CLASSIC

CONTEMPORARY

CROSS-CULTURAL

29 "Even If I Don't Know What I'm Doing, I Can Make It Look Like I Do": Becoming a Doctor in Canada

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Sociologists use the term social structure *to refer to the relatively stable patterns of social interaction and organized relationships that persist over time. Brenda Beagan's article shows how medical students who are trained at Canadian universities are socialized to fit into existing social structures rather than to change them. Notice how medical students incorporate their new professional identity as they move through their studies.*

When students enter medical school they are lay people with some science background. When they leave four years later they have become physicians; they have acquired specialized knowledge and taken on a new identity of medical professional. What happens in those four years? What processes of socialization go into the making of a doctor?

Most of what we know about how students come to identify as future-physicians derives from research conducted when students were almost exclusively male, white, middle- or upper-class, young and single—for example, the classics *Boys in White* (Becker, Geer, Strauss, & Hughes, 1961) and *Student Physician* (Morton, Reader, & Kendall, 1957). When women and students of colour were present in this research it was in token numbers. Even when women and non-traditional students were present, as in Sinclair's (1997) recent ethnography, their impact on processes of professional identity formation and the potentially distinct impact of professional socialization on these students have been largely unanalysed. What does becoming a doctor look like in a medical school of the late 1990s, where many students are female, are of diverse racial and cultural backgrounds, are working-class, gay, and/or parents?

This study draws on survey and interview data from students and faculty at one Canadian medical school to examine the processes of professional identity formation and how they are experienced by diverse undergraduate medical students in the late 1990s. As the results will show, the processes are remarkably unchanged from the processes documented forty years ago.

RESEARCH METHODS AND PARTICIPANTS

The research employed three complementary research strategies: A survey of a third-year class (123 students) at one medical school, interviews with twenty-five students from that class, and

Source: Brenda L. Beagan. 2001. "Even if I don't know what I'm doing I can make it look like I know what I'm doing": Becoming a doctor in the 1990s. *The Canadian Review of Sociology and Anthropology* 38(3): 275–92.

interviews with twenty-three faculty members from the same school.[1] Third-year students were chosen because in a traditional medical curriculum the third year is a key point for students, an important transition as they move out of the classroom to spend the majority of their time working with patients—patients who may or may not call them "doctor," treat them as doctors, and reflect them back to themselves as doctors (cf. Coombs, 1978; Haas & Shaffir, 1987). . . .

Survey respondents also identified faculty members who they believed were "especially interested in medical education." Twenty-three faculty interviews were conducted. All interviews took sixty to ninety minutes following a semi-structured interview guide, and were tape-recorded and transcribed. The interview transcripts were coded inductively using broad categories such as "pressures toward conformity," and "conflicts experienced," and using codes such as "language of medicine" derived from the literature. Initial broad codes were later subdivided into narrower codes.

. . . [T]he students who completed the survey were evenly divided by gender and were heterogeneous in "race"/ethnicity, as well as in self-identified social class background.[2] Twenty students (28%) self-identified as members of "minority groups," all identifying racial or cultural groups. The students interviewed were slightly less heterogeneous in "race"/ethnicity and first language, and were somewhat more likely to be in committed relationships. The purposive sample of faculty members and administrators was predominately male, English-speaking and of European origin—reflective of the school's faculty more generally.

FIRST EXPERIENCES BECOME COMMONPLACE

When identifying how they came to think of themselves as medical students, participants described a process whereby what feels artificial and unnatural initially comes to feel natural simply through repetition. For many students, a series of "first times" were transformative moments.

> Denise:[3] I think there are sort of seminal experiences. 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. . . . First few procedures that I conducted myself, first time I realized that I really did have somebody's life in my hands. . . . 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.

Part of the novelty is the experience of being entitled—even required—to violate conventional social norms, touching patients' bodies, inquiring about bodily functions, probing emotional states: "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. . . ."

CONSTRUCTING A PROFESSIONAL APPEARANCE

Students are quite explicitly socialized to adopt a professional appearance: "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." Most students, however, do not require such reminders; they have internalized the requisite standards.

> 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 (survey comment).

Asked whether or not they ever worry about their appearance or dress at the hospital, 41 percent of the survey respondents said they do not, while 59 percent said they do.

There were no statistically significant differences by gender, class background or "minority" status, yet gendered patterns emerged when students detailed their concerns in an open-ended question. Most of the men satisfied their concerns about professional appearance with a shave and a collared shirt, perhaps adding a tie: "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, trying to look well-dressed yet not convey sexual messages. For women, "dressed up" normally means feminine while a professional image is intended to convey competence. Striking a balance at the intersection can be difficult: "Is it professional enough? Competent looking?. . . I do not want to appear 'sexy' on the job." As one student noted, while both men and women sometimes violate standards of professional dress, men's violations tend to involve being too informal; women's may involve dressing too provocatively, thereby sexualizing a doctor-patient encounter.

CHANGES IN LANGUAGE, THINKING AND COMMUNICATION SKILLS

Acquiring a huge vocabulary of new words and old words with new meanings—what one student called "medical-ese"—is one of the central tasks facing medical students, and one of the major bases for examining them (Sinclair, 1997). Students were well aware of adopting the formal language of medicine.

Dawna: All of a sudden all I can think of is this lingo that people won't understand. 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.

The language of medicine is the basis for constructing a new social reality. Even as it allows communication, language constructs "zones of meaning that are linguistically circumscribed" (Berger & Luckmann, 1966: 39). Medical language encapsulates and constructs a worldview wherein reducing a person to body parts, tissues, organs and systems becomes normal, natural, "the only reasonable way to think" (Good & Good, 1993: 98–9). Students described this as learning to pare away "extraneous" information about a patient's life to focus on what is clinically relevant.

Becky: I 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 focussed on the disease. . . because right now there's just too much. It's overwhelming. 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.

In part through the language of medicine students learn a scientific gaze that reduces patients to bodies, allowing them to concentrate on what is medically important—disease, procedures, and techniques (Haas & Shaffir, 1987).

Not surprisingly, students may simultaneously lose the communication abilities they had upon entering medical school.

Dr. W.: Their ability to talk to people becomes corrupted by the educational process. They learn the language of medicine but they give up some of the knowledge that they brought in. . . . The knowledge of how to listen to somebody, how to be humble, how to hear somebody else's words. . . . It gets overtaken by the agenda of medical interviewing.

Another faculty member noted that 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 medical school."

LEARNING THE HIERARCHY

Key to becoming a medical student is learning to negotiate the complex hierarchy within medicine, with students positioned at the bottom. A few faculty saw this hierarchy as a fine and important tradition facilitating students' learning.

Dr. U.: You're always taught by the person above you. Third-year medical students taught by the fourth-year student. . . . Fourth-year student depends on the resident to go over his stuff. Resident depends on maybe the senior or the chief resident or the staff person. So they all get this hierarchy which is wonderful for learning because the attendings can't deal with everybody.

Students, and most faculty, were far less accepting of this traditional hierarchy—particularly of students' place in it.

Both faculty and students pointed out the compliance the hierarchical structure inculcates in students, discouraging them from questioning those above them.

Dr. G.: If they don't appear compliant and so on they will get evaluated poorly. And if you get evaluated poorly then you might not get a good residency position. There's that sort of thing over their shoulders all of the time . . . the fear.

For students being a "good medical student" means not challenging clinicians.

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

Though virtually every student described seeing things on the wards that they disagreed with, as long as there was no direct harm to a patient they stayed silent and simply field away the incident in their collection of "things not to do when I am a doctor."

Other researchers have noted that medical students develop an approach geared to getting along with faculty, pleasing them whatever their demands (Becker et al., 1961: 281; Bloom, 1973: 20; Sinclair, 1997: 29). Some students, however, had *internalized* the norm of not criticizing clinicians, adopting an unspoken "code of silence" not just to appease faculty, but as part of being a good physician. In particular, one should never critique a colleague in front of patients.

Mark: As students we all critique the professors and our attendings. . . . But 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 wouldn't do that. 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, 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."

These students had developed a sense of alliance with other members of the profession rather than with lay people and patients—a key to professional socialization. Several faculty referred to good medical students as "good team players" (cf. Sinclair, 1997), invoking a notion of belonging.

Dr. M.: That sense of belonging, I think, is a sense of belonging to the profession. . . . You're part of the process of health care. . . . I mean, you haven't a lot of the responsibility, but at least you're connected with the team.

For some students, too, the desire to present a united front for patients was expressed as being a good team player: "You have to go along with some things . . . in front of the patient. For teams it wouldn't be good to have the ranks arguing amongst themselves about the best approach for patient care." To remain good team players, many students, residents and physicians learn to say nothing even when they see colleagues and superiors violating the ethics and standards of the profession; such violations are disregarded as matters of personal style (Light, 1988).

RELATIONSHIP TO PATIENTS

As students are learning their place in the hierarchy within medicine, they are simultaneously learning an appropriate relationship to patients. Within the medical hierarchy students feel powerless at the bottom. Yet in relation to patients even students hold a certain amount of power. In the interviews there were widely diverging views on the degree of professional authority physicians and student-physicians should display.

Some faculty drew a very clear connection between professionalism and the "emotional distancing" Fox documented in medicine in 1957, describing students developing a "hard shell" as a "way of dealing with feelings" to prevent over-identifying with patients. Emotional involvement and over-identification are seen as dangerous; students must strike a balance between empathy and objectivity, learning to overcome or master

their emotions (Conrad, 1988; Haas & Shaffir, 1987): "I only become of use if I can create some distance so that I can function."

Dr. E.: 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, you're their doctor.

In contrast, several faculty members rejected the "emotional distancing" approach to medicine in favour of one based in egalitarian connection.

Dr. V.: I reject that way of dealing with it. . . . 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 I need to understand well enough so I can help them to understand. 'Cause the process of healing is self-understanding.

These faculty members talked about recognizing and levelling power or sharing power. They saw professional distancing as the loss of humanitarianism, the adoption of a position of superiority, aloofness, emphasizing that clinicians need to know their patients as something more than a diagnosis. Women were slightly over-represented among those expressing the egalitarian perspective, but several male clinicians also advocated this position.

PLAYING A ROLE GRADUALLY BECOMES REAL

Along with emotional distancing, Fox (1957) identified "training for uncertainty" as key to medical socialization, including the uncertainty arising from not knowing everything, and not knowing enough. Alongside gathering the knowledge and experience that gradually reduces feelings of uncertainty, students also grow to simply tolerate high levels of uncertainty. At the same time they face routine expectations of certainty—from patients who expect them "to know it all" and faculty who often expect them to know far more than they do and who evaluate the students' competence (Haas & Shaffir, 1987). Students quickly learn it is risky to display lack of certainty; impression management becomes a central feature of clinical learning (Conrad, 1988). Haas and Shaffir (1987: 110) 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.

Robert Coombs argues that medical professional socialization is partly a matter of *playing* the role of doctor, complete with the props of white coat, stethoscope, name tag, and clipboard (1978: 222). The symbols mark medical students off as distinct from lay people and other hospital staff, differentiating between We and They. Students spoke of "taking on a role" that initially made them feel like "total frauds," "impostors."

Erin: 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.

They affirmed the importance of the props to successful accomplishment of their role play—even as it enhanced the feeling of artifice: "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."

Despite feeling fraudulent, the role play allows students to meet a crucial objective: demonstrating to faculty, clinical instructors, nurses and patients that they know something. They quickly learn to at least look competent.

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 get the trust of the patient. . . .

RESPONSES FROM OTHERS

The more students are treated by others as if they really were doctors the more they feel like doctors (cf. Coombs, 1978). In particular, the response from other hospital personnel and patients can help confirm the student's emerging medical professional identity.

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?!"

For many students, patients were the single most important source of confirmation for their emerging identity as physicians. With doctors and nurses, students feel they can easily be caught out for what they don't know; with patients they feel fairly certain they can pull off a convincing performance, and they often realize they *do* know more than the average person.

One response from others that has tremendous impact is simply being called doctor by others (Konner, 1987; Shapiro, 1987). Survey results show 68 percent (n = 48) of students had been called doctor at least occasionally by people other than family or friends. All but two fully recalled the first time they were called doctor and how they felt about it. *Not* being called doctor—especially when your peers *are*—can be equally significant. In previous accounts, being white and being male have greatly improved a medical student's chances of being taken for a doctor (Dickstein, 1993; Gamble, 1990; Kirk, 1994; Lenhart, 1993). In this study, although social class background, minority status and first language made no difference, significantly more men than women were *regularly* called doctor and significantly more women had *never* been called doctor.[4]

These data suggest a lingering societal assumption that the doctor is a man. According to the interviews, women medical students and physicians are still often mistaken for nurses. 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: "I've often felt because I fit like a stereotypical 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." Goffman notes that the part of a social performance intended to impress others, which he calls the "front," and which includes clothing, gender, appearance and manner, is predetermined: "When an actor takes on an established social role, usually he finds that a particular front has already been established for it" (1959: 27). In this case it appears that the role doctor, or medical student, still carries an attached assumption of maleness.

SECONDARY SOCIALIZATION: SUBSUMING THE FORMER SELF?

The fact that roles carry with them established expectations heightens the potential for clashes with the identity characteristics of new incumbents. Education processes, inevitably processes of secondary socialization, must always contend with individuals' already formed and persistent selves, selves established through primary socialization. As Berger and Luckmann (1966: 129) note, "Whatever new contents are now to be internalized must somehow be superimposed upon this already present reality."

In his study of how medical students put together identities as spouses, parents, and so on with their developing identities as physicians, Broadhead (1983) stresses the need for individuals to "articulate" their various identities to one another, sorting out convergences and divergences of attitudes, assumptions, activities and perspectives that accompany different subject positions.

In this research, most students indicated that medicine had largely taken over the rest of their lives, diminishing their performance of other responsibilities. While 55 percent of survey respondents thought they were doing a good job of being a medical student, many thought they were doing a poor to very poor job of being a spouse (26 percent) or family member (37 percent); 46 percent gave themselves failing grades as friends. Fewer than a quarter of respondents thought they were doing a good job of being an informed citizen (18 percent) or member of their religion, if they had one (17 percent).

What emerged from most interviews and from the survey was a picture of medical school dominating all other aspects of daily life. Overwhelmingly, students talked about sacrifice.

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 had to sacrifice that much.

Many students had given things up, at least temporarily: musical instruments, art, writing, sports activities, volunteer activities. Some students spoke of putting themselves on hold, taking on new medical-student identities by subsuming former identities.

This sacrifice of self-identity can be quite serious. Several faculty and students suggested students from non-Western, non-Caucasian cultural backgrounds need to assimilate: "Students from other cultures leave behind a lot of their culture in order to succeed. There's a trade-off." Similarly, faculty and students suggested gay and lesbian students frequently become more "closeted" as they proceed through undergraduate training. One clinician said of a lesbian fourth-year student, "Now all of a sudden her hair's cut very business-like and the clothes are different. . . . She's fitting into medicine. Medicine isn't becoming a component of her, she's becoming a component of the machine." Some faculty suggested women in medicine may need to relinquish their identity as women in order to fit in as physicians.

Dr. Q.: The women 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 in the elevator in the hospital they talked about her as one of the boys. So the perception of the men is that this is not a woman, this is one of the boys.

Women, they argued, become more-or-less men during medical training, "almost hypermasculine in their interactions," "much more like men in terms of thought processes and interactions with people."

In addition to letting go of gender identity, sexual identity and cultural identity, some students described losing connections to their families and old friends after entering medical school. Often this was due to time constraints and diverging interests, but for some there was also a growing social distance as they moved into a new social status and education level. Lance was disconnecting from his working-class family:

Lance: My family actually were very unsupportive [when I got into medicine]. 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 see that gap getting larger over time.

Relationships with family, friends from outside of medicine, and anyone else who cannot relate to what students are doing every day are put "on the back burner." Intimate relationships are frequent casualties of medical school.

Thus some students do not or cannot integrate their medical student identities with their former sense of self; rather they let go of parts of themselves, bury them, abandon them, or put them aside, at least for a while. Another option for students who experience incongruities between their medical-student identities and other aspects of themselves is to segregate their lives. Because human beings have the ability to reflect on our own actions, it becomes possible to experience a segment of the self as distinct, to "detach a part of the self and its concomitant reality as relevant only to the role-specific situation in question" (Berger & Luckmann, 1966: 131). In this research 31 percent of survey respondents felt they are one person at school and another with friends and family. Perhaps as a consequence, many students maintain quite separate groups of friends, within medicine and outside medicine. Indeed, some faculty stressed the importance of maintaining strong outside connections to make it through medical school without losing part of yourself.[5]

DIFFERENCE AS A BASIS FOR RESISTANCE

Elsewhere I have argued that intentional and unintentional homogenizing influences in medical education neutralize the impact of social differences students bring into medicine (Beagan, 2001). Students come to believe that the social class, "race," ethnicity, gender and sexual orientation of a physician is not—and should not be relevant during physician-patient interactions. Nonetheless, at the same time those social differences can provide a basis for critique of and resistance to aspects of medical professional socialization. A study of medical residents found that those most able to resist socialization pressures minimized contact and interaction with others in medicine; maintained outside relationships that supported an alternative orientation to the program; and entered their programs with a "relatively strong and well-defined orientation" (Shapiro & Jones, 1979: 243). Complete resocialization requires "an intense concentration of all significant interaction within the [new social] group" (Berger & Luckmann, 1966: 145); it is also facilitated by minimal contradictions between the previous social world and the new world.

In this research, age played a clear role in students' ability to resist some aspects of professional socialization. Older students usually had careers before medicine, which helped put medical school in a different perspective. Often medicine was one of a range of possible things they could be doing with their lives—important, but not worth sacrificing for: "There are other things that are more important to me than this, so if at any point this conflicted too much with those things, I would give it up." One student suggested that being older entering medicine meant she had her goals and self-identity more clearly established. Most older students were in committed relationships with non-medical partners and had clear priorities about maintaining non-medical activities and connections, rather than abandoning them under the onslaught of medical school demands.

> Robin: I resolved that I wouldn't let my close friends go by the wayside. . . . My partner is important to me, and I wouldn't always make him take a back seat to what I was doing. . . . It was like an ultimatum. 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.

These outside commitments helped them minimize interactions with their new social group.

The strongest basis for resisting professional socialization, however, came from having a working-class or impoverished family background. Most of the working-class students said they are not seen as particularly praiseworthy within their families—if anything they are somewhat suspect. They expressed a sustained antielitism that keeps them from fully identifying with other medical professionals. Janis, for example, insisted 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, could never be "a proper med student." She feels very uncomfortable with social functions at school and sees herself as utterly different from her classmates and preceptors: "Let's just say I don't share Dr. Smith's interest in yachting in the Caribbean, you know what I mean? (laughing)."

Lance, who spent his summers working on fishing boats to pay for medical school, described most of his classmates as "the pampered elite." He resists the required dress code because it epitomizes elitism.

> Lance: A lot of people, the first thing they did when we started seeing patients was throw on a nice pair of shoes and grab the tie and 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 like . . . 'I'm somewhat better than everyone else.' . . . 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.

Although the number of working class students was small, the data showed quite clearly that they tended to be among the least compliant with the processes of secondary socialization encountered in medical school.

Lance: I think I'm very much different from my classmates . . . more outspoken, definitely. . . . 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. It kind of reduces to the common denominator.

CONCLUSION

What is perhaps most remarkable about these findings is how little has changed since the publication of *Boys in White* (Becker et al., 1961) and *Student Physician* (Merton et al., 1957), despite the passage of forty years and the influx of a very different student population. The basic processes of socializing new members into the profession of medicine remain remarkably similar, as students encounter new social norms, a new language, new thought processes, and a new world view that will eventually enable them to become full-fledged members of "the team" taking the expected role in the medical hierarchy.

Yet, with the differences in the 1990s student population, there are also some important differences in experiences. The role of medical student continues to carry with it certain expectations of its occupant. At a time when medical students were almost exclusively white, heterosexually identified, upper- or middle-class men, the identity may have "fit" more easily than it does for students who are women, who are from minority racial groups, who identify as gay or lesbian or working-class. If role-playing competence and being reflected back to yourself as "doctor" are as central to medical socialization as Haas and Shaffir (1987) suggest, what does it mean that women students are less likely than their male peers to be called doctor? This research has indicated the presence of a lingering societal assumption that Doctor = Man. Women students struggle to construct a professional appearance that male students find a straightforward accomplishment. Women search for ways to be in a relationship with their patients that are unmarked by gender. Despite the fact that they make up half of all medical students in Canada, women's experiences of medical school remain different. In this research, almost half (six of fourteen) of the women students interviewed indicated that they do not identify themselves as medical students in casual social settings outside school lest they be seen as putting on airs; none of the male students indicated this. It remains for future research to determine whether gender differences in the "fit" of the physician role make a difference to medical practice.

Interestingly, it is commonly assumed that the source of change in medical education will be the next generation of physicians—in other words, the current crop of medical students and residents (cf. Sinclair, 1997: 323–24). Over and over again I heard the refrain, "Surely the new generation of doctors will do things differently." This was the response to the hierarchy that stifles questioning or dissent through fear; to the inhumane hours expected of student interns and residents; to the need to show deference to superiors; to the need to pretend competence and confidence; to the need to sacrifice family, friends and outside interests to succeed in medicine. Yet, there have been many new generations of doctors in the past forty years . . . with remarkably little change. Why should we expect change now? Students, residents and junior physicians have very little power in the hierarchy to bring about change. Moreover, if they have been well socialized, why would we expect them to facilitate change? As one physician suggested, those who fit in well in medical school, who thrive on the competition and succeed, those are the students who return as physicians to join the faculty of the medical school. The ones who did not fit in, the ones who hated medical school, the ones who barely made it through—they are unlikely to be involved enough in medical education to bring about change.

Medical training has not always been good for patients (see Beagan, 2001). Nor has it been particularly good for medical students in many ways. Yet efforts at change on a structural level seem to have made little overall difference. In fact medical schools have a history of revision and reform without change (Bloom, 1988). Sinclair suggests moves

toward entire new educational processes, such as the move to problem-based learning in medical schools throughout North America, simply "realign existing elements in the traditional training" (1997: 325). Furthermore, additions of new and very different components of the curriculum—such as classes on social and cultural aspects of health and illness, communication courses, and courses critiquing the social relations of the medical profession—are often seriously undermined in clinical teaching (Sinclair, 1997). Again, further empirical research should investigate the impact of such curriculum changes on professional socialization.

Finally, this research shows that the same sources of differentiation that mark some students as not quite fitting in also serve as sources of resistance against medical socialization. Older students, gay students who refuse to be closeted, and students who come from poverty or from working-class backgrounds, may be more likely than others to "do medical student" differently. Whether that translates into "doing doctor" differently is a matter for further empirical research. Future research needs to examine how these "different" students, these resisting students, experience residency and professional practice, whether and how they remain in medical practice.

CRITICAL THINKING QUESTIONS

1. One new experience for medical students is learning *medical-ese.* Have you faced a similar process during your college education? Explain.

2. Why do you think that the traditional hierarchy in medical schools (i.e., faculty at the top, students at the bottom) is seen by many as a good thing?

3. Which groups of students were most likely to resist professional socialization? Why would this be the case?

NOTES

1. In order to gain access to the research site, it was agreed that the medical school would remain unnamed. The school in question was in a large Canadian city with a racially and ethnically diverse population. It followed a traditional undergraduate curriculum.

2. At this medical school classes have been 40 percent–50 percent female for about fifteen years (Association of Canadian Medical Colleges, 1996: 16); the class studied here was 48 percent female. Using subjective assessment of club photos, over the past fifteen years about 30 percent of each class would be considered "visible minority" students, mainly of Asian and South Asian heritage.

3. All names are pseudonyms.

4. Never been called doctor, 14 percent of women, 0 percent of men; occasionally or regularly, 57 percent of women, 78 percent of men (Cramer's V = 0.32).

5. All of the gay/lesbian faculty and students described themselves as leading highly segregated lives during medical school.

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