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## Notes

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- ii. Space constraints mean we present only a brief summary here. Readers interested in more detail are referred to the first author's 2004 dissertation.<sup>3</sup> Copies of this text are on file in the University of Malawi College of Medicine library in Blantyre and the University of Malawi's Malawiana collection in Zomba, or electronically through UMI Dissertations Online.

# 2. A Qualitative Study of Medical Student Socialization in Malawi's College of Medicine: Clinical Crisis and Beyond

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## Introduction

In a previous report we addressed the socialization of Malawian medical students during the years of basic science training. Here we turn to the heavily clinical training of the final three years of medical school.

## Research methods

Readers wishing a full discussion of the research methods are referred to our previous article. In brief, this was a three-phase cross-sectional qualitative research project involving focus groups, semi-structured interviews and questionnaires given to students and recent graduates of the University of Malawi, College of Medicine. The results we present are based on material from 4 focus groups, 31 student and 7 intern interviews (focus groups and interviews included 31% of all medical students during the 2002-2003 study period), and 121 questionnaires (representing 84% of all medical students). Material was coded for thematic content using QSR\**N6* qualitative research software.

This report presents primarily interview data, and we present as major themes any that arose in at least twenty-five percent of interviews. Where useful, we supplement the analysis with questionnaire and focus group data.<sup>a</sup> Where statistical analysis was suitable, interview themes were assessed using two-tailed proportion testing. Likert-scale items from questionnaires were analyzed using STATA 7, and effects of binomial categories, linear variables, and ordinal nonlinear variables on Likert scores were measured using t-tests, linear regression, and ordered logit regression, respectively.

## Findings

### Experience of Clinical Training

Our previous report showed that the socialization process of preclinical training for Malawian students, though possessed of some distinctive features, remains fairly close to that described for medical students in the heavily studied North American population. Medical socialization begins to diverge more significantly from the North American or European model when Malawi's students enter the hospital in their third year.

The primary site of clinical instruction is an urban public hospital in Blantyre. Students also spend time in several other public hospital and clinic settings. All these clinical education sites share problems of understaffing, overcrowding, frequently poor staff morale, and intermittent to chronic shortages of medications, diagnostic tests and supplies.

Interview and focus group data reveal that the transition to the clinical setting results in a psychological crisis for many students and increased stress for most. Two of the four focus groups, in addition to several individual interviewees, described increases in student alcohol use among in the third year, though they were not asked about this. Expressions of religious faith and of positive feelings about medicine drop in the third year. Nearly half of clinical students and two thirds of interns voiced strong criticism of the national government, characterizing it especially as unresponsive to the needs of poor Malawians, during this time.

A striking measure of trainee's increasingly troubled relationship with their profession is demonstrated in Table 1, where responses to a hypothetical question on whether a sibling should become a physician are given. Pre-clinical students were enthusiastic about the idea, nearly all responding either with an unqualified yes or a yes as long as the sibling had good reasons (usually this meant the sibling should not choose medicine as a way to amass wealth).

Clinical students were more likely to give a response we characterize as "informed consent," in which they imagined telling a sibling all the pros and cons and then allowing her to make up her own mind. Some interns simply answered: no. Even with our relatively small interview numbers, these trends were significant.

Table 1 Should a sibling become a doctor in Malawi? Responses by training category\*

Response	Pre-clinical	Clinical	Interns
Yes	59%	25%	0%
Yes if sibling's reasons are good	35%	8%	20%
"Informed consent" response	6%	50%	40%
No	0%	17%	40%

\*  $p < .01$  for trend

Major stressors reported by clinical students and interns can be clustered into four major themes: lack of support, workload, risk, and limited therapeutic options.

As they get closer to actual practice, trainees seemed to feel more acutely the weight of low salaries, lack of support from the government, and high extended family expectations. Many spoke with bitterness about the priorities of the state and what they felt to be the neglect of the health sector. They also more frequently expressed criticism of fellow clinicians: half the clinical students volunteered stories of consultants who were absent when they were supposed to be teaching, and over a third mentioned doctors who were prejudiced against Malawians, or against the poor.

Interns in particular reported that their workload felt impossible. For many, high workload meant that their care for patients felt inadequate: "subminimal attention to the masses," in one intern's evocative phrase.

Risk was also suddenly a major stressor: the body students had been considering as abstract and universal is suddenly living, suffering, and often infectious. Risks of contracting HIV, TB, cholera and other illnesses in the workplace frighten many students.

Finally, clinical students and interns struggle with the limitations placed on their abilities to help people, when their options often feel skeletal. As one said, "As a doctor, you have to have something to give patients. Here there is nothing for me to give." (However, though clinical trainees consistently reported lack of materials or inability to help patients as stressors, several also positively contrasted their own skills and flexibility with the rigidity of European and American colleagues, whom they saw as paralyzed without their customary technology.)

## Responses

How do students and interns respond to the crisis of their clinical years? Future plans seemed to be significantly shaped by the clinical experience. We saw recurrent but contrasting themes in interviews. Often more than one theme arose in responses from the same interviewee.

One response attempted to preserve the doctor-scientist identity developed in the preclinical years by finding a location – geographic or occupational – where it could be

Table 2 Difficulties of practice: interview themes by training category

Difficulty	Preclinical	Clinical	Interns
Poor salary*	41%	57%	100%
Heavy workload*	47%	36%	100%
Lack of equipment/ drugs	35%	64%	50%
Unable to help patients	35%	50%	50%
Risk of HIV and other infections	24%	36%	67%
Lack of support from government*	12%	43%	67%
Must support extended family*†	6%	21%	50%

\*  $p < .05$  for trend

† Though this theme arose in less than 25% of interviews overall, we include it because of the significant trend

more easily accomplished. Many students and interns spoke positively about emigration (33%), about work in Malawi for a well-funded NGO or research organization (35%), or about private practice (25%).

At the same time, a plurality of trainees reported that they would remain in Malawi and work in the public health sector (50%). As the numbers make clear, this is not a bimodal response; many students and interns discussed more than one option. Interviewees often spoke of their desires or commitments to stay in Malawi, and at the same time their fears that they would be "only human" and not be able to sustain what they understood to be a sacrifice. (The desire to emigrate was not predicted by student demographic characteristics. Our sample size means that the study has limited power to detect such linkages, however.)

Trainees' responses to the clinical crisis were not all about going or staying. The experience of clinical work in a materially poor setting and among materially poor patients had significant and interesting effects on trainees' ideas about the physician's mission. Respondents frequently appeared to reinvent the meaning of a doctor's work, from technological intervention to a dual role of loving witness to suffering and political activism.

Students did not demonstrate the cynical attitudes about patients that are consistently found in prior studies of medical socialization. No trainee ever spoke in a disparaging way about a patient. Instead, Malawian students, from the beginning of their training, frequently talked about something they call "heart," or "love." Good doctors love their patients; they "feel the needs of the people"; they have "a heart for their patients." These students throughout their medical training, unlike their American counterparts, believe one cannot be a good doctor without this empathic connection, even with a high degree of technical skill (see Table 3). And in fact, when other resources are lacking, the ability to have a heart for one's patients means the doctor still has something to offer. Questionnaire findings reinforce these results: love for patients was rated second only to thoroughness as an important quality for a doctor, and both were far above technical skill.

Many students with clinical experience link this love with a moral imperative to political activism. Students and interns

Table 3 Qualities of good and bad doctors: interview themes (students and interns)

Good doctor's quality	Respondents mentioning
Loves patients / heart for work	57%
Available when needed or scheduled	46%
Listens to patients	38%
Hardworking	30%
Intelligent / knowledgeable	30%
Bad doctor's quality	Respondents mentioning
Harsh to patients	57%
Not available	41%
Poor teamwork	32%

often held that working in Malawi made it impossible for them to ignore the causes of illness and health that lie beyond the level of the individual: poverty, social conditions, and problems with governance were all daily visible to them as etiologies of suffering. The health sector was not a priority for the nation's politicians or for international lenders, they felt, and political corruption further stripped the hospitals of needed drugs, money, ambulances, and other resources. Two of four focus groups, and about a third of the students interviewed, specifically suggested that collective action – on the part of doctors, nurses, and patients – could put enough pressure on the government to force a real improvement. Many of these students had entered medicine with the desire to “uplift the nation.” They channeled this desire now into a transformed nationalism: uplifting the Malawian people – by holding the state to account.

## Discussion

Here we summarize the findings of five decades of scholarship on professional socialization among medical students in the Northern countries (overwhelmingly the United States and Canada), contrasting the findings of our Malawi research.<sup>b</sup> We conclude by briefly developing the implications of this research.

- European and North American students perceive medical school as extraordinarily stressful. Rates of substance abuse, anxiety and depression are high,<sup>3,4</sup> increase during medical training and probably into practice.<sup>5</sup> Interviews with Malawian students were not focused on this topic, but it certainly does appear that students find their training stressful, and there is limited evidence of increased alcohol use as a coping mechanism. Interviews and focus groups also suggest that for Malawian students, stress increases sharply during their clinical years, while American and Canadian students usually report the greatest stress during their first year of school.
- Northern students adopt a “cloak of competence,” even when they do not feel competent, to mask uncertainty and consolidate status.<sup>6,7</sup> This cloaking increases in the clinical years, as students negotiate between their own inexperience and their need to demonstrate eagerness to perform.<sup>8,9</sup> No Malawian students discussed pretending to greater competence than they felt, nor was clinical uncertainty a significant theme in interviews. It is not

clear whether this difference represents different expectations on the part of their lecturers, on the part of patients, or on the part of the students themselves. It would appear that all three may be factors. Malawian patients are unlikely to challenge doctors; adverse clinical outcomes don't bear the scrutiny they do in other parts of the world, whether due to litigation or to other issues; students can only sometimes deploy even that knowledge they do possess, given the deficits of the public health system.

- During their training, Northern medical students take on a mechanistic and depersonalized view of humans.<sup>8,10-12</sup> This view probably functions to control unwelcome emotions, and comes hand-in-hand with a greater value placed on technology.<sup>13</sup> Malawian students initially show a similar shift toward a reductionistic view of humans, but this shift is reversed during the clinical years. Rather than discussing emotional control, a major theme among Northern students, most of the Malawian interviewees refer to an emotional and spiritual attachment to patients as a major component of their professional identities.
- As medical students become more closely allied to their future profession, Northern studies show them to be less likely to criticize their profession or fellow physicians as their training progresses.<sup>2,8</sup> Malawian students, however, are more critical of members of their profession than they were in preclinical training.
- Northern students become more politically and socially conservative during their training, as part of an attempt to conform to the pattern of ideal “neutral” doctor.<sup>2</sup> They demonstrate increased homogeneity on a number of attitudinal and behavioral measures. As our previous paper showed, in Malawi, students also quickly become more homogenous in style, dress, and manner. They report that they trade in styles that marked them by gender, social class, or region for new markers of physician identity. They do not show increasing conservatism, however, and beginning in their clinical years trend toward a stronger belief in political activism as they go through their medical training. This difference may result in part from their low (in a global sense) pay; discrepancy between status and income has been shown elsewhere to correlate with radical politics.<sup>14</sup> Interviews suggest that it also results from an acknowledgement of the real conditions in which they work, and in which their patients suffer, give birth, get better, or die.
- Northern students typically lose their idealism, shifting from a desire to help others to a desire to get by.<sup>15</sup> Loss of idealism is related to double standards accepted as normal in the profession<sup>16</sup> – for instance, a formal commitment to beneficence coupled with “backstage” encouragement to practice procedures on poor, mentally handicapped, or terminally ill patients. It is exacerbated for students by their own silence about things they find unacceptable,<sup>17</sup> a silence most view as necessary for progress in the profession but simultaneously despicable. Cynical attitudes about patients are particularly common,<sup>8,18</sup> and are reflected in the language medical trainees use when discussing patients: both depersonalized and disparaging.<sup>10</sup> Malawian students, on the other hand, do not show this cynicism, and there is no evidence of an institutionalized cynical slang. In fact, as clinical training progresses students become more strongly committed to

the idea of "heart" or love as a therapeutic link between themselves and their patients. Some trainees develop the concept of witnessing suffering, on both personal and political levels, to the extent that it becomes the core of their mission as doctors.

## Conclusion

This research was intended to explore the evolution of professional identity in students at a medical school in Malawi, documenting changes during medical training in the values and norms that make up professional identity. Research conducted in wealthy countries had consistently demonstrated the inculcation of certain values and attitudes during medical training, many of them demonstrably counterproductive to the stated mission of medicine as a healing profession. Researchers have tended to attribute the resulting professional identity to a "culture of medicine" – whether student-driven or faculty-driven – embodied in the institutional structures of training. The major findings of this research, summarized very briefly above, are best explained by the vast differences in material and cultural conditions between Malawi and the places where medical socialization has mostly been studied in the past. What does not adequately explain student socialization is the idea of a "medical culture," exported wholesale with the knowledges and practices of medicine. Medicine is not a culture that is everywhere the same, any more than it is a neutral set of technologies, brought to Africa and practiced here without impact on society or identity. We hope that others who research the process of medical socialization will be encouraged to explore more deeply the nature of professional identity and mission based on our findings.

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## Notes

- a. Readers wishing more detail on either methods or results are referred to Wendland's 2004 dissertation,<sup>1</sup> available in the College of Medicine library.
- b. We have listed at least one reference for each of these findings, but in each case there are in fact many articles demonstrating (and usually at least one disputing) these findings. We have tried to list here only those issues on which there appears to be a reasonable consensus among researchers of medical socialization, an inevitably somewhat subjective choice. This choice runs the risk of making medical socialization literature look more cohesive than it is. In fact, many significant issues in medical socialization (for instance, whether peer culture or faculty culture is more influential) remain contentious. For a thorough recent review of the North American literature, see Beagan,<sup>2</sup> especially chapters two and four.