MAT Medicine Anthropology Theory

SPECIAL ISSUE

# Therapeutic Apprenticeship

## Uncovering Truth and Performing Responsibility

David Ansari and Amy Cooper

How do practitioners learn the subtle and often unspoken rules in enacting care? This special issue takes apprenticeship in a variety of clinical and therapeutic contexts as its theoretical and empirical focus. The contributions to the issue examine how practitioners—ranging from shelter workers, ophthalmologists, psychotherapists, and other kinds of clinicians and healers—learn to develop embodied clinical and caring skills, as well as affects, judgements, and ethics, while navigating new and unfamiliar spaces of healthcare practice.

The contributors to this Special Issue[1] distinguish apprenticeship as a specific form of learning that is tacit and embodied (Polanyi 1966). Scholars of apprenticeship have characterised it as a form of learning that must be experienced rather than communicated (Coy 1989, 2), and where learning and identifying are mutually constitutive (Lave and Wenger 1991). Apprenticeship scholars emphasise the sociality of enskilment with more experienced practitioners and with peers, as well as practitioners' engagement with a variety of materials and procedures (Gowlland 2019). Others have considered how within contexts of apprenticeship a complex

1 This Special Issue arose from a panel of the same title at the 2020 annual meeting of the American Anthropological Association, which was postponed due to the COVID-19 pandemic. The pandemic has amplified the critical need to elevate the voices and truths of those underrepresented in therapeutic and academic settings, and the need to take responsibility for enacting social justice as praxis. These needs are at the centre of the accounts of therapeutic apprenticeship in this issue. We not only examine how people become clinicians or healers, but how they become practitioners committed to a more just and equitable world.

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web of rules—that consists of formal rules and informal practices—govern the work of novices (Gamst 1989, 66). Authors in this Special Issue attend to these concerns; they also examine how apprentices negotiate learning in the face of absent or obscure rules, when the terms of the apprenticeship itself are not very clear.

In their seminal text, Jean Lave and Etienne Wenger (1991; Wenger, 1999) characterised apprenticeship as legitimate peripheral participation within communities of practice. Legitimate peripheral participation refers to the position and progression of novices, and communities of practice emphasise the shared activities and sense of belonging among practitioners. Through apprenticeship with peers and more seasoned practitioners, initiates develop vision, or organised ways of seeing and sensing that characterise practice (Fountain 2014; Goodwin 1994; Grasseni 2004, 2007). Apprenticeship is unlike other forms of training, since this experiential kind of learning involves the absorption of norms, dispositions, and ways of being within a community of novices, experts, and those in between. Considering apprenticeship to be a social enterprise where learning and identifying entail one another is perhaps why Rebecca Bryant (2005) characterised apprenticeship as learning how to become someone who performs a particular task. The articles in this Special Issue all address the ways in which therapeutic apprenticeship encourages practitioners not only to hone a specific skillset, but to become new kinds of persons in the process.

This Special Issue builds on and extends scholarship on learning in medicine and other caring fields, which emphasise how practitioners learn to adhere to formal and informal rules, develop dispositions, and learn to carry themselves professionally. Influential accounts of socialisation in medicine have characterised a ‘student culture’, which refers to their shared understandings of their roles and responsibilities as medical students (Becker et al. [1961] 2003, 46). Others have identified how institutional lore and horror stories could be used to teach lessons of care and caution to trainees (Bosk 2003, 104). Semi-fictionalised accounts like Samuel Shem’s (1978) infamous *House of God* depicted, often graphically, the dehumanising experience of medical residency in the United States, and the ways that this toxic culture of clinical apprenticeship sustained institutional hierarchies, misogyny, and the inability to provide compassionate care for patients. In a somewhat different vein, authors in this Special Issue highlight oblique processes by which social structures intended to guide apprentices can actually increase uncertainty for those seeking to develop healing expertise. Taken together, these articles suggest that the process of becoming clinicians and healers is not as linear or progressive as many of us may assume.

The ‘hidden curriculum’ is a framework for understanding how the culture of clinical training is absorbed and replicated. A great deal of learning in clinical, caring, and healing professions takes place on the job and through interactions with peers and supervisors. Historically, scholars and the public have tended to emphasise formal instruction in developing expertise, neglecting the hidden curriculum—in other words, the subtle, informal, and contradictory moments of learning (Hafferty and Franks 1994). In an ethnography of medical school in the United Kingdom, Simon Sinclair (1997) explored the hidden curriculum by drawing on Erving Goffman’s (1959) framework of front- and backstage work in a theatre. Whereas the ‘manifest curriculum’ of lectures, exams, and ward rounds takes place on the front stage, the hidden curriculum could be located backstage, in the corridor, or even in the bar (Hafferty and Franks 1994; Sinclair 1997). Frederic Hafferty and Ronald Franks (1994, 865) identified how the hidden curriculum was more concerned with replicating the culture of medicine rather than the teaching of knowledge and techniques. Based on our reading of the articles conforming this issue, we suggest that the notion of the hidden curriculum could also include processes by which national political imperatives get taken up in therapeutic apprenticeship in cases where medical care is intertwined in the wellbeing of the body politic (e.g., Wong this issue; Nading this issue).

Pierre Bourdieu’s concept of the *habitus* provides insight into the ways that initiates come to embody the values, attitudes, and beliefs that are present in the hidden curriculum. Bourdieu has characterised *habitus* as a ‘system of durable, transposable dispositions’ that are ‘collectively orchestrated without being the product of the orchestrating action of a conductor’ (1977, 72) and a ‘capacity to produce classifiable practices and works, and the capacity to differentiate and appreciate these products and practices’ (1987, 170). Taking these characterisations together, we might consider *habitus* to be a manner of being, as well as of producing, perceiving, assessing, and categorising things, based on our experience. This appears to come naturally and unconsciously and is socially informed but without explicit instruction. As we will see, some of the authors in this issue combine ethnography and autobiographical experience to analyse how apprentices learn a new *habitus* over time (see, for example, Doering-White this issue; Baim this issue).

Clinical ethnographers, such as Rachel Prentice (2013, 140), identified a *surgical habitus,* referring to the embodied guiding principles and values of surgeons that accumulate over years of supervised practice and that cultivate the techniques and ethics of surgical control. Moreover, Prentice (idem, 110) characterises the hidden curriculum in biomedicine as consciously or subconsciously adopted techniques of the body. In a similar vein, Joan Cassell (1998, 40) deployed Bourdieu’s notion of the *habitus* to explain the tacit, intuitive, and embodied knowledge required to

acclimatise to clinical work, such as surgery. Cassell's pioneering ethnography examined what it means for an institutional ethos to be gendered and what happens when women enter into a male-dominated medical profession. Maryna (Bazylevych) Nading's article in this issue picks up on this approach as she explores how gender in Ukraine informs national discourses of medicine as well as medical specialisations, leading women to dominate in most medical professions except for surgery (Nading this issue).

## Beyond communities of practice, *habitus*, and the hidden curriculum

We might consider *habitus* in terms of the embodiment of a hidden curriculum that occurs through legitimate peripheral participation within a clinical or therapeutic community of practice. Going beyond the concepts of the hidden curriculum, communities of practice, and *habitus*, we attend to the affective, material, and political components of apprenticeship. The development of *habitus* in clinical settings involves more than embodied skills and knowledge – it also involves sense and affects. Recent clinical ethnographies have also examined the processes of embodiment and the training of the senses in clinical and therapeutic encounters (Cooper 2015; Prentice 2013; Smith 2017; Smith-Oka and Marshalla 2019). For instance, Prentice (2013) highlights how medical embodiment goes beyond the acquisition of skills to include the development of perceptions, affects, judgements, and ethics. Yvonne Smith (2017, 1331) details how youth care workers in residential treatment centres develop sensitivity to their social and physical environment in order to acquire local knowledge so as to practice effectively. And Kelly Underman (2020, 4), in her ethnography of the teaching and learning of the pelvic examination in medical school, has argued that affect—referring to the capacity for bodies to sense and form connections with one another—has an instrumental value for upholding the cultural, political, and economic interests of the medical profession. Building on this scholarship, authors in this Special Issue consider how affect shapes and is shaped in apprenticeship in a more expansive sense—focusing not only on how affect develops to enable a more skilled practice, but also how certain affective experiences (such as unintended, ongoing periods of anxiety and uncertainty) can undermine and impede enskilment (see, for example, Wong this issue; Ansari this issue).

We also attend to the socio-material arrangements (Mol 2002) that permit or hinder processes of learning to read, speak, and think like future practitioners (Atkinson 1995; Good 1994; Holmes and Ponte 2011; Montgomery 2006; Wong et al. 2021). For example, Kenny Fountain's (2014) ethnography of a medical school's gross anatomy programme demonstrates how the performance of expertise involved learning how to use objects, such as charts, images, and 3-D representational

images. Objects and technologies in sites of apprenticeship make certain practices possible and they mediate practice; they are not simply artefacts of the environments in which apprenticeship takes place. For instance, research on medical documents and practices of writing in therapeutic encounters has demonstrated that these documentary artefacts and practices do not simply record or reflect clinical events, but also shape them (Berg 1996; Berg and Bowker 1997; Brodwin 2013; Good 1994; McKay 2012; Street 2011). Ansari builds on this insight in this issue, analysing how a medical form designed to promote therapists' learning transforms both apprenticeship and diagnostic processes in unintended ways (Ansari this issue).

We also attend to the political dimensions of apprenticeship, since newcomers are not simply blank slates who learn within spaces free from power relations. We draw on the scholarship of Amy Cooper (2019), who in the Venezuelan context examined the distinctions made by patients between good and bad doctors: 'good doctors' refers to those who, in addition to enacting medical expertise, enact intimacy and solidarity with poor patients who felt historically disenfranchised. In France, David Ansari (2019) has identified how apprentice therapists in clinics for refugees and asylum seekers were often selected for their apprenticeships because they represented visible forms of diversity—in terms of race and religion—but their voices were often silenced by their supervisors when apprentices wanted to talk about these forms of diversity. Vania Smith-Oka (2021; Smith-Oka and Marshalla 2019) has identified how medical students and residents in Mexico may have more access to, and thus more opportunities for experiential learning with, patients in public hospitals because these patients are not in a position to refuse unskilled or unwanted touch from budding doctors in the same way that wealthier, whiter patients can do in private hospitals. And in the Malawian and Papua New Guinean contexts, Claire Wendland (2010) and Alice Street (2014) have demonstrated how learning medicine and being a medical professional are shaped when students and clinicians are acutely aware of the structural and material imbalances in power between themselves and their peers in high-income countries. Authors in this issue analyse how apprenticeship is shaped by the sociopolitical contexts of apprenticeship (e.g., Nading; Wong), and attend to the ways in which clinicians and healers learn to support structurally vulnerable clients and patients (e.g., Ansari; Doering-White).

## Overview of the contributions

In this Special Issue, we offer new insights about apprenticeship by ethnographically examining apprenticeship in diverse clinical settings and geographic regions where apprenticeship had not previously been examined. We also offer fresh conceptual understandings of apprenticeship by intentionally

attending to the affective, material, and political dimensions of apprenticeship. Our articles unsettle assumptions that apprenticeship is experienced as a progressive, linear mastery of ways to see, feel, and act. The ethnographic research in this issue highlights uncertainties that impede apprentices' desired development as experts. We consider affective dimensions of apprenticeship in a broader sense than looking at how apprentices cultivate new affective dispositions as they develop expertise. Affect—which may be experienced through anxiety, uncertainty, and a sense of injustice—may be toxic to apprentices and may hinder or delay the desired outcomes of apprenticeship.

Reading these pieces, we find ourselves transported to medical clinics in Ukraine, China, France, and the United States, and to a migrant shelter in Mexico. The authors' descriptions of apprenticeships in these settings let us share the wonderment of ophthalmology residents, who feel uniquely empowered to see the 'beauty' of human eyes (Baim) and groan in frustration for therapists-in-training who seek psychiatric competence but have little opportunity to interact with patients (Ansari). Each of these pieces provides new insights into the affective dimensions of therapeutic apprenticeships. They do more, too. These articles push us to think deeply about how politics of nationhood implicate clinical practice. They help us consider how vision and 'seeing' structures efforts to achieve therapeutic expertise. Some of this issue's authors demonstrate the value of attending to the unexpected temporal dimensions of building expertise. The ethnographic research gathered in this Special Issue suggests that for those apprenticing in medicine and social work, linear progress toward greater knowledge and social belonging is more anomalous than we might expect. Each of the articles illuminates forms of uncertainty that challenge the development of therapeutic enskilment.

In his article about embodiment, affect, and vision in ophthalmology, ethnographer and ophthalmology resident Adam Baim shows how residents' affective experiences transform in patterned ways as they progress from novice to expert (Baim this issue). New ophthalmologists in the United States struggle with uncertainties that scholars have identified as inherent to apprenticeship, such as worries over their ability to 'see' details essential to diagnosis. But even as they sit with the discomfort of (temporary) inadequacies of skill and knowledge, ophthalmology residents speak with pleasure about gaining a privileged view of human eyes and having unique opportunities to revel in beauty. Whether it's the variegated colours of the iris or the intricate pathological structures of the eye, having special access to these visions serves as a source of satisfaction that mitigates the challenges of practicing a difficult medical specialty.

While Baim's research documents apprentices' efforts to cultivate ever more detailed visions of their patients' ocular pathologies, John Doering-White shows

how the inverse process—purposefully sheltering one's vision—is an acquired skill among shelter workers who aid travellers along Mexico's heavily policed migrant trail from Central America to the United States (Doering-White this issue). Like Baim, Doering-White bases his analyses on ethnographic fieldwork and autoethnographic experience, drawing on his apprenticeship in 'shelter vision' over three years' work in a migrant shelter. Learning not to see the details of migrants' realities is essential for shelter workers for multiple reasons. A rapid turnover of migrants and minimal shelter resources guide workers to avoid intense and time-consuming engagements with individual travellers. The porous boundaries that exist between the categories of migrant and smuggler, and challenges relating to verifying people's stories, encourage shelter workers to resist looking for evidence that people who rely on shelter services may not be who they claim to be. Perhaps most importantly, shelter vision is a political strategy that tacitly de-emphasises the suffering of migrants, reframing them not as victims to be pitied but as agents with whom shelter workers act in solidarity.

In contrast to the framing of therapeutic apprenticeship as the progressive achievement of skilled vision (whether that entails seeing more or seeing less), David Ansari's research in a Parisian mental health centre for migrants finds that apprentices struggle because they cannot see what they need to see (Ansari this issue). Therapeutic apprenticeship is convoluted by the fact that supervisors ask therapists-in-training to learn their specialty by working with 'paper patients'—files written by clinicians about patients—without observing or interacting with the patients themselves. Unlike those forms of uncertainty inherent to apprenticeship that tend to resolve with experience (such as whether one has sufficient medical knowledge), therapists-in-training face unnecessary uncertainties, such as not knowing how a patient would describe their suffering in their own words, or finding that a migrant patient's paperwork lacks key information about the trauma they have experienced. Apprentices also struggle to understand the confusing language of a diagnostic form that supervisors created in an effort to make the apprentices' training more straightforward. In this setting, we see how the structure of apprenticeship presents unnecessary obstacles to developing expertise, but we also see how these could be resolved with some of the institutional changes Ansari suggests.

Like Ansari, Bonnie Wong also shows how institutional norms and practices result in unnecessary uncertainty and anxiety as doctors complete surgical training in China (Wong this issue). Drawing on participant observation in Chinese hospitals (and firsthand experience as a medical student in the United States), Wong explains that although China is pursuing ongoing medical education reform, surgical training remains unstandardised. The length of surgical training varies wildly, and trainees tend to feel they are in a perpetual, unbounded process of

apprenticeship. Adding to the frustration and confusion is a national imperative that Chinese doctors balance high-quality clinical care with internationally recognised medical research (measured in terms of publications in high-impact factor journals). China's aspirations for scientific and medical prowess as part of a national politics of *fuxing* (revival) manifests as enormous pressure on surgical apprentices to achieve research excellence, yet trainees feel lost without enough research education or supervision. Taken together, Wong claims that surgical trainees find themselves in a 'cruel apprenticeship', struggling toward an unattainable fantasy of medical accomplishment.

Maryna Nading shows how a national politics of renewal also plays an outsized role in doctors' experiences of clinical practice in Ukraine, based on her ethnography of gender segregation by medical specialty in the country (Nading this issue). In Ukraine, women dominate nearly all medical specialties with the exception of surgery, where men dramatically outnumber women. Nading explains that gender ideologies determine women's dominance in medicine generally (based on the notion that women are responsible for the protection and wellbeing of their families and, by extension, of the nation), and that gender ideologies also shape gender division by specialty. Because women are expected to fulfil the primary imperative of motherhood first and foremost, they are viewed as less suitable as surgeons because of the temporal demands associated with surgery. Concepts of beauty, which are tied to conceptions of proper femininity, also get bound up with specific medical specialties. National discourses of Ukrainian renewal invite women to contribute to the strength of the nation through motherhood as well as through valorised, gender-appropriate forms of labour. Medical practice intersects with these imperatives, and because medical practice in Ukraine for most new doctors entails long periods of low pay and uncertain placements, women (whose primary responsibility is to home and family) find these uncertainties more tolerable than men (who bear primary responsibility for financially supporting the household). Gender divisions tend to reproduce themselves as women apprentices who choose specialties deemed more suitable for men often experience problems with social inclusion into these communities of practice.

Together, the articles in this Special Issue extend our understanding of communities of practice, *habitus,* and the hidden curriculum by attending to: 1) the affective responses to the uncertainties that may alter or hinder the trajectory from novice to master; 2) the physical and material objects that apprentices need to learn to use to demonstrate vision; and 3) the sociopolitical aspects of apprenticeship. The authors of these articles also broaden the reach of therapeutic apprenticeship by examining medical specialties, clinical institutions, and

geographic settings that have not been sufficiently featured in apprenticeship ethnographies.

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