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AUTHOR(S)

Sophie Crowe, Nicholas Clarke, Ruairi Brugha

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'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

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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.

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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).

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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

sought from interviewees before interviews were conducted. Most interviews lasted 60 min and all were audiotaped and transcribed verbatim by a third party.

Thematic analysis was used to analyse the data (Braun and Clarke, 2006) and the theoretical framework for the analysis in this article was rooted in feminist engagements with concepts of power and feeling. The data were coded by two members of the research team using MAXQDA software. The analysis involved a process of line by line coding during which data were labelled and categorised and through this process key themes were identified. After several rounds of coding of a small number of transcripts by two researchers, codes were cross-checked among the team and a coding system was developed and finalised (Bradley et al., 2007). Consensus on the code system was reached, resulting in six higher order codes: work perspectives, social and professional networks, mobility imaginaries, training experiences, hospital structure, and power dynamics. While the interview guide focused on experience of work and training and perspectives on emigration, talk of power and emotion were spontaneously occurring narratives within wider discussion of work experience; where these themes arose, the interviewer probed for elaboration. As these themes were identified in an early stage of data collection, the interviewer brought these into the interview guide in later interviews. Before data collection, members of the research team consulted with a representative of junior doctors about the contemporary issues and concerns experienced by doctors training in Ireland. Findings were then validated through consultation with an external doctor completing higher specialist training.

"Power dynamics" captured talk of power within the medical hierarchy, with "bullying" as a subcode. "Emotion" was identified as a subcode of "work perspectives", where reflections on the impact of work on the self formed a central part of many accounts and portrayals of experiences and perspectives on work. These codes capture relationships between junior and more senior doctors in a training and service context and are used for analysis in this article.

2.3. Findings

Interviews were carried out with 50 participants between the ages of 25 and 44, with most in the 25–35 range. There were 29 women and 21 men (Table 1). This section presents findings on how patterns of emotion that emerged in narratives of work are imbricated with power associated with the structure of post-graduate medical training. Narratives of the hierarchical structure of medicine and the need for junior doctors to accept their position at the bottom of the tier are explored. Feelings of anger and fear, including fears of inadequacy, are discussed, followed by accounts of how intimidation and humiliation are used in training situations. Finally, patterns of narratives of alienation and disillusion are presented.

2.4. Hierarchy

Doctors are socialised to respect and reproduce hierarchy from the start of medical school, where they learn not to challenge authority (Lempp and Seale, 2004). Twenty six participants, twelve men and fourteen women, spoke about the continuing importance of hierarchy, of showing obedience to consultants and hiding the frustration they felt towards senior staff. Some described the way of relating amongst medical teams as authoritarian, illustrated in the following quotes:

> 'There's very much the patriarchal thing of the consultant, you never question them and you're there to do exactly what they say' (Participant 40, female).

> 'When I was an intern, the standard operating management is authoritarian management. So, the consultant just says stuff and you do it … The most blowback they might get is someone might raise their eyes up to the ceiling' (Participant 37, male).

The idea that doctors are expected not to question the judgements of more senior staff was identified within some of these interviews. One participant, for example, spoke of her reluctance to assert her opinion to a more senior doctor based on her lower position in the training hierarchy. She was comfortable re-asserting her concerns for a patient to a peer when it seemed to question the consensus of the medical team but decided against voicing this to her superior:

> 'I should have gone to the [registrar] and said, "There's something really wrong here and I might be not the most experienced, but I just have to say it." But that's a lot of an ego thing, that you're talking with someone really senior' (Participant 33, female).

> 'You're dealing with people who've been there for 10 years, 20 years, 30 years … You can't really say anything because it's so poorly received' (Participant 10, male).

Participants were aware that, as part of a rite of passage, novice doctors must accept their position at the very bottom of the medical hierarchy before earning the respect of senior staff. That junior doctors, in particular interns in their first year of work, are expected to put up with harsh treatment in order to prove themselves worthy of being in the profession, was articulated by seven participants. This was expressed, for example, in the following comments:

> 'there seems to be kind of a "you need to pay your dues" kind of attitude that's there in a lot of hospitals as well where the intern is the bottom of the pile and needs to be kicked a bit' (Participant 34, male).

> 'The intern is like everyone's slave really' (Participant 33, female).

While hierarchy was accepted as part of the medical structure, twenty one participants were explicit about how it could be negative in its impact for doctors lower down the rung. Some highlighted the particularly rigid nature of the medical hierarchy in Ireland through narratives of more positive experiences in foreign work environments. The culture of medicine in Ireland was described as more 'top-down' than in other health systems, in which eleven respondents worked at the time of interview, and with which most respondents were familiar through transnational peer networks. Considerable power was concentrated among consultants at the top of the pyramid, which could be limiting in its effects for more junior doctors (Wren, 2003). Four participants noted how, in other less rigid hierarchical structures, senior doctors seemed less intimidating, which was associated with a friendlier working environment. Participant 9 explained how the warm greeting from consultants in his new workplace in the US impacted the affective atmosphere, in contrast to the relative coolness of consultants in Ireland, which he associated with their higher status:

> 'The [consultants] that I work with … I'd know them better, they know me better, and they give me a warm smile and a hello when I come in, whereas it's much more reserved and distant in Ireland … I do think it is a status thing' (Participant 9, male).

'You just bleeped the consultant if you wanted them. So this kind of elusive hierarchy that we have in Ireland didn't exist in New Zealand and it meant everyone was much more approachable' (Participant 29, female).

2.5. Anger and fear

Fear of rousing the anger of the consultant was discussed in the accounts of sixteen participants. This fear was based on consultants' unquestioned authority and ability to impede their trainees' career progression. Specialist trainees depend on the power of consultants for their own career progression as it is they who provide references for future employment opportunities. This was cited as a reason to stay on favourable terms, regardless of their own feelings about consultants' behaviour. The reliance on consultants for realisation of career aspirations meant trainees sometimes hid negative feelings about angry outbursts and intimidating behaviour from consultants. As one participant explained, the fear that sometimes characterises relations between consultants and trainees encourages silence when confronted with unfair treatment of peers:

'if you see something that's going wrong, are you likely to say nothing or piss off the guy who you're depending on for a reference and maybe a job … You do not cross them because if you cross them that's the end of your employment opportunities in Ireland' (Participant 34, male).

Participant 50 was reluctant to confront an intimidating consultant because,

'it's a hard thing to do if you are a trainee as well … it goes down the road of conflict' (Participant 50, male).

Another related a story of a fellow trainee who considered taking legal action when their offer of a place on a training scheme was retracted to accommodate another, illustrating the fear of the consequences of angering or challenging those in authority:

'I told them that if they wanted to stay in Ireland they'd better keep their mouth shut because it's the kind of thing that would be blackballed against them' (Participant 45, female).

Eight participants alluded to how the fear of angering the consultant impacted their experience of work and increased feelings of anxiety, particularly during periods of being 'on-call' at night. This was often described as the most stressful work period by participants, particularly those in BST and those reflecting on intern year, when they were reluctant to ring the consultant for guidance for fear of provoking their anger. Describing experiences of being 'on-call', Participant 40 (female) stated that,

'you would never, never contemplate ringing a consultant in the middle of the night for fear of being torn to shreds'.

Participant 6 (male), reflecting on intern year, explained that,

'you'd almost be shot for calling the consultant on call'.

A fear of articulating feedback to training bodies or trainers that may be received as critical was voiced by four participants based on the perceived risk that trainers might seek to obstruct trainees' professional trajectories in a vindictive way. The following comment is an example of the more extreme statements on this issue:

'I think basically everybody is afraid to say anything for fear of the consequences, and you might not end up being able to finish, that you'd be sent to Donegal, that you'd be harassed for the rest of your time' (Participant 7, female).

The idea of not having a voice due to trainees' disadvantaged position in the medical hierarchy was present across interviews. A desire to avoid being perceived by consultants as "troublesome" was identified in narratives of ten participants; as one explained,

'you don't want to be the one giving out about stuff and telling him to change his ways. So it's hard to make your voice heard and say anything' (Participant 46, female).

Another noted how the fear of rousing the consultant's anger or irritation led to the reproduction of these relations that are imbricated with the medical hierarchy:

'You don't want to be labelled as the troublemaker, the difficult person … You just let it go and it's a self-perpetuating cycle' (Participant 26, male).

While participants wanted to avoid being seen as troublemakers, five also expressed anger at the relative powerlessness of trainees to confront or challenge existing power relations in medicine, which is illustrated in the following comment:

'"stop being such whingers, it could be worse" … [the consultant] made light of mental health issues [for junior doctors] and that only made me … glad I was leaving because I wouldn't want to put up with that kind of shit' (Participant 6, male).

In one narrative, fear did not just move in a top-down direction but also travelled across the hierarchy. This participant reflected on intimidating and bullying treatment by a female trainer on her training scheme, describing how she was advised by a second, male, trainer not to object to unfair treatment in order to avoid confrontation with this person:

'He said "If she tells you to jump, ask her how high, if she tells you to do cartwheels, do cartwheels; just do whatever she tells you and get out"' (Participant 7, female).

Fears of being exposed as inadequate were also discussed by participants in relation to the medical hierarchy. Three alluded to using a "cloak of competence" (Smith and Kleinman, 1989), where uncertainty and anxiety were hidden behind an impression of control to avoid being judged as incompetent. Five participants spoke about wanting to impress seniors, particularly during the earlier years of postgraduate training, also related to a "cloak of competence". This finding resonates with Goffman (1959) notion of self presentation, where individuals seek to regulate the perceptions of others in social interactions. Junior doctors, as performers, manage their manner and appearance in order to realise the standards according to which they are judged.

One participant articulated how this convergence of factors led to a disempowering position for junior doctors, described as,

'the pawns of the health system … you want to impress, you don't want to look like a fool and there can be some very intimidating senior doctors around' (Participant 14, female).

Because of this, seven participants described feeling reluctant to ask for help, illustrated by the following accounts:

'Certainly for the first couple of years as a [registrar] I felt you're supposed to be able to get on with it and sort things out and you're afraid to ask for help' (Participant 42, female).

One participant highlighted that an expectation that junior doctors, including interns, be able to deal independently with sick patients could cause feelings of anxiety at times of uncertainty:

'[The senior doctor] wouldn't cast an eye over a patient because you're anxious … you felt more on your own, more anxious and I think if somebody did get seriously unwell you probably would struggle to get senior help' (Participant 43, male).

Fourteen participants, however, juxtaposed dismissive treatment from certain consultants with the relief they felt working with more supportive trainers:

'You'd feel pretty isolated … some consultants I would have been comfortable calling so it was a relief if you knew it was someone … that would be fine to answer the phone' (Participant 18, female).

'Some [consultants] are great … Depending who you get, you could get a scalding or you could get someone who was like "right, let's teach you about this"' (Participant 6, male).

2.6. Intimidation and humiliation

In this section, experiences of and perspectives on humiliation and intimidation are discussed. Four participants spoke directly of the patriarchal character of the medical hierarchy and how it is reproduced through affective relations when some senior doctors were disrespectful towards those lower down in the system. This is described in the following segments:

'The whole patriarchal system still very much stands in a lot of places. I think a lot of people … especially some senior people who are a renowned consultant in a certain area, [think] it's okay that they speak to people in a derogatory manner' (Participant 40, female).

'The registrars, they were completely overworked … treated like the dogs to do the consultants' bidding … I think the consultants really treated them like dirt' (Participant 32, male).

Among female participants, twelve spoke about witnessing intimidation and humiliation of peers by seniors and eleven referred to personal experiences of this. Seven male participants had witnessed this behaviour towards peers while three described personal experiences. Participants that witnessed more extreme intimidation and humiliation of trainees by consultants found this disconcerting and unnerving. Two spoke of coping strategies such as trainees warning each other of consultants who were notorious for bullying junior staff so they could be prepared and attempt to avoid the person. Public humiliation during teaching sessions, when a consultant would attempt to humiliate a trainee with questions in front of peers, was noted by four. In one example, a participant described how the learning environment was fraught with tension when a consultant was intimidating towards doctors during training procedures: becoming nervous, the trainee who was being 'picked on' would make mistakes while other trainees and nurses present, feeling embarrassed, would avert their eyes. There was a 'bad vibe' in the room:

'He would say something like, "you're useless … you've been doing this for two months and you can't even do this" … a couple of times I almost got to the point where I would have said "… you need to stop"' (Participant 50, male).

While this participant felt compelled to challenge the consultant, he was reluctant to risk angering him due to the potential 'negative consequences' for his career. Participant 7 described a similar scene during training in a different specialty, where the consultant sought to humiliate a trainee among peers:

'She really talked her down, the girl turned beet red; she really made her feel like absolute shit, and everybody was just cowering, wanted to say that this isn't fair but afraid to' (Participant 7, female).

In Participant 21's narrative of repeatedly being the target of public humiliation from a consultant, she felt it was safer to remain silent due to a fear that any criticism of the consultant's behaviour may damage her own career progress:

'My mother was always like, "you're going to have to say something to her. You can't let her away with this" … I thought it would backfire on me, that it would affect my career … it's very hard to approach the consultant … So nobody knew' (Participant 21 female).

Challenging the consultant would cause 'unnecessary stress' so it was easier to 'just put up with it' (Participant 21). After changing specialty, she explained how, because of a closer relationship with consultants, work became more enjoyable:

'you get to know them very well … it's not the same hierarchy'.

Another participant described a particular instance of feeling humiliated by a senior doctor, which he also felt unable to confront:

'I was like, "you know what, you're not doing anything good to me by saying that; I can't fire back at you because you're my senior"' (Participant 11, male).

Many female participants who recounted personal experiences of humiliating treatment felt powerless in their inability to react. Two male participants with personal experiences of this eventually confronted the consultant in question about their behaviour. Though participants did not excuse or accept humiliation and intimidation from senior staff, the sense that this was a part of medical culture beyond their control was suggested in some narratives (Seabrook, 2004). There were a few specialties which several participants, however, felt offered a more supportive learning environment, illustrated in Participant 14's account:

'Teaching … in hospital is quite intimidating teaching – either you know this or you feel a bit humiliated if you don't know. Whereas the philosophy of the teaching in the scheme that I'm on anyway, is more – if you admit to not knowing something you're almost applauded' (Participant 14, female).

2.7. Alienation and disillusion

As Denzin contends, "[e]motionality, including alienation, estrangement, and disenchantment with the world, translates into the economic practices that reduce individuals to being defined in monetary, labour-value terms" (quoted in D'Aoust, 2014, p. 273). Alienation and disillusion were part of the pattern of emotions described by twenty-five participants, twelve men and thirteen

women, as associated with the medical hierarchy, where emotional wellbeing – including consideration for relations in personal lives – was often discounted, subsumed by bureaucratic analyses of systemic needs. The following depictions of the organisation of training posts illustrate the feeling articulated by eight participants that trainees are used in an instrumental way by hospital management, which can lead to a sense of alienation from one's workplace. Participant 35 described the alienating effects of feeling like an automaton, at times, in the hospital:

> 'It feels very much like a kind of an assembly line, it's just in, work, out, sleep, you know, and that can wear you down an awful lot at times' (Participant 35, male).

> ' … posts need to be filled, throw a trainee in it and see what happens … you very much feel like you're a commodity … they're manipulating you like you're a piece of stock as opposed to an actual person' (Participant 17, female).

Alienation and disillusion was the only terrain of emotionality which was linked to narratives of plans or desires to leave the Irish health system to seek work or training abroad. In the narratives of seven female participants, plans or the possibility of emigration were imbricated with feelings of alienation and disillusion. Among male participants, four linked their emigration plans with this narrative. Most of these participants were disheartened about the possibility of return to Ireland based on the perceived failure of the Health Service Executive (HSE), national provider of public health care, to ensure fair working conditions and its exploitative treatment of junior doctors.

Fifteen participants described a growing sense of alienation that arose, in particular, from working conditions and affective relations with other health professionals during training schemes and how this impacted their decision to leave the Irish health system. In the following accounts, Participant 10 articulated his disillusion with the lack of empathy shown by colleagues after finishing a 36 h shift, while Participant 4 spoke of her interest in medicine declining until she started training abroad:

> 'The other thing that would kill me, "why haven't you done this, where are you now" … It doesn't matter how tired you are, you need to go as fast as you can … I was just like … I've got to get out of here' (Participant 10, male).

> 'I kind of sacrificed six years of my life to the HSE. That's kind of the way I look at it and I think the longer I stayed, the more kind of bitter I got' (Participant 4, female).

The sense of futility in challenging or seeking redress for abuses was apparent across a small number of interviews. While six participants described struggling with hospital management for issues such as pay for working overtime, four complained to hospital authorities of abuses from senior doctors and concluded that the only realistic solution was to accept the status quo until the training post came to an end. Participant 1 represented fellow trainees within a medical college and spoke of fruitless attempts to address bullying by consultants, the complaint most regularly voiced by trainees:

> 'I'd say you can pursue the official avenues but it's so hard … I wouldn't tell you not to do it, I've done it myself but you generally get nowhere' (Participant 1, female).

> 'You just need to feel valued. It's not valued in terms of getting paid an awful lot more, it's value being listened to. And you're not listened to in hospitals or in Irish health at all' (Participant 41, male).

A sense of disenchantment with the work environment emerged in many of these narratives in relation to efforts to make the voices of trainees heard on issues of hospital organisation and management; as Participant 49 (male) explained, few trainees have 'got the heart left' to get involved in such actions.

3. Discussion

Few studies have explored how power is articulated through emotion roles in the experiences of contemporary postgraduate training of doctors. This study explores how emotions are a site of social control (Boler, 1999), illustrated through their role in maintaining prescribed ways of being for doctors in their relations with senior colleagues. The narratives demonstrate how emotions enact the power relations of the medical hierarchy. Power and emotion are co-constituted, which can be seen when power is acted out by some consultant-trainers through anger, intimidation and humiliation. In this way, emotions help to reinforce the paternalistic hierarchy described by participants. This was seen in narratives of hierarchy in hospitals, where trainees were expected not to challenge or question the judgements or actions of their seniors. In one participant's experience, the fear of challenging a senior colleague led to a delayed response in correctly diagnosing a patient. In a recent study on perceptions of power among nursing and medical students, Engel et al. (2016) found that nursing students felt less intimidated by the medical hierarchy when they focused on interpersonal relationships with medical students, rather than on asymmetrical power relations that define nurse-doctor relations. Our findings also suggest trainees felt less intimidated and more at ease when the professional and social distance between consultants and trainees was diminished. This was expressed by doctors working abroad, who contrasted such positive experiences with those in Ireland, and also in Ireland by encountering more approachable consultants. Palliative medicine, paediatrics and general practice were cited by some participants training in these specialties to be more caring work environments than others. Personal and indirect experiences of intimidation and humiliation were also, however, highlighted in narratives of general practice trainees, as they were reported across almost all of the specialties represented in the sample.

Participants were aware that, within the trainee-trainer relationship, they were relatively disempowered. Anger is associated with power (Martin, 1999) and, more specifically, with hierarchy (Boler, 1999). Participants understood that silently bearing the anger of senior staff was often necessary in order to successfully complete training, get a positive reference and avoid making enemies among potential future employers. Participants sometimes avoided revealing to senior colleagues, especially consultants, the uncertainty they sometimes felt when faced with complex patient management problems for fear of appearing inadequate (Smith and Kleinman, 1989). Admitting to uncertainty might be interpreted as failing to cope, leading to questions about one's competence as a doctor. This resonates with Lempp (2009) and Seabrook's (2004) studies, which found that students sought to hide gaps in competence during ward rounds for fear of being the object of consultants' anger. Lack of support for doctors in specialist training, which can encourage efforts to hide uncertainties, raises questions around the quality of training and patient safety.

The findings suggest that professional socialisation during specialist training has parallels with socialisation processes identified in medical school culture, particularly regarding the emotion scripts accessible to doctors. In previous research, undergraduate medical students often excused teaching by humiliation (Lempp, 2009; Seabrook, 2004). Our findings suggest that, while doctors do not excuse such treatment, the need to remain on favourable

terms with consultants – due to a dependence on them for career progression – presents an obstacle to change or redress of injustices. Participants articulating direct experiences of intimidation and humiliation cited both male and female senior doctors as the perpetrators, though not all disclosed gender. Among females, five experienced this from female consultants and one from male senior doctors. Among males, three experienced this treatment from male consultants and one also from a female consultant. A male and a female participant recounted witnessing more extreme instances of peers being publically humiliated by a male and female consultant respectively, while several did not disclose the person's gender. More extreme behaviour was associated with a minority of 'notorious' trainers, about whom trainees could be forewarned, if not always forearmed. Challenging the emotion roles in specialist training could incur professional costs as senior doctors write job references, influence access to training programmes and ultimately to permanent consultant posts, echoing Seabrook's (2004) study. A feeling of disenchantment, captured in talk of feeling almost dehumanised and objectified, was identified in some participants' experiences in Irish hospitals, particularly among those who had moved abroad or were considering this option.

While emotions have been examined as a site of control, they can also provide a site for resistance (Pedwell and Whitehead, 2012). Participants in this study highlighted the oppression associated with emotion roles in specialist training; and it is emotions such as frustration, hope and anger that mobilised them to seek change. Some participants had tried, mostly without success, to put a stop to abusive behaviours by senior staff, supporting Ahmed's (2010) argument that unhappiness may encourage efforts to expose abuses and injuries. Unhappiness may also lead doctors to seek better and more supportive work environments abroad, about which study participants were familiar through transnational professional networks (Humphries et al., 2015). Negative or unsupportive training environments in Ireland may encourage some doctors to consider training options abroad, a phenomenon likely to exacerbate attempts to regenerate the country's ailing health system (Thomas et al., 2014).

There was consistency in the themes across the interviews; and while other trainees might have provided more positive narratives than those that emerged spontaneously in this sample, the findings are supported by recent national surveys of trainees conducted by the Medical Council of Ireland. In 2014, over a third of trainees reported having 'been the victim of bullying and harassment in this post', compared with 13.4% in the UK; while 51.5% Irish trainees versus 19.6% in the UK had witnessed such behaviour (Medical Council, 2014b).

A 2015 report shed further light on sources of bullying (Medical Council, 2015): 49% of respondents to a Medical Council survey who experienced bullying identified a doctor as the main source, while 36% identified a nurse or midwife and 2% another health professional. In the first category, close to half of respondents pointed to a consultant or GP as the perpetrator, 32% to other trainees and 20% to doctors not in training (Medical Council, 2015). The most recent review of medical training reports tentative progress in implementing recommendations to improve training systems, working conditions and career prospects for trainees (Dept of Health, 2016). However, trainees report that 'doctors at all grades are overstretched and under pressure' and that working environments are 'very stressful due to fewer staff' (Dept of Health, 2016). What our study has not captured is the impact of under-staffing on consultants; and how this may contribute to negative behaviours and an expectation that trainees should cope, often with inadequate supervision, under stressful conditions in Irish hospitals.

An anti-bullying policy dealing with trainer-trainee relationships has been developed by the National Doctor Training and Planning Unit of the HSE, which will be implemented through service level agreements with training colleges (personal communication, HSE). This policy, along with annual surveys of trainees and clinical and training site inspections by the Medical Council (Medical Council, 2014a), should be welcomed. However, the HSE and training bodies need to establish safe and clearly delineated pathways for doctors to seek investigation and redress of bullying, with clearer lines of accountability to trainers. Training bodies can foster self-reflection and communication skills for team working among specialist trainees, to avoid the perpetuation of power and emotion scripts associated with the medical hierarchy. Wren (2003, p. 161) has argued that improved retention of junior doctors in Ireland would 'require changing the way in which the medical hierarchy is organised'. In the absence of such a culture change, the alienation and disillusion experienced by trainees, associated with stressful work conditions and exploitative treatment, may encourage Irish-trained doctors to emigrate, during and after completion of training.

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Appendix A. Supplementary data

Supplementary data related to this article can be found at http://dx.doi.org/10.1016/j.socscimed.2017.05.048.

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