MASTER'S THESIS

Turkish Medical Doctors: Historical Experience and Self-Narratives

by Ayşecan Terzioğlu

This thesis of Aysecan Terzioğlu is approved by:

Prof. Dr. Ayşe öncü (Comittee Chairperson) ----------

Prof. Dr. Diane Sunar ----------

Dr. Leyla Neyzi ----------

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ABSTRACT

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This thesis addresses a broadly formulated question: Why do medical doctors in Turkey conceive themselves as the voice of authority on a broad range of social and political issues which extend beyond their professional-medical expertise? In pursuing answers to this question, it focuses on three analytically distinct sets of factors which contribute to the self-conceptions of medical doctors in contemporary Turkey:

a) the historical experiences and narratives of earlier generations of doctors who were a part of the nation-building project and who were important social and political actors in the process of transition from Empire to nationhood;

b) career experiences of medical doctors in the context of ongoing changes in the social and political positions of the medical profession as well as the health sector;

c) power relationships between doctors and their patients in hospital contexts

Each chapter of the thesis explores one of these complex and interlinked sets of factors, using information gathered from various sources. These sources of information include autobiographies written by earlier generations of doctors; interviews with medical doctors currently in mid-career, as well as observation of doctor-patient relations in hospital settings.

KISA ÖZET

Türk Doktorları: Tarihi Deneyimler ve Kişisel Anlatılar

Ayşecan Terzioğlu

Bu tez geniş kapsamlı bir soruya verilebilecek çeşitli cevapları incelemekte ve tartışmaktadır: Neden Türkiye'de tıp doktorları kendi mesleki-tıbbi ihtisas ve becerileri ötesinde, toplumun çeşitli "dertlerini" "teşhis" ve "tedavi" etmekte kendilerini yetkili ve sorumlu görüyorlar? Tezde, günümüz Türkiye'sinde tıp doktorlarının kendilerini nasıl tanımladıkları, üç farklı analitik etmen çerçevesinde incelenmektedir:

a) Imparatorluktan ulus devlete geçiş sürecinde önemli toplumsal ve siyasi konumu olan eski kuşak doktorların tarihsel deneyimleri ve anlatıları;

b) Günümüzde sağlık sektörü ve tıp mesleğinde süregelen değişmelerin orta kuşak doktorların meslek deneyimleri üstündeki etkileri;

c) Hastane ortamında doktor-hasta etkileşimi ve otorite ilişkileri

Tez farklı bölümlerinde, değişik kaynaklardan toplanan bilgiler ışığında, bu faktörler ve aralarındaki ilişkileri incelemektedir. Tezde kullanılan veri kaynakları, doktorlarla yapılan derinlemesine mülakatlar yanısıra, eski kuşakların yazdıkları otobiyografiler ve hastane ortamında doktor-hasta ilişkileri hakkında yapılmış gözlemleri kapsamaktadır.

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INTRODUCTION

My initial point of departure in this thesis is a very broad question: Why do medical doctors in Turkey conceive of themselves as the voice of authority on a broad range of social and political issues which extend beyond their professional-medical expertise? Or, to state the same question in a different way: Why do they think they have the authority to diagnose and cure the ills of Turkish society? Why do they feel responsible for the health of their country as well as that of their patients? These are obviously very big questions, which center on the self-conception of medical doctors in Turkey and the ways in which medical practice is understood as being engaged in a mission which has to do with the well being of a nation as a whole. But when formulated in such broad categorical terms, without qualification, they immediately raise a series of further questions. Is it possible to generalize about medical doctors in Turkey as a whole? Do all medical doctors- young and old, cosmopolitan and provincial, prominent specialist or general practitioners- conceive of themselves in the same way? Assuming that most, or at least many do, how is such self-conception acquired, reproduced and legitimized in the present? What kind of dilemmas does it pose for medical doctors in different professional contexts?

To try to address all these questions within the scope of a modest thesis is not feasible or meaningful. My strategy in the present thesis will be as follows. I will begin with the assumption that there are three analytically distinct set of factors which interact in complex ways to mold the self-conceptions of medical doctors in contemporary Turkey: a) the historical experiences and narratives of earlier generations of doctors who

were part of the nation-building project and who were important social and political actors in the process of transition from the Ottoman Empire to the Turkish Republic b) the career patterns of younger generations of medical doctors as they attempt to legitimize and/or reconcile their broader self-conceived authority with ongoing changes in the social and economic position of the medical profession in Turkey over the past two decades c) doctor-patient relations which shape and are, in turn, shaped by the self-conceived authority of the medical doctors.

Each of these complex set of factors necessitates and merits a research project on its own. Instead of focusing on any single one of them in this thesis, I will try to offer fragments from each. That is, in each of the following chapters of this thesis, I attempt to capture a small piece of totality that is highly complex. In my own mind, these different chapters are like snapshots of the same phenomenon, taken from different angles. Each chapter constitute a part of how historical experience and current practices combine to shape the self- conceptions of medical doctors in Turkey.

In the first chapter, I will focus upon the formative decades of the medical profession in Turkey using studies on the historical development of modern Turkish medicine and autobiographical works written by medical doctors. Through these accounts, I will try to show how such concepts as rationality, science, medicine and national development became inter-linked in the final decades of the last century and the early decades of this century, when Turkish medicine had institutionalized. I will also try to document the ways in which medical doctors acquired considerable social and political power as the vanguards of such Enlightenment values as

secularism, positivism, belief in objective-scientific data and progress. The argument I will try to develop in this context is that medical doctors acquired a privileged status among Ottoman-Turkish intellectual cadres through their access to Enlightenment ideas and values. They were also highly active in the first nationalist movements and organizations. My main point of emphasis in this chapter will be that this historical experience is closely bound with a sense of "mission"- Turkish doctors must work to improve the living conditions of their society, not only in terms of health, but also in social and political terms. Acquired through professional education and reproduced through the rhetoric of professional associations and collegial relations, I believe that this mission of being responsible for the health of the nation and having the authority to diagnose its ills, continues to be a very important component of medical doctors' self conception in Turkey, despite the dramatic changes the medical profession and the health sector undergone in Turkey over the last two decades. The major changes in the health sector since the institutionalization of the medical profession and the present situation of the profession are also discussed in this chapter.

In the second chapter, I focus on the present. To draw a straight line of continuity from the formative decades of nation building, to the present of the medical profession in Turkey would be very misleading. Far from being static, the medical profession has undergone numerous changes which cannot be explained by referring to past experience but must be understood in the context of dilemmas facing the profession at present. The second chapter of the thesis is an attempt to provide a snapshot of what it means to be a practicing-doctor in the mid-1990's in

Turkey. This chapter is based on the interviews I made with 6 medical doctors who come from different social backgrounds and specialities, and all of whom are between 35-40 years of age. Through the narratives of these doctors about their professional life stories, I examine how they account for their initial decision to become a medical doctor, how they explain the kinds of career choices they have made, and the ways in which they understand/legitimize and/or reconcile these choices with broader self-conceived "mission" of the medical profession in Turkey. My aim in this chapter is to explore the kind of dilemmas medical doctors conceive themselves as confronting, how they formulate these dilemmas, and narrate them as coherent life stories. Rather than asking these doctors about the changing parameters of the medical profession as a whole, or about macro-social events of the past two decades which have had a direct bearing on the social and political prestige of the profession, I try to understand how these changes have been translated into career experiences of individual doctors. Can we still talk about a broader self-conceived "mission" embraced by medical doctor in Turkey? The life stories of individual doctors suggest that there is no simple yes or no answer to this question. My central point here is that regardless of the kinds of career choices these medical doctor have actually made, and irrespective of their gender or current "success" in professional terms, they still conceive of themselves as having the social authority to diagnose them.

The third chapter focuses on doctor-patient relations. Here my aim will be to examine how professional expertise becomes the basis of a broader power-relationship between doctors and their patients. Using doctors' own accounts of how they conceive of their patients and their power and

authority over them, I try to understand how the changes in the public conceptions of the medical profession and patients' attitudes towards them impinge upon doctors' own self-conception. The main substantive concern of this chapter is how the doctors whom I interviewed cope with the increasingly negative public image of the profession in recent years- "greedy doctors" who are more concerned in making money than treating patients. Hence, I look at how the doctors themselves narrate their relations with their patients-as "good doctors" who do their best to take care of the medical and social problems of their patients despite adverse work conditions.

Each of these three chapters are intended to probe a different set of factors which mold the self-conception of medical doctors in Turkey. Rather than providing comprehensive answers to the questions which I initially inspired this thesis, they capture a few fragments from a much more complex picture. In the last, concluding chapter of the thesis, I will explain my own understanding of how these different fragments might fit together. Thus, the last chapter will be an attempt to develop my own narrative as a researcher, on the basis of what I have learned by reading historical accounts and listening to doctors as they describe their own professional experiences. My arguments are also informed by my own observations on doctor-patient relations and doctors' professional experiences in the hospital setting where I was employed as a researcher in different research projects. Before proceeding with the substantive chapters below, a few brief remarks on some broader theoretical considerations may be necessary.

Some Broader Theoretical Considerations: This thesis is informed by recent developments in the field of medical anthropology where such topics as doctor-patient relations and different cultural definitions of health and illness have begun to receive growing emphasis. These have brought into the foreground such issues as the confrontation between different explanations of specific health problems. Differences between the cultural construction of a health problem in terms of the meaning that is attributed to it by lay people in society and the medical evaluation of doctors through the use of "objective-scientific" data in hospital settings have begun to be explored (Helman, 1990). Although many anthropologists argue that the different explanations offered by lay people and doctors are negotiated in doctor-patient relations or in the way patients interpret and apply the doctors' advice, they generally admit that explanations of institutionalized modern medicine dominate the way societies perceive and interpret health issues. This is related with the development of modern medicine as a separate field from religion and philosophy and, relatedly, the formation of the biomedical model which is highly suitable for the "modernized" societies whose main ideology is to shape all aspects of their lives according to the scientific and rational values (Figlio, 1977) (Conrad, 1992).

The biomedical model includes a strict mind-body dualism and reliance on the the objective-scientific data that is obtained through measurements conducted at the modern medical institutions. It attributes a prestigious position to the doctors as the only people who can legitimately acquire medical knowledge and apply it through conducting these tests and measurements in order to achieve a final evaluation about the health status of the patient and advise a treatment plan. Accordingly, doctors, in

general, have a highly respectful and prestigious position, and enjoy high social status and economic power in the societies which adopted the biomedical model with its values and institutions (Helman, 1990). Since most of the countries adopted contemporary Western ideologies, values and institutions through their modernization process, biomedicine which is one of their basic aspects, also became a dominant explanatory model in most of the countries in the world, at least at the level of modern medical institutions and official health sectors.

However, the biomedical model and the social position of doctors are also exposed to modifications during the process of the adoption of biomedicine in line with the particular social, political and cultural context in a country which shapes its health sector according to this model. Since this model is formed as a result of specific historical and social conditions, it is also bound to be challenged and changed, even in the Western countries where it was first developed.

My own attempt to study the self-conceptions of medical doctors in Turkey is an effort to understand how this "biomedical model", when adopted in non-Western settings, lends itself to distinctive patterns of social and political authority in various cultural settings. In trying to understand how the social and political position of medical doctors as a professional group is shaped through power struggles vis-a-vis the state as well as "lay people", the arguments of Turner (1987) have been especially helpful. His emphasis on the relevance of power struggles in drawing the boundaries of the medical profession, in maintaining control over professional expertise, as well as legitimizing the social authority of the medical profession, provides the conceptual background for the first chapter of this thesis. In

the second chapter, where I discuss the professional life stories of a younger generation of doctors who are currently in their mid-careers, the work of Linde (1993) has been very useful in trying to interpret how personal narratives play an important role in achieving consistency between "individual self" and "professional self".

Chapter 1

Development of Modern Medicine in Turkey

This chapter situates the development of a professional perspective and a concern with social issues among Turkish medical doctors in a historical context. The development of a professional perspective ocurred within the process of institutionalization of modern medicine during which doctors gained social power and prestige. There were close linkages between development of modern medicine and broader social changes. Major reform movements in the Ottoman Empire and the Turkish Republic influenced institutionalization of modern medicine, and doctors played key roles in the overall modernization process.

The major problems and dilemmas faced in the modernization process were also reflected in the development of a modern health sector. Both of these processes were led by a small group of pioneering intellectuals. They took their inspiration from the Enlightenment heritage of progressivist, scientific thinking, and were opposed by concervative circles with traditional and religious concerns. The state, and the negotiations over state policies were an important element in both processes. For the doctors, these negotiations were conducted mostly in oppositional terms during the Ottoman Empire when reformist movements were seen as threatening the power of the Sultan, but allies during the early Republican period.

The process of professionalization of modern medicine, involving the development of a perspective and a common stance among doctors with respect to problems of the country enabled both the formation of group

solidarity and acquisition of social power. Paul Starr (1982) in his study of medicine in the United States, argues that "the profession has been able to turn its authority into social privilege, economic power and political influence". He adds that this was not a smooth process whereby increasing "faith" in science and rationality in society conferred an immediate prestige on the doctors. The process itself was full of power struggles where the interests of other social groups, organizations, and the state clashed with one another. In his book, Starr concentrates on issues of maintaining professional authority, group boundaries, economic interests, and domination over values and beliefs concerning health. In the case of the Turkish doctors, I find it more important to study the particular ways in which their involvement in major social and political movements shaped their own professional perspective and enabled them to acquire social prestige and power.

Part A: Modern Medicine in the Ottoman Empire (1827-1923)

Even though it is hard to define an exact date for the birth of modern Turkish medicine, doctors and science historians agree on 14 March 1827, the founding of the first modern medical school, *Tıbhâne*. The founding of this school was included in the reformation agenda of Mahmud II. During his reign (1808-1839), he abolished the Ottoman traditional army, *Yeniçeri Ocağı*, and replaced it with a modern army institution which was similar to the Western military model. It was the needs of this new army which provided the impetus for the establishment of a school of modern medicine. The new army needed large-scale, institutional medical services provided by doctors who were formally educated according to European

standards (Unat & Samastı, 1990), (Erdemir, 1996). *Tıbhâne* also played an important role in the standardization of medical education which was given previously in different ways by the Muslim and non-Muslim institutions.

Before the foundation of *Tıbhâne* , medical knowledge was taught mainly in theoretical terms in the *medrese* s, which was the name given to the secondary and higher levels of schools. The teaching consisted of revision and interpretation of classical Eastern and Western medical texts such as *Kanun* (Canon) of *Ibn-i Sina* (Avicenna) and the works of Hippocrates and Galen. The new medical texts incorporated interpretations of these classical texts and some contemporary medical knowledge from Europe, usually transmitted by the non-Muslim minorities who had close economic and social contact with the West. In this respect, the Jews who settled in the Ottoman Empire when they were expelled from Spain after 1492, brought a new synthesis, which consisted of "Islamic, French and Greek" medical knowledge as well as their own medical explanations. Their unique contribution to the medical knowledge provided a privileged position to the Jewish doctors, especially in the realm of the Ottoman court (Adıvar, 1991).

The medical education in *medrese* s was far from being formal and standard , it mainly depended on a one-to one relationship between the teacher and the student. This relationship was similar to the master-apprentice relation where the teacher designed a specific curriculum for his students. There was no standard course schedule and a specific time period required for medical education. The teacher tested his student and when he decided that the student acquired an adequate medical knowledge,

he was given an *icâzet*, a written permission which authorized the student to become a doctor and to cure people (Uzunçarşılı, 1988).

The non-Muslim minority groups had their medical education either in European countries such as Greece, Italy and France (Yıldırım & Ülman, 1994) or in their own hospitals and institutions in Istanbul (I.A., 1995). Among these organizations, Kuruçeşme University (1805-1820) which was built with the permission of Selim III, included a faculty of medicine with an anatomy laboratory where medical students and doctors practiced their medical knowledge and made experiments through dissecting cadavers. Selim III was convinced that a medical faculty where the students can practice their medical knowledge as in the contemporary medical faculties in Europe was needed in the Ottoman Empire. However, he was also concerned about the reaction of conservative circles who were against the dissection of corpses, since it was considered contrary to Islamic rules. He solved this dilemma by giving permission to the Greek-origined *(Rum)* doctors to open a faculty of medicine in Kuruçeşme University which admitted only Greek-origined students. The university was closed (1820) soon after its opening, since the director of the university, Dimitreşko *Bey*, was blamed for participating in the Greek nationalist movement and executed (Unat & Samastı, 1990) (Adıvar, 1991).

Medical education and the health system in the Ottoman Empire were regulated by the *Hekimbaşı*, who corresponds approximatively to the minister of health today. He was responsible for supervising the professional activities of doctors in the country, including the doctors in the palace. However, his main responsibility was to maintain the health of the

Sultan and the members of his dynasty. Whenever a sultan died from natural causes and his follower replaced him, according to the laws his *hekimbaşı* also had to be replaced by another doctor (Uzunçarşılı, 1988). Mustafa Behçet who was the *hekimbaşı* of Mahmut II played a crucial role in convincing him that reformation was needed in the medical services. Mahmut II and the ruling elite planned a reform program which would be implemented by the state officials who would adopt a system from a European country, preferably France (Ortaylı, 1983).

Mustafa Behçet, the *hekimbaşı*, and Şanizade Ataullah, another well-known doctor of that time, were highly influenced by Western medical knowledge and developments and were accused of being atheists by the conservative circles. Both of these doctors wrote books on medicine, which combined traditional and contemporary, Islamic and Western medical knowledge and aimed to establish a new medical terminology. They both believed that a movement for modernization and nationalization in the realm of all sciences was necessary. They played a pioneering role in the formation of modern Turkish medicine and Mustafa Behçet used his official power to organize the foundation and development of *Tıbhâne* in which he had a supervising role. In addition to *Tıbhâne*, Mustafa Behçet convinced Mahmut II to open *Cerrahâne,* the military surgery school, where Muslim students could also participate in the anatomy laboratory. The Austrian doctor, Dr. Bernard who was a highly prestigious doctor in Austria and France, was invited to the Ottoman Empire in 1838 by Mustafa Behçet and became equally succesful in Istanbul, emphasized that a proper medical education could not be pursued without an anatomy laboratory and planned certain improvements in *Cerrahâne* (Gürsoy, 1996)

(Unat & Samastı, 1990) (I.A., 1993). However, the anatomy laboratory could not function properly until the beginning of 20th century since the students could not find enough corpse and had to steal them from the cemeteries in the 1890's, and the building for the laboratory was not properly cared for (Erdemir, 1996). *Tıbhâne* also admitted more and more students each year and successful students graduating from this school began to be sent in Europe for further study. In 1838, it had united with *Cerrahâne*, the surgery school, under the name "Mekteb-i Tıbbiye Adliye-i Şahane" (Imperial School of Medicine).

Debates on the Language of Instruction in Medical Education: Since the foundation of Tıbhâne, medical education was given in French and this was an important issue of debate among intellectuals in the Ottoman Empire. The non-Muslims and foreigners argued for the education in French on the grounds that it would take time to translate the major contemporary textbooks, and that in any case medical students should know French in order to understand the medical terminology in Latin. However, for the Muslim intellectuals, the medical education should be in Turkish so that the number of Muslim students who decided to enter the medical school and graduated from this school succesfully increase and that a close support network among Muslim Ottoman doctors could develop. Having nationalistic considerations, they were concerned about the non-Muslim and foreign medical students and doctors who outnumbered the Muslims students and doctors, and who were better organized, which made them more influential in the general health politics. The language of instruction in medical education was considered

as a serious problem not only for doctors but also for Muslim Ottoman intellectuals who participated in the efforts of translating medical textbooks, preparing dictionaries of terminology and lobbying for medical education in Turkish. They were explicitly against foreign and non-Muslim doctors, as in the example of Mustafa Münif Paşa who called the foreign doctor "charlatans" who came to the Ottoman State since they could not be successful in their own countries. The nationalistic and exclusionary attitudes of the non-Muslim doctors caused reactions on the side of other Ottoman doctors. Unat and Samastı (1990) tell about these attitudes by giving the example of Dr. Zambako who announced that he was Byzantine and refused to speak Turkish with his patients. This example also shows that the debates on the language of instruction in the medical education were embedded with nationalistic concerns of different groups of intellectuals.

Involved in the language debate, the political agenda of some nationalist intellectuals who aimed to create and develop "national positivistic sciences". These intellectuals considered language as an essential part of the Turkish identity and as a tool to activate people around a shared ideal (Mardin, 1985). Therefore, the efforts to create a modern scientific language using Ottoman Turkish were part of a larger project of creating a common language which could also be used in propagating political ideas. For these intellectuals there should be more Muslim Ottoman Turkish doctors so that they could organize and compete with others in terms of having access to the patients and influencing the design of a health policy in line with their own interests. Having a medical

education in Turkish served this goal as well as being the first step to create modern Turkish medicine and science.

The debates about the language of medical education were at their peak when Mahmut II made his famous speech at the opening ceremony of the Imperial School of Physical Education and Sciences: His talk began: "I have given precedence to this school because it will be dedicated to a sacred duty- the preservation of human health". He continued by saying that the language of instruction will be in French, because it would take years to translate the French textbooks and the existing textbooks in the Ottoman Turkish had become obsolete. He said that they needed well trained doctors for their troops and their people, and to have their own medical language and their own medical literature codified. He concluded: "Therefore, my purpose in having you study the French language is not to teach you French as such but that you may learn medicine- and in order to incorporate science step by step into our language. Medicine will be taught in Turkish only when this has been done" (Gürsoy, 1996) (Unat & Samastı, 1990).

Although this may seem a conciliatory speech within the debate, it is important in signifying an end to the *medrese* education based on classical medical texts, and to their replacement by modern medical schools in line with the Western model. Indeed, the new medical school where Muslim and non-Muslim Ottoman subjects, and foreigners were educated together, became a place where Western, mainly French, history, literature and culture were taught. The contemporary ideas in the West, such as different versions of nationalisms filtered through these teachings. The Muslim Ottoman intellectuals considered the speech of Mahmut II, as

pointing to a mission of creating a modern Turkish science and accelerated their studies and translations.

A civilian medical school opened in 1866 as a part of the military school to fulfill the need for doctors in the general population. According to Unat and Samastı (1990), this school attracted a lot of Muslim students who were actively involved in the debates on the language of instruction in the medical education. For the first time, the language of instruction for a "privileged class" which consisted of the most successful students, became Turkish. Finally, at the end of the 1860's the language of instruction in the civil medical school became Turkish, after consultations of the Abdülaziz's representative in education with the prominent Muslim and non-Muslim doctors, and the military medical school soon to be followed by. This resulted in a significant increase in Ottoman Muslim students so that less than one-third of the graduates from the civil military school were non-Muslims (Unat & Samastı, 1990). However, Dr. Muzaffer Sezer (1953) argues that knowing French still remained a crucial advantage for medical students even though the education was in Turkish, since the students "educate themselves better" through reading the original French textbooks rather than listening to the lectures of their professors who merely repeated the translations of these textbooks. Comparisons of the state of Turkish medicine with West and the competition with the non-Muslims in the country still continued to some extent, but Muslim and non-Muslim groups seemed to build closer and more harmonious relationships while having the same Western oriented education in the same schools which had a socially and politically unifying character. This character also helped the Ottoman doctors organize around their shared

ideas to acquire a considerable degree of political power. The political power brought the doctor into conflictual relations with the last sultans of the Empire, who saw them as a threat to their own power and reform projects.

The Modern Turkish Medicine, Its Ideology and Founders: In the medical schools, influence of contemporary Western thought, undermined religious thinking and strengthened nationalistic and scientific ideals. Dr. Bernard whose views on the necessity of dissecting human corpses, became more influential when he was charged with organization of the *Tıbhâne* as its director. The memoirs of Charles MacFarlane, quoted in Akile Gürsoy (1996), tells about "a good anatomical theater" in the medical school, which indicated that the medical students were used to this experience* . When he asked whether this was not against Islam, one of the Muslim students laughed at him and answered that this was not the place to look out for religion. He also reports about a French book lying around which was considered the "Atheist's Manual" at that time in France. He was surprised to see that this book was carefully read and highly appreciated by the Turkish medical students. Gürsoy describes the foundation of modern medicine in the Ottoman Empire, as "intermingled with the processes of non-traditionalism, Westernization, nationalism, secularism and may be also atheism".

Since these processes corresponded directly to a general project of modernization which was also derived from the Western model, doctors

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* As opposed to these memoirs, Dr. Arslan Terzioğlu (1992) mentions about a report written by an Austrian doctor in 1842, where the students in the Imperial School of Medicine work with plastic model of organs and animal bodies in the anatomy labaratories instead of human bodies.

and medical students had a privileged position among the intellectuals because of their immediate contact with Western professors and ideologies. In addition, the successful medical students had the chance to go to Western countries, mainly France and Germany for further studies when they had graduated. The medical schools together with other faculties and foreign high-schools which were opened in the 19th century, were uttered by the Ottoman intellectuals as the channels of "direct interaction" with the Western culture, the result of which is reflected in the process of "cultural change" experienced by the members of these institutions. (Güvenç, 1979) (Davison,1963) (Aydın, 1993).

Dr. Tevfik Sağlam (1981), described the spirit of being from the Medical School (*Tıbbiyeli Ruhu*) as revolutionary, having the love of nation and freedom and belief in progress which would be realized by reaching the levels of developed countries. This spirit was clearly directed to the West as Sağlam points out that the medical schools were "the first window" of the Ottoman Empire opened to the "Western world". In line with this statement, he says that the members of this school knew the difference between East and West, and felt sorry for the East's "backwardness and laziness".

In the civil and military medical schools, the Muslim students were also influenced by the nationalistic movements of the non-Muslim students. Most of the Muslim Ottoman students entered the medical faculty not only to learn medical knowledge and fulfil a crucial need for doctors in the country, but also to pursue a mission to contribute to the development of modern Turkish science and to national reformation and modernization projects both in theoretical and practical terms (Unat &

Samastı, 1990). The ultimate aim of this mission was to create a modern "Turkish identity" apart from being a subject of the Ottoman State.

In addition to language, religion, and in particular the issue of whether Islam was compatible with Westernization was an important source of debate among Muslim intellectual elites. Medical students and doctors had a particular position in this debate, which could be partly explained by the relation between medicine and religion. As Bryan Turner (1996) points out, medicine has a strong secular tradition which goes far back to Hippocratic and Galeanic medicine. Although this tradition was subsided by Christianity and its ethics of love and humanism in the Middle Ages, it was the separation of scientific from the religious and philosophical spheres in the 18th and 19th centuries which shaped the basic principles of modern secular medicine (Figlio, 1977).

The Ottoman medical schools had to differentiate themselves from the *medrese* type of education where medical knowledge was taught in accordance with Islamic rules both in terms of theory and practice. The new medical schools adopted the secular and modern medical model, hence positivism and biological materialism where the material entity is considered and scientifically studied as the basic substance of all beings , became the basic tenets of medical education. Doctors who were also prominent social and political figures at that time debated whether religion and "traditional values" could contribute to the project of social progress. Dr. Beşir Fuad, who was a strong follower of positivism to the extent that he committed suicide by cutting his wrists and reported his physical condition in detail whilst dying, believed strictly in biological materialism. Abdullah Cevdet who was under the influence of his religious family and

training, was more open to religion and tried to combine Islamic values and social progress (Hanioğlu, 1986). However, Hanioğlu notes that medical education modified the views of Abdullah Cevdet who began to favour biological materialism. He describes the civil medical school as having a particular socialization function, creating a type of intellectual who saw religion as an obstruction in social progress.

One of the most important aspects of biological materialism for these Ottoman intellectual doctors was the separation between matters of the heart and matters of the brain. Matters of the brain were considered as scientific points which could be tested and proven by experiment and observation. Interestingly, according to these intellectuals, these methods were also applicable for social and political issues, even though they were derived from positive sciences. Hanioğlu gives an example of an explanation of a political issue with concepts that are derived from positive scientific terminology from the memoirs of a highly important political figure in the Turkish nationalist movement, Dr. Rıza Nur. Dr. Nur believed that people had to unite and pursue an organized struggle in order to fight the oppressive regime of Abdülhamit II. He argued about this requirement with an example from chemistry where the combination of two chemical entities, similar to the people who came together, led to the creation of a new and highly precious entity. This example is also important in explaining the roots of political activities of doctors.

These views were also shared by a large group of Ottoman intellectuals, and Ottoman doctors played a significant political role in the modernization projects led by the Ottoman intellectual elite. Most of the Ottoman doctors, similar to the other intellectual elite, were from families

with a high socio-economic status and a high position in the state bureaucracy (Unat & Samastı, 1990). Hence, in contrast to Starr's (1982) description of the heterogeneous class position of the American doctors during the modernization process, the Ottoman doctors were concentrated in the upper class division mostly because of their familial backgrounds, so they had less economic concerns than their American colleagues. Most of these intellectual elites came from high level bureaucratic families or had organic links with government. They were concerned about the political and social decay in the Ottoman State and tried to find solutions to its problems. Mardin and Kılıçbay argue that the their ideas on modernization as Westernization differed sharply from the ideas and lifestyles of conservative masses. However, these intellectuals can be considered as politically conservative since they did not attack the existing political system and its legitimacy directly, and their Westernization and nationalism projects were directed toward restoring the power of the existing political institutions and processes. Their political power enabled them to publish and disseminate their views, and to organize as groups. Their modernization project included a mission that they assigned themselves: They had to teach the masses how to adapt to a new model in the way they lived and thought (Mardin, 1985) (Kılıçbay, 1985).

Although there were debates on different aspects of the model for social development, such as the debate on the inclusion of religious values as we have seen above, the intellectuals agreed on its basic aspects such as the emphasis on science, rationality and progress. With the aim of realizing their mission, they organized to acquire political power in order to influence the reform projects of the state and to stop the decline of the

Ottoman power, as in the cases of the first and second attempts to bring in constitutional law, and the more general, social and cultural reform project of *Tanzimat.*

The Political Role and Activities of Doctors within the Turkish Nationalist Movement: In line with the argument about the theoretical and methodological unity of the physical and social sciences, the medical students and doctors began to consider themselves as the legitimate pioneers of the modernization mission, due to their privileged access to the medical knowledge, as well as to Western ideas and resources. They considered medical knowledge and health matters crucial in the formation of a "nation" as the words of Dr. Adnan Adıvar quoted in the autobiography of Dr. Sezer (1953) tells us: "The health of a nation should have a priority over all..A nation which has a well established health system is also strong in war, and works with energy. To what extent weak citizens who often become ill can be useful in their work or in defending their country can be easily estimated". The views of Dr. Adıvar underline the critical role health and medicine play in creating strong nations, but also point to a way of thinking which assumes that knowledge of medical and physical sciences enables one to understand social and political issues and to react to them.

In the biography of Dr. Sezer, Dr. Adnan Adıvar talks about the lively political atmosphere of the civil medical school to his young high school student (Dr. Sezer) in this way: "This is a sacred place where all scientific and social cases and issues are merged into each other (*kaynaşmak*) and where a lot of young citizens with a fighting spirit are

gathered". He implies that the propagation of these views is a part of a socialization process in the civil medical school through his words: "Under the roof of the medical school, each person finds himself being involved with this political movement, without being aware of it at all " (Sezer, 1953).

For Dr. Adıvar, the civil medical school was more actively engaged in political debates than the military medical school which had a stricter discipline. Moreover, according to the views of Dr. Adıvar, which were highly influential among the Ottoman intellectuals in the last decades of the 19th century because of his high political and professional status, the future of the country belonged to civil doctors who served people from different layers of society, in different parts of the country, unlike military doctors who could merely reach the patients in the army. He says: " The medical school is a house of science which leads each of its members towards the same aim and which matures them in terms of solidarity, harmony, sensitivity and keeping secrets. Its principal aim is to serve the social and medical development of the country". The qualities, mentioned here, were also crucial for the formation of professional solidarity among the doctors (Sezer, 1953). The doctors who were trained in the military medical school, such as Dr. Abdullah Cevdet and Ibrahim Temo, also shared these qualities and their efficiency and discipline in terms of political organization assured their leaderships in the Young Turk movement (Hanioğlu, 1986).

Doctors shared the dissatisfaction of the Ottoman intellectual elite with the political situation. This dissatisfaction was the basic motive to participate in the Young Turk (*Jeun Turcs*) movement which became

increasingly influential in the political realm in the last decades of 19th century. Some doctors and medical students, such as Ibrahim Temo and Adnan Adıvar, played a leading role in the formation of this movement, and also influenced their colleagues through propagating their political and social views. Later on, the movement developed into a well organized political party, *İttihat ve Terakki Cemiyeti* (The Committee of Union and Progress-CUP) where Dr. Abdullah Cevdet was one of its three main leaders (Hanioğlu, 1986).

According to Sina Akşin (1985), the participants in the CUP had five common characteristics which helped in defining their ideology and actions: They emphasized their "Turkish identity", independent of their ethnic origins. Secondly, most of them were high school or university students or recent graduates who were not risking a professional career that they had pursued for a long time. They came from families who lived a Westernized "bourgeois style of life". The members of these families were from the ruling class, meaning they were mostly high ranking state officials. The last trait that Akşin mentions was that most of the party members were well-educated in modern Western values and ideas. He points out that they were mostly from the modern universities in the Ottoman State, including the two medical schools instead of the *medrese*s. These typical traits correspond to the characteristics of medical students and doctors such that this group can be considered a representative of the whole party members and the participants in the Westernization and modernization movement.

The political debates and activities in the civilian and military medical schools were not always tolerated by the Ottoman Sultans. Even

though Mahmut II had assigned to the members of the military school a privileged status and the mission to found the modern Turkish science. Sultan Abdülaziz (1861-1876) was disturbed by the ideological movements within the military medical school and held the French director and professors responsible. He replaced the French director with Dr. Robert Rieder (1861-1913), a German director who was followed by another German, Dr. Georg Deyche (1865-1938). The period where these two directors were in charge was later called the "Rieder-Deyche period" where German doctors improved the military hospitals and brought basic elements of preventive medicine to the Ottoman army such as vaccination against epidemic diseases. However, the new discipline did not totally curb the political movements within the military medical school (Erdemir, 1996).

Abdülhamit II (1876-1908) who came into power with the help of the political compromises he made with the CUP, felt threatened and rivaled by this party. He closed parliament on the pretext of giving priority to solving the political and social confusion caused by the Ottoman-Russian War in 1878. He began to apply an oppressive regime where the activities of the party were closely controlled and any act of opposition from the Ottoman intellectuals was punished. Many were sent to European countries on diplomatic missions or they were paid by the Ottoman State to continue their intellectual and political activities in Europe. Modern and cosmopolitan European cities of that time such as Paris and Geneva became centers of political organizations for the Young Turks who found ways of escaping to these places even though they were exiled to different places such as Fizan (Libya) in the case of Dr. Abdullah Cevdet (Hanioğlu,

1986). In these European cities, the intellectual and political activities of the Young Turks were influenced by the the policies of the *Sultan* as well as the lively intellectual and ideological atmosphere of the cities where they lived.

In exile, there began to develop a schism among Young Turks, between a more conservative group who argued for communitarian values and a group more eager to adopt the Western ideologies and promoting individualistic values. Abdülhamit II tried to persuade some of the leaders in the first group that he would undertake similar reforms in the Ottoman State, if they returned. Most of the doctors, however, such as Dr. Sabri and Dr. Abdullah Cevdet, who had a prominent role in the CUP movement, favored the second group led by Prens Sabahattin. The major reason for this support according to Hanioğlu (1986) , was that Prens Sabahattin shared a similar ideology with these doctors, particularly the view that social facts can be dealt with "in the light of" physical sciences. Hanioğlu says that Dr. Abdullah Cevdet and Prens Sabahattin shared an ideology similar to "Social Darwinism", arguing for the necessity for struggle and competition in social and economic life. This struggle was considered as the "struggle for life" and compared to the Darwinian theory about the plants and animals which succeed in adapting to their environment, establishing and reproducing their kind. Although, these views were more marginally shared among the Ottoman intellectuals, the second group's reluctance to reconcile with the Sultan brought them a privileged position within the movement (Hanioğlu, 1986).

According to Dr. Muzaffer Sezer (1953), Abdülhamit was particularly afraid of and suspicious about the medical students, and he

had the new hospital and a larger military school built in an isolated part of Istanbul at Haydarpaşa. Sezer argues that the new buildings did not only keep the medical students and doctors away from the palace and the city center, but also provided an opportunity to spy on their activities and to arrest them comfortably without getting an immediate reaction from the rest of society. Dr. Sağlam (1981) also argues that the oppressive regime of Abdülhamit was directed particularly to the medical school and caused an extraordinary solidarity, mutual respect, trust and affection grow among the students and professors and between the two groups so that it strengthened the "spirit of being from the Medical School" (*Tıbbiyeli Ruhu*) instead of weakening it.

The Institutionalization and Professionalization in the Health Sector: The opposition of the Young Turks and its fluctuating relations with Abdülhamit II lasted until the second attempt to bring constitutional law, when the oppressive regime of Abdülhamit II ended. During his reign, despite his problematic relations with the Young Turks, Abdülhamit II, adopted a development model similar to that of the Young Turks. He was interested in establishing new universities, including medical schools, where intellectuals, artists and professionals were to be educated in line with modern European ideas and methods. He was also concerned about the increasing number of medical students and doctors so that he supported the enlargements and improvements of the buildings of medical schools and hospitals. He also promoted the specialization of hospitals which began to acquire an institutional character, and was differentiated from the charity hospitals (*darüşşifa*) which were part of building

complexes centred around mosques. Besides numerous small hospitals which specialized in treating victims of the cholera epidemics, Abdülhamit II opened a children's hospital (*Etfal Hastahanesi*) and a special institution named *Darülaceze* where old people and babies who had no relatives, would be taken care of (Altıntaş, 1998).

The 19th century was also a turning point in terms of large scale developments in the health sector in line with other social and ideological developments. Besides modern medical schools, large-scale hospitals such as Çapa and Cerrahpaşa were established as a result of serious epidemics, such as small pox (1843) and cholera epidemics (1893), giving the doctors the opportunity to practice medicine, both as a part of their educational and professional experience (Uzunçarşılı, 1988) (I.A. , 1995). Military hospitals also developed primarily as a result of long-lasting, brutal wars of the 19th century such as the Crimean War (1854-1856) (Terzioğlu, 1991-1). Wars and the increasing foreign population in Istanbul due to frequent social and economic interactions with the Ottoman Empire led European communities and the United States to build and enlarge their own hospitals in the last decades of the 19th and early years of the 20th century. Among them the German Hospital which was built in 1846 was enlarged at the end of 19th century and the American Bristol Hospital was built in 1920, mainly to take care of poor foreign sailors, veterans of the wars, people from their own community in Istanbul as well as other city residents (I.A., 1995)

Crimean War had a particular significance in terms of the institutionalization of health sector. Florence Nightingale came to Istanbul with 40 nurses, and started the foundation process of modern nursing through educating new nurses, contributing to the opening of a nurse

school named after her, as well as her exemplary professional performance (Nasuhioğlu, 1975), (Woodham-Smith, 1952). The other professions in the health sector were institutionalized much later. Although the school of pharmacists was founded a few years after the foundation of the civilian medical school, it was for the students who were unsuccessful in medical education in their first years (Unat & Samastı, 1990). Only in 1909, could a separate school which had three separate divisions for pharmacists, dentists and mid-wives be built (Erdemir, 1996). With these developments in professionalization and institutionalization processes in the health sector were well established; the professions began to have defined boundaries mostly due to the standardization in education and the increasing social and political prestige and power of the professionals.

Doctors developed a more organized character in professional as well as in political terms in the last half of the 19th century and the early 20th century. The professional duties and social boundaries of this group began to be defined with more standard and regular terms so that they gained a communitarian aspect whereby most of the doctors knew, communicated with and supported each other. The first professional journal with both Turkish and French versions, *Vekayii-Tıbbiye* (Medical Cases), was issued in the military medical school in 1849 (Nasuhioğlu, 1975). The first professional organization, *Cemiyet-i Tıbbiye-i Osmaniye* (1866) , was founded in the civil medical school with the goal of encouraging medical education in Turkish, and its members prepared a list of medical terms in Turkish, besides planning and promoting the translations of Western medical textbooks (Unat & Samastı, 1990). However, during the reign of Abdülhamit, mainly non-Muslims became the members of this

organization, because of his oppressive regime which particularly affected the Young Turk doctors (Topuzlu,1945). *Hilâliahmer*, an equivalent of "red cross" in the Western countries, which was responsible for health care especially within the army, was founded in 1868 (özden, 1945). This organization became particularly efficient in the last wars of the Ottoman Empire and the War of Independence, and this increased the social prestige of doctors further.

The first course in medical history and ethics was given in the 1860's and in the 1870's, respectively, by Dr. Nouridjan who described the primary duties of doctors in his ethics courses and who became highly influential in shaping the doctors' professional perspective. He stressed that the virtues of doctors should be derived from the "love of duty" which would help them to overcome the difficulties of the profession, and a "love of science" which would guide doctors in learning every aspect of the human beings, improving the human condition and providing social development (Terzioğlu, 1993). In 1902, the same course was given by Zoeros *Paşa*, who was also employed by the Ottoman Court and founded the first institute for Rabies (1887) of the East in İstanbul, in the light of his studies with Louis Pasteur in Paris. His courses on medical ethics covered medical history, the characteristics which doctors should have, such as paying attention to their appearance, being honest, patient and tolerant, and duties such as spending the necessary effort to heal any sick person, including enemies, and giving adequate information to the patients on their health condition (Yıldırım &ülman, 1994).

In 1909, the graduates of the medical school and the pharmacists' school took a professional oath for the first time in their graduation

ceremony. The oath was based on the laws of Hippocrates and reflected the basic medical principles that the students had learned in their ethics courses (Unat & Samastı, 1990). In 1908, The civilian medical school became a part of *Darülfünun*, the first major university in the Ottoman Empire which had opened in the 19th century.

PART B: Social Mission and Struggles of Turkish Doctors in the Republican Period

The political prestige and power of the doctors increased considerably during the early years of the Turkish Republic. In contrast to political opposition towards the Sultans and their traditional ruling system, the doctors acquired a broader, unifying social mission in line with Kemalism, the official modernist and nationalist ideology which shaped the social and political transformation projects during the early decades of the Republic. As we have already seen, the Ottoman intellectual elites had varying projects of modernization which included different aspects of nationalistic thinking, and the values they promoted varying from traditional, religious, communitarian values to the scientific or individualistic ones. Suavi Aydın (1993), argues that all of these ideas were incorporated into the official Kemalist ideology which envisioned a broader, more concrete project of a major transformation in various sectors in the newly defined "Turkish society", where a new identity of "Turkishness" was described. In this framework, the Kemalist project was similar to that of the Young Turks in terms of its positivist and progressive perspective which leads to the adoption of Western social system and institutions.

The Kemalist Project and Turkish Doctors: Professional groups had a crucial function in the Kemalist modernization project. As Atatürk (1930) stated, all of the occupational groups should have a sense of duty of serving the welfare of their country while working. He had a functionalist view of the occupations, since he believed that a country's existence depended on the work, help and contributions of "its children". He also stressed that not all of the citizens contribute to the country in the same amount and significance. Having nationalist concerns which dominated the whole Kemalist ideology, he praised the Turkish doctors and tried to motivate them through inculcation of a professional self-confidence. Since the early decades of the 18th century, the Turkish doctors had struggled to build up a modern and national medical sector and science through the adoption of the Western scientific ideas. Atatürk aimed at institutional development in all sectors so that Turkish institutions and their members could compete with their counterparts in the West. He preferred to be under the care of Turkish doctors until his last years and expressed this preference with his famous words which could be translated as "Leave me in the hands of Turkish doctors". This sentence became a professional motto written on the entrances of almost every medical school and hospital. Medical education was also totally nationalized with the abolition of the educational activities in the hospitals of foreign and non-Muslim minority groups. The Turkish government passed a regulation which defined these as private hospitals with a special status and prescribed that their boards of directors should include Muslim Turks, and that the government should approve their administration, similar to the status of foreign high-schools in Turkey (I.A., 1995).

Halit Ziya Konuralp, a famous aesthetic surgeon, who went to medical school in the 1920's mentioned in his talk that medical education also improved since surgical education and dissection of cadavers were considered crucial by Cemil Topuzlu, who was in charge of the health system and politically influential both in the last period of Ottoman Empire and the first decades of the Turkish Republic. In the 1930's, he became the Mayor of Istanbul, and his activities in this position, such as opening public parks and gardens, were highly appreciated. Hence surgical operations and dissection of cadavers became an essential part of medical education (Konuralp, 1996). Starr's (1982) remark about the early period of the modernization of American medicine where the physicians mainly dealt with the theoretical aspects of medicine, and had higher social position and prestige than the surgeons whose main duty was to be involved with dead and living bodies, is also valid for the Ottoman case where involvement with dead and living bodies were traditionally conceived as an inferior activity, which even barbers could deal with, especially when it was compared to the scholarly or academic work. This differentiation was gradually abolished with the increase in the courses on surgery in the medical schools, and the success of surgeons especially during the wars at the end of the 19th and the beginning of the 20th century.

Doctors who already attributed to themselves the mission of social and cultural propagation of nationalistic and scientific values and applications in their occupational realm, now gained an officially legitimized duty to transmit and teach these values to the rest of society. Most of the doctors mentioned here such as Dr. Adnan Adıvar and Tevfik Sağlam witnessed the development of Atatürk's political ideology and

participated in its formulation and implementation both before and after the foundation of the Republic. They took active political roles in the first parliament and cabinet as the ministers of health and education. The overlap between doctors' professional ideology and values with the trend in national politics also increased the social power and prestige of doctors who began to play a more active role in political decisions taken on various topics. Among these decisions, expanding the law of rotation (which is also largely known as the law of obligatory duty) in the health sector was especially important in providing the ground for the missionary- like activities of doctors.

The Law of Rotation and its Effects on the Social Mission of Doctors:

Originally, the law of rotation was issued during the first decade of the 20th century, so that the students in the military medical school could perform their military duty by practising their profession in towns or villages for two years and obtain a higher military rank. At the end of the 1920's, this law included the graduates of civil medical schools, as a result of the concern for the lack of doctors in provinces. The rotations were good opportunities for the doctors to be in touch with ordinary, uneducated people who had local and traditional values, so that besides providing health care, they could propagate Western scientific and progressive thinking in the name of Kemalism to these lay people. As the representatives of Kemalist ideology, the doctors pursued these two equally important professional missions which were completely merged with each other and which solidified the general professional motive of "serving the country".

Dr. öncel (1951) in his memoirs, describes the first group of doctors who went to their obligatory duty as "the new country's first members who had an unlimited energy". He was among the same group who was highly "proud and excited about taking active roles in the name of the state in order to bring health (facilities) to the children of the country, who had longed for a doctor for a long time". As Dr. Sezer (1953) puts it, their duty included the education of "ignorant" village people whose way of life and thinking were still under the influence of the old (Ottoman) times. The educational process which was pursued under the name of "propagating medical science", aimed to instill among village people the progressivistic view which would motivate them to improve their lives and to alter their religious perspective in explaining "matters of life, illness and death". According to Dr. Sezer (1953), in order to fight against lay people's traditional, religious ways of thinking and to improve their poor living conditions, "a doctor should primarily know about geographical, social and economic situation of the place where he lives". Hence, during their professional practice, Turkish doctors began to acquire knowledge about national or local conditions as a complement to their medical and Western scientific knowledge which was essential for their professional mission, as it legitimized their role as "teacher" and confirmed their powerful position.

The Preventive Medical Projects: Another activity which encouraged the idea of a professional mission was the struggle with endemic diseases in Anatolia such as malaria, syphilis and tuberculosis. These public health activities were a part of the national project of creating a young, powerful and healthy society. Several medical students who

graduated with high scores were sent to European countries such as Germany, France and Switzerland mainly to specialize in these illnesses. After their return, they began to implement the preventive medicine in the places where these illnesses threatened public health. The measures varied from drying marshlands in Adana in order to fight the mosquitoes which caused malaria to collecting blood samples in the villages of the South-East region in order to detect viruses (Sezer, 1953).

While the relations of Turkish doctors with their European colleagues increased and became more regular, these projects also provided an opportunity for doctors who were mostly educated in Istanbul to learn about the social and economic conditions of Anatolian people. However, for the newly graduating doctors, obligatory duty in Anatolian provinces and specialization processes in Europe meant two contrasting experiences in terms of professional opportunities and living conditions. Obligatory duty consisted of a constant struggle with scarce medical resources and large numbers of patients with severe health conditions, whereas specialization in Europe meant that the doctors acquired valued medical knowledge which brought them an advantageous position among the Turkish doctors on their return. This contrast damaged the professional solidarity and communitarian aspects amongst doctors by arousing feelings of jealousy and injustice. The feeling of injustice was directed to the "corrupted" policies of the ministry of health in particular and to state politics in general, since the decisions about professional careers of graduates were determined by them. Hence, besides undermining the relations within the professional group of doctors, the

variation in career paths also affected negatively the otherwise harmonious relations between the government and doctors (öncel, 1951).

Female Doctors and their Pioneering Role in the Health Sector: Another interesting factor about the large-scale preventive medical projects of the 1930's and 1940's was that they were mostly planned and carried out by female doctors who were also parliament members at that time. They had a pioneering position both in terms of being among the first parliamentary members and women doctors. Both of these roles made them "powerful examples" of Kemalist modernist principles which they both represented and acted accordingly with a social mission of transforming the society in line with scientific and progressive thinking. In fact the concept of a Turkish "female doctor" is a product of the Turkish Republic, since woman were allowed to study in the civil medical school first in 1924, although they had several unsuccessful attempts before that time. Abdülhamit gave a permission for women to study medicine forthe first time, but this permission was rescinded a few years later (Tümerdem, 1996). The Kemalist view stressed that Turkish women have to be fully present in the public sphere, and that women are able and should do all of the jobs and tasks that men do. Therefore, the women who preferred a profession which was not open to them before and which was highly valued by Kemalism, were more than welcome by the first governments. The first women who graduated successfully from the medical school, were invited by Atatürk himself to the general elections.

Among these parliament members, Dr. Fatma Memik devoted her political career to drafting legislation for the struggle against malaria,

which included drying up marshlands, building high walls on the banks of major rivers to prevent floods, and providing clean water to drink. Dr. Makbule Dıblan was involved in a similar struggle against tuberculosis and for this purpose she founded a large-scale efficient organization which still functions today (*Verem Savaş Derneği* - The Association for the Struggle Against Tuberculosis). She worked actively until the 1970's for the prevention of tuberculosis and intestinal parasites, pioneered the foundation of modern tuberculosis clinics with X-ray machines all around the Black Sea Region, and followed the intensity and development of the disease in that region. She stressed the social aspects of tuberculosis and worked for implementation of the social and economic measures against this disease, such as providing cheap houses, adequate and nutircious diets, and building of railways in order to rapidly transport the people who are ill. Besides these activities, she was also a powerful representative of the women's rights. She was among the founders of the League of Turkish Women and participated the World Congress of Women where she gave several talks about the social conditions under which Turkish women lived. Another socially and politically active parliament member was Dr. Saade Emin Kaatçılar. Although she was a parliament member for only a short period of time (1943-1946), she worked for the institutionalization of a public insurance system for workers, since worker's health was the main concern in her activities. Previously, the insurance sector was in the hands of private foreign based companies, the customers of which were mostly businessmen and other people of high socio-economic status (Gündüz, 1998).

Despite the contributions of female doctors to improvement of health in Turkey, they experienced problems particularly when they entered medical school for the first time. In this profession which was totally male dominated, there was a prevalent male culture with strong stereotypes against women such as women, are weak and fragile people who could not endure the difficulties of medical education. One of the first well-known female doctors, Yıldız Tümerdem (1996) mentioned in her talk in a conference, how male medical students felt uncomfortable in studying with "hardworking and brilliant" female students and the jokes they played in order to make them leave medical school, such as secretly putting some parts, such as the ears of cadavers, in the pockets of their uniforms. Tümerdem said that these stereotypes and jokes only increased their strength and determination to become good doctors. Hence, the difficulties of being pioneers within a professional group which had a highly established cultural and social order, and the responsibilities of being one of the major representatives of the Kemalist principles were important incentives for women doctors to work hard to accomplish their social mission of serving the new country.

The "1933 Reformation" and the Reactions: Despite the positive developments in the health sector and other fields, political struggles and oppositional cliques began to occur both within the parliament and government. Due to the single-party system where the only party, Republican People's Party (RPP) , had the ultimate power, these struggles were interfering with the implementation of reform projects. The groups in opposition argued that the members of RPP abused its power in the

appointment of high-ranking state employees and in oppressing the opposition's movements. In 1933, these arguments reached their peak and created a turbulence in the attempt to improve university education in the only university which existed at that time, *Darülfünun*.

In the 1920's and 1930's, projects about reform in education were planned and some of them were realized at all levels of education. However, Tunçay and özen (1984), who discuss the characteristics of the 1933 reformation and the debates around it, stress that university education in *Darülfünun* was particularly criticized in terms of the low quality of education, low level of published academic works, low level of students who knew foreign languages, and their lack of opportunity to apply what they had learned in the university due to the poor conditions of laboratories. Some of the professors' credentials and ability to teach were questioned as they represented the older educational system. Besides, some of the professors, particularly in the literature department, were actively involved in the political debates, and were considered as threats to RPP politics. Some people in the academic circles believed that university reform would be carried out in order to eliminate this opposition and turn the university into "an organ of their government" by replacing the potentially dangerous professors" with "their own people" . The critiques increased after Dr. Refik Saydam took charge of the university reform. He was the minister of education and a person who was criticized both within and outside the RPP because of his strategies which were considered as too selfish and ambitious at that period. Saydam who had been politically active since CUP later disagreed with the politics of this party and became their major opponent in the Republican period.

Besides Refik Saydam's control, another controversial issue was that the reformation would be conducted according to a report prepared by a Swiss doctor, Mr. Malche who planned to replace the professors who had been taught under the Ottoman educational system by Jewish origined German professors who had to escape from their countries. Dr. Malche was a member of a European organization who saved Jewish professors and placed them in other countries. The high level of involvement of foreign opinion and expertise in this project brought reactions from nationalist students and professors, especially in the medical school which had been one of the most important cradles of Turkish nationalism since the 19th century. They argued that a foreign professor like Dr. Malche cannot fully understand the Turkish educational system and values, and the professors he brought to Turkey would first think about their own benefits rather than serving this country. In addition to the nationalist concerns, the objection to the project was particularly strong in the medical school , because it was one of the main targets of this reformation; highly skilful and prestigious Jewish doctors came to the school to replace 18 professors who were requested to leave their job. Some of these professors, such as Tevfik Sağlam, who held a high academic and professional standing and were greatly respected by the students and other members of the medical school.

Dr. Ekrem Kadri Unat who was a student with nationalistic concerns, at the school at that time, told about how they distrusted these German doctors and organized among themselves in order to boycott classes until their "real" professors returned (1996). However, the distrust was not shared by all of the doctors and medical students, such as in the

case of Dr. Burhan öncel (1951) who hoped that scientific concerns as opposed to political interests would at last dominate in the medical school. These hopes led him to work with the German origined professors in the medical school but he soon realized that most of these professors could not prevent the administrative corruptions in the medical schools and hospitals; their main responsibility was academic and they did not know enough to understand the administrative processes. Dr. Manizade (1976) in his memoirs, claims that these doctors could not change "the oriental mind" that was dominant in the administration of the medical school. Some of these German doctors stayed after the Second World War, even until the 1960's and 1970's and their valuable contributions to the medical sciences were highly appreciated by the Turkish doctors (Unat, 1989), (Minkari, 1993) .

Despite Refik Saydam's claims of creating a totally new institution, the "33 Reformation", could not be completed due to his early death after a sea accident. (G.A.,1986). The professors, such as Tevfik Sağlam who were highly respected by the students, were re-appointed to their positions. Especially in the medical school, this increased the number of teachers, specializations, but also created sometimes conflicts between older and new medical knowledge and teaching methods, and problems in dividing sections where some medical subjects overlapped (Unat, 1996). Another change which was brought by the 1933 reformation is that the name of the university, *Darülfünun* , was considered as an old Turkish word left over from the older Ottoman educational system and which did not fit with Kemalist innovations in the Turkish language and education, therefore, it was changed to Istanbul University.

In 1934, after several complaints from students and professors in the medical school, about its location in Haydarpaşa which was away from the main urban areas of Istanbul, several clinics where the research and applied medicine were conducted, were moved to Cerrahpaşa. This started a gradual process which had been completed in the 1960's when all the educational sections had been moved to Cerrahpaşa. Cerrahpaşa gradually became a compact medical center where the members had the opportunity to conduct and benefit from both theoretical and practical medical education and research. The opportunity to work in the hospitals and clinics while studying medicine increased, since there were a lot of small hospitals and clinics in the district around the Cerrahpaşa hospital. Moreover, the medical school re-built close ties with city life and the social and political movements within the city (Unat, 1989).

Structural Developments in the Health Sector: The 1940's and 1950's were the decades of structural changes. The projects of preventive medicine were gradually abandoned and and law of rotation was abolished. This was partly due to the mass mobilization of the army for Second World War, when many doctors joined military camps as army doctors. Another reason for this abolition can be related to Starr's (1982) argument on the large-scale public health projects, which were almost always against the interests of private companies and organizations, since the state spends a large sum of money for these projects instead of companies benefiting. Hence, according to him, when the state's policy was to support and develop the private sector public health projects diminished and this is also valid for the Turkish case in the 1950's and 1980's onwards. Interference of the

government in the values and regulations around which university education had been shaped were criticized and debated a lot in the academia, especially among the professors of the medical school after the "corruption stories" of the appointments of newly graduating doctors and the unsuccessful 1933 Reformation project. In 1946, these criticisms led to the legislation of the "autonomy law" which restricted government's intervention into university education. However, this law was not considered enough to ensure a pure autonomy for the universities, it was criticized and had to be reshaped at different times in forthcoming decades. Yet, the increasing number and capacity of hospitals, clinics and the medical schools had brought the need for an efficient central regulatory system which would also be in charge of the implementation of preventive medical projects and health security system throughout the country. The Ministry of Health and Social Aid was reorganized for these purposes and its working system and responsibilities remained almost unchanged until 1984.

Another institution, *Türk Tıp Kurumu* (Turkish Medical Institution) was founded in 1940 for the purpose of providing solidarity among doctors and supporting them through their careers by playing effective roles in their appointments. Unlike the type of institutions which existed in the Ottoman era, this was a large- scale institution with a large number of participants, most of whom had close connections with the administrative body of Istanbul University, the Ministry of Health and the government (Gökçay, 1998), (G.A., 1986).

The existing inequalities between Istanbul and other parts of Turkey in terms of access to the medical facilities were considered more critically

than in the Ottoman era because of the project of creating a new country with a young and healthy population in all parts of Turkey. Special importance to Anatolia which was considered neglected during the Ottoman time and, to Ankara, since it was the new capital and an Anatolian city. With these concerns, the University of Ankara was established in the middle of 1930's right after the 1933 reformation. The faculty of medicine was formed in 1945, and it became a part of the university in 1946. At that time, the military medical school which moved to Ankara together with other main army institutions, took the name of "*Gülhane Askeri Tıp Akademisi*" (GATA) in 1952. The military medical school became closely connected with other military institutions in Ankara, and it was differentiated from the other medical schools in terms of professional procedures, perspective and experience. These late 1940's and early 1950's projects of improvements in the infrastructure of the health sector also included the major hospitals in Istanbul such as Cerrahpaşa, Çapa and Haseki which were enlarged and modernized at that time (G.A., 1986).

In the 1950's, after the transition to the multi-party system and the election of the Democratic Party (DP), private sector was encouraged and large number of doctors became self employed or open small-scale, specialized private clinics where 5-10 doctors and nurses worked together. The private medical sector was concentrated in the large cities, and its share in the whole health sector, including the hospitals which are run by foreign groups and minorities, did not increase beyond one-fifth until the 1980's. (TTB, 1965), (Ministry of Health, 1973).

The growing health sector required standard regulations which would systematize the appointments of the newly graduating doctors and provide a balanced distribution of health care facilities throughout the country. Such regulation would also prevent the problems and criticisms about the injustices in the appointments and the inequality in the distribution of health care. Having these considerations in mind, in 1950, the doctors were divided as general practitioners and specialists, and standard criteria to become a specialist was defined by a regulation. According to this regulation, newly graduated practitioners should work for two to five years in the hospital section in which they wanted to specialize, depending on the specialization field, and with the consent of their superior colleagues. This regulation functioned similarly to the law of rotation since most of the practitioners went to the newly built or modernized Anatolian clinics and hospitals. (Konuralp, 1996), (TTB, 1965).

Health Plans and the Law of Socialization: Despite these regulations, problems in the Turkish health sector resisted. The urgent demand for more health care facilities and for public health projects in Anatolia, brought the need for an overall health plan which would give priority to the provincial places in Turkey. Before the 1960's, two different plans were made with these concerns. Their aim was to build clinics in the villages which would be responsible for primary health care, such as vaccinations, emergencies and births. However, these plans were unsuccessful because of the reluctance on the side of doctors to work in provincial places and thus the scarcity of health personnel in these places.

A larger scale and more carefully organized health plan which would be implemented step by step within a period of time was designed in 1961 by Nusret Fişek, the undersecretary of the Ministry of Health. This plan was different from the two previous attempts not only in terms of scale and organization, but also in terms of social considerations. The difference in the social perspective of the last plan was mostly related to the environment prevailing after the military coup of 1960. Most of the intellectuals and university students acted together with the army to overthrow the Democratic Party which they considered responsible for the political problems and economic inequalities in society. The new government and the constitution followed more closely the Kemalist principles and projects which had been formulated in the 1930's, but now acquired a more leftist and populist tone.

Most of the doctors supported the new government and constitution, and again played an active political role in the implementation of the new laws both within and outside of the parliament. In this framework, the 1961 socialization law, was based on the criticisms of the policies of the 1950's when the application of the public health measures which were started in the 1930's diminished. Therefore, the aim to fight epidemic diseases such as malaria, syphilis and tuberculosis lost its momentum in the 1950's, and the rates of these diseases and the number of deaths as a result of these disease remained at high levels. Another important international criteria for level of health in a country, the infant and maternal mortalities, were also at high levels in the villages (TTB, 1973). The socialization law gave a priority to the most disadvantaged parts in terms of access to the health care facilities based on the idea that the main

duty of the state was to provide a health service to all its citizens, including the ones who live in the most remote village of the country. The provinces were given a priority in this health plan, since the most disadvantaged people were thought to live there, and their population was considerably higher than the urban population. According to the plan, several provinces would be covered by the law each year. The provinces which would be covered in the first three years (1963-1966) were socially and economically the most backward places which are situated in East and South-East Turkey. These provinces would serve as "pilot provinces" in terms of testing the success of the plan for the decisions over its continuation. The plan consisted of opening health facilities of varying sizes from those serving a group of village to those in the province centres with referals up through the system. The personnel in the health centers had to follow up the general health condition of the population in which they were responsible for. They had to provide primary health care and send the patient to a higher level facility when necessary. The socialization plan included opening and improvements in existing hospitals in these provinces and professional schools which trained supporting para-medical personnel.

After 1965, the socialization plan began to lose its momentum due to the problems of administration and coordination, the lack of standardization in the payments of the health centers' personal and other health employees and the social and economic unattractiveness of pilot provinces for the doctors who were mostly raised and educated in big cities. However, in the late 1960's two important dimensions were added to the concerns of the socialization process. First of all, considering the poor

social and health condition in the squatter areas expanding in the outskirts of the three main cities, Ankara, Izmir and Istanbul, health centers which functioned in a similar way to the ones in the pilot provinces were opened. These centers also provided internship opportunities for the medical students who were in their final year. The second concern was demographic. A general consensus was reached among the members of the health sector that an increase of the population should be controlled in order not only to reach a better health status by decreasing mother and infant mortality rates and by preventing the spread of epidemic diseases, but also to ensure social and economic development which would bring a better quality of life. With these concerns, particular attention was paid to the health conditions of infants, children and mothers and family planning in the new health centers and hospitals. Clinics which dealt with the regular check-ups for the infants and children were opened in the university hospitals and major health centers.

The major reasoning behind these preventive measures was that the families would spend much more effort to maintain their children's general health condition with regular vaccinations and tests against diseases and other malfunctions so that they would acquire the idea that having fewer children meant providing better living conditions for them. These conditions not only included health but also education, job opportunities and other economic benefits. Promoting these ideas were especially important for the squatter areas and villages which had poor living conditions in terms of access to the social and economic benefits. The hospitals in the cities and the health centers in the villages and provincial places began to educate women on the issue of family planning

and implement birth control methods, particularly IUD since it was seen as the least risky method (Ministry of Health, 1973).

The Ideological and Professional Differences in the Medical Projects of the 1930's and 1960's: Doctors such as İrfan Gökçay (1996) and Yıldız Tümerdem (1996), who are interested in the history of modern Turkish medicine tend to compare the 1960's with the 1930's. In these decades, the governments carried out large-scale preventive medical projects which gave doctors an opportunity to interact with different groups in society, and a professional base to act according to their political and social concerns while pursuing their profession in various parts of the country.

In the 1960's, most of the doctors who were still under the influence of the Kemalist principles and who believed in the usefulness of the 1930's projects, supported and cooperated with the socialization initiative. Social concerns were embedded in this medical project, since it concentrated on villages and squatter areas with the mission of improving the poor living conditions and transforming the traditional life styles into a medically "healthy" life, and it promoted an ideal healthy family type where the parents would use family planning to create modern, small and nuclear families suited to modern society. Despite the similarity in the basic aim of improving the general living conditions of society with a medical, scientific and Western view which was in accordance with the professional perspective of the Turkish doctors, the medical projects of the 1930's and 1960's were quite different from each other.

The medical projects of the 1930's, such as the rotational law and "1933 Reformation"project were mostly planned by the parliamentary

members who were well-known doctors, respected as influential political figures. However, the students and professors in the faculty of medicine in the Istanbul University, which was the only civilan medical school at that time, did not fully cooperate with these projects which required radical changes in the system of medical education and professional experiences of doctors, such as the changes in the course schedule, replacement of professors and two years of obligatory duty in a remote village . The lack of full cooperation on the side of medical students and their professors led to the inefficiencies in the implementation of these projects. In contrast, 1961's socialization law was developed and implemented with the close cooperation and guidance of the professors of the faculties of medicine, particularly the faculties of medicine at Çapa and Hacettepe.

Secondly, although these university members seemed to work in close collaboration with the state organs in the 1960's, strong political movements which had an oppositional character began to shape in the faculties and affect the professional perspective of the medical students and doctors. Similar to the 19th century's political atmosphere which helped to build the "spirit of being from the medical school", in most of the 1960's political movements instigated by university members especially students of medical faculties played an active role. The movements of university students began as mass protests against the educational system and the medical students were one of the groups who complained the most. They protested against specific educational processes, such as the large number of exams and the long course hours. (Gökçay, 1998), (Türker, 1998). Dr. Gülçin Türker (1998), who is now a professor and former department head in the faculty of medicine at Çapa, gave a detailed account of these protests

while talking to me and told that she also had an active role in them. According to her, the medical students protested in a more organized way and acted with a particular solidarity since they were aware that all of them were sharing the same troubles during their education.

The Politicization in the Health Sector: Dr. Türker observes that the students movements became more political in the 1970's, under the effect of political debates and conflicts that dominated the social situation in Turkey. The youth began to organize according to different political ideologies, differentiated as mainly leftists and rightists. According to Dr. Türker, the medical students and doctors were well acquainted with the problems of their society and learned to approach these problems "humanistically" through their immediate interaction with their patients. Additionnaly, their exposure to the most "underdeveloped parts" of Turkey after 1960, helped transform their humanistic approach into leftist political views which dominated the faculties of medicine. The members of the faculties of medicine who usually shared similar political interests, also began to divide among themselves into different fractions within the leftist ideology such as Lenninists, Maoists. Another explanation about the leftist political tendency of members of medical faculty came from Dr. Irfan Gökçay (1996) who argued while talking to me, that the scientific, positivistic and progressive values embedded in medical education, makes them more prone to leftist ideologies which are compatible with these values.

Besides the different political groups in the faculties of medicine, the chambers of medicine which developed out of the Turkish Medical

Association, became institutions around which political activities were organized. The number of members increased considerably and their political profile represented the ideological variety in the faculties of Medicine. The elections to boards of these chambers became a competition among different political groups. These organizations although they claimed to include different ideological groups, tended to act according to the political tendency of the members of their boards. These chambers also cooperated with other professional chambers and groups such as the engineers' chambers and worker's unions to organize large-scale mass protests. According to Dr. Gökçay (1996), (1998), who was an active member and former director of the Istanbul Chamber of Medicine in the 1970's and 1980's respectively, in line with the general politicization in Turkish society in the late 1960's and 1970's, the chambers of medicine developed a more sharply political discourse which was not limited to the problems and the inequalities in the health sector.

The Political Activities of the Professional Chambers: Another political development of the late 1960's and 1970's which affected the health sector was also related to the increasing power of the chambers of medicine. The fact that they were in close contact with the political groups in the cities and the loss of momentum in implementing the socialization law in the villages led them to direct their social and political concerns to the most disadvantaged groups among the urban dwellers. These groups were workers and the dwellers of the squatter areas. Although most of the factory workers had health insurance since the foundation of the "Institution of Social Security" (SSK) in 1965, its hospitals and other health

facilities were not adequately organized in order to give health service to such a large number of patients. In addition, the laws and regulations governing the work process, were far from being favourable for the worker's health both in the public and private sector. The workers who became ill or pregnant women could only take short leaves of absence, only one month in the case of pregnant women, and after the long bureaucratic process of obtaining a medical report from an SSK hospital. The criticisms of the chambers were not restricted to the health system, they were also blaming the government's general policies for creating strong inequalities in other areas such as education and work life (Gökçay, 1996), (Gökçay,1998).

While being involved in the oppositional movements, the doctors also had considerable importance in the government. Sadi Irmak, who was a physiologist, a parliament member and a strong supporter of Kemalist ideals, was called by the president, to become prime minister and form a cabinet in order to avoid further political crisis in 1974 (Terzioğlu, 1991-2). This period was similar to the period between 1850 and 1900, when the Ottoman doctors were involved in the Turkish nationalist movement through their activities of creating "a modern Turkish medicine", in terms of using medical or health issues in making political arguments and being politically active. However, in 1970 the doctors and medical students were a much larger, highly institutionalized and established professional group which could be organized better around social and political problems. Besides being from the well-educated, upper socio-economic status group, these doctors, especially the older ones who began their career in the first decades of the Turkish Republic, had gained considerable social prestige

because of their being representatives of Kemalist principles and projects through their careers and professional perspective. In general terms, the support and prestige they had received from the society together with their ability to organize, led them to have a privileged position among the leftist groups and a leading role in the political debates and activities of the 1970's similar to the period of 1850-1900.

Political Tensions and Depolitization in the 1980's: In 1980, the conflictual but lively political situation in Turkey changed dramatically with the military intervention which brought an oppressive regime. The political activities of parties and organizations including the professional chambers were stopped by decree. The leaders and the leading members of these organizations were jailed and most of the rights which had allowed the development of political organizations in the 1960's and 1970's were abolished. A period of strict censorship began, where the development of any kind of oppositional thought and movement is not allowed.

The new regime tried to justify itself through condemning the politically active groups of the last two decades and stressing its efficiency in terminating a politically tumultuous period. The president of the military regime criticized the leftist groups, and among them he blamed particularly the doctors by saying that they did not possess any "love for their nation". He said that the doctors were raised and educated in the best way with all kinds of opportunities that were provided by the state, but they did not appreciate this generosity, instead they criticized the government severely and organized themselves in order to bring about anarchy and destruction (Arıoğlu, 1996), (Gökçay, 1998).

The doctors who could not politically organize themselves again until the mid 1980's, displayed their reaction to the military regime by individual acts of protest. There were allegations about systematic torturing of political prisoners and suspicious deaths in the police centers fueled these allegations. Although the allegations were denied by the military rule, many doctors refused to cooperate with the new regime by not giving false reports on the health condition of prisoners, particularly in the case of autopsies, which showed the effects of a systematic torture on the bodies in detail. Only, some of these reports and stories were published in the newspapers because of censorship and the doctors who prepared the reports were "exiled" to the small villages of Anatolia. Dr. Altay Martı who gives examples of these events in his memoirs, tells that these were the first reactions against the oppressive regime, and they increased the tension between the rulers and doctors (Martı,1995), (Martı, 1997).

The New Law of Rotation: In 1983, the political tension between the two groups had reached its peak when the president and other generals in the ruling group issued a new law of "obligatory duty" similar to the former law of rotation which required that the graduates of the faculties of medicine work two years in disadvantaged places, away from the major cities. The president explained the reasoning behind this law by saying that the doctors just like the soldiers should know all the truths about their own country and learn to love these truths. However the law was considered as a punishment by doctors since after a long and difficult period of university education, they were sent to places which had scarce resources concerning health and living conditions. Most of the health

centers in towns and villages had been built in the early 1960's and had not been improved since then. The doctors who went to the East and South-East of Turkey, witnessed the increase of terror that was born out of ethnic, political and territorial conflicts through "endless cases of autopsies", particularly in the last half of the 1980's. Similar to the first implementation of the law of rotation in the 1930's, the rumours of political and professional corruption in the "lottery" by which places of appointments were selected surfaced (Sahip, 1996) (Martı, 1995).

When censorship decreased after 1984, the doctors narrated their experiences in this type in press. The negative experiences during the obligatory duty and political tensions between the doctors and the government began to affect society's view of doctors in the sense that being a doctor came to mean struggling with social and political problems of the country during and after medical education besides coping with the academic difficulties of long and hard time of study. The faculties of medicine, similar to the professional organizations of doctors, were represented as one of the main centers of political conflicts and confrontations both by the press and the ruler's discourse. This was also another reason for avoiding the faculties of medicine just like other faculties where the members were actively involved in political activities.

The Loss of Prestige and Decline of the Educational Quality in the Faculties of Medicine: The government's harsh oppression of political activities and its promotion of depolitization affected the general social perspective on politics and political ideologies. Political and social concerns relinquished their places to the economic and individual worries. The

government began to implement a policy of economic development and privatisation as solutions to the political problems of Turkey. The efforts to revitalize and internationalize the economy increased the prestige of professions related to economy and management and after 1985 the administrative and engineering faculties began to be preferred more than the faculties of medicine (Sahip, 1996) (Arıoğlu, 1996).

The faculties of medicine have also changed shape as a result of new politics. Government started a rather unplanned process of expansion in the health sector where several hospitals and four new faculties of medicine were opened in different cities, and the student capacity of the old faculties were more than doubled. The infrastructure of these new faculties and hospitals were not fully considered and the efforts of doctors and professors to improve them could not be realized because of the financial difficulties since the share of health sector in the budget dropped considerably after the 1980's. This led to a visible decline in the quality of medical education and health services in the public sector (Gökçay, 1998), (DPT, 1989).

When becoming a doctor was preferred less as a career choice in society, the points that the students should have in the central university examination in order to enter to the faculties of medicine started to decline, and entrance to these faculties required much less competition than entrance to the faculties of engineering and administrative departments. In line with the economic considerations, the last group of faculties were also preferred since they required a shorter and easier study period than medicine and they allowed an earlier work experience. Hence, more and more high-school graduates who were from the high-socio-economic status

background and who went to private, foreign origined high-schools, preferred departments of management, economy and various departments in the engineering faculty instead of the faculty of medicine which had been a prevalent choice among this group before that time.

The Heterogenization of the Medical Students and Variations in the Career Patterns: Since this situation happened at the same time as the large increase in the number of faculties of medicine and medical students, the increasing student capacity was gradually filled by people coming from lower socio-economic backgrounds and who lived outside the three major cities until university or high school. They preferred this faculty since they considered they would have a good job when they graduated and could improve the economic condition of their family. Medical students became much more heterogeneous in terms of background and less politicized since the new group of students' was interested mainly in graduating as soon as possible and with the highest grades so that they could get a well paid job (Gökçay, 1998) (Genç, 1997).

Since the significance of having a medical education in terms of social stratification, changed from an elite recycle to the chance of upward mobility, the career patterns of the newly graduating medical students also began to vary. Academic career, although it became more competitive due to the increasing number of students, was preferred less because of the poor conditions in the universities and their hospitals since the government allocated very little to the health sector. The government promoted private clinics and hospitals which became highly prevalent in the 1980's and onwards. Working in a private hospital which is economically less risky

than opening one's own clinic became a more preferred career path for the new graduates. The private sector also brought new economic opportunities for the doctors such as working in the research and marketing sections of the large-scale foreign based drug companies. Besides working in the private sector, as a reaction to worsening the conditions in the faculties and hospitals in 1980's and 1990's, many people left medicine or did other "paramedical" jobs after their education, which varied from opening money exchange offices to directing movies. Although the number of doctors working in the private sector or doing paramedical jobs became common practice, it was not compatible with the altruistic values that the doctors attributed to their profession before and during medical education. Besides, the radical depolitization among the medical students and doctors, brought "generational conflicts" between the earlier generations of the Republic whose professional perspective was shaped much more by a social mission and the more recent individualistic and materialistic generation.

The Professional Solidarity and Increasing Competition: The professional solidarity and the sense of being a part of the corporate professional body were also undermined in the recent generation of doctors who came from highly different backgrounds. Because of the overcrowding of the medical students, they were involved in a much more competitive educational process in order to specialize in a medical field or to obtain an academic promotion. In 1984, a central examination was instituted for the final year medical students who planned to specialize in a field instead of staying as practitioners, under the name of TUS, meaning "the

examination of specialization in medicine". Before the examinations,the students listed the field they wanted to specialize in and the hospitals in which they would train as assistants during this specialization period according to the scores that those hospitals and their specialization clinics required. The listing was also crucial in the choice of academic career since the university hospitals had higher points and the specialization in those hospitals also required a research thesis.

Over the years passing the TUS examination became more difficult and staying as a practitioner became less advantageous. Although the practitioner's job was considered as one of the heaviest, since they had to work mostly in the emergency sections of the clinics and had to know all of the medical practices that were required in the primary medical care, they were paid much less than the specialized doctors. Another disadvantage of staying as practitioner was working for two years outside major cities as required by the law of obligatory duty which had lost its "punitive character" and only included practitioners after 1985. Besides the reaction of medical students to the difficulty of TUS which required a heavy study period dominating their last year when they should be improving their medical practice. The TUS examination which was becoming more difficult each year, resulted in an increasingly large number of graduates remaining as practitioners who either would have less preferable jobs in the health sector or must study for the next examination. Hence, graduating from the faculty of medicine did not mean a desirable and guaranteed job, since the jobs for practitioners were limited and unsatisfying for professional development and economic benefits.

The reaction against the TUS examination was further increased in 1989, when the Ministry of Health made an agreement with the foreign universities mostly in the countries of the former Soviet Union and Eastern European bloc, to send its graduating medical students to these countries for their specialization period without the TUS examination. Although this agreement was implemented for only few years, the doctors who took the TUS examinations criticized the ones who had specialized abroad, since they had used their monetary advantage in order to study less, did not gain adequate professional experience in the foreign countries and were unfairly favored by the state in their appointments to the hospitals when they returned. The agreement was regarded as a pity by many Turkish doctors who thought that it was taken by the parliament members to favor their own family members studying medicine at that time (Uslu, 1996), (Gökçay, 1998).

The administrators of the well-established faculties of medicine, such as Cerrahpaşa and Hacettepe began to be concerned about the ways of improving medical education in order to attract higher quality students and to be recognized in the international academia. With these concerns, those faculties opened a new section where medical education was in English and this aroused a lot of reaction both from the nationalists and intellectuals who came from the leftist tradition. Nationalists such as Dr. Ekrem Kadri Unat (1989) recalled the efforts of the last century to change the language of instruction from French to Turkish in the medical schools and argued that that process of nationalization which had been accomplished under many difficulties had now reversed. Another group criticized the application from a populist point of view, saying that once the

students pursued medical education in English, they could not communicate properly with their patients and, therefore, became isolated from them and from the whole of society. Despite these debates which continued for a long time, the application became successful as these new sections attracted a lot of good-quality students who had learned a foreign language usually in private high schools and who had much higher scores in the central university examination than the students of the Turkish section. However, this stregthened divisions among medical students in terms of their different socio-economic backgrounds, and by affecting their chances of finding a good job in private or other well-known established hospitals. The economic situation of doctors became similar to Starr's (1982) depiction, since doctors came to have varying socio-economic status both in terms of their familial background and the benefits of their careers. In addition, the heterogeneity in the job choices in terms of economic, academic and professional benefits also increased the competition among the doctors who depended more and more on the market and the demands from the private section of the health sector. This affected negatively the solidarity among doctors and their social and cultural authority by making them more dependent on the market. The social image of doctors as a united and powerful group with an influential social mission was undermined.

Another controversial act of legislation in the health sector occurred in 1992. This was the implementation of the "green card", a card for people who were too poor to afford the health services and did not have any health insurance. However, the criteria to obtain the card were not clearly defined and it was distributed to gain political favor by the party in power.

Dr. Türker (1997) notes that many of her patients with the green card did not deserve it in terms of economic status, and doctors joked among themselves that even patients who came to the hospital with their own cars and who used mobile phones had that green card.

The Activities of Professional Chambers: The professional perspective of the earlier generations of doctors was now represented in the chambers of medicine which were opened again and became politically active in the mid-1980's. Although these chambers did not have the same political power as in the 1970's to mobilize the masses, they also organized the first large-scale protests after the military regime. They protested against the government's financial neglect of state institutions in the health sector and government's intervention in the cadres of the faculties and hospitals. The members of these chambers were concerned about the increasing share of the private sector in health, thinking that it had been done in an unplanned way without considering the situation of the economically disadvantaged patients, and it was leading to commercialization of issues of health which should be one of the basic human rights provided by the state.

The professional chambers were also concerned about the newly emerging heterogeneity among the doctors both in terms of background and professional perspective. They tried to rebuild a sense of political opposition and professional solidarity among the doctors and to revitalize a sense of social mission. With these concerns, several chambers prepared studies and organized conferences on Turkish medical history, where they tried to revitalize the "spirit of being from the medical school" and talked

about the 1930's and 1960's as "golden ages" when governments gave priority to the public health activities and preventive medical projects. They also stressed the Kemalist nationalistic concerns, especially when they criticized the prime minister, Turgut Özal who went to the US for his medical operations and contrasted this behaviour with those of Atatürk. For them, Atatürk had undertaken a large number of medical projects in order to improve the Turkish health sector and general health conditions, whereas Özal accepted the superiority of the United States and did nothing significant to improve the health sector in Turkey.

Another concern of the medical chambers was to define standardize rules and regulations in order to provide similar quality of care in the medical services in different institutions of the health sector. In the last two decades, the crucial problems in hospitals such as overcrowding and malpractices of doctors began to be covered frequently in the Turkish media, and this caused loss of prestige and trust in doctors in the eyes of patients. The chambers are concerned about such news and stress that the state should design a systematic plan in order to improve the health sector instead of leaving it to the commercial private hands. These chambers are also interested in attracting the doctors who work in the private sector as members, and to include them in their activities "in order for them not to forget the basic humanistic principles of this profession" (Gökçay, 1996). However, most of the younger doctors do not participate in the activities of the chambers and come only to participate in the elections to support their candidate. Most of them are critical of their politics and think that they are inefficient in protecting doctors' interests and affecting state politics (Gökçay, 1996) (Arıoğlu, 1996).

The Effects of the Rising Islamic View on the Health Sector: The rise of Islamic ideology and movement at the end of the 1980's contributed to the heterogenization within the health sector. The faculties of medicine which had excluded religious thinking since the early 19th century where the first medical school had been founded, became one of the main secular castles that should be conquered by the students who adopted Islamic thinking. The first groups of medical students who adopted Islamic view were faced with a strong negative reaction from the university administration and their teachers. The Islamic view of these students were usually identified through their veils in the case of women, and type of beard in the case of men. Some of the teachers and administrators who were against their ideology, tried to prevent their attendance at the faculty and the examinations that were held there. The number of medical students with an Islamic view has increased in the 1990's and the boundaries of their ideology were clarified. Most of these students had a background of religious education and tried to combine their religious knowledge with what they had learned in the faculty. They accepted the prevalent medical knowledge and practice as long as they were compatible with their faith, such as claiming that a veiled female doctor did not prevent her performance in her profession. Despite their compromisation with the Western origined biomedicine, they were not accepted by the academia who had a strict professional ideology and perspective and by the administrators of the main hospitals when they had graduated.

The Islamicist medical students may pursue their profession mainly in the hospitals which were recently established by various economic and

social organizations and which and gave a priority to Islamicist doctors in chosing their staff. These hospitals functioned in accordance with Islamic rules and were mostly built near the neighbourhoods such as Fatih and Üsküdar where mostly Islamicists lived and where there were very few health centers and hospitals. Their gynaecology and child's clinic were especially developed since the female Islamicist patients, including the pregnant women and mothers, preferred to be taken care of by female doctors during the examinations and operations.

Together with the increasing numbers of that type of hospital, some Islamicists tried to revise the medical knowledge and theory in order to incorporate into it the religious sources' view of medicine. Having a religious perspective, they were concerned about bringing a humanitarian and ethical aspect to the medical knowledge and practice, since they claimed that modern sciences have become increasingly devoid of these aspects. Some of them pointed out to the parallels between the Islamic rules on medicine and the contemporary medical knowledge and argued that these rules are still valid in dealing with health problems. In contrast to other doctor's from the previous generations, who wanted to transform the lives and thoughts of the people according their own scientific values, the Islamicist doctors considered themselves as representing the views and needs of a particular social group whose voice has been heard more and more in the 1990's. Although the introduction of the Islamicist beliefs and practices into the health sector is relatively a new factor, it has aroused a lot of debates and reaction from other doctors since it was considered as shaking the ideological foundations of their secular professional perspective.

Conclusion: The social and political movements and debates in the Ottoman State and Turkey for the last two centuries have been highly influential in shaping the institutionalization process of the health sector and the professional perspective of Turkish doctors. The debates and dilemmas which ocurred during the modernization process of Turkey found their immediate counterparts in the doctors' social concerns about having the role of a guide or teacher in helping the Turkish society to adopt a secular, scientific and progressivistic perspective. This perspective is originally a product of Western thinking, particularly of Enlightenment. The doctors adopted this perspective earlier and more readily than other intellectual groups, because of their familial background which could be characterized with high socio-economic status and Western values, as well as their medical education where the major aspects of Western culture was also taught. One of these aspects was the idea of nationalism which led the efforts of the doctors towards the nationalization of medicine. The nationalistic ideas of doctors led them to have a pioneering role in such movements which supported political modernization and which drew the Sultans' reactions. Hence, questioning of and opposition the existing social and political situation became an essential part of the professional perspective of doctors during that period.

However, the professional perspective of doctors involved a mission of transforming society according to the values they represented and supported, combined with the Kemalist principles and projects after 1923. The doctors' high degree of involvement in shaping and implementing the state's projects and ideology during the first decades of republic were

overshadowed by the politically corrupted interventions by the state in the professional appointments and attempts at the reform in the university. The relations between the state and doctors involved more tensions when the doctors became more active in political terms in the 1960's and 1970's when the debates about educational and political autonomy in the faculties of medicine and hospitals were still going on. The socialization period of the 1960's and politicization in the 1970's brought an additional dimension to the social mission of doctors such as focusing on the health and living conditions of the most disadvantaged groups in the society, a systematical implementation of preventive medical services and issues on family planning and birth control.

These developments were abruptly cut with the 1980's military intervention which led to a period where the political and social concerns about society in general were subordinated by the economic and individualistic concerns which became dominant also in shaping the career patterns and professional perspective of the new generation of doctors. With this new development the social missionary aspect of professional perspective was criticized and largely replaced by alternative ideals by the new generation of doctors. The new generation of doctors were also a much larger and heterogeneous group than the former ones, due to the unplanned expansions in the faculties of medicine. The doctors became a heterogeneous group in terms of their economic and social background, professional career patterns and cultural formation as in the case of the doctors who tried to combine their Islamic view into their professional perspective. These developments have negatively affected the professional group's communitarian aspect which connected them to each other in

terms of solidarity and their common social values around which their professional perspective had been shaped.

Although the new generation of doctors took a critical distance to the idea of the social mission which they become acquainted with as a part of their professional socialization during and after their medical education, they can not fully ignore this idea since it also gives them a "legitimate power" to make judgements on the social and political situation in Turkey. They derive their social power and prestige from their professional perspective which was shaped from 1827 onwards with the high level of involvement in the social and political debates and movements. The doctors' involvement in the political activities during the modernization process of Turkey shaped their relations with the rest of society and the state through creating a professional perspective which foresees a typical doctor and patient image. According to this image which is rooted from the period corresponding to the birth of modern Turkish medicine, the doctor is a well-educated intellectual person whose major professional concern is the improvement of the living and health conditions of the society in general, and the inculcation of the modern, secular,positivistic, progressivistic and scientific values as opposed to traditional and religious ones. The typical patient, according to this perspective, pursues a life which is dominated by traditional, religious values and is mostly less educated than the doctors. However, the historical developments, particularly after the 1980's, distorted these typical images and relations between these two groups, which were supposed to be shaped by the teaching and guidance role of doctors, in line with the changes and variations in the professional perspective. The recent generation of doctors still make use of these

stereotypical images and view their social role as a "guide" or "teacher", but they are also aware of the recent variations among patients and doctors. Hence they classify doctors as "good" and "bad" doctors according to their own professional perspective and attribute the right to guide the society to the "good doctors" which usually include themselves.

In this chapter, I examined how the professional perspective of doctors have developed and varied throughout the history of the modern Turkish medicine. This professional perspective has involved different social missions which have shaped and have been shaped through the changing relations of doctors with the rest of the society and the state. Independently of the degree and the type of involvement, the doctors' long time engagement in social and political debates and movements in the Turkish society, led them to develop a social missionary project and therefore provide a legitimate ground for making social and political judgements on society. Another source of legitimation is related with the ways in which the new generation of doctors differentiate themselves from other people by suggesting a particular relationship between medical knowledge and power, which will be covered in the next chapter.

Chapter 2

The Concept of Self and Professional Experience in the Doctors' Accounts

As a result of the dramatical changes that have happened in the Turkish social structure and its health sector since the 1980's, the young doctors have lived different professional experiences and developed different professional and social concerns out of these experiences. This has also led them to look for new sources to establish a position of social authority in line with their changing social concerns. The way the young Turkish doctors relate their personal characteristics to their professional experiences has become an important source for this position since it helps them to differentiate themselves from the other people and to shape their professional perspective which includes new social concerns. The doctors whom I interviewed about their professional views and experiences stressed a considerable number of character traits such as being clever or hardworking. According to their own accounts, these traits played a crucial role in their decision to become a doctor and in overcoming difficulties they encounter in their professional life. The particular way of stressing on these traits also helps these doctors to attribute themselves an outstanding social position, since, in the interviews, they presented themselves as a small distinguished group of people who have the talent and strength to reach a difficult professional goal.

The young doctors generally interpreted the problems they had experienced in the faculty of medicine and hospital as an immediate

reflection of general social, political and economic problems that are experienced at country level. The interpretation of professional problems in linking them to a much wider social context and the doctors' particular way of stressing the professional perspective and personal traits in overcoming these problems help them to attribute themselves a legitimacy to make judgements on the social and political conditions and plan a missionary project to improve these conditions.

In studying the ways in which the new generation of doctors relate their character traits to their professional experiences, I have mainly benefited from Charlotte Linde's (1993) conceptualization of coherence. In her study about life stories, Charlotte Linde speaks about the need of representing "the self" in a coherent way both in individual and social terms (Linde, 1993). She means by "coherence" here, a consistency between the characteristics and behaviour of a person, and a general sense of integrity of self which was provided in the oral and written narratives about one's self and life story. In narratives, coherence is maintained through establishing adequate causal links for one's acts and providing a sense of continuity over the temporal and causal elements of the narrative. According to Linde, three major subjects can be used as elements of coherence. These are "the continuity of the self through time, relation of the self to others and the reflexivity of the self". In line with her categorisations, I will try to describe how the young doctors closely relate their character traits with their career patterns and the crucial decisions they have made during their professional experience. I will also study how this way of creating coherence implies a hierarchy and power relation

between the doctors and other people, as well as among the doctors themselves.

Methodological Issues: Emphasizing Coherence in Facing Discontinuities: The main reason which led me to concentrate on the young doctors' efforts in establishing their social authority in the second and third chapters, is that these doctors try to balance their individual and economic concerns which mostly emerged in line with the social atmosphere in Turkey in the last two decades and the professional perspective of the older doctors, which they acquire during their university education in an idealized way. This perspective inculcates a doctor image according to which the doctors are a small group of privileged people who do their best in order to maintain their people's health and improve their social and living conditions. However, their social and professional problems which mostly stemmed from the crises in the health sector after the 1980's as I have mentioned in the first chapter, and their new individual and economic concerns led them to question this altruistic doctor image. Despite this questioning, they cannot consider it as totally invalid, since it is an important source of social authority which was shared both by doctors and lay people from the birth of modern Turkish medicine until the 1980's. Therefore, the young doctors whom I talked to, often referred to the professional perspective of the older doctors, although they question and modify some of its aspects. However, in order for these references to be represented as valid, my informants have to emphasize a continuity between their individual traits and the altruistic doctor image that is imposed by the professional perspective, and to relate these traits with their

major professional decisions. In doing this, they display that their professional experiences are shaped mostly through their individual traits which are suitable for a "good doctor" according to their professional perspective, rather than through the professional conditions that changed dramatically after the 1980's. Therefore, the fact that they emphasize coherence and continuity in describing their professional experiences and concerns, stems from their efforts of relating themselves to the idealized doctor image as a part of the professional perspective which had been developed by the older doctors who enjoyed a high social status and respect in line with this image.

Besides benefiting from the social authority of older doctors and the sources of this social authority, this helps my informants to differentiate themselves from the bad doctors who shape their professional experiences and concerns according to the external conditions in the health sector and subordinate their individual and economic concerns to their professional perspective. The older doctors argue that this type of bad doctors are much more prevalent in the new generation of doctors who adopt the external conditions in pursuing the profession and forget the basic principles of their profession (Arıoğlu, 1996). Irfan Gökçay (1997), who was the director of "Istanbul Chamber of Medicine" for a long time, stated that this led to a kind of generational conflict between the new generation of doctors and their colleagues from the former generations. Several publications I looked at in this chamber, also refer to "the generational conflict" so that I have understood that this theme is shared among the older generation of doctors to a large extent, at least among the leading members of this professional chamber who are devoted to maintain and inculcate the

professional perspective and the altruistic doctor image. in this framework, my informants' emphasis on the coherence between their individual traits and professional experiences can be considered as efforts to situate their personal and professional "self" as " a good doctor" in the society, and , therefore, claim a position of social authority like other good doctors who are mostly thought to belong to former generations.

This chapter is based on semi-structured interviews with six doctors mainly from the younger generation whose ages varied between 30-37. I was already familiar with most of the doctors whom I talked to, before making the interviews, since I have met a number of young assistants in the faculty of medicine at the Çapa Hospital, when I was involved with another research project. Building close relations with these doctors helped me to reach the doctors who work in different hospitals, since most of these doctors' friends or spouses are also from the same professional group. The doctor I talked with, explained this fact half-jokingly as they rarely have the opportunity to meet with people other than doctors during their intensive and long medical education and professional career, or only another doctor can tolerate these doctors' tired and "shabby"appearance after the long hours of work.

These doctors had different professional perspective and concerns. These differences were also related with their socio-economic background where considerable variations could be found. Despite their differences these doctors used to meet in their leisure time and often discuss about their professional experiences and concerns. I had the chance to listen and become involved with these discussions and, meanwhile, I have learned more about their particular professional and individual characteristics. I

collected adequate information about the professional and personal characteristics of the young doctors I have met at Çapa and the doctors whom they suggested to me, and I used my other personal relations in order to decide whom to interview in order to reflect the existing variations among the younger generation of doctors. I also paid attention that my informants have different specialization fields, except the two gynaecologists, since this is another factor which influences professional experiences and concerns. Gynaecology, being the most prefered specialization field, is represented by two doctors from different gender groups. The gender distribution of my informants is also balanced, since the group of informants consisted of three female and three male doctors.

I prefered to conduct interviews in my informants' houses, since they were more likely to talk about their individual experiences which they considered as unrelated to their "professional self" in their houses. Therefore I could obtain more information about their individual characteristics and the clues which would help me to understand their socio-economic background more clearly, such as the decoration and the way they dress. In the hospital setting, their professional self is much more dominant so that they relate everything they say to their profession, and moreover, the interviews were often interrupted with the noise in the hospitals and the patients who came without an appointment.

In general, the doctors were very cooperative during interviews and forced themselves in order to find elaborate answers to each of my questions. They mostly considered me as a young sociologist and displayed a genuine interest in my questions, since they argued that the social and humanistic aspects of medicine and medical professions should be

emphasized more among doctors and in society. The fact that I am a master student led them to have a particular concentration on their university education and their assistantship in their accounts where they had a tone of older brother or sister since they are at least five years older than me and considered themselves as highly experienced and informed about the formal and informal rules and regulations of the university system. The female informants could talk about their concerns about their private life, such as their worries about their being late in finding a husband and have a child, more comfortably, since they view me as a young female student who might have similar worries. However, during our interviews, they were fully aware that they were presenting their profession, their views on it and their way of pursuing it, to a person who is an outsider to this professional realm, like me. Their efforts in depicting a highly coherent picture in their narratives about their individual characteristics, professional concerns and experiences and in describing themselves as "good doctors" can be also explained by the fact that the listener and main interpreter of their narratives would be me, a person whose job is not a part of the medical realm. If the interviewer were a doctor, they would depict a less coherent picture through telling more about the deviations from that picture and caring less in finding reasons for these deviations.

In the interviews, the deviations were narrated usually as stemmed from the external factors such as inefficiencies and corruptions in the health sector and problems with patients' behaviours. However, some of the deviations from the professional perspective that is established by older doctors, may indicate the development of a new professional perspective

where the old categorisation of good and bad doctors is no longer valid. Instead of taking this categorisation that is largely accepted among the professional group and presented to the lay people as a main reference point, the young generation of doctors might underline their different individual concerns and benefits in pursuing their profession. Relatedly, another topic to study would be how these doctors differ their own professional concerns and experiences from other doctors and present their personal and professional self more like "individuals" rather than belonging to a professional group. How they develop their own category about good and bad doctors out of the established category would be another interesting subject to study. One might also ask how the young doctors might question and criticize the established professional perspective and its category of good and bad doctors without refering to the external factors which have effected their validity. It is possible to find clues to answer these questions in my informants' accounts about their professional experiences and concerns.

Although I had prepared a list of questions beforehand, I also asked a considerable number of questions that were shaped during the course of interviews. I tried to collect as much as information I could, about the professional experiences and evaluations of my informants. I also let them talk about their individual characteristics, even if they did not seem to be related with their profession, and I paid a special attention on how they connect these two issues during the interview. The interviews lasted about 3-4 hours. All the interviews were tape-recorded and transcribed. Pseudonyms are assigned to interviewees for ethical reasons. The characteristics of these interviewees are briefly summarized in the

appendix. I have the transcriptions for several times and I applied the method of "thematic field analysis" (Rosenthal, 1993) which is particularly useful in understanding how a narrative is "temporarily and thematically ordered". In studying these interviews according to this method, I have taken into account the changes style of presentation such as argumentation, narration and describing and thematic shifts where the informants change the subject of their accounts sometimes by themselves without being interrupted by a new question. These kind of shifts provided valuable clues to see how they connect different subjects which might seem as unrelated on the first instance.

The Periodization of Professional Experience: The causal consistency between the character traits and professional decisions persists through the the consecutive periods of the doctors' professional experience. This periodization also helped me in shaping my interviews as well as their analysis. The periods can be broadly defined as the high-school education where usually the decision to become a doctor is taken, the university education where the person first gets acquainted with medical knowledge and practice and plans a career as a doctor, the early years of the professional experience, where the person is no longer a student but a doctor who is exposed to the rules and hierarchy of the professional group, and the later years of professional practice where the doctor internalizes the professional rules. The doctors whom I interviewed were mainly in the first years of their third period. This was a conscious choice by my part, since the doctors from the fourth period used to speak less in individual terms, but rather prefer to make general statements about their profession.

Moreover, the doctors from the third period still remember and were under the influence of the first two periods where the professional perspective was acquired and two important decision making processes are involved. These processes are the decision to become a doctors and the choice of a medical field for specialization. In this chapter, I will mainly concentrate on the first two professional periods of doctors and, a part from these periods, some of the findings of the background questions which I asked before the questions about the doctors' professional lives will also be mentioned with respect to their effects in career planning and the formation of a professional perspective.

The Character Traits of Doctors and their Professional Decisions: The doctors' stress on their character traits in relation to the two crucial decision making processes also implies that being a doctor and specializing in the chosen field are particularly in accordance with their conceptualization of themselves in the oral accounts. Their individual characteristics and professional choices are interwoven in a highly consistent way to the extent that the professional decision seemed to be the obvious path for these people to follow. Linde (1993) applied her categories on her research about the career patterns of middle-class American professionals and she also found that character traits are mentioned as an adequate explanation for professional choice according to common sense as a widely used coherence system. However, the doctors' consistency between their character traits and professional decisions provides more than temporal and causal continuity. It also implies a different causal relationship where people with certain positive characteristic traits, such

as perseverance and courage, have the chance to acquire highly valuable medical knowledge and enter this "sacred" profession in contrast to others who fail to have these characteristics. Besides this exclusionary aspect, this consistency suggests a categorisation among doctors, since by showing how their individual characteristics are harmonious with their profession, the interviewees imply a definition of a "good doctor" where their own cases are also included. Hence, the power relations between the doctors and other people and within the doctors themselves are accounted to be shaped through the consistency between the requirements of the profession and the individual traits.

In this chapter, I am planning to focus on the representation of the "professional self" through the accounts of personal experiences of doctors, and benefit from the Linde's "continuity of the self through time" and "reflexivity of the self" concepts. How doctors relate themselves with other people in the professional realm and lay world will be covered in the next chapter. I will also study the two processes of decision-making which play an essential role in displaying the consistency between the doctors' personal traits and professional position. The accounts of these processes also help us to understand the interviewees' general views about being a doctor in the current Turkish medical context and their particular position in this context, including relations with other doctors, patients and with other lay people. These accounts are about the professional experiences which cover the last two decades, since I mostly interviewed the last generation of doctors who are in their early years of professional practice.

The Decision to Become a Doctor and its Consistency with Character Traits: In this section, I would like to show the ways in which the coherence is maintained through representing the self as an integrity. In the interviews, the integrity is mainly achieved through explanations and examples which show how decisions to become a doctor and to specialize in a specific field of medicine fit the character traits of these doctors. The reasoning behind this way of achieving integrity is to justify these decisions which play an essential role in their life course. In some explanations, the justifications are so richly made that the professional decisions seemed almost as the "natural" paths to follow in the life course given the people's character traits.

In the interviews, the doctors represented themselves as being successful and having an outstanding position with respect to the rest of the people in their environment since their childhood. The success and outstanding position were stressed increasingly more as the doctors went on narrating their medical education and professional experiences. The doctors mentioned several character traits as evidence for their outstanding position which also implied the required character traits in order to become successful as "a good doctor". Among these character traits, one of the most emphasized one was being hardworking. Several of the doctors connected this characteristic with their decision to be a doctor in a more direct way. Some of them emphasized more specific criteria and gave external or official evidence which justified their working hard. The examples given as evidence of being hardworking vary from having "a red ribbon" in the primary school (an award for the students who learn to read well in a short period of time) and having a high honours degree (*takdir*)

each year in the high school as in Dr. Meriç's examples, to Dr. Sakin's reading whatever she found even it was not related at all with her studies in the primary and high schools.

However, being hardworking is not the only character trait which was stressed as a criteria to become successful especially before the medical education. For example, Dr. Sarol implied his cleverness and his special skill to get the average grades in a private and highly competitive high school without working too much and admitted that he used to despise the people who studied too much with "the typical vanity of the people who went to private high school":

"Everybody in the Austrian high-school were chosen people..I never had failing grades...I had a grade average which could be considered as successful considering I am from the Austrian high-school... I had the typical vanity of the people from private high school (*kolejli burnu büyüklüğü*). I believed I could get satisfactory grades without working too much". (1)*

During the interview, he constantly stressed that his studies and work are not the most important aspect of his life and he has to have diverse interests such as playing football in order to become relaxed and refresh his concentration for more work. Similarly, Dr. Çağlar mentioned that he always had and should have diverse interests such as sports and commercial activities but he stressed that these activities did not prevent his being responsible in his main work. Both of these doctors emphasized that they took their studies and work as a game where they knew its rules quite well and played accordingly in order to continue in the game

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* Excerpts from the original interviews are in the "Appendix 2".

successfully. Similar to Dr. Sarol, Dr. Çağlar also implied that his being intelligent or clever and his aim of benefiting from this trait were one of the main reasons for choosing this profession. He said that his main aim for the future was to understand and apply a knowledge which was perceived as difficult by other members of the society, for their benefit. This wish also includes a comparative aspect where Dr. Çağlar implicitly attributed himself an outstanding position in the society through emphasizing his cleverness.

According to these doctors, rather than working too hard, they astutely worked enough to have satisfactory grades in order to be evaluated by themselves and by others as "successful". Although, both had many diverse interests in life, they stressed several times that they gave a general priority to their studies and work in contrast to other students who also have diverse interests. Besides their cleverness or astuteness in terms of knowing the rules of the game and playing it successfully, the concept of responsibility as it was used by Dr. Çağlar is another important trait which was much emphasized by him and by other doctors in the accounts of their experiences in the medical school and hospitals which correspond to the later period of their life course. Hence, responsibility as a character trait which helps differentiate doctors from the others, will be examined below, in the study of the accounts about the later periods of the educational and professional life course.

According to their accounts, either by being hardworking or by planning the life and studies skilfully and cleverly, the doctors became successful in their education. Their educational success was appreciated by everybody in their environment, and their decision to go to the faculty of

medicine seems like an ultimate confirmation of their success. Most of the doctors referred to the difficulty of entering the faculty of medicine, a process which involved severe competition. Although the doctors did not directly mention about their being competitive, their explanations of their becoming successful implied that they were content to be more successful than the others, since they assumed that they obviously deserved being successful thanks to their character traits. Dr. Meriç, a female pediatrician, told about a direct relationship between being hardworking and the decision to enter the faculty of medicine by saying that the hardworking students, like herself, have that "psychology" (she most probably means motivation) to enter a faculty of medicine without any exception, since it is the most prestigious place to enter for university education:

"The hardworking students have the psychology to obtain the highest scores (in the university entrance examination) under any condition and become a doctor. In general being a doctor brings a prestigious position in society. Every parent wants their child to become a doctor". (2)

The last argument of Dr. Meriç is also consistent with her own family who mobilized their scarce financial resources so that she could study medicine comfortably without being aware and suffering from her family's economic problems. Dr. Sakin, a female gynaecologist, spoke about the same relationship for a specific period of time, the early 1980's where "doctors still had a prestigious position in society", which also included the year she entered the faculty of medicine:

"In our time, all of the successful students used to enter into the faculty of medicine...The year was 1983.. .Entering the faculty of medicine was a big event" (3)

Similar to the doctors who emphasized their working hard, the ones who were skilful and clever enough to play "the game" successfully, also mentioned about their success in the examination in a consistent way with their own character traits. Among them, Dr. Sarol mentioned that he had a hard time in deciding about the major he wanted, but, he added that, once he had decided to enter a faculty of medicine, the rest was very easy, since he answered the exact number of questions in each section in order to enter that faculty without any problem. All of the interviewees talked about their success in the University Entrance Examination (ÖSYS) in detail and they remembered the precise scores that they had in each section of the examination, despite the fact that they had had this examination at least ten years ago. Their emphasis on this examination and on their being successful at it, is significant since it signifies not only the first step to the profession, but also an initial stage to be admitted to a highly respected professional group.

Bryan Turner's (1987) arguments on the power relations within professional groups and on the internal strategies they use to maintain their professional boundaries and control, are helpful in explaining the importance of this initial stage which involves a large amount of competition. The competition is related with the principle of social closure where, in the case of doctors, they maintain their occupational control through their role in deciding who will participate in their own group (Turner, 1987). He argues that this principle "in a society based on

knowledge, depends on university education as the basis for credentialism". This statement is particularly relevant for the Turkish university examination system where in the 1980's, people had to have the highest scores in order to enter into the faculties of medicine (TTB- 1990). Being successful in medical education and fulfilling the criteria required to specialize in the profession are other difficult and competitive stages where medical students had to be tested by their professors in the faculties of medicine in order to take part in their professional group. In sum, both before and during the university education, being outstandingly successful through using different strategies which are consistent with these doctors' particular character traits, is presented as both the key element in shaping professional decisions and as a major criteria in realizing these decisions. In the interviews, when entering one of the faculties of medicine was stressed as difficult and competitive, the doctors also felt challenged since they saw this as a test for the confirmation of their outstanding characteristics. However, this challenge was reflected in the form of an enjoyable game in the interviews, since all of the doctors had overcome this entrance examination successfully a long time ago.

The Conceptualization of Medical Knowledge before Medical Education: Another aspect which is related with the challenging aspect of the profession and which makes the profession attractive for my interviewees, is about the characteristics that were attributed to medical knowledge before entering the faculty of medicine and in the first years of medical education consistently. In this section, I concentrate on their views on medical knowledge, which they reported they had before medical

education. However, since these evaluations were recently made by today's doctors on their personal views of the past, they were also shaped by their current professional position and concerns rather than merely belonging to the past.

Among the strategies of occupational control and monopoly, Turner (1987) writes about the first dimension in which these strategies take place: "..the production and maintenance of a body of esoteric knowledge which requires considerable interpretation in its application". This point becomes especially relevant in the case of medical knowledge where the terminology is mainly in Latin and the professional experience and personal skills forms an essential part of the application of the knowledge. Learning the medical terminology is discussed through the metaphor of "learning a foreign language" in Good and Good's (1993) article, where they argue that learning this language corresponds to "the construction of a whole new world". The motivation to acquire this "esoteric knowledge" in order to take part in the construction of this "new world", can be easily tracked down in Dr. Sakin's reasons to choose the medical profession and the subject she would specialize in. Dr. Sakin also emphasized that she was familiar with how doctors worked and used their medical knowledge even before the medical education, since her father is a well-known pharmacist in Denizli and his pharmacy was often visited by doctors who spent long hours there conversing with her father. She answered a question about her expectations in her decision to enter the faculty of medicine:

"Medicine seemed to me as something different from everything else ..I don't know, you read certain things, you are interested a little bit in certain things, like management etc.. But it seemed to me that not

everybody can study medicine, be a doctor, understand medicine...I liked the terminology that is used, the prescriptions.. I could not believe at all, it was a very important business for me, how they keep all of drugs in their mind, how they diagnose the illness...He [the doctor] says that this man has this [illness], gives a drug and the man is cured...In fact being a doctor seemed highly incredible to me, it seemed highly unreachable too. But I said that I will try whatever I can in order to reach my aim and I persisted in what I said". (4)

The acquisition of medical knowledge became attractive for my interviewees not only through its level of difficulty which meant the necessity to re-test and prove their positive character traits, but also through its unique aspects which strictly differentiate it from other types of knowledge and which also ultimately confirms the outstanding position of doctors. Hence, the quotation of Dr. Sakin displays another common aspect about the doctors' presentations of themselves in relation to their professional position: The more difficult realizing a certain goal is, the more motivated the doctors become and the less understandable a kind of knowledge is, the more challenged they feel in order to acquire that knowledge and reach that goal. This can be partly explained by their characteristic of being hardworking, since it forces them to reach "the highest point". However these doctors believe that they deserve to reach this point since they made a courageous decision to study something "which not everybody can study". In the above quotation, the mystification of medical knowledge by defining it with such adjectives as "incredible and unreachable" implies that there is a highly exclusionary competition which only the deserving attain. By describing the examination process as a

mystic ritual through the eyes of a lay person, with the sentence, "he says that the man has this, gives a drug and the man is cured" , Dr. Sakin also attributes almost a magical power to medical knowledge, which is used to heal people as if in a highly automatic manner without any difficulties in the healing and medical process. Attributing a great value to the medical knowledge is also another indirect way of confirmation of the outstanding position of doctors. What is "unreachable" is reached only by a few people as a result of their diligence, cleverness, responsibility , courage and decisiveness which differentiate them from other lay people.

The Character Traits and University Education: The doctors' accounts about their university education correspond to the second part of their professional life course according to the periodization designed for the study of these interviews. This period is important not only in terms of displaying the continuity through time since the character traits that were mentioned for the first period were repeated even with a stronger emphasis, but also in more clearly differentiating the doctors and others since it signifies the beginning of the acquisition of a professional perspective as well as medical knowledge and practice.

In line with Bryan Turner (1987) who stressed the relevance of university education to the formation of the "esoteric knowledge, as we have seen above, Carr-Saunders (1964) also believes in the importance of university education for professionals, since the students learn about "the ideals and norms" of a profession through "professional socialization". The concept of the professional socialization is a significant concept of the professionalization theory of which Carr-Saunders is one of the followers.

In this theory, as we will study in more detail later, it is assumed the professionals are a corporate body of people who are tied to each other through solidarity. The solidarity stems from acquiring a unifying professional perspective where the members of the profession share the same concerns and ideals about their profession and the world which is shaped through this profession. However, the professionalization theory which has an idealistic view of professions, is now evaluated in critical terms, and the process of professional socialization is not considered as a smooth process of learning as it was assumed by the theory. In contrast, the doctors whom I interviewed, questioned some of the aspect of this process, even if it requires self-criticism made through self-distancing. They mentioned that they internalized some basic aspects of the professional perspective, such as the idea of being useful for people and the prevalence of the objective scientific criteria that were given in their faculty on condition that these aspects were suitable with their character traits.

When we study the character traits emphasized in the accounts of medical education, we see that the traits that were mentioned for the former period, were much more stressed through direct comparisons with other people, since a process of differentiation had started. This fact is especially true about being hardworking which was represented as one of the basic requirements of medical education. Dr. Meriç who also stressed her being hard working in the high school, consistently said that she had to give up all of her hobbies such as drawing pictures and playing the piano, since she had to study "extremely hard". Accordingly, she compared the medical students including herself with the other university students, by saying that because of their studies they had no time to learn about, discuss

and organize around the political issues that were debated in Turkey at that time, in contrast to others who were more politically active and organized. Although she had a regretful tone in accounting that her studies prevented her other interests, she emphasized that she had to study hard in order not to be "eliminated" in the first two years "like almost half of the students".

If we take into account that she was speaking about the mid-1980's since she was born in 1967 and went university around 1985, a strong tendency of depolitization could be perceived in most of the social and professional groups in society including doctors. As I have also mentioned in the first chapter, the particular political conflicts between the rulers and doctors in the early years of the 1980's, also became highly influential in the depolitization process of doctors who had often played an active role in politics mostly with an oppositional political character since the early years of modern Turkish medicine. Their political character was also highly influential in shaping their professional perspective from the early years of the modern Turkish medicine until the mid-1980's. However, in making her comparative argument, Dr. Meriç did not refer to that contextual situation at all, rather she consistently took a conscious distance from the general political issues during the whole interview, and the only reason she mentioned for this, is that like all of the medical students in her surroundings, she had to work too hard to spend time on political issues. The other reasons of the majority of the last generation of doctors' critical evaluation of the idea of being politically engaged to an idea or organization will be discussed in the next chapter, but, it is interesting to note here that being a hardworking student in the faculty of medicine was given as a reason for not being interested in politics like other university students.

The particular internal dynamics and personal relations in the faculties of medicine also helps to develop an "individual responsibility" to be hardworking. This is especially valid after the second year of medical education where the students first contact patients and learn about the examination process in groups led by a professor. Dr. Sakin, described the psychological situation of students in this session as suffering from great tension since they-including her- felt themselves "as being in a shop window". This metaphor comes from the fact that the professor individually asked the students certain questions and not being able to fully answer these questions or making a slightest mistake in the examination process, closely watched by the group, resulted in the professor's getting furious and other student's depreciation of the "wrong-doer". Dr. Sakin said that the students also felt tension because of the patient who did not understand the dynamics of this process:

"When you take care of patients for the first time, you behave in a very careful way. Your dear professor and your friends judge you (She laughs) ...When your professor ask you a question, you have to answer it correctly...Slowly, you begin to feel the tension. It is enjoyable and stressful at the same time, the stress is related with your avoidance of being ashamed...In the clinic, you are among people all the time. The professor asks you something and you do not know the answer (She raises her voice). What a big shame in front of your friends! (She laughs). At the same time you will feel ashamed in front of the patient, it is annoying as well...You have to read a lot in this period, because in one way or another you have to learn these things, and then the panic starts...You also have to avoid the scoldings of the professor... (In case you cannot answer the professor) The

professor may even kick you out of the clinic and tell you not to touch the patient". (5)

This is related to the particular group dynamics where the students watch or control each other, and force each other to work harder under the main control of the professors and the university system. This is also related to the notion of mutual responsibility among students as well as between the students and professors.

The process of learning through the examination of the patients in the classes is also important since it shapes one of the main professional activities of doctors. In this process, the students must learn how to treat the patient and how to gain the patients' trust through their behaviour and their appearance, from their professor who is a much more experienced doctor. In this respect, according to Dr. Çağlar who did not stress his being hardworking but his responsibility in giving priority to his work in general, the medical student really internalizes the rule of being responsible. He said that, since " a doctor cannot say to the patient, oh, I can't diagnose your illness, I don't understand what is happening in your body," the students who answered their professor as "I don't know" in the examination session, were not tolerated at all by the professor and the class. Dr. Çağlar added that the only thing that the student should do is, his or her best to find an answer and ask for one or two days at the end of which he or she would give a detailed and complete answer after studying extremely hard.

He generalized the way the students' handle this problem, for the whole process of acquiring medical education whereby the students were faced with a strong notion of moral consciousness. By way of comparing,

he explicitly said that since the medical students, including him, were more clever than the other university students, they could acquire the responsibility of medical duty and complete their task even if at the last instance. If they had one day or few days left to do it, he added, they stayed awake all night or for several nights to complete it.

Another doctor who emphasized the importance of being clever as we have seen for the first professional period, Dr. Sarol, criticized the medical student who came from "the provincial places" and who had low socio-economic status, since they did not nothing but studying for "twenty-four hours per day" and got the highest grades in contrast to his average grades in most of the classes. He said that medical education was their most important social and economic hope for the future and his remark is interesting in terms of evaluating the heterogenization of medical students and the differentiation of professional career patterns and perspective after the mid-1980's, as we have seen in the first chapter. Unlike the student who came from the provincial places, Dr. Sarol said that he was not devoted to all of the courses in the university, but that he gave a priority to a few medical fields which included surgery, in which he was highly interested and at which he found himself particularly skilful in learning and applying.

According to the interviews, for a clear-cut success in the faculty of medicine, the students had to be much more hardworking and clever than before, partly because of the in-group control and competition, as we have seen above, and partly because of the level of difficulty of the knowledge that had been learned.

The First Encounters with Cadavers, Courage Test and Group Control: As we saw in the accounts about education before university, being courageous was implied with respect to persisting on becoming a doctor, which was presented as a difficult goal which only a few people could consider reaching. In this framework being courageous is related with the students' fearlessness and even enjoyment about the challenging and competitive aspects in the first steps towards their goal. However, during the university education, they had to "endure" a much more difficult courage test for proving their emotional and intellectual capacity which is strictly required in order to become a doctor. In their third year of university education, the medical students had to dissect cadavers in the anatomy laboratory.

According to Good and Good (1993) , it is a process whereby the medical students learn to "reconstruct the person as an object of medical gaze"and attribute new meanings to the human body. Good and Good argue that while exploring inside bodies, the student develop new manners in interacting with these bodies, and accordingly their perception of their own body and self change considerably in this process. For them, this two-sided reconstruction process is "essential for students to become a competent physician". Similarly, Lella and Pawluch (1988) stress the importance of this process in terms of its role in differentiating the medical students from the lay people through signifying " a rite of passage into the hallowed realm of medicine" and enhancing the sense of privilege of becoming one of the chosen few. Lella and Pawluch claim that, besides its differentiating role, dissection of the cadavers has also an integrating function for the medical students. They learn to integrate their

professional and personal self through suppressing their personal feelings, stressing the objective-scientific benefits to be gained by dissection and developing scientific and medical concerns in all aspect of their lives.

Similar to the findings of these studies, the informants also dramatically expressed how they felt during the dissection process. Dr. Sakin spoke in a detailed way about the "horrible" conditions in the laboratory such as the smell of formoldehyde which preserves the dead-bodies and the half-opened eyes of some of the cadavers. However, she also added that she eventually learned to suppress her fear and disgust since these are not suitable for a future doctor. Dr. Meriç, Dr. Yaş and Dr. Çağlar mentioned that they tried to build an empathy with the cadavers by asking themselves whether they wanted to be in the place of their cadavers, what kind of people were these cadavers , whether they had any relatives and what were the conditions which had brought them to this anatomy laboratory. These questions were based on the students' concerns about the invasion of the private life of an unknown person which is also stressed in the article of Lella and Pawluch (1988). However, they were aware that they had to learn how to struggle with this concern too, since invasion of private life of an unknown person would cover an important part of their professional practice. Hence, these students had to be courageous not only in terms of tolerating the horrible material conditions in the laboratory such the blood which was spilt and the dissected organs spread out everywhere, but also being able to find a comforting solution for their psychological and philosophical worries about dissecting cadavers. Among these doctors, Dr. Meriç suppressed her concerns and rationalized her acts in the laboratory as what she did with the cadaver, did not mean

anything to the person whom this body belonged to, since he or she was dead long ago, and all the things she had done in that laboratory was in the name of science and medicine.

Dr. Yaş, a male orthopedist, brought another explanation for the suppression of feelings, which is related with the group dynamics and rules among the medical students similar to the Dr. Sakin's account about the classes where they learned about the examination process. Dr. Yaş who stressed that he could not even bear seeing blood, felt a "disgust" at the beginning of this process, thought it was against his "humanitarian values"and had to have a one year break from university because he could not tolerate working in the anatomy laboratory. However, he also added that he should not display his thoughts and feelings to other students:

"It was actually like a game. First we went around these places with a feeling of a nausea in our stomachs, we had never seen a dead body before. We were afraid of the fear which we might feel when we first see the dead bodies. Would I be ashamed in front of my friends, would I faint out of fear, with these worries I was afraid more because of the paranoia of fear. I tried not to be afraid and projected my fear by looking happy. I took the arm of the dead body and raised it saying ' Ah, this man is dead'... I did not even wear gloves. In fact I was trembling out of fear, but I did not show my fear to anybody. But,then, it affected my studies, I quit the school at that period for one year". (6)

In his account, we again see that the medical students became a group wherein certain rules were set according to the medical and scientific professional perspective in line with the biomedical model. The students, if not fully internalized, were fully aware of these rules and seem

to comply with these rules at least when they were among the other medical students. Hence, the students maintained their courage either by subordinating their stress and fear to their faith in science and medicine or by pretending that they went beyond this stress through jokes as in the quotation above. However, several of them also mentioned that a considerable number of students failed this courage test and had to leave the faculty of medicine.

Role of Personal and Social Values in the Acquisition of Medical Knowledge and Practice: The doctors continued to differentiate medical knowledge and practice from other types of knowledge and attribute a mystic character to this knowledge and practice in the accounts of university education. As we have seen above, the report of this view serves as a way of emphasizing their courage and outstanding position in terms of their persistence to reach a goal, the difficulty of which partly comes from its unrelatedness with other types of knowledge. The difference of the medical knowledge from the common-sensical understanding of health issues has been particularly emphasized in the accounts of medical education. Dr. Çağlar stated that one of the first things he learned in the classes was that all of the statements about the health issues that he had heard from various people, such as "Don't drink cold water, you will get a cold" or "Drink linden tea to get better", were completely wrong. He added that he learned that these issues had much more complex aspects and experienced a great surprise while learning these aspects.

The complexity of medical knowledge was not only surprising but also fascinating for the students such as Dr. Yaş who reflected his fascination about this process in this way:

"....I saw how complex even a finger can be. When I studied the autonomous nervous system, I was totally shocked..I was saying: "Oh my God, oh my God, how amazing!"..You began to make religious judgements in a particular way. Probably each medical student ask questions about God and existence, while studying pathology, physiology and anatomy... because a finger has a much more complex structure than a thousands of computers and when you think about the hormonal system, it is incredible how they [the hormones] balance each other..how they are controlled in the brain.. It is incredible. When you could not believe it, you say [to your self] that there is probably a God (He laughs)". (7)

This quotation is particularly interesting in showing how in a rather emotional impression about medical knowledge, medical knowledge and religion are interconnected in contrast to the dominant biomedical approach where these two spheres are considered autonomous (Lella and Pawluch, 1988). In contrast to the biomedical view of medicine which also shaped the contemporary medical education in Turkey, the particular complexity of medical knowledge led Dr. Yaş to perceive it in a way which transcends the "gap between medical science (indeed science generally) and other forms of cultural expression". The quotation of Dr. Yaş can be also examined as an example of Foucault's (1970) term "scientific consciousness", since it shows how medical knowledge is acquired in the form of "personal knowledge" through the attribution of "personal meanings" which led to "the construction of medical knowledge as an

intersubjective reality" (Good and Good, 1993). The construction of medical knowledge also includes the construction of "the medical body" which is defined by Good and Good as "quite distinct from the bodies with which we interact in everyday life". They argue that "the intimacy with that body reflects a distinctive perspective, an organized set of perceptions and emotional responses". In line with their argumentation, the quotation of Dr. Yaş is an example of the construction of the "medical body". Here, he stressed the complexity of the systems in the body and compared these systems with those of computers. However, in contrast to this technological metaphor, his reaction to what he has learned-his surprise and his questioning the existence of God- are more emotional and spiritual rather than rational.

In general, Dr. Yaş has a more critical view on medicine and doctors than the rest of my informants. This is partly due to the fact that his mother forced him to enter the faculty of medicine, since she had several chronic illnesses and expected him to take care of her and to solve the economic problems of the family to a certain extent by being a doctor. Dr. Yaş admitted that he could never like his profession like other doctors, nevertheless, that he did his best to become a "good doctor".

In the process of the acquisition of medical knowledge, it is interesting to note how Dr. Yaş attributes a personal meaning to what he had learned, rather independent from the biomedical perspective that is taught in his faculty. He had learned about and interpreted the medical knowledge consistent with his own values and thoughts. This also proves that the inculcation of the biomedical model and the professional perspective accordingly, is not a smooth process, especially after the 1980's

where the biomedical model is criticized in line with the discussions about the problems and boundaries of modern medicine, and the ethical concerns about the generally assumed predominance of biomedicine over other health models.

Similar to medical knowledge, medical practice is also mystified by attributing it certain terms from other spheres of cultural expression. For example, Dr. Sakin spoke about her professor of gynaecology who calls the two fingers which are used to examine the abdomen of a pregnant woman as "eyes" and teaches the students to "see" everything which is going on inside the womb through correct touches with the "eyes". Dr. Sakin said that she really liked this spiritual terminology since this "specific knowledge" led her to understand highly complicated body processes with just two fingers.

The comparison of medical knowledge and common-sense views on health issues and the acquisition of medical knowledge from the perspective of personal values seemed as if related to the recent concerns about health and medical models. However, in the interviews they also served to prove the idea that these doctors were not just hardworking students who internalized whatever they had taught without questioning. In contrast, in line with having a strongly coherent personality, the way they acquire this knowledge was accounted to a realisation in accordance with their own values and ideas.

Career Planning after the University Education as a Strategy of Self-consistency : The third period in the professional life course begins after university education. This period is largely shaped by the students'

decisions on their specialization in a medical field and career patterns. The decision on the specialization field is usually taken in the last three years of medical education where the students deal with the patients in most of the clinics and learn about their particular rules and relationship patterns. In deciding, the students consider the particular characteristics of the clinics, their own medical interests and skills, the medical and popular demand for the fields, and accordingly the fields' required score in the specialization examination (TUS) that they take immeadiately after their graduation. Before taking the examinations, the students fill out a list of their preferences of two or three related medical fields and hospitals they would like to work in as assistants. The doctors who prefer to pursue an academic career, choose university hospitals and after being admitted to these hospitals they write a research thesis in their field besides taking care of the patients who visit the clinic of their own branch during the specialization period.

The choices of the field of specialization and the clinic the doctors work in, in this period were highly influential in shaping the further developments in these doctors' professional life and these decisions cannot easily be changed since the doctors would have to take the TUS examination again in order to change their specialization field, which is something largely protested against by the new graduates and professors since, they negatively affect the chances of new graduates who take this examination for the first time. However, changing the workplace where the doctors specialize is becoming easier thanks to the variations in the alternatives and an increase in the number of different types of hospitals since the mid-1980's, as we saw in the first chapter. In terms of work place, there are

several alternatives such as private hospitals where patients are in general "from higher socio-economic status", private clinics owned by the doctors themselves, which require more professional experience and money to spend, public hospitals which are usually evaluated as inadequate in terms of medical facilities, and university hospitals which are for the doctors whose skills and ambition are evaluated as adequate to pursue an academic career. The choice among these alternatives depends on the doctors' economic concerns, professional experiences they had in different clinics before the TUS examination* and career plans they had in line with their professional perspective. The realization of their choice is also related to their relationships with the more experienced doctors who are either professors in the university or their superiors in the hospital during their assistantship. If as a student or assistant they make a a good impression on their superiors through their display of interest and high quality work, then they are able to begin to work with these superiors in the same hospital. Hence their choice of work place is also highly affected by the relations with their superiors and the professional decisions of these superiors about the work place where both of them will work as "a team".

Considering all of these external and individual factors which influence the choice of the specialization field and the plans about career patterns as a doctor, the choices of my interviewees are accounted to be, particularly consistent with their individual traits. This consistency is built as continuous through time since the character traits which had been

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* Most of the students and assistants work in private hospitals and clinics on a part-time basis or at nights in order to have an extra source of income and more professional experience. Although this was criticized by few doctors and the laws forbid the state employee having other jobs, it cannot be fully stopped since a large number of doctors work in this way.

influential in the decision to become a doctor, were also mentioned with reference to the doctors' career plans. In the accounts of the first two professional periods, the doctors differentiated themselves from lay people through underlying the outstanding position that they had reached thanks to their being hardworking, clever and courageous. In the accounts about the third professional period, the doctor's main concern in their own representation shifted so as to now they stress the consistency between their careers and character traits, or in other word, their personal self and professional self as a proof of their being "good doctors". Hence, after the differentiation of doctors and lay people, a further social differentiation occurs among the doctors in line with their professional plans.

In the first period the general social views on being doctor and medicine, such as "Hardworking people enter the faculty of medicine" was stressed as influential in the informants' choice of profession. In the second period the medical students' character traits and professional perspective were largely influenced by the group dynamics and control of the members of the faculty, including other medical students. The accounts about the third period differ from the first two periods since in this period, the doctors' professional decisions and plans were represented as based on individual concerns rather than the general professional perspective which was acquired through social relations in the first periods. Accordingly, the character traits that were emphasized in relation to the decision on the specialization field are somewhat different than the traits of the first periods, since they reflect more individual characteristics and seem to be more independently developed from the general social attributions to a doctor's characteristics.

For instance, doctors' are attributed an exceptional place in society because of their profession which deals with the vital matters of the peoples' lives such as health and illness and requires an intensive educational and working process. In the first part of this chapter, we saw that the doctors whom I interviewed were highly aware of their exceptional position and justified it through underlying the character traits which were required in order to deserve that position. However, this sense of exceptionality gained another dimension in the accounts of Dr. Sakin who wanted to have full control about her working process. Her claim of having independence and full control over her work is also relevant in terms of the theoretical arguments on professionals, since according to Turner, the professional groups claim to have more initiative in setting and maintaining the rules and regulations of their own professions, defining the boundaries of the professional group, and therefore having full control over their occupation. Their reason behind these claims is that professionals evaluate themselves as experts on all aspects of the professional process since they pursue this profession and experience its problems directly and on an immediate basis. These claims bring out power struggles with the other sources of power such as state and private institutions which have different interests in intervening the professional process (Turner, 1987). Accordingly, Dr. Sakin confronts the state regulations about the working process of its employees, which makes doctors "dull state employees" who have to work from nine-to-five every weekday. She also said that these regulations seriously limits the choice of work place, if doctors "insist on working in a state hospital".

Dr. Sakin who decided to be a doctor with the thought that not everybody can learn medicine and be a doctor, as I have mentioned above, chose the field of gynaecology as a specialization with the same concern of having full professional control and autonomy: She said that her field is highly "specific", and even if doctors from different fields can treat each other's patients, they cannot do the same thing in gynaecology since they will not be able to apply its specific methods. She added that the doctors from other specialization fields became so unsuccessful in treating the patients who should have been treated by a gynaecologist, that even these patients complained about them saying they did another doctor's business. She claimed that the gynaecologists, however, can also check the liver and some other internal organs since they know the "particular way of touching" the abdomen of patients with their fingers that her professor used to call "the eyes". Therefore, through the choice of her specialization field, she also gains an outstanding position among the doctors and acts according to her wish to be independent in work in a way consistent with her aims in the past.

Another gynaecologist, Dr. Sarol correlated his character traits with his professional decisions in a highly skilful way, so that these decisions seemed as "natural" paths to follow in his life course, given his character:

"First, I thought about a profession through which people whose only capital is their brain, can earn money in order to continue their lives under any conditiony. Secondly, I wondered about the professions where people can work independently... I would like to have a job which is not monotonous and which people have respect. In fact the whole issue was this: I would either play a team game or do an individual sport. I would

chose to be a goalkeeper...of a football team or to be a tennis player...When there is a team spirit, you have to hide other people's mistakes a little bit, or you have to take the responsibilities of what other people do and I think that their bad performance would also effect your success. At the end, with these considerations, I decided to become a doctor". (8)

Through these statements and metaphors, similar to Dr. Sakin, he stressed his wish to be a successful and independent individual in all aspects of his life including his work. However, whereas Dr. Sakin emphasized her outstanding position among doctors through her specialization field's particularities and broad coverage of medical practices, Dr. Sarol did the same mostly through stressing his own cleverness and outstanding individual skills in surgery. By working as an independent individual, Dr. Sarol would not be responsible for the low level of professional performance and mistakes of others and, thus, be able to fully display his skills and cleverness. Besides, in line with his emphasis on his independence, Dr. Sarol stressed that he had decided to become a doctor without being influenced by any other people. He said that he came from a relatively well-off family where his father and brother expected him to become a businessman like them. He argued that being a doctor was not considered by his family members as a socially prestigious and economically beneficial profession in contrast to other families with low socio-economic status, who expect social and economic benefits from their children who became a doctor.

Dr. Sarol also stressed his diverse interests, his dynamic character and dislike of monotony both in his professional and daily life. His dynamic character is also represented as essential for his particular field, where he

"can hardly finish his meal" each time because of an emergency call for an unexpected delivery. He generalized this dynamism to all gynaecologists by saying that one can recognize the field of doctors from their manners, and gave the example of formal buffet dinners of doctors from specific fields: He said that doctors usually make a line by the table in a proper way, whereas gynaecologists rush towards the table in order to be the first person to have the meal. This notion of dynamism is also related with the concept of courage as used by Dr. Sarol, since he said that a good doctor, just like him, should not avoid any medical cases even though they include vital risks. He also said that he liked the "excitement" in his profession, of which he compared the enjoyment of bungee jumpers.

Gynaecology, for him, involves a great deal of surgery that provides the necessary ground for him to prove his personal skill and courage in addition to his theoretical medical knowledge. He combined his emphasis of his individual skills and courage with his field of specialization by drawing an analogy between the job of a bomb disposal expert and that of a surgeon, since the slightest mistake in decision making or in an application process may lead to extremely serious trouble ot the death of more than one person, and only the correct application can lead to a "happy ending" in both jobs.

The linkage between particular character traits and the choice of specialization field was drawn by Dr. Çağlar, in a similar way with Dr. Sarol, since he also spoke about his avoidance of monotony in all aspects of life. He stressed that he always had to have diverse interests in life and accordingly he chose to become a general practitioner, also known as family doctor and which consists of five main specialization fields

including gynaecology, pediatrics and psychiatry and pointed to his wish to become pioneer:

" When you want variations (in your profession), you may choose to become a family doctor where you may either concentrate on one of its fields or work in all of the five fields at the same time. This means there are variations in your application of medicine, there are variations when you take care of your patients. I thought that nothing could be better than this. Besides, it is a new field where people create new things...I mean like the pioneers who went to America, this kind of thing seems suitable for me." (9)

Dr. Çağlar said that being a doctor was the first step in this aim of his, since in this profession he acquired a knowledge which is too difficult for a lot of people and helped many of these people with this knowledge. Being a family doctor was the second step which was consistent with the first one, since this specialization field was recently founded in Turkey, in the mid- 1980's which means only four years before his decision on specialization and the debates about the organization and boundaries of this field are still going on. He evaluated himself as successful with respect to his choice in the specialization field, since he defined success as doing something before everyone else does. This skill can be related to being both clever and farsighted which are the two character traits which he believed he possessed according to his statements about himself in different parts of the interview.

Dr. Meriç drew a more indirect linkage between her being emotional and concerned about the helpless living beings and her becoming a pediatrician. She considered herself as highly emotional and related this

characteristic with her sign in the horoscope (cancer). She drew a connection between this character trait and her emotional and professional concern about babies who seemed to her the most fragile and vulnerable beings in the world. She also mentioned about the babies who did not understand what was happening and why they were hurt when they were vaccinated, for stressing their vulnerability, and therefore her being attracted by them.

The doctors' decision on the specialization field is followed by a specialization process where they work from two to six years according to their field, in the clinics as assistants under the supervision of specialists or professors in the case of university hospitals. The accounts of this period, as we have seen above, included many examples which show the consistency between the character traits of the doctors, the decision to become a doctor and the choice of the specialization field. This consistency also justifies the choice of field where the doctors used mostly their own initiative in deciding. Unlike this choice, the decision on the work place depends much more on the external factors and social relations, and providing a similar consistency is more difficult. These factors and relations may not always fit with the professional perspective which the doctors have acquired in the first two periods of their professional life and with their character traits which seemed in accordance with this professional perspective.

When the assistants realize that they are no longer medical students but doctors who are a part of the "actual" power relations in hospitals, a discontinuity through time may appear in the sense that the positive characteristics which were attributed to the profession and its members

can be replaced by bitter remarks as a result of disappointing professional experiences with other doctors and patients. The awareness of the limits of medical knowledge and practice in the hospitals also causes further disappointment in " ambitious" assistants in Dr. Sakin and Dr Meriç's terms.

Idealization of Medicine and Management of Discontinuities: In the accounts about the first two professional periods, we see that medical knowledge and its potential are highly idealized . Dr. Meriç said that before her medical education she viewed medicine as something perfect, which can cure every illness. In this remark, she emphasized the value of medical knowledge which is another source of motivation to obtain it. The value she attributed to medical knowledge is also consistent with her expectations in becoming a doctor: She said that her ultimate goal is to be able to help people who are really in need of help, such as children and people who suffer from "starvation and infectious diseases" in the remote parts of Anatolia. She called this romantic view of medicine as "its humanistic dimension". This view is more common and elaborate in the previous generations of doctors as in the example of Prof. Dr. Türkcan, a well-known female ophtalmologist from the second generation of doctors, who spoke about how her idealism about the profession developed in her youth:

"At that time, we used to read a lot of novels by Cronin. I was a different type of young girl. Medicine attracted me more than other things. I dreamt that I would be useful to people (by being a doctor)...I mean, I thought I would be useful in the development of the Turkish society by

studying medicine. I was highly idealist at that time, now I am not that idealist". (10)

This view of medicine is highly consistent with the Durkheimean approach to the professions. Durkheim argues that the professionals act mainly with altruistic values for the general well-being of their society, rather than considering their own personal benefits (Turner, 1987). This argument is criticized because of its neglect of power relations both among the professionals and between the professionals and lay people. The concept of benefit is divided into two categories, material and symbolic benefits (Hughes, 1958) and Freidson (1970) stressed the social closure in terms of occupational control and monopoly. These criticisms and elaborations led to the emergence of the concept of professionalization which is a process where the degree of being professionalized is determined by "display of social altruism, professional competence, social responsibility and service to the client". Turner (1987) criticizes this view since it reflects the dominant view of the profession itself, ignores the role of power relations and has a unilinear evolutionary approach. Within the framework of these developments on the sociological approach to the professions, Turner's first criticism is especially relevant for this study, since it allows us to find out whether Turkish doctors share the same "idealized" view .

If we return to the examples of Dr. Meriç and Dr. Türkcan, we see that they idealize their profession mainly before and during the medical education. The unpleasant experiences they had during professional practice and their general living conditions affected not only their views about medicine, but also their professional plans. However, in terms of idealization, in Linde's (1993) terms, a sense of continuity through time

could still be found in the accounts. In order to study how this notion of idealization is distorted and reformulated in a different way, we have to study how the accounts of Dr. Meriç and Dr. Türkcan's professional life story continued.

Dr. Meriç, whose ultimate aim was to help the people who are really in need, such as children as I have mentioned above, became frustrated during her specialization period, when she understood that doctors cannot cure every illness and they cannot even be totally certain about the outcome of their medical practices. Her dramatic narrative about an unexpected death of a baby because of an extremely rare allergy to a treatment was evaluated by her that medicine is not like a "machine" where "the usefulness or harmfulness is measured". According to her, there is an important element of uncertainty in medicine to the point that "chance" plays a crucial role. In the case of the death of that baby, she implies that she was mainly unlucky, however, she said that she felt "devastated" :

"It was actually a very sorrowful death for me...It stemmed from a medical fact which you cannot even detect with a microscope. It was not a case of doctor's malpractice. But I was a new assistant and until this was checked I wanted to die. I tried to resign and thought that this profession is not suitable for me" (11)

This event took place during her assistantship where a transition from being a student to a doctor is realized. The account of the event stands as a turning point in the course of both her professional experience and the interview which continues mostly with limits of medical practice and professional problems in the medical realm .

Dr. Meriç's idealized view about medicine is replaced by "bitter realities" also due to the application of "non- academic"- mainly personal and political- criteria in choosing chief assistants, the extreme bureaucracy in the hospital she works and the lack of a patient's trust in doctors. The first point is highly elaborated, since she is also among the people who could not stay as a chief assistant in the university, despite her being hardworking and her ultimate aim of pursuing an academic career. According to Dr. Meriç, these accounts indicate that idealization of the profession is compromised when a person is faced with actual power relations and occupational control after the medical education where professional solidarity and communal ties were much more pronounced. She claimed that each medical student thought that everything worked perfectly in the hospital and university until they began to work there as assistants. She also added that the professors were much more helpful and supportive during the education.

Dr. Meriç's claim about these criteria is in line with Linde's argument on professionals: "Reasons for unsuccessful choices are either shown to be external.. or specifically evaluated as undesirable because of speaker's character traits". Linde says that she has never encountered a sentence like "I was bad at it" among the reasons for leaving a career choice in her interviews. Similarly, Dr. Meriç mentioned a number of interrelated factors which led to her leaving the university hospital at Çapa and her academic career:

"It was imposible for me to stay at Çapa...I was not an ambitious assistant...I mean in terms of getting close with professors, anyway I am not that type of person who shows off. They had never viewed me as a

valuable assistant. I was an average assistant, who always did whatever was asked of me and stayed silent. However, the criteria for staying in the university was highly different, they were nothing to do with how you did your work and your knowledge. The doctor who was working with me at that time had a very highly level of medical knowledge...He used to read much more than me. He had the top score in the TUS examination, they did not accept him either. He was not suitable for their criteria.Their criteria was not making research or dealing with patients...Their criteria were too political. It is the same "oriental mind" which you can find everywhere in Turkey. they chose people who are like them. Unfortunately, this may even be in terms of physical appearance...The ones who look good, show off, are charismatic, have a high socio-economic status and who are from private high-schools (are chosen)...We could guess in advance who would be chosen and who would not...I do not know how they collect this much information on you. Each time some of the assistants get particularly close to the professors and spy on you for these professors". (12)

She also added that she did not want to stay in the university at that time, since she considered the economic difficulties of her family and saw that the material benefit would be inadequate in the academic career. Coming from a family who immigrated from Bulgaria about twenty-five years ago, Dr. Meriç experienced severe social and economic difficulties with her family and is a good example of a recent heterogenization of medical students and doctors in terms of socio-economic background as we saw in the first chapter. Hence, she felt economically and socially responsible for her family which strongly supported her education since

she was the only person who went to university, and said that now in her turn, she has to give a priority to economic concerns to support her family. She viewed this situation as another reason for her leaving academic life and starting to work in a private hospital.

Considering that all of these explanations are given as reasons for her inability to pursue an academic career as she had planned, the large variety of the reasons indicate that she has often thought about this issue which affected her self-confidence, her professional and self presentation. Linde calls this kind of accounts as "multiple non-contradictory accounts", where a "rich multiple causality" is maintained through using different type of explanations which support each other. The explanations of `Dr. Meriç also function as reasons for a highly unexpected break in an unquestioned causal relationship between being hardworking and successful, which is especially found in Dr. Meriç's accounts. This is about a general ideology which states that being hardworking will ultimately lead to success as I have discussed at the beginning. This ideology is related with the idealization of the educational system and health sector in the sense that the scientific and academic- therefore "neutral"- criteria are dominant in determining professional positions and relations. This notion of idealization and the belief in the immediate linkage between hard work and success, were no longer valid in Dr. Meriç's case, during her assistantship due to the deviations from the scientific criteria.

The deviations from these criteria through using individual or "political" preferences in the appointments has been a common accusation in the health sector through the history of modern Turkish medicine, as we have seen in the first chapter. However, the recent political

heterogenization among the members of the health sector, alleviated these debates on corruptions in appointments. Although the use of non-academic criteria is criticized through relating it with the "oriental mentality"- therefore implying its irrationality -, Charles L. Bosk (1979) states that one of the most important normative criteria in promoting the assistants in an "elite teaching hospital" in the US, is the assistants' maturity which is measured by their relationships with the nurses, other doctors and patients, and their "general level of enthusiasm" in working. Therefore, the criteria that led to Dr. Meriç's complaints, are by no means peculiar to the Turkish academic and medical realms as she argued, but a normative rule which can be generalized in different contexts. However, in this context, deviation from the idealized view and practice of medicine mainly through the external professional conditions, is skilfully presented as a personal choice to modify a career plan rather than a failure in adapting to the medical system and professional relations enacted within this system. Accordingly, her being hardworking which is a frequent motive in the interview, acquired an additional meaning of perseverance, since she always worked as much as she can and, because her work was not appreciated as she expected, changed her workplace to continue to work as before in order to cope with external problems.

Despite the fact that her idealized expectations about the profession have not been met, Dr. Meriç still provided a continuity through time by mentioning her future professional plans which are in line with her aims in being a doctor. Although the "non-academic evaluations" in the academic environment and economic difficulties led her to give up the ideal of reaching the highest point, i.e becoming a professor, she still maintain

one of her aims in being a doctor and choosing a specialization field: She consistently wanted to help the living beings who really need help, such as babies and baby animals, through her daily and professional life. Accordingly, working in remote parts of Anatolia where people are much more hopeless in terms of their health condition, is still among her plans for the future, when she will have more money to take care of her family with whom she has very close emotional and material ties.

Dr. Türkcan who had more general social concerns than Dr. Meriç in becoming a doctor, has lost her belief in the sincerity of her patients after certain events which she narrated as a turning point in a similar way with Dr. Meriç. During the first years of her assistantship, she realized that her patients deceived her by pretending that they were much poorer than they actually were in order not to pay the treatment costs. Due to these events where the patients abused her good intentions, her "idealism" was compromised and turned into a "materialism". She is also disappointed by the patients who never really appreciate her medical treatments and want more care mostly through unacceptable ways such as the patients who wanted her to take care of them even during her vacation. Nevertheless, her ideal of "being useful to the Turkish society" has continued with her stress in the "university professor and scientific researcher" part of her professional identity. When she lost belief in the sincerity of the patients for whom she wanted to improve all aspects of their life, including their health, she shifted the focus of her interest to her students whom she now fully supports through providing research opportunities in her private clinic and giving all kinds of academic help in order to raise "many new

doctors who will be useful for society". Her patients also became her objects of scientific research rather than subjects of care.

The Changes in the Views on Medicine, Routinization and Critical Moments: The routinization of work is another factor which undermines the idealization of medical knowledge and practice. All of the doctors say that after a certain point their profession becomes "routinized" and that they are used to its positive aspects such as the " pride and joy" of saving someone's life as in the example of Dr. Yaş, who worked for five years in the emergency section before he became an orthopedist, and its negative aspects such as the inefficiency of the Turkish medical system. The negative aspects are represented mostly as external factors that are beyond the control of these doctors. Especially the problems in the medical system and hierarchical relations between doctors are seen as deviations from an ideal scientific order from which they had expected to benefit all through their professional life, since they evaluated this order as suitable for their character traits which brought them success and an outstanding position in the first two periods of their professional lives.

Before becoming directly involved in the professional relations, these doctors are, in general, more inclined to view their profession as having a high degree of professionalization where altruistic values are considered as the main principles, due to the influence of social values that were attributed to doctors and professional socialization that they underwent in the faculty of medicine, as I have discussed above. However, actual professional life is accounted to be full of non-academic, non-scientific, bureaucratic and even commercial (mostly in the case of private hospitals)

applications which prevent the maintenance of altruistic values, and make doctors compromise their ideal view of medicine and their altruistic professional work, in favour of "materialism". These applications which obstruct the development of professionalization are related with the abuse of power relations mostly by the professionals in superior positions, whose decisions are crucial for the career of their subordinates.

Besides routinization and non-scientific criteria, there are also challenging critical moments in medical operations where the doctors become aware of the limits of medical practice in the sense that it fully depends on the particular initiative and skills of doctors. Dr. Meriç and Dr. Sarol differ highly in terms of their views on the critical moments in medicine. Their personal and professional approach to these vary mainly because of their professional experiences: Dr. Meriç stressed the elements of uncertainty and chance in medicine and told about the death of a baby during her assistantship in a highly dramatic way, as we have seen above. Dr. Sarol also mentioned a critical point where medical knowledge by itself is inadequate, and an outstanding degree of skill and experience are required. He compared doctors professional experiences in these moments to the work of bomb disposal expert, as we have seen above in terms of how they both lead directly other people living or dying. However, there is a crucial difference between these doctors with respect to their emotional reaction towards this critical point: Dr. Meriç who always struggled to reach the highest place, becomes anxious when she is faced with a critical moment because of the fear of doing something wrong or in an inadequate way, whereas Dr. Sarol who evaluated himself as highly skilful and successful, feels a "special pleasure" in these moments where he can

demonstrate his skill to the participants of the operation. Several times in the interview, as if to give an external proof of his skilfulness, he talked about a large amount of people varying from highly experienced doctors to nurses who participate in his operations in order to learn from his skills or just to admire his skill. Although the difference in reaction may be partly explained in terms of different degrees of self- confidence, it is mostly due to different ways of experiencing the social closure within the professional realm: Dr. Sarol who is well accepted in professional circles and appreciated by his superiors, did not talk about experience of a professional failure. However, Dr. Meriç's major aim of being a professor has not been realized because of the "non-academic" criteria that are used in choosing the chief assistant, according to her.

Reconstructing Self-consistency and Continuity through Time, Self-Reflexivity: The doctors whom I interviewed, do not want to represent their professional life as "drifted" by the external conditions which I have mentioned above, in line with the Linde's discussion about the American professionals' accounts about their career planning patterns. So far, we have seen that the doctors used several strategies to indicate their initiative in providing the consistency between their character traits, professional perspective and experiences at work in the third period of their professional life. They also gave examples of " bad doctors", such as "the assistants who spied on their colleagues for their superiors" as in Dr. Meriç's example. These "bad doctors" complied with the professional rules or adapted to the "external factors" even if they are not consistent with their character traits and professional perspective, . In contrast, the doctors whom I

interviewed, stressed the consistency between their character traits and the particular specialization field they chose, solved a case of inconsistency between their professional perspective and external relations by changing the workplace in order to work in line with the scientific criteria they were used to and activated different parts of their professional identity in order to reach their professional aims.

However, these efforts of rebuilding self-consistency are not smooth processes as they are presented in the interviews. They involve a self-reflexive perspective which can particularly be found in the accounts about the modifications in a career plan or professional perspective and identity, which happened due to the inconsistencies between the ideals and external, "real" conditions. This is also related with the maintenance of the moral value of the self, since the doctors re-built a continuity through time with respect to the relationship among their character traits, professional perspective and professional experience. Hence, by doing it that way, they would like to indicate that their individual and professional self are still consistent, therefore they are always "good doctors" as they had envisioned to be before and during the medical education, despite the problems coming from "the external factors" in the work life.

Linde (1993) determines self-reflexivity as the differentiation of self as the "narrator" and the "protagonist" in a narrative, so that the former can evaluate the latter with the critical perspective of "an outsider". Self-reflexivity allows editing of certain aspects of the self in relation to the time dimension by differentiating protagonist of the past and narrator of the present. This is especially relevant in building a relationship between how they see themselves and how they think they are seen by others, especially

by their superiors. For example, there is a tone of self-criticism in Dr. Meriç's evaluation of herself as a silent, modest assistant who merely accomplished her professional duties. The alternative is to be "charismatic"- which means good looking and sociable according to her definition- and to form close personal relations with professors as a part of their strategy to impress them. However, this categorisation of assistants does not involve a pure self-criticism, since Dr. Meriç was against being a "flatterer" type of assistant , since this does not fit her principles about her scientific and academic work. She also said that she maintained her professional principles and began to work in a private hospital where she can pursue these principles.

Dr. Türkcan also has a self-reflexive style, in telling how her professional views have changed from "idealism", expressed as being useful to patients and to Turkish society, to "materialism" where she does not let her"romantic concerns" interfere in her relations with her patients. She related her idealism to her youth, to her romantism, to her interest in the novels of Cronin and to the humanistic political tendency prevailing in the university where she was a student. During the interview, she evaluated that period of time and located herself within that period from the point of view of a middle-aged woman with a highly established scientific career. The main cause of the change in her professional conceptualizations in time is given as her loss of belief in the sincerity of patients and the economic and administrative problems she has experienced during her professional career. Nevertheless, for her, she seems to balance her past ideals of becoming useful for the general improvement of the society, and her actual professional position with her

contributions to medicine through her scientific research and with her academic career where she educates many new doctors "who will be useful for Turkish society".

Unlike Dr. Türkcan, Dr. Sakin has not yet accomplished a balance between her ideals about her profession and her professional position. As a primary reason of her decision about being a doctor, she mentioned her envy of the doctors who used to visit her father in his pharmacy, since they work independently and seem to have highly flexible working hours. She said that her main aim in entering the faculty of medicine was to work independently, as those doctors, in the future. She now evaluated this reasoning as "childish" and admitted that she did not know that she would become an assistant in a state hospital after university education, and therefore be a state employee whose professional practice is strictly limited by rules and procedures. However, in order to establish continuity through time with respect to her professional plans and perspective, and consistency between her professional experiences and plans, Dr. Sakin mentioned that she was planning to realize her ideal of independence by opening their own private clinic. She also talked in detail about how much money she had to save for this purpose and argued that she clearly had to work in a private hospital in order to collect that sum. This shows that she had not given up this idea totally, even though she evaluated it as "childish". In this case, we see that, in terms of time dimension, the inconsistency between the professional plans of the past and the present professional position is reconciled by mentioning future plans which are in line with the ones in the past. Therefore, the continuity in time in terms of the presentation of the self and professional plans is maintained.

Conclusion: In general, the doctors whom I interviewed presented themselves in a highly self-consistent way both in personal and professional terms, despite the gap between their professional expectations of the past and their current views about their profession. They try to fill this gap through various strategies of career planning such as choosing a specialization field that is consistent with their own character traits, trying to find the type of hospital where they can work according to their professional principles or underlying different aspects of the identity of a "good doctor".

During the first period of professional life which involved the decision to become a doctor, the interviewees mostly reflected the social attributions to this profession, and underlined their success and outstanding position among other people, with respect to their character traits of being hardworking, clever and courageous. These character traits were also implied as being required to be a doctor both for the first as well as the second period of professional life which consist of the medical education. However, these traits were more affected by the group dynamics among the members of the faculty of medicine. In the third period the character traits were similar to the ones which were emphasized in the former periods, but they acquired a more individualistic significance. In this period, the major consistency was drawn between these character traits and the choice of a specialization field. In contrast, this period also involves disappointments that stemmed from the "external" views and practices that are thought as deviations from the idealized, altruistic image of the profession. However, this image is also determined to change as the professional career of the

doctors becomes established, since "idealization" and mystification of medicine are subordinated with "materialism" and "routinization".

The doctors whom I interviewed eventually notice that professionalization, as it is discussed in Turner, can not be fully realized mainly because of the complexity of power relationships which are based not only on scientific or academic criteria, but also on a hierarchical order where the superiors have the right to impose their "personal" rules and of the state's restrictions or the bureaucracy in private hospitals which routinize the profession. These "external problems" were not experienced particularly by my interviewees, but, as we have seen in the first chapter they were among the main problems in the Turkish health sector in the 1980's and onwards when my interviewees mostly began to pursue their profession. These problems also influenced the process of professional socialization which my interviewees and other doctors from their generation had undergone during and after their medical education. Accordingly, even though they mostly accepted the basic aspects of professional perspectives they had been given, they have also questioned it, in line with their individual experiences, character traits and particular social conditions. Despite the fact that they question the professional perspective and that they sometimes take a personal distance from it, they are generally well aware of it and often refer to its basic aspects such as the prevalence of scientific criteria, the idea of social progress and doctors important role in this process, in their comments about their professional self, their profession, the health sector and society. Hence, they indicate that they fully internalized the basic aspects of the professional perspective, which were also consistent with their individual character, so that, in line

with this professional perspective, they can make legitimate political judgements about their society and have a social mission to improve the general social condition.

Despite the problems, these doctors still present themselves as "good doctors", since their professional decisions are mostly shaped by their major character traits and idealized views on medicine and science, rather than a passive obedience to the "external" professional applications which they do not approve. Through their character traits which were presented as major requirements to be a doctor, they had reached the outstanding success of entering the faculty of medicine, the first step to be a doctor, and, therefore, they have differentiated themselves from lay people and attributed themselves a higher position. In the following professional periods, the interviewees differentiated themselves from the other doctors, by implying that they are "good doctors" because of the consistency between their individual and professional self which means a harmony and continuity through time with respect to their character traits, professional perspective, professional experience and future plans. The outstanding position these doctors attributed to themselves both in relation to lay people and other doctors, and their overcoming external social and political problems which they have experienced in their workplace, without compromising their character traits and professional perspective on the last instance are presented as two important sources of legitimacy for them to make social and political judgements and to have a social mission about the health sector and society in general. They also generalize their views and experiences on the health sector in order to make comments about the social and political condition of the country, since they stressed that all of

the problems encountered in Turkey are reflected in or find their counterpart in the Turkish health sector.

In the last chapter, I would like to study how the recent social problems of the country are reflected in its health sector, particularly in terms of the changing social position of doctors and, accordingly changing relations between doctors and patients. Through their experiences in the health sector, the doctors understood that the typical images of doctor and patient, and the view about the ideal relationship between these two people which were given them in the process of professional socialization, were no longer valid. In the next chapter, I would like to study how these images were changed, and how the doctors still built a legitimate power position for themselves despite these changing relations and images. Again, as in this chapter, I will mainly benefit from the interviews and try to find out the interviewees' ways of establishing legitimacy to make social judgements from their accounts on the place of doctors in society and on the relationship between doctors and patients.

Chapter 3

The Social Position of Doctors and the Changing Doctor-Patient Relationship

In this chapter, the ways in which the new generation of doctors maintain and secure their position of social authority with respect to the changes in the social view on doctors and in doctor-patient relations will be covered. In studying these issues, I will mainly benefit from the interviews I made with a group of doctors mostly from the younger generation, as in the previous chapter. The social structure and cultural values in Turkey have undergone a period of rapid transformation since the 1980's, which have influenced particularly the sectors of health and education. The ability to provide and benefit from all types of medical services have become a conflictual issue in society because of the increasing economic inequality among different groups of people and the recent variations in the type and quality of medical services. In this framework, Helman's (1990) conceptualization of the medical system as "an expression of- and to some extent a miniature model of- the values and social structure of society from which it arises" helped me to study how the changes in the general social structure and values affected doctors as a professional group and their social position.

Helman indicates how the dominant ideology in a society may influence the views on health and medical care, and, therefore the policies

which are conducted in line with these ideologies and views. He argues that depending on the dominant ideologies of the society such as capitalism, the welfare state or socialism, the health and medical care may be viewed as a source of profit and " a commodity to be bought by those who can afford it" as opposed to many poorer members of the society who are excluded from this system, or as a basic right of citizenship where very old and poor people are particularly provided "with free or relatively inexpensive health care" (Helman, 1990).

However, the dominant ideology and social view on the health care in Turkey cannot be labeled in such definite terms and have changed particularly in the last three decades. Particularly, the governments' efforts to fully adopt the contemporary Western capitalist system with all of its policies including privatisation after the mid-1980's, are a distinct departure from the health policies of the 1960's and 1970's, which were in line with the socialization law and political concerns of that time, and which favoured the access of socially and economically disadvantageous groups to medical services. Hence, despite the efforts of the medical chambers to bring back the view of the health care as a basic citizenship right, the view of health care as a commodity and the policies in line with it have become more prevalent especially among government members, and among businessmen who have begun to make considerable investments in the health sector (Gökçay, 1996) (Arıoğlu, 1996).

These changes have led the doctors to evaluate their professional group and its social position in new terms, since their professional perspective has been shaped mainly by the view of health as a basic citizenship right during their professional socialization in the university.

The changes in the professional concerns and perspective of doctors have affected negatively the social image of this professional group and negative images in the society such as "greedy doctors" have become prevalent. The professional experiences of doctors are influenced by the changes in these views and policies, and the doctors try to incorporate their newly developing economic concerns into their professional perspective. The doctors whom I talked to, argued that their relations with their patients have altered dramatically in line with the changes in the social image of doctors. Therefore, doctor-patient relations have become a crucial domain for the doctors to display their professional and social concerns in order to maintain their position of authority despite the negative social view of them.

The Characteristics of Doctor-Patient Relations: Doctor-patient relations is a multidimensional issue where the two groups have different conceptualizations of health and illness and interact in accordance with highly unequal relations of power and authority (Helman, 1990). Parsons (1951) is among the first social scientists to conceptualize medicine as an institution of social control in a modern society where deviant behaviour can be legitimately considered as an illness providing that the deviant person acts according to the socially defined "sick role". This role includes certain rights and obligations that the "sick" person should be in compliance with, such as being diagnosed as such and a treatment plan which is designed in accordance with the prevalent medical model and methods which are applied by the doctors. In sum, in a modern medicalized society where the biomedical model and techniques dominate the health sector, the patients have to subordinate their own views about

their health condition to the doctors' medical explanations and fully obey the treatment plan which is designed by doctors (Conrad, 1992), (Helman, 1990). Therefore, Helman views the doctor- patient relations as "transactions which are separated by social and symbolic power" since the doctors' social and symbolic authority and power come from the fact that they are socially considered as the only people who can make valid medical judgements and treatments particularly in a hospital setting thanks to their medical education and experience.

In addition to these statements on the doctor-patient relations, which are made in general terms, Helman also argues that the context where the doctor-patient consultation takes place is also influential in shaping "the types of communication between doctor and patient". He mentions two aspects of this context: The internal context which consists of "prior experience, expectations, cultural assumptions, explanatory models and prejudices (based on social, gender, religious or racial criteria) that each party brings to the clinical encounter" and the external context " which includes the actual setting in which the encounter takes place and the wider social influences acting upon the two parties-such as the dominant ideology, religion, or economic system of the society-and which in turn helps to define who has the power in consultation and who does not". Therefore, the patients' full compliance to the medical explanations and treatments is not always guaranteed, but rather depends on the contextual elements that are mentioned here. Besides, doctors and patients negotiate their explanations of health and illness to some extent since the doctors have to be aware of and act according to the cultural values and social

status of the patients in order to build a common communication pattern for an efficient treatment.

In the last two decades, the patients have suffered from the problems in the health sector and a negative social view on doctors became prevalent in Turkey. As a result, the patients' attitudes and behaviours towards doctors have been transformed from one of compliance to distrust and disrespect . Therefore, Turkish doctors began to look for new ways of re-gaining their social prestige and providing patients' compliance such as contradicting the negative images of doctors through their professional concerns and experience. Before studying how the doctor-patient relations have changed, I would like to briefly tell about the doctor-patient relations in Turkey before the 1980's.

The Doctor-Patient Relations in the Past: When describing the doctor-patient relations in the past, the doctors whom I talked to, gave examples from an idealized period of time when their own family's behaviour and attitude towards doctors were completely based on the feelings of respect and trust in line with what they have learned as a basic rule in the faculty of medicine. They compare and contrast these examples of the past with today's professional experiences in order to bring a historical explanation to the changing doctor-patient relations. These examples also serve them to differentiate their own family from their patients in terms of their attitude towards doctors. For instance, Dr. Yaş told about how his mother scrupulously prepared him for his visit to the doctor when he was a child, even though his parents were quite poor and had a low level of education similar to his patients. He gave a detailed list of

what his mother did to him and his brothers before they saw a doctor, "in order not to experience a shameful situation in front of the doctor":

"In my childhood, when my mother took me to the hospital, even though it was only for vaccination, she even used to cut our nails, change our underpants. We used to take a bath, (since she said) perhaps the doctor would want you to undress my son. In order not to experience a shameful situation (in front of the doctor), we used to wear our most beautiful clothes which were bought for holidays (*bayramlık elbise*). hence we had that considerable feelings of respect and timidity when we were going to visit a doctor". (13)

Dr. Türkcan, whose account about her family's attitude towards doctors dated at least twenty years before Dr. Yaş's account which was pertaining to the late 1960's, spoke about the family doctors who visited the families in their houses and had a close relationship with the members of the family:

"The house used to be cleaned before the doctor came to our house. Even his payment was put in an envelop beforehand...the coming of Cahit Sami Gürsoy was like a festive event for the household members; my father used to pick him up from his private clinic and people used to say "thank you" several times to him. Now, of course, these kind of things have disappeared. The doctors also do not go to their patients' house, I mean they do not like to go there, unless they know the patients well and have close relations with them. But now they do not go often, they do not have time". (14)

The accounts of the memories of the past which constitute a sharp contrast with the evaluation of today's doctor-patient relation, implies that

crucial changes have happened in the contextual factors, in Helman's terms, due to several interrelated reasons. The reasons were also given by my informants in order to display the disappointments of doctors during their professional experiences. They are also important in showing how the doctors balance their economic and humanistic concerns with respect to their relations with patients. The doctors from the former generations played an active role in shaping the major social and ideological movements within the society since the birth of the modern Turkish medicine. Thanks to this active role which had been shaped in accordance with the process of the professional perspective's formation, these doctors gained a considerable social prestige and position of authority in the society. Relatedly, an idealistic image of doctors became dominant in the society, as people who are altruistically devoted to saving people's lives, to improving their health and having active social roles in shaping the modernization process of the country along their progressive and scientific lines. This socially privileged position was also reflected in doctor-patient relations where a completely respectful and trustful attitude was almost taken for granted by doctors, as we see in the accounts of Dr. Yaş and Dr. Türkcan above and in the written autobiographical accounts of the past where the patients, besides the payment of the bill, gave valuable presents to the doctors such as a ram in order to thank them and the families invited them to their picnics (Sezer, 1953) (Minkari, 1993). As we saw in the first chapter, the economic power of doctors was also consistent with their privileged social position, since most of them came from families with a high socio-economic status and their own income was also satisfying. Although doctors began to express their wish to earn more from their

profession in the last half of the twentieth century, the economic problems and fluctuations in the country did not seem to be highly influential in shaping the doctor-patient relations until the 1980's (öncel, 1951) (Gökçay, 1996).

In these conditions, the doctors enjoyed a prestigious position and in line with this position they acted with a missionary professional perspective which included working toward transformation in the living and thinking patterns in society according to the objective-scientific values of contemporary Western societies. Therefore, the missionary professional perspective of doctors and their social prestige as opposed to economic concerns of both doctors and patients became the dominant factors in shaping doctor-patient relations in the past. Dealing directly with monetary issues in relation with doctors would be an indicator of the patients' disrespect towards them and were socially evaluated as unsuitable behaviour considering the doctors' social prestige, and this is the reasoning behind the Dr. Türkcan's father's giving money to the doctor in an envelop. However, the interrelated contextual changes in society have altered the balance of social and economic concerns of doctors and affected the patients' attitude towards them.

The Contextual Changes which have Influenced Doctor-Patient Relations: One of the contextual changes which has influenced the patients' attitude is the decline in the quality of medical education and medical services after the 1980's due to the state's policy of privatisation in the health sector which played an important role in lowering the sector's share in the state's budget.

Together with the decrease in financial support to health, the rapid and unplanned expansion in the numbers of faculties of medicine and medical students caused a decline in the quality of medical education (Gökçay, 1996), (Sahip, 1996). Most of the doctors whom I interviewed, complained about the crowded classrooms and laboratories, which particularly hampered their active participation in the dissection of cadavers and examination of patients. As a result, these doctors did not view themselves as competent in terms of medical practice, and even felt anxious and doubtful about the ways they would care their patient. This situation is also a general problem for the last generation of doctors who started their professional careers in the 1990's. Hence, the problems in medical education have directly affected the doctors' professional experience and the quality of their professional service. Some of the doctors whom I interviewed confessed about their uneasiness in the examination and treatment processes, which stemmed from lack of practice.

With respect to the medical services, the typical result of the governments' politics is the public hospitals' becoming overcrowded with patients who wait for hours in line in order to be examined, or who manage to get an appointment for weeks later in order to be hospitalized and have an operation. As a result of the growing economic problems of the public health sector, it is becoming more and more difficult to open new state hospitals and clinics, and enlarge the old hospitals in an efficient way in order to respond to the medical needs of a rapidly growing population in big cities like Istanbul. Moreover, the economic problems also lead to a decrease in the number of personnel in the state hospitals. More and more talented and young doctors who have recently specialized in their fields

prefer to work in the private hospitals due mostly to economic and individual concerns. Personnel are not replaced when they retire, since their wages cannot be paid because of the state's policy to decrease the professional positions in the state hospitals. The insufficiency in personnel and in clinical facilities such as hospital beds are also accompanied with a high-level of bureaucracy experienced in the admission of patients which adds another difficulty for the patients in the state hospitals. Most of the doctors whom I interviewed said that the patients who had to endure a hard and long time because of the large number of patients and bureaucracy, before seeing them in the hospital, blame all of the problems that they had encountered in the hospital on the doctors. For Dr. Yaş, patients ignore the problems in the health sector, see the doctors as responsible for the difficulties they experienced in the hospital, since they think that the doctors have much more control over the hospital system and that they can listen to their complaints and find solutions to them.

However, according to other doctors, there is another reason for the patients' blaming the doctors for their problems in the hospital. For Dr. Türkcan and Dr. Gökçay the particular political clash with the military regime and doctors that were highly active in politics before the military coup, as I have mentioned in the first chapter, led the military regime and particularly Kenan Evren to campaign against this professional group with defamatory speeches. These doctors said that these speeches presented the Turkish doctors as giving a priority to their individual concerns rather than worrying about the health condition and social situation of their patients. Evren also criticized the former political activities of doctors for undermining national unity and leading the country into terror and

anarchy (Gökçay, 1996) (Arıoğlu, 1996). Dr. Türkcan said that these speeches were largely covered by the state television and influenced general public opinion.

The media has also continued to influence the public opinion on doctors and remained as a contextual element in shaping doctor-patient relations in the 1990's through "reality shows" which depicted poor conditions of the hospitals and cases of mal practice in a sensational way. The doctors whom I interviewed highly criticized these programs; they agree that the people have a right to be informed about the mal practices of doctors, however, they stressed that these programs merely point out the negative and sensational aspects of doctors and hospitals, but never give examples of the happy events experienced in hospitals. Especially, Dr. Meriç said that she was very frustrated by the negative image given by these programs and had even thought about writing a critical letter to one of their directors. However, she also added that she has taught herself not to let these programs frustrate her by avoiding watching them. All of my informants agree on the crucial role of the media in propagating negative images of doctors, such as "greedy doctors" in Dr. Çağlar's terms, whose economic concerns dominate their professional experience and unskilled doctors who are frequently involved in malpractice cases. However, the doctors whom I talked to also implied that the malpractice cases might actually became more frequent due to the decline in the quality of medical education and admitted that the economic concerns of doctors have increased due to heterogenization of doctors in terms of socio-economic background.

As I have mentioned in the previous chapters, as more people who were born and raised outside of the three main cities and who have low socio-economic status began to chose and enter the faculties of medicine. The economic concerns became highly influential in the changing professional perspective and career patterns in line with it (Gökçay, 1996) (Gökçay, 1997). The heterogenization among doctors has also gone parallel to the process of differentiation in hospitals. In line with the policies for the privatisation in the health sector, the number of private clinics and hospitals has considerably increased. These hospitals have become an attractive choice for the young doctors whose economic concerns are dominant in planning their professional life. However, the doctors' preference of the private sector has other, more complicated reasons which stem from the changes in their political position and their relations with the state, which will be discussed later. Despite the recent heterogenization of doctors in terms of their socio-economic background and professional career patterns, the doctors whom I talked to, still continue to view and describe their patients as a totally different group from themselves, and this also serves as an explanation to the problems in doctor-patient relations.

Doctors' Evaluation of their Patients: The doctors whom I interviewed, generally talked about the negative social attitude towards their professional group with respect to its reflection on the behaviours of their patients. In line with their argument about the social, economic and political problems of the country which find their immediate counterparts in the health sector as we have seen in the first chapter, the doctors evaluate the social attitude towards themselves through their experiences

with the patients. This also helps them to make generalizations about the patients and to view them as an undifferentiated category. The image of the patients is drawn by the doctors in very different terms than those used to construct an image of themselves.

Although the doctors admit that the patients also differ in terms of their socio-economic status and attitude towards doctors, they mainly describe them from their own stereotypical images of the people who have low-socio-economic status. Dr. Yaş, a male pediatrician who works in a state hospital, argued about the importance of precautions that lay people have to take in order to maintain their health status and prevent illnesses. For him, the people who are not educated and intelligent enough to understand the importance of these precautions, or who are too poor to practice them, become ill much more often and visit hospital. Accordingly he said that the people who are "rich, intellectual and have high social status do not often become ill" in contrast to "the poor people who live in squatter areas and who struggle hard to gain their bread-money" and who constitute " ninety-percent of the sick people" who visit the hospital. Similarly, Dr. Meriç said that dealing with the rich patients is less problematic, because they in general know how to take care of themselves and their health and have the opportunity to benefit from all types of medical services any time they like.

Dr. Türkcan, a female opthalmologist, stressed that she had felt highly alienated in dealing with the patients in her early years of work. The reason for her alienation lay in the difficulty of achieving a shared communication with her patients, due to the differences "in their familial background, their educational level and life style". She gave examples of

her misunderstanding of patients due to their low level of education: The illiterate patients who try to identify the letters from a distance, may call the letter "E" as fork, since they may not know the concepts of left and right, they may tell the directions of letters with the names on the wings that blow from that direction.

The problems of different languages is also mentioned in several interviews, since most of the patients in the state hospitals are recent migrants from the South-Eastern cities and know only Kurdish, due to the recent mass- migration from the South- Eastern region. Although most of the patients are generally accounted as having a low socio-economic background and a low level of education, particular references to these migrants prove that this group has other disadvantages such as linguistic. Dr. Sarol, a male gynaecologist, said that in addition to their lack of understanding of Turkish, these patients and their families do not know anything about the rules of the hospital; for instance, in the middle of an surgical operation of a pregnant woman, her husband may suddenly enter the surgery room in a calm manner. Dr. Sarol said that if the doctors like himself, tell the husband to leave the room in a polite manner he would not understand anything and not quit the room, in contrast to the doctors who shout at the husband angrily and make him go out immediately. He argued that the migrant patients are more offended when they are not treated there by the doctors or when they can not be hospitalized because of the overcrowding of the patients, since they think that they are particularly rejected by the doctors because of their ethnic identity as Kurds. Dr. Sarol also stressed their ignorance and lack of intelligence as difficulties in building a communication pattern. He said that most of his patients in the

state hospital did not really understand his explanations about their own health condition, for instance, he could not properly explain the menstruation cycle since he saw that "they do not have this intellectual capacity" to understand it. Similarly, Dr. Sakin, a female gynaecologist, said that most of her patients cannot remember when they had their last menstruation period and ask their husbands who record this period in respect of birth control.

Dr. Sakin not only said how she viewed the patients, but also commented about their familial relationships which put her patients in a socially disadvantageous position. For her, the young brides are oppressed by their mother-in-law and husbands at home, hence, in order to attract their attention and to be cared, for the young women pretend to faint and their husbands take them in their arms and immediately bring them to the hospital. Dr. Sakin and Dr. Çağlar stressed that they often accept patients alone in the examination room, which is highly unusual since most of the patients are accompanied by their relatives and neighbours everywhere in the hospital. In this way, they argued that they are able to diminish the negative effects of these people to the patients' social and medical condition to a certain extent and that they can talk with the patients privately and, hence more openly, about their medical situation. Dr. Meriç, a female pediatrician, also said that, one of the reasons why she preferred to deal with children is that the adult people complain about their health problems which mostly stem from their psychological rather than physical condition. Both of these doctors said that these patients should go to a psychiatrist rather than a doctor.

These two doctors' clear separation of psychological and physical problems both in terms of conceptualization and treatment is related with the perspective which they acquired in their medical education and professional practice and which enables them to make legitimate medical judgements on the patients' health condition by "medicalizing deviant behaviour as well as many of the normal stages of the human life-cycle", in Helman's terms (Helman, 1990). Doctors scrutinize their patients' social and psychological situation in addition to their health status in line with their medical knowledge and professional perspective. Helman gives examples from the critics of modern medicine such as Illich, who argue that the doctors through labelling their patients as ill, incurable, malingering or hypochondriacal, try " to control the behaviour of the population". Conrad defines this concept of medicalization as a process which occurs at the conceptual level where the problems are "defined and ordered" in medical terms, the institutional level where specialized organizations where doctors have effective roles, may adopt a medical approach to treating a particular problem, and finally at the interactional level where doctors are most directly involved in the definition of a problem as medical or social. In the last level medicalization occurs as part of a doctor-patient relationship where the doctor has legitimate authority and power to make a judgement on the physical condition of the patient (Conrad, 1992). However, in the examples above, the medical perspective which was given to the doctors leads doctors to go beyond the aspects of the physical condition in their evaluations about their patients. It also shapes the doctors' judgements about the psychological traits, social relations and life-style of the patients. The doctors who define themselves as having a

modern life-style in accordance with the scientific and positivistic values that they have acquired since their medical education, talk about their patients in opposite terms, such as having traditional and religious life patterns, lacking a scientific mind and education, finding temporary and primitive solutions to their social and medical problems and acting with their emotions rather than their limited reasoning capacity. The doctors' observation of the family members of the patients who accompany them in the hospital and of the social relations between these family members and patients also provide clues for doctors in order to make judgements about the social position of the patients.

The medical perspective which is first given in the faculties of medicine, is in line with the "basic premises" of the biomedical model where a clear-cut mind and body dualism is conceived (Helman, 1990). Other basic aspects of the biomedical model as given by Helman, are also implied in these doctors' examples. The doctors evaluated the real reason behind the patients' complaints as psychological through conducting scientific and objective tests. Complying with the premises of the biomedical model, the doctors' do not consider a complaint about health status as a physical problem that is to be cured by medicine, unless it is scientifically detected by the objective medical tests (Jackson, 1994). Hence, they gave priority to the explanations which are made according to scientific rationality and objective, numerical measurement. However, in evaluating the results of these medical methods, they go beyond making medical judgements about the health condition of the patients through evaluating and trying to improve the social and psychological condition of the patients.

Another premise of the biomedical medical model is "the emphasis on the individual patient rather than on the family or community". This is not or probably can not be realized in Turkey, since doctors have to consider the characteristics of the family or community members who have a considerable influence over the patients' decisions on their health condition and who often accompany the patients in the examination room. For instance, Dr. Sakin angrily spoke about her patients who compare the way they are treated in the hospital with the treatment of their neighbours and want the same treatment as their neighbours even though they do not have the same illness, since they trust their neighbour's medical evaluations more than the prescriptions of their doctor. Through their comments on the family and community ties of their patients, the doctors also make generalizations about the social relations in Turkey, and therefore enlarge the scale of their social judgements.

The doctors' judgements about the poverty, low level of education, ignorance about science and medicine, traditional views and life patterns in society through their evaluations of the patients' behaviours and illnesses contradict with one of the most important criticisms of the Western medical system, in the sense that it ignores that "much of the ill-health in Western society may be caused by other factors- such as poverty, unemployment and economic crises" because of "its main focus on the individual" (Helman, 1990). This criticism is not valid for the Turkish medical system where the doctors are highly aware of their patients' economic and social problems. This is highly related with the Turkish doctors' active roles in shaping the social and political developments in the country since the birth of modern medicine, as I have mentioned in the first

chapter. This active role is also influential in shaping the professional perspective which has traditionally included social concerns for the whole society. Moreover, in contrast to the general picture of Western doctors as a privileged group who have a high social status and economic power (Helman, 1990), Turkish doctors are influenced by the social economic problems of the country daily since they are reflected in the hospital structure as a lack of enough medical equipment or personnel. Their social status and economic power are also lower than medical doctors' in the West and have tended to decline in recent decades. Therefore, they have a more immediate understanding of the social and economic problems in the country than the doctors in Western countries, since these problems play a more influential role in shaping their professional perspective and experience. Especially, considering the inflation rates, the "real value" of the wages of the doctors who work in the state hospitals have dropped considerably in the last two decades, because the states' policies of privatisation in health sector (Arıoğlu, 1996).

Despite the recent heterogenization of the doctors in terms of socio-economic background and professional career patterns, they depicted the patients not only by making a high level of generalization but also by representing them as a totally different group than themselves in terms of their social and cultural background. All of the doctors mentioned or implied that they come from higher socio-economic backgrounds than their patients, they are obviously much better educated and have much higher intellectual capacity and concerns. However, besides these general remarks, when answering specific questions about the differences among the patients with respect to the type of hospital they attend, the doctors also

accepted that there is also a heterogenization among the patients with respect to their social background and attitude towards the doctors accordingly. Several of the doctors argued that the patients who come to the private hospitals and clinics are from a higher socio-economic status and have a higher education level. They added that these patients demand more detailed information about their health condition and the doctors are more likely to have closer relations with them.

Dr. Sarol who is highly satisfied with working in a private hospital, said that his profession even helped him to build close and personal relations with some of his patients whom he also meets outside of the hospital. He argued that as a gynaecologist he becomes an "essential person" in some of his patients' lives, since they may need him any time during the day and they owe much of their happiness and life to him. For him, these patients really appreciate his professional skills and "the real value" of his operations, and they always do more than just saying thank you and paying a high price for their medical treatment, like bringing him flowers and thanking him through announcements in newspapers.
Similarly, Dr. Sakin says that the patients who come to the university hospital are more concerned about their health condition and behave more respectfully towards the doctors. Dr. Türkcan made a similar differentiation between the patients who come to the university hospital by making an appointment by telephone and the patients who come without giving any notice.

Despite these comments about the different kind of patients, the overall evaluation of the patients as an uneducated group with a low socio-economic status is much more common in the doctors' oral accounts. This

type of evaluation supports their prevalent argument which is about the fact that the patients and the society in general, do not have enough intellectual capacity to appreciate the value of the doctors' professional efforts and skills. The degree of doctors' differentiation and alienation from the patients is so high that the doctors are surprised when they encounter a patient with a similar social background and interests as them. For instance, Dr. Sakin who saw that one of her patients was reading "*Aktüel* " (a popular weekly magazine) in her hospital bed, said that she was very surprised and called her colleagues to witness the situation. She said that all of the doctors were so happy in seeing "that kind of patient" that they gathered around her and asked several times about her health and whether she wanted anything from them. These type of patients are usually evaluated as nice surprises and exceptions, particularly in the accounts about the professional work in the state hospitals. These accounts are prevalent in all of the interviews, since in their specialization period which lasts from two to six years, all of the doctors must work in the state hospitals. The doctors acquired a considerable professional experience in the state hospitals, and although most of them work in the private hospitals from time to time on a part-time basis and in informal ways as I have mentioned in the first chapter, working full-time in a private hospital is still a recent phenomena about which the doctors have certain professional doubts. Therefore, the generalization about the patients in terms of their education level and social background is partly due to their common work experience in the state hospitals where the patients are more in accordance with the stereotypical images of the doctors' than the patients in the private hospital. However, these stereotypical images of patients also help the

doctors to explain the problems they have encountered in their relations with patients. With their low socio-economic background and education level, the patients cannot evaluate the professional performance of doctors properly and may think that the doctors get more money than they deserve under the influence of the "greedy doctor" image that has become prevalent in society and that is propagated by the media. The doctors whom I interviewed were highly concerned about differentiating themselves from the negative images in society, which also contradict with their idealized, altruistic view of their profession. Although, they admitted that there actually are doctors who fit these negative images, they have put them in the category of "bad doctors" which is generally an exceptional category and does not include themselves in any way.

The Professional and Economic Concerns of Doctors: As we have seen in the last chapter, the doctors whom I interviewed, stressed how hard they had worked, what kind of difficulties they had to overcome, and which aspects of their personal lives they had to compromise in order to become doctors, in order to legitimize the fact that they deserve an outstanding position in society, since only a small group of people have the ability to reach this professional position. In line with their outstanding position, they also expect a high degree of social prestige which should be reflected in the patients' respectful and trustful attitude towards the doctors. Moreover, according to the doctors' accounts, from the beginning of their education in the faculty of medicine and onwards, they have learned to evaluate their social position in that way, as a part of the professional perspective that they have acquired. This perspective basically taught them

that their profession is one of the most sacred professions and the doctors should act as "the hands of God" since they are dealing with life and death matters. The "sacred" aspect of the professional related with the fact that they save people's lives and maintain their health, "the most valuable thing they own", in Dr. Sakin's terms, is preserved. For Dr. Sarol, doctors have an essential place in all people's lives because everybody badly needs a doctor at some point of their lives.

It is interesting to note that the classification of good and bad doctors is still mostly done by the informants through the idealized view of the professional group in line with the professionalization theory as we have seen in the second chapter. Accordingly, good doctors including the informants themselves, are generally presented as doing their best to preserve and improve human health in contrast to the bad doctors who give priority to their economic and individual concerns. My informants speak about the professionally wrong behaviour of bad doctors such as demanding unnecessary medical tests and performing unnecessary surgical operations in order to make more money. Dr. Türkcan said that there has always been a group of "greedy doctors who acted against medical ethics" in trying to gain more money than the actual costs of treatments in several illegal ways.

A similar kind of criticism of these kind of doctors came from Dr. Yaş and Dr. Çağlar, who said that a doctor should always consider the economic and social condition of their patients and design a treatment plan which costs less in the case of poor patients. However, they added that, there are very few doctors including themselves, who paid attention to this issue, since most of the doctors' only concern is "to get rid of the patient as

soon as possible" , since there are so many other patients waiting to be examined in the state hospitals. These informants think that a greater majority of the doctors are so concerned with themselves and their economic situation that they are not really interested in their patients' health and economic problems. For them, the economic and health problems of patients are interrelated, since the patients who cannot or do not want to afford the prescribed treatment, go to different doctors with a hope of a less costly treatment or stop seeing any doctor with the thought of they cannot afford any medical treatment. Both ways lead to a high level of inefficiency in the medical treatment which is a frequent case with the patients with a low socio-economic background who constitute the majority of the patients especially in the state hospitals. Dr. Yaş presented his concerns as a striking contrast to that type of doctors, since he argued that he can predict everything about his patients' family, economic conditions and social background at first sight. He also gave an example of his correct predictions that he always understands when he sees a female patient entering his examination room, whether her bra is fastened with a pin or not from the way this patient is dressed.

For my informants, in contrast to the economic situation of the patients, the economic situation and concerns of the doctors should always be subordinated to their altruistic aim of improving the health of as many patients as possible. This aim is also supported by the emphasis on the sacredness of medicine and the professional activities of doctors, which stems from their active role in saving people's lives and preventing diseases and deaths. This concept of sacredness also brings a social prestige to the doctors and legitimizes their socially outstanding position. However, "the

bad doctors" who give priority to their economic and individual concerns are the exact opposite of with this idealized image of altruistic doctors. Accordingly, when trying to balance individual or economic problems with altruistic concerns, all of the informants stressed that the satisfaction of serving people dominates their economic concerns.

Even though, some of the doctors claimed that they deserve to earn more money from their work, they always justified their demand by pointing out that they had studied really hard to pursue this profession or that they deal daily with crucial matters such as health, illness, life and death. Dr. Sarol's case may seem to be a contradiction in what other doctors said, since he emphasized his individual and economic concerns the most among the informants. He said that he tried to build an individual professional perspective for himself, which is independent of any social concerns, including the motto "serving the people", and that money is required to maintain "a certain life standard" which includes entertainment opportunities at bars and restaurants. However, in the last instance, he added that he needs these entertainment opportunities to get rid of his stress at work and to return to his work in the morning with "a clear head". Hence, similar to what Dr. Yaş said that he should not deal mentally with his economic problems when he is with his patients, Dr. Sarol stressed that money brings a certain living standard which offers opportunities for him to get rid of his individual worries and stress in order to work better in the hospital.

However, the doctors' stress on their economic concerns for different reasons can be also explained by the recent heterogenization among doctors in terms of socio-economic background after the mid-1980's. The doctors

who come from families with a low socio-economic background and who are materially supported by their families only to a limited extent in contrast to their colleagues from the previous generations, have to support their families themselves after being a doctor. Dr. Meriç who came from a family who migrated from Bulgaria two decades ago, is a typical example of these doctors. She said that her family was already poor in Bulgaria and had severe economic problems when they came to Istanbul. However, her sisters and mother did not let her suffer from these problems during her medical education by giving all of their extra money for her expensive text books and other medical items. Now, being a doctor thanks to their support, she feels that she owes a lot to her family whom she has to look after also in material terms. This is also presented by her as a reason for her quittance of an academic career and her entering a private hospital, as stated in the previous chapter.

Privatisation in the health sector is another contextual factor which has changed the doctor-patient relationship, particularly with respect to the doctors' and patients' economic concerns and interactions. Privatisation and the doctors who work in private hospitals on a regular basis are also criticized by some of the informants, since they believe that the health services are too essential and crucial activities to be commercialized. Even though most of the doctors work in private hospitals and clinics on a part-time basis or on night-shifts (*gece nöbeti*) , they conceive full-time work in private hospitals as being a tiny part of a huge commercial system, the main aim of which is to make as much as profit as possible rather than improving the health condition of people in general. Dr. Meriç admitted that she had a hard time in explaining her colleagues the reasons of her

working in a private hospital. She angrily said that a colleague of hers, even though he had also some work experience in private hospitals, blamed the full-time doctors as their profession becomes similar to prostitution, since they "sell" their medical skills.

Dr. Çağlar, made a more moderate and refined criticism of privatisation in the health sector by saying that the general logic of privatisation which is "it leads to a competition which will eventually increase the quality of health services", is not valid for the health sector where all hospitals should achieve a standard level of "high quality" in their services. Similarly, Dr. Yaş said that in ideal terms private hospitals must be better than state hospitals only in terms of the minor services which he called "hotel services" which are related to the decorative aspects, such as the uniforms of nurses and the paintings in the wall rather than medical treatment of the patients. In line with the professional perspective they have received, most of the doctors argued for an ideal health system where the patients who have the same illnesses should have the same treatment with the same medical "quality", independent of their paying ability. However, these doctors admit that when they began to work in the hospitals, they saw that the current health system is very far from this ideal goal.

In criticizing privatisation, the doctors acted in accordance with the professional perspective they had acquired during medical education, which includes social concerns especially with respect to the necessity of providing health services to the socially and economically disadvantaged groups. Even the doctors who support privatisation, argue that there should be means like a more efficient general security system, whereby

these disadvantageous groups can benefit from all kinds of health services easily and with low costs. The doctors' criticisms of privatisation is also effected by the media's and society's negative view towards this professional group, with respect to their ambition to earn more money, which dominates their professional perspective and career. In order to oppose this image, my informants stressed several times that they can still take care of patients with low or middle incomes even in the private hospitals and make monetary arrangements in order to make their treatments less costly, usually in informal ways, such as giving free the drugs that they received as a promotion from the drug companies, to these patients. As opposed to the media's frequent news about the doctors who reject the patients who are in a critical health condition, but who cannot pay the treatment costs, the doctors whom I interviewed stated that they can always make monetary arrangements in order to treat them such as using other patients' health insurance.

These arrangements may even lead some patients to deceive the doctors by acting as if they are much poorer as we can remember from the previous chapter. Dr. Türkcan had one of her first professional disappointments in her assistantship when she spent a great deal of effort to make arrangements for a patient in order for him not to pay for his treatment, since he said he did not have any money. When she accidentally heard from the family members of this patient that they had cleverly deceived her, she said that she got angry with herself since her attitude towards her patients was so naive and well- intentioned. She also gave several examples of patients and other lay people who try to abuse her well-intentions by demanding professionally inappropriate favours such as

wanting to obtain a better room or bed in the hospital and to be medically treated by her during her vacation time. Besides the patients' abusing the professional concerns of doctors, the patients can not appreciate the professional and social concerns of doctors and refuse to comply with the doctors' advices and display distrustful and disrespectful attitudes.

Influence of Economic Problems and Gender Issues in Maintenance of Patients' Trust and Respect: One of the major problems that my informants complained about in their relations with their patients is the patients' becoming less trustful towards them. Doctors mostly blame the media for fostering a negative image of doctors and for indicating doctors as responsible for the problems of the health sector and hospitals. Dr. Sakin drew attention to these programs' particular effects on most of her patients who have a low-socio-economic status and a low level of education who view doctors as enemies" and come to the clinics as "in an armoured way". She also said that the patients, before seeing the doctors prepare themselves to oppose whatever the doctors will say to them.

The doctors whom I interviewed considered the patients' distrust towards doctors as a crucial problem since this affects treatment process. According to Dr. Meriç and Dr. Yaş, this leads to a vicious circle since the doubtful patients tend to visit many doctors in order to compare different treatments and receive different medical advices which may even contradict with one another. Dr. Yaş blames particularly the "greedy doctors" for these contradictory treatment plans, since they may urge a costlier treatment such as an operation even if it is not medically necessary or urgent.

The distrustful attitude of patients also negatively affects the doctors confidence in themselves and their medical knowledge. The doctors who think that they did not have enough medical practice and experience with the patients during their university education, as I have mentioned at the beginning of this chapter, may become highly anxious during the examination with the fear of a possible negative feedback from the patients. Dr. Sakin thought they did not take full responsibility for the patients nor feel comfortable during their medical education when their examination of the patients was strictly supervised and supported by their assistants and professors. She said that she had a highly stressful time full of uncertainties about the details of the treatments, such as the type of drugs to use, when she was suddenly left alone with her patients in her obligatory duty after the university. Dr. Meriç said that she has become "extremely prudent" (*aşırı temkin*) in talking about the health condition of patients and has taught herself not to talk in an optimistic way about it in advance, before seeing all of the test results. According to her, talking optimistically may ruin the lives of doctors and patients, since the smallest possibility of a bad result may be happen. She considers the health condition as something which cannot be reversible and she admits that she fears the way the media stress these type of malpractice cases. For her, the tension which stems from the fear of doing something wrong or incomplete in the medical treatment of patients, especially in the tests of babies and children since she had a bad experience on this issue as we have seen in the second chapter, has highly influenced her professional life. She added that she is also under the effect of this extreme prudence in her daily life since she always analyses the advantages and disadvantages of a certain act beforehand and

has become sceptical in terms of feeling the necessity of seeing the negative aspects of anything. Similarly, Dr. Sakin explained that because they studied psychiatry as a part of medical education and met with "all kinds of people" as patients, she immediately understands who is lying about anything or exaggerating while talking both in her daily and professional life.

Besides the problem of trust, the disrespectful attitude of the patients towards doctors creates problems for my informants. Most of the doctors complained that a lot of patients do not even say a mere "thank you" to the doctors so that they become highly disappointed in thinking that they spend that time and effort on the patient "in vain" in Dr. Sakin's terms. Another example of disrespect is given by Dr. Meriç, as some patients have chewing-gum in their mouths while talking to her and she considers this as something unacceptable and argues with the patients about it.

The doctors also complained about the extreme rudeness of some patients and their family members which goes as far as saying bad words to the doctors and beating them when the patients' health is damaged or the patient dies in the hospital. Another common complaint of doctors about the disrespectful behaviour of patients is that they ignore the strict hierarchical order according to different academic titles of doctors which indicate the years they have pursued this profession, (*kıdem*) in the hospitals, especially in the university hospitals where the professors also teach in the faculties of medicine. Several informants said that they warn the patients before entering a professor' s room to knock the door, to button their jackets and to speak politely to the professors. Dr. Türkcan implied that these warnings are effective so that the patients are slightly more

respectful towards the professors in the university hospitals. Gender of doctors is another factor which influences the respect of patients towards doctors as we can see in Dr. Sakin's example where the patients in the gynaecology clinic confuse female doctors with nurses and mid-wives, and do not see the difference between these people even if it is explained to them. She also added that the patients often call the female doctors as Mr. Doctor (*Doktor Bey*), since they are used to or expect to be treated by male doctors. However, we also understand that the doctors also evaluate the professional performance of their colleagues under the influence of gender stereotypes such as Dr. Sarol's argument about the female doctors who cannot be good surgeons because they panick at the slightest complication in surgical operations. The doctors spoke about these kind of cases in a vivid and detailed way also to display that they are working under difficult conditions but that they can still enjoy treating patients even if there is no external financial and psychological motivation.

The doctors generally consider the patterns of economic interaction with their patients as a reflection of the patients' trust and respect towards them. The increasing economic concerns of doctors and patients, and the "greedy doctor image" are also other aspects which lead to the patients' distrustful and disrespectful attitudes . As we have seen in the Dr. Türkcan's account about the doctor-patient relations in the past, her father gave the doctor his money in an envelop which was prepared in advance, in order not to desecrate the altruistic aspects of his profession and his social status by letting him be involved in a direct monetary interaction with his patients. Coming to the current professional experiences, although my informants expressed their wishes of not discussing the monetary aspect of

the treatment with their patients, they complained that their wish is rarely realized. Dr. Meriç and Dr. Sakin said that they were particularly offended when the patients claimed that the doctors spent very little effort (*iki tık tık bir şık şık*) during the examination of the patients, but demanded a high price for that effort. Dr. Meriç said that even though the doctors seem to do very few things during the examination, learning these "few things" requires a long and intensive education which only a minority of hardworking and clever medical students can endure. However, instead of explaining that she deserve this money in detail, she prefers to be silent on this issue, since she thinks discussing monetary affairs will damage her social authority over her patients and their respect towards her.

Dr. Çağlar considers the ability of building social authority over the patients "extremely important" by saying that fifty-percent of the treatment of all illnesses is realized in psychological terms, in cases where the patients are totally convinced that they will recover after a particular treatment. He explained that if doctors could not gain the full compliance of their patients in the medical treatment plan they had designed, they would not be evaluated as successful doctors even if they have an "immense medical knowledge". This idea which indicates the crucialness of doctor-patient relationship is shared more or less by all of my informants. However, Dr. Çağlar gave a more detailed explanation of why and how the economic concerns of doctors should be repressed and excluded in building relationship with patients. For him, the doctors have to pretend that they have no economic problems and on the contrary act as if they are really prosperous and hide the facts which show up their poor living conditions, such as living in a poor neighbourhood, using public transportation and

staying in a very dirty and small place during the night-shifts in the hospitals. Otherwise, they may damage their social authority over the patients and their respectful and trustful attitude, and support the patients' negative view on doctors as acting according to their economic concerns.

In line with Dr. Çağlar's rule that doctors have to act as if they are prosperous when they are with their patients, he also believes that doctors should be presentable in the hospital, in the sense that they have to wear clean and tidy clothes, they have to shave everyday and keep their body, especially their faces and hands clean. He said that the rule of being presentable is taught in the medical school where the professors strictly controlled the requirements of this rule. He quoted from one of his professors who told them that the doctors have to present themselves to the patients with the consideration that the patients will open their most intimate secrets to them and ask them to build an empathy with the patient with the questions of "To what sort of people would you prefer telling your intimate secrets?" and "To what sort of doctor would you prefer taking your sister or mother?". Dr. Çağlar said that these rules fit "his nature" perfectly since he mostly enjoy wearing good quality, formal clothes and looking presentable instead of wearing jeans. To highlight his concern with being presentable, Dr. Yaş said that since he sometimes used to stay at his friends' house to study during the whole night when at the faculty of medicine, most of the days he did not always wear clean clothes and did not shave. He said how he was ashamed of the way he looked, when he was with patients, and particularly with the female patients in the gynaecology classes.

Gender is another factor which influences the doctor-patient relations as mentioned above. As we also saw earlier in Dr. Sakin's example of a patient as a young bride who was oppressively controlled by her husband and his family, especially his mother, doctors frequently use the gender stereotypes which are prevalent in society. Doctors usually view mothers as responsible for their child's health and development as the statement of Dr. Çağlar "The main cause which leads children to have a low IQ is that they have a mother with a low IQ" indicates. These stereotypical gender differentiations also affect the behaviour and attitude of the doctors towards their patients. Dr. Sarol, who is a young male gynaecologist, said that one of the main advantages of his field of specialization is that he is dealing with female patients, *cins-i latif* on his own terms with whom he can build "a bond" more easily, because he has been taught to behave well and be kind towards the girls since his childhood. Hence, he tells that he gets angry with a patient or shows his anger less frequently.

Dr. Sarol evaluates his relations with his patients also in personal terms and considers his profession as providing an opportunity to meet new people, some of whom he continues to meet outside the hospital setting. Unlike Dr. Sarol's comfortable manner in talking about his close relationship with his patients, which goes far beyond the general doctor-patient relations, Dr. Sakin, being a female gynaecologist, was more careful in separating doctor-patient relations from other social relations. This difference is also due to a reality show which was shown on TV few weeks before my interview with Dr. Sakin and which was about a male doctor who sexually abused his female patient and proposed having sexual

relationship with her without knowing that he was being watched by secret cameras. This program aroused a fervent debate, about doctor-patient relations and medical ethics in different social groups including doctors , and Dr. Sakin also seemed highly influenced by it, since she insisted several times that the doctors should always be conscious of and act according to their professional identity in the hospital setting. Hence, for her, even if a doctor examines his girl-friend their relations should not go beyond doctor-patient relationship in the hospital. She also argued that this type of wrong behaviour of doctors attracts the attention of media further in order to foster another negative doctor image

The maintenance of trust and respect towards doctors is crucial for doctors not only for securing patients' full compliance on their doctor, but also for the acknowledgment of the social authority and powerful position of doctors in their relationship with their patients and in society. In addition to the problems in the health sector, the changing concerns of the doctors from social and political to the more individual and economic ones, and accordingly their decreasing active role in shaping social and political developments in the country have also affected the general social attitude towards doctors and their social status. In my informants' accounts about the "good old past", the patients fully trusted and respected the doctors without questioning their professional concerns, knowledge and skills. They think that the doctors whose professional perspective was dominated by economic concerns were rare, there were fewer malpractices since the doctors had a higher opportunity to practice medicine during the medical education, and these cases of mal-practice were only heard of by a few doctors instead of being subjects of sensational reality shows. Through

talking about the doctor-patient relations in the past in idealizing ways and relating the recent changes in the patients attitude towards doctors with the historical changes that have taken place place in the larger social structural context in the last two decades, my informants implied a continuity in the sense that they still believe that they nevertheless deserve high social status, because of their profession and their concerns in pursuing their profession.

The Doctors' Conceptualization of their "Self" in the Medical Realm:

In line with the Linde's argument about the presentation of the self "as separate but related to" the other people, my informants did not, in general, differentiate their generation of doctors from their colleagues from the former generations even though the latter group is suffering from the negative attitudes and behaviour of the patients. In this framework, the doctors who have more professional experience deserve the full respect of the other doctors in obvious terms, since Dr. Meriç and Dr. Çağlar indicated that medical practice is as valuable as acquiring medical knowledge since a lot of new things can be learned through medical practice and the professional skills are refined in this process. Dr. Çağlar argued that a person who has more professional experience (*kıdem*, as it is used among doctors) are usually called "older brother" or "older sister" by the other doctors in the faculties of medicine and hospitals, even though they may be younger than the doctors with less professional experience.

Dr. Sakin said that the doctors who have less professional experience deal with the patients when they first come to the university hospital, if these doctors cannot treat these patients' they send them to the more

experienced doctors who have more responsibility and higher professional rank in the same hospital. She also added that the doctors with less experience and lower academic ranks such as assistants deal with the medical students in much more immediate terms. She said that this hierarchical order is so important especially during the medical education, that the whole educational system is built on it and that the slightest distortion of this order may cause severe warnings and scoldings. Through such accounts, my informants implied that they have really internalized the hierarchical order as opposed to patients who cannot understand and act according to this order.

In this framework, Linde's argument about the use of pronouns such as "I" and "we" in displaying how the people relate themselves with other people provide us with clues about how my informants organize their social positioning and relations with other people. For instance, in line with my argument that the doctors implied the existence of a more solid professional solidarity and a communal organization during the medical education, where all of the responsibilities are shared among the students as well as between the students and their professors, and the professional socialization take place, my informants used a lot of "we" in talking about their experiences in this period. Especially Dr. Sakin told about how "they" studied and spent their leisure time together with other medical students. The "we" pronoun is also used for comparative purpose with the students in the other faculties as in the quotation of Dr. Meriç "We did not have time to be interested in politics like the other university students, because we have to work really hard".

The "we"s turned to "I"s in further professional periods when the doctors make individual choices in their professional life. This is in line with Dr. Meriç's and Dr. Sakin's argument that the doctors suddenly feel very alone in their professional world and professionally responsible as individuals after they have completed their university education. This also relates with the recent heterogenization of career patterns of doctors with the opening of different types of hospitals, and accordingly, the increase in the doctors' alternatives of work place such as these hospitals and drug companies. Having this variety of alternatives, the young doctors who now consider their economic and individual concerns more than the former generations of doctors, plan their career and experience the consequences of this plan on more individual terms.

Despite these variations in the professional career patterns and experiences, to some extent the doctors still view their professional group as a united body of people, and refer to this group as "we", particularly in defining their professional boundaries and outlining their different characteristics with the other people. The doctors always used the pronoun "they" in talking about the patients and reflected the conflictual relationship between them and the patients with the frequent use of "we" and "they" in the same sentence. They rarely used the pronoun "we" in referring to the doctors and the other personnel in the hospital together, and these "we"s are used mainly with reference to the activities which are outside of the professional setting such as Dr. Meriç's quotation: "We are planning to go to a ballet this week-end" in referring to the nurses and doctors of the hospital she is working. The doctors' talking about their professional group as a corporate body with clearly defined boundaries, also

help them to identify themselves and their professional concerns with the former generations of doctors, and establish a continuity in that sense with these "good doctors" despite the recent heterogenization of doctors in terms of the socio-economic background, professional concerns and experiences. In identifying themselves with the former generation of doctors who were highly respected and trusted by society until the 1980's, the informants differentiate themselves from the recently appearing "bad doctors" whose professional skills are poorly developed or whose professional lives are dominated by their economic concerns, and imply that they also deserve the trust and respect of their patients and society unlike the bad doctors.

The Changes in the Social Concerns of Doctors: Despite all of the crucial factors which led to the changes in the social view on doctors, the attitude of patients' towards this professional group and doctor-patient relations, the doctors whom I interviewed, stressed that they still have social concerns and plans for the social development. This emphasis may be partly due to their efforts of differentiating themselves from the recent negative doctor images of the doctors whose professional experiences are dominated by individual and economic concerns, that are prevalent in the society. However, it also allows the doctors to make judgements about the living and thinking patterns of the members of the society, and therefore to rebuild their position of social authority, at least within the framework of the interview. Despite this continuity in terms of having social concerns, the type of social concerns that the doctors has also changed, especially in terms of scale, in the last two decades.

The doctors whom I interviewed, acquired a sense of social responsibility in the process of their professional socialization during their university education, and often referred to it in the interviews in order to indicate that they still have social concerns, despite the problems that they have encountered during their practice. As we have seen in the second chapter, the theme of continuing to have social concerns in professional life after medical education not only provide a temporal continuity and a character consistency in Linde's (1993) terms, but also a legitimate ground for doctors to make social judgements and to confirm their socially outstanding position and authority. However, the social concerns of my informants, that are usually summed up by them as the general aim of serving the people in order for them to have better health status and social living conditions", mostly include their patients rather than the whole society as opposed to their colleagues of the former generations. This difference is also related with the changes in the social view on doctors and the doctor-patient relations where a full compliance of the patients is not guaranteed any more. Hence, as opposed to the social authority of the doctors from the former generations which was built on a much wider level of the whole society and reflected itself in the doctor-patient relations, young doctors derive their social concerns from their experiences with their patients, since the doctor-patient relationship is their "new battleground" in order for them to re-establish their socially prestigious position and contradict society's negative views on doctors.

This issue is often referred to and problematized in the interviews with respect to the doctors' efforts to find a common communication pattern whereby the patients fully understand and follow doctors'

recommendations. Dr. Yaş's case is a good example of these efforts, since he said that he stubbornly tries to convince his patients about the importance of providing the necessary social and medical conditions to prevent illnesses in maintaining a better health status in line with his general medical view which favours preventive medicine. He said that he always tells the patients and their families to heat all the rooms of the house equally so that the members of the family, especially children do not catch cold going from one room to another. Similarly, Dr. Sakin said that she advises her patients who are mostly young and uneducated women, that they should always know when they had their last menstruation and should be ashamed if their husbands were the only people who knew about the menstruation dates. The accounts of these efforts also imply the perseverance of doctors who still try "to reach" their patients despite their disrespectful and distrustful attitudes and prove their loyalty to their professional perspective. Hence, these doctors mainly express and realize their professional perspective and their social concerns in line with it, through the attempts of educating their patients, rather than through a large-scale mission for the whole society. On the other hand, as in the case of Dr. Türkcan who began to think that her aim of serving for the good of society cannot be realized through her patients, who do not appreciate or even try to abuse her well-intentions toward them, some doctors realize their social aims in giving priority to their teaching and researching activities. The transformation on the type and scale of the doctors' social concerns is also related with the changes in the doctors' views on politics and their relations with the state as I will try to explain in the next section.

The Changes in the Doctors' Relationship with the State and Political Issues: As opposed to the doctors from the former generations who took active roles in shaping the political ideology and developments in Turkey, the more recent generation of doctors, in general, take a distanced view of political issues in the last two decades. This is also related with the doctors' political confrontation with the state after the military intervention of 1980 and the general political apathy in society. As we will see in the quotation of Dr. Sakin below the term "political" is generally used with a negative connotation in order to indicate the conflictual interests of different power groups particularly in influencing the governments' policies in the health sector. Dr. Sakin criticizes these policies in this way:

"Political, it is all political..What I mean by this, is that nothing is actually done with the consideration of human health in Turkey, nothing is done for humans. Everything is done merely for politics. Whenever a new government comes, a new policy is applied".

My informants criticized the governments' recent rather populist policies on the health sector, such as issuing a green card which would ideally provide free access to the medical services for the poor patients , but was only distributed to a few people most of whom were active members of the government's party, as they are applied in order to gain "more votes" and "favour the members of their party" as Dr. Sakin's and Dr. Türkcan argued in the interviews. The privatisation policy of the governments is also criticized by the doctors whom I interviewed, as it makes economically disadvantaged peoples' access to the medical services even more difficult. However, these doctors do not play an active role in the medical chambers

where these policies are protested in an organized way, and some of them even criticized the activities of these chambers. Dr. Sarol said that the doctors in these chambers do not have the right to represent the doctors in Turkey since their activities such as demanding the liberation of prisoners who were condemned from political reasons, are totally ideological. The term ideological has a similar meaning to the term political as used by Dr. Sakin in the above quotation, and this meaning is stressed by Dr. Sarol who said that the activities in these chambers are organized by the doctors who subordinate their professional experience and concerns to their ideological views. For him, these doctors must have worked for fewer hours in a day than the doctors like him, so that they have plenty of leisure time to organize and participate in these activities.

Through his criticisms, Dr. Sarol also indicated that the doctors' professional concerns should be separated from their ideological views. This view is also stressed by Dr. Sakin, Dr. Meriç and Dr. Çağlar in other contexts, and it is important in terms of highlighting the difference between the professional and social concerns of the new generation of doctors and their colleagues from the former generations. As we have seen in the first chapter, the professional perspective of doctors has always included political and ideological aspects which led them to take active roles in Turkish politics, from the birth and institutionalization of modern medicine until the 1980's. Their active role in politics reached one of its peaks in the 1960's and 1970's conflictual political movements where different ideologies clashed. The medical chambers which were highly influential in organizing these political movements at that time, still represent the populist and leftist ideology through its current directors and

members who took an active role in the movements of the 1960's and 1970's. This is also negatively evaluated by the young doctors who were influenced by the period of depolitization in the 1980's when particularly leftists intellectuals and doctors were criticized by the rulers and media. Accordingly, Dr. Sarol, views the active members and directors of these chambers as a small and marginal group who are the residues of the 1970's.

Another criticism shared by most of my informants is about the ineffectiveness of these chambers with respect to governments' health policies. Dr. Sakin said that membership in the medical chamber of Istanbul only provides "psychological support" to the doctors, by making the doctors feel that they are not alone in their professional world and with the help of chambers, can protest against it if they are appointed by the government to a place they do not like to work. However, she added that, a doctor cannot be influential in changing the governments' policies even with the support of the medical chambers. This view is also shared by most of my informants who do not consider that anything can be done to influence and change the state's policies on the health sector even though they complained about and criticized these policies because of their negative influences on their professional experiences.

The doctors whom I interviewed and their colleagues from the same generation of doctors, as far as I could detect from their oral accounts and bibliographical works, speak about political issues only with reference to their effects on the health sector and their own professional experiences (Sahip, 1996) (Martı, 1997). The recent political issues which aroused fervent debates are also discussed by these doctors in terms of their effects

on the hospital setting and their social and economic aspects in shaping the doctor-patient relations. For instance, the opening of private hospitals where the medical services are provided in accordance with the basic Islamic rules, such as treating female patients by female doctors is commonly seen as indicators of the political rise of the Islamic movements. In contrast, my informants viewed these type of hospitals mainly as a social and economic necessity in supplying the demand of a considerably large group in society. The doctors with Islamic views are also evaluated in terms of the effects of their religious view on their professional concerns and performance. They are tolerated by the new generation of doctors as long as they give priority to their professional concerns over their religious views, unlike one of the most frequently given example of a female gynaecologist who refused to perform a caesarian operation since she knew that a male baby would be born and avoided touching him.

My informants said that they can work with the doctors with Islamic views, with whom they share the same professional concerns, and Dr. Meriç who now works in the hospital of an Islamic association criticized the doctors of the state and university hospitals who do not accept these doctors amongst themselves. In contrast, Dr. Sakin considered these doctors as an interest group who are becoming increasingly powerful and threatening for other doctors. However, she also generalized this argument for each ideological view, since she said that when a new government comes with a new ideology and its followers, the directors and chief-doctors of the state hospitals are changed for the new doctors accordingly, without considering their professional experiences and this leads to further inefficiencies in these hospitals. She viewed Islamic

ideology as having that potential and gave examples of state hospitals where the doctors with the Islamic view are appointed as chief-doctors.

The young doctors in general think that they cannot be influential in shaping and altering the state's policies on the health sector and hence in establishing control over their working process. They view the policies of the state as bureaucratic arrangements which severely limit the professional efficiency of doctors and as enacted with "ideological" or "political" interests as opposed to social and medical concerns. In both cases, the doctors do not want to be involved in any political activity which would have an effect on the issuing of policies, since they do not want to be a part of the political interests groups and blame the policy makers as they do not care about the social, economic and professional problems of the doctors.

They particularly criticized the fact that the working process of the doctors who work in the public sector are tightly shaped by the same laws which are applied to any state employees (*memur*) . For Dr. Sakin, these laws are far from providing the flexibility the doctors need in their profession, since they impose fixed working hours and seriously limit the doctors' initiative on the choice of the hospital where they will work. As we have also seen in the second chapter, Dr. Sakin argued that the doctors have to be different from any other state employee, since they have to have a much greater degree of professional autonomy and control. She claimed that only she would know the best conditions under which she would work in the most efficient way, because she knows best how to profit from her own working capacity and medical knowledge.

These views are also in line with Turner's arguments on the professional groups who wish to define their boundaries by differentiating themselves from lay people as we see in Dr. Sakin's efforts to differentiate the doctors and state employees in different parts of her oral account, and to maintain an autonomy and control over their working process which is largely prevented by the state (Turner, 1984). Working in private hospitals as Dr. Sakin is planning to do is an alternative to avoid partly the limiting laws and procedures of the state. However, for Dr. Çağlar, the doctors can still create a space where they have more initiative in their working patterns in the state hospitals, by thoroughly knowing their rights and responsibilities that are imposed by the laws and by building their own informal system in managing personal relations skilfully in the hospital settings. For instance, he told about how he gave informal permissions to leave the hospital earlier to the nurses who work well and allow other doctors to quit work when they have important things to do outside of the hospital, so that they also allow the flexibility in his own working patterns in return, particularly during his obligatory duty .

Hence, the doctors do not want to deal with the problems that they consider "political" or "ideological", but rather try to find individual solutions in order to increase their control over their working process, at least in their own small-scale hospital setting. In shaping their professional and social concerns, they distance themselves from the political debates and issues, but also find their own ways of altering the inefficient and problematic bureaucratic system in the hospitals they work which, according to my informants, reflect the political and social problems of the country in general. For instance, most of my informants said that

they try to build a system where the doctors arrange a day and time for the patients before they come to the hospital and where they can see less patients in a day in order to spare more time for each patient. The patients with economic difficulties are also helped by my informants in quite informal ways, such as giving free the drugs that were given by the drug companies to these doctors as a gift and using other patients' health insurance for the treatment expenses of poor patients.

In addition to the inefficient bureaucracy in the state hospitals, the poor medical conditions, such as the lack of personnel and medical equipments are also discussed in political terms by my informants, since they are aware that the problems stem from the governments' low rate of health expenses. Although most of my informants said that they are used to these inadequacies and inefficiencies to a large extent, the ones who did their obligatory duty on the provincial places complained more and in a bitter way about these issues. The quality of medical services are much lower in the hospitals of the Anatolian towns and villages, and the living conditions of the doctors who go there to do their obligatory duty are much more difficult. There, they usually stay in the lodgings or pensions that are provided by the state and Dr. Sakin and Dr. Çağlar speak in detail about the "terrible condition" of these houses. Dr. Sakin said that the house, "the state thought that she deserves after all these years of education", had windows without glass in them and broken doors. At that moment, she understood that the "state is not interested in doctors and does not consider under which conditions they live at all" doing her obligatory duty. Despite the fact that she managed to be appointed to a better place in the second year of her obligatory duty, her views on the state and its lack of consideration on

health matters and doctors have stayed the same since she stresses them at different times in her accounts about her further professional experience. Additionaly, the doctors who did their obligatory duty not only have a more negative view of the state policies and worse professional experiences, but also gained more experience in terms of having more professional initiative vis-a-vis the inflexible and limiting state's laws and procedures, as we have seen in Dr. Çağlar's case which is mentioned above.

Conclusion: In sum, the doctors prefer to distance themselves from political issues in shaping their social and professional concerns and view the efforts to confront the state's policies as totally unnecessary since they would not be able to change these policies. Rather than trying to find large scale solutions to existing social, political and health problems of the country, they find it more useful to work out small-scale and individual solutions, where they make little modifications " in the rules of the game" that they know pretty well, in Dr. Çağlar's terms, usually in informal terms. Despite this informality which may sometimes mean illegality, as Dr. Çağlar and Dr. Sarol implied as in the case of using other peoples' health insurance, they never blamed themselves, since they always stressed that they used these informal procedures and little modifications in this system always for the good of their patients. In this context, Dr. Sarol's giving priority to his "individual ethical system" rather than to "social ethics" which is, for him, full of double standards where people are evaluated according to their economic condition is understandable. This is important in indicating that the social concerns which the medical profession internalized in its dominant perspective has become to be shaped

in more individualistic terms, and when beyond the individual, encompass a smaller scale of responsibility such as the hospital system where they work.

CONCLUSION

The doctors in Turkey are generally known as a professional group who have played an active role in shaping major political and social movements and issues in the country. They share a particular professional perspective which includes social concerns such as improving the living conditions of the members of the society through inculcating their own values and ideas that were mainly developed during the professional socialization period which starts during the medical education. These values and ideas stemmed from the basic principles of the biomedical model which is a product of Enlightenment and which was adapted to the Turkish context during the institutionalization process of the health sector, that correspond to the second half of the Nineteenth century. These values and and ideas include the transformation of society in accordance with a scientific, positivist, progressivist and secular perspective where the traditional and religious views are subordinated with science and rationality. The doctors who had an easier access to the Western world than the rest of the Ottoman intellectuals, had a privileged status in the adoption of the prevalent values and ideas in the West, that are mentioned above and that also includes nationalism. The concern of having a leading role in that kind of a social transformation led doctors to design and share a

missionary project for the whole society which would be enacted by them as a part of their professional experience and concerns.

The social missionary role that the doctors attributed themselves, constitutes a "legitimate ground" for them to make social and political judgements about their society and act according to these judgements in their professional and social life. It also shaped the doctors' position in the society and their relations with the state. However, this missionary project was developed as a result of particular historical and social conditions where the political issues and debates not only affected the health sector and the professional experiences of doctors , but also washighly shaped by the social concerns of doctors. The missionary project of the doctors has also been modified in line with the variations in their professional and political experiences under the influence of social and structural changes through time. Especially in the 1980's and onwards, large-scale missionary project has been replaced by smaller scale social concerns that were shaped through the doctors' individual characteristics, particular professional experiences and priorities. This transformation has happened as a result of various historical changes in the social and political context of the country and in the health sector, such as conflictual political confrontation between the doctors and the military regime in the early 1980's, depolitization, heterogenization of the doctors in terms of their socio-economic background and professional experience, the rise of economic and individual concerns as opposed to the political ones in shaping the career patterns of doctors, as well as other members of the society, the increase in the number of private hospitals in line with the policies of privatisation and the birth of Islamic hospitals, the changes in the social

view on doctors and in the doctor-patient relations relatedly. The social view on doctors has been transformed from the pioneering intellectuals who always work to improve the medical and social conditions from the "greedy doctors" whose careers are dominated by individualistic and economic concerns and doctors who did not have adequate medical education and who are known for their malpractices. This transformation has also affected the doctor-patient relations where the full compliance of the patients which shows itself in terms of trust and respect is not guaranteed any more.

In this framework, my basic premise was to study how these rapid and radical changes in the social structural context have influenced the professional perspective and the social concerns as a part of this perspective, of the last generation of doctors whose professional careers have been largely shaped through these changes. How are they differentiated from the former generation of doctors in terms of the scale and type of their social concerns? In what ways are these social concerns enacted in shaping the particular professional experience and perspective of the last generation of doctors? How do these doctors still refer to the missionary professional perspective that they have been taught mainly from the doctors from the former generations in the accounts of their own professional experiences, despite their different social concerns? How do the doctors express their social concerns in order to attribute themselves an outstanding social position and to provide a legitimate ground to make judgments on the social issues despite their recent negative image in the society as "greedy" or "malpractising" doctors?

In order to explore these questions, first I studied the social and political dynamics which led to the formation and institutionalization of "modern Turkish medicine", as opposed to the traditional Ottoman health services and the dominance of the Non-Muslim minorities in the contemporary health sector. The doctors' politically active role in this process has also continued in accordance with the social and political developments and debates which have found their immediate counterpart in the modern institutionalized health sector, and became highly influential in shaping their professional perspective. This role has also become an important source of legitimacy which the doctors attributed themselves in order to make judgements about the social and political problems of the society and design missionary project in order to solve these problems as a part of their particular professional perspective. In studying the history of modern Turkish medicine with respect to the doctors' involvement with the social and political issues and debates that have shaped the country's structural context, my main aim is to clarify the particular social and political conditions which led doctors to develop their own professional perspective through which they gain a considerable social authority and political power.

I would like to point out that the social and political role of doctors in the formation of "the modern Turkish Medicine" and the provision of the suitable contextual conditions for this formation, is one of the basic sources of legitimacy that they have attributed themselves in expressing their social concerns and acting according to them. However, this source of legitimacy lost its validity considerably in the 1980's and onwards, since most of the doctors from the last generation no longer have large-scale social

missionary projects which shapes their professional perspective and concerns mostly due to the social, political and economic changes that have happened in Turkey. This led these doctors to look for other sources of legitimacy in order for them to re-built their social authority, this time in more individual and less political terms. In particular, the last generation of doctors have a common way of describing their individual self through their knowledge of medicine. This type of description involves a relationship of power and hierarchy, where these doctors draw the boundaries between their professional group and lay people through the definition of the required characteristics, such as being hardworking, clever and persevering which are necessary in order to acquire medical knowledge and practice medicine.

These doctors describe their "individual self" and "professional self" in highly consistent terms so that in their oral accounts, they have presented their decisions on their professional career as obvious, "natural" paths that they have to take considering their character traits. Their particular character traits help them not only to become "good doctors" but also to gain success and a socially outstanding position which they deserve through overcoming the problems they have experienced through their professional life. These problems largely stem from the large-scale, economic and bureaucratic problems in the health sector, and the increase in professional competition and individual responsibility in the later periods of the professional life. In these periods, the doctors question their idealized view of medicine and medical practice which they had acquired before and during the medical education, when their professional activity has become routinized, and they do not receive the full compliance of the

patients that they think they deserve through their socially outstanding position. However, the way they deal with these difficulties are also accounted as a test of their character traits that are suitable to be a doctor and their ability to take individual initiative to organize their professional life according to their own professional and social concerns rather than being "drifted" by external conditions. The doctors whom I interviewed, have "passed these tests" through the choice of their specialization field the reasons for which are highly consistent with the reasons they use to explain their decision to become a doctor and their character traits, and through their choice of hospital that they are currently working in, in line with their professional perspective and concerns.

Hence, the way these doctors overcome the difficulties in their professional life is another source through which the doctors attributed themselves a legitimacy to make social judgements, since
they view these difficulties as stemming directly from the large-scale social, economic and political problems of the country and they have overcome these difficulties without compromising their character traits and professional perspective that are in line with these traits. This helps these doctors to view themselves as "good doctors" whose main professional and social concern can be summarized as "serving for the good of their society" despite all the difficulties. As being good doctors whose professional life is still dominated by this concern, the doctors attribute to themselves social authority and an outstanding place in society and expect that this social position is also acknowledged and respected by society and their patients.

However, in the 1980's and onwards, the increasing social and economic problems of the health sector, the heterogenization of the doctors

in terms of their socio-economic background and professional perspective, the political campaign against doctors and the influence of the media where the reality shows particularly concentrates on the problems in the health sector and describes doctors as lacking appropriate skills and knowledge to practice medicine, and as giving priority to their economic concerns, negatively affected the social view on doctors. This has also influenced the doctor-patient relationship where the patients' full compliance as mentioned in my informants' accounts about the past, is replaced by their highly distrustful and disrespectful attitudes and behaviours towards doctors. The doctors from the last generation talk about these negative attitudes and behaviours in detail and describe them as frustrating as they prevent their professional satisfaction to a large extent similar to the other social, economic and bureaucratic problems that they have encountered in their professional life. However, despite the patients' negative attitudes and behaviour, the doctors said that they still do their best in order to improve not only the medical or health condition of their patients, but also their social conditions. The last generation of doctors, differentiate themselves from the "bad doctors" who see their patients as a source of material benefit, since they emphasize that they try to understand and improve the living conditions and social relations of their patients in order to achieve a solid doctor-patient relation which will lead to an efficient medical treatment and the prevention of further diseases. The doctor-patient relationship is largely discussed and problematized by them, as a major way of expressing their social concerns to the patients, guiding them to have better living conditions , and therefore re-establishing their position of social authority at least over their patients, if not over the whole society.

The last generation of doctors took a critical distance to the political issues and debates because of the 1980's depolitization in the society which involves the criticism of the 1960's and 1970's political movements where the doctors played an active role, and the conflictual confrontation between the state and the doctors. For the first time since the foundation of modern Turkish medicine, the professional perspective of doctors does not include a large-scale political agenda according to which the doctors shape their political actions. My informants criticize the governments' policies on the health sector in that their real concerns are to gain more votes in the next elections rather than improving the working conditions of doctors and increasing the health status of the society through providing easier and cheaper access to the medical services. However, they prefer not to be involved in an organized political opposition or in an association with such characteristics as medical chambers, since they evaluate these kind of organizations as ultimately dominated by different political power groups, whose main interests would not be medical improvement and increase in the health status.

Instead of a large-scale social mission which involves the inculcation of the scientific, secular and positivistic values to the whole society, the doctors develop and express their own social concerns during their medical education and professional experience as a result of their interactions with other doctors and their patients. Their social concerns, although consistent with the above mentioned values that all of the doctors should promote as a part of their medical and professional perspective, differ from the social mission of the former generations of doctors, since they do not include a political aspect and the last generation of doctors give

priority to their individual professional experience in defining their social concerns. Therefore, instead of the political arena where different power groups fight over their conflictual interests, the hospital setting where the doctors are currently struggling to re-gain the patients' respect and trust, and relatedly the social recognition of their outstanding position and authority, has become the new "battleground" for the new generation of Turkish doctors in order to provide a legitimate ground for themselves to make social judgements and act according to them.

The doctors referred to their individual characteristics and experiences much more than a historical social position of a professional group, in talking about their efforts to re-establish their social authority over their patients. This is also related with the fact that the professional group's communitarian aspects have almost vanished due to the increase in the number of doctors and heterogenization of the doctors in terms of socio-economic background and professional perspective. Currently, the doctors have different career patterns in line with their different social and economic concerns, and in their particular professional experience they are exposed to professional competition more than professional cooperation. Therefore, building a legitimate position of social authority is represented by the new generation of doctors as their individual concern and responsibility. For these doctors, not all the doctors from their generation have this concern and responsibility in equal degrees since increasingly large number of doctors give priority to their economic concerns, rather than spending effort to build a position of authority over their patients and in the society.

My informants believe that they deserve to have social authority and legitimacy to make social judgements mostly since they have the specific character traits and professional perspective that are suitable to acquire the "precious" and "sacred" medical knowledge after an intensive and long education, and to practice medicine in the best way despite the problems that stem from the political and bureaucratic processes in hospital, patients and other doctors. Overcoming these difficulties and still having social concerns for the patients are the basic criteria which my informants mentioned in order to be included in the group "good doctors" like them. This group includes most of the doctors from the former generations whose professional perspective is not deteriorated by the problems that have been experienced in the health sector since the 1980's. Although, the young generation of doctors question and criticize the professional perspective of their colleagues from the former generations, because of its inclusion of large scale social missionary project, its political aspect and its idealistic or altruistic view on the profession and society, they are also effected by it since it became a base for them in order to build their own professional perspective during and after the medical education. They also refer to the social authority and professional perspective of the former generation of doctors in order to argue that there should be a continuity among the generations of doctors in this sense and that the changes in the social position and concerns in many doctors of their own generation are caused by the particular social and economic conditions at the larger contextual level.

However, the sense of continuity among the generation of doctors in terms of making use of the same type of social concerns in order to achieve

social authority may be damaged with the rise of Islamic medicine where the doctors with an Islamic view try to combine the biomedical model with the religious rules. Although my informants evaluated the rise of Islamic medicine and hospitals as merely responding to a demand by the religious groups in society, with more economic than political concerns, some of them felt threatened by the fact the doctors with Islamic view have begun to organize as a powerful interest group which would impose its own system and values in the health sector. The rise of Islamic hospitals is a recent tendency which started in the mid- 1990's, but it has developed fast enough to produce important criticisms of the biomedical model, such as its emphasis on "medicine as a science" which damages the humanistic side of medicine and its own rules in the hospital setting, such as female patients being taken care of by female doctors. I would like to cover these issues in detail in this study in order to find out the ways in which they claim a social authority and develop their social and professional concerns in relation with other doctors. However, this topic is broad enough to be the subject of another study, and Islamic medicine is developing rather fast in different directions as different religious groups and organizations build their own hospitals.

For further studies on these issues, it would be interesting to study whether the continuity among the generations of doctors in terms of claiming social authority through social concerns would remain despite the rise of economic concerns and differentiation in the professional perspectives and experiences of doctors. One might argue that the professional socialization during the medical education would still be influential in reproducing this continuity, because of the initiative of the

former generation of doctors to elect the new members of the academia in the faculties of medicine. However, as the number of the new generation of doctors with new professional concerns increase and as they begin to claim their social authority more through their increasing professional experience and success rather than referring to the social authority of their colleagues from the former generations, they may acquire a new type of authority through their professional success in improving the medical and living condition of their patients, rather than their active role in shaping the social and political issues in society. This position of authority would be maintained and secured by doctors as individuals rather than a professional group or community, because the new generations of doctors, in line with their particular professional perspectives, would also differ from each other in terms of their sources through which they claim social authority, such as the way they treat their patients, economic power, religion, the social authority and the professional perspective of the former generation of doctors.

REFERENCES:

- Adıvar, Adnan A. , 1991, Osmanlı Türklerinde İlim, (Science in the Ottoman Turks), Remzi Kitabevi.

-Akşin Sina, "Jön Türkler", Tanzimattan Cumhuriyete Türkiye Ansiklopedisi, 1985, v:3, İletişim Yayınları. 1985.

-Altıntaş, Ayten, "Tıbhâne-i Amireye Adım Adım", (Step by Step towards the Military Medical School), Tarih ve Toplum, v: 171, Mart 1998, pg. 4-9, İletişim Yayınları.

-Atatürk, Mustafa Kemal, 1930, Yurttaşlık Bilgileri, (The Information on Citizenship), Cumhuriyet Yayınları.

- Aydın Suavi, 1993, Modernleşme ve Milliyetçilik, (Modernization and Nationalism), Gündoğan Yayınları, Ankara.

- Bosk, Charles L., Forgive and Remember: Managing Medical Failure, The University of Chicago Press, Chicago, London, 1979.

- Carr-Saunders A. M., Professional Culture, The Professions, A. M. Carr-Saunders and P. A. Wilson (eds), 2nd edition, Frank Cass & Co. Ltd., 1964.

- Conrad, Peter, 1992, "Medicalization and Social Control", Annual Review of Sociology, v:18, pg. 209-232.

- Davison, Roderic H. ,1963 in Aydın Suavi, 1993, Modernleşme ve Milliyetçilik, (Modernization and Nationalism), Gündoğan Yayınları, Ankara.

-Erdemir, Ayşegül Demirhan, 1996, Tıbbi Deontoloji ve Genel Tıp Tarihi, (Medical Ethics and General History of Medicine, Güneş&Nobel, Bursa.

- Figlio, Karl, 1977, "The Historiography of Scientific Medicine: An Invitation to the Human Sciences", Comparative Studies in Society and History, v: 19, No:3. pg. 262-286.

- Foucault, Michel, 1970, in Byron J. Good and Mary-Jo Delvecchio Good, "Learning Medicine, The Constructing of Medical Knowledge at Harvard Medical School", Analysis in Medical Anthropology, S.Lindenbaum and M. Lock (eds.), University of California Press, Berkeley, 1993.

- Freidson, 1970, in B. Turner, Medical Power and Social Knowledge , Sage, London, 1987.

- Good, Byron J. and Good, Mary-Jo D. "Learning Medicine, The Constructing of Medical Knowledge at Harvard Medical School", Knowledge, Power and Practice: The Anthropology of Medicine and Everyday Life , pg. 81-104, S. Lindenbaum and M. Lock (eds.), University of California Press, Berkeley, 1993.

- Gündüz, Feryal Saygılıgil, "Sağlık Alanından Gelen Ilk Kadın Parlamenterler", (First Woman Parliament Members from the Health Field), Tarih ve Toplum, v: 171, Mart 1998, pg. 15-20, Iletişim Yayınları.

-Gürsoy, Akile, "Beyond the Orthodox: Heresy in Medicine and Social Sciences from a Cross-cultural Perspective", Social Science and Medicine, 1996, V:43, No:5, pg.590-620, Pergamon.

-Güvenç, Bozkurt, 1979 in Aydın Suavi, 1993, Modernleşme ve Milliyetçilik, (Modernization and Nationalism), Gündoğan Yayınları, Ankara.

- Hanioğlu, M. Şükrü, 1981, Bir Siyasal Düşünür Olarak Doktor Abdullah Cevdet Bey ve Dönemi, (Dr. Abdullah Cevdet Bey as a Political Philosopher and his Time), üçdal Neşriyat, Istanbul.

- Helman, C. , 1990, Culture, Health and Society, pg. 86-126, Wright, Boston.

- Hughes, 1958, in B. Turner, Medical Power and Social Knowledge , Sage, London, 1987.

- Jackson, Jean E, 1994, "After a While No One Believes You: Real and Unreal Pain", in Pain as Human Experience: An Anthropological Perspective, Mary-Jo Delvecchio Good, Paul E. Brodwin , Byron J. Good, Arthur Kleinman (eds), University of California Press.

- Kılıçbay, Mehmet Ali, "Osmanlı Aydını", (The Ottoman Intellectual), Tanzimattan Cumhuriyete Türkiye Ansiklopedisi, 1985, v:1, Aydınlar, (Intellectuals), İletişim Yayınları.

- Lella, Joseph W. and Pawluch, Dorothy, Medical Students and the Cadaver in Social and Cultural Context, Biomedicine Examined, pg. 125-153, M. Lock and D. R. Gordon (eds), Kluwer Academic Publishers, Dodrecht, Holland, 1988.

- Linde, Charlotte, Life Stories: The Creation of Coherence, pg. 12-19, 98-162, Oxford University Press, New York, Oxford, 1993.

- Manizade, Derviş, 1976, 65 yıllık Cerrahpaşa Hastahanesi (39 Yılda Gördüklerim ve Duyduklarım), (The 65 year- old-Cerrahpaşa Hospital- The Things I Have Seen and Heard in 39 Years), Matematik Araştırma Enstitüsü, Baskı Atölyesi, İstanbul.

- Mardin, Şerif, "Tanzimat ve Aydınlar", (Tanzimat and Intellectuals) Tanzimattan Cumhuriyete Türkiye Ansiklopedisi, 1985, v:1, Aydınlar, (Intellectuals), İletişim Yayınları.

- Martı, Altay, 1995, öldürmenin Erkek Yüzü, (The Male Face of Killing), Leman Yayınları.

- Martı Altay, 1997, Savaş ve Kalbim, (War and My Heart), Leman Yayınları.

- Minkari, Tarık, 1993, Bir Cerrahın Anıları, (The Memoirs of a Surgeon), Milliyet Yayınları.

- Nasuhoğlu, Ilhami, 1975, Tıp Tarihine Kısa Bir Bakış, (A Brief Study of the Medical History), Ayyıldız Matbaası, Ankara.

- Ortaylı Ilber, 1983, Imparatorluğun En Uzun Yüzyılı, (The Longest Century of the Empire), Hil Yayınları.

- öncel,Burhan, 1951, Bir Beyaz Gömleklinin Romanı, (The Novel of a Person with White Coat), pg. 9-13, 174-182 Nebioğlu Yayınevi, Istanbul.

-özden, Akil Muhtar, 1945, Canlı Tarihler, (Living Histories), Türkiye Yayınevi, Istanbul.

- Parsons (1951) in Conrad, Peter, "Medicalization and Social Control", Annual Review of Sociology, v:18, pg. 209-232, 1992.

- Rosenthal, Gabriele, 1993, "Reconstruction of Life Stories: Principles of Selection in Generating Stories for Narrative Biographical Interviews" in The Narrative Study of Lives, R. H Josselson&A. Liebblich (eds), pg: 19-91, London& Beverly Hills, CA: Sage.

- Sağlam, Tevfik 1981, Nasıl Okudum?, (How did I Study?), pg. 40-45, İstanbul üniversitesi, Cerrahpaşa Tıp Fakültesi, Atatürk'ün Yüzüncü Doğum Yılını Kutlama Yayınları, özel Seri 4, İstanbul Matbaası, İstanbul.

- Sezer, Muzaffer, 1953, Hekim Aşkı, (Love of a Doctor), pg. 42-48 Istiklal Matbaası, İstanbul.

- Starr, Paul, 1982, The Social Transformation of American Medicine, Basic Books, Harper Collins.

- Terzioğlu, Aslan, "Kırım Harbi Esnasında Osmanlı Hastahaneleri ve Dünya Hastahaneciliğine Etkileri", (Ottoman Hospitals and their influences on the World Hospitals during the Crimean War), Tarih ve Toplum, v:85, Ocak 1991-1 , pg. 39-47, İletişim Yayınları.

- Terzioğlu, Aslan, "Sadi Irmak ve Hümanizm", Tarih ve Toplum, v: 86, Şubat, 1991-2 , pg. 16-22, İletişim Yayınları.

- Terzioğlu Aslan, "Galatasaray'daki Mekteb-i Tıbbiye-i Adliye-i Şahane'ye Dair Şimdiye Kadar Bilinmeyen Almanca Kaynaklar" (The Sources in German, which have not been discovered until now about the Imperial School of Medicine at Galatasaray), , Tarih ve Toplum, v: 100, Nisan, 1992 , pg. 17-26, İletişim Yayınları.

- Terzioğlu, Aslan, "Dr. Nouridjan ve Onun Mekteb-i Tıbbiye-i Şahanede Verdiği Tıbbi Deontoloji Giriş Dersi", (Dr. Nouridjan and his Course on the Introduction to the Medical Ethics), Tarih ve Toplum, v: 111, Mart 1993, pg. 22-27, Iletişim Yayınları.

- Topuzlu, Cemil, 1945, Canlı Tarihler, (Living Histories), Türkiye Yayınevi, Istanbul.

- Tunçay, Mete & özen, Haldun, "1933 Darülfünun Tasfiyesi veya Bir Tek-Parti Politikacısının önlenemez Yükselişi ve Düşüşü" (The 1933 Reorganization of Darülfünun or an Unpreventable Rise and Fall of a Single-party Politician), Tarih ve Toplum,v:10, Ekim 1984, pg. 6-21,Iletişim Yayınları.

- Turner, 1987, Medical Power and Social Knowledge, Sage Publications, London.

- Turner, Bryan S., 1996, The Body and Society: Explorations in Social Theory, Second edition, Sage Publications.

- Unat, Ekrem Kadri, 1989, Istanbul üniversitesi Tıp Fakültelerinde 50 Yıl Hizmet, (50 years of Service in the Faculties of Medicine, Istanbul University), Istanbul üniversitesi Fen Fakültesi Döner Sermaye Işletmesi Basım Atölyesi, Istanbul.

- Unat, Ekrem Kadri& Samastı, Mustafa, 1990, Mekteb-i Tıbbiye-i Mülkiye (Sivil Tıp Mektebi) 1867-1909, İstanbul üniversitesi, Cerrahpaşa Tıp Fakültesi Yayınları, İstanbul.

- Uzunçarşılı, İsmail Hakkı, 1988, Osmanlı Devletinin Saray Teşkilatı, The Organization of Palace in the Ottoman State, Türk Tarih Kurumu Basımevi, Ankara.

- Woodham- Smith, Cecil, 1952, Sonsuz Fedakarlık (Lady-in-Chief: The Story of Florence Nightingale), translation: S. Huri, Mohrbooks A. G., American Bord Publication, İstanbul.

- Yıldırım, Nuran& Ülman Yeşim Işıl, "Zoeros Paşa ve Deontoloji", Tarih ve Toplum, v:127, Temmuz 1994, pg: 29-34, İletişim Yayınları.

- İstanbul Ansiklopedisi, (I.A.), 1993, Türkiye Ekonomik ve Toplumsal Tarih Vakfı &Kültür Bakanlığı.

- Gelişim Ansiklopedisi, (G.A.) 1986, v:6, Gelişim Yayınları.

- Tanzimattan Cumhuriyete Türkiye Ansiklopedisi, 1985, v:1, Bilim: Tıp ve Sağlık, (Science: Medicine and Health), İletişim Yayınları.

-1923-1973, İlk Elli Yılda Sağlık Hizmetleri, (1923-1973,The Health Services in the first Fifty Years), 1973, Sağlık Bakanlığı, (Ministry of Health), Ankara.

- T.C. Devlet Planlama Teşkilatı, (DPT), Sağlık Sektörü Master Plan Etüdü, Mevcut Durum Raporu, 1989, DPT Yayınları, Ankara.

- Türk Hekiminin Dünü, Bugünü, Yarını, (The Yesterday, Today and Tomorrow of the Turkish Doctor), (TTB) 1965, Türk Tabipler Birliği Merkez Konseyi Neşriyatı, Yaşar Matbaası, İstanbul.

- Talks by Orhan Arıoğlu and Halit Ziya Konuralp and Yıldız Tümerdem in the conference organized by Çapa Faculty of Medicine &Turkish Chamber of Medicine (TTB), "73. yılında Cumhuriyetin Sağlık Hizmetlerine getirdikleri" (The Contributions to the Health Sector by the Republic in its 73th year), 29 October, 1996, Çapa University, İstanbul.

- Talks and interviews with doctors: Bülent Genç (1997), Irfan Gökçay (1996), Yusuf Sahip (1996), Gülçin Türker (1997), Ekrem Kadri Unat (1996) and Aysun Uslu (1997).

- Class talk by Irfan Gökçay in Spring 1998 in the SOC 490, Sociology of Health, Instructor: Belgin Tekçe.

APPENDIX

A Brief Description of Informants

1) Dr. Meriç

Born in 1967 in Bulgaria

Comes from a family with a low socio-economic status and who migrated from Bulgaria when she was a child

Went to the Faculty of Medicine at Cerrahpaşa

Specialized in pediatrics at the Faculty of Medicine at Çapa

Could not make an academic career there despite her wish

Currently works in a small hospital directed by an Islamic Foundation

2) Dr. Sakin

Born in 1963. Born and raised in Denizli

Comes from a family with a middle socio-economic status

Her father and her brother in-law are pharmacists in Denizli

Went to Faculty of Medicine at Ege University in Izmir

Went to obligatory duty in Giresun

Specialized in gynaecology at Haseki Hospital where she works now at part-time basis

Currently plans to work in a private hospital

3) Dr. Türkcan

Born in 1945 in Istanbul

Comes from a well-off family

Went to the Faculty of Medicine at Çapa

Specialized in opthalmology

Took active roles in the political movements in the universities in 1970's

Currently have a private clinic and professor at Çapa

4) Dr. Sarol

Born in 1965 in Ankara

Comes from a well-off family

Went to the Austrian High School (Private high school) in Istanbul

Went to Faculty of Medicine at Cerrahpaşa

Specialized in gynaecology at Kartal State Hospital

Currently works in the Acıbadem Hospital (Private)

5) Dr. Yaş

Born in 1960 in Istanbul

Comes from a family with a low socio-economic status

Went to Faculty of Medicine at Cerrahpaşa

Highly interested in music and cinema besides medicine

Specialized in orthopedics at Istinye State Hospital where he currently works

Plans to open a private clinic soon

6) Dr. Çağlar

Born in 1961 in Ankara

Raised and went to the medical school in different countries such as India and Pakistan because of his father who was ambassador

Comes from a well-off family

Went to Faculty of Medicine at Ankara University

Went to obligatory duty to Karaman

Specialized as a family doctor in kartal State Hospital where he currently works

Appendix 2: Excerpts from the Original Interviews

1) Orada tabii herkes...gerçekten böyle seçilmiş insanlar... ondan sonra hiçbir dönem kırık falan olmazdı yani böyle işte,ee Avusturya Lisesi için başarılı sayılabilecek bir ortalamam vardı... Bende klasik kolej burnu büyüklüğü falan vardı, yaa onlar çalışsın ben çalışmadan da iyi notlar alırım falan.

2) Mümkün olduğu kadar, çalışkan öğrencilerde o psikoloji oluyor, işte en yükseği olsun, ne olursa olsun da onu kazanayım... Genel olarak tabii doktorluk toplumda saygın bir meslek. Her anne baba ister çocuğunun doktor olmasını.

3) Bizim dönemde hep böyle başarılı çocuklar tıbba giriyordu.. öyleydi o zaman, 83 dönemi... Tıp fakültesine girmek çok büyük birşeydi.

4) Tıp herşeyden farklı görünüyordu bana...Ne bileyim, bazı birşeyler okursun, biraz ilgilenirsin, işletmedir şudur budur. Ama bir herkes bir tıbbı okuyup, doktor olamaz, tıbbı anlayamaz gibi geliyordu... Kullanılan terminoloji hoşuma gidiyordu, reçeteler..Hiç böyle inanamıyordum, çok büyük işti bana göre, yahu o ilaçlar nasıl akıllarında tutuyorlar, nasıl tanı koyuyor bu adam bunu nasıl anladı.. hani şunun şusu var ve ilaç veriyor adam iyileşiyor. Aa diyorum ne kadar güzel birşey (Hım). Çok bana inanılmaz geliyordu açıkcası doktorluk (Gülme). Çok da ulaşılmaz geliyordu. Ama dedim bu işi ben çalışırım, yaparım, diye inat ettik.

5) Hastayı çok özenerek, BEZENEREK, artık böyle gözüne bakıyorsunuz. Hocacım değerlendiriyor, arkadaşların seni değerlendiriyor (Gülme). Ne bileyim, hoca soru sorduğu zaman cevap vermek lazım... Stres başlıyor yavaş yavaş. Hem zevkli hem de mahçup olmama sıkıntısı. Klinikte, hep insanlarla karşı karşıyasınız. Hocanız size soru sorucak, bilemiyeceksiniz

(-ses yükseltme-) arkadaşlarınızın yanında çok ayıp (Gülme). Hem hastanın yanında mahçup olucaksınız, hep o sıkıntı da var...Hem kitap okumanız lazım, sürekli birşey okumanız lazım, bir şekilde bilmen lazım, birşeyler bilmen lazım. Panik başlıyor tabii, fırça yemiyeceksin...Hoca kovar, vizitten atar, terket, vizitten terket, çık çık, dokunma, hastaya dokunma der.

6) Oyun gibiydi ya, yani aslında ilk önce çok midemiz bulanarak o salonları, o cesetleri, hiç ceset görmemiştik daha önce. Görür görmez böyle ee ne olucak diye korkudan korktuk, yani arkadaşlarımıza ayıp olur mu acaba, yani korkup bayılırmıyım diye o korku paranoyasından daha çok korktum yani... Korkmamaya çalışıp onu, o projeksiyonumu mutlu mizaçla gösterdim, aaa bu ölüymüş diyip kolunu kaldırdım bıraktım. ...Eldiven bile giymeden bıraktım. Aslında içim titriyordu... Ama daha sonra o işe yansıdı, bir yıl o sene okulu bıraktım zaten, bir yıl okula gitmedim o yıl.

7) Bir parmağın bile kompleksliğini gördüm. Otonom sinir sistemini okurken hayretler içinde kalıyordum... Aman Allahım ne kadar müthiş, ne kadar müthiş diyip... özellikle dinsel yargılamalara falan geçiyorsun daha çok yani öyle. Her tıp öğrencisi herhalde fizyoloji okurken, patoloji, fizyoloji, anatomi okurken, böyle biraz Tanrı yı sorgular herhalde, varoluşu sorgular... Bir parmağın binlerce bilgisayardan çok daha kompleks bir yapısı var... ve bir hormonlar sistemini düşündüğün zaman inanılmaz, içinden çıkamıyorsun, nasıl dengeliyorlar birbirlerinin, nasıl o artıyor o azalıyor... o nasıl beyinde kontrol altına alınıyor filan o inanılmaz birşey. Inanılmaz birşey. Inanamayınca da ya Allah var galiba falan diyorsun (Gülme).

8) Bir insanın yani sadece sermayesi beyin olarak, her şart altında ne şekilde yaşamını kazanabileceği. Birincisi bu, ikincisi peki yani bağımsız olarak ne iş yapabileceği... monoton olmayan ne iş yapabileceği, öyle veya böyle saygı duyabileceği insanların, ne iş yapılabileceği. Sonuçta ee ya olay şeydi ya takım oyunu oynayacaktım ya bireysel bir spor yapıcaktım...ya işte bir futbol takımının kalecisi... gibi birşey seçicektim , ya da tenisçi gibi tek başına yapabileceğim bir şey olacaktı. Tabii takım ruhunda biraz da başkalarının hatalarını örtmek zorundasın, veya işte onların yaptığı şeylerin sorumluluğunu üstlenmek zorundasın ve işte onların kötü olması sonuçta senin başarını da etkiler diye düşünüyorum.

9) Şimdi böyle değişkenlik yani istediğiniz zaman, ya bir dala yönelebileceğiniz, istediğiniz zaman beş dala birden ve bunu zaman şeysiyle, yani tıbbı uyguladığınız zaman, hasta baktığınız sürece uyguladığınız birşey olduğundan değişkenlik var, bundan daha güzel birşey olamaz diye düşündüm... Bir de yeni bir dal, birileri birşeyler yapıp, ortaya birşeyler çıkartıp ee ondan sonra öyle bir çerçeve içerisinde, yani bir "pioneer" denilen Amerika'da işte öncüler gibi, öyle bir şey bana daha uygun geliyor.

10) O dönemde de Cronin'in romanlarını çok okuyorduk. Biraz değişik bir gençkızdım ben, bana tıp daha bir cazip geldi, insanlara çok faydalı olacağımı düşünüyordum. Topluma faydalı olacağımı, yani Türk toplumunun gelişmesi için, ee tıbbı seçerek daha faydalı olacağımı şey yapıyordum. Çok idealisttim o zamanlar, şimdi o kadar idealist değilim.

11) Bu çok acı bir ölümdü bence gerçekten... Mikroskopla bile görülemeyecek şeyler vardır, bu da ondan doayı oldu. Hekim hatası değildi. Ama ben ilk baştan, yani yeni asistanımda, öyle mi falan diye

kontrol edilene kadar ölümlerden ölüm beğendim yani. Istifa etmeye kalktım. Bu işin bana göre olmadığını düşündüm.

12) Çapa'da kalma imkanım yoktu ...İddialı birşey değildim. öğrencilikteki başarımı asistanlıkta gösterdim diyemem gerçekten... Yani gerek hocalara karşı yakınlaşmak açısından, yani kendimi gösteren bir tip değilim zaten. Hiçbir zaman onlar beni değerli bir asistan olarak görmemişlerdir. Ama hep, sıradan, vasat bir asistandım işte, ne denilse yapan, sessiz bir insandım. halbuki kalma kriterleri çok farklıydı üniversitede, bu yaptığın işle alakalı bir şey değil, bilgiyle de alakalı değil. Şimdi benim yanımda çalışan doktor mesela çok çok bilgili, ben de okurdum, o çok daha fazla okur. Eee, işte bu uzmanlık sınavında da birincilikle girmişti, süper bilgili bir çocuk, onu da almadılar işte. Onların aradığı kriterler değildi, işte araştırma yapabilen, hastalara bakan değil...Çok politik, Türkiye'nin bütün işte şark kafası diyorlar ya, aynen öyle. Aynı çizgi bizlerde de var. Yani kendileri gibi olanları seçiyorlar. Işte hatta bu fiziksel görünüş bile olabiliyor ne yazık ki... Fiziki iyi olan, işte gösterişli olan, karizmatik olanlar, sosyo-ekonomik düzeyi iyi olanlar, kolej mezunu olanlanlar...Biz tahmin ediyorduk, şu kalır, şu kalmaz... Gerçekten bilmiyorum onlar nasıl herşeyi biliyorlar... Ha, kendilerine yakın olan asistanlar var, her dönemde oluyor tabii, onlar da jurnalliyorlar da seni.

Chapter 3:

13) Ben çocukluğumda, annem beni hastahaneye götürürken, ya aşı olucaz belki sadece, ama tırnağımızı dahi keserdi, kilodumuzu değiştirirdi. Yıkanırdık, yani doktor ister belki olum, soyunursunuz filan. Mahçup olmayalım diye en güzel bayramlık giysilerimizi giyer giderdik, yani böyle bir çekingen, böyle bir saygıyla giderken...

14) Doktor eve geleceği zaman, işte ev temizlenir, doktorun ücreti dahi önceden bir zarfa yerleştirilirdi... Cahit Sami Gürsoy'un gelişi bizim ev için böyle bir şölen gibiydi, onu gider babam muaynehanesinden alır getirir, ee teşekkürler edilir falan filan. Şimdi tabii böyle birşeyler yok. Doktorlar da ev hastasına falan girmeyi semiyorlar yani, pek gitmiyorlar yani. Çok tanıdıktı bilmem neydi, yakını gidiyor, ama pek gitmiyorlar yani, vakti yok.