CHAPTER 1
CHAPTER - 1

THE PROBLEM OF RESEARCH

A major part of socialization occurs at a relatively younger age in the family and the patterns crystallized in the early years of life significantly affect a person for the rest of his or her life. However the social learning process of an individual continues in a variety of other settings outside the family. First, parents as a socializing agent not merely perform their familial roles but they articulate these with other structures of the society as well. This fact is a necessary condition for their effective functioning as the socializing agents. Secondly, the child is never socialized only for and into his or her family of orientation but also into structures, which extend beyond his or her family tree. These include, the school peer groups in their later childhood as well as family of procreation which the individual will form through his or her marriage and the occupational roles which he or she may perform that is to say pre or post marriage.

The family offers a wide range of role participation for the young child. He or she must learn about more roles by actual participation in a progressive manner than his family of orientation can offer him or her. It is at this juncture that the peer groups and the schooling assume an important platform.
It has relatively been a recent development to envision the possibility that adults undergo significant specialization when they move into new environments. Adult socialization includes more than what is ordinarily described as education and training.

In the case of Medical Students, they learn not only from perception or even from deliberate examples but through sustained involvement in the society of professional staff, fellow students and parents that comprise the medical school as a social organization (Merton et al., 1957).

During the course of their social interaction with others in school, students acquire certain values which will be basic to their professional way of life by observing and evaluating the behaviours of their teachers. The way in which these students are shaped both by intended and by the impromptu circumstances of their school environment, constitute a major part of the process of socialization.

The Medical school comprises of a unique and highly distinctive, world within itself. Its members possess a special identity and culture for the indoctrination of its new members into certain codes of behaviour which influence them as adults. Professionalization is a process of socialization which involves a matrix of social relations in which the medical student
internalizes and makes his or her own set of attitudes and values which will largely determine his or her future professional life. The institution which has involved within the profession of medicine for the purpose of professionalizing its recruits is the medical college. It has been said that achieving any occupational status usually involves a probationary ordeal which inculcates the requisite technical skills sometimes and the necessary social attitudes and behaviour patterns always. The medical school provides the social environment in which this process of social maturation takes place (Bloom 1973). In the development from studenthood to physicianhood at one stage, it appears to be important for the student to perceive the patient as a diseased entity. In this way, he or she masters and gains control of an important area of knowledge and adapts to significant requirements of his or her future role as a physician.

The medical students who come in contact with others related to the profession of medicine in one way or the other, think it to be the best profession to be taken up because it has status, money and provides satisfaction towards working with patients while enjoying interpersonal relationships at the same time. These students decide quite early but as they go through different stages or status sequences of medicine they realize that it is not so simple to inculcate some of the values upheld in the profession of medicine and to acquire status and money. In fact, it is time consuming and needs hard work. Besides, one needs to know the attitudes that the students develop towards patients and internalization of ethical and moral principles.
that are ethical if they are to be trusted by colleagues, patients and the community in order to maintain their professional autonomy. (Merton et.al, 1957). During the course of their stay in the medical college, they come across various types of exposures which enable them to acquire knowledge, develop skills and imbibe human relations and values. Infact, by the content of his or her education, the student is socialized to become a physician.

The present study is an attempt to examine the professional socialization of physician students within the organizational and socio-cultural milieu of the Medical School or College setting. This would warrant looking at the internalization of certain attitudes and values of a physician while passing through status sequences or various stages of the Profession of Medicine.

**Theoretical Consideration:**

In order to understand the research problem in a wider perspective it is important to take into account some of the theoretical constructs.

**Profession and Professionalization:**

The concept of profession denotes service, occupation that applies a systematic body of knowledge to problems which are highly relevant to central values of society (Rueschemeyer, 1964). The physician is the most prominent among members of the generally recognized professions. He is
seen by the public as possessing a higher standard than any other professional. There are various orientations towards the concept of profession. One orientation sees a professional as an aggregate of people finding identity in sharing values and skills absorbed during the course of intensive training through which they all have passed in order to become professional. In this view, the professional is primarily a particular kind of person. Another orientation defines a professional by his status, irrespective of the norms to which he subscribes and explains his behaviours by reference to the work structure in which he participates. Professions are not primarily oriented towards the pursuit of self-interest but are distinguished by their concern for the common good. Many have seen the profession as an instrument for a moral change in industrial societies: the means whereby ideals of personal service might gradually permeate society and challenge the individuals self interest of the market place (Tawney; 1921, Halmos, 1970) and provide an industrial base from where men could enjoy a measure of freedom, dignity and responsibility (Carr Sanders and Wilson (1933).

Professional is a state of mind (Seymoner,1966). It is what is thought about a profession. Professionalism is the internal process to organize and set up a code of ethics. A good example of professionalism exists in the medical profession. Physicians have obtained direct control over the development and maintenance of the body of knowledge and the specialized expertise resulting from it. Under professionalism, a continuous
and terminal status is shared by all members. Equal status and the continuous occupational career are important mechanisms maintaining a sense of identity, colleague - loyalty and shared values (Oswald Hall, 1948).

There are two main aspects involved in the process of professionalization:

a) Body of Knowledge

b) Service Orientation

The body of knowledge enriches through specialization, research, experimentation and experience. The body of knowledge is affected by university education and professional orientation and a need for higher education. The professional interests also affect the body of knowledge and professionals learn from it for their professions.

The second main aspect of the profession is service to the community. This is highly vocalized by the professionals because of the vested interests and craving for monetary gains. This appears to be more in such cases where the State Control over the professionals is nominal, that is, the State takes up the responsibility of providing service of the professionals to the public. Such interests are gradually subdued. But even then, the professionals look for some rewards or higher status.
Socialization

After having a brief understanding of the concept of profession, it would be desirable to gain insight into the concept of socialization. Socialization gained currency in the 1930's as a term denoting the process by which culture is transmitted from one generation to the next. Dollard (1935) described the process as an account of how a new person is added to the group and becomes an adult, capable of meeting the traditional expectation of his society for a person of his "sex and age". A large number of students come to medical college with the intention of becoming a primary care physicians, given the uncertainties of the role of the medical students during the training. However the student is influenced by the context and values dominant in the training situation. When students begin medical college, they have only a limited understanding of the nature of medical work or the possible choices they will have. Medical college and even the internship and easily residency years confront them with a more complex reality to which they too make a continuing series of personal, social and academic adjustments. As reality tends to diminish their naive idealism and make them aware of the uncertainty of clinical problems, they begin to take on a more professional perspective.

Socialization also means coming together and making adjustment for doing work and discharging responsibility of the society. This is what has been defined by Bogardus (1949). "Socialization is the process of working
together of developing welfare needs of others”. Every individual in the beginning is recalcitrant, rebellious and selfish. By and by, his social consciousness develops and he starts accepting the social responsibilities.

In the context of the medical student, it is implied that when medical students pass through various stages in their training in college, they become capable of helping people in distress and discharging their duties as a healer to the needy. However, earlier they have in their mind monetary gains but slowly they become conscious of their responsibilities towards the patients and start thinking in terms of serving the humanity.

Merton (1957) defined socialization as the process by which people selectively acquire the values and attitudes, the interests, skills and knowledge, in short the culture content in the groups in which they are, or seem to become members. It refers to the learning of social roles. In its application to the medical students, socialization refers to the process through which the students develop their professional self, with its characteristics values, attitudes, knowledge and skills fusing these into a more or less consistent set of dispositions which govern their behaviour in a wide variety of professional situations. Socialization takes place primarily through social interaction with people who are significant for the individual in the professional school probably with the faculty members, above most others with fellow students, with doctors in the hospital and with clients. Cooley (1922) felt that the primary group ought to be studied particularly
because of its importance in the socialization process. He emphasized the point that a close-open relationship in which some degree of intimacy was permissible and in which there existed emotional rather than pragmatic ties was needed in order for the individual to become a socialized member of the society. In other words, the individual must be able to perceive the responses and attitudes that he must internalize in order to become socialized. Cooley's “looking glass self” describes this process. He says that the person’s conception of himself is the reflection of his behaviour in the responses of his primary groups. To him, he looks to the group as he would look into a mirror. Just as the mirror responds to his action by adjusting its images the group responds to his behaviour showing its approval or disapproval. In the primary group he is most likely to see himself as others see him.

The medical profession is often held to represent the professional ideal in the modern society. It ranks high in social prestige and financial remuneration and it performs essential services within the community backed by specialized and effective knowledge and expertise (P. Eloit 1967). Doctors occupy a higher social status in the society not only because of high professionalization but also because they deal with health and life of human beings. The patients have to depend entirely on them for their recovery. The risk of the patient’s life forces him to do, so says the doctors. This,
therefore, becomes a necessity for the doctor to possess high moral character and maintain high professional ethics.

The aim of socialization is to induce the individual to conform willingly to the ways of society and to groups to which he belongs. Socialization can be looked at from two points of view. From the point of view of society, socialization is the way the culture is transmitted and the individual is fitted into an organized way of life and in due course of time, learns to take part in the group life and to embody to some degree, the values of the society and the groups within it. From the point of view of an individual socialization, it is the fulfillment of his potentialities for personal group and development. Socialization humanizes the biological organism and transforms it into a self, having a sense of identity, capable of disciplined and ordered behaviour and endowed with ideas, values and aspirations. It also regulates behaviour but it is the indispensable condition for individuality and self awareness. Thus socialization has two complementary meanings - the transmission of culture and the development of personality (Selzwick 1963).

**Professional socialization**

Professional socialization thus becomes only one of many strands with which the individual is dealing in becoming an adult among the other who are acquiring matured values, defining and acting out sex roles, learning norms which guide adult behaviour and shaping and sharpening the understanding
of social and life goals. Professional socialization as necessity is seen as the process of shaping the individual to fit the needs of the profession and by implications that of a society. Professional socialization becomes a type of equilibrium concept, the socialized professional being regarded as socialized in terms of how the balances are worked out as the profession distributes knowledge. "What would provide more plausible criteria for conceptual adequacy in professional socialization, a theme which considers the confluence between socialization and professionalization, would be the consideration of reciprocity between an individual's aspirations and occupational and institutional structures. This implies the transformation of the aspirations of the structures in which the aspirations are realized to whatever degree" (William J. Goode 1968).

In a broader sense, professional socialization is acceleration, that is, groups in contact and exchange shape certain themes for conceptual adequacy. One such being when the individual shifts from one culture to another and consequently his or her adjustment to this shift. The concept of "Student Culture" used in studies of medical students allows analysis of this shift. In recent times, professional socialization has come into being a specialized institution One of very attributes of professionalization is the establishment of a specialized formal training school, most usually within a University. In any event, socialization into a profession is largely
experienced within an institutional setting, be it a university, college or a specialized academy.

Role Perspective

The important thing to be analyzed here is how the “socialize” learns the gestalt, that is the organized form, how the idea of a whole is incorporated into the individual and to know how an individual becomes capable of recognizing certain innovative behaviours as expressions of the role. As Turner (1985) says “to understand the process by which learning takes place in such a way that the role incumbent may decide that what are accepted as standard features of the role are not really part of the roles”. Thus we can say that socialization takes place in particular role relationships which thereby enable us to understand the whole process of socialization.

A role includes the attitudes, values and behaviours ascribed by the society and as perceived by the focal person that is the incumbent of social position. Status refers to a position in a social system occupied by designated individuals. Linton defined roles as a set of social norms which were ‘parts of the culture transmitted to interactants in any given situation’ (Linton 1945). Parsons (1968) argues that the expectation guiding the role behaviours of any actor must always be dichotomous corresponding to the duality implicit in any interaction or setting. Thus any actor will have certain
notions concerning his own behaviour in the given role which includes the current definition of how the incumbent should act towards other. These are his role expectations. At the same time, the actor will also have expectations relative to the contingent probable reaction of others. The two sets of expectations are always reciprocal, that is, what are sanctions to ego, are role expectations to alter and vice versa. In consequence, there will be a natural steering of behaviours resting on this complementarity of expectations about how the given roles are to be played.

Robert K.Merton (1968) states that a single status in society involves not one role but an array of associated roles relating the incumbent to the various other role players with whom he has to deal in fulfilling the obligations of his status. "The related concept of social role refers to the behaviours of status occupants that is oriented towards the patterned expectations of others (who accord the right and exact the obligations). This constitutes the role set. Thus a person in the status of a medical student plays not only the role or a student vis-a-vis the co-relative status of his teachers, but also an array of other roles relating him diversely to others in the system, other students, physicians, nurses, social workers, medical technicians and the like". In Merton's terminology, role sets are complemented by the way every individual occupies a variety of statuses which when added together constitute his status set. Among the different role obligations, there may be contradictory performances shown by different actors within a system. The
individual is thus likely to face a wide, distracting and somewhat conflicting array of role obligations. Moreover the role of an individual is influenced by the role performance of other individuals in the intersectional process.

Newcomb (1950) brought the concept of role from anthropology to social psychology and referred to role as expected or appropriate behaviours. He stated that a social role could be distinguished from its actual performance enacted in a specific situation. Using Meads concept of 'role-taking' he envisaged a new term for it namely 'role-playing'. According to him an individual's status set involves a wide variety of role relations, thus the individual will find himself occupying positions within compatible role requirements.

Role theory also has its important basis in the works of George Herbert Mead. His concept of role taking makes it possible for individuals to react to their own gestures and anticipate the others behaviour as one's own. With his theory of communication he has demonstrated a fundamental feature of human sociality. As Joas (1985) states, in human society, an individual non-naturalistically determined behaviour develops and is integrated into a group activity via mutual behaviour expectations. Role then becomes situationally specific normative expectations towards position holders. In this sense an individual while taking on the role of the other is also able to see the situation as an objective one that is from the stand-point of the '
Generalised other'. This enables the individual to comprehend the situation and orient his actions towards the others accordingly.

Goffman, (1969) elaborated the idea further and explained his theory in terms of role performance and role distance. Role performance may be viewed as an activity of a given participant or a given occasion which serves to influence in any way of the other participants. According to Goffman "When an individual or a performer plays the same part to the same audience on different occasions a social relationship is likely to emerge". Defining social role as an enactment of rights and duties attached to a given status, we can say that a social role will involve one or more parts and that each of these different parts may be presented by the performer on a series of occasions to the same kind of audience. In his concept of role distance he emphasized the separateness between the individual and his role. According to him, role consists of the activity the incumbent would engage in, were he to act solely in terms of the normative demands made upon someone in his position. Role in this sense is different from role enactment which includes the actual behaviours of an individual on duty in his position according to him, role differentiation is likely to occur when role is in formation. Role distance falls between role obligations and actual role performance. It refers to typical role performance, different from normative framework of role which constitutes a wedge between the individual and his role. Thus Goffman implied on the one hand "public signalization by the actor of differentiation
between himself and his role with the aim of articulating the difference between his image of himself and his implied role identity”. On the other hand, a ‘sovereign’ distance demanded by the role itself from its obligations. Thus the period of initiative into the role of the physician appears to be one wherein the two cultures, “lay” and “professional” interact within the individual.

Some of the above theoretical constructs reviewed will have bearing in analyzing the professional socialization of the student physician in the Medical College Organizational or socio-cultural setting.

**Review of Studies**

The present review is divided into two sections, the first dealing with reports and studies carried outside India whereas the second part deals with the studies done in India.

Oswald Halls (1948): 'The Stages of Medical careers', points out that the decision to study medicine is largely social in character, that is, it originates in a social group that is able to generate and nurture the medical ambition.

Regarding the professionalization of the medical group/ William J.Goode (1957) in his study “Community within a Community” noticed that once a professional group becomes established, it begins further to consolidate its power by formalizing social relationships that govern the interaction of the professionals with their clients, their colleagues and with
official agencies outside the profession. Recognition on the part of clients, the wider society of the professionals claiming to competence as well the professional ability to control its own membership, are necessary if professional decisions are not to be reviewed by outside authorities. Once this situation occurs, Goode believes that additional features of the profession can be established.

Mary Huntington (1957) in the development of a professional self-image discovered that medical students felt least like doctors around their fellow students or the medical school faculty but their professional image was enhanced by their interaction with patients who attributed physician status them regarding the orientates of students to join the medical profession.

Reene Fox in his "Training for uncertainty" (1957) found that Medical School organized basically two traits as a result of their medical training, ability to be detached from the patient and to tolerate uncertainty. Fox, as a part of an extensive study on the student physician, noted that the medical students experienced three types of uncertainties. First, there was uncertainty resulting from an awareness of not being able to learn everything about medicine. Secondly, there was realization that limitations existed in current medical knowledge and techniques. The first two uncertainties led to a third type of uncertainty in which the medical students had problems distinguishing between the personal ignorance and the limits of the available knowledge. However, Fox observed that as the student acquired medical knowledge and gained experience along with a sense of personal adequacy in
medicine, he or she learned to cope with the uncertainty and to assess conflicting evidence objectively in assuming diagnosis. This process was assisted by the realization that other medical students were coping with the same problems and that the faculty also experienced uncertainty in their everyday work.

In another article Howard Becker and Blanche Green (1958) “the fate of idealism in medical school have argued that cynicism on the part of the medical students represented growth towards a more realistic perspective what appeared as a harmful change of attitude was actually part of a functional learning process of the physicians role of maintaining an objective perspectives of health & disease. Therefore he found that medical students developed an appreciation of clinical experience and medical responsibility for patients.

At Tulane University Medical School, Leonard Riessaman and Ralph Platoo (1960) in their study on "The Motivation and Socialization of Medical Students" found that a majority of both junior and senior medical students could be described as "humanitarians" rather than 'Scientists' or 'professional', a major characteristic of the humanitarian being working with patients and enjoying interpersonal relations.

Howard Becker in his Study “Boys in White, Student Culture in Medical School" (1961) determined that the students developed a strong appreciation of clinical experience (working with patients rather than reading
about disease and studying it in the laboratory) and that they acquired sense of responsibilities about patients. They also learned about new diseases and death as medical problems rather than as emotional issues. The focal point of their passage through medical school was to graduate since they could not learn everything they need to know in order to practice medicine, so they directed their efforts towards finding the most economical ways of learning. Generally, they tried to give what the faculty wanted them to know and then they studied this material for the examination. Even so, they found that they put in an eight hours a day of classes and laboratories. They also studied four to five hours on week nights and continued studying in the weekends. Becker observed that the medical students may in fact become cynical while in the school but he also pointed out that attitudes are situational. Thus when graduation approached, idealism seemed to return as the students could set aside the immediate problems in order to complete their programmes of study. In certain cases, the medical students are isolated in an institutional setting and are faced to adjust to the demands of the setting. But once the medical students are ready to return to the mainstream of the society, they again become concerned about the service to the humanity.

Wheeler (1966) outlines different settings under which socialization occurs. These include socialization that occurs when one is socialized as an individual, group socialization when one is socialized as a part of the group, distinctive socialization when all, an individual or a
group is being socialized for the first time without any previous established norms and tradition. Lastly the serial socialization in which individuals or groups of individuals are being socialized continually within a context. These differences in the socialization structures are important because these provide knowledge about the flexibility traditions present in the socialization context. Viewed in this way, medical socialization occurs in its serialized setting and in a group socialization which does not take into consideration the individual needs.

Cole Stephen (1968) stated that beginning in the early 1970s, there was a dramatic increase in the proportion of women admitted to medical school. The entering of women in medicine could have resulted from sex role - socialization that influenced women not to inspire for a career in medicine and from direct discrimination by medical schools as there was admission discrimination against women from 1929 to the present time. Women applicants to medical school have now as good a chance of being accepted as men applicants. Also the qualifications of the men and the women applicants were essentially equal. These findings suggest that as far back as 1929, the low representation of women in medicine was primarily result of differences in socialization based on occupational choice.

John Columbos (1969) in his 'Social Origins and Ideology of Physicians', a Study of the effects of early socialization, found out that
physicians belonging to the lower class origin emphasized upon the success values as reasons for taking up medicine than the upper class. Those who were less success oriented became more so after commencing their practice while it was reverse with those who were more success oriented. Success oriented physicians were probably encouraged to be less obvious about their ambitions and the less success oriented were most likely encourage to strive for the level of status indicative of their professional group. Columbos suggested that this was most likely due to socialization by colleagues.

Harold I. Lief (1971) in his ‘Personality characteristics of Medical Students, suggested that the medical students go through a process of anticipation which is aided by increasing responsibility and competence during the clinical years of medical school. Thus the student ‘self’ image as a ‘doctor develops as the medical student approaches his or her graduation’.

Samuel Bloom (1973) In ‘Power and Dissent in the Medical School’ pointed out about the orientation of students to join the medical profession. He found that while medical students at the State University of New York, Downstate Medical Centre, tended to make a career decision for medicine relatively late, those students having sustained contact with immediate or close family relationship considered medicine as a career earlier than the other students.
Studies Conducted Within India:-

Rao's (1975) study reviewed the differences in the work values, professional aspirations and perception of campus climate of first year, mid year and final year students. The main finding is that increase in years of experience to medical education is accompanied by rise in students interest in economic status, dimensions of the job rather than academic and service orientations.

T.K. Oommen in his book "Doctors and Nurses, A study in Occupational Role structures" (1978) revealed that persons who enter prestigious professions such as medical, do so with great aspirations and enthusiasm. It is unlikely that their aspiration will be fully met in the initial phase, that is, in the first five years, but this time span is too short so as to develop serious frustrations. Their enthusiasm continues, aspirations flourish and role commitment persists. But after this phase, at least some of them fail to realize their aspirations and the period of frustration and disenchantment with the professional role begins.

T.N. Madan (1980) in his study of “Doctors and Society”, at the A11 India Institute of Medical Sciences, has analysed the perception and conceptualization of doctors’ professional roles, evaluation of the place of their professional work or role performance and their overall conception of the manner in which they relate as professionals to the society as a whole.
He states that college syllabus has failed to impart a medical student with a sense of social awareness and responsibility. Hence his role performance is not adequate when he enters the real work setting, that is, the hospital, after completing his MBBS training. The successful achievement of the goal of a doctor is dependent upon high professional competence, intellectual capabilities combined with technical skills and not merely good will. Recognition by one’s professional colleagues is highly valued by the doctors in the work setting. In terms of evaluation of their profession in the society they regard it as the "greatest achievement of mankind", highly conducive to human welfare and happiness.

Vandana Sharma (1986) in her study on 'Doctors in the making'. A study in professional socialization of the student physicians" revealed that the student - physicians warrant reorientation of their ideals and values as they pass through the various stages of medical training. The idealism of the students is culture specific while the most significant factor motivating them to join this profession is the professional aspect of career.

Harleen Kaur (1991) in her study on “Socialization Process among Medical Students” revealed that students who had family members or relatives in this profession decided earlier to take up medical profession. Comparatively boys then girls took this decision earlier. Perception changes
as students pass through different stages, from being idealistic they become materialistic in their outlook.

OBJECTIVES OF THE STUDY

Keeping in view, the nature of the problem and the review of studies, an attempt has been made to set the following objectives of the study.

1. To analyse the demographic and sociocultural profile of the medical students in the two selected colleges.
2. To delineate the factors motivating the students as well their decision making process to join the profession of medicine in the two selected colleges.
3. To find out the views of the medical students regarding the medical profession at the initial stage of joining as well as while completing the course in the two educational institutions.
4. To analyze the attitudes and values formed by the students towards the profession while they are about to complete their education in two different organizational milieu.
5. To analyze the future orientations and expectations of medical students in two different organizational settings.
6. To examine the level of satisfaction of students with the medical education in two different organizational settings.
Hypotheses of the Study

How do medical students change in their perception, attitudes and values in a few years period of training? In what way, do their experience in college affect them? In what way, has it left them untouched? How will their experience in College affect their practice as a doctor? These are still some of the questions which have remained unanswered. Initially, the medical student views the profession from outside as a layman but as he assumes the role of a medical student, he comes to realize that there is much more to the profession than only 'service to humanity' and a 'higher status' in the society. They try to find out what the faculty want them to know and study only the things that are likely to appear in the examination. The decision to join the profession is closely linked with the family experience that is, whether a parent or relative is in this profession or not. Frequent contact and socialization with the doctors during childhood help to shape the attitudes of an individual favourably towards this profession.

The teaching hospital being the subsystem of the social system on one hand, is influenced by the main system while on the other hand, it influences it. Recruited personnel and selected students, patients’ population and other visitors carry with them the cultural and social values of the larger societal system and affect the culture and the functioning of a medical teaching organisation. Formal power structure and policies of government
and other agencies also influence the internal system of the medical organization. The teaching hospital acts as a functional unit of the total system and renders certain important functions for the existence of the society, like rehabilitation of the sick members of the society to their normal social roles, maintaining a standard of health and keeping the flow of medical personnel. So the extent, to which the goals in an organization are achieved will depend largely on how its various active components constitute the organizational roles. The roles of the members of an organization can be known by the positions they hold in the context of an organization. For any evaluation of the achievement standards of these individuals and the factors accounting their role performance, the organizational structure of a teaching hospital or medical college is important. As such a medical college which has a post graduate specialization as the central thrust will have higher inputs of research and teaching as well as consultancy, besides technical facilities and environmental settings, than a medical college having only graduate level teaching in Medicine. These two different organizational climates with varying inputs of men, money and material will effect the socialization of physicians differently.

In the above backdrops, some of the main hypotheses pertaining to this study in the two selected medical colleges are as follows:
1. Medical students are motivated to join the profession more for money and status factor than for serving the humanity.

2. For medical students, the perception of profession of medicine is full of idealism initially but this idealism diminishes and they tend to become practical as they move on towards the final year in the college.

3. Medical students in contact with individuals either in the family or in the relations belonging to this profession, decide to join this profession and some may do it at an early age than others.

4. Organizational structure and culture of a medical college may affect the socialization process of the student physician in terms of acquiring attitudes and values towards the profession.

METHODS AND TECHNIQUES OF DATA COLLECTION

UNIVERSE OF THE STUDY

Keeping in view the problem of research as well as to understand the influence of organizational structure of medical colleges, it was decided to select colleges in Delhi. Delhi being a metropolitan city draws students from the different regions of the country. As such, students with different cultural orientations, attitudes and values could be drawn. In order to analyse the effect of different cultural settings, on the “Professional Socialization of the Student Physician,” it was thought best to select two medical colleges having different organizational structures. As such, it was
decided to select one, All India Institute of Medical Sciences which has a higher teaching and research input than the other hospital, that is Maulana Azad Medical College. The two colleges have similar teaching programmes leading to the award of MBBS. Their organizational structures in terms of hierarchical arrangements, staff positions services and clinical experiences are different and thus they represent two separate socio-cultural settings. This comparison is useful as it helps us to know about in what respect students from both colleges differ in their socialization process. The first and the final year medical students from both the colleges were taken to find out the changes in their perception, attitudes, and expectations as they pass through the different stages of professional socialization. In all, 50 students each from the first and the final year of AIIMS (100 in total) and 145 students each from the first and the final year of MAMC, (290 in total) were interviewed. At MAMC, out of a total students only 145 students were present. All those present at the true of carrying out the study were taken for the collection of data. An equal number of student 145 were included in the study from the final year of the same college. In the case of AIIMS, only best of the 50 students are admitted into first year and they continue till the final year. The study was carried out during the year 1993.

INSTRUMENTS OF DATA COLLECTION

Data were collected with the help of the structured interview schedules/questionnaire designed separately for the first and final year students, Information was collected on the following broad aspects:
1. Personnel Characteristics of the student such as respondents’ name, age, sex and caste etc.
2. Information regarding their educational history.
3. Major motivating factors for them to enter medical profession.
4. Perception of the students towards the medical education before and after entering the college.
5. Level of satisfaction of medical students with the medical education and whether they had any doubt regarding medicine as the right choice of career for them.
6. Type of professional life, the students would like to lead after completing their courses.
7. Problems faced by them during the studentship.
8. Difficulties faced by them from seniors and teachers regarding studies.

In order to supplement the data collected through structured interviews, observations were also carried out in selected situations in order to know the student physician interaction with the seniors and the fellow physicians as well as with the patients.

Analysis of Data

A code design was developed and used for tabulation of data. Data analysis was carried out by using simple ratios and proportions. Statistical
analysis and mean score values were worked out for ranking and rating scales.