Seduction in The Classroom: Reflections of a Medical Student

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Dr. Maddox recorded these impressions during his final year in the Univeristy of Missouri-Columbia School of Medicine.

I have been asked on numerous occasions how medical school has influenced me. The question was once phrased, "Do you think you have been brainwashed?" The answer is regrettably affirmative. During our orientation the first week of medical school, we were informed that even more than to transmit facts, it was the goal of our "instructors" to "socialize" us, to mold us "to think, act and be like doctors." The methods and definitions were not at all clear to us at that point, nor am I convinced they were entirely clear to our professors and "models," several of whom professed Christianity.

Many in the class initially rebelled against this "socialization" concept. The reasons varied, from altruism to a desire for "an independent spirit." None was based on a fear that the desired product might be inconsistent with Scriptural demands. And none of those reasons has been sufficient to prevent molding into the "image."

There was no open attack on Scripture or Christianity during our basic science classes. On occasion a professor would make reference to the results of evolution; but with the same frequency, professors would mention the "design of the Creator." After all, if science is neutral, one would not expect simple basic science lectures to conflict with the Truth, since they purportedly relate facts. This was the attitude of Christian classmates, professors and, indeed, of the American public in general. But science is not neutral and the presuppositions of the lecturers were not indiscernible. Behaviorism was undeniably the basis for our anatomy, physiology, biochemistry, and even pathology. The disease, or eradication of it, was made ultimate. Man was a machine, like the animals, and animals served to model everything from protein malnutrition to alcohol abuse. Furthermore, and more insidious, there was the attempt to divorce morality from pathology, an easy enough task when one's purpose is "to teach the facts." The discrepancy was obvious enough when the lecturer on lung cancer was smoking every break. But lectures on the relationship of herpes and multiple sexual partners to cervical carcinoma fogged the obvious moral implications with statistics, emphasis on early detection and treatment as the cure, and complex grading and staging schemes. In physiology, homeostasis was substituted as the "chief

end of man."

The more obvious, though still often ignored attack was in our Social and Behavioral Sciences (SBS) course which ran continuously through our first two years. We studied the family and life cycles, interviewing techniques, and alternate health care system models (Great Britain, Sweden, Canada). The response from the students to this course was generally negative, though usually not for any Scriptural reasons. The open challenge to God's institutions- was still often ignored by Christians in my class; the less obvious attitudes we were developing went completely ignored. The concept of "physician" was being adopted un wittingly even as the class denounced the course.

The role of the physician in society, the attitude toward the patient and the basis for medical decision-making were developed from a humanistic framework. The technological myth, the right of the public to health care, the dissociation of morality from practice and the disease-free society were goals that classmates developed, either directly or indirectly from the course. Not one disagreed with the precept that they should not impose their ethical standards on a patient.

The clinical years provided the modeling and molding on a larger scale. The attendings and residents had experience in dealing with patients, disease and death and therefore became natural role models. It was from them that we learned to refer to patients as "dirtballs" or "gomers," to joke coarsely about patients' problems, to ignore pleas that we could not answer. The older attendings sometimes commented on attitudes but in many situations they resorted to the same "defense mechanism" (as they explained it). There were again the discussions on not letting your "moral feelings" influence your treatment of the patient, though by now this was natural. Cost-containment was the major ethical topic discussed. Medical ethics was being considered as a course elective for following years and several attendings brought up the topic for discussion, though none recognized a standard apart from themselves, society or the AMA. "Code status" was not as much of an ethical consideration as it was an issue of convenience for the resident on call.

Psychiatry was the clinical parallel to SBS in that it was most openly hostile to Scripture in its presuppositions and practices. The exposure of these is beyond the scope of this article. However, despite the shock of seeing psychiatry's failure, most students persisted in the belief that medicine was the answer to these patients' problems.

The seduction of medical students is apparent to at least a few "on the outside." Pastors must be particularly aware and warn (and counsel) their Christian medical students. Not all the students will be irretrievably seduced. But until medical training is done in the context of Scripture principles, the student must constantly be on guard and must frequently revaluate his practices and attitudes. Priorities must be kept straight, as neglecting the activities of the Christian life may be the area., of

greatest seduction. In addition, the student must begin to take measures to counter the tide of humanistic practice. On many services, the student may be the major patient advocate. He may have access to patients in ICU's where pastors and Christian friends are restricted.

"Let us stand firmly then, and walk circumspectly,
not as unwise, but as wise, for the days are evil."