Evaluating Emotions in Medical Practice: A critical examination of 'clinical detachment' and emotional attunement in orthopaedic surgery[1]

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ABSTRACT: In this article I propose to reframe debates about ideals of emotion in medicine, abandoning the current binary setup of this debate as one between 'clinical detachment' and empathy. Inspired by observations from my own field work and drawing on Sky Gross' anthropological work on rituals of practice and Henri Lefebvre's notion of *rhythm*, I propose that the normative drive of clinical practice can be better understood through a notion of rhythmicity and attunement. Individual types of emotions in this framework are not, as such, appropriate or inappropriate, but are evaluated depending on their synchronicity with the specific rhythms of the concrete practice. To set up this proposal, the article shows how typical arguments about emotions in medicine – what I call emotion-entity focused frameworks – are insufficient. I then draw on ethnographic observations from two orthopaedic departments and interviews with medical practitioners to show how clinical practice is driven by rhythmicity, shaped in this specific instance by a clinical aim of efficient, controlled intervention, and how clinicians continuously refer to this drive and flow of rhythms when evaluating inappropriate or problematic emotion. I argue that the use of a rhythm framework rather than ideals of detachment or empathy allows sensitivity to the complexity and situation-dependent elements of emotional ideals in clinical practice; and I end by proposing the term 'attuned concern' – which stresses the importance of regulation and adjustment to circumstances rather than of maintaining a constant distance/involvement – as a more fitting alternative to 'clinical detachment'.

Introduction

The ideal emotional stance of clinicians has been portrayed as 'detachment', that is, avoidance of emotion (see Halpern 2001, 15n1). Yet in the past 20 years, with a growing focus on patient perspectives and calls for medical practitioners to be more empathetic (e.g. Halpern 2001), this ideal has been criticised for compromising patient care, as well as obstructing doctor-patient relationships, and contributing to burnout among medical practitioners (e.g. Meier, Back, and Morrison 2001, 3008; Aase, Nordrehaug, and Malterud 2008, 767; Orri, Revah-Lévy, and Farges 2015; Robinson 2019; Isbell et al. 2020, 2).[2] Further, a surge of medical memoirs have highlighted the personal and emotional complexity of medical practice (e.g. Gawande 2008; Marsh 2014). All this has, in turn, led to calls, particularly associated with the medical humanities, for

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[2] Ironically, one argument *for* detachment has been to avoid burnout, but this strategy has been challenged as there is at least a correlation between emotional disengagement and burnout (see Halpern 2001, 15n2 for more references on this).

a rebalancing of medical practice, and for the training of medical practitioners to include more focus on emotional intelligence, often understood as equivalent to empathy training (e.g. Zinn 1988; Halpern 2001, 26; Meier, Back, and Morrison 2001, 3012; Austen 2016).

In this article, I will suggest that appropriateness of emotion in clinical practice is not properly captured by either *detachment* (lack of emotion) or *empathy* (presence of one particular emotion); nor some balance between them. Instead, based in ethnographic fieldwork and practitioner interviews, I explore an alternative normative framework, namely one of *rhythmicity* (attuned emotions). I argue that while both detachment and empathy can be appropriate responses, neither of the two are sufficient as clinical ideals, and thus we need a better normative framework for emotions in medical practice, if we wish to rebalance and discuss the improvement of emotional training for medical practitioners. I suggest that as an alternative, a rhythmicity framework offers a more nuanced and situation-sensitive approach to evaluating the clinical appropriateness of clinician emotion, allowing evaluation not merely of the *type* of emotion, but also the intensity/degree and the timing/place of emotions. To develop this framework, I draw on the notion of rhythmanalysis from the philosopher-turned-Marxist-sociologist, Henri Lefebvre (1901-1991)[3] and in particular his concepts *polyrhythmia*, *eurhythmia*, *arrhythmia*, and *dressage*. From observations of rhythms at two orthopaedic departments in Denmark, and from practitioners' accounts of emotionally uncomfortable moments, I unfold orthopaedic medical practice as rhythmicity driven onwards by particular *practice imperatives* of efficient function-oriented intervention; and, further, I show how emotions are evaluated through their synchronicity or asynchronicity with both specific practices and in regard to practice imperatives. Doing so, I hope to provide for more nuanced debates on ideals of practitioner emotions in medical practice. First, however, I briefly summarise the circumstances under which the empirical material of the article came about, providing context for my observations.

1. Method and Field

Although 'clinical detachment' is a term discussed in relation to multiple aspects of medical practice, the notion has historical ties to surgery in particular (see section 2). This, and the prevailing 'myth of the surgeon' as cold and non-introspective (Orri et al. 2014; see also Page 2011) make surgical departments an interesting location for exploring clinical detachment and (in)appropriateness of emotions. The argument of the article is therefore based on ethnographic work conducted during autumn 2019 at two orthopaedic

[3] It should be added here that although the notion is commonly ascribed to Henri Lefebvre, he developed it in close collaboration with Catherine Régulier (1957-), to whom he was also married. They have co-written on the topic, as seen in one of the texts referenced here. Lefebvre worked with the notion before he met Régulier (e.g. Lefebvre 1991, 205–7 originally published in 1974 when Régulier was still only 17)), and is credited as the sole author of the posthumous publication *Éléments de rythmanalyse* (Lefebvre and Lourau 1992), however the role and contributions of Régulier remain unsettled. Here I follow common practice, naming him as the theoretical source. (I thank Riki Scanlon and Stuart Elden for helpful input on this matter).

departments in public, Danish hospitals, and on eight semi-structured interviews with clinicians – four who worked in the departments, and four who were recruited via professional networks prior to the fieldwork.[4]

I was invited to the departments by senior staff and my schedule was planned between me and the consultant surgeon. At the outset of each stay I signed a non-disclosure form regarding sensitive information that I would be party to during my stay, and the staff were introduced to me as a visiting PhD student and philosopher. In both departments, the surgeons were incredibly open and let me choose freely where to go and whom to follow. I was in the departments for three weeks each, three to four full days a week, and predominantly during dayshifts. In order to get a sense of the daily flow I usually shadowed a single surgeon throughout the shift. I shadowed surgeons in all aspects of their work: in the outpatient clinic; during surgical procedures (both elective and acute); at ward rounds; in the A&E (accident and emergency) unit; and sat in for morning conferences and other professional meetings – also sitting with them while they did administrative work in their offices or had coffee breaks. Each morning I would change into scrubs. This meant that I naturally became part of the already well-established routine of tag-along medical students or surgeons in training, and that in general no one questioned my presence. Much as they do with medical students, surgeons would explain simultaneously to me and to patients (or in surgical settings, sometimes to the nurses) what they were doing and why. When entering the operating theatre, the surgeons would often introduce me to the rest of the team; in the outpatient clinic surgeons would introduce me to the patient – sometimes as a philosopher, sometimes merely as a colleague or a PhD student – and also ask if my presence in the room was acceptable.[5] During fieldwork I openly took extensive notes. The only time I deliberately did not take notes was during outpatient clinic consultations, as I felt it would be inappropriate. Instead, I took notes between consultations while the clinician wrote up the medical records, following the clinicians' rhythm of switching from consulting to writing.

In interviews, I asked clinicians to recount strange, unpleasant, or curious episodes of their practice, and I then followed up with questions to elicit reflection on which elements of the episodes had made them seem strange, unpleasant, or curious, and in what ways; and how they – the practitioners – had responded. During fieldwork I would use coffee breaks, or moments while surgeons were waiting for patients, to ask the surgeons I shadowed similar questions. Recorded interviews were transcribed verbatim and coded based on iterative reading of both transcripts and fieldnotes.

[4] In accordance with GDPR regulations all interviewees signed a data management agreement, and no recordings were made without consent.
[5] As my project concentrated on observing the clinicians rather than the patients, I trusted their evaluation as to when, and to what degree, to inform patients. However, in almost every encounter I greeted the patient, shaking their hand, and introducing myself by name.

2. Evaluating Emotions in Clinical Practice: Regulating and distancing

The term 'clinical detachment' immediately invokes the question: detachment from what? Typically, what is implied is the need for some measure of emotional decoupling (in a commentary, Luke Austen, a medical student, phrases it as 'numbing' oneself (Austen 2016, 377)) from the dire circumstances that medical practitioners find themselves in, in order for them to perform clinical tasks, whether this be amputating a leg or letting a patient know death is approaching. In this article, I will discuss detachment with regard to its *normative value*, that is, not whether clinicians are in fact 'detached', nor how 'detachment' might or might not be established through medical socialisation – although it is important to highlight that several studies have shown that medical practitioners *do* have emotions throughout their career (Orri et al. 2014; Silva and Carvalho 2016; Isbell et al. 2020).[6] Rather, the aim is to consider what we might call the *emotional ethos* of clinical practice, that is, the way emotions are seen as appropriate or inappropriate, and, specifically, how these judgements are made by clinicians themselves. In doing so, I am interested in the emotions of *clinicians*, not (the importance of) the clinicians' ability to deal with patient emotions.[7]

Historian Lynda Payne argues that some form of ideal of emotional regulation is 'as old as systematic practice of medicine itself' (Lawrence 1996; quoted in Payne 2016, 2). In early modern England (ca. 1500-1800) this ideal – of emotional regulation in medicine – was termed 'clinical dispassion' (Payne 2016, 1). Later, in the eighteenth century, William Hunter coined it as the need for 'a necessary inhumanity' (Payne 2016, 2), and later again, by the beginning of the twentieth century, William Osler recommended medical students must learn 'the Art of Detachment' as a means of self-control and a condition for a panoramic perspective (Osler 1905, 34 and 279 respectively; see also Halpern 2001, 22). In contemporary literature the ideal for emotional regulation exists as both 'clinical detachment' (e.g. Richardson 2000; Walter 2004) and as 'detached concern' (e.g. Halpern 2001; Tseng and Lin 2016) – the latter attempting to address the issues of balancing detachment and sensitivity to patient emotion and wellbeing (although the extent to which it addresses this sufficiently is debated (e.g. Halpern 2001; 2003)).[8] In their different formulations, the terms point to the general intuition that while we do not want indifferent medical practitioners, we also do not want medical practitioners who are led astray by personal interests, panic at the sight of blood, or collapse in sobbing grief at the thought of death. We want medical practitioners who make unbiased observations and keep their cool when the going gets tough, so to speak – in fact we expect it.

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[6] Both in forms of empathy towards patients and unpleasant emotion related to 'errors and adverse events' (Orri et al. 2014, 772–74). Some studies find that reported emotional episodes decline with experience; however, these same studies also show that emotional episodes occur throughout the career of medical practitioners (e.g. Silva and Carvalho 2016).
[7] While the latter issue may have significant clinical consequences, I think it is important to keep the two problems separate, and thus limit the interest of this article to the first issue.
[8] Anthropologist Rachel Prentice recounts a debate between surgeons in which they suggest a similar inclination in the term 'compassionate objectivity' (Prentice 2013, 129).

During fieldwork, medical practitioners themselves expressed this ideal in different ways. For example, interviewing Rose, a surgeon in training at one of the departments, about which subspecialities she found interesting, she replied that she did not want to work with children.[9] When asked to expand, she explained that it is important to not take the terrible stories and injuries you encounter too much to heart, and continued:

> I have a hard time with this when it's kids. […] I don't know, I always find it a little hard to perform surgery on children. I think it can sometimes be a bit…[*hesitates*] to see them being put under anaesthesia. I don't know if it's because I have small children of my own. That may be what makes you a little more affected by it. […] Especially if you can see the parents, and they have a really hard time having their child put under anaesthesia. Then you can kind of put yourself a bit in their shoes. I think it can be a bit hard sometimes. (Rose)

Here, Rose speaks of some situations that she actively wishes to avoid, in which she feels her emotional regulation is not how it should be. Notice that she suggests a possible link between her own situation and that of the patient and relatives (this trigger for emotionally charged situations has been described in other studies (see for example Aase, Nordrehaug, and Malterud 2008, 768)). That is, she focuses this on (disproportionate) empathy, and an inability to let go of certain emotions that, in her opinion, go against something important to the profession.[10]

Following up on the topic, Rose added that she could feel the same with patients of her own age or in similar circumstances to hers – not just with children – and in this context remarked: 'An important thing in our profession is to be able to, uh… distance ourselves a bit from what we do' – thus invoking exactly the idea of distance, or detachment, which is well-established in the field.[11] And in fact, when I discussed my fieldnotes or interviews with colleagues – historians, anthropologists, and philosophers – 'clinical detachment' was often alluded to as a potential explanation for this or that behaviour. That is, while challenged as a sufficient emotional ideal, especially from the medical humanities, *clinical detachment* still dominates our preconception of medical practitioners, when explaining medical professionalism.

In the field, however, inserting myself into some of these 'inhumane' spaces; observing the surgeons at work and talking to them about why they acted one way or another, or about memorable experiences or patient

[9] For clarity's sake I have given most interviewees names in this article. These names are all anonymised.
[10] Brown points to treatment of children as something that is also an emotional trigger in other historical periods (Brown 2018, 331). Childers and Arnold frame the same structure not in terms of only children, but in terms of unexpected death or illness (Childers and Arnold 2019, 31; also Aase, Nordrehaug, and Malterud 2008, 768).
[11] I should note that several surgeons also recounted having no issues with operating on their actual family members, whom they love, and thus, Rose's response is not meant as a generalisation, but as an example of moments where the intuitive concepts of 'clinical detachment' is invoked by practitioners.

relations, the notion 'clinical detachment' appeared more and more crude to me. Not because I disagreed that emotional *regulation* and distancing made up part of what constitutes good clinical practice, but because it seemed too simple a notion to capture what I witnessed.[12] Here, it is perhaps worth noting the slight hesitation in Rose's use of the term 'distance', as an indication that the terms used do not tell the whole story.

This article is an attempt to unfold the complexity of emotions in the clinic and the ties to the professional ethos of medical practice. I want to suggest, that approaching the intuition about medical professionalism through what I will call an *emotion-entity focused framework*, that is, with a notion of emotion as something that medical practice needs either more or less (or only specific kinds) of, misses the mark slightly, as it cannot grasp the degree to which the appropriateness of emotions (type, degree, intensity, expression) is a situated matter, deeply embedded in and dependent on the imperatives and rhythms of the particular clinical practice. In the following I will argue that motivations for framing the emotional ideal in the concept of 'clinical detachment' (as avoidance of emotion) do not hold, and that we can make better sense of emotional regulation by looking at clinical imperatives and their active expression in clinical rhythmicity.

3. Dismantling the appeal of detachment as a 'necessary in humanity'

The reference to 'clinical detachment' as a suiting ideal for medical practice is often grounded in two central underlying motivations: namely that – firstly – clinical practice requires its practitioners to regularly deal with and perform intrinsically gruesome or 'inhumane' tasks,[13] and – secondly – that medical practice should be carried out with unbiased rationality (medicine as a science-based profession).[14] Both of these characteristics of medical practice are seen to demand absence of emotion – for the sake of the clinician and the sake of the perfection of performance – and thus make up the foundation for an argument against appropriateness of emotions as such.

Overcoming horror: Detachment and pity

It is perhaps worth remembering that the discussion of 'inhumanity' (by Hunter) occurred in the context of surgeons, and in a time when the surgical settings had none of the refinements we know today, and notably, was conducted without anaesthesia. The surgical setting of Hunter's time is described as involving large amounts of blood and cries of agony (Brown 2018). The inhumanity necessary here – which Hunter recommended be taught through repeated dissection work on corpses (Richardson 2000, 104; Payne 2016, 6)

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[12] I share this observation with Rachel Prentice, who writes, 'Detachment does occur, but I have observed more nuance than these depictions convey' (Prentice 2013, 37).

[13] Bioethicist Jodi Halpern phrases this as, 'Detachment is needed, physicians and nurses both assert, to concentrate and perform painful procedures.' (Halpern 2001, 16).

[14] Guidi and Traversa attach this conviction to the medical culture that came from the Flexner report which lobbied for a vast increase in natural scientific training among medical students in the US in the early twentieth century (Guidi and Traversa 2021, 575)

– is thus one of being able to perform surgery undisturbed by screams; of carrying out the task at hand with professionalism. What is perceived as the 'inhumanity' in such a scenario has led some scholars, for example literary scholar Kathleen Rogers, to assume that being able to operate (in the face of agonised cries) must require desensitisation (Rogers 2007, 168), and several eighteenth century pictorial renderings of the surgical practice of their time hint at association with insensitive butchers (see for example Rogers 2007, 166; and Brown 2018, 330). The notion of surgeons as unemotional butchers has, however, not gone unchallenged.[15] Payne points out that texts would often advise surgeons to follow the words of the Roman Encyclopedist Aulus Celsus:

> A surgeon should be filled with pity, so that he wishes to cure his patient, yet is not moved by his cries to go too fast, or cut less than is necessary; but he does everything just as if the cries of pain cause him no emotion. (Celsus, Aulus Cornelius (1953), 'De re medicina: Book Seven: The Prooemium,' in *Medical Works in Facsimile*, London: Pergamum Press, p. 296 – from Payne 2016, 3).

That is, the surgeons should overcome panic, horror, or disgust by way of a different emotion, pity, not by way of no emotion. Likewise, historian Michael Brown stresses the role of 'compassion and emotional expression' in early Victorian surgery (Brown 2018, 343).[16]

Descriptions of contemporary surgery similarly refer to required inhumane acts of surgical practice – even if current surgical settings are of course very different to those of Hunter and early Victorian (mid-nineteenth century) surgeons. For example, Orri et al. talk about surgery as an 'aggressive act' (Orri, Revah-Lévy, and Farges 2015, 7) and Rachel Prentice repeatedly references the surgical task as 'doing violence' in order to do good (Prentice 2013, 65). Emotionally detaching themselves might be one strategy to enable modern surgeons to cope with these tasks, but as for the eighteenth-century surgeons, it is not obvious that this should be a better strategy than one of regulation through differentiation of emotions – whether this be pity, empathy, or something else. In other words, the fact that medical practice requires the performance of

[15] Historian Michael Brown cautions against interpreting the visual renderings of surgeons too literally (Brown 2018, 330). He notes that in some stages of surgical history the association between surgery and butchers was present. This link is made, however, in a context of surgeons' wishing to emphasise the *physical* stamina demanded by their trade (Brown 2018, 331) – not the emotional.

[16] Brown, mistakenly, I think, takes Payne's comment on the prevailing presence of some form of dispassion throughout systematic medicine to mean a practice of lack of emotion. As the above quotation from Celsus shows, this does not seem to be Payne's point. Rather her point is, I think, one of some form of normative stance on the regulation of emotion, much like Brown himself – even in his description of the sensitive early Victorian surgeons – stresses, using examples of a medical student who panics as an 'example of how not to conduct oneself' (Brown 2018, 342, also 335) or referring to the enlightenment ideas of Locke, Hume and Smith that one must have 'the capacity to feel the pain of others and to *moderate* our actions accordingly' (Brown 2018, 337, my emphasis), that is, employing specific emotions for a specific aim.

'inhumane' tasks does not imply that detachment is a *necessary* emotional stance in order to practice medicine well.

The appeal to 'pity' as an alternative, sounds, perhaps, akin to current calls for more empathy in clinical practice. And we may very well desire some form of empathy in clinicians (on occasions it might even be necessary for good medical practice). However, unregulated empathy (or pity) can, as already indicated by Rose, have adverse effects on the clinician and their ability to perform necessary actions. One might think then that the ideal lies in some balance between distance and empathy, or perhaps – as elsewhere suggested (e.g. Guidi and Traversa 2021; Halpern 2014) – in cultivating certain kinds of empathy.[17] And while I think there is much value in discussions around the role of empathy in clinical practice, my point here is that an overall regulatory framework that focuses only on one emotion, or on the suppression of emotion as such, misses the variety and nuances with which medical practitioners can regulate emotions appropriately, and the fact that regulation is not evaluated by the specific strategy used, but by its efficiency.

Detachment and objectivity

Beside the notion that the medical task, with its horrors, demands detachment, medical literature also argues for detachment by invoking a contrast between emotion and rationality. In his commentary on the need for increased emotional support for practitioners, Austen contrasts 'clinical detachment' – as linked to scientific objectivity – with 'true empathy', as linked to trust and emotional resonance (Austen 2016). Medical doctors Julie Childers and Bob Arnold talk about the doctor as 'a paradigm of rationality in a sea of patient emotions' (Childers and Arnold 2019, 29), and philosopher James A. Marcum speaks of medical professionals as individuals providing 'objective quality healthcare […who] must remain neutral and unaffected by emotions that accompany human pathologies and relationships' (Marcum 2013, 505). Orri et al. note the worry of surgeons that too much involvement may 'increase risk of being "less scientific"' (Orri, Revah-Lévy, and Farges 2015, 7).[18] A similar argument is found in Guidi and Traversa, who – quoting Helen Reiss points at the 'overvaluing of scientific measures' in medical practice, as the reason for neglected human connection in medicine (Guidi and Traversa 2021, 575). In the interests of keeping medical judgement unbiased, rational, or scientific, arguments from science and scientific ideals slide into ideals of medical practice.[19] Although most of the cited authors actually argue for *more* emotion in medical practice, this is framed as an act of balancing the objective, scientific, rational frame of mind (i.e., detachment), with the emotional, empathic, involved modus, and the argument itself establishes the two realms as opposed,

[17] Guidi and Traversa point out that there are multiple types of empathy, arguing one is more appropriate than others, but we might also imagine that they are appropriate at different times.
[18] They follow this point directly with the observation that surgery is nonetheless 'charged with intense emotion' (Orri, Revah-Lévy, and Farges 2015, 7), including strong emotional bonds between patient and surgeon.
[19] Historian Ruth Richardson speculates that the priority of the term 'clinical detachment' over other terms for the same intuition is linked specifically to its scientific undertone (Richardson 2000), something similar is expressed in Prentice's 'compassionate objectivity' (see footnote 7).

drawing on some – rather classical – dichotomies between the clinical and the personal, the scientific and the emotional, the rational and the involved. That is, arguing against detachment through balancing it with empathy, link between rationality and absence of emotion is often maintained as legitimate (even if in need of supplement).

However, here again we find reasons to question the argument and the necessity of the contrast (between emotion and rationality). The divide or even conflict between rationality/science and emotion has long roots in Western thinking. Sociologist Jack Barbalet traces the notion that 'emotions undermine reason' back 'from Plato (in the *Phaedrus*) to Descartes, and from Kant to the Logical Positivists' (Barbalet 1998, 30). In these views, emotions are seen to distract people, and distort clear thinking. However, in recent sociology of science (e.g. Barbalet 1998; Morton 2009; Parker and Hackett 2014), and founded in changes in cognitive theory (e.g. Damasio 1994; De Sousa 1997), the traditional distinction between science (or rational thinking) and emotion – or between objectivity and emotional engagement – has been challenged. Several scholars have argued that there is a necessary emotional element in the motivational drivers of scientific investigation and the commitment that scientists feel to their theories (e.g. Merton 1974; Barbalet 2002; Morton 2009; Brady 2013; Alfano 2017); other authors, such as psychologist Lisa Osbeck and philosopher Nancy Nersessian, have argued that the role of emotion goes even further (Osbeck and Nersessian 2013). Although it remains debatable exactly what role emotion plays in scientific inquiry, it is at least clear that emotions and their place in cognition are a far more complex matter than one of simple opposition to rationality, and there seem to be indications that (some) emotions are (sometimes) essential to scientific, rational thinking.

Summing up: we may think detachment – that is, supressing, or ridding oneself of, emotion – is needed in medical practice because medical practitioners have to do things, we would otherwise think inhuman. However, as Payne and Brown point out, performing surgery even of the macabre pre-anaesthetic kind did not need to rely on detachment, but could in fact rely on emphasising emotions (such as pity), and it is not clear why this should have changed. Detachment might also seem necessary because medicine, as a science-based profession, should be based on rational principles: 'hard facts' not 'soft emotions' – as a stereotypical notion of science would have it. However, from recent theories in sociology, history, and philosophy of science, as well as from cognitive science, it is clear that the distinction between rationality and emotion (which much medical literature reproduces) is a false dichotomy. This, in unison with the critique from medical humanities that detachment is not – at least not in present day medical practice – a sufficient emotional stance means that theoretical reasons for regarding detachment (absence of emotion) as an ideal, become questionable: it is neither necessary nor sufficient.

Conversely, there may be moments in which empathy seems crucial for medical practice, but focusing singlehandedly on this, misses out on other emotions we may desire from medical practitioners, for example classical epistemic emotions such as curiosity about symptoms and their potential explanation, and also

struggles to properly delineate moments in which too much empathy harmfully takes up mental energy better used otherwise. That is, while we may want doctors to be empathic, we do so *at the right moments*, and *in the right degrees*. In other words, detachment is not necessary, and medical humanities have made a strong argument that it is not sufficient. Conversely, unregulated empathy is not ideal either. Hence, we need some framework beyond pointing to either of the two stances, to make sense of emotional ideals in clinical practice. For this purpose, I suggest that a rhythmicity framework and the idea of *emotional attunement* may better help us understand when and why emotions become inappropriate and what we may want to pose as the professional ethos in training of medical practitioners. In the following I unfold this idea, starting by outlining what I mean by rhythms of clinical practice, specifically the clinical practice at an orthopaedic department.

4. Rhythms and Arrhythmia in Orthopaedic Surgery

I suggest understanding appropriateness of emotion – and hence emotional regulation – as a function of inherent clinical imperatives, and the emotional synchronicity or asynchronicity in respect to those. This suggestion is inspired by sociologist Sky Gross' work on depersonalisation in brain surgery. She argues that depersonalisation is neither (at least not necessarily so) about an acquired/learnt skill of surgeons to not feel anything,[20] nor is it even a lack of emotion – it is rather a shift to a *different set of emotions* dependent on certain rituals and features of the material surroundings of the practices (such as ritualistic preparation for surgery, and the sharply delineated physical boundaries between spaces where patients and families speak and move, and the operating theatre (Gross 2012)).[21] While Gross points to the important link between practice and emotion, she does not discuss what it means for emotions to be inappropriate or uncomfortable in the clinic (only how emotions are appropriately shaped by ritualistic practices). In order to do so, we need to locate a normative framework that can tell us when and why emotions may not be appropriate.

Integrating material surroundings and temporal practices, I wish to foreground the *rhythms* of practice as a concept that helpfully captures the co-constitution of material surroundings, activities, aims and ideals of the clinical space. I do so, inspired by my own fieldwork and drawing on Lefebvre's notions of rhythm. Such a framework – rather than an emotion-entity focused framework – allows greater sensitivity to situational factors, recognising difference in appropriateness relative to timing or for different practices, depending on their rhythm and the imperatives that drive them.[22]

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[20] Gross's argument is that as a sociologist who never had clinical or medical training, she is perfectly capable of entering the surgical space with its clinical gaze at the sedated body, encountering a dear friend not as the patient she knows personally, but as brain and tumor tissue that needs to be carefully examined and dealt with (Gross 2012).
[21] Gross is not the first to note the ritualistic aspect of surgery (see for example Katz 1981; and Hirschauer 1991).
[22] Note, that by sensitivity here, I do not mean increased emotional sensitivity, but rather increased situational sensitivity in the framework used to discuss normativity of emotion (namely: as something relative to the rhythm, rather than a consistent level of detachedness).

In her book on rhythmanalysis, Dawn Lyon, starts by motivating her focus on rhythm from her field (Lyon 2021, 1). I want to start in a similar way, by showing how the notion of rhythmicity entered my work, not as a theoretical decision to focus on Lefebvre, but through empirical engagement and attempts at making sense of the medical practices around me, so that Lefebvre's concepts only entered later to deepen and develop the theoretical aspect of the rhythmicity framework that I am proposing here.

Maintaining rhythms of practice

To learn more about emotions and affective responses in clinical practice, parts of my interviews focused on asking clinicians to recount moments of discomfort or strangeness in response to patients. These might be moments where they reacted, or moments where they specifically strove *not* to react to something; and I asked them to explain why either was the case.[23] In talking to clinicians about this, what became important were not only the events they recounted, but also the way they narrated these.

When I asked Sarah, a surgeon in training, to expand on a distinction she made between *situations that were repulsive* and *situations that she experienced as repulsive*, she explained how some emotions (like disgust with faeces or blood) would not be significant, they would rather stay in the 'background', as long as she knew what she had to do – and hence, she might in hindsight judge the situation to be somewhat repulsive, while at the time not having experienced it as such. Retelling a recent experience with a patient who vomited while lying on their back, choked and went into cardiac arrest, she said:

> As soon as you start giving CPR [Cardiopulmonary Resuscitation], the first thing you feel is that you press down, and you break the ribs. Then you think 'ugh'. There is this slight 'ugh, oh well, moving on', right. It isn't something that makes you pause, it isn't something that makes you stop because, thank God, you know this happens. It's something you know – well, effective CPR leads to broken ribs in many cases, especially with older patients. So, it's just a 'hey, it was true what they said', while you keep going. (Sarah)

Importantly, it is not that Sarah is void of emotions, she does in fact have a disgust reaction to the ribs breaking. However, this emotion is not ascribed significance because it does not intersect with the goal of practice; rather, there is an emphasis on the importance of taking action. What is more, her calmness in acting in a situation which is both potentially stressful (attempting to save a patient in cardiac arrest) and in the face of what we might think of as an inhuman or violent act (breaking ribs) she does not talk about

[23] There is a distinction here between emotions *as had* and emotions *as expressed*. As I am interested in normative ideals for regulation, which happens to a great extent in the interplay between the two, I will not deal further with this distinction, but align myself with sociologist Arlie R. Hochchild's 'interactive view' (Hochschild 1979), that is, I have an interest in 'how people try to feel, not […] how people try to appear to feel' (Hochschild 1979, 560), or what historian William M. Reddy might be said to call a *dynamic* view of the relation between emotion and expression where the two work in synergy (Reddy 2001, xii).

detachment, but rather stresses the fact that what happened was in accordance with expectations.[24] She continues, explaining that the 'ugh'-response would dominate, if she did not know how to 'move on', offering a different example:

> If you're standing there with a patient who is bleeding from his behind: old blood running out and it keeps running, and his blood pressure drops and the like. And you know to say 'well, set up the needles so that we can give blood and give some fluids [too]', and start doing x, y, and z, but then you stop, because now what? And then you stand there thinking, well, I did this and this and this. And you stand there ticking things off, I mean going back and forth over the first four steps and you can't get to the fifth one. And this feeling, of not being able to move on, and you can see that the patient is not getting any better. Then, then my go-to is usually to ask a friend[25] […] Because, then you get out of that growing sense of helplessness or uncertainty, which becomes unproductive. (Sarah)

Here, Sarah is recounting a situation in which she does not immediately know how to act, and she explains how – we might say – she tries to get back to the rhythm, to regain the flow by repeatedly going over steps, in the hope that the next step will come to her.

Trying to make sense of these scenarios, I find that notions of empathy and clinical detachment mischaracterise what Sarah is expressing. Perhaps there was detachment at stake in the first scenario, but what was relevant to Sarah's emotional management and her evaluation that she managed successfully, was that things went according to plan, and she could carry on with procedure. In the scenario where this was not the case, she repeats this focus on moving forward, and on avoiding – not detaching from – emotions that would hinder this progression. That is, her evaluation foregrounds an onward drive and the importance of maintaining or keeping up with this – of things going according to plan.

This active orientation onwards, is perhaps one particularly present in surgical practice, as it is typically a practice arranged around decisions of whether to intervene or not, and focused on very concrete, physical moments of intervention.[26] Talking with a young surgeon about his choice of specialisation (in surgery rather

[24] Some interviewees used the term 'natural' when talking about these types of situations, specifically on bleeding, in several interviews; that they handled the excess of blood by reminding themselves that blood was natural. In the next part of Sarah's scenario, vomit from the patient exits the lungs and sprays onto her, and she explains that she can see how this is disgusting, but that it didn't feel repulsive. When I ask her if she had any hypothesis on why this was, she replied that it was natural, that if you had vomit in your lungs and someone pressed on them, it made sense that it would spray out.

[25] By 'friend' she is implying a colleague (she gives as examples asking the nurse who is there with her or calling a colleague).

[26] Orri et al. talk about how *ideals of surgery* revolve around the notion of the surgical procedure as the ultimate or even only cure (Orri, Revah-Lévy, and Farges 2015, 10). See also Zambrano et al.: 'Most surgeons described as an attribute of the "surgeon's personality" their status as "people who like to fix things"' (Zambrano, Chur-Hansen, and Crawford 2013, 937). Fixing something here, however, need not necessarily mean operating, but can also mean talking, referring, or explaining (Zambrano, Chur-Hansen, and Crawford 2013, 937), i.e. *doing something*.

than in internal medicine or primary care), he explained that he enjoyed surgery because of its being a very concrete and efficient way of addressing the needs of the patient. In orthopaedic surgery, the aim of consultations is to regain or ensure future mobility function – in other words, it is a speciality focused on action.

Going back to Sarah's case, two things are worth noticing in her narration. First, she highlights how emotions that arise out of not being able to move on – helplessness and uncertainty – can end up also contributing to the inability to act (i.e., 'becomes unproductive'), that is, reinforcing the situation which brought about their dominance (i.e., the dominance of helplessness and uncertainty). In the story Sarah does of course act – she employs several strategies to attempt to keep the rhythm going – but in this effort and in the narration of these strategies as ways of escaping from a certain state (of helplessness), she stresses the self-same feelings (helplessness and uncertainty as something that may reinforce the inability to act) as things to avoid. Second, interestingly, in Sarah's example, her concern is that the patient is 'not getting any better' after step four, that is, not that the patient is still getting worse. While it is unclear whether the patient was in fact stabilised or not in this situation, the choice of words indicates that the drive to progress, the rhythm which I have outlined as central to the practice, and Sarah's efforts, are all aspects of a struggle to keep the rhythm going. Uncertainty serves as a threat to the imperative of practice; it creates disorder in the rhythm, and we see how explicit efforts are made by Sarah to get back on track.

While the practice imperative may be different in other fields of medicine, my point here will be that the rhythms of orthopaedic surgery are directed – or orchestrated, if you will[27] – by the this onwards drive. And my argument, is that whether or not an action or emotion is 'in tune', so to speak, will be dependent on this drive – but that the appropriateness at a certain time will also depend on whether it is fitting with that particular moment in the rhythm. So that there is variation and nuance in the ideals at the same time as there is consistency. That is, the normative framework of practice is not fully described by the practice imperatives, as these would again provide a static framework, but is determined by rhythms based in these imperatives.

The orchestration of rhythms

One of the first things that struck me, as I trailed surgeons in the different tasks at the departments, was the different rhythms of each task, and at the same time, the distinctiveness of *a rhythm* in all of them. My fieldnotes filled up with the term 'again', and 'again', and 'again', and the notion of rhythmicity that I suggest here took shape as the constant drive of clinical practice kept returning. In one department, the outpatient clinic consultations were set up to last 40 minutes (including notetaking, etc.) for introductory meetings, and 20 minutes for follow-up meetings. I sat in the consultation room with the surgeon, and patients arrived in a steady flow. Every 20 to 40 minutes the surgeon would get up to fetch the next patient.

[27] I am not the first to use this term about clinical practice, see for example (Jensen 2016).

As the patient came in, we all greeted each other, then sat down. Then the surgeon asked the patient to recount their symptoms, the medical history related to these, and their own ideas about what needed to be done. After this, there would be some reshuffling – moving the chairs around so the surgeon could reach the patient and the patient had more space to move freely – or the patient would go to the examination bed, and the surgeon would make a physical examination. Then, we would all return to sit in our original places, and the surgeon would give their evaluation, laying out possible courses of action and reasons or considerations for one or the other, and some time would be spent coming to agreement, after which the necessary actions to initiate the agreed course would be taken, information would be given about who to talk to next (the nurse for details on surgery, the radiography team for scans, the surgeon for follow-up, or their GP if patients were being discharged in case anything else came up and they needed a re-referral). Then the patient would leave, and the surgeon would spend five to ten minutes registering final points in the electronic records, checking things for the next patient, get up, and fetch a new patient. Again: sitting down, patient account, reshuffling, physical examination, returning to original seats, surgeon information, decision and actions, end, and notes. And again. And again, only interrupted by a brief lunch, or a delayed patient.

On other days, following surgeons in the operating theatre, the pace was different. More time was spent preparing and waiting for the rest of the team to be ready, but a rhythm was clearly perceptible. We would prepare in the office – going over patient files and clinical guidelines, or technical specifications for the equipment needed for the surgery, and so on – then walk to the surgical area (in one department, this trip included stopping on the way to talk to patients who had already had surgery or were having it later). Entering the surgical area, we put on hairnets in the hallway, and in an entrance room: surgical masks. Entering the operating theatre, everyone (including me) began by stating their full names and task.[28] The surgeon would then leave to scrub up while the nurses and anaesthetist made the final preparations.[29] The surgeon would re-enter, dressed in a sterile surgical gown. The nurse would help them put on sterile gloves and they would do a 'check-in' (stating the name of the patient and the procedure that was about to happen, as well as the expected timeframe, to everyone in the room). Then the surgical procedure was carried out. Approximately 10 minutes before the surgeon finished the procedure, they would inform the team, who would start preparing to wrap up the procedure. By the end, the surgeon would stich the patient up, the nurse and surgeon, in collaboration, would remove sterile surgical wrappings, any blood or liquid would be cleared away, and finally a surgical dressing or bandage would be applied (often just before the patient woke up). Then the surgeon would leave (with me following), and we would walk back to the office to fill in the medical records. Then there was a wait again for the next surgery, where the surgeon would prepare, or do

[28] At this point nurses and anaesthetists had already been preparing for a while, the patient would often already be asleep (or almost asleep), and the room already set up with equipment lined up and instruments laid out, still in their protective wrappings.

[29] In this period, I would often spend the time finding a chair and an appropriate place in the room where I could sit without disturbing, but have a proper view, and be able to hear what the surgeon said to me.

other desk work. Once the team was ready, we would be called, and again: walk, (see other patient,) hairnet, mask, greeting, wash, check-in, procedure, 10-minute announcement, stitch-up, clean-up, bandaging, walk and records. Depending on the length of the procedures, this would happen two to four times in a day.

While the rhythms varied between different activities, they were all orchestrated by a drive towards personal action and efficient function-oriented intervention, inherent to orthopaedic surgery. That is, whether in the out-patient clinic or in surgery, days took their turn through certain repeated structures, marked in my notes by the word 'again'.

Rhythm, Lefebvre, and normative measure

So as to capture this complex of organised flows directed by an imperative, I draw on the notion of *rhythm* as used in *Rhythmanalysis* by the French sociologist Henri Lefebvre. *Rhythm* is something which has both direction and place – integrating both space and time into the everyday (Lefebvre 2004, 15 [1992]). In the clinic, there are times – and spaces – for pondering and debating (e.g., morning conference) and times and spaces for fast decision-making (e.g., A&E), times for listening to and talking with the patient (the first and final part of the consultation) and times for doing tests and looking at test results (the middle part of the consultation). These, and their organisation and intersection in daily flows of practice make up rhythms of orthopaedic surgery, as demonstrated above, and the norms by which emotional responses are evaluated vary depending on time and space.

In 'The Rhythmanalytical Practice' Lefebvre and his co-author Catherine Régulier characterise rhythm as follows: 'There must be repetition in a movement, but not just any repetition' (Lefebvre and Régulier 2004, 78 [1985]), that is, monotony alone does not make rhythm, there must be 'differentiated time': 'strong time and weak time, which return in accordance with a rule or law – long and short times, reoccurring in a recognizable way, stops, silences, blanks, resumptions and intervals in accordance with regularity, must appear in a movement' (Lefebvre and Régulier 2004, 78 [1985]). The medical practice just described has all these elements of rhythm: 'strong' times and 'weak' times, that is, not just repetition but also differentiation as well as temporal and spatial integration. Each consultation follows a similar pattern, but not a mechanical one – there is room for variation. We might say that most practices have this. In fact, Lyon makes the point that looking at rhythm can be a methodological choice that reveals interesting things about most human practices (Lyon 2021, 44). While rhythm as method may be an interesting approach to making sense of medical practice, my point here, however, is more extensive than that. Perhaps, let me rather say that rhythmicality is salient with *overtness* in medical practice as something which fundamentally guides the activities, driven by an imperative of efficient, controlled intervention. That is, rhythmicity as such provides a normative framework for the practice itself – one that is emphasised by the clinicians in their evaluations

and narratives of practice. Rhythm becomes interesting not only as a tool to describe this or that rhythm of medical practice, but as a central framework for the practice as such.[30]

In my fieldnotes, the rhythms of clinical tasks emerged, largely, through the repetition ('again'), but also through two other prominent features: Firstly, the orientation onwards, for example in the outpatient clinic's orientation towards decision and action-on-the-decision – the session always being ended by a handing-over of the outpatient to someone else (the radiologist, the nurse, the GP), or by an agreement as to the next appointment, ensuring continuous momentum – and in the operating theatre's continuous temporal updates and continual anticipation, looking ahead to the next step – this orientation already anticipated by the young surgeon's stressing efficiency as characteristic of surgery. And secondly, the rhythms were characterised by clearly marked differentiation between the different steps of the proceedings, the control over *what* happens *when* – for example by announcement, or by moving from one place to another. While there is continuous flow (repetition directed onwards) of the practice, this is an organised flow made up from well-structured units, each with their appropriate place in the practice, and all coordinated by the drive of an imperative of efficient controlled intervention; like music – one note takes the other, yet for there to be rhythm, melody, the notes remain distinct. This organisation of flows permeates the clinical practice on multiple levels. They are concretely expressed in clinical guidelines that follow an evidence-to-decision format. Or they are established through hierarchies of prioritisation that guide clinical practice – whether these be for access to certain resources (e.g., one orthopaedic department shared its operating theatres with vascular surgeons, who had clear priority of use, as their speciality deals with conditions that are often more immediately acute than those of orthopaedics), or focus of treatment (e.g., the standard procedure for receiving trauma patients being the ABCDE-model which regulates the point of focus of treatment, securing stability in the order – and *always* in this order: Airways, Breathing, Circulation, Disability [neurofunction], Exposure [other injuries] (Soltan and Kim 2016)).

The salience of rhythm – and of orthopaedic surgery as made up of rhythms that share an orientation towards efficient, controlled intervention – becomes particularly clear, I think, in the importance expressed by clinicians of 'not getting stuck'; or one might say: keeping the rhythm of practice going. When I asked surgeons what they would do in cases where emotions took over, either so they were not able to control these emotions, or in ways that made them (i.e., the surgeons) physically incapable of carrying on (e.g., through dizziness or nausea), many replied that this (i.e., allowing emotions to take over) was simply not an option. Several clinicians emphasised that this was not a matter of insensitivity (detachment), but rather that what

[30] Here the notion of rhythmicity might intersect with the Weberian notion of *ethics of office,* that is, the expected behaviour and normativity tied to and specific to a vocation (du Gay 2008). However, my aim is not to say anything about how different rhythms come about or why they take their specific shape – questions for which looking at the formal vocational structures is most likely crucial. Instead, what I am interested in is establishing that there *are rhythms*, and that evaluation of emotion may depend on the way in which certain emotions fit into, or do not fit into, these rhythms. (I owe this important hook into the classic sociological literature to Cecilie Glerup).

was of importance was getting on with the task at hand and that such emotions could be dealt with later; you follow the rhythm until your beats have been played, so to speak, then you hand over to the nurses in the operating theatre, or to the radiologist through a referral in the outpatient clinic.

Importantly for this point, the notion of rhythm from Lefebvre holds an element of *dressage* (Lefebvre 2004, 47–53 [or.1992]; see also Elden 2004, 7; and Lyon 2021, 27): directing, smoothing of rough edges, and keeping in step with a certain 'choreography'. That is, rhythmicity establishes normativity: 'everywhere, where there is rhythm, there is *measure*, which is to say law, calculated and expected obligation, a project' (Lefebvre 2004, 8 [1992]). For Lefebvre this *measure* is sometimes located in the human (biological) body as a metronome (Lefebvre 2004, 24; see also Elden 2004, 6; and Lyon 2021, 31). Yet he also recounts how *dressage* is the act of integrating and disciplining the body into the rhythms around it (Lefebvre 2004, 45; see also Elden 2004, 6; and Lyon 2021, 25): we teach our bodies to be hungry at lunch-break-hour; we learn to leave rooms, stand up or sit down at certain paces, matching the paces around us and the tasks at hand.

To make sense of medical practice in this conception of rhythm, I take not the body but the clinical imperatives as the *measure* guiding the rhythms. These imperatives simultaneously shape the norm of the rhythm (as measure) and, in turn, the rhythms and flows of practice support the realisation of the imperatives through taming and bending practitioner action, orientation, and emotions (dressage). For Lefebvre, this dressage (of rhythm) is not willed or intellectual but habitual and bodily, inserting our bodies into the ongoing flow of practice in order to habituate them into the flow – such as it happens in medical apprenticeship. By integrating structure and flow in a rhythm, any action is embedded in a temporal and spatial positioning, which although not strictly determining, is strongly indicative of future course. As described by Gross, such dressage does not only involve physical attunement but also emotional attunement. The rituals of surgical practice, the pace, and divisions of space tamed and shaped her own emotions, so that in the surgical theatre she found herself taking on a surgical curiosity towards her friend's exposed brain tumour with no trouble (Gross 2012, 1176).

That is, rhythms ascribe certain things to certain spaces and certain points in time, and the rhythmicity itself works as dressage to ensure this. For example, touching the patient's thigh may be inappropriate during the first part of the consultation, whereas it may be expected during physical examination. Rhythms placing the patient first in a chair somewhat distant from the practitioner, and later on the examination bed, support the compliance to such norms. Likewise, uncertainty may be warranted at the beginning of an out-patient consultation, but inappropriate at the end or in the A&E, when decisions have to be made.

Finally, for Lefebvre's notion of rhythmicity, it is important to note that rhythms are never isolated. 'It suffices to consult one's body; thus, the everyday reveals itself to be a polyrhythmia from the first listening'(Lefebvre 2004, 25). Likewise, medical practice is made up of a variety of rhythms that proliferate throughout the hospital: from the sleep patterns of individual practitioners to the rotations of medical

students, and the schedules of patients. These all interact, and, according to Lefebvre can do so as eurhythmia (compatible), isorhythmia (identical),[31] or arrhythmicity (discordant, disruptive) (Lefebvre 2004, 77; see also Lyon 2021, 25). I return to this in the next section.

Only very rarely – too rarely for me to witness during my fieldwork – do clinicians have to break rhythm before their task in the process has been completed. In conversation with David, a surgeon, about situations that affected him he recounted an incident – similarly to the comments from Rose – when a severely injured child was brought to A&E. The child had been about the same age as his own child at the time. Overwhelmed with horror, he had been incapable of making any decisions, and had had to call a colleague to step in. In cases when emotional regulation is impossible, such as when David was incapable of making decisions about the injured child, or, if the surgeon starts feeling dizzy or nauseous during surgery, 'you say it [out loud]', as two surgeons told me: you inform your colleagues and then you step back to allow someone else to take over; that is, always keeping the momentum going.[32]

Uncomfortable emotions: Inappropriateness as rhythm break

Often, when practitioners spoke of inappropriate or uncomfortable emotional episodes, the dominant feature was emotions that overwhelmed them. These were linked to empathy and identification with the patient, but also showed up in experiences of adverse emotions such as disgust. In an interview with Cecilia, a medical student working as a locum doctor at a surgical department, I asked how the physical appearance of patients affected her. She replied:

> If you meet a patient who, for example, has not been washed for a long time, and, smells a lot, then you have to pull yourself together more […] So I try to make an effort, because you really just want to not be there at all. […] I also kind of try to seem professional, but [with a smelly patient] it's much harder for me than with other patients. (Cecilia)

Here, Cecilia expresses very clearly the battle to live up to an ideal or appropriate attitude: a conflict between appearing professional, and emotions that Cecilia sees as getting in the way of this. Although disgust is a very different emotion to that of empathy (in the introduction I touched upon using one 'against' the other, that was, pity to override disgust or horror), what the two scenarios from David and Cecilia share is the force of affective reactions. In Sarah's example (see the subsection 'Maintaining rhythms of practice'), her worry was that overwhelming emotions such as insecurity would arise out of the inability to move on (from events

[31] Technically, this is not a polyrhythmia, as isorhythmia are not diverse rhythms, however, I mention it here as it is one way in which two or more rhythms can intersect (Lefebvre 2004, 77).
[32] This response mirrors the response in cases where the disruption is epistemic, e.g., when patients present symptoms that the surgeon cannot make sense of, leading them either to call upon a more experienced colleague, or, if the symptoms point to a condition outside their speciality (e.g., indicating neurological issues) to refer the patient to another unit.

that frustrate the action, e.g., uncontrolled bleeding), whereas with David and Cecilie we find emotions that result in incapacitation (or the need to overcome the emotions to be able to act or live up to the norm). That is, some instances of loss of momentum seem to originate first in the inability to act leading to inappropriate emotions, while in others, emotions seem to be the cause of this inability. Common for both roles of emotions, is that evaluation is based on their effect on the continuation of the rhythms of practice. Further, in most cases, the one potentially brings about the other, as inability to act leads to incapacitating emotions (such as overwhelming helplessness or bringing into focus the disgust that Sarah otherwise barely noticed), and incapacitating emotions lead to inability to act (such as David's inability to make decisions).

Another surgeon in training, Peter, gave the following description of overcoming emotions about dead bodies, when I asked him in an interview about the relation between living patient bodies and dead bodies. Describing the task of post-mortem examination, he said:

> There's always a certain type of distancing when you go into a room like that where you know there's a dead person. Maybe not right after they died […] but when you're in the basement for the examination where everything is lit with cool lighting and the temperature is also a bit cold and they're lying there covered in white sheets, then I feel best just parking my emotions outside the door and entering with a, I don't know, official kind of… in any case, that it needs to be done correctly. And I try also – for those that I bring along down there to show them how to do something like that – then I draw on the fact that there are some legal requirements, and some things we just have to do correctly. (Peter)

Peter stresses that the reason for putting the emotions to one side is that there is something that needs to be done properly (i.e., he 'parks' emotions that may get in the way of this), and the way he teaches novices, is to tell them to focus on the task, to stick to procedure – to the rhythm. As in the quotation from Cecilia about trying to remain professional, there is some emphasis here on overcoming: temporarily leaving behind emotions ('parking them outside the door', as Peter says, to be picked up again afterwards, one might add) – explained in a manner that seems very close to what we might take 'clinical detachment' to mean. Here is an opportunity to stress that the argument of this article is neither for nor against the idea of distancing or detachment as a tool for emotional regulation. Instead, what I want to point out is the dynamic aspect in the relation between emotions and a certain drive onwards in clinical practice.

What is in question is not whether or not surgeons (e.g., Peter or Rose) are detached, or use this strategy of emotional detachment, but a question about the normative force of this term: whether it is a helpful way to make sense of, and think about, appropriateness of emotions in clinical practice. In other words, detachment may very well be a helpful strategy, and perhaps even a very prevalent one to manage emotions and avoid

emotions that are *too much*, without it being the ideal standard for our evaluation of them (i.e., that surgeons or medical practitioners *ought* to generally be detached). [33]

When Sarah explained to me why she was happy to have had another colleague be in charge in a situation where she had been overwhelmed by emotions, she said: '[When] it [emotion] takes up thinking time, it takes up, well, cognitive ability is probably a good way to put it. […] If you spend one half [of your thinking time] being upset and feeling your own emotions, then you only have half left to do a proper job.' It is when emotions get in the way of intervention that they become a problem (not the feeling or the emotion itself) – such as when Sarah feared getting stuck because of uncertainty, or David needed to hand over to a colleague because he was unable to make decisions. Rather than protection from feelings, it is when 'feeling too much' is linked to the inability to think/act, or to seem professional, or follow proper procedure that problems emerge.

Returning to the rhythms of medical practice that I established earlier in this article, and the concept of rhythm from Lefebvre's rhythmanalysis, I argue that – while the practices of the departments had different rhythms depending on the tasks that were in focus – all the rhythms I describe were characterised both by salient rhythmicity in the form of organised flows through well-ordered units, and a striving for controlled and efficient interventions. And more importantly, I suggest that these rhythms function as inherent normativity, shaping practice through implications of maintaining momentum – a normativity inscribed between the memory and the direction of movement inherent in any rhythm (Lefebvre and Régulier 2004, 79 [1985]). This normative 'measure' of emotions does not only frame what inappropriate emotions are but might also direct (or act as 'dressage' for) practitioners in terms of where to place, or when to have, or when to give significance to, certain emotions. When clinicians often reply that strong emotions simply are not an option, this does not have to mean that they are incapable of having these or do not have them, but rather that the rhythms of medical practice displace these emotions to other moments or other 'rooms', they may be – as Peter implied – something to pick up later.

Drawing more explicitly on Lefebvre's work on rhythm, we may think of inappropriateness not just as halts or collapses of a single rhythm, but as a 'pathological' intersection between multiple rhythms. For example, emotions may be seen to make up their own rhythms, along with heartbeats, work schedules, daylight, and a whole range of other rhythms. Each rhythm – the physical condition of the practitioner, the allotted time slot, or the seasonal light conditions, can work either with or against actions in the clinic. Each rhythm has its own normativity – its own momentum and pattern – and as it unfolds amongst other rhythms (that of the clinical,

[33] Bringing the parallel back to scientific practice again, Bruno Latour – drawing on the work of Isabelle Stengers – notes that 'distance and empathy, to be useful, have to be subservient to this other touchstone [i.e. maximising occasions for inquiry]' (Latour 2004, 13). That is, they are not useful *per se* but in relation to the optimisation of scientific practice.

that of the patient, that of the physician's own body etc.), interactions between these may create new harmony, or interlink, or they may break each other. Clinician emotions can then be in discordance with the guiding rhythms, driven by the clinical imperative – a pathological polyrhythmicity, so to speak (Lefebvre 2004, 25): an arrhythmia, which does not only halt rhythms, but disrupts the harmony of the host of other rhythms unfolding in the clinic. There are multiple ways for something to be 'arrhythmic' (i.e., breaking the dominating rhythm). Something can be out of rhythm in timing (in the wrong context): temporally – for example, empathy may be more in sync during the first part of the outpatient clinic consultation, and less so during physical examination (which does at times demand asking the patient to perform painful tasks); spatially – for example, sympathy may be more fitting in the company of a deceased patient's relatives than when working with a colleague in the morgue. It can be out of rhythm in intensity (being too loud, too low): for example, being overwhelmed by the sight of an injured child, or conversely, being indifferent to the success of a difficult operation. Or it can be out of rhythm in type (some emotions generally being problematic): for example, Halpern references the Hippocratic corpus in stating that emotions such as 'lust and greed' are never appropriate in medical practice (Halpern 2001, 19). The specificity of what is arrhythmic (in timing, intensity, or type) will however depend on the concrete rhythm. What such a view allows is, that while different rhythms may be broken by different things, there may also be different places or times within one rhythm where (some) emotions are asynchronous and problematic, but others where they are not.

We may ask what exact role emotions play in making or breaking rhythms, and in particular in making or breaking guiding rhythms that follow the professional imperative. From the literature on emotions in science – despite debate about the type of appropriate emotions, the degree and the parts of the process they should be involved in – there is general agreement on the role that emotions play in keeping scientists committed to the progression of science, that is, to its goal (e.g. Morton 2009, 388; Parker and Hackett 2014, 553). We might guess that something similar is the case in medical practice, and that emotions are appropriate insofar as they perform this task. Here, however, I do not want to make any claim as strong as this: that emotions are *only* appropriate if they help maintain the rhythm. Rather, I am making the somewhat weaker claim that emotions become inappropriate when they break the rhythms of clinical practice. And can thus be appropriate as either isorhythmic (in unison) or as 'merely' eurhythmic (compatible).

5. Concluding remarks: Suggesting the phrase 'attuned concern'

Historian Ruth Richardson has made an argument in favour of the term 'necessary inhumanity' rather than 'clinical detachment', as she points out the *necessary* indicates both the modification of the inhumanity to a certain (appropriate/necessary) degree and no more, and the idea that it is only appropriate if it is in fact needed (i.e., '*How* necessary in *these* circumstances? For *how* long? And with *what* effect?' (Richardson 2000, 106)). My point here aligns somewhat with this teleological procedural view. However, as I have

argued, at the core of the rhythm of the orthopaedic surgical departments that I visited was the drive to intervene in order to help patients. And while this motive may at times not be directly present in concrete actions, it shapes the rhythm which in turn shapes the evaluation of emotional appropriateness, and hence, I find the term *inhumanity* somewhat unsuitable. Perhaps instead, we might talk of *attuned concern*, that is, *concern* in the sense of engagement, but *attunement*, indicating 'to a degree' which stays within the bounds of the rhythm of clinical practice; attunement also in the sense of adjusting to a complex situation. That is, rather than the notion of balance (of empathy / detachment), attunement avoids implicating dichotomies but maintains a framework for differentiated evaluation, allowing less rigid yet still regulated navigation of the multitude of elements and considerations that make up medical practices. In this way, perhaps I agree with the recent article from Guidi and Traversa that *concern* rather than *cognitive understanding* is important in medical practice (Guidi and Traversa 2021), but I have tried to show that the emotional regulation in medical practice reaches beyond empathy: Emotional management is being able to attune oneself with the situation and the inherent drives of that situation (the context *and* the process) and adjust appropriately when settings change. Empathy, for example, may be important for the practitioner's ability to attune themselves to the rhythms of the patient, but other rhythms and context are also at play in medical practice.

Thinking of emotional ideals in the clinic in terms of attuned concern, discussions on how and what to teach medical practitioners and medical students in terms of emotional management, should turn towards learning how to attune and regulate emotion, rather than towards teaching certain types of emotions (e.g., empathy). Further, a rhythmicity framework for emotional management in clinical practice also directs our attention more to the clinical imperatives, and their effect on the daily practices in the hospitals – distancing debates somewhat from the idea that the emotional setup in the clinic lies solely in the clinicians' emotional abilities and introducing the idea that different imperatives may allow different rhythms, including different emotional attunements. This means, that if we disagree with medical practitioners' use of detachment, but this detachment strategy does work rather well, the debate to be had might be one about the professional ethos and underlying drivers of practice, and not one of training individuals to be more or less empathic.

I should note that the article depends on the particular practices of orthopaedic surgery in two specific departments in Denmark, and this, of course, has implications for the specific points I make about these practices. However, the scope of the article is to point to a potentially more general lens through which we might view emotions in clinical practice. The aim of this article has thus not been to uncover novel points about sources of emotion in clinical practice (this is more skilfully done by for example Meier, Back, and Morrison 2001; Aase, Nordrehaug, and Malterud 2008; Orri, Revah-Lévy, and Farges 2015; Zambrano, Chur-Hansen, and Crawford 2013; Silva and Carvalho 2016; Isbell et al. 2020). Rather, what I aim to contribute is a framework which allows for an understanding of situated emotions and their relative appropriateness in clinical practice through *rhythmicity* and captured in the term *attuned concern*. I have done so particularly for orthopaedic surgery, highlighting the professional imperatives in this practice as the

measures that guide rhythms of practice. While I do not have empirical material from other medical specialisations – and thus cannot speak to the exact layout of rhythmicity in these fields – the suggestion of this article is that a rhythmicity framework for evaluating the appropriateness of clinician emotions would be helpful for most medical practices, albeit guided by varying professional imperatives, and thus that the notion of 'attuned concern' might helpfully open up nuanced debates about proper emotional regulation across the medical field.

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