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Review article

Detached concern?: Emotional socialization in twenty-first century medical education

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ABSTRACT

Early works in medical sociology have been pivotal in the development of scholarly knowledge about emotions, emotional socialization, and empathy within medical training, medical education, and medical contexts. Yet despite major shifts in both medical education and in medicine writ-large, medical sociologists' focus on emotions has largely disappeared. In this paper, we argue that due to recent radical transformations in the medical arena, emotional socialization within medical education should be of renewed interest for sociologists. Developments in medical education such as increased diversity among enrollees, the rise of patient health movements, and curricular transformation have made this context a particularly interesting case for sociologists working on a variety of questions related to structural, organizational, and cultural change. We offer three areas of debate within studies in medical education that sociologists may be interested in studying: 1) gendered and racialized differences in the performance of clinical skills related to emotion, 2) differences in self-reported empathy among subspecialties, and 2) loss of empathy during the third year or clinical year of medical school.

1. Introduction

Early works in medical sociology have been pivotal in the development of scholarly knowledge about emotions, emotional socialization, and empathy within medical training, medical education, and medical contexts. Indeed, influential works on these topics, such as Becker et al. (1961), Fox (1988), and Smith and Kleinman (1989), have been cited 2287, 637, 382 times respectively. Yet despite major shifts in both medical education and in medicine writ-large, medical sociologists' focus on emotions has largely disappeared. Sociologists' role in medical education, once considered both valuable and central, has declined in the past thirty to forty years (Badgley and Bloom, 1973; Hafferty and Castellani, 2011). This is of key importance because scholarship and interest about empathy, emotional socialization, and professionalization more broadly within the field of medical education has increased exponentially over the past few decades (Pedersen, 2009). At the same time, research on emotion and affect has been of renewed interest in sociology (Turner and Stets, 2005; Clough and Halley, 2007).

In this paper, we argue that due to recent radical transformations in the medical arena, emotional socialization within medical education should be of renewed interest for sociologists. Developments in medical education such as increased diversity among enrollees, the rise of patient health movements, and curricular transformation have made this context a particularly interesting case for sociologists working on a variety of questions related to structural, organizational, and cultural change. To demonstrate our claim, we begin by reviewing past sociological contributions to understandings of emotional socialization within medical education. Next, we describe some of the key shifts in medical education and larger medical contexts, followed by a discussion of how these changes specifically affect emotions and emotional socialization in both medicine and medical training. Finally, we offer three areas of debate within studies of medical education that sociologists may be interested in studying, and we situate these debates within micro-, meso-, and macro-levels of sociological analysis.

1.1. Classics in the sociology of medical professionalization

Within medical sociology, a key focus for many early scholars was on professional socialization of trainees into the medical field. *Boys in White* (Becker et al., 1961) is considered particularly

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foundational among these studies of the sociology of medical education. This well-cited, in-depth, ethnographic study followed medical students as they collectively made meaning of their medical school experiences and learned to "play their role" as doctors. Many of the experiences Becker and his colleagues describe relate to emotional socialization. For example, in Becker's study, medical students learned to contain their anxiety about patient contact not to reassure patients but in order to impress their supervisors. They also learned to adopt cynical and depersonalizing attitudes toward patients, such as deriding patients who don't present any clinical findings with their complaints as "crocks."

Also in this line of research on the adoption of attitudes in medical school, Renee Fox's path-breaking work on medical education described the process as training for uncertainty (1957) and detached concern (1988). Training for uncertainty involved grappling with the limitations of medical knowledge while detached concern was the "counterattitudes of detachment and concern to attain the balance between objectivity and empathy expected of mature physicians in the various kinds of professional situations they encounter" (1988: 56). While training for uncertainty focused mainly on the management of medical students' own emotions, detached concern involved management of both patients' and medical professionals' emotions. Specifically, detached concern was the balance between distancing themselves from the emotion-laden experiences they faced as medical students and professionals and maintaining appropriate amounts of concern for patients. Fox argued that it is through encounters with the autopsy that medical students learned to develop detached concern in order to manage the emotionally-charged situation of handling and cutting open a dead body, and thus to develop their self-identity as physicians. Such aspects like the nakedness of the dead body and waiting for a cadaver to arrive (and thus for a person to die) heightened the emotional response of students to autopsy. The sterility of the room and covering the face and genitals promoted detachment, as did adopting a "scientific orientation" or a focus on the pathology and anatomy of the autopsy. Students also learned to curtail or manage their discussion of emotions about the autopsy: "Students share the unspoken conviction that 'admitting you had qualms about the autopsy' or that 'it made you feel queasy' is not in keeping with standards of professional objectivity" (Fox, 1988: 67). Notably, while Fox raised the concept of the "new" medical student of the 1970s, who maintains objectivity in dealing with patients with "regret" (Fox, 1988: 100), she did not focus much on which aspects of medical training led to such development. Nevertheless, Fox's mention of this "new" medical student foreshadowed a number of changes to medical school culture and medical student demographics that occurred during the 1980s and 1990s, which we discuss below. In his work on psychiatrists, Donald Light (1980) builds on Fox's concept of training for uncertainty and describes the emotional components of the development of their professional selves.

While Becker's and Fox's work did not focus solely on emotional socialization, further studies have made them an explicit topic of interest. Frederic Hafferty (1988, 1991) built upon Fox's work in considering how experiences with corpses shape students' emotions during medical training. Indeed, according to Hafferty, the anatomy lab was an important arena in which medical students learned the "feeling rules" of medical culture. Medical students learned to detach their fear, anxiety, and disgust from their judgments about patient care because that was what was expected of a physician. Hafferty (1988) used narrative analysis of "cadaver stories" to understand the values and norms about emotions that medical students learned. Hafferty demonstrated how cultural objects such as jokes and "urban legends" about medical students who are pranked by their fellows with cadavers stolen from the cadaver lab served to reinforce the implicit lesson that in the face of death and dead bodies, medical students must remain unemotional.

Allen Smith and Kleinman (1989) likewise used ethnography/participant observation to study medical students' encounters with cadavers, but also with living patients. They connected how medical students learn to experience and express emotion with the power of the profession of medicine: "Because we associate authority in this society with an unemotional persona, affective neutrality reinforces professionals' power and keeps clients from challenging them" (1989: 56). Despite this, students learned early on in their training that they cannot and should not talk about their emotions, especially not to faculty. Smith and Kleinman (1989) outlined several strategies that medical students learned to use to manage their emotions about bodily contact. These included the use of clinical language and reducing the body to anatomical points of contact to transform the context, while taking pride in their training as professionals to reduce stigma. Students also made jokes or blamed the patient to reduce their anxiety. This kind of emotional socialization led to dehumanizing and objectifying patients.

The overarching findings of these studies is that it is through pivotal moments in medical training, such as encounters with living patients and with cadavers, and through the mundane everyday experiences of clinical work that medical students are emotionally socialized into the profession of medicine. A key part of this process is how medical students learn to adopt the emotional dispositions valued in the clinical medicine. This was variously described as training for detached concern (Fox, 1988) or as becoming affectively neutral (Smith and Kleinman, 1989); scholars since have discussed this process in terms of learning how to *not* feel, as if emotion is being socialized out of the medical student (Underman, 2015). These findings influenced how the profession of medicine is understood; the culture of medicine is now believed to strive for objectivity and emotionally-neutrality (Good and Good, 1989). As Mary-Jo DelVecchio Good (1995) has argued, the pursuit of competence in medical training is often at odds with the push to develop caring and compassion. Yet this model of socialization is based on processes, demographics, and structural arrangements that are no longer commonplace in medical schools today. We turn toward a consideration of these changes in the next section.

2. Transformations in medical education

The studies we have described were all written prior to the mid-1990s, yet medical education has since undergone massive transformation, echoing the broader shift in medicine from medicalization to biomedicalization (Clarke et al., 2003). Indeed, medicine since the 1980s has been reorganized from within and without by transformations in science and technology (hence the *bio* in biomedicalization) (*ibid*). The increasingly rapid uptake of new technologies and the proliferation of scientific techniques and ways of knowing, coupled with the pressures of patient health movements and managed care, means that almost all aspects of daily life and even health itself become the patients' constant focus and responsibility to manage through engagement with medical advances (*ibid*).

As a result, the medical profession is no longer the autonomous, self-regulating world that Becker et al. (1961) studied. In their recent review of the literature on the medical profession, Timmermans and Oh (2010) identify three crucial changes to the profession. First, patient consumerism has accelerated since the 1980s alongside declining trust in physicians. Patients increasingly manage their own care through choice of physician and adherence