# The medical order and the subject disorder in medical professional formation

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**Abstract**

**The medical order and the subject's disorder in medical professional training**

This paper aimed at analyzing the construction of medical professional identity, considering the diversity of relationships involved in this process, (in particular, that between the doctor and the) especially the physician-patient, and the dehumanization of medicine problematic. Adopting the notion of habitus as reference, as formulated by Pierre Bourdieu, and the notions of identification and defense mechanisms of psychoanalytical theory, one seeks to investigate the social and psychic mechanisms involved in the construction of the doctor's identity, through an analysis of the internalization process and externalization of the elements that characterize being a doctor, during the professional training. It was revealed the existence of institutional mechanisms that annihilate student's subjectivity, disorganize their personal identity, and requiring conditions that are impossible to put into practice, forcing the student to make use of defense mechanisms preventing them from experiencing healthy relationships with the other.

**Key words:** Education, medical. Social identification. Stress, psychological. Defense mechanisms. Power (Psychology).

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*Il est inexact de dire seulement que la modecine dépossède le malade de sa maladie, de sa souffrance, de sa position subjective. Elle en dépossède tout autant le modecin, appelé a faire taire ses sentiments parce que l'exige le discours modical. Dans le même temps où le malade, comme individu, s'efface devant la maladie, le modecin en tant que personne s'efface aussi devant les exigences de son savoir*.

Jean Clavreul, *L'ordre medical*

Having the *dehumanization* of medicine as starting point, which fundamentally regards the physician-patient relationship, the research that precedes this article was inspired in the fundaments of Psychoanalysis and Anthropology, particularly in the ideas about the alterity concept [1-5]. The research hypotheses were built from formulations on

relationships of alterity that presuppose the possibility of recognition of the other as subject.

Criticism and discussions related to the dehumanized practices of medicine through which the patient is seen as the object denote the approached problematic, which corresponds in the framework of Anthropology to the *recognition* process. The notion of recognition, in this paper, was related to the *identification* process, exactly as Psychoanalysis defines it. The hypothesis, thus, was that during medical formation there would be mechanisms that could lead the student to a process of loosing identification with the patient.

It was taken as premise, according to studied literature, that these processes would correspond to defense mechanisms developed with the objective of protecting and distancing the student from difficulties in face of emotional experiences lived with the patient during medicine apprenticeship when he begins to identify himself with the *being a physician*. Such mechanisms make him incapable to recognize patient as a (another) human being [6,7].

However, one knows that during medical formation, at the university, the contact of a student with patients happens already in a preset way by the institution's internal tradition: it is not a free experience, but subordinated to trans-generational process, applied to successive classes by teaching staff, that is, it takes place within a set field, been subject to the *rules of the game*. It is fit to come up with the field concept that, for Bourdieu, is the space where shared social objects are disputed by agents invested of specific knowledges have the access of these agents to the several places of this space [8]. This concept sustains the idea that every social interaction around an object of knowledge is not neuter, but socially delimited. From these premises, that author's notion of *habitus* became reference, which corresponds to the set of practices and values related to a specific field, a set that is socially built and that pervades individual subjectivity[8].

Therefore, this work aimed at investigating social and psychic mechanisms, that is, the manifested forms in the individual and in society, which involve the construction process of medical identity through analysis of the internalization and exteriorization process of the elements that characterize *being physician*, or, according to Bourdieu's definition, the medical *habitus*.

**Method**

The phenomenon studied in this research regards the processes related to the individuals' emotional dynamics, as well as the elements that, according to the used theoretical reference, are internalized by individuals through relational processes in unconscious and involuntary manner. Therefore, it is necessary, in order to evaluate it, to choose a research methodology that would allow the undertaking of analysis that

would go beyond the readings of the objectively manifested reality, evidencing the meanings. Given this comprehensive and interpretative feature intrinsic to the studied phenomenon, it was opted for using the qualitative methodology, common to researches in Human Sciences area.

Anthropology constitutes, according to Laplantine [2], the field that bases the scientific process of *the thought of man about man*. Research techniques, as intended in this study, derived from anthropology provide an integrative approach that considers the multiple dimensions of man in society.

Malinowski [9] stresses, in the *Argonauts of the Western Pacific*, that in order to understand a society one must study it *in loco*, that is, to observe its functioning, at the moment and how this takes place. It is possible to observe, through this approach, the manifested behavior in the relationship between observed subjects. Thus, the *fieldwork* or *field research* comprises the way of collecting data for the anthropologist's reflection regarding his object of study.

Still according to the author, the ethnographic technique of participatory observation provides researcher with in depth knowledge of the other and it takes place by means of participating in its existence. Ethnography is based and is made feasible in the inter-subjective contact between the "object" and the researcher, who bases in a dialectic analysis that evidences revealing elements. Therefore, one chose to use ethnographic research techniques, selecting participant observation and open interviews from previously defined scripts as elements.

**Subjects and research space**

The research was carried out among students from a Medical school in a public university of the state of Sao Paulo, reputed as one of best in the country. The entire observation work as well as the interviews was done in different spaces of the university campus, such as the university hospital, student entities, auditoriums, laboratories, etc. Students from every graduation year of medicine at the university where the study was undertaken were the subjects, as well as recently graduated physicians from this university, in addition to professors and preceptors of its medicine graduation course. The research was carried out during the period of January 2006 to December 2009 with fieldwork developed at different moments throughout these three years. The whole observation work was undertaken by the researcher herself, a physician graduated at this same university.

**The research techniques**

**Observation**

Fieldwork was initiated through observation of students' activities in their first graduation year in medicine, a time of initial contact with the new social structures provided by the university, and their adaptation process in this new universe. *Freshman year students* were followed in different activities during the first semester of the school year since their enrollment day at the university.

Next, during two consecutive semesters, students from third and fourth graduation years were followed up, which is the beginning of contact with the patient, in practical and theoretical activities jointly developed or accompanied by professors or professional physicians, as well as the moments of discussing these activities (Medical Psychology classes). These moments were chosen because this work supposed that possible tensions emerged from contact with patients at the beginning of the clinical practice apprenticeship. The elapse of these activities, mostly at the hospital, also allowed the contact with students from other years of the course, and with interns and professors.

The development of these activities allowed to understand how entrance in professional formation and the contact with the patient takes place, which enabled defining the subjects to be interviewed, following the guidance about the place of the participant observation in the ethnographic method.

**Interviews**

Subjects to be interviewed were defined from the study of the observation data. It was selected those students and professor whose speeches brought in significant elements related to the *dehumanization of medicine* and to contact with patients, such as criticism, difficulties, and doubts. The observation of non-verbal features – expressions of fear, uneasiness, etc. -, as well as of students, physicians, and interns with patients and among themselves also served as selection criterion.

The interviewed medical students were on the following periods of the course: four in the first year (two per gender); six in the third year (three per gender); three in the fourth year (two male and one female); six in the fifth year (four female and two male); two in the sixth year (one of each gender). Two recently graduate physicians, a female Psychiatry intern and a physician from Family Health team, and two Semiology professors from the third year (one of each gender) were also interviewed

In interviews with students and recently graduated physicians topics referring to interviewee's view on the values, attributes, and expectations related to medical profession, the process of choosing the profession, entrance and adaptation to university environment, relationships inside the university, Professional formation, and contact with patients were approached. The main objective of the interviews, in pertinence to professors, was trying to understand their comprehension related to students' needs in their first contact with the practice; in which way they prepared students to go to hospitals, and in which way they deal with issues brought in by students.

Interviews were carried out in previously set locations and schedules, after -

reading and signing the free and clarified consent term (FCCT), recorded and later transcribed by the researcher.

A "Field diary" was used throughout the entire fieldwork, in which not only the observed aspects and speeches were recorded, but also the non-verbal aspects that are of crucial importance for this analysis, as well as impressions and thoughts emerged during the work process.

The number of interviews covered the diversity of subjects and the data saturation point was defined when it was considered that satisfactory responses had been gotten for the issues proposed in the study, within the procedures that characterize qualitative research [10,11].

**Analysis of results**

The treatment of the material was undertaken in accordance with the common procedure to the treatment of data gotten in a clinical-qualitative research [12]. Data analysis began, after collected material had been entirely transcribed, from a first reading that aimed at identifying the points related to raised issues based in theoretical foundation and in the survey's initial hypothesis: the *dehumanization of medicine* and the contact with patient.

Next, a second free reading was undertaken in order to open space for arising new guiding questions or new hypothesis, not foreseen in the initial design of the research. Effectively, new topics stood out.

Such elements were grouped then in thematic axes and they were submitted to a first analysis from initially used theoretical reference and from new bibliographic references. This first phase of the study allowed for identifying the main institutional mechanisms acting during the medical formation process at the university, referring to which analytical categories were built: i) Hierarchization; ii) Undifferentiation; iii) Requirement of absolute knowledge.

Then, a third reading was undertaken aiming at identifying all points related to them. Finally, the material was organized and analyzed again and interpreted according with the theoretical presumptions identified in the process.

**Interpretation of the study**

In accordance with Durkheim in *apud* of Setton[13], interiorization of social dispositions derives from the socialization process to which individuals are submitted. Effectively, the socialization process to which students are submitted at the Medical school, evidence during the research undertaking, allowed for inferences about its relationship with the peculiar features of medical institution.

Many of the defense mechanisms developed by students, opposite to what

had been presumed, seem to be related exactly to these processes, or to institutional mechanisms implicit in medical formation and not exclusively the anguish awaken in the relationship with patients, such as issues related to death, disease etc. – as some studies point out [6,7]. The difficulties derived from these experiences with the sick may find space for elaboration if the student is not taken, absolutely, by the requirements and expectations of the institution introjected in his socialization.

One attributes to medicine as institution the Power over life and dealt. Knowledge socially recognized regarding Man, the functioning of the body, the etiology of diseases and their respective control derive from it. Culturally, the healing power is attributed to medicine not in a technical and scientific meaning, but religious, absolute. Medicine, in this focus, occupies a *status* of *order* [14].

The power of this institution is symbolically attribute to the physician, since he is found legitimated as its representative. However, in practice, one verifies that it is not possible to reproduce this power or control that medicine represents, for its absolute character, in the daily professional practice. This symbolic attribution of rights and powers is conferred, mostly, through the *institution's rites* [15].

The institution's rites correspond to the institute of an identity, of a social essence. The institution consecrates a state of things and it sanction an established order, setting a difference that is given to recognize (by the instituted) and to recognize (by others) while social difference. More than establishing a condition, the institution's rites also establish a separation – in most of the times translated in *status* or power – among the initiated and those that will never occupy this place [15]: they establish an inclusion and, simultaneously, an exclusion.

The harshest violence and intensity of mockery at medical schools reveal peculiar characteristics to this order and its members: effectively, as we were able to realize in students' speeches during the research, the mockery, through its violence, fear, and submission, institutes hierarchical or power relationships, announcing what constitutes the universe in which the students is entering. The initiation rites use in every society, just as the mockery, of body inflicted suffering, treated then as memory. The harsher and more painful is the imposed suffering, those who underwent the ritual adheres to the institution that imposes it more strongly. More than na initiation ritual, mockery at medical school corresponds to an *institution rite*.

The institution's act, according with Bourdieu [15], by means of an effect of *statutory attribution*, obliges or makes that the subject to feel compelled in remaining or be in conformance to its definition (instituted). The rites of institution establish *magical borders*

preventing those who are inside to leave. Bourdieu states: *It is also one of the functions of the institution's act: to discourage, in lasting way, the temptation of passage, of transgression, of desertion, of dismissal* [16].

The institution's rite grants, for Bourdieu, in addition to an identity, a competence. It imposes a *right of being* that, at same time, and a *duty of being* and consecrates or legitimates the passage for the instituted group, in this case, the *medical order*. Effectively, a study undertaken in a national scope by the Carlos Chagas Foundation, in 2007, showed that the course of medicine presents the lowest annual dropout rate (only 4%). This average, according to the study, is much lower to subsequent courses with lower rates [17].

Medicine, as order, has a speech. According with Foucault [18], *speech* means a set of enunciations that are sustained in a same *discursive* formation or thematic unit, presenting logical unit capable to oppose other speech, that is, another set of enunciations sustained in a same topic. Speeches are formed both by enunciation and by observation that regulates and disciplines recognized truths or admitted in face of this set of enunciations [18].

Speech is delimited, still according to the author, and it has certain conditions of functioning that are complied through imposed requirements to individuals. It is exactly the compliance to these requirements that selects those who can have access to a certain speech and it determines to those singular proprieties and preset roles. According with Foucault, some mechanisms assure the speech imposing to individuals these requirements, in addition of acting as barrier in accessing the speech.

Among the *requirements* that need compliance for appropriation of the speech is "*knowledge of all*", an explicit expression in students and teachers' speech. Students are *absorbed* and encompassed by this *knowledge*, whose focus is in the technical apprenticeship that allows responding to this requirement. When questioned about their greatest difficulties or concerns, students referred to "*fear of not knowing all*".

Medicine, for Foucault, characterizes itself by *discipline* [that] is *defined by mastering of objects, a set of methods, a corpus of propositions considered as true, a game of rules and definitions, of techniques and instruments*[19]. *To know all* regards exactly the mastering of these methods, propositions, techniques and instruments, and, mostly, of the object of medicine, the disease [14], and it is imposed as requirement not only for the appropriation of speech, but for a supposed protection against failures in the struggle against this object.

The requirement of the absolute knowledge, which characterizes the speech of medicine, leads the student to a feeling of incapability and frustration. Thus, students attempt to surpass their limits seeking for

compensation of this something that is always missing and that is impossible to fulfill, but that the order demands. Knowledge becomes the major conscious parameter that governs this differentiation - from student to physician.

Therefore, despite been instituted as representative of the medical order, the physician's speech is different from the speech of medicine. While that of medicine postulates an absolute knowledge, that of physician's is pervaded by tension between the Power that he bestows by recognizing to himself as legitimately instituted, and by impotence, which takes on him in face of the impossibility of responding to this requirement.

Permanence in this place of conflict between power and impotence is potentially *sickening* for the student. He may use, in order to defend himself from the anguish derived from this situation, defense mechanisms, isolating himself in an omnipotent belief, denying and challenging his characteristics and human needs. This formulation allows us to understand situations that are common to physician's activities, such as endless on-duty periods, added to different Jobs, as insistence in undertaking the heroic procedures in limiting situations, for example.

The institutional mechanisms that work on the medical student's socialization processes during graduation seem to act in the sense of annihilating the subjective elements and the student's individuality so he moulds himself as faithfully as possible to a physician's figure that materializes medicine. There is not space. for maintenance or development of the individual's characteristics or for the student's singularity.

Creativity, differences, and innovation make difficult and threaten the features attributed to this figure, which is intended to be absolute

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In this sense, several mechanisms, called in this work as undifferentiation mechanisms, impose a homogeneity or massification to students, hitting their singularities, inhibiting their subjective elements, repressing their individual resources, and violating their personal identities. Students feel compelled to share the same experiences, and to divide delimited spaces. They have their activities targeted and restricted, their creativity and freedom of thinking and act limited, as well as taste and style features are imposed. Therefore, it is imposed to student an identity that coerces, annihilates or opposes its personal identity, which causes him anguish and confusion.

The university's rigid hierarchy, evidenced since the beginning of this research, seems to be related both to the issue of knowledge and to the undifferentiation mechanisms. The promotion system inside hierarchical categories happens through opinions on competences (of *knowledge*) and to pertaining to social delimited spaces and places. The defense mechanisms that prevent students from living a health relationship with the other seem to come from experiences lived from contact with these institutional mechanisms that involve the medical professional identity formation, such as the imposition of power relationships associated to hierarchy, undifferentiation, and the requirement of absolute knowledge.

The study carried out with the undertaking of Rorschach's diagnosis test in students from the third and fourth years in medicine course confirms these findings by revealing major difficulties in their interpersonal relationships, as well as difficulties in self-affirmation and the failure feeling in using their own values [20]. The difficulties in the interpersonal relationship are apparently associated to the *difficulty in appreciating the other in his wholeness*[20]. The emotional reactions identified in the analysis of the diagnosis test were *predominantly egocentric, impulsive, and explosive* [20]. Still, according with this study, *emotional constructions resulting from infantile fantasies resulting interfering in the development of roles suitable to social companionship, blocking their self-affirmation capacity prevail* [20]. Students show still *instability of attention, subjective perception, and partial judgment of facts* [20].

Medical formation establishes itself in negation of subjectivity of the student and his change into object a higher instance, with his subjectivity disrespected and, often, annihilated through the imposition of elements related to that instance: *medicine*. The individual begins, in the physician's role, to symbolically reproduce or represent the medical institution, without space or permission for manifesting his singularity. This representation, in practice, occurs through the *medical speech*.

Thus, this study points toward a conclusion that the buildup of medical identity takes place by imposition and internalization of institutional and subjective mechanisms related to the *social dimension that it represents*, and not by the development of the students' own elements, capabilities, and potentialities. The requirement of knowledge and the impossibility of *been oneself* make the development of the contact between the medical-student and patient impractical as a relationship, that is, the institutional mechanisms acting during medical formation suppress the student's experience as subject in this relationship.

From the social phenomena study in Mauss [3], Levi-Strauss [4] and Bourdieu [8,15], Miceli, in *apud* of Bourdieu, states: (...) *to any group is given the possibility of seen the arbitrary character of the social order under penalty of surpassing the limits and the significant oppositions that limit its operation. The only exception, (...) would be the "deviant", capable of questioning and relativize the governing social rules by guiding its behavior and its praxis to radically other logic and strange to the prevailing one inside the group* [21].

Throughout this work, through speeches and movements, even if fragile and implied, it was evidence the possibility, both by physicians and students, of bypassing or facing these institutional mechanisms, whose objectives are to keep the social order in medicine that Miceli refers. Similarly, one may also observe that the *emotional path* for those who become *deviants* and touched by abandonment, feeling of exclusion and impotence. Thus, this confrontation subsists to an intense psychic pain.

## Final considerations

The reality observed in this research shows that is not simply the fragmentation of knowledge [6] that causes the nullification or sets obstacles to the establishment of the alterity relationships between the physician and patient. What causes most impact in this picture is the fragmentation of the medical student and physician's personal identity (as well as patient's identity), underlining teaching of medicine, which has the medical speech or valuation of the biomedical knowledge as conducive [22].

Thus**,** effective changes in medical teaching curricula structure will not take place by means of any methodology that is presented, even if better, well founded or well intended they may be. If they do not discuss and work toward changing deeply, or better, radically, the institutional practices translated into the medical speech, its outcomes will inevitably be despicable or null.

Therefore, teaching proposals that open space for understanding medicine in articulation of its subjective and social dimensions are necessary. Just this deep comprehension enables to legitimate the discussion about the difficulties related to articulation of these dimensions, concerning the place of the physician under formation, allowing him to become accredited to care for himself and the other.

**Resumo**

Este trabalho teve como objetivo investigar a construção da identidade profissional de médico, considerando a diversidade de relações envolvidas nesse processo, em particular a relação médico-paciente, e a problemática da desumanização da medicina. Adotando como referência a noção de *habitus*, tal como formulada por Bourdieu, e as noções de identificação e de mecanismos de defesa da teoria psicanalítica, buscamos investigar os mecanismos sociais e psíquicos envolvidos na construção da identidade médica, por meio da análise do processo de internalização e exteriorização dos elementos que caracterizam o ser médico durante a formação profissional. Revelou-se a existência de mecanismos institucionais que anulam a subjetividade do aluno, desorganizam sua identidade pessoal e dele exigem condições impossíveis de ser respondidas na prática, obrigando o estudante a lançar mão de mecanismos de defesa que o impedem de viver relações saudáveis com o outro.

**Palavras-chave:** Educação médica. Identificação social. Estresse psicológico. Mecanismos de defesa. Poder (Psicologia).

**Resumen**

**La orden médica Q el desorden del sujeto en la formación de la identidad profesional médica**

Este trabajo investiga la construcción de la identidad profesional del medico, teniendo en cuenta la gama de relaciones involucradas en este proceso, en particular entre el medico y el paciente dentro del tema de la deshumanización de la medicina. Teniendo como referencia la noción de habitus, formulada por el sociólogo Pierre Bourdieu, y las nociones de identificación y mecanismos de defensa de la teorla psicoanalltica, trata de investigar los mecanismos sociales y pslquicos que participan en la construcción de la identidad del medico, a traves de un análisis del proceso de internalización y externalización de los elementos que caracterizan lo que significa ser medico durante la formación profesional en medicina. Se ha revelado la existencia de mecanismos institucionales que anulan la subjetividad del estudiante, configuran su identidad personal, y requieren condiciones imposibles de poner en práctica. Estos mecanismos obligan al alumno a recurrir a mecanismos de defensa que les impiden la formación de relaciones saludables.

**Palabras-clave:** Educación medica. Identificación social. Estres psicológico. Mecanismos de defensa. Poder (Psicologla).

**Referências**

1. Laplantine F. Antropologia da doença. São Paulo: Martins Fontes; 2004.
2. Laplantine F. Aprender antropologia. São Paulo: Brasiliense; 2005.
3. Mauss M. Sociologia e antropologia. São Paulo: Cosacnaify; 2005.
4. Lévi-Strauss C. Tristes trópicos. São Paulo: Anhembi; 1956.
5. Todorov T. A conquista da América: a questão do outro. São Paulo: Martins Fontes; 2003.
6. Siqueira JE. A arte perdida de cuidar. Bioética. 2002;10(2):89-106.

7. De Marco MA, organizador. A face humana da medicina: do modelo biomédico ao modelo biopsicossocial. São Paulo: Casa do Psicólogo; 2003.
8. Bourdieu P. RazOes práticas. Campinas: Papirus; 1996.
9. Malinowski B. Argonautas do PacIfico Ocidental. São Paulo: Abril Cultural; 1976.
10. Becker H. Métodos de pesquisa em ciências sociais. 4ª ed. São Paulo: Hucitec; 1999.
11. Victora CG, Knauth DR, Hassen MNA. Pesquisa qualitativa em saüde: uma introdução ao tema. Porto Alegre: Tomo Editorial; 2000.
12. Turato ER. Tratado da metodologia da pesquisa clInico-qualitativa: construção teórico-epistemológica, discussão comparada e aplicação nas áreas da saüde e humanas. Petrópolis: Vozes; 2003.
13. Setton MGJ. A teoria do habitus em Pierre Bourdieu: uma leitura contemporânea. Rev Bras Educ. mai/jun/jul 2002;(20):60-70.
14. Clavreul J. L'odre medical. Paris: Editions Du Seuil; 1978.
15. Bourdieu P. O que falar quer dizer: a economia das trocas linguIsticas. Portugal: Difel; 1998.
16. Bourdieu P. Op. cit.;1998. p.116.
17. SilvaFilho RLL, Motejunas PR, Hipólito O, Lobo MBCM. A evasão no ensino superior brasileiro. Cad Pesqui. set/dez 2007;37(132):641-59.
18. Foucault M. A arqueologia do saber. Rio de Janeiro: Forense Universitária; 2007.
19. Foucault M. A ordem do discurso. São Paulo: Loyola; 1996. p. 30.
20. Rossetto MAC, Skawinski LSR, Coelho ACP, Rossetto Jr. JA, Bolla K. Avaliação das caracterIsticas psicológicas dos estudantes de medicina por meio do metodo de Rorschach: Psikhe. jul/dez 2000;5(2):41-51. p. 49-50.
21. Bourdieu P. A economia das trocas simbólicas. São Paulo: Perspectiva; 2004. p. xxvii.
22. Camargo Jr., Kenneth R. A biomedicina. Physis (Rio J). 1997;7(1):45-69.

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