Managing Emotions in Medical School: Students' Contacts with the Living and the Dead

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Professionals are not supposed to feel desire or disgust for their clients, and they presumably begin to learn "affective neutrality" in professional school. Medical students learn to manage the inappropriate feelings they have in situations of clinical contact with the human body, but two years of participant observation revealed that the subject of "emotional management" is taboo. Yet the culture of medicine that informs teaching also includes a hidden curriculum of unspoken rules and resources for dealing with unwanted emotions. Students draw on aspects of their training to manage their emotions. Their emotion management strategies include transforming the patient or the procedure into an analytic object or event, accentuating the comfortable feelings that come from learning and practicing "real medicine," empathizing with patients or blaming them, joking, and avoiding sensitive contact. By relying upon these strategies, students reproduce the perspective of modern Western medicine and the kind of doctor-patient relationship it implies.

How do I set aside 25 years of living? Experience which made close contact with someone's body a sensual event? Maybe it's attraction, maybe disgust. But it isn't supposed to be part of what I feel when I touch a patient. I feel some of those things, and I want to learn not to. (Third-year, male medical student.)

All professionals develop a perspective different from, and sometimes at odds with, that of the public (Freidson 1970). "Professionals" are supposed to know more than their clients and to have personable, but not personal, relationships with them. Social distance between professional and client is expected (Kadushin 1962). Except for scattered social movements within the professions in the late 1960s and 1970s that called for personal and egalitarian relationships with clients (Haug and Sussman 1969; Kleinman 1984), professionals expect to have an "affective neutrality" (Parsons 1951) or a "detached concern" for clients (Lief and Fox 1963). Because we associate authority in this society with an unemotional persona, affective neutrality reinforces professionals' power and keeps clients from challenging them. One element of professional socialization, then, is the development of appropriately controlled affect.

Medicine is the archetypal profession, and norms guiding the physician's feelings are strong. Physicians ideally are encouraged to feel moderate sympathy toward patients, but excessive concern and all feelings based on the patient's or the physician's individuality are proscribed (Daniels 1960). Presumably, caring too much for the patient can interfere with delivering good service. Other feelings such as disgust or sexual attraction, considered natural in the personal sphere, violate fundamental medical ideals. Doctors are supposed to treat all patients alike (that is, well) regardless of personal attributes, and without emotions that might disrupt the clinical process or the doctor-patient relationship. As several sociologists have shown, both doctor and patient use dramaturgical strategies to act "as if" the situation were neutral (Emerson 1970; Goffman 1974, p. 35). Such detachment presumably helps doctors to deal with death and dying (Sudnow 1967), with the pressure of making mistakes (Bosk 1979), and with the uncertainty of medical knowledge (Fox 1980b).

In this paper we examine another provocative issue—the physical intimacy inherent in medicine—and ask how medical students

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manage their inappropriate feelings as they make contact with the human body with all of their senses. We look closely at the situations that make them most uncomfortable: disassembling the dead human body (i.e., autopsy and dissection) and making “intimate” contact with living bodies (i.e., pelvic, rectal, and breast examinations). From the beginning of medical training, well before students take on clinical responsibility, dealing with the human body poses a problem for them (Mudd and Siegel 1969). Clothed in multiple meanings and connected to important rituals and norms, the body demands a culturally defined respect and provokes deep feelings. Even a seemingly routine physical exam calls for a physical intimacy that would evoke strong feelings in a personal context, feelings which are unacceptable in medicine.

The ideology of affective neutrality is strong in medicine; yet no courses in the medical curriculum deal directly with emotion management, specifically learning to change or eliminate inappropriate feelings (Hochschild 1983). Rather, two years of participant observation in a medical school revealed that discussion of the students’ feelings is taboo; their development toward emotional neutrality remains part of the hidden curriculum. Under great pressure to prove themselves worthy of entering the profession, students are afraid to admit that they have uncomfortable feelings about patients or procedures, and hide those feelings behind a “cloak of competence” (Haas and Shaffir 1977, 1982). Beneath their surface presentations, how do students deal with the “unprofessional” feelings they bring over from the personal realm? Because faculty members do not address the problem, students are left with an individualistic outlook: they expect to get control of themselves through sheer will-power.

Despite the silence surrounding this topic, the faculty, the curriculum, and the organization of medical school do provide students with resources for dealing with their problem. The culture of medicine that informs teaching and provides the feeling rules also offers unspoken supports for dealing with unwanted emotions. Students draw on aspects of their experience in medical school to manage their emotions. Their strategies include transforming the patient or the procedure into an analytic object or event, accentuating the comfortable feelings that come from learning and practicing “real medicine,” blaming patients, empathizing with patients, joking, and avoiding sensitive contact.

In this case study of the professionalization of emotions, we examine how students learn to handle unsettling reactions to patients and procedures in a context in which faculty members expect students to socialize themselves. We argue that the students’ emotion management strategies affect the medicine they learn and threaten their individual well-being. By relying on the strategies provided by the school, the students reproduce the professional culture of medicine.

METHODS AND SETTING

Methods

We studied students as they encountered the human body in clinical situations during the first three years of their training at a major medical school in the southeast. The first author conducted participant observation for two and one-half years, February 1984 through August 1986. He observed for 35 hours in the gross anatomy laboratory, 34 hours in the physical diagnosis course (classroom, session on the pelvic examination, and practice with patients), and 168 hours in the five third-year clinical clerkships. We selected sites that included major body contact situations: dissection, practice sessions on physical examination skills, and services in the clerkships where contact with the breasts, genitals, and rectum is officially routine.

Over the same period we conducted open-ended, in-depth interviews with 16 first-year, 13 second-year, and 15 third-year students and with 18 others, including residents, attending physicians, nurses, spouses, and a counselor in the student health service. We recruited primary respondents from the students in the observational sites and secondary respondents from others whom the first author met during informal discussions of the project.

The data were analyzed in a framework which evolved with the study. Periodically we discussed our findings with student respondents and with two members of the medical school faculty who did not participate in the fieldwork. Toward the end of the study seven students, four residents, and three clinical faculty members commented on a draft report.
Setting

The school is a well-established university-based program with a traditional four-year curriculum. The first two years are devoted primarily to the basic sciences: biochemistry, gross anatomy, histology, mechanisms of disease, pharmacology, and so on. The third year is a series of five clerkships (medicine, pediatrics, surgery, obstetrics and gynecology, and psychiatry) which assign students as the junior members of clinical teams in the hospital. The fourth year is devoted to clinical electives and to finding a residency position for postgraduate training. There are 160 students in each class. Just over 40 percent of the most recent class are women.

Students have direct contact with the human body in a variety of situations. They begin dissection in gross anatomy on the third day of the first year. For 70 hours they progressively disassemble a preserved human body (cadaver), removing, examining, and discarding tissue while searching for specific "structures." Beginning in the first year, students spend 20 hours practicing a limited set of physical examination skills on each other. Although they do not examine the breasts, genitals, or rectum in these sessions, the practice still becomes uncomfortable at certain points, such as listening to the heart and examining the abdomen.

In the second year, students also practice examination skills for about 10 hours with patients in the hospital. Again, the breasts, genitals, and rectum are excluded unless a specific instructor requires them for his or her group of students. In a special session in the second year, students learn to conduct the gynecological examination. A local women's group sends trainers who serve as demonstrator and model for groups of four students. Each student practices the basic examination once. Another special session, the autopsy, also is required in the second year. The autopsy is more upsetting to students than dissection, largely because the body is freshly dead and is accompanied by personal information in the patient's medical record (Fox 1979). As one student put it, the body is "much closer to life than the smoked herring (cadaver) in gross anatomy."

In the third-year clerkships, the students conduct physical examinations and assist with a wide variety of tests and procedures. Depending on the relationships they establish with residents and faculty, clerks are included in much of the clinical service offered in the hospital. Some are involved actively in the clinical process, while others remain at the margin of their teams. The students' roles and the range of their direct contact with patients vary much more widely than in the first two years, when they are together in large classes.

THE STUDENTS' PROBLEM

As they encounter the human body, students experience a variety of uncomfortable feelings including embarrassment, disgust, and arousal. Medical school, however, offers a barrier against these feelings by providing the anesthetic effect of long hours and academic pressure.

You know the story. On call every third night, and stay in the hospital late most other evenings. I don't know how you're supposed to think when you're that tired, but you do, plod through the day insensitive to everything (Third-year male).

Well before entering medical school, students learn that their training will involve constant pressure and continuing fatigue. Popular stories prepare them for social isolation, the impossibility of learning everything, long hours, test anxiety, and the fact that medical school will permeate their lives (Becker, Geer, Hughes, and Strauss 1961). These difficulties and the sacrifices that they entail legitimate the special status of the profession the students are entering. They also blunt the students' emotional responses.

Yet uncomfortable feelings break through. Throughout the program, students face provocative situations—some predictable, others surprising. They find parts of their training, particularly dissection and the autopsy, bizarre or immoral when seen from the perspective they had "for 25 years" before entering medical school.

Doing the pelvis, we cut it across the waist. . . . Big saws! The mad scientist! People wouldn't believe what we did in there. The cracking sound! That day was more than anxiety. We were really violating that person . . . Drawn and quartered (First-year male).

I did my autopsy 10 days ago. That shook me off my feet. Nothing could have prepared me for it. The person was my age . . . She just looked (pause) asleep. Not like the cadaver. Fluid, blood, smell. It smelled like a butcher shop.
And they handled it like a butcher shop. The technicians. Slice, move, pull, cut . . . all the organs, insides, pulled out in 10 minutes. I know it’s absurd, but what if she’s not really dead? She doesn’t look like it (Second-year female).

The “mad scientist” and the “butcher” violate the students’ images of medicine. Even in more routine kinds of contact, the students sometimes feel that they are ignoring the sanctity of the body and breaking social taboos.

Much of the students’ discomfort is based on the fact that the bodies they have contact with are or were people. Suddenly students feel uncertain about the relationship of the person to the body, a relationship they had previously taken for granted.

It felt tough when we had to turn the whole body over from time to time (during dissection). It felt like real people (First-year female).

OK. Maybe he was a father. But the father part is gone. This is just the body. That sounds religious. Maybe it is. How else can I think about it? (First-year male).

When the person is somehow reconnected to the body, such as when data about the living patient who died is brought into the autopsy room, students feel less confident and more uneasy.

Students find contact with the sexual body particularly stressful. In the anatomy lab, in practice sessions with other students, and in examining patients, students find it difficult to feel neutral as contact approaches the sexual parts of the body.

When you listen to the heart you have to work around the breast, and move it to listen to one spot. I tried to do it with minimum contact, without staring at her tit . . . breast . . . The different words (pause) shows I was feeling both things at once (Second-year male).

Though they are rarely aroused, students worry that they will be. They feel guilty, knowing that sexuality is proscribed in medicine, and they feel embarrassed. Most contact involves some feelings, but contact with the sexual body presents a bigger problem.

On occasion students feel unsure about differences between the personal and the professional perspectives. Recalling the first day of “surface anatomy,” when they are expected to remove their shirts in order to examine each other’s backs before beginning dissection of the back, students remember an unspoken tension. The lab manual suggests that women wear bathing suit tops, but few students read it in advance. Some of the few women who comply wear bras.

I remember surface anatomy. That first day when they asked us to take our shirts off, including the girls. That was real uncomfortable. You know (pause) seeing some of the girls in bras. Some of them were wearing swimsuit tops. But (pause) and drawing on their chests. So I got a guy for a partner (First-year male).

What’s the difference between a bra and a bathing suit top? Don’t know. But there is one! (First-year female).

When students are standing in the anatomy lab beside the cadavers, the difference between a bra and a bathing suit is surprisingly hard to describe. The differences are clear from a personal perspective, but in the technical objectivity of the laboratory, the details and meanings of the personal perspective seem elusive and irrational.

Students also feel disgust. They see feces, smell vomit, touch wounds, and hear bone saws, encountering many repulsive details with all of their senses.

One patient was really gross! He had something that kept him standing, and coughing all the time. Coughing phlegm, and that really bothers me. Gross! Just something I don’t like. Some smelled real bad. I didn’t want to examine their axillae. Stinking armpits! It was just not something I wanted to do (Second-year female).

When the ugliness is tied to living patients, the aesthetic problem is especially difficult. On opening the bowels of the cadaver, for example, students permit themselves some silent expressions of discomfort, but even a wince is unacceptable with repugnant living patients.

To make matters worse, students learn early on that they are not supposed to talk about their feelings with faculty members or other students. Feelings remain private. The silence encourages students to think about their problem as an individual matter, extraneous to the “real work” of medical school. They speak of “screwing up your courage,” “getting control of yourself,” “being tough enough,” and “putting feelings aside.” They worry that the faculty would consider them
incompetent and unprofessional if they admitted their problem.

I would be embarrassed to talk about it. You're supposed to be professional here. Like there's an unwritten rule about how to talk (First-year female).

It wouldn't be a problem if I weren't in medicine. But doctors just aren't supposed to feel that way. (Interviewer) How do you know? (Student) I don't know how, just sense it. It's macho, the control thing. Like, "Med student, get a grip on yourself." It's just part of medicine. It's a norm, expected (First-year male).

The "unwritten rule" is relaxed enough sometimes to permit discussion, but the privacy that surrounds these rare occasions suggests the degree to which the taboo exists. At times, students signal their uncomfortable feelings—rolling their eyes, turning away, and sweating—but such confirmation is limited. Exemplifying pluralistic ignorance, each student feels unrealistically inadequate in comparison with peers (yet another uncomfortable feeling). Believing that other students are handling the problem better than they are, each student manages his or her feelings privately, only vaguely aware that all students face the same problem.

The silence continues in the curriculum; discomfort with medical intimacy is not mentioned officially. The issue is broached once or twice in class with comments such as "You can expect to be aroused sometimes, examining an attractive woman." Yet there is no discussion, and such rare exceptions occur only according to individual faculty members' initiative. In welcoming new classes to the school, a senior orientation speaker states that although humanitarian values are critical in the competent physician, the proper purpose of the school is to address the other foundation of medicine, namely scientific knowledge.

EMOTION MANAGEMENT STRATEGIES

How do students manage their uncomfortable and "inappropriate" feelings? The deafening silence surrounding the issue keeps them from defining the problem as shared, or from working out common solutions. They cannot develop strategies collectively, but their solutions are not individual. Rather, students use the same basic emotion management strategies because social norms, faculty models, curricular priorities, and official and unofficial expectations provide them with uniform guidelines and resources for managing their feelings.

Transforming the Contact

Students feel uncomfortable because they are making physical contact with people in ways they would usually define as appropriate only in a personal context, or as inappropriate in any context. Their most common solution to this problem is cognitive (Hochschild 1979; Thoits 1985). Mentally they transform the body and their contact with it into something entirely different from the contacts they have in their personal lives. Students transform the person into a set of esoteric body parts and change their intimate contact with the body into a mechanical or analytic problem.

I just told myself, "OK, doc, you're here to find out what's wrong, and that includes the axillae (armpits)." And I detach a little, reduce the person for a moment . . . Focus real hard on the detail at hand, the fact, or the procedure or the question. Like with the cadaver. Focus on a vessel. Isolate down to whatever you're doing (Second-year female).

Well, with the pelvic training (pause) I concentrated on the procedure, the sequence, and the motions . . . With the 22-year-old, I concentrated on the order, sequence (pause) and on the details to check (Second-year male).

Feeling guilty about "mangling" a cadaver, one student begins to ask difficult questions about nerves in the neck. Feeling "uneasy" about a pelvic exam, another student concentrates on the Bartholin gland, which is hidden under more disturbing flesh. Distinct from the body as a whole, these anatomical and procedural details become personally insignificant but academically important. Students learn to recognize them, even if they do not always understand how the specifics will be important in medicine. In the process, the body loses its provocative, personal significance.

Students also transform the moment of contact into a complex intellectual puzzle, the kind of challenge they faced successfully during previous years of schooling. They interpret details according to logical patterns
and algorithms, and find answers as they master the rules.

It helped to know that we were there for a training experience. My anxiety became the anxiety of learning enough. We saw a movie on traumas, like gunshots, burns, explosions. If I had just come off the street, I would have felt sick. But I focused on learning. Occupying my mind with learning and science (Second-year male).

The patient is really like a math word problem. You break it down into little pieces and put them together. The facts you get from a history and physical, from the labs and chart. They fit together, once you begin to see how to do it . . . It’s an intellectual challenge (Third-year female).

Defining contact as a part of scientific medicine makes the students feel safe. They are familiar with and confident about science, they feel supported by its cultural and curricular legitimacy, and they enjoy rewards for demonstrating their scientific know-how. In effect, science itself is an emotion management strategy. By competing for years for the highest grades, these students have learned to separate their feelings from the substance of their classes and to concentrate on the impersonal facts of the subject matter. In medical school they use these “educational skills” not only for academic success but also for emotion management.

The curriculum supports the students’ efforts to focus on subpersonal facts and details. In 20 courses over the first two years, texts and teachers disassemble the body into systems and subsystems. Students are presented with an impossibly large number of anatomical and pathophysiological details which define the body as a collection of innumerable smaller objects in a complex system. Furthermore, faculty members reward students for recognizing and reciting the relevant facts and details and for reporting them in a succinct and unemotional fashion. Intellectualization is not merely acceptable; it is celebrated as evidence of superior performance in modern medicine. The curriculum equips the students with the substantive basis for their intellectual transformations of the body, and rewards them for using it.

The scientific, clinical language that the students learn also supports intellectualization. It is complex, esoteric, and devoid of personal meanings. “Palpating the abdomen” is less personal than “feeling the belly.” When we were dissecting the pelvis, the wrong words kept coming to mind, and it was uncomfortable. I tried to be sure to use the right words, penis and testicles (pause) not cock and balls. Even just thinking. Would have been embarrassing to make that mistake that day. School language, it made it into a science project (First-year female).

Further, the structure of the language, as in the standard format for the presentation of a case, helps the students to think and speak impersonally. Second-year students learn that there is a routine, acceptable way to summarize a patient: chief complaint, history of present illness, past medical history, family history, social history, review of systems, physical findings, list of problems, medical plan. In many situations they must reduce the sequence to a two- or three-minute summary. Faculty members praise the students for their ability to present the details quickly. Medical language labels and conveys clinical information, and it leads the students away from their emotions.

Transformation sometimes involves changing the body into a nonhuman object. Students think of the body as a machine or as an animal specimen, and recall earlier, comfortable experiences in working on that kind of object. The body is no longer provocative because it is no longer a body.

After we had the skin off (the cadaver), it was pretty much like a cat or something. It wasn’t pleasant, but it wasn’t human either (First-year female).

(The pelvic exam) is pretty much like checking a broken toaster. It isn’t a problem. I’m good at that kind of thing (Second-year male).

You can’t tell what’s wrong without looking under the hood. It’s different when I’m talking with a patient. But when I’m examining them it’s like an automobile engine . . . There’s a bad connotation with that, but it’s literally what I mean (Third-year male).

Working on a cat, a toaster, or an engine, the student effaces the person and proceeds “as if” contact were something entirely different (Hochschild 1983). The secularized body is sometimes disturbing to students (“It’s just like any meat”). At other times it is reassuringly neutral; contact becomes truly impersonal.

The curriculum supports these dehumanizing transformations by eliminating the person
in most of the students' contact with the body. Contact is usually indirect, based on photographs, X-rays (and several newer technologies), clinical records, diagrams, and written words. Students would have to make an effort to reconnect these images to the people they remotely represent. It is harder to disregard the person in direct contact, but such contact constitutes a very small part of the students' school time in the first three years. In addition, a large part of the students' direct contact occurs with a cadaver in the anatomy lab. Contact with living persons represents less than three percent of their school time over the first three years. Students must take the final step in transforming the body into a specific nonhuman thing, but the curriculum provides the first step by separating the body from the person.

**Accentuating the Positive**

As we hinted in the previous section, transforming body contact into an analytic event does not merely rid students of their uncomfortable feelings, producing neutrality. It often gives them opportunities to have good feelings about what they are doing. Their comfortable feelings include the excitement of practicing "real medicine," the satisfaction of learning, and the pride of living up to medical ideals.

Students identify much of their contact with the body as "real medicine," asserting that such contact separates medicine from other professions. As contact begins in dissection and continues through the third-year clinical clerkships, students feel excited about their progress.

"I can't remember what it was like before coming. It's enveloping. When I wake up I start thinking about being in med school. It's like a honeymoon, knowing I'll be an MD some day. It's just a real good feeling. I don't know how long it will last. And the work is demanding, almost all my time. But it is real, and it does make gross (lab) easier. Lab makes it real, even if it is gross (First-year male)."

This (dissection) is the part that is really medical school. Not like any other school. It feels like an initiation rite, something like when I joined a fraternity. We were really going to work on people (First-year male).

After years of anticipation, they are actually entering the profession; occasions of body contact mark their arrival and their progress. The students also feel a sense of privilege and power.

"This is another part that is unique to med school. The professor told us we are the only ones who can do this legally. It is special (pause) and uneasy (First-year female)."

I remember my second patient. An older guy . . . There I was, a second-year student who didn't know much of anything, and I could have done anything I wanted. He would have done whatever I told him (second-year male).

Eventually students see contact as their responsibility and their right, and forget the sense of privilege they felt at the beginning. Still, some excitement returns as they take on clinical responsibility in the third year. All of these feelings can displace the discomfort which also attends most contact.

Contact also provides a compelling basis for several kinds of learning, all of which the students value. They sense that they learn something important in contact, something richer than the "dry facts" of textbooks and lectures. Physicians, they believe, rely on touch, not on text.

"I guess I learned the intuitive part in the practice sessions (on physical examination skills). After all that training in science, this was different . . . Like feeling someone's side. Feeling (pause) it begins to mean something . . . All the courses don't mean anything 'til I have them in my fingertips, my ears (First-year male)."

The bimanual (in the pelvic exam) was different. Like I knew what I was supposed to feel (with my hands), but I didn't feel anything. Like when you palpate the spleen. Most people never feel it. So this is just another of those. I had read the book on the exam, and it seemed like an ancient rite. It felt good to have a sense of it after that evening (Second-year male).

We learned a lot about the body before, and about the disease in the abstract. Now, those abstractions are right in front of us. We can begin to connect the abstract lessons to the facts we find with the patients (Third-year female).

Students also develop clinical intuition and a fascination for the body and the "personality" of its parts. They find the learning that occurs with contact gratifying, sometimes satisfying a long-standing curiosity, and frequently symbolizing the power of medicine.

Similarly, students can intensify the good
emotions that come with practicing medical ideals. By attending to those ideals, students can feel a pride which overrides any spontaneous discomfort.

If it’s something uneasy, like moving her (breast) to listen to her heart, I also know that I’m doing the right thing. It’s both, and it feels good to know I’m doing it right (Second-year male).

The personal stuff just doesn’t apply to the real exam of a patient. This is a completely different relationship than any other in my life. It’s my job. It would be inappropriate if I didn’t examine them, touch them. It’s expected (Second-year female).

In proceeding with contact despite their discomfort, the students are “doing it right,” and that feels good. Some feel pleased about passing important landmarks in their training. Some feel proud of “practicing good medicine.” Pride and self-respect diminish awkwardness and embarrassment.

There are two ways in which students accentuate their pride and excitement. First, they can “go with” the good feelings that arise spontaneously. Second, they can create good feelings when they do not arise naturally. By transforming an uncomfortable contact into an analytic event, students can produce the feelings of excitement and satisfaction that they have learned to associate with problem solving. Transformation and accentuating the positive are mutually reinforcing strategies.

**Using the Patient**

Students sometimes take patients’ feelings into account as a means of managing their own discomfort. They do this in two different ways: empathizing with the patient and blaming the patient. When they are uncomfortable, students can control their feelings by shifting their awareness away from their own feelings and to the patient’s. Empathizing with the patient, they distract themselves from their own feelings. At the same time, they can feel good about “putting the patient first.”

Sure, my feelings matter. But theirs do too, even more. I’m here for them, and it’s only right to give theirs priority. It feels good to listen to them, to try to understand (pause) to care. And I don’t feel so weird (Second-year male).

Empathy, then, can be an effective emotion management strategy as well as an appropriate professional quality.

Students sometimes use the patient as an external locus for their own uncomfortable feelings. They make the patient responsible for their feelings, blaming the patient or simply projecting their own feelings onto the patient. A student can manage feelings of sexual awkwardness, for example, by defining the patient as inappropriately sexual.

I know he is embarrassed. I would be. (Interviewer) Are you embarrassed too? (Student) Yeah. Maybe part of it’s mine. Not just his. Embarrassed isn’t quite the right word. Uneasy. But he might be embarrassed too! (Second-year female).

My very first patient was a young girl, 14 years old. I had been told she was a pediatrics patient, but I sure didn’t expect a 14-year-old (pause) and well-developed. I think she was promiscuous. I forgot to do the heart at first. Went all the way to the end and then said, “I’ll have to listen to your heart.” It was extremely uncomfortable (Third-year male).

Labelling the patient as “promiscuous,” the student can forgive himself his awkwardness and perhaps replace it with feelings of superiority or anger. Patients can be difficult in many ways: frustrating the student’s sense of clinical and interpersonal power, violating personal values, demanding extra time, and so on (Lipsitt 1970). Yet in order to manage their own feelings, students sometimes manufacture or exaggerate negative conclusions about the patient or project their own feelings onto the patient, where they are less threatening.

**Laughing About It**

Students can find or create humor in the situations that provoke their discomfort. Humor is an acceptable way for people to acknowledge a problem and to relieve tension without having to confess weaknesses. In this case, joking also lets other students know that they are not alone with the problem.

When the others are talking it’s usually about unusual stuff, like jokes about huge breasts . . . Talking in small groups would help. The sexual aspect is there. Are they normal or abnormal? What’s going on? (Second-year male).

The way we talk. Before we wouldn’t talk about
the penis or vagina. Now we do casually, with folks in medicine. And we say more about what’s happening with us sexually. Lots of comments about ejaculation, orgasms, getting it back in less than 20 minutes, that kind of thing. Some of it is serious learning conversation. Sometimes it’s just joking, banter (Second-year female).

By redefining the situation as at least partially humorous, students reassure themselves that they can handle the challenge. They believe that the problem can’t be so serious if there is a funny side to it. Joking also allows them to relax a little and to set ideals aside for a time.

Where do students learn to joke in this way? The faculty, including the residents (who are the real teachers on the clinical teams), participate freely, teaching the students that humor is an acceptable way to talk about uncomfortable encounters in medicine.

We get all our grandmotherly types around the first day of (gross anatomy) lab, in case some of (the students) wimp out. Wonder why it’s such a problem (Faculty member).

If I had to examine her I’d toss my cookies. I mean she is enormous. That’s it! Put it in the chart! Breasts too large for examination! (Resident). (The team had just commented on a variety of disturbing behaviors that they observed with the patient.)

None of these comments is particularly funny out of context and without the gestures and tone of voice that faculty members use to embellish their words. Yet the humor is evident in person, akin to gallows humor, and thick with references to sexuality and aesthetic extremes (Fox 1980a). Eager to please the faculty and to manage their emotions, students quickly adopt the faculty’s humor. Joking about patients and procedures means sharing something special with the faculty, becoming a colleague. The idea implicit in the humor, that feelings are real despite the rule against discussing them, is combined with an important sense of “we-ness” that the students value.

Unlike the students’ other strategies, joking occurs primarily when they are alone with other medical professionals. Jokes are acceptable in the hallways, over coffee, or in physicians’ workrooms, but usually are unacceptable when outsiders might overhear. Joking is backstage behavior. Early in their training, students sometimes make jokes in public, perhaps to strengthen their identity as “medical student,” but most humor is in-house, reserved for those who share the problem and have a sense of humor about it.

Avoiding the Contact

Students sometimes avoid the kinds of contact that give rise to unwanted emotions. They control the visual field during contact, and eliminate or abbreviate particular kinds of contact.

We did make sure that it was covered. The parts we weren’t working on. The head, the genitals. All of it really. It is important to keep them wrapped and moist, so they wouldn’t get moldy. That made sense. But when the cloth slipped, someone made sure to cover it back up, even if just a little (pubic) hair showed (First-year female).

Keeping personal body parts covered in the lab and in examinations prevents mold, maintains a sterile field, and protects the patient’s modesty. Covers also eliminate disturbing sites and protect students from their feelings. Such nonprofessional purposes are sometimes most important. Some students, for example, examine the breasts by reaching under the patient’s gown, bypassing the visual examination emphasized in training.

Students also avoid contact by abbreviating or eliminating certain parts of the physical examination, moving or looking away, or being absent. Absence is usually not an option, but many students use the less obvious variations.

I had most trouble with the genitalia . . . Quite an ordeal. Taking the skin off. The girls did the actual dissection. I went into the corner and read. Turned my back. Didn’t want to be involved (First-year male).

At the genitals, I was embarrassed. I had never touched a guy’s genitals before. Even though this was medical, it was a pretty quick exam. I mimicked the preceptor, but I didn’t really have any knowledge of it. It was not comfortable (Second-year female).

The students explain their limited and “deferred” examinations by claiming inexperience or appealing to the patient’s needs: “Four or five others will be doing it. Why should I make the patient uncomfortable?”
Some students admit they use these arguments to avoid or postpone disturbing contact.

Conveniently, the faculty do not supervise students' contact with patients in the second and third years. When the faculty members are present they do the work themselves, leaving the students to observe. This lack of supervision gives students the freedom to learn without the pressure of criticism. It also gives them opportunities to avoid the kinds of contact that make them uncomfortable.

Also, faculty members protect students from contact with the parts of the body that make them most uneasy. There is no pressure to continue with "surface anatomy," where students examine each other in the region of the body to be dissected. In fact, students stop after the first three or four sessions; some students do not participate at all. There are limits on the range of physical examination skills that the students practice with each other and in the gynecological training session: the student does not examine the breasts and does not conduct the rectal component of the examination in this session. There is a policy excluding the genitals and the rectum in practice sessions with patients in the second year. The faculty rarely challenge students who "defer" the breast, rectal and genital examinations in the clerkships, and they abbreviate such contact in their work.

Mostly, (the residents) don't do the breasts, pelvic, or rectal. We had a woman with a vaginal discharge (noted in the chart), but I didn't do a pelvic on the workup. Almost never. Sometimes a quick external check. That is the extent of their concern. For most docs and residents those are outside their area of expertise. If they think an exam should be done, they call in a consult, like GYN. . . . On medicine, the rectal is often important. I did a couple. Hopefully, the resident or attending did it. We thought we should do screening on the breasts, but I only did one or two (Third-year male).

If you skip the genitals or rectal, and you note "exam deferred" in the chart, there's no problem. Sometimes they tell you to go ahead and do it, but there's no problem. So long as they don't think you just forgot. Just say "pelvic deferred" (Third-year female).

Silent acceptance of the boundary around the sexual parts of the body suggests that the faculty do regard and treat the sexual body as "different," despite the official line (neutrality) that conceals the difference. As neutrality fails and feelings arise, the faculty give the students, and themselves, permission to reduce or eliminate the kinds of contact they find most upsetting.

TAKING MEDICINE HOME

In their studies, students gradually come to see the human body as an interesting object, separate from the person. This new, intellectualized body is stripped of the meanings the students knew before coming to medical school. The impersonal body is relatively neutral and easy to contact clinically, but students have a vague and unsettling sense of loss.

The heart. I know it's just a blood pump. Mostly muscle. Valves. But it's something more, too. Interesting to touch it, see it. But it felt funny. Like (pause) I went up in my head when we lifted out his heart. Funny feeling (pause) partly physical. Won't be any place to go when we open his head (First-year female).

I had to confront the fact that we are just flesh, made of flesh, like the animals we eat. It took a week to work it out, partly (Second-year male). According to the official perspective of the school, the body is "just" a complex object. The heart may be an awesome, marvelous pump, but something which has been valuable is lost during professionalization. Mysterious and romantic meanings are publicly discarded, and students are not sure what their world will be like without them. They try to shift culturally sacred meanings from the body to the abstract person, and their efforts do diminish the uncomfortable feelings that spill over into medicine from their personal lives. Yet the new perspective is sometimes awkward at school, and it creates other issues for students as medical neutrality spills over into their personal lives.

For some students, medical training creates a problem as new meanings for the body and for body contact go home with them at night. The clinical perspective enters into moments of contact with spouses and friends, an arena where personal meanings are important.

I have learned enough to find gross problems. And they taught us that breast cancer is one of the biggest threats to a woman's health. OK. So I can offer my expertise. But I found myself
examining her, right in the middle of making love. Not cool! (Second-year male).

I'm learning, but it's still a little uncomfortable. I'm sure glad I could talk about it with my wife. It felt like something about my masculinity. In GYN you don't think so much in sexual terms. Not with that big piece of metal (the speculum) in her. But there's no metal at home, and I still don't feel the same about it. They say you get over this pretty quick. I wonder how. What will it be like later? (Third-year male).

Particularly in the sexual domain, the progressive neutralization of the body threatens personal meanings that the students have long attached to physical intimacy. Without alternative meanings that could promise a comparable sense of attachment and gratification, some students fear that the special power of intimacy may be lost as they neutralize the body for medicine. Acknowledging the threatening quality of intimacy in personal life, some students are also concerned that they may bring their emotion management strategies home and use them in unhealthy ways to minimize personal pains.

For other students, neutralizing the body at school helps them to achieve greater intimacy at home. If intimacy has been over romanticized in their personal relationships, for example, it can become less awesome and more manageable as they redefine it for medicine.

Well, it's been fun, trying things on him. I'd practice things like the ear exam, or (pause) we didn't do the (male) genitals at school. I tried it at home. He was real good about it, and I think I learned something. I was glad to have a chance before trying it on a real patient. And we talked afterward, more than we usually do (Second-year female).

I had fallen way behind in touching (in my personal life). It had gotten so touching wasn't an option for me. But I'm catching up. It's an option. It's allowed. Almost like I'm practicing on my patients . . . I don't know if that makes sense. Like I have been blocking on touching every time. But with patients I get beyond the blocks, and I can sense a little of what it's like. Look! I'm out here beyond the blocks, and it's OK! Then I can try it a little more in my personal life (Third-year female).

As some special meanings are stripped away, these students can proceed more comfortably with personal intimacy. Their training demystifies physical intimacy, making it easier to discuss with personal partners. In some cases they find it easier to initiate contact. Whether the effect is comfortable or threatening, the fact that students bring home their professional perspective on the body indicates the strength of the training process, particularly as it affects the sexual body. Maintaining a personal perspective at home becomes yet another challenge that many students face.

CONCLUSION

Medical students sometimes feel attracted to or disgusted by the human body. They want to do something about these feelings, but they find that the topic is taboo. Even among themselves, students generally refrain from talking about their problem. Yet despite the silence, the culture and the organization of medical school provide students with supports and guidelines for managing their emotions. Affective socialization proceeds with no deliberate control, but with profound effect.

Significantly, men and women have similar experiences and find the same solutions. Because recent research (Gilligan 1982; Sampson 1988) suggests that women have a relational rather than an individuated view of the world, we expected them to find it difficult to see the patient as a mechanical system of parts. Why didn't they? First, in preparing and competing for medical school, women (like men) have had years of training in the natural sciences, an experience which fosters an impersonal perspective consistent with biomedicine. Second, female students, more than males, may expect faculty or patients to challenge their claim to this high-status role (Hammond 1980); therefore they may want a strong authoritative basis for it. Because scientific medicine legitimates the profession's claim to expertise, those who may need "extra" legitimation (i.e., women) have good reason to conform. Thus the surprising finding regarding gender may be that the men have as much trouble as the women in creating emotional distance from patients.

The five emotion management strategies used by the students illustrate the culture of modern Western medicine. In relying on these strategies, the students reproduce that culture (Foucault 1973), creating a new generation of physicians who will support the biomedical model of medicine and the kind of
doctor-patient relationship in which the patient is too frequently dehumanized. Students sometimes criticize their teachers for an apparent insensitivity to their patients, but they turn to desensitizing strategies themselves in their effort to control the emotions that medical situations provoke. These strategies exclude the patient's feelings, values, and social context, the important psychosocial aspects of medicine (Engel 1977; Gorlin and Zucker 1983). Contradicting their previous values, students reinforce biomedicine as they rely on its emotion management effects.

Analytic transformation is the students' primary strategy, and it does tend to produce affective neutrality. As we stated, however, the medical culture provides other strategies that involve strong feelings instead of the neutrality of medical ideals. The particular feelings allowed by faculty members and by the culture fit with the basis of all occupations that have achieved the honorific title of "profession": acquiring hierarchical distance from clients (if not always emotional indifference). Much of the humor that students learn puts down patients who are aesthetically, psychologically, or socially undesirable (Papper 1978). Blaming patients and avoiding uncomfortable contact lend power to the physician's role. Even the effort to accentuate the comfortable feelings which come with learning contributes to the distance. In concentrating on the medical problem, students distance themselves from their patients. As Becker et al. (1961) observed years ago, uninteresting patients who have nothing to teach are "crots." All of these strategies maintain the kind of professional distance that characterizes modern medical culture, a distance which provides for comfortable objectivity as well as scientific medical care.

One of the students' strategies, however, operates differently. Empathizing with patients diminishes the students' discomfort and directs attention to the patient's feelings and circumstances. Students are taught that excessive concern for patients can cloud their clinical judgment, but moderate concern allows them to manage their own feelings and to pay close attention to the patient.

Depending on how easily they can switch their strategies on and off, students and physicians may influence the character of their personal relationships as well as their medical practice. For some the effects can be healthy, enhancing personal intimacy by diminishing its mystique. Yet for others the results, particularly the long-term results, may be disruptive (Hochschild 1983). We speculate that the professionalization of private emotions may help to explain some of the health problems associated with the practice of medicine.

It would be unfair to conclude that medical training is uniquely responsible for the specific character of the students' emotion management problem and for its unspoken solution. The basic features of the culture of medicine are consistent with the wider cultural context in which medicine exists. Biomedicine fits with the emphasis in Western culture on rationality and scientific "objectivity." In Western societies the mind is defined as superior to the body, and thoughts are defined as superior to feelings (Mills and Kleinman 1988; Tuan 1982; Turner 1984). Not surprisingly, students know the feeling rules of professional life before they arrive at medical school. Childhood socialization and formal education teach them to set aside their feelings in public, to master "the facts," and to present themselves in intellectually defensible ways (Bowers 1984). Medical situations provide vivid challenges, but students come equipped with emotion management skills that they need only to strengthen.

We suspect that the patterns we found in medical education occur as well in other professional schools and situations. Most health professionals face similar challenges and maintain a similar silence about them (Pope, Keith-Spiegel, and Tabachnik 1986). Comparably provocative challenges exist elsewhere, requiring potentially similar strategies of change and control.

The generality of the questions and the answers is illustrated by fundamental aspects of military life. Missions, tactics, and equipment are all designed to kill, and the possibility of death is real. Combat training would provoke uncomfortable disruptive feelings if individual and collective emotion management strategies were not at work. The first author recalls that in his basic training in the army, instructors required recruits to learn that "an M-1 rifle is a 30-caliber, gas-operated, clip-fed, semi-automatic, repeating rifle with an effective range of 600 yards." The military perspective and nomenclature neutralize the moral dimension of the gun in the same way as the medical perspective and
nomenclature neutralize the moral dimension of the cadaver. In combat and in preparation for combat, soldiers and sailors reduce the enemy to "slopes" and "gooks," making it easier to transform the enemy soldier into a target or a devil. The names are similar to the medical students' "crock" and "gomer"
—blunt, blaming names for disturbing patients. Fatigue is an accepted feature of both military and medical training, blunting emotions for soldier and for physician.

Our study suggests that the emotional socialization of professional training will influence the character of performance in the workplace and will have consequences for life outside the workplace. Medical students accept that they must change their perspective on the body in order to practice medicine, but they worry about the consequences. Often using the word "desensitization," they are concerned that medical training will dull their emotional responses too generally.

Those feelings just get in the way. They don't fit, and I'm going to learn to get rid of them. Don't know how yet, and some of the possibilities are scary. What's left when you succeed? But what choice is there? (Second-year female).

It's kind of dehumanizing. We just block off the feelings, and I don't know what happens to them. This is pretty important to me. I'm working to keep a sense of myself through all this (Third-year male).

Quietly, because their concern is private and therefore uncertain, students ask questions we might all ask. Will we lose our sensitivity to those we serve? To others in our lives? To ourselves? Will we even know it is happening?

REFERENCES

Lipsitt, D. 1970. "Medical and Psychological Characteristics of 'Crocks.' " Psychiatry in Medicine 68 SOCIAL PSYCHOLOGY QUARTERLY


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