

Initiation Phenomena During Becoming a Doctor

PhD Theses

Zoltán Zsinkó-Szabó MD

Semmelweis University

Doctoral School of Mental Health Sciences



Supervisor: Dr. Imre Lázár, C.Sc., senior lecturer

Opponents: Dr. Károly Cseh, D.Sc., professor
Dr. Regina Molnár, Ph.D., senior lecturer

President of the final exam committee:
Dr. László Tringer, C.Sc., professor

Members of the final exam committee:
Dr. Péter Molnár, D.Sc., professor
Dr. Péter Csépe, Ph.D., research fellow

Budapest

2014

INTRODUCTION

I take part in the education of medical anthropology at the Institute of Behavioural Sciences of Semmelweis University since 1995, so I can keep track of its attitude shaping effect on medical students. Demonstration and deeper analysis of rites and ceremonies has been an integral part of the theory and practice of our educational curriculum in the past 19 years. During practice lessons it became apparent that being aware of and understanding the rites of social transition for future doctors produces gain of self awareness, which can be well used built into their tacit knowledge for their future work.

In the course of my educational work according to students' reports, scientific literature, and my own experiences gained during medical years I asked the question: *does initiation exist during becoming a doctor?* If so, what stations, what kind of phenomena indicate it as rites of passage in the process of medical socialization?

The research theme of the basis of the thesis is the initiation phenomena during professionalisation and becoming a doctor. During these transitions medical students and young doctors (residents) collect personal experiences by which their continuously collected - often unnoticed - knowledge transform via "quantitative" into "qualitative" change.

Although the word, initiation is of sacral character, using it as an expression was of conscious choice. It refers to the originally sacred nature of medicine, in addition, putting the word of initiation into the center offers exciting possibilities for the process of becoming a doctor or for a comparison of initiation forms of a variety of religious and spiritual trends.

First as a cultural anthropologist, on the other hand as a lecturer of medical anthropology I enthusiastically represent the cultural relativist values of anthropology in the biomedical sciences. *Postmodern anthropology* is legitimate and valid since it is aware of the possibility of alternative routes experiencing plurality and culture-boundness of medicine. I always put great emphasis on the open mindedness of my students within the frame of medical anthropology for alternative methods outside biomedicine, but certainly with enough criticism when dealing with them. I tried to represent the same attitude in this present research as well.

OBJECTIVES

As a christian priest or a buddhist healer knows exactly that he is initiated (their process is named initiation from the start) and what kind of rites it is escorted by, for a medical student it is mostly not so unambiguous, this way the revelation and interpretation of most rites needs to be investigated.

The most important question this study aims at is whether there is real initiation in the process of becoming a doctor and how it is caught in the act in the hidden course of initiation rites.

The *purpose* of the present study is therefore the uncovering and studying of the phenomena that can be interpreted as rites of passage during becoming a physician, analysis and systematizing of the results and comparison with other initiation rites and similar research results.

Although this present study reflects the experiences and opinion of the students of Semmelweis University, there is the possibility to draw conclusions on processes of other Hungarian medical students and medical students from foreign countries having a similar biomedical attitude.

It has long been an important question for me what the fundamental similarities and differences are in becoming healers among traditional folk healers (such as shamans), traditional and alternative medical practitioners and doctors socialized in the approach of modern medicine. Therefore, I tried to extend the research – tangentially and for comparative purposes only – for conventional and alternative therapies and healers as well, keeping the focus on the initiation process of medical students all the time.

METHODS

Research background

The background of the research in a broader sense is the Faculty of Medicine at Semmelweis University, the most of the research participants are so naturally current or former medical students of SU. In the narrower sense - because of my position – the background is the Institute of Behavioral Sciences, since “I’m here at home” and as teaching medical anthropology I am here in connection with students and teacher-researcher colleagues.

Target groups

The research focused on three target groups.

The most important group (they were the greatest part of the interviewees) was made up of higher grade (from third to sixth year) medical students. It was important for me, that all of them were “after” medical anthropology, so I did not have to deal with the definition of major concepts in a considerable part of the time. In addition they had much more experiences in comparison to first or second year students and had a better view of the process of “becoming a doctor”. Their disadvantage was that they already did not have so clear memories of the entrance examination and the first years of university, and also that they have not finished university yet, so their “initiation” was not complete. When selecting the interviewees I also took care that the students should not know each other, and there should be some among them that already postponed a year, since I assumed that postponement would be important because of the initiation.

The second (narrower) target group was formed of residents and specialists with one or more special examinations. This group therefore includes doctors that already have completed university. They've already completed the process of becoming a doctor, so they can express their opinion of the entire process. The residents' opinions and experience reports makes an exciting surplus at the same time, since their situation in many respects is similar to students, but they are officially physicians already.

Into the third group were chosen finished alternative therapists dealing with some alternative therapeutic branch. My goal with this investigation was how the differences manifest between the two similar healing activities with the two different training background

in the initiation process of “becoming a healer”. On the other hand I believe it is important to analyse how alternative therapists – working at the border-line of official medicine – view the training and role of physicians in the mainstream of education.

Research tools

The meaning centered applied cultural anthropological research is based on analysis of texts gained by deep interview and focus group techniques, so I based this present work on collecting *qualitative* data against the *quantitative* approach using statistical methods (e.g. questionnaires).

On the other hand, the HuMania¹ group material is part of this work, which is composed of a *written questionnaire* conducted among 62 medical students. This study assessed initiation events during medical training according to the students. The one or two line answers I classified into categories in a table for analysis.

During the oral interviews I combined the use of two basic interview methods: the focus group and the semi-structured deep interview methods.

The *focus group* method is one of the most commonly used qualitative interview technique, with 5-12 interviewees – their parameters determined previously - taking part in a group discussion. The benefit of the focus group technique over the individual interview techniques is the interaction of the participants with each other, which significantly increases the effectiveness of the interview: in a two to two and a half hour interview session we can collect several people’s opinions and experiences of a problem specifically examined in a well-ordered form.

The advantage of the *individual deep interview* method is that we have the possibility to become acquainted with the deepest possible level of emotions, values, attitudes of the interviewees, and also we can exclude the effects of social behaviour during group interviews (e.g. secrecy, fibs of force etc.). The disadvantage is that only one interviewee opinion can be collected at a time, so a number of interviews are required for a representative sample, which can last quite long.

¹ A HuMánia Professionalisation Workshop organized by the Institute of Behavioural Sciences of SU is a skill development group for medical students.

In the case of medical students as a research method I partly used the *semi-structured deep interview* which is commonly used in anthropology (5 senior students as participants), on the other hand the *focus group* method (7 group interviews were carried out with a total participation of 41 students).

In addition to the medical students I carried out *semi structured deep interviews* with 6 physicians (2 residents and 4 specialists) and 7 alternative therapists.

Preparation of oral interviews

In the preparatory phase of the individual and focus group interviews during personal (telephone) contact I outlined the subject of the investigation and we decided on potential dates. In addition, in the case of medical students they were also “initiated” into the baselines of the research examining the process of their initiation. The invitation letter sent to participants – as a common denominator – provided a starting point and the opportunity to prepare for the future debate or discussion.

Procession of the interviews

For the interview procession *category-content narrative analysis* was used in many cases. This method, although not so usual as a standard questionnaire-based quantitative approach commonly used for doctoral dissertations, was reasonable for an anthropology based study: in our study semantic changes embedded into a biography as qualitative changes become emphasized rather than quantitative samples, and the individual’s experiences become focused rather than social aspects as usual.

With the help of the category-content focused narrative analysis method during a qualitative study based on interviews the interview answers – different by style, length, compactness and diversity - can be categorized and systematized according to key categories. According to their content they can be analyzed more easily. This makes the subjective opinion, responses of diverse content of interviewees "objectively measurable".

RESULTS

The realization of initiation during becoming a doctor

Overall we can state, that during becoming a doctor initiation takes place more covertly and unconsciously in comparison to the sacred nature of becoming a priest, traditional initiation of a shaman or initiations in alternative medicine based on ancient Eastern traditions. The little obviousness of initiation is shown by the fact that students during the interviews generally first denied, devaluated the fact and value of initiation, but during the conversation (dissolution) they reassessed their views and mostly recognized the initiation aspects of their own professionalisation. HuMánia students receptive for psychology, sociology and anthropology showed a different attitude, for whom the initiation process was more obvious, and usually did not cause them difficulty to specify the most initiating event during medical training.

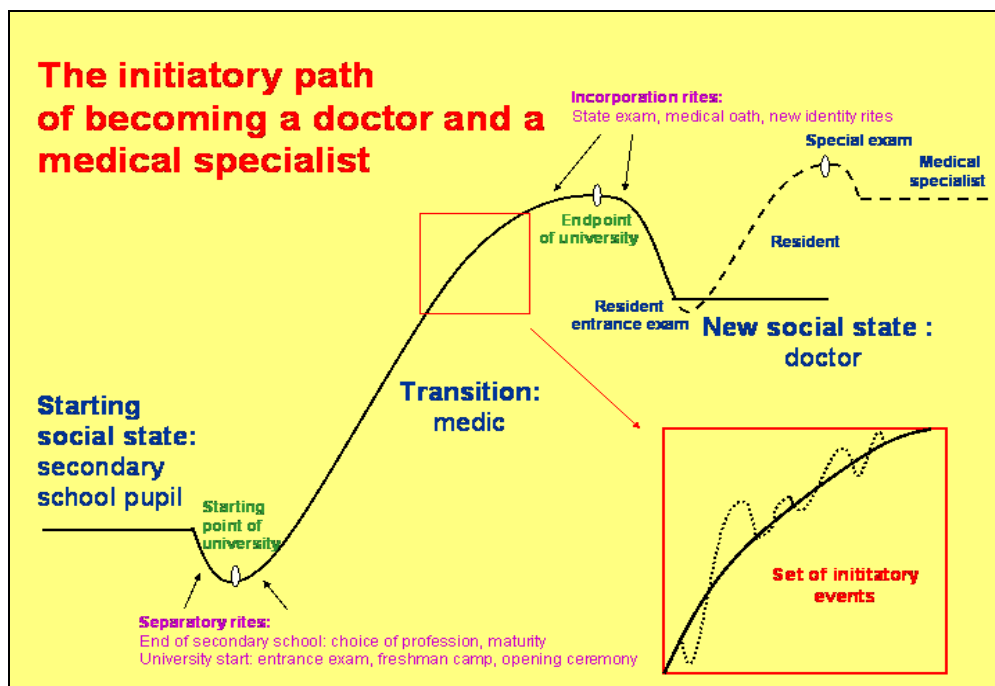


Figure 1: The initiatory path of becoming a doctor and a medical specialist

The entering of the initiation process dates back to high school years, to the period of career choices. The students mentioned loving biology courses above all as the most important career motivation, so we can ascertain its selective nature. The second most

common cause of choosing medical profession was the determining role of a physician family member, in their cases the phenomenon of early closing was observable.

Becoming a doctor does not happen because of the state exam or the medical inauguration oath, although they all show and legitimize as ritual symbols that the initiation took place. The initiation is a process with countless events worth an initiation itself. The events mentioned by the interviewees attached to in general on the one hand to the examinations, final examinations and examination periods, and the related private and public rituals, on the other hand to events and situations during exercises (autopsy, nursing practice, ambulance practices, clinical work).

These initiation events (often rituals) can be classified according to their nature and incidence density, and on this basis the initiation process can be divided into characteristic phases that can be correlated to the phases of the rite of passage (the years leading to university = separation, university = transition, the end of sixth year = incorporation).

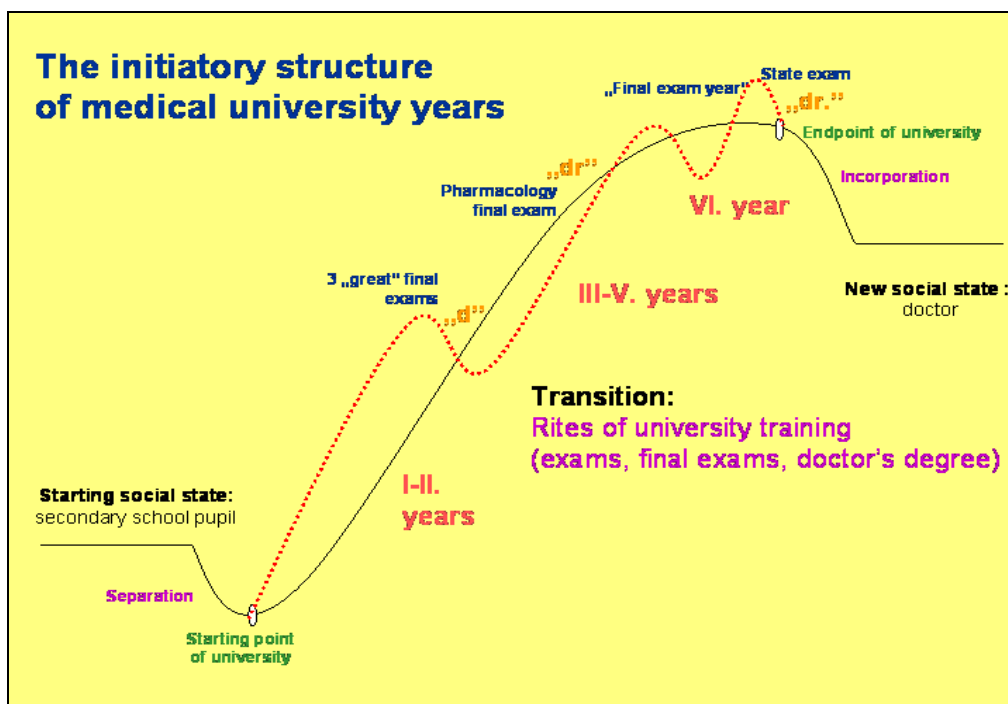


Figure 2: The initiatory structure of medical university years

Pulling the phase of university years to pieces (I-II years, III-V years, VI. year), we obtain a fractal-like "simple model" of the rite of passage. If we look at it three-dimensionally we can see the initiatory trip of students in a ziggurat rising form.

Similarly to these sections we can state as well as of the resident period that it repeats the initiation process of becoming a doctor in “small” (resident entrance examination=separation, resident years=transition, special examination=incorporation).

Factors affecting the initiation of becoming a doctor

During exercises (anatomy, pathology, nursing practice, clinical part) the order of encountering the body, diseases and death prepares (initiates) students typically to modern, reductionist biomedical approach. In anatomy practices medical students first study body parts (such as machine parts) soaked in formaldehyde (impersonal) and dead (without a soul), to which joins the enormous amount of theoretical studies, its new language and the incredible detailedness of becoming acquainted with the body.

The initiating role of the bodies continues with the dissection of fresh cadavers in pathology, students experience it as rather an interesting event, at the same time they are touched by “the more personal”, “more alive” nature of the dead bodies.

In the first two years students only see living patients during their nursing practice, therefore they are usually “initiated” into healing this way. In the clinical part (after third year) focus falls on the diagnosis and therapy of patients, students test in practice what they learned in theory.

The development of students’ manuality is important in terms of the management with the body, its success can be the basis of later medical profession choice (manual professions vs. psychiatry).

Medical anthropology having a postmodern approach - depending on the openness of students - provides an important opportunity in contrast with the modern biomedical body- and disease image to learn alternative interpretations, testing and practical comparison of official biomedical and alternative medicine during fieldworks.

Towards medical anthropology generally those students relate critically and with denial, who already are committed towards some manual profession and are effect oriented. Those students are most open to the awareness forming impact of medical anthropology, who have not yet committed themselves to a given specialization, or have more open personality and are interested in psychiatry, psychosomatics or alternative medicine. Among them the initiating effect of medical anthropology is obviously seen.

Initiation is always stressful, but the students can live it as a positive (eustress) and a negative stress (distress) as well. Distress to some extent is inherent in the liminality of the initiation process and is worth of an initiation itself. An excessive amount of distress in turn could lead to illness and burnout.

Based on the interview answers, the first most stressful event of medical education is the entrance examination. In the first years of university one of the most significant source of stress for medical students is demonstrations, exams and university final examinations in anatomy, physiology and biochemistry, the other is facing death in the dissection room or at nursing practice. The clinical years are fraught with many sources of stress as well: the sense of responsibility increases, medical services begin at night, and patients die among the hands of medical students. The resident doctors get into a liminal position again, which is also associated with significant stress.

The effect of stress response produced by stressors is increased by the person's susceptibility to anxiety and depression, physical environmental burden (eg toxic formaldehyde vapor), the lack of availability of social support (e.g. breaking-up of groups in the sixth year), the uncertainty of the economic situation (e.g. low payment as a resident doctor) and the competition among students.

The characteristic method of processing distress among medical students is a sarcastic black humor and the objectification of bodies in dissection rooms. The gradual construction of anatomy lessons and confrontation with death also have a distress reducing effect according to interviewees.

Medical students may be witnessing the death of many known patients during nursing practice in the first two years. This involves considerable distress. In the clinical period students are faced with many deaths, in this part greater sense of responsibility also causes distress. It is a major challenge even as a graduated doctor to endure the death of patients: this time even the helplessness, consciousness of guilt and the sense of self blame is typically associated with the experience of death.

Initiators taking part in initiations (initiating persons, communities and medical subculture) have an especially important role in the process of becoming a doctor. With medical students having a physician parent (or parents) the phenomenon of early closing can be observed. Medical students of upper years may be attractive examples before choosing a career and in the first years of university. Based on the interviews, on the professional identity of medical students in medical school principally a physician as a role model (practice leader, clinician, scientific student circle leader) has a significant affect.

Media often appears as a filter during choice of medical career. Positive or negative role models appearing in medical themed films or soap operas often have an important impact on identity formation of medical students, but during clinical years students typically become disenchanted of medical soap operas.

Various ritual symbols, mainly signaling medical identity have an important role in the initiation process of medical students becoming doctors. The interviewees emphasized the first use of the white coat and the gradual acquisition of a doctor's degree.

Dramatic elements and role-playing have an important role in the initiation process, where students practice their later medical identity. The study participants mostly highlighted the rite of wearing the white coat for the first time as having the greatest influence on them.

At the description of the character of medical role alternative therapists generally recognize the expertise of doctors, they respect and admire the responsibility attached to medical role, but due to the nature of medical training are quite critical of medical identity. However they admit, and often lack the initiation attached to medical training of their own training.

The “exitiation” phenomenon in medical education

There is another process parallel to initiation which goes to the opposite direction: at any of the critical events of initiation the student "may fail", consequently partially or temporarily but also permanently may be “exitiated”, which may lead to postponement, burnout or in the worst case to attrition. As causes of “exitiation” interviewees mentioned mostly disappointment experienced in the clinical period (the difference between theory and practice, shortcomings in the practical training, negative or lacking role models), lack of community support and the difficulties of the resident years.

Based on the interviews the cause of frequent delays is a failed exam, which may lead only to a temporary exitiation, since it may even strengthen the student in the long run, so in the initiation process as well. The students continuing their training later have all reported the positive proceeds of postponement (frequent practical experiences as a nurse or a member of the ambulance staff, membership in an extra group).

Would be students unsuccessful at the entrance examination are exitiated before university years, unless they try again and are later successfully admitted to the university. They reported of a fertile (this way having a positive initiation value) period like postponers in the interviews.

CONCLUSIONS

The most important theses of the present research are the following:

- During modern (basically secular and biomedical) medical training initiation occurs similarly to the initiation process of sacral, folk as well as alternative healers.
- This initiation is not a one-time event, but a process of many initiation type components built upon each other.
- Most of the initiation processes of becoming a doctor is hidden, barely conscious, unlike sacral initiation rites.
- This initiation process is a transition as well, thus corresponds to the model of the rite of passage known from anthropology.
- In the process of becoming a doctor initiators and initiating communities may have an important role, the medical – and in a wider sense – healing subculture.
- In the process of becoming a doctor the following occurrences may have initiatory role: encountering the body, disease and death, stress during training and a variety of symbols. Also here we can mention role models – occurring in personal interactions or in the media - providing positive and negative examples and education of medical anthropology designed to ensure wider attitude of approach.
- The successfulness of an initiation in the case of a medical student (or doctor) is not clear, may depend on a number of factors and may end with “exitiation” as well.

LIST OF OWN PUBLICATIONS

1. Zsinkó-Szabó Z., Lázár I. (2013) Cultural initiation of medical doctors. *Collegium Antropol.*, 37 (4): 1047-1056.
2. Lázár I, Zsinkó-Szabó Z. (2013) Initiation and Death in Becoming a Doctor [Beavatási jelenségek és a halál az orvossá válás során]. *Kaleidoscope: Művelődés-, Tudomány-, és Orvostörténeti Folyóirat*, 4 (7): 74-84.
3. Zana Á, Zsinkó-Szabó Z. (2013) “Olykor úgy éreztem, én jobban értem még, mit akar a beteg mondani”; *Orvosi antropológia - orvostanhallgatók terepmunka-tapasztalatai. Lege Artis Med*, 23 (7-8): 360-367.
4. Zsinkó-Szabó Z. (2013) Medical rituals and media rituals. *KOME – An International Journal of Pure Communication Inquiry*, 1 (2): 64-80.
5. Zsinkó-Szabó Z., Lázár I, Túry F. (2012) A test gyarmatosítása – a civilizáció vadhajtsái. *Lege Artis Med*, 22 (3): 234-240.
6. Zsinkó-Szabó Z. (2001) Hányszor születünk, hol a helyünk a társadalomban...: Izraeli terepmunka-tapasztalatok. *Szenvedélybetegségek*, 9 (4): 280–285.

As textbook chapters:

7. Túry F, Lázár I, Zsinkó-Szabó Z., Mezei Á. (2013) Az étel értéke az evészavarok hátterében - spirituális szempontok. In: Ittész G (szerk.), *Cura Mentis – Salus Populi Mentálhigiéné a társadalom szolgálatában. Interdiszciplináris szakkönyvtár 9*, SE Egészségügyi Közzolgálati Kar Mentálhigiéné Intézet, pp. 133-141.
8. Zsinkó-Szabó Z. (2012) Beavatási jelenségek az orvossá válás folyamán. In: Lázár I, Pikó B (szerk.) *Orvosi Antropológia. Medicina, Budapest*, pp. 505-516.