians to be out, but that they themselves are not homophobic nor do they condone homophobia.

Again, as with racism and sexism, the dominant ideology in our society is one of tolerance for gays and lesbians. Liberal individualism understands equality as the absence of overt violence or discrimination. Equality is achieved once equal opportunity is available to all. So the dominant attitude is one in which gays and lesbians should be free to be themselves (particularly in private) but there is no need for anything to change in ‘mainstream’ society. Again the processes are less those of hostility and exclusion than those of marginalization.

One source of homophobia is other medical staff and clinicians. One physician indicated that locker-room type jokes are common.

Dr. Q.: There’s a lot of you know comments, behaviors, and sort of locker room jokes that are made that really can let you know that you’re not sort of perceived as, as equal. And it takes a very strong personality as a medical student to say, ‘Excuse me sir, but that was an inappropriate comment.’

Students also indicated that jokes about gays and lesbians were fairly common. If you hear homophobic jokes from an attending clinician you hope to get a good reference letter from, you are unlikely to feel safe disclosing your homosexuality.

Another source of homophobia that gay and lesbian students have to face is patients. While there are some sanctions for health care staff who are formally accused of making harassing comments, students have no recourse if the comments come from

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20 See footnote #8 in this chapter for details on types of offensive jokes.
patients. One clinician (male, did not identify as gay) indicated that students just have to learn to handle it.

Dr. F.: As a physician you will be told the ‘F-word’ [fag]. You will be also told that you’re gonna get punched if you don’t leave. And if you’re gay or, you know, of different orientation, they might tell you, ‘Hey, you take it in the ass and I’m not gonna talk to you.’ It will happen. And I think it’s part of their education – how to deal with it, you know.

Again, like the surgeon’s comments about women simply needing to accept that surgery and family don’t mix well, this strikes me as a too-ready acceptance of the prevalence of homophobia. And as with the assumption that racism is only perpetrated by “dinosaurs” it avoids the responsibility for challenging homophobia. Students are told they simply have to learn to cope with it.

Certainly students face some degree of homophobia from their classmates, as well.21 One heterosexual student raised the issue on her own, commenting on the high level of homophobia in the school. Two students were aware that their heterosexuality is an advantage, commenting that it would be difficult to be gay or lesbian in their class.

Robin: I see huge homophobia. Okay, I’m not gay, but out of a hundred and twenty people, statistically there’s gonna be a few gay or lesbian people in my class. And no one will admit to it. . . . They obviously don’t feel comfortable saying that, and why not? It’s a sad thing. One of my colleagues in first year had someone scribble ‘fag’ on his nametag on his desk. . . . I think it does relate back to not wanting to stand out in any way. I think it’s seen as a don’t rock the boat situation, and that any boat-rockers will be frowned upon. . . . I think people try to avoid standing out in any way and I guess one way to stand out is to be gay.

As one clinician pointed out, it only takes a few instances such as that described by Robin to have an effect. Even if only a few students are vocally homophobic, that may be sufficient to cause the gay and lesbian students in the class to feel unsafe.

21 Whether the level of homophobia in medical school is higher or lower than that in the rest of the society is not the point. I am not attempting to make a comparison, nor to say that medical school is a distinctively homophobic place. I am simply arguing that students who identify as, or are identified as, gay or lesbian have distinctive experiences in medical school in part because they have to deal with homophobia from patients, staff, faculty, and classmates. It makes their experience of school different from that of students identified as heterosexual.
The one gay student I interviewed described an ongoing low-level heterosexism that sometimes crossed over into homophobia.

Jason: With respect to my sexual orientation, that was very difficult... What I've experienced is a lot of— not overt homophobia, well, a little overt homophobia, especially by a vocal sect in the class. I'm more or less out to some people in my class, but they also understand that there's a lot of homophobia within the context of that class, too. So I'm very careful about who I do come out to. So I feel inhibited that way. Like, if somebody talks about what they did on the weekend, I don't say, 'Well, my partner and I—'. Within the context of the teaching faculty, there's some homophobia. And, again, it's just underneath the surface. They never come out and say it, they're always politically correct, but you know it's there. Fellow students, I guess that's one of the reasons why I also felt more distant from a lot of people in the class... if I did party, I'm not gonna tell them that I went to one of the gay bars.

A student who identified as heterosexual informed me that the buzz around his class after I had administered my survey was that it was full of questions about gays and lesbians. He claims many students were turned off by the survey and neither completed it nor volunteered for an interview. In addition, a few students scribbled in the survey margins beside questions on sexual orientation comments such as, "Damn I'm sick of this question! Not everyone is limp-wristed!" and, "A few less questions about gay/lesbian/bisexual etc etc would be nice. Who cares?" Taken together these individual responses suggest some degree of discomfort with homosexuality. To be clear, no one seemed troubled by the number of survey questions about religion or social class, or any other social variable. In conjunction with the description by the gay student above, the overall picture suggests a kind of low level denial of and intolerance for gays and lesbians disrupted by occasional more blatant incidents.

One student's impassioned reaction to how the medical students are "hit over the head" with equity stuff about gays and lesbians illustrates what I would call intolerance. She stated that while issues of sexual orientation "never come up" among the students themselves they get "lots, lots of lectures about it." According to her, students' reaction is to "roll their eyes."
Maureen: The majority of people of my class don’t really care one way or the other. That [the existence of gays and lesbians] is just a fact of life living in Vancouver. And if you have problems with that you shouldn’t be living in the city much less being a medical student. . . . I just think it’s annoying that we waste – there’s things that we waste a lot of time doing. Like, not that sexual harassment or orientation lectures or things like that are a waste. But, to spend 10 hours doing them when 1 hour was sufficient . . . I guess the thing is too, it’s just not an issue for me. I don’t have a problem with that. So, for me those lectures aren’t necessary.

One of the things this instance illustrates is the hegemonic status of heterosexuality. Maureen never thinks to question whether her sexual orientation might be a problem for any of her patients. In the style of true liberal individualism she believes that if she is ‘okay with’ some of her patients being gay that is all that can be expected of her. She does not need to learn anything about gay or lesbian culture, or attempt to understand the lives of her gay or lesbian patients, nor does she need to examine the potential impact of her own heterosexual orientation on the assumptions she brings with her into encounters with patients.  22

Finally, even if gay and lesbian medical students were comfortable being open about that aspect of their identities in the context of their particular class, they may still have (justifiable) concerns about what happens if the head of a department finds out, or the person they need references from to get into a particular residencies. One gay clinician described a student coming out gradually by third year of medical school, "then slipping back in, in fourth year, because he was afraid – and, I hate to say it . . . my feeling is that he’s probably right. If he were gay and out he probably wouldn’t get into a surgical residency."  23 Other faculty members agreed that being out as gay or lesbian could be costly in terms of desired jobs. One suggested that even if the risks of

22 She also assumes gays and lesbians do not live in small towns.
23 As we saw in Chapter 2, surgery is perceived to be one of the least hospitable environments for women and for gays and lesbians; there is also some evidence that this is accurate. Throughout my study I was told there is a “type” of student who enters surgery – male, big ego, perhaps somewhat arrogant, a bit full of himself. In addition, surgery is a highly competitive field, hard to get into, so presumably a student would not want any unnecessary strikes against him in applying.
being out are more perceived than real, "you’re giving up an awful lot if you’re wrong, if you feel that, ‘Gee they would accept me,’ and find out they won’t.”

It is also possible that sexual orientation may influence residency choices, at least for some gay and lesbian students. One clinician who identifies as gay remarked that he sees students trying to identify which fields might be most comfortable and safest for them as 'out' gays and lesbians. Another clinician who identified as heterosexual suggested that it would be very risky to be openly gay or lesbian if a student wanted to get into one of the more competitive specialties. This is supported by research evidence that found though two-thirds of residency program directors for family medicine held positive attitudes toward gay men and lesbians, nonetheless 25% would rank gay or lesbian applicants lower in residency competitions (Oriel et al., 1996). Thus, students' fears that disclosure of their homosexuality might reduce their chances of getting a desired residency position are well-founded.

The contradiction for gay or lesbian students is that the more students suppress their gay or lesbian identities, centering their lives in heterosexual communities, the easier it is to 'pass' as heterosexual and fit in at school. At the same time, the stronger their ties to a gay or lesbian community, the more support they have for that part of their self-identities and the easier it is to hang onto that aspect of self – and possibly even to challenge inappropriate comments or behaviours encountered in the school. The problem is, these two approaches are completely contradictory, leaving the gay or lesbian student caught in the middle.

Everyday heterosexism and homophobia, like everyday racism and sexism, is not necessarily life-threatening, though gay and lesbian students can never know whether it may be accompanied by a more virulent homophobia. From the simple assumption that everyone around you is heterosexual, to teasing about (hetero)sex at school social gatherings, to laughing at or making homophobic jokes, to not challenging homophobic remarks, to refusing to rank residency applications from openly gay
students (see Chapter 2), again the process of constructing and maintaining the hegemonic status of heterosexuality is one of constant repetition of numerous small practices. The cumulative effect on gay and lesbian students is a message that they must either not be fully themselves, or accept that they will never really fit in.

6.2.4 Social class background / Classism

In terms of social class, there was fairly widespread agreement that children of doctors are often better prepared for what to expect in medical school, making things a little easier for them. They may adopt their new student-physician identity more readily.

Dr. D.: A partner of mine, his son who went to medical school struck me as being very ‘physicianly’ even as a student, you know. Almost overly so.

In contrast, people whose backgrounds are not upper or upper-middle class may have a harder time fitting in, or feeling understood by their classmates. Two clinicians said they themselves never fit in during medical school, and they continue not to fit in. Both came from working class families.

Dr. V.: While I was growing up we were really poor to the point of being hungry. . . . I learned to identify with the disadvantaged. Because I understood it. That was my identity. I certainly didn’t identify with the privileged. And most people if not all in my medical school class were privileged.

Dr. P.: [One] reason that I had a very difficult, very different time is that I come from a working class family, the only person in my extended family to finish high-school, to go to university. . . . That puts me in a very different spot than the upper middle class white male, whose father was a doctor, who liked the medical school, who was part of the ‘in group’ at the school and who is now part of the ‘in group’ as faculty.

And in fact when students rated the extent to which they feel they fit in, on a scale from 1 (not at all) to 7 (completely), working class students had a distinctly lower mean score (mean =4.7; population mean=5.4), though the difference was not significant (p=0.3).
Poor and working class students were somewhat more likely to say their class background had a negative impact during medical school (Gamma=-0.42, p=0.005). 

When survey respondents were asked to indicate whether “students who come from upper class backgrounds find it easier to fit in during medical training,” 45% of the respondents disagreed with this statement, while another 31% agreed that being from an upper class background makes it easier to fit in. There was a clear relationship to the class background of the respondent, with working class and poor students indicating most strongly that being from an upper class family facilitates fitting in (mean=3.5, difference between groups p=0.08). In other words, upper and upper middle class students tend not to see that class matters, while working class students believe that it does have an impact. Upper and upper middle class students were most likely to agree that the majority of their social time is spent with other medical students (mean=3.2 out of 5), lower middle class students were less likely to agree with this (mean=2.6) and working class and poor students less likely still (mean=2.0). 

Students’ written explanations for why they do not feel they fit in also indicate that class background makes a difference.

- I have a part-time job which sets me apart. My friends are outside of school.

- I cannot relate to many of my classmates who come from very wealthy, Anglo-Saxon backgrounds.

In describing ‘cliques’ in their class, a substantial number of students talked about the ‘elite’ students who come from wealthy families and upper class backgrounds as one of the distinct subgroups they see in the class. There was a substantial number of comments in the survey and interviews about “rich doctors’ kids” whose parents buy them condos near the hospital and give them expensive cars. This points to some social-

24 The mean score for working class and poor students was 3.9 compared with 4.1 for lower middle class students and 4.7 for upper and upper middle class students (ANOVA F=3.7, p=0.03) where 1=very negative impact and 7=very positive impact.

25 Analysis of variance shows the difference between groups is significant F=3.8, p=0.03.
class based divisions within the class, and indicates a certain amount of resentment about these differences.

Finally, the construction of a professional appearance, which as we saw in Chapter 4 is part of building a professional self-identity, may be more problematic for students from working class or poor family backgrounds. In part this is simply an issue of money; students mentioned their inability to meet the costs of ‘dressing up’ for the wards. But in addition, if ‘up-scale’ or professional style of dress was not taken for granted in students’ homes when they were growing up, they may be less likely to feel comfortable dressing that way as adults.

- I worry about not appearing ‘formal’ or ‘professional’ enough, as my background has never involved wearing dressy clothes.

When interviewed one working class student said she finally felt like she belonged in medicine when she worked in a clinic in the less-affluent side of the city, where she could just dress as herself.

Janis: I had the thrill of my lifetime at the XXX Clinic. I could just dress like what’s in my closet and not feel bad about it. And I could talk my natural way. And I totally fit in over there.

She went on to describe a social gathering at the home of one school administrator where she felt completely out of place, not knowing where to sit, or how to interact, what fork to use or what kind of small talk was appropriate.

Janis: I didn’t feel comfortable. Other people who were there, they were comfortable in that house. I wasn’t comfortable in that ... expensive house.

One British clinician was surprised when I asked about social class, commenting that he rarely hears the term in Canada. Canada is assumed to be a classless society, anyone can make it to the top if they work hard enough. Unlike our neighbour to the South the extremes of poverty and wealth here are mitigated by the redistributive aspects of our social welfare system. Universally accessible student loans mean university education and subsequent upward mobility is available to all. But social class
is not just about money. Class also operates on the more subtle level of cultural capital that Janis alludes to: knowing the right people, being able to make the right sort of small talk, having the right hobbies and playing the right sports, knowing the right fork to use, and having the right clothes, accent and demeanour. In all of these ways working class students may be marginalized. They are not excluded; they can gain entry to medical school and thus enjoy formal equality. But they may never feel they belong there, enjoying substantive equality. One clinician was moved to tears during our interview when she recognized that the extreme isolation she felt as a working class medical student has never really lessened.

6.2.5 Age differences / Greater maturity and clarity

When students were asked to identify any distinct subgroups or cliques in their class the most common distinctions were based on age and activities. Most students distinguished between older and younger students, though some added in a third category in the middle, as the student below does:

- The ‘90210’s’, young, attractive, outgoing, popular, party crowd. The ‘moderates’ – somewhat older, more life experience, more laid back....
- The ‘elderly’ – older students who have come back to do medicine.

In particular this class was seen as having a distinct clique of “younger, hipper” students who are “richer, good-looking,” and “trendy.” They were widely referred to as “the 90210 crowd” after a popular television show about wealthy, beautiful, young college students. In contrast “the elders” were seen as “more mature and experienced.” Some students associated this group with being academically inclined, keeners, or brains, in contrast to the social and athletic groups, and/or the partiers.

Older students also indicated that they feel they fit in slightly less well than others, though the age difference was not statistically significant. Their written comments to explain their self-rankings of how well they fit in in medical school indicate that age is a factor for some students.
• I feel older than average and I do not get involved with many within-the-class social activities.

A few faculty members also thought older students sometimes feel a little distant from the younger classmates, just don't quite fit in. Scores on a scale designed to measure the degree to which students feel connected to others in medical school\(^{26}\) showed a fairly clear inverse relationship to age with the youngest students feeling most connected (mean 8.3 out of a possible 15) and the degree of connectedness lessening with age to the 31-35 year old group (mean 5.5).\(^{27}\)

Faculty cited greater maturity as the most obvious benefit of having older students in medicine. Older students may be more willing to work hard, more certain about being in medicine, more willing to question aspects of their training. Some suggested older students have had previous exposure to the realities of life and are less likely to be shocked: "When you're a rookie first-year resident and living with your parents . . . in a sheltered environment, you're shocked by what you see." Older students may also have an easier time making the sorts of transitions that are necessary to become a full-fledged professional. One clinician argued that they enrich the whole class, with their "broad and interesting backgrounds."

One clinician stood out for countering the general approval of older students. She argued that it is largely a negative trend to admit increasing numbers of older students. Not only do they have a shorter career ahead of them, but they also have more difficulty while in school – as do their teachers. They have too much prior knowledge and experience that they need to let go of in order to start learning to be a physician. This clinician thinks younger students who are more of a blank slate have an easier time.

\(^{26}\) See Chapter 5, footnote 11 for the details of the "connectedness" scale.

\(^{27}\) The oldest students did not fit the pattern, feeling more connected than many others. Keep in mind that there were only 2 students in the over-35 group. Age differences did not reach significance (p=0.2).
Dr. E.: I prefer getting the student who's got a clean mind on which you then write. And if you get somebody who didn't really do anything else that's the way it is. You get people who have had previous lives, previous careers, previous knowledge, they will not empty themselves to start medicine fresh. So that some of them have to overcome certain things. They have to re-orient themselves, their thinking, their lives and I think that causes troubles... [for] the student. And for the rest of us who are trying to behave in a manner we wish them to behave.

She went on to say that the lifestyle attached to medicine is unlike all others, and if you have become used to a 40-hour work-week it is hard not to resent the extent to which medicine takes over your life. "If you get a young person, they don't care. This is the way it is, they have nothing else to relate it to." In addition memorization is often harder for older students, and they may not be able to handle sleepless nights the way a 23 year old can.

Two other faculty members agreed with her observations but disagreed that the problem is one of age. They argued that students who have been professionals in some capacity, particularly health-related professionals such as nurses, pharmacists, physiotherapists and so on, have particular difficulties making the transition into their new role as medical professionals. Their prior accustomed relationship to patients interferes with their ability to learn a new and different relationship to patients, as well as to other health care professionals.

Dr. L: Being a nurse means that you work as a nurse and you have the mentality of a nurse. And now you're becoming a doctor with the mentality of a nurse – in the hierarchy, you're confused... [A] nurse that's worked for five years in the ICU or a pharmacist who worked for ten years in a pharmacy, these are very formed people, you know. And to change them around is, of course, challenging.

Of course having been a professional for five or ten years would imply the student is older than the average medical student, so the intersection of age and prior professionalism may be more complex than these faculty members imply.

Students tended to agree with the majority of faculty, that being older upon entry was an overall advantage in medical school. Students of average age tended to
think age made no difference to their experience of medical school, while older students were slightly more likely to think their age has had a positive effect, and the youngest students were slightly more likely to say their age has had a negative effect (Gamma=0.29, p=0.06). In terms of how they think about themselves day-to-day, the older the students the more important their age was (Gamma=0.44, p=0.002). For younger students, the importance of age had declined slightly since entering medical school\textsuperscript{28}, while for older students it had increased in importance slightly, especially for 31-35 years olds (F=2.4, p=0.06). In general, then, being somewhat older seemed to be a positive thing, though it did mean students tended to fit in slightly less well, and may have been regarded as less effective students by a minority of faculty members.

6.3 Difference as a Site of Resistance to Conformity

We have seen that there is still a great deal of pressure towards conformity in medical school. The socialization processes that are part of becoming a doctor generate similarity. From dress, to language, to social activities, to thought patterns, to lack of time – students face similar pressures and similar experiences and move toward a certain homogeneity. Social differences such as ‘race,’ gender, social class, sexual orientation, age and so on are largely ignored or their impacts are denied. The tendency is toward assimilation or invisibility.

However, it appears that who you are going into medicine makes a difference to your ability to resist some of those pressures toward conformity.\textsuperscript{29} The clearest difference revolves around age, but some other social distinctions also seem important. Most (though not all) of the older students I interviewed seemed clearest about who they are and what they want their lives to be about. They seem most able to keep

\textsuperscript{28} Again see Appendix V, Tables A.3 and A.4 for details.

\textsuperscript{29} There is some support for this finding. Shapiro and Jones (1979: 243) report that one study found medical residents most able to resist socialization pressures entered their education programs with a “relatively strong and well-defined orientation;” minimized their contact and interaction with others in medicine; and maintained outside relationships that supported an alternative orientation to the program.
medicine in perspective, to insist on their right to do medicine and medical school differently. Being older can mean having explored other things and made more conscious decisions to enter medicine, knowing well what the alternatives entail. It can mean being more fully aware that medicine is not the only thing you could do, and that there are other things more important in your life. And it can mean having a more stable life outside medicine, and more confidence in yourself and your abilities.

Denise: Having had a bit of a life outside of medicine has helped . . . For example, I'm not nearly as strategic, if that's the right word, as some of my classmates who are always positioning themselves to get the best residency or whatever. At this point, there are a lot of things that would make me happy and I don't necessarily have to get at a residency at Harvard to do that. And other people who have only ever focused on goals in medical school have a lot more stress to have to study hard, and have to do everything right, and please every preceptor, and I don't feel that stress either.

Other social differences that mean you will never quite fit in with your peers also seem to make it easier to resist medical school pressures toward conformity. For example the one gay student in the sample holds back large parts of his life from his school colleagues, knowing it is not always safe to express himself there. It is easier for him to see the importance of maintaining connections to people outside of medicine, since he is not usually free to be totally himself in medical circles. He cannot completely conform, so he evades some of the pressure toward conformity.

Social class background also seems to be a strong basis for resistance to a uniform image of medical student. Students who came from working class backgrounds, or who came from poverty, appear to have a fairly sustained anti-elitism that keeps them from fully identifying with other physicians. A common characteristic of working class communities is dismissal of 'book-learning' and heightened respect for 'life experience' (Dunk, 1991). Three working class students said they are not seen as particularly praiseworthy within their families – if anything they are somewhat suspect. That seems to help these students keep medical school in perspective; they retain an...
anti-elitism that prevents them from wanting to completely identify with other medical
professionals. Janis came from the “wrong side” of Main Street, and wants to stay
affiliated with that side, the poorer side, of the city. As we saw above, she feels
uncomfortable with the social functions at school, where it becomes clearest to her that
she does not, and never will, fit in: “Let’s just say I don’t share Dr. XXXX’s interest in
yachting in the Caribbean (laughing). You know what I mean?” She sees herself as very
different from her classmates, and never wants to be “a proper med student.”

Similarly, Lance described himself as less impressed with authority, more
confident and willing to take risks than most of his classmates. And he is strongly anti-
elitist in his approach to practice.

Lance: (laughing) I think I’m very much different from my classmates... more outspoken, definitely. I mean, if I don’t like something, I feel I’m paying tuition and something should be said. ... Where other people tend to say the right thing because they’re a little afraid of the consequences. I don’t care. ... It comes from my background, you know, fishing. I’ve seen these tough, hard guys, think they’re pretty something, but they’re puking their guts out being seasick. So, I mean, it kinda reduces us to the common denominator and all.

He refuses to follow the required dress code because it epitomizes an elitism he cannot support.

Lance: I never wear a tie. I mean, there’s a lotta people, the first thing they did when we started seeing patients was throw on a nice pair of shoes and grab the tie and, you know, button up. I’ve never worn a tie. And I never will. ... To me, it symbolizes everything that sets the doctor and the patient apart. It’s sorta like (putting on an elite-sounding voice) ‘with this little tie, I can strut around, I’m somewhat better than everyone else,’ you know, kinda thing. I think it gets in the way of good communication. I think you want a level of respect there, but you don’t want that B.S. that goes with it, right?

Nor will he attend social gatherings organized by the medical school, describing them as B.S. He distances himself from his classmates, whom he sees as elite.

Lance: Most of my class is the pampered elite, I think. Lot of them have parents that are doctors and whatnot. I don’t know. If I was to pick the ultimate clinician or whatever, I’d pick somebody from a background that

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struggled. Because you know the value of hard work; nothing’s come easy. So you’d have respect for your patients. I think that’s the difference – a lot of these pampered devils have no basic human respect for the dignity of other people.

6.4 Dealing With ‘Differences’ in the Medical School

What we have seen in the previous section is that ‘social differences’ do make a difference to students in medical school. While faculty and most students deny the existence of racism, there are also deep-seated beliefs about the significance of cultural differences, some of which entrench the hegemonic status of cultural norms derived from white Canadians of European origin. There is also an understanding that as long as students are willing to assimilate neither cultural nor racialized differences will matter. Predictably, students who identify as members of visible minority groups are most likely to have experienced their ‘race’ or cultural background as negative during medical school. There is a clear desire to attribute racism to older faculty or patients, or to people in other parts of the province; but there are also clear indications that racism also exists more generally in the school itself in everyday forms whose impact accumulates.

Similarly, gender differences matter, at least to the women students and faculty. Incidents of outright sexism and sexual harassment are uncommon, as are instances of outright racism. Nonetheless, students and faculty described a subtly gendered climate in which women may feel less welcome, especially in some departments, and may be less likely to be automatically granted the authority of doctors. Women must worry more about presenting themselves as doctors. And they must worry more about combining a medical career with traditionally female roles of wife and mother.

Gay and lesbian students, and students who come from working class or poor family backgrounds, also seem to ‘fit’ less well in medical school. Again this is less an issue of direct discrimination than prevalent assumptions and ways of being that take...
on hegemonic status and that are firmly rooted in heterosexual culture and upper/
upper middle class culture. Lastly, though older students may fit less well, it is also
apparent that they have many advantages in medical school, not least of all bringing
greater maturity to their studies – or being believed to do so.

Nonetheless, it is clear that some students may experience more struggles than
others “justifying and explaining away” their Other identities in order to take up an
emergent identity as medical professional. They may have attachments that make full
identification with the medical student identity more problematic. They may have
commitments they cannot easily abandon or compromise. It may be harder for some to
adopt Medical Student as their primary social identity at the cost of other social
identities. And some may have more difficulty being fully accepted – may remain Other
regardless of their own wishes.

One faculty member spoke quietly and with conviction as he gave example after
example of the subtle ways in which women, racialized minorities and other
marginalized people are made to feel they don’t quite belong. From the hiring of faculty
to the social functions of students, visible signs of difference can mark people as
outsiders: an accent, not playing the right sports, wearing a turban, not drinking
alcohol, not dressing ‘right,’ having children, and so on.

Dr. J.: [Most people] are unaware of how subjective it is... when it comes
to hiring and promotion. Are you comfortable with this person playing
darts at the faculty club? That’s a big factor... English accent would have
an effect without people being conscious of it. Drinking beer of course is
an ‘accent.’ Very little thought about well some people don’t like to drink
and most of our social functions would make somebody who doesn’t
drink uncomfortable. And yet social functions are how you make it in
Graduate school, if you can’t socialize you’re in real trouble.

He was getting at the very subtle level at which there may be no prejudice, exactly, but
you simply don’t feel as comfortable with this person as with that one. This subjective
assessment enters into evaluations, references, interviews, and the formation of school-
based cliques.
As we saw in the last chapter, students display a range of ways of integrating—or not integrating—their medical student identities with the identities they hold prior to, or outside of school. Some work to blend potentially-conflicting parts of themselves, some maintain carefully segregated parts of themselves, and some let go of aspects of themselves, bury them, abandon them, or put them aside for a while, in order to fit in more easily while they are in medical school. The medical school, too, has to deal with differences among its students. The school as social institution is embodied in the people who work in it, the staff, faculty and administration. Their reactions to social differences help to create the sort of atmosphere students encounter in medical school.

There are several possible bases for responses by the school to the presence of students whose social backgrounds differ from those traditionally associated with physicians. Like any institution responding to social changes of this nature, it is likely to demonstrate some combination of all of these. Some responses arise out of ignorance of the new peoples represented, and the significance of their presence in the school. Some responses emerge out of intolerance for difference. Some responses arise out of denial that these social differences matter, and desire to erase diversity. Some responses come from genuine desire to accommodate the types of students that were under-represented in the past. And some responses come from recognition of the value and importance of social differences, and a willingness to decentre the foundational hegemony of medicine, to celebrate and maintain diversity.

6.4.1 Dealing with differences -- ignorance, intolerance, erasure

Part of the response of (at least some) medical school faculty and administrators arises from simple ignorance. One faculty member discussed the general lack of awareness that standards of dress, appearance and behaviour promoted in the medical school as universally professional are in fact upper class standards. He spoke of well-meant desires to do out-reach with cultural groups, such as Aboriginal peoples,
hampered by total lack of awareness of appropriate actions. He described some of the
most well-meaning faculty as “liberal positive but not well informed.” And he talked
about students whose “lives don’t fit the patterns [many faculty members are] used to.”
Faced with issues of poverty, abuse, racism, homophobia, and so on, many faculty and
administrators simply have “no understanding of the complexities of the situations.”

Dr. J.: We tend to appoint people who are successful and prestigious in
situations where maybe some people whose careers didn’t go so well –
because they were themselves struggling with these things – might be
more useful.

He concludes that the institutional response to a diverse student population has not
been primarily one of institutional change or accommodation: “[We’ve] made the big
transition from being hostile to it [change] to seeing it as a positive thing we should do
– but in fact we don’t because we’re ignorant.”

I have already given numerous examples of the types of responses that emerge
from intolerance of difference: locker room banter and a general climate in some
specialties that make it clear gay men and lesbians are not welcome; women
discovering in certain specialties, “It’s a real man’s world there”; assumptions that
students who are from different cultural backgrounds should assimilate; racist
comments, sexist comments, homophobic comments. Some suggested it is not that
faculty do not want women or other traditionally marginalized students in medical
school, but that they speak and act out of habits formed when medical students were
almost all white, upper class men. They are inadvertently intolerant, unable to adapt to
an altered reality. Regardless of the degree of intent, though, the impact on students (or
faculty) who are not straight, white, upper class men is the same: a general climate in
which they may feel less welcome.

Perhaps the most pervasive response to social difference and the reality of an
increasingly diverse medical student population, though, is denial of differences – or of
the significance of differences. One surgeon flatly denied the statistics that show
women's continued under-representation in fields such as surgery. Another faculty member seemed unable to think about diversity except in terms of admissions. He recognized that it is inequitable to disproportionately deny entry to one social group over another, but once they are in he sees no further impact of social differences. He mentioned the recent graduation of an Aboriginal student from this medical school.

Dr. H.: No one even knew she had a Native background until she was gearing up for graduation. And I think that's great. You know, as far as I'm concerned, that's the way that it should happen.

This denies that structured social differences have any impact beyond the admissions process. Once in the school, no one should be able to tell you are 'different,' much less have to make any changes to accommodate your values, beliefs, culture, and so on, nor acknowledge the racism you may face as an Aboriginal person. Neither should you draw attention to your difference by identifying yourself as Aboriginal.

The desire to produce 'neutral physicians' to work with 'generic patients' discussed in Chapter 5 is another aspect of denying or, more actively, seeking to erase social differences. One clinician argued that medical students need to be taught "to look at the patient as a patient, not as a Black or White, or male or female, or Caucasian or Asian, but a patient is a patient." As I discussed in Chapter 5, this erases important differences in the name of equality. Requiring assimilation of those who do not fit the norms of the dominant group is not equality. Furthermore, it may impair the health care of patients when their gender, sexual orientation, culture, and other social particularities are central to their health, illness or treatment.

A major part of the difficulty for educators seems to be finding ways to acknowledge differences without reinforcing negative stereotypes. Discussing ways to make Asian students feel comfortable in tutorials Dr. H. quickly defended his acknowledgment of the reality of cultural differences:
Dr. H.: We're not here to reinforce stereotypes. We're in fact here to break them all down, because the worst thing you can do is stereotype somebody.

Social differences have historically been used as the basis for oppressing some groups of people. So to many people denying that such differences matter at all seems the route to equality. However, that leaves the dominant culture unchanged. The overwhelming response to questions about difference was, "that will change with time." The implied solution then is that either newcomers will adapt to the existing dominant ways of being, or the dominant social and institutional culture will somehow change, though unspecified processes.

It is my view that denial and erasure of difference are the dominant stances of the medical school. This is not surprising, since liberal individualism is the dominant ideology in Canadian society, as I commented in the previous chapter. Under liberal individualism equality is achieved by treating all individuals the same way; equal treatment results in equality. This view is reflected in the formal commitment to equality embodied in open admissions procedures in the medical school. It is formal equality – everyone has equal opportunity to apply, and will be considered equally. Once admitted, treating everyone the same will ensure equality.

In contrast are views that focus on substantive equality (equity), equality of outcome rather than equality of opportunity. From this view differences that accompany membership in distinct social groups have systemic impacts on the material conditions of people's lives. These impacts cannot be wished away or denied. They do not simply disappear when members of formerly-excluded groups are allowed entry into medicine. 'Same treatment,' the liberal prescription for equality, implies treating everyone according to the same neutral standards. Views that insist on recognizing social differences deny the existence of neutral standards; the standards in medicine were established within a culture that for generations excluded women, people of colour, poor and working class people, and required gay and lesbians to stay closeted.

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They are the standards of a distinct (hegemonic) social group. Denying the reality or significance of 'race,' gender, sexual orientation and so on conveys the message, 'We will cease to actively prevent your entry into our club, but once here you must assimilate.'

6.4.2 Dealing with differences – accommodation

Some responses by the medical school arise from recognition of and genuine desire to make room for the differences students bring with them entering medicine. The two main ways the school accommodates difference is through policies and procedures and through increasing the representation of those who have been historically under-represented on faculty and in positions of authority. This school has been active on both fronts.

In 1991 the medical school established a Gender Issues Committee to study the situation of women students and faculty in the school. Out of that group came a recommendation to appoint an Associate Dean of Equity. The position has existed since 1993. Faculty told me there are very few such positions in medical schools in North America, and none at that rank. People are justifiably proud.

Other changes in policy or procedures were raised in the interviews. One department has a policy on establishing a "hospitable climate" for all members of the department. One person told me about a cross-cultural clinic in his department. The Associate Dean of Equity and the University Equity Office provide harassment workshops for students and educational sessions for faculty, particularly those on admissions committees. Overall there is a general sense that there are policies and structures in place to deal with inappropriate behaviours.

There are also support groups and services available for those who may feel marginalized at the school. One person mentioned a "Women in Science" group. Several people raised the existence of a gay and lesbian group or club, which advertises
openly in the school and is treated respectfully by all. One faculty member described this as a school where there is "complete openness about issues in terms of sexuality, gender, all the rest of it."30

Dr. H.: I know of no other medical school where you could go in downstairs and see something, you know, to the effect of a gay and lesbian club [advertised]. And it's there, it's not defaced, the students have left it there. . . . In the medical school that is just an alternative lifestyle. Just one of the ranges in normality.

The policies, procedures, and support services that facilitate accommodation of previously under-represented social groups in the medical school have an impact that may extend beyond the actual scope of the policy, procedure or service itself. Simply the existence of a policy geared toward equity, or of an equity office, can set a tone within the school. It establishes some institutionalized ground rules that say what is or is not acceptable, and those rules become the starting point, even if no one ever invokes the policy officially. It shifts the culture of the medical school just by existing. It provides institutional support for individuals who “call” someone on their inappropriate behaviour.

Dr. W.: What’s changed is that it’s a little safer for people to call it. And there are a few more people around who will stand by the student who calls it. . . . [By] setting up a policy statement . . . we can say to our learners when they come in. . . . this is the ground you stand on. And if somebody behaves differently from what this says, here is the way you deal with it.

It is also the case, though, that even the best of services and so on are subject to “slippage” over time. They may be set up to address certain issues but once in place take on an institutional life of their own, and the original issues may be lost sight of. This is a serious risk, since then administrators and others are able to point to the policies or services in place and say, 'There, see, we’ve dealt with that issue.'

30 In fact he even wonders if things may have gone a bit too far toward accommodating the traditionally-marginalized: “There’s Women in Science groups [but] you never get a man saying, ‘I’m a member of a Men in Science group.’ . . . you know it’s almost gone the other direction, where women now can get away with a lot more than— you know, some of the things that women faculty come out with would never pass my lips.”

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The other major way the medical school accommodates difference is through increasing the representation of those who have been historically under-represented in the school, including as faculty and administrators. Some faculty suggest change is inevitable simply because of numbers:

Dr. W.: The culture shifts proportionate to the number of people who believe that a shift should occur. . . . There are 50% women in medical schools now in Canada. Now that has made a difference. . . . It was never okay to do some of the things that were done in medical education. But if you were the one person in the room when the slides [went up], the sort of snide remarks [were] made about breast exam, it was really hard to be the one that stood up. If there are 50 of you in the room you can object. And if you object and there’re 50 of you in the room even the most hard line sort of dinosaurs look around the room and say, ‘Oh gee, there’s so many of you.’

Critical mass counts, in that the “natural attitude,” the taken for granted ways of thinking and doing can start to shift when there are sufficient numbers to validate differences.

Dr. P.: It’s that whole natural attitude thing, about being on the outside, and navigating your way in. Instead if there are enough people who think like you—. . . . So that in a group like McMaster where almost 70% of the class is women, it becomes very difficult for you not to find somebody who will validate your opinion and your perspective, and so maybe it’ll be extinguished less quickly or it will persist or it’ll be given some value.

A few faculty pointed out that the changes need to extend beyond the student body to represent greater diversity among the faculty and administration.

Dr. R.: When I was in medical School, [there were] four other women in the class so you know there was less than 5% in class so you’d say well then at this point in time there’d be 5% Chairs that are women. You know, what’s a reasonable expectation? Now there’re 50% women so in 25 years will there be 50% Chairs – who knows?

Equally important though is the need to bring “non-conformists” into medicine, people who seek change.31

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31 Clearly some of this is happening; as should be apparent, the faculty members I interviewed represented a wide range of views on how social differences should be addressed in the school.

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Dr. W.: Some of the most interesting changes that have occurred in medicine have occurred because there has been enough permeability that people who didn't believe in the system as it existed could get into positions where they could begin to shift the system.

What matters may not be getting numbers of women or minorities or gays and lesbians or Aboriginal peoples into medicine, but getting people who will be visible in their differences, people who will speak up for themselves and for others: “All of us who see those people who are hanging onto an alternate way of looking at medicine, when we see them being victimized, the rest of us need to support them. And they often don’t get support.” There needs to be enough of these people that they have a critical mass, so individuals do not get dismissed as troublemakers. As one woman said, the current number of feminists on faculty, plus “people who think about power issues,” could probably be counted on her fingers. Especially discouraging is that when she raises these issues she faces blank looks that show most people do not begin to get what she is talking about.

While accommodation of differences is an improvement over denial that structured differences exist or matter, it is not sufficient. This type of response is still based in the assumption that the norm, the mainstream, is neutral and need not shift at all. In other words, all is well, except that some special students require special treatment for a time, to bring them up to speed. Otherwise it is business as usual. What this approach fails to do is challenge the hegemonic status of dominant social groups and their ideologies. By not pointing to the social constructedness of hegemony, by leaving it intact in its claims to be natural and neutral, it also leaves those who differ from the norm as deviant, lesser, not-quite-right. To the extent that they can be absorbed into the mainstream, using accommodations that do not alter the fundamentals of medical education, hegemony adapts but is not shaken.
6.4.3 Dealing with differences -- recognizing their importance

The last type of response to difference embraces differences, acknowledges their importance and explores their impacts. It is rooted in a politics of difference (e.g., Phillips, 1993; Young, 1990) which I will discuss in more detail in the next section. From this angle there should be no privileged or dominant group holding court at the centre, with everyone else relegated to the margins. Equality is not a matter of same treatment, but rather a recognition of the need for different treatment based on differing social circumstances. The measure of equality is substantive outcomes, not formal equality of opportunity and access. I estimate that almost a quarter of the faculty members demonstrated some version of this type of response, which is promising. At its heart this type of response says that social difference is not threatening, it is a good thing and is welcome. This type of response is in direct opposition to the desire to deny or erase social differences in the name of equality.

Dr. J. spoke most articulately about the limitations of an approach that aims to produce physicians who are neutral to work with relatively neutral patients. He argues that believing we are all the same regardless of gender, race, class, sexual orientation, cultural background and so on is based on a liberal desire for equality. But erasing differences does not work.

Dr. J.: We are different, we have to deal with the differences, we shouldn’t assume the differences have to do with one group being inferior to the other but if you want to deal with somebody’s life you have to know what that life is really like. And there’s a big difference between living in the Downtown Eastside and living in Kits. I think they [students] need to be much more aware of what other lives are like rather than just trained not to be prejudiced against them which I think never really long term works because sooner or later you’re forced to admit there’s differences. You’re forced to admit that, 'Yes I noticed this person has a different color skin.' He argues that it is a privilege of the dominant social group to be able to believe difference does not matter. If you are beaten up for being gay, you know it matters; you
do not have the luxury of saying, 'It doesn't matter to me whether someone is gay or heterosexual.'

Dr. J.: A lot of social groups have to deal with the realities that the dominant group can manage not to see. [There are] right-wing bigots who insist there's a difference and the difference is they're inferior to us. [And there are] liberals, 'Oh no we're all the same,' But both are lying. The reality is there's differences -... anybody who lives those lives knows there's differences. And I think medical students need to be aware of that.

Recognizing difference means recognizing your own distinctiveness, too. As well as trying to understand the values that govern other cultures or classes, a few faculty members suggested it is also essential to begin to see your own culture. Your own values too are culturally derived, and they are very present when a physician interacts with a patient. One clinician, for example, described coming to understand that his assumptions about 'the patient's right to know' are rooted in Euro-Canadian culture and belief in individual autonomy. His assumptions are culturally bound, not neutral and not universal.

Beginning to understand that all values are culturally-derived makes room for different ways of understanding things, different ways of doing things, different values. It begins to make space for difference, decentering the norm. Dr. P. insisted that having more women in medicine makes less difference than does making room for "women's ways of knowing," whether held by men or women. The latter makes clear that the dominant ways of knowing in medicine are gendered too, have developed out of, and in service to, a male-dominated profession. Those ways of knowing are not necessarily wrong, or 'bad,' but neither are they neutral. They bear the traces of the social locations from which they emerged.

Being colour-blind, or culture-blind does not make difference go away. What it does do, as Dr. W. argues, is destroy the possibility of safety: "It is not a safe environment when people pretend equality." Rather than say "I don't even notice skin
Dr. W.: I'd like you to be reflective enough that you can identify the differences because then we can be safe together. My experience in the world has not lead me to conclude that we can wash out differences.

Denying difference, or denying the importance of difference, makes it harder for students who see things happening to object or do something about it.

In terms of the social and cultural backgrounds of patients, the goal might be to treat all with equal respect, rather than treat them all the same. Similarly, though the end goal might be equivalent levels of competence upon graduation, assuming medical practitioners can be unaffected by their social and cultural characteristics is unrealistic.

Dr. W.: The awful truth is that we will do a dis-service to the patient population if we collude with this notion that all doctors are the same. Because there is in the bureaucratic side a wish for that to be so. That you can have a, a bakery system. Get your ticket for open heart surgery and whoever comes up doesn't matter.

Dr. R.: To think . . . that students are all the same is ridiculous 'cause they come with a whole set of things. What you want is for them to understand their own prejudices, their own comfort zones, their own knowledge base so that they know what they do know, what they can't handle, what they're uncomfortable in and want some help in. So to me, that's ridiculous and unbelievable.

Dr. N. talked about how he makes social differences explicit with his students. He gets students to say to patients things like, "how does it feel for you to be looked after by a Sikh medical student?" He admits that the patient is likely not to raise any objections, in the interest of social approval, but that patient may later feel free to raise questions such as how long the student has been in Canada and so on. Furthermore, simply asking the question forces students to reflect on the impact of their race, culture, gender etc on the encounter with a patient. Interestingly, Dr. N. gave the example of a Sikh student. It is not clear whether he would do the same with dominant social
identities. Would he, for example, encourage students to ask patients if they were bothered by being looked after by a white medical student, or a heterosexual student?

While these forms of sensitivity heightening are clearly crucial, Dr. J. pointed to some of their limitations, and the need to continue training medical professionals who come from differing backgrounds. He commented that the class background of many students simply leaves them with no experiential understanding of many of their patients' lives.

Dr. J.: It's one thing to tell people not to be actively prejudiced but actually understanding what somebody's telling about their life requires a whole different level which you generally pick up only if you've actually shared parts of lives of people who are similar.

In particular he finds medical students, "whatever ethnic group they come from," tend to come from higher class backgrounds and are unable to relate to patients who live in poverty, "even if officially, ideologically they believe one shouldn't be prejudiced."

Dr. J.: They'll recommend things in terms of changes in lifestyle that are just irrelevant and not understand why they don't get compliance. . . . I remember one student, she'd just done some work for the first time in the Downtown Eastside. These people whose lives to her were total disasters, she wasn't sure why we're bothering to save their lives. . . . She couldn't understand what was worthwhile in the lives of people who were addicts and stuff. Whereas if you've had friends who were addicts, and you've known decent people who ended up addicted to drugs—

One clinician takes the strong stance that matters of cultural difference, gender differences, and other forms of social inequality are so important that medical students should not be able to graduate without clear understanding of how these things impact on health and illness, as well as on physicians' own behaviour: "It's what people who are going to be in positions of responsibility and power in the society should have to understand."
6.5 Medical Education and the Politics of Difference

Dr. W.: The student, learner, who's got an identity . . . I don't want them to wash out and become something you know. And that's the challenging thing about bringing people into a guild structure and into a culture, is can you be Canadian about it? Let them maintain their identity.

Interviewer: Be multi-cultural?
Dr. W.: Yeah. With all the struggles that entails . . . Can we allow people to maintain their identity and recognize the value added of their maintaining their identity as they come in.

Medicine has always allowed for the existence of 'difference' in the objects of its gaze, but not in its subjects, the medical gazers themselves. Medicine has been centrally implicated in the historical oppression of all of those subordinated social groups defined as Other. From medical decrees that intellectual stimulation would cause a woman's uterus to atrophy, to biological theories of racial inferiority, to the construction of homosexuality as a category of psychiatric illness, to eugenic theories of and 'treatments' for 'feeble-mindedness,' physical disability, and 'social undesirability' (read poverty) - medicine has been willing to recognize cultural and social differences among its patients.

Medical knowledge, on the other hand, has been understood as devoid of such biases as social, historical or cultural specificity. Medicine, perhaps the epitome of scientific knowing, is based on the ideal of impartiality. Impartial reasoning is dispassionate, abstract, and objective, separated from feelings, desires, commitments, experiences. The impartial knower moves away from the particularities of situation or context, divorces him or herself from social context or affiliation by carefully applying objective rules of logic. The impartial view, the view of science and reason, is a view from nowhere (Haraway, 1991; Harding, 1991; Young, 1990). It is a "point of view emptied of particularity, a point of view that is the same for everyone . . . a universal point of view" (Young, 1990: 105). As we saw in the last chapter, medicine incorporates an ideal of the socially neutral physician working with universal medical knowledge
following universally accepted medical thought processes to come up with the same
diagnoses that any other medical colleague would reach.  

This ideal of the impartial knower assumes people can transcend the
particularities of their lives. But in fact there is no unsituated knowledge (Haraway,
1991). All knowledge carries the stamp of its creators, and all knowers are socially
located. “[All] knowledge claims that have ever been made inside or outside the history
of Western thought and the disciplines today . . . bear the fingerprints of the
communities that produce them” (Harding, 1993: 57). Claims of universality construct
as normal and neutral what is actually the knowledge of socially dominant groups. By
abstracting from social particularities it claims blindness to differences, in effect
repressing and denying differences, disallowing the validity of their claims.

As I have argued in Chapter 5 this ideal of impartiality echoes a social
commitment to formal equality based in liberal individualism. Discussing a sudden
increase of African-American medical students in predominantly white medical schools
in the late 1960s James Curtis argued that it was crucial “that these students were
treated as individuals, as all students should be treated, and that they were protected
against pressures to lump them together into one group” (Curtis, 1971: 120-121). Iris
Marion Young describes this desire as characteristic of liberal humanist individualism.

We seek a society in which differences of sex, race, religion and ethnicity
no longer make a difference to people’s rights and opportunities. People
should be treated as individuals not as members of groups (Young, 1990:
157).

This is a notion of justice rooted in transcendence of group differences, rooted in an
ideal of assimilation. When medical faculty and students say all medical students are

32 The view of science as impartial may reach its purest form during training, when an ideal version is
typified and taught; later, in practice, most physicians and even many scientists might admit to external
influences — though even then such standards as the objectivity of controlled trials and evidence-based
decision-making guide medical practice.
(or should be) the same, they appeal to a desire for equality rooted in equal treatment (see Henry et al., 1995: 27).

The ideal of assimilation, the elimination of group differences, has been a central component of most emancipatory struggles as they sought inclusion, fought for their share of the pie. But it is restrictive, and its costs too high. It demands of formerly excluded groups that they assimilate to standards and norms that are supposedly neutral and universal, but in fact are the standards of specific privileged groups. "The rejection and devaluation of one's culture and perspective should not be a condition of full participation in social life" (Young, 1990: 166).

Nor is the ideal of assimilation possible. People do not easily give up their social group identifications. But even if they wish to, they cannot always give them up. Though medical students may adopt the impartial stance of science, may become impartial knowers divorced from their social particularities in their heads, they remain embodied. And bodies are a key site of differences. Thus women students talked about gender differences most in terms of sexual harassment and family-career conflicts. Their bodies remain gendered (eroticized, sexualized) and they still have to grapple with the realities of pregnancy, childbearing, and the socially-constructed reality of woman-as-primary-caregiver based in part on women's capacity to breastfeed. Students from racialized minority groups remain in bodies whose skin colour will never assimilate. They remain 'marked,' subject to the interpretations others may make about the meanings of their skin colour.

When participation is taken to imply assimilation the oppressed person is caught in an irresolvable dilemma: to participate means to accept and adopt an identity one is not, and to try to participate means to be reminded by oneself and others what one is (Young, 1990: 165).

In recent years many members of emancipatory movements have moved away from an ideal of equality based on assimilation, to one based in a politics of difference. Such a politics recognizes that treating people differently is sometimes the only way
toward equality. It involves the assertion of a positive group identity, such as the Black Power aspect of the civil rights movement. A politics of difference sees group social differences as welcome and desirable. Despised identities are reclaimed and celebrated. The distinctiveness of subordinated groups' cultures, experiences and perspectives are seen as a valuable resource. And rather than the success of a few individuals who leave behind their roots in order to 'make it,' the goal is the solidarity and liberation of the whole group. To be clear, the point is not difference for its own sake, but a refusal to give up group membership to gain formal equality; it is an insistence on the validity of group differences and an insistence on the right to substantive equality without relinquishing group membership.

A politics of difference is the cornerstone of radical democratic pluralism (LaClau & Mouffe, 1985; Phillips, 1993; Young, 1990). This is a different notion of liberation and equality, one that incorporates group differences rather than transcending them. It requires a new understanding of differences that decenters the mainstream, the neutral center. When subordinated groups insist on the positive value of their identities, the place of the dominant social group as neutral and universal is undermined. By disrupting the normal/deviant relation, all that remains is simple difference. The possibility is opened up for examining privileged or hegemonic identities as just as socially constructed and relational as all other identities.

And understanding difference as relational is crucial. As Young says, "Difference now comes to mean not otherness, exclusive opposition, but specificity, variation, heterogeneity" (1990: 171). Rather than 'the normal' and the 'Other' that requires accommodations to be made, the result is a plurality of social groups that coexist in equal specificity. Whiteness is as culturally specific as Blackness. Heterosexual culture is as specific as is gay or lesbian culture. Difference, then, is not an attribute of the individual or group, it is not understood as essential, grounded in some biological or inherent essence, immutable and unitary. Rather difference exists only in social
relations. There is no longer 'normal' and 'deviant,' but simply alternative ways of being in the world that differ from one another. One, though, has the power to establish itself as privileged or hegemonic. This view exposes claims to 'normalcy' or neutrality as power moves.

One of the most dangerous possibilities posed by insisting on non-essential and non-unitary group identities, as well as on the legitimacy of politicizing around social differences (Phillips, 1993), is a tendency toward liberal pluralism (e.g., Harding, 1987), toward valorization of difference for the sake of difference (Crosby, 1992). This dissolves structures of inequality into a mere multitude of stories: “To solve the problem of different conditions of oppression by focusing on different truths ... is to equalize what is not equal, to spread a patina of equivalence over brutal realities and their inverse insights” (Gorelick, 1991:472). What translates such liberal proliferation of differences into a radical pluralism is articulation of the social relationships that exist among groups (Laclau & Mouffe, 1985). It is not enough to adopt multiple stories; these different stories, and people's differing experiences, exist in relation to one another and that relationship is key.

Black women's experiences are relevant not only to other Black women but to understanding the situation of white women, and indeed of Black and white men. It is only because Black women empty bedpans that white men can run hospitals. It is only because Native American women are poor that ruling class men and women are rich. It is only because Guatemalan peasant women are oppressed that North American businessmen have power (Gorelick, 1991:472-73).

As we have seen, the predominant approach to group differences in the medical school is denial/erasure. Gender ('race,' class, sexual orientation, age) makes no difference really; opportunities to get in have been equalized and once in all students are treated equally, on a level playing field. Students do not need to hear about 'Others' because they 'are okay' with those people. Policies and procedures are in place to deal with any remaining "dinosaurs" who continue to display outdated attitudes. These
approaches are rooted in an ideal of assimilation which asks members of social groups that have traditionally been excluded from medical school to abandon their social, cultural, historical specificity to fit in. Students are learning that it does not and should not matter whether they are Chinese or White, gay or straight, working class or rich; as long as they are treated identically in school, equality will have been served. And as long as they act impartially as doctors, treat everyone the same, equality will have been served.

Many medical schools in Canada, including the one where this research took place, are adopting new curricula, or new courses in old curricula that address the complexities of cross-cultural medicine. This is a major step toward recognition that patients are not interchangeable, that they need to be treated in the context of their social and cultural particularities. But it retains the notion of difference as an attribute – moreover, difference as an attribute of *others*. If the approach to group differences is one in which students learn that ‘Chinese-Canadians believe in yin and yang, Pakistanis believe in three bodily humors…’ and so on (see, e.g. Loustaunau & Sobo, 1997), group differences are constructed as essential, unitary and static, at the same time that the specificity of the dominant group remains unmarked, invisible.

The former is a process of containment (Essed, 1991) in which heterogenous groups and even the heterogeneity within individual members of those groups is pinned down for explanation to outsiders. As Anneliese Truame argues, “If my representation of myself is figured by others, not as a ground for movement, but as a place I am expected to consistently occupy, and occupy in a particular way, it is easy for me to become frozen by the look that sees me in stasis” (Truame, 1994: 209). This can only ever result in partial recognition, a “circumscribed place for participation” (Truame, 1994: 209).

And by not examining difference as a social relation, this type of instruction in cross-cultural medicine leaves unexamined not only the cultural specificity of the
hegemonic group, but also the social relations that group’s dominance depends upon. For example, (White) researchers have devoted extensive resources to uncovering what exactly it is about Aboriginal cultures that results in their under-utilization of the Canadian health care system relative to White people in the same geographic areas (Waldram, 1994). This is usually portrayed as an issue of “cultural difference” – mysticism, inadequate education, lack of self-care, and inability to understand the implications of illness or the complexities of the health care system. Waldram (1994) found that Aboriginal under-utilization of health care is primarily an issue of poverty and racism. When poverty is controlled for, “cultural differences” disappear. Furthermore, when highly under-utilized health clinics on reserves have been taken over and run by Bands themselves, even with no other changes in staff, policies or procedures, utilization of the clinics increases dramatically. We cannot understand Aboriginal under-utilization of health services while ignoring the impact of colonial heritage (Waldram, 1994). This is the sort of misunderstanding that results from understanding group differences as attributes of individuals; focusing on cultural difference excludes attention to the power differentials that underlie racism (Henry et al., 1995). Racism is a social relation. Cultural difference is an attribute. And heightening or exaggeration of cultural differences is part of the processes of everyday racism experienced by people of colour in liberal democracies (Essed, 1991).

A politics of difference would examine distinctions between social groups as a product of social relations. That allows greater diversity within groups, as well as greater overlap between groups. This would enable exactly what Dr. H. is looking for, a way to acknowledge differences without reinforcing negative stereotypes. If the medical school were to respond to the growing social diversity among its students not by denying that those group differences have any impact, but rather by embracing a politics of difference, the end result, I believe, would be better for students as well as patients. It means acknowledging power as well as difference; it means acknowledging
racism as well as cultural diversity; it means acknowledging there is no neutral category, only dominant ones.

Students would not be pressured to assimilate, become more-or-less white, heterosexual middle-class men, in order to become doctors. They would feel less pressure to abandon parts of themselves to fit in. They might be better able to recognize the impact of their gender, their cultural background, their sexual orientation on their experience in school and in practice. They might begin to see how their own social particularities impact on their interactions with patients. That is the first step toward taking responsibility for continuing the oppression of other social groups.

I am not suggesting medical students need to take up the study of social inequality because they are to blame for the ways medicine has mistreated or poorly served subordinated social groups. Nor, for that matter, am I suggesting medical faculty and administrators are to blame for the ways students have felt excluded from full participation in medical school. As Young says, “It is inappropriate to blame people for actions they are unaware of and do not intend” (1990: 151). The denial of group differences has stemmed from genuine desire for equality, through the mechanisms of liberal humanist individualism. The fact that it is inherently limited is not the fault of its believers.

It is, though, their responsibility to cease to reproduce marginalization and oppression. The cultural habits (here I include the culture of medicine) that generate and reproduce oppression may be unconscious. But once people have been made aware of their participation in those actions or habits they can be held accountable should they choose to continue practices they now know oppress or marginalize others. Thus a kind of consciousness-raising that brings to privileged groups awareness of how their privilege is integrally linked to the subordination of others is a first step toward social change. Simply allowing more ‘differently marked’ bodies into medical school is not necessarily a step toward fundamental change.
Chapter VII: Conclusions

Certainly there are very real differences between us of race, age, and sex. But it is not those differences between us that are separating us. It is rather our refusal to recognize those differences. . . . Too often, we pour the energy needed for recognizing and exploring difference into pretending those differences are insurmountable barriers, or that they do not exist at all. This results in a voluntary isolation, or false and treacherous connections. Either way, we do not develop tools for using human difference as a springboard for creative change (Lorde, 1984: 115).

Are the processes of medical professional socialization significantly different from those described 40 years ago by Merton (1957) and Becker (1961) and their colleagues? In short, there is surprisingly little difference. The socialization process is still an intense induction into a vocation or calling, though that perception of medicine is increasingly contested by students and younger faculty. A competing notion of balanced lifestyle is prevalent, but has not been significantly incorporated into educational processes. At this point medical training remains a process of bringing novitiates into the vocation. The other persistent metaphor is that students are learning to be 'team players.' A significant part of this is negotiating hierarchies within medicine and within the larger health care sphere. Students learn not to challenge the clinicians and residents above them in the hierarchy, even when they see things they believe are wrong. As Becker (1961), Merton (1957) and others found, students learn that they are in a position of relative powerlessness vis-à-vis other medical staff.

Other hierarchies are changing somewhat. The nurse-handmaid role is no longer accepted by nurses, and the relationship between nurses and doctors is increasingly one between two groups of professionals (Armstrong, Choiniere & Day, 1993). Thus while students in the late 1990s are still learning how to take an appropriately authoritative role in relation to nurses and other health care staff, they employ more of a team concept than a traditional power-over model. Similarly, relationships to patients are changing and contested. There is now widespread belief that patients are equal partners in their own health care (Frankel, 1994) and that a power-over stance taken by doctors is...
no longer appropriate. It is being displaced by a belief in egalitarian relations between doctors and patients. But neither students nor clinical faculty seem entirely clear on how to be a medical professional without the 'professional distancing' that has been the dominant mode for so long. Furthermore, students seem so focused on their own powerlessness relative to doctors that they fail to even examine the power-relations between themselves and patients.

Among the changes students go through are adopting professional ethics, beginning to identify with the concerns of the profession, fashioning a professional appearance, learning a new language and communication style, and learning a new (reductionistic) thought process – all in keeping with descriptions of professional socialization 40 years ago. Though students display some loss of idealism, consistent with earlier studies, they increasingly direct that growing cynicism toward the political and economic conditions within which their new profession operates. The processes of medical professional socialization are also consistent with earlier research. Students take on their emergent identities through a series of novel experiences that become more routine; through exploring newly sanctioned freedom to violate personal boundaries with patients; through the responses they receive from others, especially patients; through being called doctor and expected to act as a doctor. A significant part of the process is, as Haas and Shaffir (1987) detailed, playing a role, complete with props and dialogue. Eventually it comes to feel real, especially as the responsibilities increase.

One of the specific questions I sought to address in this research was what happens to the pressures toward homogeneity and conformity documented in earlier studies of medical education, when the students are a highly heterogeneous group? I found that although students devise a range of individual strategies to maintain balance between school and other aspects of their lives, there remains a strong impetus toward homogeneity, or the “deindividualization of students.” The metaphor of a robot was
common. A major homogenizing influence is the lack of time to do much other than medical school; outside contacts, activities and interests that helped differentiate the students are severely curtailed.

At the same time attitudes and values tend to converge toward a shared 'natural attitude,' in which students learn what is normal and acceptable within medicine and what is not. In particular we saw that students learn detached concern is the appropriate and professional way to respond to patients. They dampen down their automatic responses, which they associate with "common human decency," and replace them with a professional dispassion that takes on the status of hegemony within medicine.

Students need to find ways of articulating their emergent professional identity to prior identities, especially when the professional identity does not encompass them as neatly as it might for white, middle or upper class, heterosexual men. Some allow medicine to largely displace other aspects of self; others maintain quite distinct segregated selves; and a relatively small number manage to fully integrate their new medical-student identity with the rest of their lives. It does appear that the latter is most possible for white men.

Part of the difficulty for other students arises from the fact that embedded in the identity of medical professional is an assumption of neutrality, impartiality. The ideal image of physician is someone who is classless, 'raceless,' sexless and so on. He (the generic he) treats all patients equally, regardless of their social or cultural background or characteristics. The 'selfless professional' – quite literally, someone devoid of social particularities – remains the dominant ideological construction of physician. I have argued that there is no such thing as social neutrality; claims to neutrality simply deny the hegemonic status enjoyed by the standards, values, beliefs etc of dominant social groups. Striving for neutrality, in the name of equal treatment for all patients from unbiased doctors, negates important social differences that simply cannot be

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eliminated. Pretending such differences do not matter masks the operation of micro-inequities.

Those micro-inequities operate in the form of everyday practices that through constant repetition cumulate in the complex though barely-visible marginalization of people of colour, women, gays and lesbians, people from poor or working-class backgrounds. Instances of outright racism, sexual harassment, and homophobia were rare enough to stand out in student and faculty descriptions of medical school. And clearly all students enjoy formal equality, equal rights to lay claim to protection from violence, harassment and discrimination. Though intolerance for those who are Other is still experienced on occasion, and was still present in the words of some research participants, there are formal policies and procedures in place to deal with such transgressions.

Far more prevalent, though, is the marginalization of Others, through innumerable minute ways in which people are told they do not quite fit and should change to be more like the (neutral) norm in order to better assimilate. From jokes which target the specificities of a particular social group, to ignorance as to the very presence of a distinct group, to over- or under-emphasis of their group distinctiveness – all of these are processes by which the racial character, gender, sexual orientation, class, and other attributes of the normal are established, defining them against the Other who does not quite belong. Thus the dominant response within the medical school of assuming students will assimilate to the cultural norms of the school is part of the process of maintaining hegemony and denying difference – and thereby oppressing.

There is also a strand within the school that responds to social difference through efforts at accommodation. The most visible instance is the position of Associate Dean of Equity. Though this ensures formal equality through recourse to redress should one's individual rights be violated, it still operates under the premises of liberal individualism. Individuals should be treated equally as individuals without regard to

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their group memberships or affiliations. This view centers on an assumption of the possibility of neutral individuals (Phillips, 1993). Accommodations such as these, while better than nothing, are in the long run designed to facilitate processes of assimilation.

I argue instead for a politics of difference within medical education, an approach discernible in the comments of some faculty in this school. Such an approach fully accepts the reality and desirability of social differences, as well as the need for different treatment for different groups if the goal of substantive equality, equality of outcome, is to be achieved. There is no longer any center toward which marginal groups must assimilate. The hegemonic universals are seen as just as socially particular and constructed as are the margins. This is the only approach that begins to undermine the presumed neutrality of hegemony; with the micro-level ways everyday racism, sexism, heterosexism, and classism operate, undermining neutrality is an essential aspect of any effective challenge to inequalities.

In 1961 Becker et al. wrote that, "Elements in the students' background do not exert any decisive influence" on their experience of and behaviour in medical school (1961: 47). Yet the earliest women medical students, near the turn of the century, were distinctively influenced by their gender – they were harassed and heckled, forced to sit behind screens in class (Walsh, 1977). By the early 1970s, women in medical school still faced daily harassment, belittling, undermining, ostracism, and frequent use of pornographic slides to 'spice up' lectures (Campbell, 1973). Similarly, the first African Americans to attend predominantly white medical schools in the United States in the late 1800s faced vigorous protest, racist violence, exclusion, and harassment (Curtis, 1970; Gamble, 1990). They too were asked to sit behind screens, separated from the white students (Curtis, 1970: 16). By the early 1970s, racism was more subtle. Students of colour faced racist jokes and slurs; they were singled out as exceptions to their race; they were made to feel inferior; they faced constant assumptions that they were cleaning staff, not future doctors (Blackstock, 1996; Essed, 1991; Gamble, 1990).
In the late 1990s, the day-to-day operation of oppressions is increasingly subtle, occurring in a context of formal commitment to equality and nondiscrimination. "Racism, sexism, homophobia, ageism, ableism," Iris Marion Young argues, "have not disappeared with that commitment, but have gone underground, dwelling in everyday habits and cultural meanings of which people are for the most part unaware" (1990: 124). Struggles for equality must not pit themselves against the spectre of earlier manifestations of oppressions; we must identify and come to understand their contemporary manifestations and how these vary by place and time.1

7.1 Everyday Oppressions in a Time of Formal Equality

Contemporary manifestations of oppression have been outlined by two theorists whose work is central to this study: Philomena Essed (1991) and Iris Marion Young (1990). Essed's study of processes of everyday racism in the United States and the Netherlands, is particularly relevant because the context of the Netherlands is very like Canada – and the medical school where my research was conducted – in its emphasis on liberalism and denial of structured inequalities such as racism (Henry et al., 1995). Though her study is exclusive to racism, I think it can be extrapolated to illuminate some of the processes of other everyday oppressions.

In an exhaustive study Essed (1991) found that there are three primary modes of everyday racism: marginalization, problematization, and containment. Marginalization includes outright rejection, ignoring the presence of the marginalized, indifference to the realities of the marginalized, and passive tolerance for racism. She argues that

1 As Iris Marion Young states, "In its focus on individual growth, the concept of discrimination obscures and even tends to deny the structural and institutional framework of oppression. If one focuses on discrimination as the primary wrong groups suffer, then the more profound wrongs of exploitation, marginalization, powerlessness, cultural imperialism and violence that we still suffer go undiscussed and unaddressed. One misses how the weight of society's institutions and people's assumptions, habits, and behavior toward others are directed at reproducing the material and ideological conditions that make life easier for, provide greater real opportunities to, and establish the priority of the point of view of white heterosexual [professional] men" (Young, 1990: 196-7).
segregation of the Other, or more subtly simply withdrawal from the Other, is a central component of marginalization. Thus, for example, as Sinclair (1997) found, Asian medical students were rarely seen in the bars and social gathering places frequented by the medical students from dominant social groups. While such segregation was less obvious in my study, it is suggested by reports of a distinct group of "culturally-Chinese" students who stick together. The fact that most of the white students were unaware of this group may indicate the indifference to the presence or realities of the Other that Essed outlines.

Essed's category of "problematization" includes assuming the (racialized) Other to be biologically or culturally inferior, less capable, pathological or criminal, less civilized, oversensitive, or deficient in some way. This was probably least obvious in my study, though it was implicit in the automatic reaction of most respondents to questions about the impact of social differences that assumed I meant problems. I would also argue that the stress on assimilation arises from assumptions of cultural inferiority. There was also some pathologizing of Asian students as unhealthily 'driven' to succeed, and of women students as unable to cope with authority.

Finally, the category of "containment" includes denial of racism, anger at those who name racism as divisive, "ethnicization" or overemphasis on cultural differences, humiliation or belittling, and intimidation. As we have seen, denial of racism, as well as sexism, homophobia, and classism were prevalent in the medical school. And if there is no real issue, then those who name their own experiences of oppression are easily dismissed as overly-sensitive or biased. This was most evident in my research when women who identified and challenged micro-inequities based on gender were dismissed as 'strident feminists.' It was also implicit in many students' need to state that they were not feminist, and that gender was not a concern for them, before they detailed gender-based inequities. "Ethnicization," a form of "encapsulation," is the reduction of racism to 'cultural differences' (Henry et al., 1995); it roots the problem in
those who insist on being ‘too ethnic.’ This was evident in the understanding that Asian students are subject to culturally derived pressures that are the source of any difficulties they may experience in medical school. Similarly structures which mitigate against women entering specific residencies were reduced to women’s individual choices. Sexual harassment and homophobic comments illustrate belittlement and intimidation, as do jokes rooted in a humour that can only be understood by presupposing the inferiority of the Other, the target of the joke. I would also argue that relegation of sexual orientation to the private sphere, and desire not to address it in lectures, are forms of containment. Containment, Essed argues, is about keeping people ‘in their place.’

Iris Marion Young identifies what she calls five faces of oppression. They include: exploitation, marginalization, powerlessness, cultural imperialism, and violence (Young, 1990). Exploitation, an economic relation which she draws from Marx, applies least well here. All of the people in this study are preparing for or practicing one of the most esteemed and well-remunerated occupations in our society, and one which is unusually able to decide the terms of its own employment. Economic exploitation is not a central concern here. Similarly, marginalization refers to being excluded from full participation in the productive relations of social life, and is not a major force evident in this study. Young means here the elderly, people with disabilities, people on income assistance – not doctors, nor even students.

Powerlessness is a condition of “those who lack authority or power. . . . The powerless . . . do not command respect” (Young, 1990: 56-57). While relative to most Canadians, medical students are privileged and powerful, within the group there is some indication that respect and authority are gendered and racialized. The expertise of a medical professional cannot be ignored simply because she is a woman, or a member of a racialized minority group. That expertise is the basis for the power and authority of the medical profession. Nonetheless, within that framework, there is evidence in this
study that authority and respect may be more automatically granted to white men than any others. Even in the late 1990s women in medicine still face the assumption that they are nurses. Students of colour still face some degree of racism from patients that may limit the authority they are granted in doctor-patient interactions.

Another prevalent form of oppression evidenced in medical school is cultural imperialism. This “involves the universalization of a dominant group’s experience and culture, and its establishment as a norm” (Young, 1990: 59). The dominant group defines the differences of other groups as deviance, inferiority, lack, negation. The Other is stamped with an essence, defined from the outside. Yet, at the same time that differences are exaggerated there is simultaneous nonrecognition and delegitimation of differences. Others are rendered invisible in their specificity. Their cultural expressions do not even touch the dominant culture.

Culturally imperialist groups project their own values, experience and perspective as normative and universal. Victims of cultural imperialism are thereby rendered invisible as subjects, as persons with their own perspective and group-specific experience and interests. At the same time they are marked out, frozen into a being marked as Other, deviant in relation to the dominant norm. The dominant groups need not notice their own group being at all; they occupy an unmarked, neutral, apparently universal position. But victims of cultural imperialism cannot forget their group identity because the behavior and reactions of others call them back to it (Young, 1990: 123).

A “double consciousness” can arise when one finds oneself defined by two different cultures, a dominant culture and a subordinated culture. This was most apparent in relation to gay/lesbian students’ maintaining very separate lives during medical school, and students from working class and poor backgrounds who detest medical school, cannot identify with the “elite devils” around them, and cannot wait to graduate so they can be themselves again, returning to work on the ‘wrong’ side of the tracks. While formal equality provisions mean members of particular social groups are no longer excluded from the field of medicine, once admitted they may have a profound sense that they do not quite belong.
Young (1990) includes systematic violence in her “five faces of oppression.” This is less common in the medical school, though as mentioned above sexual harassment and homophobic remarks are forms of violence. It is important to note, though, that Essed stresses in everyday racism individual episodes or instances are experienced in the context of the whole of one’s life, which incorporates stories of racism experienced by others, as well as one’s own personal history of racist incidents. A ‘trivial’ racialized joke may come on top of an unending series of ‘trivial’ incidents that form an overwhelming pattern. The joke is experienced in a context that includes awareness of the possibility of, if not direct experience of, racist violence. Similarly, as one clinician said, it only takes a few openly homophobic remarks to create a climate of danger for gay medical students, when they live with the constant awareness that men are beaten up, even killed, for being perceived to be gay. “Members of some groups live with the knowledge that they must fear random, unprovoked attacks on their persons or property, which have no motive but to damage, humiliate or destroy the person” (Young, 1990: 61). The oppression of violence lies in the awareness that all members of the social group are liable to violation, solely on account of their group identity, even if they never experience it directly themselves.

7.2 Impartial Scientific Professionalism: Annihilation of the Located Self

I want to be clear that I am not arguing that medical students in Canada in the 1990s are an especially oppressed group. They are being trained to take up a social position that enjoys some of the greatest prestige, financial rewards, professional power and autonomy of any occupational group in the country. Nonetheless, I am arguing that within this elite social group, doctors, all are not equal. Furthermore, I would argue that part of learning to take on that particular professional identity is a pressure to exclude those parts of self that do not fit neatly with the definition of the traditional...
occupant of the position doctor – white, upper-middle class, heterosexual male. That pressure is in itself oppressive.

It is not simply the case that time constraints prevent students from involvements and connections outside of medical school, which leads them to sacrifice some aspects of their lives. I argue that pressures toward neutrality run much deeper than that. While not all medical faculty agree that the goal of medical education should be to produce "undifferentiated doctors" (Duffin, 1996: 38) stripped of the biases of gender, class, ‘race,’ culture, that is nonetheless an underlying aim. Medicine exemplifies the application of scientific reasoning. Science is above all a search for impartial, objective, untainted knowledge. Its purpose is the pursuit of laws and truths which, applied rationally and without bias, are equally true for all. “The impartial reasoner is, finally, a universal reasoner... abstract[ed] from the partiality of affiliation, of social or group perspective, that constitutes concrete subjects” (Young, 1990: 100). Science is a view from nowhere in particular, based solely on weighing the evidence in light of universal principles.

Medical students are being trained to become dispassionate, impartial knowers. The extent to which students are taught to distance themselves from their own emotional reactions has been documented in this study (Chapter 4), and in many earlier studies (Chapter 2). Moreover, we have seen how students feel forced to shut off basic human responses to suffering to be good medical students (Chapter 5). But at an equally fundamental level they are learning that it makes no difference whether they are male or female, gay or straight, Chinese, African-Canadian, Sikh, Korean, or European-Canadian. They are learning to deny the significance of social differences, they are learning to transcend their own social locations. By taking up the medical

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2 Though this too, is true, as I indicated in Chapter 5.
3 This is not a huge leap for most members of our society. I would argue that science is a dominant paradigm in our culture, and its notions of impartial knowing are widespread. Furthermore, as I have discussed in earlier chapters, liberal individualism is paramount in how people in Western capitalist societies think about self and membership in social groups. Liberal individualism with its faith in...
professional stance of impartial knower, not only do they transcend their own passions and feelings, but they transcend their social particularities—‘race,’ class, gender, and so on.

There is an element of this transcendence of the particular in all forms of professionalism. To be professional is to repress the particularities of the body—sexuality, bodily functions, emotional expressions—and to demonstrate cleanliness, control, modesty, manners. Professionals are clean and ‘clean-cut,’ dressed unrevealingly and undecoratively, behaving appropriately.

Professional behavior, which in this society signifies rationality and authoritativeness, requires specific ways of sitting, standing, walking, and speaking—namely without undue expression. Professional comportment entails an affable cheer, but without excitement or demonstrativeness. In speaking one should keep one’s voice steady, certainly not giggling or expressing sadness, anger, disappointment, or uncertainty. One should speak firmly, without hesitation or ambiguity, and slang, dialect, and accent should be absent from one’s speech (Young, 1990: 139-140).

Bodies, then, must be transcended to accomplish professionalism.

While this is true for all professionals, I would argue that it is compounded for medical professionals by the content of their expertise, the impartiality and universality of science. Interestingly, non-traditional students in medicine seem to feel far less marginalized than do similar students in law. Guinier and her colleagues (1997) describe much more intense feelings of exclusion and repression among women and racialized minority students in law school than I detected among the medical students I surveyed and interviewed. I suggest that this is a function of the content of training.

Whereas both law and medicine require of students that they become impartial knowers, the subject matter of law deals directly with social realities that would make it more difficult for students to remove themselves from their own social particularities. So while all law students are taught to apply impartial legal reasoning, dealing with a...
rape case might stir awareness of gender for a woman law student; dealing with a case about land claims might make it more difficult for Aboriginal law students to ‘transcend’ their Aboriginal identity. In contrast, medical students deal with scientific facts, such as blood counts, vital signs, lab results – humanity reduced to the level of cells, tissues, organs and organ systems. The level of reduction may allow more successful denial of the impact of membership in social groups. Medical students may almost be able to transcend, leave behind, their own social locations.\(^4\)

But as I have argued, impartial (transcendent) knowing is not possible. There is no view from nowhere, no unsituated point of view (Haraway, 1991; Harding, 1993). Supposedly-neutral, universal knowing is located among privileged social groups, those who are able to gain the status of hegemony for their (particular) ideologies.

The privileged groups lose their particularity; in assuming the position of the scientific subject they become disembodied, transcending particularity and materiality, agents of a universal view from nowhere. The oppressed groups, on the other hand, are locked in their objectified bodies, blind, dumb and passive (Young, 1990:127).

Furthermore, the repression of the body and its emotions required by professionalism is a striving toward disembodiment. While some students may be able to reside in the (privileged and particular) ‘universality’ of medical professional knowledge most of the time, their bodies are not transcendent.\(^5\)

7.3 The Embodiedness of ‘Difference’ – and Reactions to ‘Difference’

Specific social groups have historically been defined by their embodiedness. Women are understood to be closer to nature, more emotional, more affected by their reproductive organs and hormones. Peoples of African, Latin, Asian or Aboriginal

\(^4\) Hence, I suggest, their difficulties even talking about their selves as racialized, gendered and so on. They spend the vast majority of their time and energy transcending those group affiliations.

\(^5\) I believe it is a part of the everyday oppression of cultural imperialism to learn to not be what your body remains. “Self annihilation is an unreasonable and unjust requirement” for equal participation (Young, 1990: 179).
heritage are seen as less civilized, more sexualized. Even as we move away from old-fashioned understandings of social differences, we still grapple with notions that women, gays and lesbians, racialized minorities, poor and working-class people are too governed by their bodies. Too loud, too colourful, too emotional, too irrational, too sexual, too expressive – too different. Furthermore even if these (Other) medical students successfully adopt the norms of professional/scientific comportment, they remain marked by their physical bodies. “In being thus chained to their bodily being they cannot be fully and un-self- consciously respectable and professional, and they are not so considered” (Young, 1990: 141). They must continue to earn the authority and respectability granted automatically to ‘neutral, unmarked’ professionals.

Identity is unavoidably embodied. As Henrietta Moore argues, “bodies marked through by the social, that is by difference (race, gender, ethnicity and so on) are presented as part of identities” (1994: 3). Bodies are simultaneously individual and social, internal and external (Shilling, 1993), as are identities (Jenkins, 1996). While bodies are by no means unchangeable, there are limits on the degree of change possible. And while the meanings of different bodily features are socially constructed and mutable, in practice change is not effected easily. Nor is change effected by individuals. It must occur at a broader social and discursive scale through collective efforts.

More specifically, while some medical students may adopt the stance of impartial knower – which as we have seen means assimilation into the culture of privileged social groups – they may only do so to a limited extent. They are held back by their bodies. An Indo-Canadian medical professional may believe he is impartial, believe it doesn’t matter what his cultural or racial origins. Yet, when he encounters patients who retain the ideal of doctor as white male, they may still react to his darker skin colour, regardless of his own belief in its lack of significance. The bodies of most marginalized social group members cannot completely assimilate to the standards of privileged social groups. Those bodily differences are a central basis of the definition of
particular social groups as marginal. As Dr. E. described in her own experience, a woman may *behave* as professionally as a man, but she will still be mistaken for a nurse. "Social identity," argues Richard Jenkins (1996: 21), "is never unilateral." What others think of us is as important as what we think of ourselves. We cannot simply assert an identity; it must also be affirmed by others.

Pierre Bourdieu's (1977; 1990) notion of habitus is useful in understanding the connections between body and identity. By habitus he means the embodiment of habit, the ways we present ourselves that are neither conscious nor unconscious, deliberate nor automatic (Jenkins, 1996). These representational practices, simultaneously individual and collective, become embodied through repetition and enactment (Cassell, 1996). This embodiment of externality, the bodily expression of habitus, Bourdieu calls bodily hexis, "a permanent disposition, a durable manner of standing, speaking, and thereby of feeling and thinking" (1977: 93-94). So, for example, the class-dependent practices of masculinity predispose working class men to strength building sports such as boxing and weight lifting, while upper-class men are predisposed toward tennis, golf, and polo. Social class thus becomes embodied in very different types of preferred masculine bodies.

Cassell suggests that the embodiment of gender and the embodiment of surgeon bring the two into inevitable conflict. Women surgeons are perceived as either not real women (possibly lesbian) or not real surgeons (Cassell, 1996: 43). Several women in her study of women surgeons were advised to wear lipstick to clarify which thing they really were. Thus medical students who are women, who are gay or lesbian, who are of Asian, African, Aboriginal, or Indian heritage, who are from poor or working class family backgrounds may strive toward becoming unsituated impartial knowers, only to be yanked back to their situatedness in their (wrong) bodies when others respond to them in the context of their social and historical particularities.

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At the same time, Young (drawing on Giddens, 1984) suggests that at the level of "discursive consciousness" people are usually committed to ending discrimination and inequality, but at a much deeper level, the level of the "basic security system," aversion and repulsion toward people who are different from oneself often reside (1990: 131-136). The liberal imperative that such differences should not matter silences those more gut-level reactions we may experience. It also silences the members of oppressed groups when they experience avoidance, rejection, condescension and so on. To speak their perceptions, and their anger or discomfort, is to name what is not supposed to be happening, the presence of which members of dominant groups may be genuinely unaware. To speak their anger is to risk being seen as overly-sensitive.

I am arguing that bodies intersect with group differences in three ways. First, people who differ from dominant social groups embody those differences – either biologically, in skin colour, secondary sex organs, disability, or in the constructed body type, gait, mannerisms, voice, laugh, desires, and so on. We embody our social statuses. Secondly, those of us who are socially located outside dominant norms and standards are perceived to be more governed by our bodies. We are overly emotional, overly sexual, overly physical – unable to transcend our bodies to fully enter the impartial life of the mind. Thirdly, our responses to others are also embodied, often occurring at a visceral level. We may consciously oppose inequalities that we nonetheless continue to reproduce in our bodily reactions to Others.

7.4 Theorizing Identity

The notion of identities as embodied was understood by some of the earliest social psychologists and social interactionists who grappled with the processes of identity formation, though it usually remained underdeveloped (e.g., Berger & Luckmann, 1966; Goffman, 1959; Mead, 1934). More importantly, though, issues of power and difference, which have shown themselves to be central in this study of
medical students' coming to identify as medical professionals, were almost completely ignored in these earlier theoretical works. For example, George Herbert Mead's (1934) well-known concept of the "generalized other" explains that the self arises as an object solely through social experience. Encounters with a larger community or social group allow the individual to develop a self based on internalizing the attitudes of the generalized other. Only this internalization makes possible shared social meanings, the basis of communication and social life as well as language and thought. Commonality of responses is what makes society possible.

Yet his theory assumes a single generalized other, a unitary community of attitudes to be internalized. He refers to the "person who has in himself the universal response of the community" (1934: 268). He cannot explain how individual selves develop when faced with competing realities, or definitions of the situation. This is what I have been arguing is the experience of members of marginalized social groups. Communities are not singular and there is no universal response. There are dominant responses and subordinated responses. Our bodily attributes may predispose us toward one or the other.

Similarly, Erving Goffman's (1959) important analysis of the presentation of self, which as we have seen is crucial to an understanding of the processes whereby medical students come to identify as medical professionals, is also limited by his lack of attention to the multiple – and potentially conflicting – identities each of us hold at any one time. For example in his discussion of performance teams he tends to assume each individual is only a member of one 'team' at a time. He makes passing mention of the fact that membership in other teams may coexists when he argues that while a team is "backstage" it may not be able to fully relax its performance if members of widely divergent social groups are present (Goffman, 1959: 130). Furthermore, when he discusses "communication out of character" he does not address the individual who is not fully able to perform the role because he or she lacks some of the props, such as the...
right gender or skin colour. He does say, "that a performer tends to conceal or underplay those activities, facts, and motives which are incompatible with an idealized version of himself" (1959: 48), but again, my point has been that some embodied aspects of self cannot be transcended. Lastly, in his examination of the performer who enacts "discrepant roles" he addresses those who deliberately follow another agenda alongside the team performance, but he fails to acknowledge that there may be some team members whose performance the audience simply refuses to buy – because the audience sees aspects of self they consider incompatible, or discrepant.

Unlike Mead, Berger and Luckmann (1966) are aware of the existence of competing worldviews, and they attempt to explain socialization processes that simultaneously incorporate conflicting or sharply divergent "symbolic universes." They argue that secondary socialization must confront an existing primary socialization, and either override it or split off role-specific parts of the self. We saw examples of both of these in Chapter 5. Presumably when one of the two (or more) aspects of self presupposes a social positioning that is universal and impartial, the impetus is to override (exclude) another clearly socially-situated identity.

Thus, in their analysis of socialization, Berger and Luckmann attend to the issue of competing identities, or competing symbolic universes. Furthermore they acknowledge the important role of power in determining which "definitions of reality will be 'made to stick' in the society" (1966: 100). They argue that the presence of alternative world views, alternative symbolic universes, by their very existence demonstrates that one's own universe is less than inevitable. Thus pluralism is "inherently subversive of the taken-for-granted reality of the traditional status quo" (1966: 115). Such alternatives are usually dismissed, destroyed or integrated within the original symbolic universe. In the end though, the determination of which representation of reality will win out is a matter of power.
The valuable insights Berger and Luckmann (1966) provide include the notion of multiple identities, or at least role-specific aspects of self, and the recognition of the importance of power – and, as I have argued, hegemonic status – to determining the outcome of competition over world views. What remains underdeveloped, though possibly implicit, in their argument is the potential of the body to be a source of alternative symbolic universes. They suggest that conversion to a new sense of self through secondary socialization is most effective if the individual is segregated with a new community of socializing agents (see Chapter 4): “one must be very careful with whom one talks,” systematically avoiding “people and ideas that are discrepant with the new definitions of reality” (1966: 146). But I have argued that one’s body itself may tie one irrevocably to an external, discrepant community.

So, from Mead, and Goffman, and Berger and Luckmann, we have several important components of a theory of identity. All three agree that identities are social and developed interactionally. Goffman adds that identity is not a possession, but a process, an enactment.

A status, a position, a social place is not a material thing, to be possessed and then displayed; it is a pattern of appropriate conduct, coherent, embellished, and well articulated. Performed with ease or clumsiness, awareness or not, guile or good faith, it is none the less something that must be enacted and portrayed, something that must be realized (Goffman, 1959: 75).

Berger and Luckmann (1966) clarify that the process of identity enactment is clearest at the intersection with other identities: I illustrate what I am in part by indicating what I am not. Because they are processual, enacted, and interactional, identities are at least potentially flexible and mutable – though within limits, as I have argued (see also Jenkins, 1996).

Goffman (1959), in particular, explicates the crucial role played by those outside the self – not just as cues to one’s own performance, but also in their willingness to accept a performance, or not. The audience must accept a role, and affirm it, for it to be
successful. Iris Marion Young (1990) argues that group identities should be understood not as properties of individuals, but as affinities.

Affinity names the manner of sharing assumptions, affective bonding, and networking that recognizably differentiates groups from one another, but not according to some common nature. ... My 'affinity group' in a given social situation comprises those people with whom I feel most comfortable, who are more familiar. Affinity names the manner of sharing assumptions, affective bonding, and networking that recognizably differentiates groups from one another, but not according to some common nature (Young, 1990:172).

Social identity is a matter of subjective affirmation of that affinity with a particular group – I belong here, I am like these people – as well as affirmation of that affinity by other members of the social group, and external assignment to that social group by people external to it (Jenkins, 1996:102; Young, 1990:172). While it remains tempting to essentialize the traits around which group affinity forms, it is not necessary to do so. As I argued in Chapter 6, recognizing group differences as relational relativizes difference, showing up the social constructedness of the meaning of differences, and relativizing even the 'neutral' norm.

7.5 Strengths, Limits, and Implications of the Research

One of the greatest strengths of this research is that it is the first study of medical professional socialization to give sustained attention to issues of gender, racialization, sexual orientation and other social differences. There has been some critique that studies of medical education tend to bemoan and over-psychologize the struggles and difficulties faced by students, rather than taking a more useful turn toward examining the structures and institutional practices that reproduce such struggles (Light, 1988). While I agree with this critique, I do think it is important not to treat medical students as a homogenous group. Even recent research has ignored differences by gender, 'race,' class, sexual orientation, and age among medical students (Sinclair, 1997). It was important to determine whether what we already knew about the struggles experienced
by medical students applied in the same ways to women, students from racialized minority groups, gay and lesbian students, and so on. Having examined that in this project, it is clear that experiences are not uniform across group differences, despite pressures toward homogeneity. Thus, future research must be sure to attend to differences, rather than colluding with the desire to erase or deny differences.

With that in mind, it is crucial to turn to examining the institutional practices that reproduce the socialization processes I have documented here. Comparative research across different types of professional training would be a useful direction. In particular that would help to clarify what aspects are attributable to professionalism itself and what are aligned with the content of the training, the impartiality of science I have been discussing. At the same time, comparisons within the same subject field, medicine, but across differing types of institutional arrangements and curricula would be a fruitful direction for study. In particular, as medical schools across North America move toward a 'problem-based learning' (PBL) curriculum, which often includes a course designed to address relations between medicine and society, it would be timely to investigate to what extent this curriculum shift affects the processes I have shown in this research. To be specific, we need to know whether PBL curricula with greater emphases on social issues in fact alter the tendencies toward assimilation, conformity, homogeneity, and erasure of social differences.

Lastly, research that seeks to study changes in students, or practitioners, over time is not ideally conducted with cross-sectional designs. There is a clear need for longitudinal research in this area. Though the classic studies like Becker’s (1961) and Merton’s (1957) did study students throughout their undergraduate medical education, they paid no attention to differences. If, as I have shown, the greatest pressures toward conformity may be felt by students who are other than the traditional white, male, heterosexual, upper-class student, we need to know how those pressures are experienced in a daily way over the duration of training. Only a longitudinal design can
adequately capture this. It would need to examine social attitudes and values, as well as connections to and involvements with communities outside of medicine, early in students' training, then periodically remeasure these over the four years and into residency and medical practice. It would not rely on students' own memories of changes in themselves over time.

Another strength of the current research is that it has moved beyond the tendency in the sociology of medicine to focus on oppression in its most blunt and heavy-handed formats, by examining racism, sexism, heterosexism and classism as processes that go on at a micro level in everyday ways. Following the theoretical move away from 'race,' and gender and so on as immutable attributes of individuals that subject them to individual acts of violation and/or structural forces of systemic discrimination, I have broadened empirical analyses such as Essed's to study multiple processes of everyday oppressions. By analyzing oppression within a group of relatively elite students and faculty, I show how processes of racialization and gendering for example, occur even in situations where commitment to formal equality is very high. Furthermore, while studies of racialization and gendering have tended to focus on how socially dominant groups proceed to construct the deviant Other, my research has been less than perfectly able to demonstrate this. It has, however, illuminated aspects of the other side of the coin: the maintenance of the hegemonic status of dominant groups and ideologies through the employment of ideals of neutrality, impartiality, and universality.

The strength of the research's focus on processes such as racialization and gendering also points to a limit of the research. By far the most effective way to document the micro processes by which a social status such as medical student or physician is gendered as (preferably) male, racialized as (preferably) white, and so on, is through participant observation. After-the-fact interviews simply cannot fully capture the dailiness of these processes. Thus, future research should not only be longitudinal,
but should also include substantial components of observation, which may be the only
way to get a sense of the subtleties by which students may be taught that they do not
quite ‘fit’ the way they are, that they should change somehow. Given students’ strong
inclinations not to admit or even see the impacts of gender, ‘race,’ sexual orientation,
class, it is highly probable that their self-reflections under-report their experiences. It is
also desirable that such longitudinal examination of experiences be part of a broader
institutional ethnography (Smith, 1987) that maps out the local and extra-local
determinants of those experiences, to meet the criticisms leveled by Light (1988) above.

Ideally, too, such longitudinal research would follow students after graduation
to determine what happens when they enter residencies and later enter into practice.
There is some evidence in my research that physicians themselves are able to ‘regain’
aspects of self that they may have shut-down while in school. Knowing whether this
happens, how, and over what time frame would be important to patients who seek out
doctors who share their own social backgrounds, as well as to students who fear they
are losing touch with parts of themselves during medical school. In short, how long-
lived are the conformity and assimilation I have examined here? To what extent do
doctors eventually ‘return to their roots,’ and do specific factors facilitate or mitigate
against this?

The implications of my research for medical education – and by extension other
professional education – relate to the need for examining differences up front,
examining issues of power and privilege, and challenging the neutrality of any
knowledge. Medical schools have made tremendous strides in recent years in
acknowledging the importance of social and cultural differences, at least as they apply
to patients. Courses in cross-cultural medicine, and instruction about how patients from
divergent social backgrounds may differ in their approaches to health and illness, are
increasingly common. I do not want to underestimate the importance of this turn in
medical education. But it is not enough.

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As I have argued, while approaches such as this at least name group differences, they both essentialize those differences and root them in the Other, making them an attribute of marginalized social groups and leaving the supposedly-neutral norms embodied by physicians themselves unexamined and unrelativized. By not identifying the 'neutral' privileged group as equally particular and socially laden, differences cannot be understood as social *relations* between dominant and subordinated social groups. Disadvantage becomes visible, but not its flip-side advantage. At the same time, power – which only exists in relationships – is reduced to pluralistic difference.

It is at least as important that medical students learn to see their own selves as socially located, as privileged where they hold privilege. Such an approach would need to be akin to a consciousness-raising strategy, to get at the gut-level responses to social difference that continue beneath the belief in egalitarianism widely shared at the discursive level of consciousness. Starting from students' own deep sense of their own powerlessness might be a way in. As I have documented, and others before me, medical students are very aware of their status at the bottom of the medical hierarchy. They are overwhelmed with feeling powerlessness to the point where it is difficult for them to see their power over patients (Wear, 1997: 62-66). Frequently members of dominant groups avoid coming to terms with our own sources of privilege because we want to cling to oppression to validate an oppositional politics. The lines between oppressed and oppressor appear to be clearly drawn, and while we are on the oppressed side we enjoy a particular solidarity and comfort (Gabriel & Scott, 1993; Yeatman, 1993). Nonetheless, I suspect that educators can use the experiences students have of feeling marginalized as a starting point to lead them toward others' feelings of marginalization, and how they participate in the social relations that marginalize others.

Delese Wear (1997) suggests that the use of fiction is a particularly powerful way to convey to medical students the way patients experience doctor-patient encounters, to help them view themselves through the eyes of the Other (Harding, 1991), and to feel
emotion in a context where emotion is permitted. Fictional accounts told from the perspective of a character undermine the desired impartiality of medicine, encouraging readers to feel, experience and identify with a particular person. Stories of patients may help "to remind students of what is behind the gazes of many of their patients" (Wear, 1997: 67).

The most basic implication of the current research for medical education, then, is that it is essential to help students begin to see themselves as just as socially located as are their patients. On a more profound level, though, it also points to the need to teach students that medical knowledge itself is as socially constructed as is any other form of knowledge. Impartiality, the view from nowhere is a myth. This is a far more fundamental and far-reaching challenge to medical education. At the most straightforward level, I would suggest a (mandatory) course in the history of medicine. Seeing the changes in medical knowledge may shake some students' beliefs that after a steady process of progressive discovery medicine now knows the Truth (Duffin, 1996).

A more thoroughgoing approach, though, would include (mandatory) courses in the sociology and philosophy of science and medicine. Even the history of science and medicine can be presented such that it tells a tale of unfaltering progression toward more and more accurate (impartial, universal) truths (see Shapin & Schaffer, 1985). The study of philosophy and sociology that contextualize knowledge claims and the possibility of impartiality would provide an essential corrective (e.g., Chalmers, 1976; Kuhn, 1962; Woolgar, 1988).

Recent feminist critiques of science, for example, suggest that conventional notions of objectivity are too narrow, operationalized to eliminate only those values that differ within the community of scientists, and applied only to processes controllable by scientific methods (Haraway, 1991; Harding, 1991). Such "weak" objectivity cannot see the cultural biases shared among researchers in a scientific community. In contrast a feminist "strong objectivity" extends systematic critical examination to the powerful...
background beliefs operating unseen in science.\textsuperscript{6} It recognizes the differences that arise from different historical and social locations, naming knowledge that claims to be universal as “unsituated” and therefore “irresponsible” because it cannot “be called into account” (Haraway, 1991: 190-191). Strong objectivity requires strong reflexivity, the ability to see oneself from the outside, to look at oneself as socially, culturally, and historically particular, to take responsibility for knowledge claims that are socially situated (Collins, 1990: 236).

In the name of health – the health of doctors and their patients – medical educators must begin deconstructing the notion that individuals can and should transcend themselves in order to become physicians. The medical science that has emerged from a supposedly impartial, unsituated location has not done well by many members of oppressed groups. Documentation of the ways misogyny, sexist biases, racism, homophobia, heterosexism, and classism have negatively affected the health of subordinate groups is now overwhelming. Patient advocates and those seeking social equality in health care have too often assumed that getting more of ‘their own’ into medicine would begin to alter the inhumane treatment they have historically suffered at the hands of medical professionals. As long as medicine is taught, learned, and practiced from an assumption that the patient’s and the doctors social particularities matter little if at all, this transformation of medicine will not occur. Until physicians learn to see their own biases they will not be able to recognize their impact in encounters with patients; such recognition is the first step toward substantive equality in health care.

Finally, this research points to fruitful directions for understanding social inequalities more generally. Violence, aggression, humiliation and discrimination are only some of the more obvious mechanisms of oppression. More commonly such

\textsuperscript{6} Similarly, feminist political philosophers have begun to argue for a strong democracy, one rooted both in liberal aspirations toward a universal equality, \textit{and} in acceptance of the impossibility and undesirability of transcending social particularities and differences (Phillips, 1993).
manifestations are denounced and ‘managed’ through policies and procedures. While documenting the more blatant forms of oppression is still useful – if nothing else to prove the existence of such oppressions to those who refuse to believe – the risk is overlooking more subtle forms of marginalization and containment. Empirical research must attend to the micro-processes that perpetuate oppression and dominant-group hegemony if effective counter-strategies are to be formulated.

Both in political contestation and in theory development, though, some unresolved tensions in this research may prove both productive and problematic. A politics of difference risks disintegration into a multiplicity of fragments. Without the promise of universal equality that accompanies liberal humanism there may be no unifying goals around which to build counter-hegemonic solidarity (Phillips, 1993). Instead the solidification of exclusive identity-based social groups could degenerate into narrow special interest groups. I suspect this tension between goals of universal equality and insistence that universalities are false and deceptively neutral cannot be resolved. In theorizing and in social and political activism it may be necessary to work from social particularities continually challenging new hegemonic norms for their hidden social specificities, even while striving toward a generalized equality.
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TABLE A.2: Activities students would like to do after medical school
TABLE A.3: Importance of Various Factors to How Students Thought About Themselves Day to Day Before Entering Medical School
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Appendix I: Survey Instructions

Private, public and professional identities: Congruence and conflicts in medical school.

Questionnaire for Third-year Students, XXX Medical School

Thank you for participating in this research about medical students' identities. I believe the results will be of interest to other medical students, to students in other professional and graduate programs, as well as to medical school faculty and administration.

Participation is voluntary. Refusal to participate will not affect your standing as a medical student in any way. However, the only way to ensure your particular viewpoints are included in the final results, along with those of your classmates, is to complete the survey.

All survey information will be kept completely confidential. Your survey will be identified only by number. You will not be identified in any reports from this research. If you feel uncomfortable with any question you need not answer it.

Instructions

1. Do not write your name on this survey.

2. Some questions ask you to choose one or more responses from a list of alternatives. For those questions simply check the appropriate box or boxes. Other questions ask you to indicate the strength of your response on a scale from 1 to 5; for those questions just circle the appropriate number. Finally, some questions simply ask you to write your response briefly in your own words.

3. Please answer each question as completely as possible to ensure the quality of the survey results. If you want to add comments, just write in the margins or on the last page.

4. If you have any questions, concerns or comments, please call Brenda at ###-####.

5. When you have completed the questionnaire, please return it in the addressed, stamped envelope provided.
Appendix II: Interview Cards, Follow-Up Letters and Notices

I would very much like to interview some of the students who complete this survey, to examine these issues in greater depth.

If you would be willing to participate in an interview — at a time and place convenient for you — please write your first name and your phone number in the spaces below.

Interviews will take about one hour, and information will be kept completely confidential.

First name: ____________________________
Phone number: _________________________
What is the best time to reach you? ________________________________

You can mail this card back with your survey or mail it separately in the small envelope provided. Thank you!
January 29, 1997

Dear third-year medical student:

Medical students in the 1990's are a far more diverse group than they were even 20 years ago. What complexities does that diversity bring to medical education? Do you ever have time to think about who you were when you entered medical school and who you are becoming through your medical training? Do you think all students experience medical school the same way? Do some students change more than others in medical school? Do some students "fit" more easily than others?

With your help, I hope to explore these and other questions through the survey you are holding. I am a doctoral student in the Sociology Department at the University of British Columbia, and I am interested in the impact of the diverse social backgrounds of medical students in the mid-1990s on processes of undergraduate medical education. My thesis is on "Private, public and professional identities: Congruence and conflicts in medical school." I am asking all third-year students at UBC medical school to spend about 30 minutes completing this survey.

I think you will find filling out the questionnaire interesting and thought-provoking.

In addition to helping me earn my Ph.D., your participation will also benefit future medical students and medical educators. Your experiences, opinions, and ideas are important if medical education is to be guided to meet the realities of medical students' lives in the 1990's. The research findings will benefit administrators, faculty and students, who may wish to know how contemporary diversity in medical schools affects experiences of undergraduate training. Students will benefit from analyses of how other students integrate their developing medical professional identities with other identities important to them. I will provide a summary analysis of the data to the Medical Undergraduate Society and the Dean’s Office.

Completing the questionnaire is entirely voluntary. All responses will be kept strictly confidential. There is a number written in the upper right corner of the first page of each questionnaire. It will allow me to know who has returned the questionnaire. However, after recording that you have returned your survey, from then on it will only be identified by survey number. No one but me will ever see the one file that links names with survey numbers. Surveys will be kept in a locked file cabinet.

Completion of the survey will be assumed to indicate informed consent. Should you have any concerns about this research feel free to contact my thesis supervisor, Dr. XXX (Department of Anthropology and Sociology) at ####. Or call me at ####.

Sincerely,

Brenda Beagan
Doctoral Candidate
Reminder #1, February 13, 1997

What are you putting on hold until you finish Medical School?

Answer this and other thought-provoking questions in the survey you received two weeks ago
"Private, public and professional identities."

Please complete your survey and return it to me!
If you've lost your copy please call me at ####-####.

There is no hidden agenda — I want to know how students survive medical school,
what compromises you are making in other parts of your life,
how you deal with these pressures.
The only way to ensure your particular viewpoints are included is
to complete the survey.
Remember all information will be kept completely confidential.

If you've already sent your survey in, thank you very much!
If you said you'd like to be interviewed, I'll be in touch soon.
If you'd like to do an interview but not the survey
just send the interview card that was enclosed.

Brenda Beagan
February 27, 1997

Hi!

You got a survey from me a few weeks ago. I’m giving you another copy, in case you no longer have the first one, and I would like to encourage you to fill it out. I’ve received completed surveys from about a third of your class, but unless I get more the results will be inconclusive.

The ID#s of all surveys I receive by March 21 will be entered in a draw for $200.00!

I know you are extremely busy — you should be compensated for your time. As a graduate student I cannot afford to financially compensate each of you sufficiently to make it worth your while filling out the survey. So instead I will have a sort of lottery. If you send me a completed survey, I will enter the ID# on your survey in a draw for $200.00. The winning number will be chosen randomly, and the name of the winner will be posted by your student mailboxes the following week. The winner will be contacted immediately to arrange delivery of the $200.00 cheque.

The survey is about how medical students experience medical training, and how they think about themselves during that process. It’s about compromises medical students may have to make between who they are outside of school and the overwhelming demands on their time in school. It’s about how students find ways to balance all the various aspects of themselves during an intense education process.

Why should you fill it out? First, the money! Second, I think you will find it thought-provoking. Third, it will add to knowledge about medical education processes and how they are experienced by students.

Completing the questionnaire is entirely voluntary. All responses will be kept strictly confidential. The ID# in the upper right corner of the first page of each survey is solely to allow me to keep track of which surveys have been returned. The list linking names and ID#s will be destroyed after March 21. Completion of the survey will be assumed to indicate informed consent. Should you have any concerns about this research feel free to contact my thesis supervisor, Dr. XXX (Department of Anthropology and Sociology) at ####. Or call me at ####.

Sincerely,

Brenda Beagan
Doctoral Candidate
Final Reminder, March 13, 1997

Last call for surveys!

This is your last chance to get your views represented in the survey on medical students' experiences of med school! I recently gave you a second copy of the survey, in case you had lost the original one. If you meant to fill it out but have not yet done so, please take a few minutes right now and fill it out.

The deadline is March 21!

I very much want to include your confidential responses, so please return your survey by then.

Remember, the ID # from each completed survey will be entered in a draw for $200.00.

Brenda Beagan
April 2, 1997

Dear _______________,

Remember the survey you completed a while ago, about your experiences as a medical student, and other such topics? Well, if you were in the room when I spoke to your class a few weeks ago, you'll know that I tried to encourage more students to complete the survey by holding a lottery.

I entered all the ID numbers from the surveys I received into a draw for $200.00. You are the winner! Congratulations! And thank you for completing the survey.

I don't have a phone number or address for you, so I am contacting you through your student mailbox. Please call me so we can arrange a way for me to get the $200 to you. I can leave it here if you think that is safe. Or leave it in the medical undergrad education office for you to pick up. Or mail a cheque to your home address. Or meet you to give it to you in person. Whatever is easiest for you.

Also, I promised to announce the name of the winner, so the rest of the students will know that I actually did do a draw and there really was a winner. But I'll only post your name as the winner if you agree to that. It compromises your confidentiality to some extent.

Another option, if you don't want me to post your name as the winner, is that I could tell someone in the Medical Undergrad Education office who the winner was, and simply tell the rest of your class that someone in that office office can confirm there was indeed a winner. That holds me accountable to the class, without compromising confidentiality. It's up to you. You can let me know what you prefer when we arrange to get you the money.

Again, thanks and congratulations. I look forward to hearing from you. My number is ####-#####. If I'm not in, leave a message with a number where I can reach you.

Sincerely,

Brenda Beagan
And the $200 goes to . . .

XXXX XXXXX!

Thank you to everyone who completed a survey for me. Your assistance is greatly appreciated. I'll let you all know when the results of the research are available.

Every ID number of the surveys I received was entered in a draw for a $200 honorarium, to thank all of you for your time and assistance. Congratulations to XXXXX whose ID number was drawn randomly.

Another draw for $100!

All you have to do is be interviewed for an hour or so. Twenty of you have already agreed to be interviewed in more depth about the same sorts of topics covered in the survey. (I'll be in touch shortly.) I'd like to do another 10 interviews, for a total of 30.

Again, I cannot afford to compensate each of you for your time, so again I will hold a lottery. If you are interested in being interviewed sometime over the next couple of months, please call me at ###-####. The names of everyone interviewed will be entered in a draw for $100 as soon as I finish the interviews.

All interviews are voluntary, and all information will be confidential. Interviews will take about one hour and will be held at the time and place most convenient for you.

Brenda Beagan
May 12, 1997

Dear ____________,

You may recall that several weeks ago I was conducting a survey about experiences and questions of identity in medical school? I am now in the second stage of the research, doing interviews with a smaller sample of students from your class. I don’t know if you completed a survey or not, but I do know that you did not express a desire to be interviewed. 

However, at least one of your classmates who has been interviewed has suggested to me that you would be an ideal person for me to talk with. Based on their suggestions, I am writing to ask you to consider volunteering to be interviewed. 

I very much want a range of perspectives to get as accurate a picture as possible of students’ experiences in medical school. There are very diverse groups of students in your class with widely differing ideas and opinions. Your particular viewpoints would be very valuable to my research. It might also win you $100! I would like to be able to compensate students for their time when I interview them, but I cannot afford to compensate everyone. Instead I will have a draw, and one of the 30 students interviewed will win $100.

The opinions and experiences of students like you are particularly important if medical education is to be guided to meet the realities of medical students’ lives in the 1990’s. I believe medical school administrators, faculty and students will benefit from knowing more about students’ experiences of their undergraduate medical training. I also think it could be very beneficial to prospective or incoming med students to know more about what the experience might be like.

If you volunteer to be interviewed, I will come to whatever location is most convenient for you, at whatever time is best for you (sometime before the end of July would be best). I realize that you are very busy; I’ll make this as easy as possible. The whole interview will take about an hour. I would ask very open-ended questions about your experiences of medical school, what struggles you may have had and what things have made it easier for you, your observations of changes in yourself and your classmates as you go through your training, and your future personal and career plans. Students I have interviewed so far have said they enjoyed the interview. If you might be willing to be interviewed, please contact me at ### and we can arrange a time and place.

Should you choose to participate in an interview everything you say will be kept strictly confidential. Doing an interview would be completely voluntary. You will incur no penalty whatsoever if you choose not to grant me an interview — and this will be the last time I bother you! If you have any concerns about this research, feel free to contact my thesis supervisor, Dr. XXX at ###-####.

Sincerely,

Brenda Beagan

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Appendix III: Student interviews consent form, interview guide

Consent Form – Student Interviews

Private, Public and Professional Identities:
Congruence and Conflicts in Medical School

I agree to participate in a study of students' experiences of professional identity formation in medical school, and the effects of other social identities on that process. I understand that I will be interviewed by Brenda Beagan and that this research is for her doctoral dissertation. I will be asked questions about my experiences as a medical student, the aspects of my identity that are important to me, and the connections among different parts of my identity and my experience of medical school.

I understand that the interview will take approximately one hour and that it will be tape-recorded. I understand that I can refuse to answer any question and that I can turn the tape-recorder off at any time or have any portion of the tape deleted if I wish. If I feel that I have not been able to express my beliefs adequately during the interview, an additional interview can be scheduled at my request.

I understand that anything I say during the interview will be kept strictly confidential and my name will not be used in any reports from the research. Interview tapes and transcripts will be identified only by number and pseudonym and will be accessible only to Brenda Beagan. In particular, nothing with my name will ever be shown to anyone affiliated with XXX Faculty of Medicine.

My decision to participate in this study is entirely voluntary and I am free to withdraw at any time without any jeopardy to myself.

If I have any questions about the study, or want further information, I can contact Brenda Beagan at ###, or her thesis supervisor, Dr. XXX (Department of Anthropology and Sociology, UBC) at ###. If I have any concerns about my treatment or rights as a research subject I can also contact Dr. XXX, Director of the UBC Office of Research Services and Administration, at ###.

I consent to participate in this project and acknowledge that I have received a copy of this consent form for my records.

_________________________  __________________________
Date                             Signature

...292...
Interview Guide – Students

• Can you tell me a little bit about yourself before we start? (age, what doing before med school, why this school, relationship, past degrees etc)
• Why did you decide to enter medicine?
• How did your friends and family react to your going into medicine?
• What did you know about what medical school would be like before you started? Has it been what you expected? How so / how not?
• Have you ever had doubts about your decision to enter med school? (Incidents?) Would you do it again?
• In the survey, one of the things students ranked as most stressful was balancing school and personal life. Has that been true for you? Can you talk a bit about that?
• Do you ever feel conflicts between your med school self and other “parts” of yourself? What do you do with that?
• In what ways have you changed during medical school?
• In what ways do you think your experiences of med school have been affected by who you were coming in to the program? (probe gender, race, class, cultural heritage, academic background, age etc)
• One of the main things I am interested in is the process of becoming a doctor, starting to think of yourself as a doctor. When did you start to think of yourself as a med student? When did you start to speak of yourself as a med student?
• When did you start to feel like you belonged in the hospitals?
• In Third and Fourth Years a major focus is deciding what you want to do in terms of residencies. How have you made decisions around that? What things are important to you in deciding?
• If I were about to enter med school and I told you I was afraid I’d end up losing touch with parts of myself that are important to me, what advice would you give me?
• Imagine yourself 10 years from now. How do you see your medical career? Your personal life? Do you expect any difficulty putting together family and career?
• What would being a “good doctor” look like for you? How are being a good med student and being a good doctor are similar or different?
• If you could transform medical school, so that it worked better for you and other students how would you change it? (response to the new curriculum?)
• Is there anything I haven’t asked that you’d like to add, in relation to the things we’ve been discussing?
• I’d like to do a few more interviews with as wide a range of students as possible. Can you think of any of your classmates that would be particularly good for me to talk with?
Appendix IV: Faculty interviews – letter, consent form, interview guide

July 7, 1997

[ADDRESS]

Dear Dr. ________,

I am a PhD candidate in the Sociology Department at UBC. In the context of my research, your name was mentioned by one or more medical students as a faculty member who has significant contact with med students, and as someone I should talk to.

My research is on undergraduate medical education, particularly how an increasingly diverse group of med students experiences their training, and how they put together who they were before med school with who they are becoming. I am already finding out some interesting things from a survey I administered to medical students at UBC, and from a series of in-depth interviews I have done with some students.

But I think it is important to also get the perspective of academic and clinical faculty, a perspective that may be longer-term and broader than the perspective available to students. I'm planning to interview 12-15 faculty members from the medical school, and I hope you might be willing to be one of them. I'm told you are interested in medical education processes and would have valuable opinions for me.

I am writing to ask whether you would be willing to grant me an interview, at a time and place convenient for you. It would take an hour or less. I would be asking for your opinions and observations about changes in the population of students entering medical school, what impact increasing diversity among students has on medical education, and how you see students struggling with different aspects of their lives, their experiences, and their self-identities as they go through medical training. The questions will be open-ended. Your participation in the research would be entirely voluntary, and should you choose to grant me an interview everything you say will be kept strictly confidential.

If you might be willing to be interviewed, please contact me and we can make arrangements. I know it's summer, and you may have plans; we can schedule the interview at your convenience. If I do not hear from you in a short while I will try to reach you by phone to see if you are interested. Should you have any concerns about this research, feel free to contact my thesis supervisor, Dr. XXX (Department of Anthropology and Sociology) at ###.

Sincerely,

Brenda Beagan
[phone # & email address]

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Consent Form – Faculty Interviews

Private, Public and Professional Identities:
Congruence and Conflicts in Medical School

I agree to participate in a study about the professional identity formation of medical students, and the effects of students’ other social identities on that process. I understand that I will be interviewed by Brenda Beagan and that this research is for her doctoral dissertation. I will be asked my opinions and observations about how medical students change during their training, about changes in medical student backgrounds in recent years and how that affects medical education, and about the connections among different parts of students’ identities as they go through medical training.

I understand that the interview will take approximately one hour and that it will be tape-recorded. I understand that I can refuse to answer any question and that I can turn the tape-recorder off at any time or have any portion of the tape deleted if I wish. If I feel that I have not been able to express my beliefs adequately during the interview an additional interview can be scheduled at my request.

I understand that anything I say during the interview will be kept strictly confidential and my name will not be used in any reports from the research. Interview tapes and transcripts will be identified only by number and pseudonym and will be accessible only to Brenda Beagan. Nothing with my name in it will ever be shown to anyone affiliated with XXX Faculty of Medicine.

My decision to participate in this study is entirely voluntary and I am free to withdraw at any time without any jeopardy to myself. If I have any questions about the study, or want further information, I can contact Brenda Beagan at ###, or her thesis supervisor Dr. XXX (Department of Anthropology and Sociology, UBC) at ###. If I have any concerns about my treatment or rights as a research subject I can also contact Dr. XXX, Director of the UBC Office of Research Services and Administration, at ###.

I consent to participate in this project and acknowledge that I have received a copy of this consent form for my records.

_________________________  _________________________
Date                        Signature
Interview Guide – Medical School Faculty/Administrators

• Perhaps to start you could tell me a bit about yourself, especially in relation to medicine and medical education?

• From your perspective, how do students change during undergraduate med school?

• Comparing med students in 1997 with those when you went to med school, what changes have you seen in the medical student population over time? What impact do these changes have on medical education?

• From your perspective, when do most students start to identify as medical students / future doctors? When do they start to feel they belong?

• Do particular types of students tend to fit in better or feel like they belong more readily? Take on the professional identity more easily?

• Another key focus in the research is how the social identities a students brings into med school with them affect their experiences there. Any thoughts on that? (Age. Class. Gender. Race/culture. Prior career or academic bkgd. Sexual orientation. Marital/parental status.)

• What things do you see students considering when they are making residency choices?

• Women and some minorities still tend to cluster in particular specialties. Why do you think this is the case?

• In your view, does being a good med student require the same things as being a good doctor?

• Do we do a good job of preparing students for what they will face as doctors? How could it be done better?

• Is there anything you’d like to add in relation to what we’ve been talking about, that I haven’t asked?
APPENDIX V: Additional Survey Results

**TABLE A.1**
Hours Spent on Various Activities the Previous Week (N=72)

<table>
<thead>
<tr>
<th>Hours spent on . . .</th>
<th>Mean (hrs)</th>
<th>Minimum (hrs)</th>
<th>Maximum (hrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>School-related activities</td>
<td>59.7</td>
<td>25</td>
<td>110</td>
</tr>
<tr>
<td>Other activities</td>
<td>11.1</td>
<td>0</td>
<td>46</td>
</tr>
<tr>
<td>Time with spouse/partner</td>
<td>10.4</td>
<td>0</td>
<td>50</td>
</tr>
<tr>
<td>Time with friends</td>
<td>6.0</td>
<td>0</td>
<td>30</td>
</tr>
<tr>
<td>Watching TV</td>
<td>4.6</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Sports activities</td>
<td>4.4</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Housework</td>
<td>2.7</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Family, other than spouse, children</td>
<td>2.2</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Music, art, films</td>
<td>1.9</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Restaurants, bars, nightclubs</td>
<td>1.8</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Religious activities</td>
<td>1.1</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Reading for pleasure</td>
<td>1.1</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Social or political activism</td>
<td>0.7</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Time with child(ren)</td>
<td>0.3</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Volunteer activity</td>
<td>0.2</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Cultural/racial/ethnic community</td>
<td>0.1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Gay/lesbian/bisexual community</td>
<td>0.0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Political party involvement</td>
<td>0.0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

'Other' includes one case of 46 hrs for sleeping. Two instances of 50 hours with a spouse/partner elevate what would be a mean of 8.9 hrs, max 28 hrs. One case of 20 hrs on activist work raises what would be a mean of 0.2 hrs, max 3 hrs.

**TABLE A.2**
Activities students would like to do after medical school (N=72)

<table>
<thead>
<tr>
<th>After medical school I would like to . . .</th>
<th>Agree (%)</th>
<th>Neutral (%)</th>
<th>Disagree (%)</th>
<th>Does not apply (N=)</th>
</tr>
</thead>
<tbody>
<tr>
<td>travel</td>
<td>91.6</td>
<td>7.0</td>
<td>1.4</td>
<td>1</td>
</tr>
<tr>
<td>spend more time with spouse/partner</td>
<td>90.4</td>
<td>7.7</td>
<td>1.9</td>
<td>20</td>
</tr>
<tr>
<td>exercise more</td>
<td>90.2</td>
<td>5.6</td>
<td>4.2</td>
<td>1</td>
</tr>
<tr>
<td>develop other skills, talents</td>
<td>88.9</td>
<td>4.2</td>
<td>6.9</td>
<td>0</td>
</tr>
<tr>
<td>spend more time with friends</td>
<td>87.5</td>
<td>9.7</td>
<td>2.8</td>
<td>0</td>
</tr>
<tr>
<td>get married/enter a committed relationship</td>
<td>84.8</td>
<td>10.9</td>
<td>4.3</td>
<td>26</td>
</tr>
<tr>
<td>explore other intellectual interests</td>
<td>83.3</td>
<td>9.8</td>
<td>6.9</td>
<td>0</td>
</tr>
<tr>
<td>spend more time with family</td>
<td>81.9</td>
<td>13.9</td>
<td>4.2</td>
<td>0</td>
</tr>
<tr>
<td>take better care of myself</td>
<td>78.3</td>
<td>13.0</td>
<td>8.7</td>
<td>3</td>
</tr>
<tr>
<td>have children</td>
<td>77.3</td>
<td>9.1</td>
<td>13.6</td>
<td>6</td>
</tr>
<tr>
<td>read non-medical books</td>
<td>70.9</td>
<td>15.2</td>
<td>13.9</td>
<td>0</td>
</tr>
<tr>
<td>explore my creative side</td>
<td>65.3</td>
<td>19.4</td>
<td>15.3</td>
<td>0</td>
</tr>
<tr>
<td>be more informed about current events</td>
<td>55.5</td>
<td>34.8</td>
<td>9.7</td>
<td>0</td>
</tr>
<tr>
<td>be more active with my religion</td>
<td>44.2</td>
<td>32.5</td>
<td>23.3</td>
<td>29</td>
</tr>
<tr>
<td>do some/more volunteer work</td>
<td>42.3</td>
<td>22.5</td>
<td>35.2</td>
<td>1</td>
</tr>
<tr>
<td>be more involved in my cultural/ethnic community</td>
<td>30.0</td>
<td>27.5</td>
<td>42.5</td>
<td>32</td>
</tr>
<tr>
<td>be more involved in community activism</td>
<td>24.7</td>
<td>29.1</td>
<td>46.2</td>
<td>7</td>
</tr>
<tr>
<td>be more politically active</td>
<td>15.6</td>
<td>25.0</td>
<td>59.4</td>
<td>8</td>
</tr>
</tbody>
</table>

Percentages are of those respondents who did not circle "does not apply." Rows total 100%.
**TABLE A.3**
Importance of Various Factors to How Students Thought About Themselves Day to Day
*Before Entering Medical School (N=72)*

<table>
<thead>
<tr>
<th>Factor</th>
<th>Not important (1-2)</th>
<th>Neutral (3)</th>
<th>Important (4-5)</th>
<th>Does not apply</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being a partner/spouse</td>
<td>17.9%</td>
<td>5.2%</td>
<td>76.9%</td>
<td>N=32</td>
<td>3.7</td>
</tr>
<tr>
<td>Academic performance</td>
<td>4.3</td>
<td>8.6</td>
<td>87.1</td>
<td>1</td>
<td>4.3</td>
</tr>
<tr>
<td>Athletic skills, talents</td>
<td>14.3</td>
<td>24.3</td>
<td>61.4</td>
<td>1</td>
<td>3.7</td>
</tr>
<tr>
<td>Creative skills talents</td>
<td>7.0</td>
<td>26.8</td>
<td>66.2</td>
<td>0</td>
<td>3.7</td>
</tr>
<tr>
<td>Age</td>
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<td>38.0</td>
<td>24.0</td>
<td>0</td>
<td>2.7</td>
</tr>
<tr>
<td>Gender</td>
<td>49.3</td>
<td>29.6</td>
<td>21.1</td>
<td>0</td>
<td>2.4</td>
</tr>
<tr>
<td>Cultural heritage</td>
<td>59.4</td>
<td>17.4</td>
<td>23.2</td>
<td>2</td>
<td>2.5</td>
</tr>
<tr>
<td>Religion</td>
<td>63.0</td>
<td>13.0</td>
<td>24.0</td>
<td>17</td>
<td>2.4</td>
</tr>
<tr>
<td>Racial background</td>
<td>67.1</td>
<td>15.8</td>
<td>17.1</td>
<td>1</td>
<td>2.1</td>
</tr>
<tr>
<td>Social class background</td>
<td>54.3</td>
<td>31.4</td>
<td>14.3</td>
<td>0</td>
<td>2.3</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>75.4</td>
<td>14.5</td>
<td>10.1</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Political affiliations</td>
<td>75.0</td>
<td>17.3</td>
<td>7.7</td>
<td>19</td>
<td>1.8</td>
</tr>
<tr>
<td>Volunteer work</td>
<td>36.2</td>
<td>27.6</td>
<td>36.2</td>
<td>2</td>
<td>2.9</td>
</tr>
</tbody>
</table>

**TABLE A.4**
Difference Between the Importance of Various Factors to Students
*Before and During Medical School (N=72)*

<table>
<thead>
<tr>
<th>Factor</th>
<th>Less important (-2 to -4)</th>
<th>Slightly less important (-1)</th>
<th>Same (0)</th>
<th>Slightly more important (+1)</th>
<th>More important (+2 to +4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteer work</td>
<td>60.0%</td>
<td>15.7%</td>
<td>22.9%</td>
<td>1.4%</td>
<td>0%</td>
</tr>
<tr>
<td>Academic performance</td>
<td>18.8</td>
<td>27.5</td>
<td>40.7</td>
<td>7.2</td>
<td>5.8</td>
</tr>
<tr>
<td>Creative skills talents</td>
<td>15.7</td>
<td>32.9</td>
<td>47.1</td>
<td>1.4</td>
<td>2.9</td>
</tr>
<tr>
<td>Athletic skills, talents</td>
<td>5.8</td>
<td>27.5</td>
<td>53.7</td>
<td>7.2</td>
<td>5.8</td>
</tr>
<tr>
<td>Political affiliations</td>
<td>11.4</td>
<td>11.4</td>
<td>67.3</td>
<td>7.1</td>
<td>2.8</td>
</tr>
<tr>
<td>Being a partner/spouse</td>
<td>2.9</td>
<td>14.3</td>
<td>65.6</td>
<td>5.7</td>
<td>11.5</td>
</tr>
<tr>
<td>Social class background</td>
<td>4.4</td>
<td>17.6</td>
<td>63.3</td>
<td>14.7</td>
<td>0</td>
</tr>
<tr>
<td>Religion</td>
<td>7.1</td>
<td>4.3</td>
<td>71.4</td>
<td>11.4</td>
<td>5.8</td>
</tr>
<tr>
<td>Age</td>
<td>5.7</td>
<td>17.1</td>
<td>38.6</td>
<td>20.0</td>
<td>18.5</td>
</tr>
<tr>
<td>Gender</td>
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<td>4.3</td>
<td>57.1</td>
<td>30.0</td>
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</tr>
<tr>
<td>Cultural heritage</td>
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<td>8.6</td>
<td>74.2</td>
<td>12.9</td>
<td>4.3</td>
</tr>
<tr>
<td>Racial background</td>
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<td>2.9</td>
<td>78.6</td>
<td>15.7</td>
<td>1.4</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>0</td>
<td>7.1</td>
<td>81.4</td>
<td>7.1</td>
<td>4.3</td>
</tr>
</tbody>
</table>
### TABLE A.5
Importance of Various Factors to Selection of Residency (N=72)

<table>
<thead>
<tr>
<th>Importance of...</th>
<th>Not very to not at all important</th>
<th>Neutral</th>
<th>Fairly to very important</th>
<th>Mean (5=very important)</th>
</tr>
</thead>
<tbody>
<tr>
<td>your interests</td>
<td>0.0</td>
<td>2.8</td>
<td>97.2</td>
<td>4.7</td>
</tr>
<tr>
<td>career aspirations</td>
<td>2.9</td>
<td>8.6</td>
<td>88.6</td>
<td>4.4</td>
</tr>
<tr>
<td>type of clinical setting</td>
<td>0.0</td>
<td>14.1</td>
<td>85.9</td>
<td>4.3</td>
</tr>
<tr>
<td>your skills, abilities</td>
<td>2.8</td>
<td>15.5</td>
<td>81.7</td>
<td>4.1</td>
</tr>
<tr>
<td>regular schedule probable</td>
<td>7.0</td>
<td>19.7</td>
<td>73.3</td>
<td>3.9</td>
</tr>
<tr>
<td>marital/relationship status</td>
<td>18.3</td>
<td>11.3</td>
<td>70.4</td>
<td>3.7</td>
</tr>
<tr>
<td>type of patients</td>
<td>12.7</td>
<td>21.1</td>
<td>66.2</td>
<td>3.8</td>
</tr>
<tr>
<td>having children or not</td>
<td>22.6</td>
<td>12.7</td>
<td>64.8</td>
<td>3.7</td>
</tr>
<tr>
<td>residency opportunities</td>
<td>22.5</td>
<td>23.9</td>
<td>53.6</td>
<td>3.5</td>
</tr>
<tr>
<td>encouragement from others</td>
<td>23.9</td>
<td>25.4</td>
<td>50.7</td>
<td>3.3</td>
</tr>
<tr>
<td>financial rewards possible</td>
<td>46.5</td>
<td>28.2</td>
<td>25.3</td>
<td>2.6</td>
</tr>
<tr>
<td>your gender</td>
<td>64.8</td>
<td>12.7</td>
<td>22.5</td>
<td>2.2</td>
</tr>
<tr>
<td>your religion/lack of religion</td>
<td>84.5</td>
<td>5.6</td>
<td>9.8</td>
<td>1.6</td>
</tr>
<tr>
<td>your social class background</td>
<td>83.1</td>
<td>11.3</td>
<td>5.6</td>
<td>1.6</td>
</tr>
<tr>
<td>your race/culture/ethnicity</td>
<td>83.1</td>
<td>11.3</td>
<td>5.6</td>
<td>1.5</td>
</tr>
<tr>
<td>your sexual orientation</td>
<td>94.4</td>
<td>4.2</td>
<td>1.4</td>
<td>1.2</td>
</tr>
</tbody>
</table>