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“We’ve all had patients who’ve died…”: narratives of emotion and ideals of competence among junior doctors

Abstract

Although there is reasonably rich literature on socialisation in medical schools, few studies have investigated emotional socialisation among qualified doctors; specifically how specialist training reproduces the norms, values, and assumptions of medical culture. This article explores expressions and management of emotion in doctors' narratives of work and training for insights into how socialisation continues after graduation. The study employed qualitative methods - in-depth interviews - with fifty doctors at early and advanced stages of specialist training in teaching hospitals in Ireland. The study found that performance of competence, particularly for doctors at earlier training stages, required them to hide signs of struggle and uncertainty. Competence was associated with being emotionally tough, which involved hiding emotional vulnerability; however, some challenged the assumption that doctors should be able to transcend emotionally painful events. Tensions between this expression of competence and making time for self-care meant that the latter was often neglected. Some participants highlighted how they enjoyed more personal interactions with patients, which was juxtaposed with the expectation of being detached and an associated potential to objectify patients. This theme resonates with recent debates on “appropriate” expressions of empathy and its implications for patient-doctor relationships. The article discusses how ideas underpinning the image of medical invincibility should be questioned as part of efforts to reform medical culture and in the training of specialists in emotional wellbeing and self-care.

Keywords: Ireland; doctors; specialist training; qualitative interviews; emotion; socialisation

Introduction

Recent research from Britain and Ireland shows that junior doctors face high levels of stress at work, aggravated by recent economic austerity responses (Thomas et al., 2014; RCP, 2016), and that there is lack of attention to their emotional well-being (Hayes et al, 2017; RCP, 2016; RCPI, 2014). Literature on burnout and the associated phenomenon of depersonalisation also highlights the real dangers for doctors practicing today (McCray et al., 2008; Orton et al., 2012; (Shanafelt, Boone, Tan, & et al., 2012); Shapiro and Galowitz, 2016). Rich literature on medical socialisation suggests that underlying and sustained attitudes and values reproduce particular emotional norms among doctors (Hafferty, 1991; Prentice, 2013; Sinclair, 1999; (Sointu, 2017): in a recent longitudinal study on cultural reproduction among medical students, (Sointu, 2017) illustrates subtle ways that emotion, disguised due to "affective neutrality", is implicated in sustaining and enforcing power relations.

Much of the interest in the particularities of medical culture has focused on the medical school as the crucible in which this culture is inculcated among new recruits. This article is concerned with medical culture as experienced by medical graduates undertaking specialist training (junior doctors). It draws on recent findings on wellbeing among medical graduates in Ireland and the UK and builds on research carried out since the 1960s about the internalisation of medicine's norms and taken-for-granted assumptions during undergraduate training, much of which was carried out in the US (Becker, Geer, Hughes, & Strauss, 1961; Hafferty, 1991). These studies explored how emotion is implicated in the normative image of a competent doctor, and how this affects students' management of difficult emotions arising during undergraduate training (Hafferty, 1988; Smith & Kleinman, 1989). This research was ground breaking in relation to developing an understanding of the nuances and subtle processes in which medical students become entangled. Recently, (Underman & Hirshfield, 2016) have called for further investigations into these emotional processes given developments in medical education since the publication of landmark studies such as (Becker et al., 1961) . In responding

to this call, this article also aims to fill another important gap through exploring how inculcation into medical culture is enacted and felt by qualified doctors undertaking specialist training. In particular, drawing on new empirical data from Ireland, it explores the role and implications of emotion in the embodied experiences of junior doctors. High levels of stress, burnout, mental health problems and the lack of and need for self-care among these doctors were highlighted in a national training body position paper (RCPI, 2014); and a large national survey subsequently measured and reported high levels of poor mental health, especially among junior doctors in Ireland (Hayes et al, 2017;). Only half reported normal psychological wellbeing, one third had experienced burnout and two thirds experienced self-stigma, which was an obstacle to their accessing psychological support. This demonstrates the need for better understanding of professional subjectivities in this context.

The norms of emotional expression expected from doctors, particularly in the context of relationships with patients are implicated in this debate about competence and emotion. (Lief, 1963) formative article considers the idea of “detached concern” as a goal of medical training in the US. They suggest that detachment is necessary to do things that lay people may react to with disgust and fear. Detached concern allows doctors to “apply” empathy without getting entangled in emotional bonds, thereby promoting better understanding of patients’ emotional experience. This engagement with the ways that emotion has been approached, negotiated, and ultimately controlled by actors in the field of medical education was foundational for subsequent inquiries into how emotion is or should be integrated into the training of doctors (Cadge & Hammonds, 2012; Lampert, 2018; Wei-Ting & Ya-Ping, 2016). Since then, authors have interrogated the usefulness of detached concern (Fox, 2006; Halpern, 2001, 2003). For Halpern (Halpern, 2001, 2003), detached concern, which encourages doctors to intellectualise their emotional experiences, is qualitatively different from empathy. The latter, defined as emotional attunement to patients, has clinical value in promoting better patient-doctor

relationships. In the end, the problem for Halpern is that emotions are not recognised as being inherently part of doctors' interaction with, and therefore their ability to optimally manage and care for, patients. Once acknowledged, they can be incorporated into training, enabling doctors to have genuinely empathic relationships with the people they treat. Debates over the role of emotion in doctors' professional encounters is relevant to the aim of better understanding how cultural assumptions about emotion shape doctors' embodied experiences of, and responses to, their work. Leaving aside normative ideals about medical training, we now discuss empirical evidence of emotional socialisation in previous research, including research on medical students. In this way, we foreground how this process forms a trajectory that continues, albeit lived in different ways, during the postgraduate training of qualified doctors.

The focus in medical education on producing competent doctors can be at odds with promoting caring dispositions (DelVecchio Good & Good, 1989; Sinclair, 1997). For Sinclair (1997), this results in inner conflict for both students and junior doctors as they attempt to integrate the scientific dimension of medicine with ideals of care and compassion. This conflict is produced by a reflexivity understood as conscious preoccupation and unease with norms and assumptions that are implicitly taught and often unconsciously adopted. Underman (2015, p. 181) argues that competence, far from being antithetical to emotion, 'is itself an affective disposition, a particular way of feeling embedded in a cultural context'. This supports Sinclair's (1997) argument that the tension inherent in the process of shedding lay identities constitutes an emotional experience. In Underman's study, medical students sought to embody competence by managing their emotions in front of patients so as to mask anxiety and discomfort. This resonates with an earlier study of medical students which found the intimacy of working on a patient's body could be mitigated through emotion management (Smith & Kleinman, 1989).

In a recent UK study, medical students could assert 'legitimate professional identity' only when they adopted the right set of dispositions to access the social and cultural capital required to

succeed as doctors (Lempp, 2009, p. 79). Prentice (2013) argues that surgical trainees in the US implicitly learn emotional restraint; and that much of what is actually learned involves 'the adoption of values, styles of practice, priorities for treatment, and techniques that are rarely invoked as explicit curricular objectives' (2013, pp. 104-105). Some studies identify anatomy laboratory as pivotal in teaching students the dichotomy between emotional competence and weakness (DelVecchio Good & Good, 1989; Hafferty, 1988, 1991; Prentice, 2013; Sinclair, 1997). Hafferty (1988, 1991) found that, through students' "cadaver stories", emotional detachment was set in opposition to vulnerability and weakness. Fear was taboo while emotional competence, being able to handle 'the horrors' of anatomy dissection, was the ideal; it positioned those struggling to 'adopt a medical frame of reference' as outsiders (Hafferty, 1988, p. 351). For Prentice (2013), the ontological duality of cadavers, where they can be medical objects yet activated as former persons when needed, reveals that neat categories of thought and feeling cannot explain the shifts students experience during dissection lessons. Emotions, understood 'as embodied through culturally and historically situated practices, rather than as individual internal states,' are inextricably part of how and what students learn (Prentice, 2013, p. 65).

Bourdieu's (1990) theory of the habitus has been used to explain the process by which students and junior doctors come to embody and reproduce medical culture (Brosnan, 2009; Lempp, 2009; Prentice, 2013; Sinclair, 1997; Underman, 2015). The habitus refers to the non-conscious processes through which individuals adopt the cultural traits of and adapt to the "field", defined as any arena marked by struggles for resources, or "capital" (Bourdieu, 1990; Brosnan, 2010). A field comprised of actors can be likened to a game with players, who, upon entering the field, learn to 'play the game' (Brosnan, 2010; Lempp, 2009). The habitus is this ongoing sense of, and embodiment of, the field in question. Borrowing from Bourdieu, Luke (2003) shows how the early years of postgraduate training continue the steep learning curve, as doctors adapt to

and learn to acquire social and cultural capital in the real world of medicine. While the literature cited above provides rich insights into emotional training of students, less is known about what happens when junior doctors are faced with putting these emotional lessons into action. This article draws on the notion of medical education as 'the production of a habitus' (Brosnan, (2009, p. 58) – based on adoption of dispositions through which students acquire instincts on how to succeed in the field – to gain insights into how junior doctors grapple with embodying the emotional dispositions expected of them.

The understanding of habitus as the physical embodiment of dispositions is useful for thinking about medical education as, while doctors progress from medical school to the later stages and completion of specialist training, they adopt and come to embody more easily the emotional dispositions expected in the medical field. This is a useful way of conceiving the lived experience and negotiation of emotion norms if we accept that there is not a clear cut distinction between emotion and reason, or feeling and thinking. As Underman (Underman, 2015) argues, understanding medical competence as a kind of emotional disposition allows for a nuanced appreciation of the interplay and co-constitution of affective practice and scientific learning. In the remaining sections, we examine how the medical habitus, specifically the expected emotional dispositions in the field of medicine, impacts the lived experiences of junior doctors who were at different stages of specialist training. The article is also interested in the self-reflexive or introspective discussions by some participants on what they found to be the jarring or dissonant effects of the emotional dispositions associated with a medical habitus.

Methodology

The article is based on 50 semi-structured interviews conducted in 2015 with doctors, 29 women and 21 men aged 25-44, who were undertaking postgraduate training in Irish hospitals and general practices, derived from a nationally representative survey of trainees undertaken

in 2014. Informed consent was sought from interviewees before interviews were conducted and interviews were, on average, sixty minutes in length. A fuller description of the interview and ethics review processes is outlined in Crowe, Clarke, and Brugha (2017). Trainee grades in Ireland progress from internship (first year post graduation) to senior house officer (SHO), registrar and finally specialist registrar (SpR), culminating in a certificate of completion of specialist training. This study focused on junior doctors; however, four participants had finished SpR training by the interview phase and had recently taken up consultant roles. Since interviews focused on training experiences, their accounts remain relevant for the article. Aside from these four, the sample is composed of SHOs, SpRs and GP trainees. The sample included a range of specialties, though, to ensure anonymity, which was a particular concern for them, given the small number of training posts for some specialties in Ireland, the article does not identify participants with particular specialties.

We developed the interview schedule to elicit accounts of doctors' experiences of training environments and of working in hospitals, and how these might influence career choices including decisions to emigrate or remain in Ireland. Emotion was not part of the original interview schedule; though, as participants spoke about norms and rules surrounding the expression and management of emotion in their roles as professionals, this theme informed many interviews, with 23 participants elaborating such accounts. When participants spontaneously discussed or alluded to themes relating to the role of emotion, the interviewer probed for further explanation and elaboration.

Weakness" and "detachment from patients" were sub-codes of "emotional impact of work". The interviewer did not directly ask participants about interactions with patients, and narratives of detachment or objectification of patients were spontaneously occurring narratives. The authors created "gender" as a code that included narratives of expectations that doctors be stoic

and emotionally tough, as ways whereby participants processed emotionally painful events privately. The authors used thematic analysis to analyse transcripts (Braun & Clarke, 2006); and two researchers coded the data using MAXQDA software. Data were categorised according to dominant themes and subthemes through a process of line-by-line coding. The coding system was cross checked by members of the research team before being finalised. Case study analysis was then used to look in-depth at an interview that illuminated more clearly the patterns we identified in other interviews, and to show how certain themes interacted with each other. We decided to include this case study as we felt this person's reflexive elucidation of the dissonance experienced between the primary habitus and the medical habitus, in this context, reflected aspects of other participants' narratives in an insightful way. The analysis involved a close reading of this participant's transcript and of the ways the themes spoke to and expanded on themes identified in other transcripts. All names are pseudonymous.

Findings

This section presents findings on the role of emotion in the work narratives of junior doctors. First, we examine accounts of expectations for emotional composure and competence, then the impact of this theme on self-care practice and attitudes, followed by participant concerns about how emotion norms impact patient care. Finally, a case study presents one narrative that clearly illustrates how these themes interact.

Demonstrating competence and emotional composure

Resonating with earlier research, succumbing to emotional weakness through expressing taboo emotions was policed as a sign of not being able to 'carry their own weight' (Hafferty, 1988, p. 350). Conversely, masking or disguising a certain understanding of weakness, particularly for doctors in earlier stages of training, was a way to demonstrate competence. Participants were concerned not to reveal uncertainty and several, discussing their early years as a qualified

doctor, avoided asking for help or being seen to need it, believing this would be considered a sign of weakness. This is illustrated in Karen's account. The link between competence and emotional toughness is seen in the following statement on hiding feelings of uncertainty and stress related to her particular working environment:

> 'I didn't want people knowing that I wasn't liking it because then they would start thinking that she's struggling, so I kept it to myself. That was probably hard.'

Some were eager to demonstrate competence as doctors to senior staff, expressed as part of fitting in with the norms and values embedded in the work environment. Sadie, during her internship, approached other interns for help rather than more senior doctors due to 'the fear of being seen as weak… or not able for it'. The working ethos could vary according to specialties within the hospital; for example, 'the perception is that in surgery it would be worse, that you wouldn't ask for help, that you have to be able for it' (Sadie). Katie also spoke about hiding the need for support when starting her first registrar job, for fear of appearing incompetent to senior doctors:

> 'You were afraid of what you were going to hear at the end of the phone… "You're just ringing me because you don't know what you're doing"… I always thought that was a sign of weakness … letting on that you didn't know what was wrong.'

Some participants highlighted a marginalisation of the emotional dimensions of medicine, discussing the absence of formal debriefing for doctors after traumatic events. This was outlined by Claire, who worked in an intensive care unit (ICU) where she regularly encountered patient deaths; an aspect of work that seemed to be disregarded at the organisational level. Her experience of working in Britain, where debriefing on emotional impact was routine after

traumatic events, illuminated the lack of organised support for doctors in ICUs in Irish hospitals:

> ‘We just don’t talk about [emotionally difficult events]… because it’s just not normal over here and because people debrief by talking to their friends… [But] it’s important to recognise that it’s a strange job to do, with that level of mortality.’

Sylvia related an upsetting experience at an emergency procedure that was fraught with complications. She emphasised how the consultant dealt with the event privately, though his treatment of her subsequently felt impersonal and detached: ‘He didn’t say a word to me ever … again and basically avoided eye contact from [then] on; maybe because I reminded him of the incident.’ Sylvia immediately returned to work but a nurse encouraged her to take a moment to process the emotion:

> ‘She said “you probably are very traumatised by that” and I was like “yeah, fairly traumatised”… I sat down with her for about fifteen minutes and had a cup of tea and cried about it.’

The need for formal support and care for doctors after traumatising events was illustrated by Sylvia’s description of how the event had the power to traumatise her at a later date:

> ‘I was having problems with my second pregnancy at delivery, and was kind of having flashbacks to what had happened with that one… I guess a post-traumatic stress kind of thing.’

Similarly, Dylan remembered a distressing scene in the emergency department where a young patient died. Doctors were expected to maintain emotional composure and return to seeing patients while other health care staff were taken off duty to process the event. Dylan was struck

by the expectation that doctors should transcend these painful emotions while nurses and other staff were allowed space to reflect:

> ‘Within 15 minutes … I was back seeing patients and there was nothing offered to any of us doctors, any debriefing, any sort of “are you all right, how has that impacted?”… I’ll never forget that my allied health professionals were all stood down or offered counselling’.

According to Fisher (1995), nurses cultivate caring dispositions during training while doctors are cast in the role of “curers” not carers. Nurses may be socialised to care for patients and to show emotion in a way that doctors are not (Sinclair (1997). This was suggested in the accounts of Sylvia and Dylan, where nurses provided a caring role and were permitted to show emotion after tragedy.

More female participants than male discussed this theme. However, Julia was the only participant to directly engage with the gendered dimension of assumptions underpinning the display of emotion, suggesting that female doctors may have to unambiguously adopt the disposition of emotional detachment in order to ‘play the game’(Brosnan, 2009; Lempp, 2009). When finishing a very long shift, a female colleague became upset with exhaustion after her team had to continue working. The male registrar immediately dismissed her as ‘emotional’, based on cultural associations between femininity and emotionality (Jaggar, 1989; Lutz, 2008). This vignette indicates the centrality of bodily practice – and potentially denial – for demonstrating the correct dispositions to be taken seriously as a doctor:

> ‘Especially if you were a girl, if you even got one way emotional, which a colleague of mine, I remember her getting very, very upset, and one of the [senior doctors] just said, “Oh, it’s because she’s a girl”… she had a couple of tears’.

Along with de-briefing, participants spoke about the absence of formal support systems. As seen from these accounts, participants processed difficult emotions by talking to colleagues after emotionally painful events if there was an opportunity to do so. Though many relied on peers for emotional support and admitted the importance of informal networks, some felt this may be harder to access for some doctors and organised support was needed. Dylan, for example, appreciated being able to talk about feelings evoked by the event described above with his partner, also a doctor, acknowledging that others did not have such support.

An absence of space to reflect on emotionally difficult dimensions of work was implied in several accounts relating to desires for a more caring environment. Margot contrasted a friend's work experience in a foreign hospital with her own workplace, where care for the self and for colleagues was not emphasised. The system of working in rotations across hospitals in Ireland meant that informal peer support was not always available while the distant relationship some junior doctors have with their consultants created the sense, here, that care for one's clinical team was not prioritised. As Margot explained, referring to her friend working abroad:

> 'She was very close with her consultant mentor, they always made sure to check in on her and it just sounded really nice, very caring environment…Wouldn't hear that about training here…There aren't supports there at the moment for people and you can become overwhelmed. As trainees you're moving hospitals so often… I wouldn't have anyone that I feel that close to that I could talk to if I'm having a rubbish day'.

Liam also suggested that his peers often dealt with stress at an individual level: 'the amount of people going out drinking at the weekends to try get over how horrible their week was; it's pretty bad'. Many participants, however, pointed to variation in support from senior doctors. Jack observed that in cases where doctors were nearing the stage of burnout, senior staff could either be compassionate or dismissive:

> ‘There’s two polar opposites here, I’ve had people … in senior roles who are very supportive or people in senior roles who basically think you’re a waste of space if you can’t handle it’.

Jack’s account, however, illustrates the association outlined above between emotional vulnerability and incompetence. These accounts of struggling to embody a medical habitus, and of dissonance experienced with these emotion norms, emerged spontaneously in some interviews, although other participants did not engage in any reflexivity with regard to the emotional dispositions they were required to adopt.

Impact on self-care

Sinclair (1997) argues that emotional dimensions are almost completely overlooked in medical education, where students learn to detach from emotionally painful events, forced to deal with such emotions individually and privately (McNaughton, 2013). Some participants drew a connection between emotional vulnerability and incompetence in narratives of work and working relationships. The denial of emotional vulnerability in order to maintain an idealised image of competence was implicated in practices of and attitudes towards self-care. The impact of this emotion norm on self-care is illustrated in the following account. Julia, who had experience in treating doctors for stress, found that doctors were reluctant to use services for emotional support in the hospital due to fears of looking weak. She explained how, when making referrals to counselling, doctors did not want to be seen by colleagues as struggling with difficult emotions at work:

> ‘There was a lot of stigma about people seeing them come and people talking about them… for a doctor in general to admit weakness or if anybody, god forbid, even saw you there people would talk’ (Julia).

A report on doctor wellbeing in Ireland (RCPI, 2014, p. 11) presents some junior doctors' accounts of an expectation that they work through illness and emotional anguish without seeking help, based on a 'macho code of invincibility'. In narratives presented there, doctors felt they should hide both physical and emotional pain from others. Julia's account also resonated with the idea that competence is associated with total commitment to medicine, where self-care should not be prioritised over dedication to the job:

> 'You don't want to say that you're not feeling well, you don't call in sick… one boss… got really mad that somebody had the flu… and had stayed home that day and he said; "I only want to hear that one of you is sick if you're on your deathbed" … You just cannot admit to being weak.'

While a small number of male participants spoke about the impact of the expectation to be emotionally controlled on their own wellbeing, again more female participants discussed this. Several participants were explicitly critical of what they found to be an expectation for junior doctors to maintain emotional composure when feeling overwhelmed. Liam pointed to a dismissive attitude about the pressures faced by junior doctors, particularly mental health concerns, among parts of an older medical generation. An expectation that doctors should be able to handle any medical situation caused anxiety for newly qualified doctors related to asking for support:

> 'It comes to some situations where it's getting dangerous and that support just isn't there… there's a mentality in medicine in Ireland that's like "come on, sort yourself out, you're a doctor"' (Liam).

This account suggests that some consultants, those responsible for postgraduate training, expected junior doctors to embody "medical invincibility" (RCPI 2014). Michael remembered

how, as an intern, he was in awe of his registrars who appeared impervious to physical and mental frailties, suggesting an idealised image of medical invincibility:

> ‘I looked at them like heroes. They literally could operate all night long and function the following day and I might have had two or three hours sleep during the night that they were operating’.

These narratives suggest that to show vulnerability or uncertainty is not a medical disposition. Doctors should avoid expressing uncertainty and feelings of being overwhelmed, which may be read as emotional vulnerability. This reflects the logic that Hafferty (1988, 1991) identified in medical school, where emotional vulnerability, mapped on to incompetence, was set in opposition to emotional stability. Internalisation of this denial of emotional vulnerability discourages junior doctors from asking for support at work and from placing their own wellbeing above that of the demands of the workplace.

Detachment from patients

This section discusses the implications of a lack of space for and failure to acknowledge the importance of self-care with regard to articulations of patient care. Earlier studies about objectification of patients by doctors, where emotion was understood as an aspect of lay identity that could be kept at bay by ‘the rationalising effects of science itself’, reflect cultural understandings of emotion (Prentice, 2013). Echoing wider debates over detached concern, several participants in this study articulated concerns and unease about the impact on patient care of expectations of the emotional dispositions described above, challenging doctors’ epistemological stance ‘of the “detached observer” (Wilson, (2000, p. 206). Two participants explicitly questioned the concept of detached concern. Jack’s account, including reflections on patients who felt they had been treated like ‘a sack of potatoes’ rather than as people, suggested that detachment from patients might lead to their objectification. Though he conceded that, at

certain moments, dehumanising patients was unavoidable, when a pathology must be objectified to investigate and treat patients, this dimension dissuaded him from pursuing hospital medicine. In the following, he suggested that some doctors felt they must maintain this emotional distance in order to succeed at work:

> ‘That’s as invested as some doctors are able to get and it’s another reason actually why I really didn’t fancy [Accident and Emergency] in particular but hospital medicine in general because that kind of aspect of it where you’re losing sense of the patient as a person, it’s just becoming a problem to be solved, that’s not very fulfilling to me’ (Jack).

Having the space to engage with patients on a more human level was more fulfilling as ‘you get to actually develop a relationship with people’. Liam felt that medical education did not teach students how to communicate with patients in an engaging manner, focusing instead on producing competent and successful doctors. He suggested that training privileges competence, rather than the development of caring and communicative dispositions:

> ‘They have no idea what to say to the patient… it’s not their fault either; they were told you need to achieve this grade to get this job to be in line to be so and so then do all this research so you can become a [SpR].’

For Liam, engaging with patients was an important part of what made him enjoy his specialty, where he felt being competent did not require the same detached approach towards patients. Rather, he could “be himself”:

> ‘They’re reassured by me being myself but also being able to tell them everything I’m doing and that’s a nice feeling to be able to be myself and to be a doctor. I don’t think you get that in every specialty’.

Liam contrasted this environment with other specialties that required more formal or detached approaches to patients. In surgery, 'they're there to make a diagnosis and cut something out or send them home. There's none of this interaction.' Other participants also alluded to observing a detached and impersonal attitude to patients when colleagues refused to help them care for very sick patients, illustrated here:

> 'It was just that kind of attitude: "It's five o'clock. We're finished the surgery stuff. Anything else is not our problem, even if the patient is really sick"' (Leah).

> 'I did find that there tends to be a lack of focus on the patient and more focus on one's own job, which was quite frustrating' (Ben).

Claire reflected that the ideal of caring almost inevitably became eclipsed by the immediate demands on junior doctors to get through a heavy workload, as she described:

> 'This is what I see with my more junior colleagues … you end up kind of losing that idea of caring for people, because you're just so exhausted constantly, you know, it's more about coming in, getting your job done'.

Only one participant spoke directly about feeling detached from patients due to a growing feeling of burnout, or emotional and mental exhaustion. Sarah had wanted to be a doctor 'to make people feel better' but a feeling of being unsupported in the bid to care for patients impacted her morale: 'it almost felt like the more you wanted to help someone, the more you got punished.' The stress of working in what she described as a sometimes dysfunctional and understaffed health system led to feelings of burnout, which included a decreasing interest in caring for patients, as Sarah explained:

> ‘There’s always something during the day that’s going to be a battle and it just wears you down… like, “I’m going to stop caring soon.” And that day when I had to actually cry when I got a [patient’s] scan, I said “no, that’s enough; I can’t do this anymore”’.

According to Sinclair (1997), doctors experience mental health problems due to a clash between the desire to help people and the subsequently acquired disposition of competence, or “professional idealism”. Clearly, the primary habitus, which had led Sarah to a medical career out of a desire to help people, was in conflict with the particular expectations and understandings of competence in this medical field. Unlike the findings outlined above, there were no distinctive differences in the way male and female participants spoke about the issue of feeling detached from patients.

Case study

One interview illustrated with particular clarity the ways some participants struggled with normative expectations of competence and emotional composure, as well as their negotiation of taken-for-granted attitudes on appropriate expressions of empathy towards and relationships with patients outlined in the previous section. Leila described a self-reflexive process of coming to understand the cultural particularities and taken-for-granted assumptions related to being a competent surgeon in Ireland. This shift in perspective came through the experience of a new work environment abroad, where different values and assumptions shaped daily working life and therefore required a different professional habitus. Feeling burned out due to gruelling work hours, Leila decided to leave Ireland and possibly medicine as stress and exhaustion were impacting her mental health and enjoyment of work. She described a dichotomy between toughness and weakness in the values and assumptions embedded in surgery. Being a surgeon, with high exposure to death and acute illness, exacted an ‘emotional toll’ on her life that remained unspoken in the workplace:

> ‘A lot of time there was that kind of aspect of “…We’ve all had patients who’ve died, let’s just get on with it.”’

Her narrative includes themes of responsibility and guilt when she explained how it was not always possible to leave behind emotionally painful or troubling events, such as feeling responsible when something went wrong in the care of a patient. Leila felt the “ethos” within surgery discouraged doctors from discussing these kinds of concerns. Admitting to finding aspects of the work ‘tough’ could be regarded as a sign of weakness, and emotional weakness was associated with incompetence:

> ‘It would have just been perceived as a sign of weakness, if you got upset about something or if you said you were terribly tired and didn’t feel you could do call again this weekend…a sign that you just couldn’t cope.’

Emotional ‘toughness’, the ability to transcend difficult emotional as well as physical demands, was associated with competence. Leila challenged this idea, suggesting that being affected by and empathising in a more personal way with patients’ suffering was part of being human and should not be dismissed:

> ‘… people are people as well … people can take things hard and that doesn’t necessarily make them a weaker person or somebody that can’t cope with doing surgery… to me that’s a sign of strength.’

She added that doctors ‘see more of life … people who are in awful circumstances or have very sad stories’, which was difficult to process initially but became easier as she learned through experience not to hold on to patients’ personal stories. This environment was in contrast with her new training post in another country, where closer relationships with consultants created a more caring environment for doctors:

> ‘In those situations where patients died or you felt things weren’t managed very well or you were upset about something, I would have had a lot more support in terms of feeling that I could say “can I chat to you for 10 minutes?”’

Leila’s account suggests that taken-for-granted assumptions, including an association between emotional vulnerability and incompetence, can lead to doctors dealing with the ‘emotional toll’ on an individual level. In her current workplace, talking about emotionally painful events was not associated with being incompetent and therefore was not taboo. While Leila contested the association between emotion and weakness, she explained that surgery is a very male environment and that surgeons need to be “tough”, implying that the typical surgeon is gendered male. Sinclair (1997) argues that the dispositions adopted during medical training are all masculine because medicine was initially developed as a profession by men, excluding women. While patterns emerge in research on medical culture in different parts of the world, the framing of emotion in terms of weakness must be articulated with reference to wider western norms which place rationality and the mind in opposition to and privileged over emotion and the body (Jaggar, 1989; Lutz, 2008). Stereotypes of the doctor as scientist, therefore, are marked by emotional control, depicting them as transcending ‘the extremes of human suffering’ (Prentice, 2013). The cultural association between emotionality and femininity and their binary opposites, reason and masculinity, may help to explain why showing emotion may be interpreted as irrational and an obstacle to scientific judgement (Prentice, 2013).

Discussion

Emotional wellbeing and emotional intelligence are increasingly routine components of medical school curricula (Doherty, Cronin, & Offiah, 2013). Yet, findings from the present study iterate Hafferty and Frank’s (1994) argument about a disjuncture between caring and emotional competence, conceived in medical culture as an ability to transcend and detach from

the emotional upheaval arising during medical training. This article illustrates that protection of one's emotional wellbeing – taking space to process and be supported through difficult events – can be at odds with expectations of maintaining emotional competence. Taking self-care seriously and at times putting one's own mental and physical health before the job (but also so as to be a better doctor) can be viewed by trainers as weakness.

Our findings support earlier research suggesting that, in adopting the medical habitus, the display of competence and emotional composure is privileged over caring dispositions during specialist training (Brosnan, 2009; DelVecchio Good & Good, 1989; Sinclair, 1997). This was articulated through accounts, particularly among participants in earlier stages of training, of needing to maintain emotional composure when faced with emotionally painful events and when feeling stressed or overwhelmed. A lack of emotional composure might be seen as weakness and therefore incompetence. Sinclair's account of medical training's silence around difficult emotions resonates with junior doctors' narratives in this study of processing painful emotions privately or with close friends.

(Pierre Bourdieu & Wacquant, 1992) suggest that reflexivity occurs – effectively disrupting the unconscious or non-introspective performances of the habitus – when there is conflict between an actor's habitus and the positions in a given field. (Mouzelis, 2007), however, argues that reflexivity also takes place when there are contradictions *within* an actor's habitus. Given that this study is concerned with the professional, or secondary, habitus, the tensions between an individual's primary habitus and the medical habitus might help to explain why some participants entered into reflexive discussion of the unspoken and implicit dimensions of medical training that relate to emotion and others did not. Julia suggested that doctors who are women must try harder than men to adopt a "doctorly" way of being, since traditionally medicine was 'dominated by male values, attitudes, and stereotypes (many of which are decidedly anti-female)' (Hafferty, 1988, p. 352). This may explain why more women than men

in the sample discussed the taboo of emotional weakness and its relation to competence. Babaria et al (2009) found that female medical students felt female doctors had to try harder to prove themselves than male counterparts by presenting themselves as more serious. Gender is also central to understanding the primary habitus, which can influence how men and women talk about emotion (McNay, 1999). The role of gender in the dispositions outlined in this study, including disavowal of weakness and the image of "medical invincibility", may be illuminated through considering the cultural binary between emotion, associated with femininity, and reason, gendered as male (Evans, 2003; Jaggar, 1989).

Findings about emotional composure and absence of space to debrief after traumatic events resonate with a recent report about junior doctors in Britain's health service, which points to 'stigma around seeking assistance from pastoral care services in times of professional or personal difficulties, meaning that trainee doctors are often left feeling isolated and without help' (RCPI, 2016). This report explained that, due to heavier workloads and consequent time pressures, debriefing was no longer a priority, which had 'a profoundly negative effect on the emotional resilience of the junior doctor.' Findings from our study, which complement and build on findings in a recent survey of 1,750 doctors in Ireland (Hayes, Walsh, & Prihodova, 2017), demonstrate that mental health problems experienced by junior hospital doctors in Ireland are stigmatised. Some participants spoke about processing traumatic events individually or with someone close to them, while several highlighted the taboo around admitting to mental health struggles. Research by Lempp (2009) and Smith and Kleinman (1989) also found that students felt they should not express to trainers or each other the difficult emotions arising during training.

In the debate over whether empathy, and therefore emotional expression, impacts scientific objectivity (Evans, 2003; Wilson, 2000), some call for a more patient-centred medicine that eschews the reason-emotion binary found in western culture (Jaggar, 1989; Lutz, 2008), and

that is reproduced in medical education (McNaughton, 2013; Prentice, 2013). The medical habitus prepares junior doctors for close contact with patients that, in other contexts, would be emotionally difficult (Prentice, 2013; Underman, 2015). Yet socialisation that distances doctors from the emotional dimensions of medicine risk also distancing them from patients (Hafferty, 1991; Sinclair, 1997). Echoing these concerns, a small number of participants in this study emphasised the importance of empathising and engaging with patients in a more personal way.

McNaughton (2013, p. 75) argues that to conceive of emotion as individual and private 'has the potential to add to increased student and practitioner isolation and burnout'. Leila's account of silence around emotionally painful events in the field of surgery in Ireland, gestures towards this point. In her new workplace, surgeons were allowed to express difficult emotions; and she appreciated closer working relationships with consultants, with whom she felt comfortable discussing uncertainties and anxieties. Her narrative suggested tensions in Irish hospital medicine between a caring disposition towards patients and being "tough", leading to a denial of doctors' need for self-care. Ireland may be culturally distinctive, due to the historical influence of an ultra-conservative Catholic Church on a national 'emotional habitus', which engrained discipline and control as hegemonic values (Heaney, 2013). Several participants reflected on differences between the medical field in Ireland and other countries, to which many of their colleagues had emigrated, with regard to taken-for-granted assumptions in the workplace. Further research would be required to draw out how medical fields in different settings shape and are in turn shaped by the medical habitus.

While only two participants disclosed experiences of burnout, more highlighted this as a risk for doctors. Literature on burnout lists mentoring, a supportive work community and the practice of self-care as preventative measures (McCray, Cronholm, Bogner, Gallo, & Neill, 2008; Shapiro & Galowitz, 2016). A recent study on doctor wellbeing in Ireland (Hayes et al.,

2017), reports that 78% of respondents continued to work when they were ill and a third suffered from burnout. Such findings resonate with research on burnout from the US, which finds that doctors are more likely than the general population to experience burnout from work-related stresses (Shanafelt et al., 2012). As Brown et al (2008) note, adopting a habitus is not to inevitably reproduce hegemonic norms as individuals can exercise agency over how dispositions are realised in their working lives. This may also explain why some doctors took a more self-reflexive perspective when reflecting on medical norms, with some explicitly challenging the dispositions that doctors were expected to embody. It suggests, further, that some emotional dispositions, adopted in order to 'play the game' of medicine, and therefore imbricated with structures of power in hospitals, were damaging for doctors' own mental and physical wellbeing.

The impact of economic austerity on staffing levels and the growing demand for health services have led to heavier workloads and greater stress for doctors (Clarke et al., 2017) as reported in the UK (RCPI, 2016), which may be aggravators of the behaviours presented here. Greater interest in emotional wellbeing in the training of new medical students is a positive development (Doherty et al., 2013). However, this interest will not change embodied experience until employers, training bodies and senior doctors pay more attention to creating space to protect junior doctors' emotional and mental health (RCPI, 2016); and to recognising the importance of emotional sensitivity as qualities to be valued and developed in becoming caring and competent doctors. Prioritising self-care for doctors will not be easy in Irish hospitals, given understaffing and inadequate resources (Thomas, Burke, & Barry, 2014). Yet, given the association between intolerable working conditions and the rising numbers of doctors leaving to practice medicine abroad Brugha, Crowe, and Humphries (2015), responses that better value and protect doctors are crucial (Clarke et al., 2017)

Scholars argue that medical institutions encourage students to understand their difficulties as internal rather than located in the structures of medical education and training (Hafferty, 1991; Sinclair, 1997). This article has extended this work from medical school to the experiences of junior doctors in postgraduate training, where responsibility for training across training bodies and employing hospitals lies with consultant trainers, senior managers and ultimately with Ireland's national Health Service Executive. Reforms are needed in medical culture to shift understandings of emotional competence from the goal of "transcendence" towards a greater emphasis on reflexivity and self-care for doctors. Understanding training for junior doctors as an adoption of the medical habitus requires further examination of the structures that feed into and interact with subjective and intersubjective experience (Brosnan, 2009). The narratives presented here suggested that participants felt that their training bodies and employers sought to produce a certain type of doctor. They also indicate that the medical habitus, as a professional subjectivity, appears to reproduce the dichotomous framings of emotion and feeling against, and in conflict with, reason and thinking. Further research might explore the interactions between the field and the habitus in specialist training programmes, to see if the medical habitus emerges in different iterations across different specialities.

References

Babaria, P., Abedin, S., & Nunez-Smith, M. (2009). The Effect of Gender on the Clinical Clerkship Experiences of Female Medical Students: Results From a Qualitative Study. *Academic Medicine, 84*(7), 859-866.

Becker, H., Geer, B., Hughes, E. C., & Strauss, A. L. (1961). *Boys in White: Student Culture in Medical School*. New Brunswick and London: Transaction Publishers.

Bourdieu, P. (1990). *The Logic of Practice*: Stanford University Press.

Bourdieu, P., & Wacquant, L. J. D. (1992). *An invitation to reflexive sociology*. Chicago: University of Chicago Press.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa

Brosnan, C. (2009). Pierre Bourdieu and the theory of medical education: thinking 'relationally' about medical students and medical curricula. In C. Brosnan & B. S. Turner (Eds.), *Handbook of the Sociology of Medical Education* (pp. 51-68). New York: Routledge.

Brosnan, C. (2010). Making sense of differences between medical schools through Bourdieu's concept of 'field'. *Med Educ, 44*(7), 645-652. doi:10.1111/j.1365-2923.2010.03680.x

604 Brown, B., Crawford, P., Nerlich, B., & Koteyko, N. (2008). The habitus of hygiene: discourses of
605 cleanliness and infection control in nursing work. *Soc Sci Med, 67*(7), 1047-1055.
606 doi:10.1016/j.socscimed.2008.06.016
607 Brugha, R., Crowe, S., & Humphries, N. (2015). Irish Trainees Continuing to Emigrate. *Ir Med J, 108*(9),
608 262.
609 Cadge, W., & Hammonds, C. (2012). Reconsidering Detached Concern: The Case of Intensive-Care
610 Nurses. *Perspectives in Biology and Medicine, 55*(2), 266-282.
611 Clarke, N., Crowe, S., Humphries, N., Conroy, R., O'Hare, S., Kavanagh, P., & Brugha, R. (2017). Factors
612 influencing trainee doctor emigration in a high income country: a mixed methods study. *Hum*
613 *Resour Health, 15*. doi:10.1186/s12960-017-0239-7
614 Crowe, S., Clarke, N., & Brugha, R. (2017). 'You do not cross them': Hierarchy and emotion in doctors'
615 narratives of power relations in specialist training. *Soc Sci Med, 186*, 70-77.
616 doi:10.1016/j.socscimed.2017.05.048
617 DelVecchio Good, M.-J., & Good, B. J. (1989). Disabling Practitioners: Hazards of Learning to Be a
618 Doctor in American Medical Education. *American Journal of Orthopsychiatry, 59*(2), 303-309.
619 Doherty, E. M., Cronin, P. A., & Offiah, G. (2013). Emotional intelligence assessment in a graduate entry
620 medical school curriculum. *BMC Med Educ, 13*, 38. doi:10.1186/1472-6920-13-38
621 Evans, R. G. (2003). Patient centred medicine: reason, emotion, and human spirit? Some philosophical
622 reflections on being with patients. *Journal of Medical Ethics: Medical Humanities, 29*, 8-15.
623 Fisher, S. (1995). *Nursing Wounds: Nurse Practitioners, Doctors, Women Patients, and the Negotiation*
624 *of Meaning* (Vol. 27). New Brunswick: Rutgers University Press.
625 Fox, J. (2006). "Notice How You Feel": An Alternative to Detached Concern Among Hospice Volunteers.
626 *Qualitative Health Research, 16*(7), 944-961. doi:10.1177/1049732306290233
627 Hafferty, F. W. (1988). Cadaver Stories and the Emotional Socialization of Medical Students. *Journal of*
628 *Health and Social Behaviour, 29*(4), 344-356.
629 Hafferty, F. W. (1991). *Into the Valley: Death and the Socialization of Medical Students*. New Haven
630 and London: Yale University Press.
631 Hafferty, F. W., & Franks, R. (1994). The Hidden Curriculum, Ethics Teaching, and the Structuring of
632 Medical Education. *Academic Medicine, 69*(11), 861-871.
633 Halpern, J. (2001). From Detached Concern to Empathy: Humanizing Medical Practice. *BMJ : British*
634 *Medical Journal, 323*(7325), 1373-1373.
635 Halpern, J. (2003). What is Clinical Empathy? *J Gen Intern Med, 18*(8), 670-674. doi:10.1046/j.1525-
636 1497.2003.21017.x
637 Hayes, B., Walsh, G., & Prihodova, L. (2017). *National Study of Wellbeing of Hospital Doctors in Ireland:*
638 *Report on the 2014 National Survey*. Retrieved from Dublin:
639 Heaney, J. (2013). Emotions and Nationalism: A Reappraisal. In N. Demertzis (Ed.), *Emotions in Politics:*
640 *The Affect Dimension in Political Tension* (pp. 243-263). London: Palgrave Macmillan UK.
641 Jaggar, A. (1989). Love and knowledge: Emotion in feminist epistemology. *Inquiry, 32*(2), 151-176.
642 doi:10.1080/00201748908602185
643 Lampert, B. G., Jurgen. (2018). Detached concern in client interaction and burnout. *International*
644 *Journal of Stress Management, 25*(2), 129-143.
645 doi:http://psycnet.apa.org/doi/10.1037/str0000053
646 Lempp, H. (2009). Medical-school culture. In C. Brosnan & B. S. Turner (Eds.), *Handbook of the*
647 *Sociology of Medical Education* (pp. 71-88). New York: Routledge.
648 Lief, H. I. a. F., R. C. (1963). Training for "detached concern" in medical students. In H. I. Lief, V. F. Lief,
649 & N. R. Lief (eds.) The psychological basis of medical practice. New York: Harper & Row, pp.
650 12-35. . 12-35.
651 Luke, H. (2003). *Medical Education and the Sociology of Medical Habitus: "It's not about the*
652 *Stethoscope!"*. Dordrecht, Boston, London: Kluwer Academic Publishers.

Lutz, C. (2008). Engendered emotion: gender, power and the rhetoric of emotional control in American discourse. In M. Greco & P. Stenner (Eds.), *Emotions: A Social Science Reader* (pp. 63-71). New York: Routledge.

McCray, L. W., Cronholm, P. F., Bogner, H. R., Gallo, J. J., & Neill, R. A. (2008). Resident Physician Burnout: Is There Hope? *Family Medicine, 40*(9), 626-632.

McNaughton, N. (2013). Discourse(s) of emotion within medical education: the ever-present absence. *Med Educ, 47*(1), 71-79. doi:10.1111/j.1365-2923.2012.04329.x

McNay, L. (1999). Gender, Habitus and the Field: Pierre Bourdieu and the Limits of Reflexivity. *Theory, Culture & Society, 16*(1), 95-117.

Mouzelis, N. (2007). Habitus and Reflexivity: Restructuring Bourdieu's Theory of Practice. *Sociological Research Online, 12*(6), 9.

Prentice, R. (2013). *Bodies in Formation: An Ethnography of Anatomy and Surgery Education*. Durham and London: Duke University Press.

RCPI. (2014). *'Caring for the Care-givers': Physician Well-being Position Paper*. Retrieved from

RCPI. (2016). *Being a Junior Doctor: Experiences from the front line of the NHS*. Retrieved from

Shanafelt, T. D., Boone, S., Tan, L., & et al. (2012). Burnout and satisfaction with work-life balance among us physicians relative to the general us population. *Archives of Internal Medicine, 172*(18), 1377-1385. doi:10.1001/archinternmed.2012.3199

Shapiro, J., & Galowitz, P. (2016). Peer Support for Clinicians: A Programmatic Approach. *Acad Med, 91*(9), 1200-1204. doi:10.1097/ACM.0000000000001297

Sinclair, S. (1997). *Making Doctors: An Institutional Approach*. Oxford and New York: Berg.

Smith, A. C., & Kleinman, S. (1989). Managing Emotions in Medical School: Students' Contacts with the Living and the Dead. *Social Psychology Quarterly, 52*(1), 56-69.

Sointu, E. (2017). 'Good' patient/'bad' patient: clinical learning and the entrenching of inequality. *Sociology of Health & Illness, 39*(1), 63-77. doi:10.1111/1467-9566.12487

Thomas, S., Burke, S., & Barry, S. (2014). The Irish health-care system and austerity: sharing the pain. *The Lancet, 383*(9928), 1545-1546. doi:10.1016/s0140-6736(14)60744-3

Underman, K. (2015). Playing doctor: Simulation in medical school as affective practice. *Soc Sci Med, 136-137*, 180-188. doi:10.1016/j.socscimed.2015.05.028

Underman, K., & Hirshfield, L. E. (2016). Detached concern?: Emotional socialization in twenty-first century medical education. *Soc Sci Med, 160*, 94-101. doi:10.1016/j.socscimed.2016.05.027

Wei-Ting, T., & Ya-Ping, L. (2016). "Detached concern" of medical students in a cadaver dissection course: A phenomenological study. *Anatomical Sciences Education, 9*(3), 265-271. doi:doi:10.1002/ase.1579

Wilson, H. J. (2000). The myth of objectivity: is medicine moving towards a social constructivist medical paradigm? *Family Practice, 17*(2), 203-209.