Social Backgrounds and Some Selected Attitudes of Clinical Students in a Medical School

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DURING recent years many medical schools have included in their curriculum studies a more searching evaluation of what a student is being and should be taught. This has usually been approached by having the school's departmental representatives describe to each other what they are teaching.[1] This concern is increasingly directed not only to the basic and clinical subjects, but also to the development of attitudes toward the medical profession. Thus, studies have been carried out on both students and faculty alike with the hope of developing and/or modifying the student-physician's attitudes toward the medical profession. For example, research at the professional level of medical school includes studies done by Fredericks and Mundy[2, 3, 4, 5], Woods, Jacobson and Netsky[6] who examined social class in terms of medical school performance. Studies on the attitudes of medical students include the work by Miller and Erwin[7, 8] and that of Eron[9, 10] who investigated anxiety and cynicism in medical students. Parker[11] concerned himself with authoritarianism, while Platou et al.[12] described student attitudes towards teachers and patients. Neibuhr, Steiger and Hoffman,[13] on the other hand, investigated student attitudes toward a comprehensive care program.

However, to a limited degree have empirical studies investigated the social class backgrounds of clinical students in medical school in order to discover what exactly are some of their attitudes toward the medical profession—attitudes which may very well have a bearing on medical education, as well as the future practice of medicine in the United States.

The present paper is concerned with the exploration of the possible socio-psychological aspects of social class backgrounds and some selected attitudes of clinical students in their senior year of medical school. It is hoped that the present study might offer some indication of how persons from different socio-economic classes respond to professional medical training.

METHOD

The sample studied consisted of 79 clinical students in their senior year attending a midwestern school of medicine during the academic years 1965-66. Of the 79 medical students, 75 were males and four females. All the medical students in the study group were Americans, with the exception of one male foreign student from Hong Kong. Seventy-eight of the students were Caucasians and two were Orientals.

The data for this study were gathered mainly through self-administered questionnaires and attitude inventories given near the end (May 1966) of the clinical year 1965-66. Previously, data had been obtained from interviews with the study subjects from the very commencement of their freshman year, and also from participant-observation of the students in their school situations and in their living quarters. All these data were subjected to both a qualitative and quantitative analysis. Some of the findings have already been or will be reported elsewhere.[2, 3, 4, 5] Certain socio-economic characteristics and attitudes have been selected for reporting in this paper.

The study subjects were first divided into five social classes on the basis of Hollingshead's two-factor index of class position, based on their father's education and occupation.[14] For the pur-

pose of analysis, Class I and Class II were combined in a single category comprised of 19 (24.1 per cent) subjects and Class IV and Class V into another comprised of 32 (40.5 per cent) subjects. Class III remained unchanged with 28 (35.4 per cent) subjects. Subsequent to the regrouping, the classes were identified simply as 1 (formerly I and II), 2 (formerly III), and 3 (formerly IV and V).

The concept of socioeconomic class is used throughout this study to refer to the kinds of psychological and social characteristics found differentially distributed among medical students classified by the weighted index of their father's occupation and education.[2]

SOCIAL BACKGROUND CHARACTERISTICS

As of the time of the students' entry into medical school, the majority of them were young, unmarried and predominantly Catholic. Their ages ranged from 20-24. Sixty-two per cent of the 79 students had entered medical school after having completed a four-year college education and had obtained a bachelor's degree. Forty-eight per cent had attended a Catholic institution for their premedical studies.

The occupational backgrounds of the fathers of these medical students are indicated in Table 1. Some 73.3 per cent of the respondents came from homes where the father was engaged in white collar or non-manual work; 26.7 per cent had fathers occupied in blue collar or manual work. This finding roughly parallels Pavalko's investigation of occupational backgrounds of predental students.[15] It would appear that the available data concerning white collar and blue collar occupational backgrounds of medical and dental students are approximately the same.[16] And sons have, by and large, aspired to occupations with the same or greater prestige than those of their fathers.[17]

These fourth-year medical students came, in general, from rather small, fairly-educated families living in urban communities at a reasonably high socioeconomic level.

Table 2 shows that about 24.3 per cent of their fathers had completed four years of college or some graduate or professional training. Sixteen per cent of the respondents have Irish ancestry and 18 per cent are of Italian descent; in both cases the progenitors were primarily from the lower-middle and upper-lower classes.

An analysis of further breakdowns of responses to other questions indicate that, of the fathers of respondents in the sample, 14 per cent had a university degree in medicine, four per cent had a degree in law, and three per cent had earned degrees in engineering.

Although coming from relatively comfortable families, two-thirds of the members in the study group have had economic problems while attending medical school. The majority depended upon internships for food and lodging, incomes from their working wives, and loans in order to complete a substantial portion of their medical education.

DECISION TO ENTER FIELD OF PRACTICE

The decision of these students in the sample to enter into a field of practice upon completion of their medical education is the extent to which various factors have influenced their choice of practice as a career. In this study, the most important source of influence affecting such a deci-

TABLE 1.—OCCUPATION OF FATHERS OF 79 CLINICAL MEDICAL STUDENTS BY PERCENTAGE DISTRIBUTION

Occupational Category	*Per Cent*
Professional	24.2
Physician (14.6)	
Semiprofessional or Technical	15.8
Managers, Proprietors, and Officials	17.5
Clerical and Sales	15.8
Skilled Workers, Craftsmen, and Foremen	8.5
Semiskilled Workers	18.2
Total	100.0

TABLE 2.—EDUCATION OF THE PARENTS OF 79 CLINICAL MEDICAL STUDENTS BY PERCENTAGE DISTRIBUTION

Education	*Father*	*Mother*
Some Graduate or Professional Training	21.9	13.4
Completed Four Years College	2.4	3.0
One to Three Years of College	12.2	9.8
Completed Four Years High School	26.8	38.4
One to Three Years of High School	23.2	20.7
Eight Years of School or Less	13.4	14.6
Total	99.9	99.9

sion was asserted to be the student's own intellectual interests. Once the decision had been made, parents, spouse, and clinical chiefs during internships encouraged the respondents to continue their hospital training beyond their internship. This finding roughly parallels Fredericks' and Mundy's investigation of physicians in a developing notion.[18] It is of interest to note that 45 per cent of the members in the study group had made a final decision during their internship on how much hospital training they would obtain for the future practice of their profession.

The future practice arrangements are highly salient and constitute a major subject of the respondents' conversations and thoughts. The vast majority report thinking a great deal about the type of practice they want to have, its location, and the branch of medicine it will comprise.

Of those expecting to practice with someone else, 22.8 per cent of the respondents intend to associate with another physician of the same age or a junior physician. Seventeen per cent intend to pursue individual practice; 12 per cent intend to pool facilities with another physician of older age group as contrasted with above group (Table 3).

To get some indication of the breadth of activities the clinical students might pursue, they were asked how interested they would be in joining one of the international medical organizations such as *Medico* or *WHO*. Since these activities all face recruitment problems and are off the main career line of individual practice, it is worth noting that one-third of the students in the sample asserted that they are interested in such organizations and would be willing to join them.

ATTITUDES TOWARD THE MEDICAL PROFESSION

Medicine as a profession has some general features which are important in identifying a good medical student over and above his knowledge and ability to apply such knowledge. There undoubtedly are other vital features, but the authors have limited their attention in this report to the following list:

a. Ability to establish rapport with patients.
b. Ability to discern and deal with social and psychological problems of patients.
c. Ability to get along with other medical students.
d. Ability to get along with the faculty.
e. Academic abilities as evidenced by examinations, recitations, written assignments, etc.

Together, these five features of medicine provide a basis for analyzing some selected attitudes of the respondents in identifying a good medical student; the assumption being that members in the study group are revealing simultaneously their own judgements toward medicine. An analysis of the data indicates that students irrespective of social class position were nearly unanimous in the high importance assigned to the ability to establish rapport with patients.

Although the majority of the respondents asserted that the ability to establish rapport with patients was the most important feature in identifying a good medical student, they were also aware of possible dangers of such relations to

TABLE 3.—SOCIAL CLASS OF MEDICAL STUDENTS BY TYPE OF PRACTICE INTENDED AT PEAK OF CAREER

Practice Type	*Total*		*Social Class Categories*					
			Class 1		*Class 2*		*Class 3*	
	N	*Per Cent*	*N*	*Per Cent*	*N*	*Per Cent*	*N*	*Per Cent*
Alone	14	17.7	3	15.8	6	21.4	5	15.6
Alone but sharing facilities with another doctor	10	12.6	4	21.1	6	21.4	—	—
Group practice	14	17.7	1	5.2	4	14.2	9	28.1
Full-time hospital appointment	4	5.1	1	5.2	—	—	3	9.4
Partnership with senior physician	4	5.1	1	5.2	1	3.6	2	6.2
Partnership with same age or junior physician	18	22.8	6	31.6	5	17.9	7	21.9
Other types	3	3.8	—	—	1	3.6	2	6.2
Do not know	10	12.6	3	15.8	4	14.2	3	9.4
No response	2	2.5	—	—	1	3.6	1	3.1
Total	79	99.9	19	99.9	28	99.9	32	99.9

their future professional role. Two-thirds asserted that "if you are not on your guard in practice, patients will take you for a ride . . . and that one of the problems in getting friendly with patients is that patients do not know how far to go in drawing the line . . . ultimately they often lose respect for you." Similar findings were found in a recent study of physicians practicing in a developing, newly independent nation.[18]

In their conceptions of themselves as future physicians, the respondents took a positive view. Students were asked for a realistic appraisal of how well they were doing in their classes compared with their classmates. Ninety-five per cent asserted "favorable;" less than 2 per cent admitted their comparative performance to be "unfavorable."

ATTITUDES IN DIFFERENT SOCIAL CLASSES

The members of the study group were also questioned regarding their feelings about race, education, social class position, and the religion of their future patients in order to assess whether any of these factors loomed as influential in affecting a physician's judgement of a patient as a person. It is interesting to note that middle and lower class medical students were more likely to consider education, religion, and social class as important factors while upper class students were more consistently emphatic in not considering these extrinsic factors (and race) as important (Table 4).

TABLE 4.—SOCIAL CLASS ATTITUDE OF 79 CLINICAL MEDICAL STUDENTS IN SAMPLE WITH REGARD TO SOME SELECTED FACTORS INFLUENCING THEIR JUDGEMENT THAT A PATIENT IS A PERSON

Selected Factors	*Social Class Categories*		
	Class I Per Cent	*Class II Per Cent*	*Class III Per Cent*
Race			
Important	10.5	7.1	6.2
Not Important	73.6	82.1	84.4
No Opinion	15.8	7.1	6.2
No Data and not Codeable	—	3.6	3.1
Total	99.9	99.9	99.9
Education			
Important	10.5	28.6	28.1
Not Important	73.6	60.7	62.5
No Opinion	15.8	7.1	3.1
No Data and not Codeable	—	3.6	6.2
Total	99.9	100.0	99.9
Religion			
Important	5.3	14.2	—
Not Important	78.9	71.4	93.8
No Opinion	15.8	10.7	3.1
No Data and not Codeable	—	3.6	3.1
Total	100.0	99.9	100.0

In the present study, clinical students looked upon medicine as possessing the greatest prestige among occupations in the U. S. However, 73.6 per cent of Class I respondents viewed medicine as prestigious in contrast to Class II (60.7 per cent) and Class III (59.4) respectively. Interestingly, a similar high percentage has been reported for physicians practicing in a developing nation.[18]

The data on the respondents' attitudes toward socialized medicine for the U. S. indicate that nine in 10 were against the introduction of such a program for the future, irrespective of social class position.

Another aspect of the respondents' attitude toward their profession is their estimate of future satisfaction with it as a career. The factors which seemed to be most important in bringing about this satisfaction are a) opportunity to help patients, and b) the opportunity to identify diagnostic problems. The factors which seemed to be least important in bringing about this satisfaction are a) opportunities for research, and b) status in the community.

DISCUSSION

The results of this study suggest that since finances play a large role in the education of a physician, it would appear that medical schools are not attracting a larger share of qualified students who might become outstanding physicians to fulfill the health needs of the various communities and the demands of hospitals in the U. S.

Medicine, as practiced in the U. S., "needs to do little to recruit students from the upper social classes who can afford the expense of a medical education; students from other social classes cannot afford the expense, so they select a career with less financial burden."[19] If additional programs could be initiated to alleviate the financial burdens of able or gifted students (from other social

classes) who cannot afford the expense of a medical education, the possibility would also exist that there would be an improvement in the calibre of applicants and in the success of student selection.

The student-physicians in this study judge that the most vital feature in identifying a good student-physician, over and above his knowledge of medicine and his ability to apply such knowledge, is the ability to establish rapport with his patients. It would appear, therefore, that Professor Michael H. Beaubrun's statement is most apropos of this finding: "it is most important that not only the psychiatrist but every doctor be taught the social anthropological background of the patients with whom he deals and how these patients perceive him; for a doctor from the middle class or social elite is usually surprisingly unaware of his patient's beliefs and value-systems."[20] Hence, it would seem that greater emphasis should be given to the importance of psychology, sociology, and anthropology during the premedical and preclinical years of study.

It is worth noting here that steps have been taken at the School of Post-graduate Medical Education of the new Mount Sinai School of Medicine to offer courses in philosophy, literature, languages, sociology, anthropology, political science and economics on a continuing basis. The goal is to humanize the practice of medicine by broadening the outlook of physicians who sometimes become so immersed in their specialty that they become more interested in symptoms than patients. Doctor Martin Steinberg, director of the hospital, asserted that "you can't teach kindness alone," and he added that "what we can teach is the value of the humanities."[21] Doctor George James, former city Health Commissioner, who is the school's present dean, has said:

> Anybody who takes a look at medicine today sees that there's much more involved than the bio-medical skills and sciences . . . the physician must relate the medical condition to the total life experience of the patient. He must understand the socioeconomic factors that created his condition.[21]

The data also seems to show considerable interest among students in joining one of the international medical organizations, although not as a full time career. Is this interest real, and does it suggest a major resource that might be tapped if the methods of recruitment could be more aggressively pursued?

Since the representatives of the three social classes covered in the study came from predominantly white, Catholic, urban settings, further research is required to determine whether or not the results would be similar for all regions and subcultures.

SUMMARY

In summarizing this study of clinical students in their senior year of a medical school, certain points should be highlighted.

1. This paper has presented a summary description of the social class backgrounds, together with some selected attitudes and aspirations of clinical students in their senior year of a medical school. It has not considered the variations that might exist either with preclinical students in the same school or with students from other medical schools. The latter two aspects of comparisons will be considered in other articles.

2. Respondents held that the most vital feature in identifying a good medical student, over and above his knowledge of medicine and his ability to apply such knowledge, is the ability to establish rapport with patients, irrespective of the social class backgrounds of the students.

3. Middle and lower-class medical students in the sample were more likely to consider education, religion, and social class as important factors affecting their judgement of a patient as a person. Upper-class students were more consistently emphatic in not considering these factors—and race—as important.

4. Although coming from relatively comfortable families, two-thirds of the members in the study group had economic problems while attending medical school. The majority depended upon externships for food and lodging, incomes from their working wives, and loans in order to complete a substantial portion of their education.

5. In terms of practice plans, results indicate that of those expecting to practice with someone else, 22.8 per cent of the respondents intend to pursue individual practice; and 12 per cent intend to pool facilities with another physician as contrasted with above group.

6. Two-thirds of the respondents in the study group wanted to practice in small and medium-sized cities. One-third expected to practice in their home town. This finding appears to be very important, if widespread. The question arises: Would

there be a rejection of the future health needs of metropolis where most Americans will live and die?

7. Analysis of the data seems to show interest among members of the study group in joining one of the international medical organizations such as WHO or MEDICO although not as a full-time career. The question arises: Is this interest real and does it suggest a major resource that might be tapped if the methods of doing so could be invented?

8. Clinical students in the study group looked upon medicine as possessing the greatest prestige among occupations in the U. S.

9. In examining the attitude of each social class toward socialized medicine in the United States, nine students in 10 were against the introduction of such a program for the future, irrespective of class position.

10. The factors which seemed to be most important in bringing about future satisfaction to the student-physicians in the practicing of medicine are *a*) the opportunity to help patients, and *b*) the opportunity to identify diagnostic problems. The factors which seemed to be least important in bringing about this satisfaction are *a*) opportunities for research, and *b*) status in the community.

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