Social Science & Medicine 186 (2017) 70–77

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

'You do not cross them': Hierarchy and emotion in doctors' narratives of power relations in specialist training

Sophie Crowe*, Nicholas Clarke, Ruairi Brugha

Royal College of Surgeons in Ireland, Department of Epidemiology and Public Health Medicine, Ireland

ARTICLE INFO

Article history:
Received 10 November 2016
Received in revised form
19 May 2017
Accepted 24 May 2017
Available online 27 May 2017

Keywords:
Ireland
Emotion
Hierarchy
Medical education
Power
Qualitative research

ABSTRACT

Studies of medical education often focus on experiences and socialisation processes among undergraduate students, with fewer examining emotionality among postgraduate trainees. This article explores the relationship between power and emotion, questioning how affective relations between senior and junior doctors are patterned on the hierarchical structure of medicine. The study employs qualitative methods of in-depth, face-to-face and telephone interviews with fifty doctors at initial and advanced stages of specialist postgraduate training in teaching hospitals across Ireland, conducted between May and July, 2015. The study found that respect for hierarchy, anger and fear, intimidation, and disillusion were key themes in participants' narratives of relationships with senior staff who oversaw their postgraduate training. The implications of these emotional subjectivities for quality of training, patient care and willingness of junior doctors to pursue careers in Ireland, are discussed and recommendations and areas for further research proposed.

1. Introduction

Much has been written in recent decades on the relationship between emotion and power, emphasising the social context of emotion, with arguments that 'emotions cannot be uncoupled from relations of power that characterise and permeate the social field' (D'Aoust, 2014, p. 271). In the field of medical sociology, there have been calls for more research on emotion in medical training (Underman and Hirshfield, 2016). The medical profession has also come under scrutiny for how power operates in the medical hierarchy and its impact on medical students and graduates undergoing hospital training (Chen, 2012). Research on medical culture points to the recurrence of bullying and the abuse of students (Richardson et al., 1997). Surveys of undergraduate medical students in New Zealand (Wilkinson et al., 2006) and the US (Frank et al., 2006) found that humiliation and belittlement, along with verbal abuse, were the most common forms of adverse treatment reported. A study of medical education in the UK found that, as part of a 'hidden curriculum', students learned of the importance of hierarchy through teaching by humiliation (Lempp and Seale, 2004). Many studies of medical education focus on undergraduate students with fewer examining the emotional lives of postgraduate trainees (Quine, 2002). In Ireland, the setting of this research, the duration of postgraduate training is between six and twelve years after graduation from medical school, making the duration of training schemes in certain specialties considerably longer than those in other countries. This article explores the relationship between emotion and power, questioning how affective relations are implicated in maintaining professional hierarchies in medical practice.

1.1. Emotion and power

Emotion has been studied as a tool for social inquiry in recent years (Boler, 1999), with its relationship with subjectivity coming under scrutiny (Blackman and Cromby, 2007; Hemmings, 2012). For Ahmed (2004) and Hemmings (2005), emotion circulates between bodies, including the individual and the collective. This happens through pre-established circuits, along which emotion travels. Such circuits shape the direction and figuration of emotion, becoming instrumental in the creation and 'securing of social hierarchy' (Ahmed, 2004, p. 4). In other words, emotion can be a medium of power (Fineman, 2000, p. 2).

Emotions such as humiliation, fear and shame, for Boler, are

* Corresponding author. Department of Epidemiology and Public Health Medicine, Royal College of Surgeons in Ireland, Beaux Lane House, Mercer Street Lower, Dublin 2, Ireland.
E-mail addresses: sophiecrowe@rcsi.ie (S. Crowe), nicholasclarke@rcsi.ie (N. Clarke), rbrugha@rcsi.ie (R. Brugha).

http://dx.doi.org/10.1016/j.socscimed.2017.05.048

used as a form of social control. Others, like anger, are hierarchical in nature. Emotions here are performative as they rehearse power dynamics and are understood to '"embody" and "act out" relations of power' (Boler, 1999, pp. 3–4). In other words, emotional expression is shaped in line with rules that are enforced in society, making them a field in which power can take hold. Emotion is therefore important for understanding the textures of lived experience as individuals perform roles that maintain social stratifications. Fineman (2000) has pointed to the role of emotions, such as anger, admiration and frustration, in relationships of control within organisations. We take "organisation" to be a group with a set purpose, characterised by structure and formal arrangement. We also follow Fineman's (2000, p. 1) definition of organisations as '*emotional arenas*'. Different positions within hierarchies of power give access to different emotion scripts; and our place in this structure will influence how emotions 'such as fear, anxiety or disdain can be exploited' (Fineman, 2000, p. 8). In Fineman and Sturdy's (1999) study of control in the workplace, power was bound up with feelings of fear and humiliation, as well as pride. Control, then, is negotiated through emotions.

1.2. Power relations in medical education

Earlier research has foregrounded how power and emotion are interlinked in the field of medical education (Babaria et al., 2012). Smith and Kleinman (1989) found that medical students felt pressure to demonstrate their worthiness for medicine and were therefore afraid to show discomfort with practices and emergent feelings, which they masked behind "a cloak of competence". Students feared a judgement of incompetence from senior staff so emergent feelings in training viewed as deviant, including embarrassment and disgust, came to be understood as issues to be dealt with individually, separate from the "real work" of medical training (Smith and Kleinman, 1989, p. 59). Through professional socialisation, undergraduate medical students learn to accept medicine's hierarchical structure and their place in it (Lempp and Seale, 2004). In a study of medical school in Britain, students came to understand that career progression was in many ways dependent on their capacity to tolerate and accept humiliation and intimidation, 'especially without their questioning the underlying power relations and rules of engagement' (Lempp, 2009, p. 78). The transmission of power takes place at the level of culture, as students must comply with tacit regulations and norms before being accepted into the professional ranks, which results in medical school culture reflecting that of senior doctors. Lempp suggests the interests of medical schools are privileged over those of their students and it is in practicing doctors' interests to attain control over their acolytes by accumulating economic and cultural power (2009, p. 79).

This article builds on this body of work by focusing on how emotions are implicated in relations of power in the context of postgraduate medical and surgical training in Ireland. Boler highlights the emotional terrain of pedagogical settings, including self-doubt, shame and 'fears of judgement that occur in a competitive climate of grades and evaluation', and anger, alienation and hopelessness (1999, p. 3). The present article aims to shed light, firstly, on the emotional terrain of doctors' lived experience of postgraduate training and, secondly, on what emotions do, regarding their performative role in social stratification, rather than on what they are (Ahmed, 2004). We understand emotions as publically constituted rather than private and individualised, which recognises the co-constitution of emotion and social control (Boler, 1999); and as a circuit through which power is felt, negotiated or contested (Pedwell and Whitehead, 2012, p. 120). Following a reading of emotions as travelling 'along already defined lines of cultural investment' (Pedwell and Whitehead, 2012, p. 123), this article explores how affective relations between senior and junior doctors are imbricated with the hierarchical structure of medicine.

2. Methods

2.1. Study sample

The article is based on a broader project on emigration of Irish-trained doctors from Ireland, which explores decision making, emigration intentions and work experiences of doctors undergoing postgraduate specialist training, mainly in Irish hospitals. The article is based on in-depth interview data collected in 2015. Ethical approval was obtained on October 22nd, 2014, from the host institution's Research Ethics Committee (REC976). We sampled from a survey of doctors registered on training schemes, run by the Medical Council of Ireland, into which we nested questions on emigration plans. To achieve a sample size of 50, email invitations were sent to 342 doctors in batches of 20. Survey respondents were asked if they wanted to participate further in the study and those that consented and gave contact details were approached for interview. The aim of achieving variety across specialties, geographic location, and sex informed the sampling strategy. The sample includes an even spread of doctors practicing in Ireland, recent emigrants, including doctors with both temporary and long-term plans to live abroad, and those planning or considering to move abroad in the future, in order for comparisons to be drawn on working conditions and experiences in Ireland and elsewhere (Table 1). Postgraduate training consists of one year of internship, after which doctors choose a specialty in Basic Specialist Training (BST), typically lasting three years. This is followed by Higher Specialist Training (HST), of at least four years duration. Most hospital-based specialties require doctors to spend one or more years abroad to complete a fellowship before being employable as a consultant, on completion of HST. Four participants had competed HST since responding to the Medical Council survey and were employed as locum or permanent consultants at the time of interview.

2.2. Data collection and analysis

The interview guide was developed to elicit accounts of experiences of working and training as a doctor in Ireland, and decision-making around future career options. Themes that emerged throughout initial interviews informed the interview guide for later data collection. Interviews were conducted by two members of the research team between May and July 2015. Informed consent was

Table 1
Participant characteristics.

	N	%
Sex		
Female	29	58
Male	21	42
Current grade		
Basic Specialist Trainee	16	32
Registrar	3	6
Higher Specialist Trainee	13	26
GP (General Practice) Trainee	7	14
GP (General Practitioner)	4	8
Consultant	4	8
Fellow	3	8
Location at time of interview		
In Ireland	39	78
Abroad	11	12