Cultural Initiation of Medical Doctors

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A B S T R A C T

Eighteen years experience of teaching medical anthropology at a Hungarian medical school offers insight into the dynamics of interference between the rationalist epistemological tradition of biomedicine as one of the central paradigms of modernism and the cultural relativism of medical anthropology, as cultural anthropology is considered to be one of the generators of postmodern thinking. Tracing back the informal »prehistory« of our Institute, we can reveal its psychosomatic, humanistic commitment and critical basis as having represented a kind of counterculture compared with the technocrats of state-socialist Hungary's health ideology. The historical change and socio–cultural transition in Hungary after 1989 was accompanied by changes in the medical system as well as in philosophy and in the structure of the teaching of social sciences. The developing pluralism in the medical system together with the pluralism of social ideologies allowed the substitution of the dogmatic Marxist-Leninist framework with the more pragmatic and empiricist behavioral sciences including medical sociology and medical anthropology. The conflict between the initiation function of the hard preclinical training of the first two years, and the reflective, relativistic and critical narrative on »biomedicine as culture bound entity« constructed by medical anthropology during the second year of medical training is discussed. We also submit our fieldwork data gained as a result of a two year investigation period focusing on diverse initiation types of »would be« physicians. The main proportion of our data derives from individual semi structured deep interviews together with focus group interviews carried out with medical students of upper years. Finally, the role of medical anthropology in the »rite of passage« of becoming a medical doctor is summarized, paying attention to their field work reports and the risks and gains in this process.

***Key words**: rites of passages, initiation of medical doctors, medical identity, modern versus postmodern, epistemological traditions, teaching medical anthropology, field work as initiation, emic, etic approach*

Introduction: Modern Versus Postmodern

Biomedicine and medical anthropology are both hermeneutic sciences having a common aim: to explore the hidden meaning behind the signs and patterns. But while the history of biomedicine is one the most important *sagas* of modernity, medical anthropology shares another paradigm as well, namely that of postmodernism.

Whereas biomedicine is based on the biological universality of the human being, medical anthropology is interested in the cultural diversity of healing and health, as well as illness-related phenomena, as socially constructed entities.

This difference suggests more than a pure contrast of different paradigms focused on biological-natural versus social phenomena and the humanities. The conflict of modern and postmodern seems obvious between the Western, powerful, somatically-oriented, analytical, reductionist and highly technologized biomedicine and its critical analysis offered by medical anthropology based on its cultural relativism, and sensitivity to the culture-bounded particular.

If we accept that modernity produced a set of disciplinary institutions, practices and discourses which legitimate its modes of domination and control, medical systems cannot be excluded from this revisited horizon.

Political psychiatry, extended and sometimes risky medicalization of everyday life may induce critical research on these advantages of modernity. Medical anthropology shares the postmodern criticism in exploring, and deconstructing the ideology and power-related structural aspects of medical systems. Naturally, anthropology can be anchored to modernity as well, taking into consideration the Marxist critical anthropology of health or the

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psychoanalytic tradition of psychiatric anthropology. Nevertheless, its cultural relativism, and criticism of technological, instrumental rationality, and bureaucratization, market commodity relationship, medicalization and health industrial power relationships create a postmodern point of view, as well.

The hermeneutic approach played a great role in the configuration of the postmodern. Thus, if we compare the hermeneutic style of biomedicine, psychosomatics and medical anthropology, we can reveal both the differences and the basic similarities.

The body may be considered as a text, as the field is a text for the field worker. The category of normality creates a difference, while it is incompatible with the anthropological orientation, it is crucial in the biomedical praxis.

The semiology of the pathological has a parallel vocabulary of symptoms, fevers, pains, eruptions etc., and the hermeneutics of disease needs the understanding of the normal at the same time. This double coding needs double sensitivity, one for the standard, the normal, the biological canon, the universal truth, and the other one directed toward the disease, the special, deviant, rare, sometimes exotic, but nevertheless universal in its special forms.

Social and cultural anthropology avoids the judgement of normal and abnormal regarding the cultures to be observed, and stands on the other side of the Cartesian precipice avoiding the persuasion of biological theories. (Although human ethology, and evolutionary psychology may offer heuristic approaches to anthropological understanding). Cultural relativism is suspicious of normality, challenging and multiplying canons. Its existence multiplies acceptable canons for the sake of understanding, inducing anarchy regarding authorities, truths. There is an »emic« empathic drive to understand the observed phenomenon in its terms, and there is another critical one, an etic approach to deconstruct the observed, showing its limitations and culture-boundedness. As medical anthropological object, biomedicine is a similar target to the alternative, traditional, ethno- or professional medicine. Medical anthropological inquiry is not sensitive to the biological validity of any observed object, this practical value has no crucial importance in the ethnographic exploration of human healing.

The greatest challenge towards biomedicine appears when it is considered to be as culture-bound as the traditional and professional healing systems like the Unani medicine, Ayurveda, or TCM. The tension of this challenging view has its energy in challenging the accepted universality of cosmopolitan western medicine. The category of the modern is attached to the concept of universality.

Transforming the patient from a unique human being into a statistical vehicle and the bearer of signs and patterns, the clinical thought became a framework for seeking and manufacturing rational truth with a claim for universality. The universality of disease categories frees the disease entities from local social, cultural and individual psychological contexts.

If modernity is about to conquer, as Bryan Turner writes, – similarly to the conquest and imperial regulation of the land – the discipline of the soul and the creation of the truth, biomedicine may be expressed in similar terms. Biomedicine successfully conquers everyday human states like birth, menopause, pre-menstrual tension, shyness or melancholy, as well as aging and dying. Technocratic birth is a ritual transformation of a natural process to a technologically and socially controlled one, the estrogen substitution in menopause reflects a shift of the semantics of biochemical patterns regarding normality. The social construction of social phobia as a pathological entity covering the category of the human state of shyness, or recruits experiencing melancholy with labels of minor depression with the necessity of antidepressant treatment, all serve pharmacological market interests. Advertisements of sport activities, healthy nutrition, not to mention life insurance, implicitly suggest the feeling of the never aging style of modern humans. Meaning that we can achieve to become good consumers of mass production forever – regardless of age, even in death.

The claim for the universal biomedical truth is supported by evidence-based, a research derived, statistically reliable, and validated, epidemiologically explorable truth, which is universal, independent of place and time.

Change of Gatekeepers: A Postmodern Moment

In the former ideological frame of state socialism Marxism was considered to be a scientifically based, universal system of social truth, based upon historical materalism. Political economy and the Engelsian dialectical framework are typical products of the so called »modern«. This kind of social science is both criticism and derivation of the ideology of an industrial *state*-technocracy. As the revolution of the information age with its faxes, microcomputers, telecommunication system and the global turn of neoliberal world economics opened up the Communist regimes after the collapse of Soviet Union, the doctrine and teaching practice of Marxism-Leninism disappeared from the universities in Central-East Europe. Marxism – just as psychoanalysis – was one of the great modern meta-narratives. But as Lyotard[1] remarked, in our age there is no faith in meta-narratives that legitimate science and other totalizing visions of the world. As Crapanzano[2] writes, these meta-narratives in their causal over-determination and totalizing assumption resemble the magical systems described by Lévi-Strauss. The deconstruction of these meta-narratives is a real social anthropological way of understanding and interpreting them.

That is one reason why it was a kind of postmodern act that behavioral sciences – with medical anthropology embedded among them – took the emptied niche of Marxist social sciences in the Semmelweis University in 1993. Fredric Jameson[3] is right when stating that post-

modernism always seems to be understood in terms of a kind of »radical break« with modernist features of socio-economic organization and cultural and aesthetic orientation. This happened in an extended period of social transition from state-communism to the pluralistic democracy of a consumer society in Hungary.

There is another dating of postmodern which has polysemous significance in our case. The postcolonial world is thought to be a postmodern world, as well. The loss of a colonial center with claim for universality results in the juxtaposition of contradictory styles without a unified narrative or vision of the world. This kind of off-centering of exclusive interpretations of the world is accompanied by a radical, and prompt pluralization of the medical system, as well. The period of 1988–1991 is a real post-colonial transition, when not only the free-market of ideologies, concepts are developing faster, but also the appearance of traditional and alternative healing systems like TCM, homeopathy, massages, manual medicine, eclectic New Age practices and so on. The need for medical anthropology arises because of the growing consumer interest in these practices, and psychosomatic approach, as well.

If biomedicine with its »traditional modern« scientific assumptions excludes these approaches, medical anthropology is invented to deal with them. As we have shown, social anthropology and behavioral medicine are themselves postmodern phenomena.

Medical anthropology based on its cultural relativism has a completely different ethos towards these phenomena. Cultural relativism is the key to understand the role of social anthropology in the rise of postmodern as a cultural paradigm, too. This cultural relativism destroyed the exclusivity of rationalism, and created an off-centering juxtaposition. The hermeneutics of postmodern anthropology rejects totalization and questions the authority of any hermeneutic and refuses any transcendental position. The greatest challenge is the rejection of those meta-narratives that justify our criteria of accuracy and truth.

The position of the interpreter may also have another postmodern trap, because of implying the viewpoint of a »higher semantic authority«. This »intimate« distance of an anthropological approach, which recontextualizes and deconstructs its target, is challenging for the biomedical identity, as well. This way of thinking is, naturally, in a serious conflict with both the rational, evidence-based biomedicine and the education and socialisation of medical doctors.

The other postmodern shift is the bridging of the Cartesian precipice. Tracing back the informal »prehistory« of the Institute of Behavioral Sciences in Budapest, we can reveal its psychosomatic, humanistic commitment and critical basis as having represented a kind of counterculture to the late technocratism of state-socialist Hungary's health ideology.

Medical anthropology reveals the nature of metaphors in forming scientific visions of a mechanical kind, like the body-machine equation (hydraulic metaphors of circulation, heart as a pump, telephone cable-like nervous system) and juxtaposes the ancient, naive but meaningful quasi-cybernetic model of circulating, and regulated Qi in TCM, or discloses the parallels in symbolic healing and talking therapies of western psychotherapeutic traditions. Showing the tribal interpretation of illness as a sanction and healing as complex social regulation in the light of contemporary family therapies and system theories is an influential intervention in building the meanings of biomedicine. As mechanistic biology offers a machinelike view of an organism, the behavioral sciences give another multilevel, ecological, and system based organic model of the human being. The importance of self-determination, the interference of unique individually shaped internal relations and social, cultural, natural and technological context-dependent influences contradicts the universalizing and general, purely statistically-driven approaches. That is the main shift from modern 'Mecho-logical' to postmodern 'eco-logical' thinking.

Behavioral Sciences and the Postmodern Tendencies

Postmodern science has features of moving away from the mechanistic, deterministic and the reductionist world view associated with modern science. So does the psychosomatic and behavioral approach with its holistic social-psycho-physiological framework based on circular logic, and interdisciplinary, multilevel approach. That does not mean a radical break away or detachment from the basic assumptions of modern science, with its statistical validation, replicability, reliability, and analysis, rather an extension and integration of different integration levels like neurobiochemistry, psychophysiology, cognitive psychology and so on. The real shift is a decisive step from the Mecho-logic of a reductionist epistemology towards a system theory based ecological framework of interrelationships, and mutual influences. The analytic approach offers an understanding of the processes from the parts towards the whole. The postmodern »organicism« reverses it, and argues against the ontological reductionism according to which all causations run sideways and upward, from parts to parts, and from parts to the whole. Postmodern organicism and social-psychosomatic medical approach stress the importance of downward causation, from the whole to the parts.

Beyond this change of perception of causal relations, psychosomatics offers a free passage between the biochemical, cellular (e.g. immunological), psychophysiological, and social-psychological integration levels. This approach is not far even from social science and anthropology as mirrored by Moss's »Biosocial resonation theory«[4] or the MMF (Multimodal framework) anthropological approach of Geoffrey Samuel[5]. The psychosomatic approach may have been formulated even in the traditional modernist, materialist framework without violating the biomedical canon, just as behavioral psychology,

which may offer explanations and descriptions of human behavior in terms of efficient causes within the framework of modern narratives. This avoidance of the problem of mind-body dualism is based upon the doctrine that mind and brain are identical. This naturalism is enhanced and extended by human ethology and evolutionary psychology. So that niche or doctrinal environment gives a secure »modern« shell for the partly postmodern medical anthropology.

This polysemous Janus face of scientific and materialistic bridging of mind-body dualism, and ecologic escape from modern to postmodern is useful for accepting behavioral sciences and medical anthropology in the medical curriculum.

Teaching Medical Anthropology

In the preclinical period of medical curriculum, when assertivity, commitment, professional group identity is built up with high mental load and stress in a liminal state of a »rite de passage«, the challenge of medical anthropology is obvious. This challenge is more pronounced if we take into consideration the social and ideological transitions that have happened in Hungary in the past decades. This may be overcome by a syncretic synthesis of modern and postmodern, bioscience and social anthropology. As we have shown, psychosomatic medical philosophy may be an interface. The case is similar in the American universities, where medical anthropology used to be part of behavioral and social science departments. We compared the American literary data published before the initial steps of teaching medical anthropology in Hungary in the late eighties and early nineties. According to Todd and Clark[6], the adaptation to medical schools is easier in the case of those medical anthropologists who define themselves as biomedical medical anthropologists.

In our department the medical anthropology[7] has been taught as part of behavioral sciences since 1993, and during this two decades it has been evolved through different stages. The niche for teaching medical anthropology in the curriculum was open by a historical change, when the former Marxism based social science institute ceased to carry on its ideological work following the decision of the leadership of the University. This transformation reflected also an ideological shift from modernism towards a postmodern state. Marxist ideological truth, as exclusive normality was present in political economy, philosophy, scientific socialism and the history of the working class movement, even in ethics for medical students. These disciplines had low prestige because of their political content, and professional distance.

If the analytic, reductive biomedicine had its tensions with behavioral medicine, psychosomatic holistic approaches, the absolutist East–European Party-state ideology based on Marxism was incompatible with relativistic social anthropology the same way. That is the main reason why social and cultural anthropology as a discipline was taught only after the social-political transition started in 1989.

Usually behavioral sciences create a niche for teaching medical anthropology. As Robert C. Ness[8] writes about his experience of teaching medical anthropology in the preclinical curriculum, we see that students in the first year of the curriculum receive medical anthropological theories and concepts as part of teaching social and behavior sciences (plenary lectures, a 22 hour elective seminar entitled »Alternative Strategies of Healing« Cross-Cultural Review, 24 hours elective seminar entitled Social Factors in Health and Mental Health). As Todd shows us, in the USA 120 medical schools had a faculty appointment with 83 anthropologists in 1980, who worked as teachers, researchers, consultants, administrators, patient-advocates, and ombudsmen. The teaching practice was absorbed in other disciplinary teaching practice, as interviewing techniques used to be taught under the aegis of the department of psychiatry. Kennedy and Hughes[9] emphatically suggest that behavior science materials should be adapted or adopted in the clinical model rather than try to construct a different, competing track. On the other hand, if the medical anthropologist is the only social scientist in the school of medicine, it may lead to intellectual isolation and loss of professional identity.

The situation of teaching was different in the case of our practice for a decade of teaching. The historical change and socio-cultural transition in Hungary after 1989 was accompanied by changes in the medical system, as well as in the philosophy and structure of the teaching of social sciences. The developing pluralism in the medical system together with the pluralism of social ideologies cleared the way for the substitution of the dogmatic Marxist-Leninist framework with the more pragmatic and empiric medical sociology and medical anthropology.

When comparing our practice with samples of Todd, Clarke, Kennedy and Hugh or Ness, medical anthropology was settled as not an elective course, but a compulsory, full semester long discipline. The compulsory nature of teaching medical anthropology made it possible to exert a general influence on the medical socialization process. This fact increased our responsibility in finding a compromise between a modern science and its postmodern narrative offered by medical anthropology. As we have mentioned before, medical psychology creates an interface between natural sciences and humanities embodied in medical anthropology. (This status of the course has been transformed to be an elective one in the last years following the international standard practice along the curriculum reform.)

The anchoring of medical anthropology enforces the psycho-physiological explanatory models in interpreting schemes, just as Ness emphasizes it. The buffering of criticism and cultural relativism of medical anthropology may be useful, because similarly to the experience of Ness, »overly forceful and unbalanced critiques of medical science and practice are not well accepted and only serve to alienate the audience«. It is really counterproductive in a critical phase of the »rite de passage« of becoming a doctor. The relative low status of the social sci-

ences in the hierarchic structure of medical schools may cause a resistance in the student based on their identity. The time constraint of learning higher status disciplines may build other barriers.

Medical Anthropology and Medical Identity

Cultural self-knowledge is essential in critical clinical thinking, which may help control medical behaviors and ideologies 'taken for granted'. In a plural medical system the skills of critical and self-reflective judgement is even more important. The development of professional identity is determined by the preclinical period, although it is not a linear process. Researchers didn't prove a direct association between professional reflection during the preclinical years and the later identity status[10], which lessens the responsibility of teaching medical anthropology in the preclinical period.

In an overview the problems of traditional medical curricula Niemi[10] points out the difficulties to develop critical thinking, problem-solving skills, which is thought to be tractable by problem-based learning, early patient contact courses. Niemi does not mention the problem of cultural self-reflection in the medical profession, although it seems probable that quality control must include the control of a medical way of thinking and habits implying cultural factors, as well. The preclinical period is fundamental in establishing professional identity, while cognitive conflicts may activate a student's self-reflection. It is important to create possibilities for the communication of feelings and thoughts about the medical profession for the sake of being aware of our own way of thinking from cultural points of view, too. The »committed reflection« as a skill of critical thinking, perspective-taking and commitment is crucial in becoming a medical doctor. It implies strong professional confidence and reflectivity at the same time. It is to be measured, how teaching medical anthropology may influence this quality, but it can be explored in our feedback reports, as well.

The students with interest in manual medical professions seem to show early commitment, like surgeon-, traumatologist-, and orthopedic surgeon- oriented ones. The critical or denying attitude of these medical students towards the medical anthropological cultural reflectivity is based on a sort of foreclosed identity, firm commitments supported by expectations of authority figures. Their achievement-orientation is accompanied by less reflectivity and rigid viewpoint without the skill of integrating information from diverse perspectives[11].

Foreclosed identity and achieved stable identity are two phases of the same process with a possible moratorium phase of active exploration in between. One-third of the medical students at the end of the preclinical term were characterized as »active explorers« in Niemi's study, which compared and considered different alternatives without becoming committed. Such openness is found among those, who were very active in learning medical anthropology according to the feedback reports. Those of psychiatric and psychosomatic interest showed the greatest affinity towards medical anthropology.

There is another group of medical students, the »scant and avoidant reporters« mentioned in Niemi's study, who were overrepresented among those who had considered quitting medical training in Niemi's study. According to the feedback to our teaching practice, we had no feedback contents about such decision based on gaining cultural self-reflection regarding the medical profession.

Initiations along the Medical Curriculum

We all live our lives in the cycle of initiations, the series of social births carries on throughout our lives. Rituals are a feature of all human societies. They are an important part of the way any social group celebrates, maintains and renews the world in which it lives, and the way it deals with the dangers that threaten that world. A key characteristic of any ritual is that it is a form of repetitive behavior that does not have a direct overt technical effect. For those that take part in it, ritual has important social, psychological and symbolic dimensions.

Ritual therefore manifests and restates certain basic values and principles of a society, and shows how its members should act towards other men, the natural world and the supernatural, and it helps to re-create, in the minds of the participants, their collective view of the world. Each ritual is an »aggregation of symbols«, symbols are »storage units« into which the maximum amount of information is condensed [12], this is because ritual symbols are »multi-vocal«, representing many things at the same time. Rituals of social transitions (rites of passage[13]) are »critical periods«: birth, puberty, initiation into adulthood, pregnancy and delivery, death or a severe illness etc. In each of these stages the individual passes from one social status to another. These transitions are signalled by the rites of passage (rites of transition).

Medical anthropology is an integrated part of our curriculum since the very beginning of the formation of our Institute. During practice lessons we analyze rites with the title 'critical periods'. Through increasing consciousness of transition rites, and also the rites of misfortune students gain deeper self recognition. Both authors of this paper are medical doctors having graduated from Semmelweis University. Moreover, they both have a degree in cultural anthropology, and thirdly they also have more than ten years experience of teaching medical anthropology. As a result, it was both natural and also questionable for us to take into closer consideration phenomena that can be interpreted as initiation rites during the professional socialization of medical students. The aim of our study was to test our hypothesis whether these initiations exist at all and if yes, in what form. Our investigation, therefore, represents a clear example of the žresearch at home' type: the examiners study their own profession, namely the processes of acculturation.

For two years we carried out qualitative anthropological research questioning phases and types of initiation processes. The subjects of our investigation were former

students of ours had been attending upper years. As to methods, we carried out both individual semi structured interviews with seven students and also four focus group interviews with altogether 19 students. In the case of focus group interviews we put emphasis on some extra selection criteria: students (like in the cases of individual interviews) had to be of upper years so that they should be familiar with basic concepts of anthropology, they should have been unknown to each other in order to avoid subgroup formation and we also laid emphasis on the fact that some of them had to have a year postponed already. The latter aspect we regarded to be important since we assumed that postponement itself may be a possible manifestation of initiation[14,15].

In the preparation phase of the interviews we contacted the potential interview subjects twice: first we made a phone call (they were our former students) inquiring about their willingness to take part in the research interview and also giving them an outline of the aim of our research. Secondly – for those having expressed their willingness – we mailed a written overview of our investigation as an orientation, the content of which was as follows:

- The number of participants in a focus group is 10–12 persons of upper years
- We are focusing on phenomena that can be interpreted as manifestations of initiation during the process of becoming a doctor

Subjects were given a »definition« of initiation: a concept mainly used in religious ethnology. Its core content is to introduce an individual or community in the world of religious culture, dogmas and practice given to them. It can be conceptualized as a universal human experience in which one goes through the process of learning beliefs of the community, after having passed žtests' of bodily preparation requirements, and it happens within ceremonial circumstances in the presence of the community of believers. As a result, the initiate becomes a full grown member of the sacral community and also a part of religious reality.

It is a commonplace in current anthropology that for secularized humans of our industrialized world science embodies religion. Thus, biomedicine or scientific healing is the conceptual framework of the »religion of health« with its institutions and committed »priests« that are responsible to expel the »demons« of illnesses out of the sick with the help of their professional knowledge, diagnostic and therapeutic instruments.

Coming to our interview results, we can state *in general* that initiation type life events in the case of medical students occur mainly as unconscious knowledge. They – especially in the introductory phase – seemed to be »afraid« of the concept of having been initiated into medicine starting with various types of suppression: denials, repression, undoing. It is a general phenomenon in the interview texts that they mention »…these things do not count, they are not important…, …it is just something that may happen to anybody…, …such things are not at all, they do not exist«. So far, we could reason such introductory reactions as manifestations of analytic psychological reactions or rather forms of ethnocentrism. Namely, they declared this way as follows: »we are not tribal, primitive, rural craftsmen, we represent the world of high science, therefore phenomena of initiation cannot reach our circles«. Later on, in the warmed up phase of the interviews as they, one after the other, came up with the initiation like experiences from their personal student lives we experienced acceptance. They remembered and distributed a number of personal examples of their student career belonging to the realm of initiations. In this middle phase they mentioned a number of critical aspects towards the system, we could experience cynicism, and also signs of »inner fatigue« from their reports. In the end phase of the interviews we were in all cases given a kind of positive feedback, namely, the overall message they passed on to us was: »it was worth coming here this evening… bringing up the topic (of initiation) and discussing it in detail«.

In the forthcoming part we shall go *into detail* regarding our interview results trying to render the multitude of our data in a kind of structuralized order. Normally, the initiation is bound to a certain (symbolic) time and scene, at the same time participants and the context of initiation are equally important. Knowledge, skills, expertise are transferred from the initiator onto the novice, the initiate. The otherwise »empty« symbolic scene and time of the initiation has to be »filled up« by two other accessory types of objects. These are »Objects«, namely, persons of the community of the initiate at present and also »real« specific objects, prerequisites that belong to the material part of the scene. A greater community may 'be present' at the ceremony, as well (distant relatives, members of a greater community, representing even a whole subculture). According to our above mentioned scheme first we can speak of typical settings or situations of initiation in a kind of chronological order. The actual events (»whats«) related to certain educational periods (»whens«) in connection with initiation phenomena formulate a »matrix« or system of co-ordinates in which we may orientate, and it also suggests an imprinting like timing optimum of initiation phases. Secondly, we can speak of the initiators (»whos«) enabling us to have an insight into this highly heterogenous but at the same time crucial subculture. These persons – as it goes without saying – represent a higher level of knowledge and rank of being initiated, although here we have some off beat examples, extraordinary forms of manifestation, too. Thirdly, we take a closer look at the community around, trying to demonstrate its forms of manifestation. The community in which initiation happens exerts a considerable role in modifying the quality and depth of the actual process. We shall formulate the term of »scanty initiations« here as well, in which case they happen in the absence of some of the above mentioned inherent components.

We can uncover the dynamics of hidden rituals also, like the role of medical soap operas as media rituals in

becoming doctor[16,] or the initiative aspects of medical anthropological field work[17]

Fourthly, in order to close our initiation panorama we shall speak of »exitiations«. We might address the phenomenon as a symptom in the medical career since its effect is exactly the opposite of a normal initiation, namely adverse, because of which medical students may leave their profession.

1) When speaking of the events of initiations, it is reasonable to set a timeline appropriate to guide us 'where' we actually are in the course of medical training. The following time phases help us orientate and serve as a 'thread of Ariadne' in our structural-functionalist analysis. Here again we found four remarkable periods, namely that of the way towards medical school (a), the first two years (b), third to fifth years of training (c) and finally the sixth year (d).

a) On the way towards university: this phase comprises events of early childhood, those of secondary school, and the entrance examination, but also their experiences in the freshmen's camp, the opening ceremony, freshmen's ball and early period of group formation. Experiences before the very event of taking the entrance examination all belong to the orientation or choice making elements of professional socialization. Among their multitude we would start with the example of the illness or of getting sick of somebody in the family or rather their own illness. We try to illustrate it with two excerpts: »When I was a little girl and my grandpa was very ill my father – he is a doctor – used to nurse him home for a long time. I was six or seven years old and always used to play with some pots and I told myself I shall cure grandpa. This was an experience when I got in touch with these medical things and I also used to go to the hospital many times since my parents couldn't look after me… and, therefore, practically I played with nurses.«

»My mother is a doctor, but there are four of us brothers and sisters and she used to stay home with us for a long time… She had patients that visited her, she used to treat them at home… I always got on very well with them, because they didn't only come to her, but they were also with the family for half a day or so and they might've been cured by that, as well. There was always a good atmosphere at our house, it was really important for the patients, and I think that is why they visited us. This experience was very important and I assume it was why I wanted to be a doctor from my early childhood.«

Summarizing our results, we can firmly state that medical initiations do exist, students go through many initiations until they reach the formalized act of being conferred the degree of a doctor. Before medical school period one can find important childhood event playing role in becoming a doctor too. That may be a serious illness in the family (sometimes their own experience), hospital experience or the example of a physician relative, model of secondary school teacher etc. During university they list the experiences of the freshmen's camp, Hippocratic oath, some more serious illness. Passing or failing an exam may appear as an initiation stage but they all count the summer nursing practice after the freshman year[18] as one. Writing medical anthropological field work paper in an alternative clinic or other clinical setting may be categorized similar way[17].

In the later years working on an ambulance, assisting in the operating theatre etc. function also as initiations. One remarkable category we would like to draw attention to is personal example or model giving. 'Objects' (analytic psychological term) serving as models is an outstanding category regardless of situation, age, certain act etc. These initiators may condense almost all ingredients of a 'standard type initiation'. Initiators as model giving 'objects' may be significant members of the students' family, an outstanding secondary school teacher, seminar or practice lesson leader or the leader of a students' scientific circle. They all may serve for students as a lifelong 'compass', authentic pattern, during their personal and professional lives.

In the course of investigating medical initiations, we took note of a special, very important and interesting phenomenon, namely – for want of a better word we named it – »exitiation«. This experience of alienation from biomedical roles and practice may lead to shift the direction of medical students' professional carreer towards the world of pharmaindustry, or alternative/complementary medicine.

From these results it seems to be clear, that medical students are not aware of psychological and cultural contents of their professional transitions, motives and shifts in their value systems during the hidden initiations of their hidden curriculum.

Medical anthropology may help the processes of identity formation, in which evaluation, selection and personal and cultural self-perceptions may be integrated. The cultural relativistic approach may offer a way of learning and safe process of critical and reflexive medical self-exploration diminishing the risks of crisis along the process. In that sense it is similar to the stress inoculation processes as a sort of controlled crisis.

The aim of developing a medical identity is to gain a state of cultural self-reflection by relating the personal thoughts to other alternatives, and finally an achieved identity with high acceptance of the (cultural) self, a stable self-definition, emotional stability and a capacity of interpersonal and intercultural perspective taking.

Medical anthropology helps the phase of moratorium[10,11], which is a state of active exploration without »early closure« or early commitment. In this phase one can find true the values of anthropological »world view«or features of postmodernism, like relativistic approach, tolerance of contradiction in thinking and syncretic or synthetic tendencies. The education may gain dynamism of this activated transient phase of education as the intensive cultural self-exploration induce emotional reactivity, feeling of progress and a Gestalt-process of identity development. Medical anthropology may play a crucial role in this moratorium phase of creating a medical identity.

The field work made by medical students during medical anthropology course may play also ritual and iniciative role. Being observer participants they have different position than other anthropologists, the field work is part of their professional socialization. During the preclinical period they have to carry out fieldwork at a medical facility of their choice: inpatient, primary care clinic or alternative medical center.

Analysing the field works made during the last nine years proved that both emic understanding of different healing cultures and practice and the reflective and critical analyses help to build a self-reflective practical wisdom of healing with openness towards the plural decisions of the patients. The field experience in centers of alternative medicine may help the cooperative inter-professional communication and behavior, as one third of the patients are also open to consume these complementary or alternative healing forms simultaneously with biomedicine. The student reports reflect these insights, just as cultural reflections of doctor-patient relationship. As the field reports integrate these miniature clinical ethnographies and the analytic-theoretical abstraction, etic explanations, the result is observant sensitivity and critical reflectivity. Both skill is central in everyday clinical world, and part of becoming better doctor[17].

Instead of Conclusion: Chances of the Synthesis

The double perspective offered by the biomedical studies and the medical humanities like medical communication, medical sociology and medical anthropology induces a hermeneutic openness and reflects the conflict of modern and postmodern also. (Even loosing the obligatory status of teaching medical anthropology may be seen as a post-postmodern re-action of late-modernity.) The strongest challenge is produced by the hermeneutic contrast of biomedicine and medical anthropology as applied cultural anthropology. The striking conflict of technocratic accents of professional identity, professional »ethnocentrism« conserved by the »hidden curriculum« versus cultural self-reflectivism, and pluralist cultural relativism offered by medical anthropology deteriorates teaching climate for such a subversive discipline. The binocular view of medical phenomena rendered in pairs, like technocentrism versus criticism of medicalization, understanding based on biological versus social-psycho-cultural context etc. as the following table of typology shows, may be accepted as a source of reflective and flexible professional identity, or may be regarded as a subversion of basic biomedical cognitive frameworks of professional Self.

The medical anthropological affinity of students with interest towards psychiatry and psychosomatics underlies the »niche« role of behavioral sciences for medical anthropology. Nevertheless, this anchoring implies a challenge toward medical anthropology as an interpretive, culturalist discipline, too. The syncretism of modern and postmodern recalls the debate of Browner, Montellano and Rubel[20]. They emphasize that an analytic framework combining the emic perspective of ethnomedicine with the etic measures of bioscience can generate valuable new interpretations for cross-cultural, comparative studies of human physiological processes, the ways in which such processes are perceived, and the culture-specific behaviors these perceptions produce. Her bio-behavioral expertise and bio-behavioral scientific background establish a firm context, just as Kleinman's double professional identity is reflected in his statement: »We consider the dialectic of nature and culture to be one of the primary theoretical problematics of medical anthropology«.[21] Although they also pay attention to the autonomy of interpretive medical anthropology approach, when stating: »the biomedical framework has significantly obstructed the wide anthropological and comparative study of disease/illness, health and ethnomedicine, because it has ethnocentrically devalued, if not excluded, the knowledge of other ethnomedicines, including lay beliefs and practice.« But the modern reductionist scientific framework is not enough for qualitative interpretation because these methods are reductionistic or incapable of analyzing phenomena within their context. In Browner's approach the claim to universality and cross-cultural comparability is brought back by the specieswide universality of human physiological processes. The speech community with biomedical sciences creates a working interface for modern and interpretive postmodern, too. That calls for a stronger »mutualism« of psychobiology, psychosomatics, social medicine and medical anthropology. From this point of view the debates arguing for the anchoring of medical anthropology among the mainstream disciplines give us support, like Kleinman advices.

The emic and etic hermeneutic circularity may constitute a bridge between postmodern (meaning-centered, interpretive and emic) and modern (bioscience-based, etic) approach. As Browner points out in the cross-cultural comparative study of folk illnesses, the objective is to understand how specific biological, psychological, and sociocultural processes interact to produce a constellation of signs, symptoms, and behavioral changes that are recognized by the members of a specific cultural group and responded to in a standardized fashion. Ignoring the role of organic factors even when organic signs and symptoms are clearly observable, would be certainly a serious mistake. Identifying the phenomena under investigation in emic terms, then determining the extent to which the described phenomena can be understood in terms of bioscientific concepts and methods help the convergence of cultural anthropological and bioscientific understandings. The aim of this hermeneutic sequence is to place descriptive, emic materials into the standardized, measurable, and verifiable units of bioscience.

This approach is as old as medical anthropology, as the physiologist Cannon's physiological explanatory model 1942 for Marcell Mause's concept of sociocultural death in 1926. This syncretic approach played also central role in the early, founding phase of the process of de-

TABLE 1
TYPOLOGY OF CULTURALLY SHAPED COGNITIVE FRAMEWORKS OF BIOMEDICINE, PSYCHOSOMATICS AND MEDICAL ANTHROPOLOGY[19]

Biomedicine as modern	Psychosomatics	Medical anthropology as postmodern
bioscientific reductionism	psychosomatic holism	sociocultural holism
analytic	psychoanalytic and narrative syntethic	synthetic
upward causation	downward causation	circular causation
linear logic	circular logic	eco-logic
universalistic	personality-based unicity	culture-based unicity
randomized, statistical	case-oriented	culture-oriented
diagnostic, judgemental	acceptive, Rogersian	cultural relativism
semeiologic	semantic	semantic (re)interpretive
truth is out there	truth is in psycho-physiological context	truth is socially constructed
chemical dialogue	encounter	participant observance
animal models	personal- psychological	socio-cultural
morphological, organ based	info-logical process-based	(re)interpretive
codificated	context-dependent creative	emic, empathic re-presenting
rationalism	cognitive-emotional approach	meaning centered-interpretive
technocratism	refusal of technocratism	criticism of technocratism
philosophy of instrumental rationality	philosophy of communication	philosophy of intercultural communication
form (comitted, conjunctive, closed)	disjunctive, open	uncommitted, open
voluntary (purpose-driven)	playful (purpose-driven)	self-restraining, observant
directive	client-centered, accepting	active –receptive
hierarchy	submissive,	poliarchy
dualism	psychosomatic monism	sociocultural holism
distance	participation	observant participation
synthesis	deconstruction,	reorganisation
centring	recentring, readjustment	perspectivism construction
social coherence	social difference in personal, narrative context	social difference in context
theory mirrors reality	reality is personal and linguistically mediated	reality is cultural and linguistically mediated
form (committed, conjunctive, closed)	disjunctive, open	uncommitted, open

veloping our curriculum[22], as we perceived social psychophysiology as a hermeneutic interface in medical anthropology [23].

These challenges can be solved by the double competence as in the case of our teaching group, because most of the members of the teaching staff in the Dept. of Medical Anthropology of Inst. of Behavioral Sciences in Semmelweis University have both cultural anthropological and medical specialization. Perhaps this double identity helped us in choosing the medical doctor and medical anthropologist C.G. Helman's work[24] as the textbook for the teaching of medical anthropology, in a translated version.

Although the postmodern contents of medical anthropology cannot be muted as being faithful to the principles of cultural relativism, the hermeneutical constraints of the emic approach and the qualitative cultural analysis, the role of psychophysiology as explanatory model of numerous enigmas presented by medical anthropology are helpful to keep alive the modern in postmodern, as well. It does not violate mainstream culturalism or the interpretive sociocultural approach. It is another kind of postmodern holism and organicism with polysemous meaning. But this approach helps us save the dignity and mastery of biomedical identity while building cultural self-knowledge and critical but understanding professional self-knowledge and tolerance in a multicultural healing system. Medical anthropology helps the medical students - quoting Attila Bánfalvi[25] »to understand it as a special culture with the freedom to put questions regarding its assumptions, basic language games, the discrepancies of its sounded and real working values, and the values and personal attitudes of the participants – which may open new alternatives of the existing praxis«.

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KULTURALNA INICIJACIJA DOKTORA MEDICINE

SAŽETAK

Osamnaest godina iskustva u podučavanju medicinske antropologije na mađarskim medicinskim fakultetima nudi uvid u dinamiku međuodnosa racionalističke epistemološke tradicije biomedicine, kao jedne od središnjih paradigmi modernizma i kulturnog relativizma medicinske antropologije, koja se smatra jednom od generatora postmodernog razmišljanja. Pogledom unatrag na neformalnu »pretpovijest» našeg Instituta, možemo otkriti njegov psihosomatski, humanistički angažman i kritičku osnovu tako što je predstavljao svojevrsnu kontrakulturu u usporedbi s kasnim tehnokratima iz državnog socijalizma mađarske zdravstvene ideologije. Povijesna promjena i društveno-kulturna tranzicija u Mađarskoj nakon 1989. bile su popraćene promjenama i u zdravstvenom sustavu, kao i u filozofiji i u strukturi nastave društvenih znanosti. Rastući pluralizam u zdravstvenom sustavu, zajedno s pluralizmom društvenih ideologija, dopustio je zamjenu dogmatskog marksističko-lenjinističkog okvira s više pragmatičnim i empirično-bihevioralnim znanostima, uključujući medicinsku sociologiju i medicinsku antropologiju. U radu raspravljamo o sukobu između inicijacijske funkcije tvrde, predkliničke obuke u prve dvije godine, i reflektirajućeg, relativističkog i kritičkog poučavanja o »biomedicini kao kulturalno vezanom entitetu«, koji je izgradio medicinsku antropologiju tijekom druge godine medicinskog usavršavanja. Također, predstavljamo naše terenske podatke sakupljene kao rezultat dvogodišnjeg istraživanja, s naglaskom na različitim vrstama inicijacije budućih liječnika. Glavni dio naših podataka proizlazi iz individualnih polu-strukturiranih dubinskih intervjua zajedno s intervjuima fokus grupa obavljenih sa studentima medicine starijih godina studija. Konačno, sažeta je uloga medicinske antropologije u »rites de passage« u postajanju liječnikom, pridajući pozornost na izvještaje s njihovih terenskih istraživanja te na rizike i dobitke u ovom procesu.