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Being Well while Doing Well — Distinguishing Necessary from Unnecessary Discomfort in Training

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During his internal medicine clerkship, Dr. A. (now an intern) dove into tasks medical students often undertake: getting outside records, faxing forms, updating patients' primary care physicians. But he sensed that some of his peers disapproved of his willingness to engage in such "scut work." Believing that these tasks weren't educational, fellow students suggested that by "leaning into" them instead of setting boundaries, he was reinforcing problematic norms. Dr. A. saw the work as integral to both his education and patient care, but he found it difficult to challenge their perceptions. If you disagree with someone who's trying to set such boundaries, he explained, you're seen as "part of a toxic culture and not supporting people in their wellness."

Several educators around the United States told me stories revealing a similar dynamic: once-routine aspects of education or training are now deemed potentially harmful. A department chair noted that encroachments on time away from the hospital — whether for reading at home or staying after a shift to deal with evolving illness — were often deemed threats to mental health. A vice dean of education told me that students, concerned about peer-to-peer comparisons, had protested the existence of the Alpha Omega Alpha honor society. Educators described being admonished for giving medical students or trainees any negative feedback, and being told to include only positive comments in the written record. Summarizing this shift, one recent chief resident observed, "It's become almost 'cool' to view being a doctor or medical training — and the demands that come with it — as a huge slight and unfair."

Tension between once-acceptable workplace demands and well-being is hardly unique to medicine. This tension seems particularly salient in fields that are theoretically committed to a broader social cause. Analyzing how perceived harm among employees is crippling progressive organizations, Maurice Mitchell, formerly of Black Lives Matter and now national director of the Working Families Party, notes that leaders of social justice organizations are finding their jobs "untenable," as workers consistently describe workspaces as "toxic" or "problematic."[1]

For medicine, an enterprise currently balancing a crisis in well-being with the requisite rigors of training and evolving workplace demands, perhaps the biggest and most relevant expectation Mitchell debunks is the belief that one's "mental, physical, and spiritual health is the responsibility of the organization or collective space." Mitchell writes that "Discomfort is part of the human condition and a prerequisite for learning. Violence and oppression are to be avoided but not discomfort. The ability to discern the difference is a form of emotional maturity we should encourage."

Because the ability to make such distinctions is also critical for trainees, medicine faces a bind. Our educational systems have clear shortcomings. But maintaining our commitment to excellence while remedying our failures requires distinguishing unnecessary harms from necessary discomforts. So why has it become so hard to make these distinctions?

THE NEW HIERARCHY

When Dr. S. began her chief residency at a West Coast academic medical center about 7 years ago, she assumed she should model what she considered good doctoring habits — arriving early, stay-

ing late, being detail-oriented. But she sensed a cultural shift: suddenly, everyone was talking about wellness, self-care, work–life balance. The traits she'd nurtured were becoming obsolete, if not frowned upon.

Whereas the traditional hierarchy elevated trainees with the intellectual and emotional fortitude necessary for managing acute and evolving illness, another kind of social capital was also emerging. In the new order, high status was accorded to people who spoke out about the ways in which the demands of residency, such as high caps on admissions or long-call durations, were not simply exhausting, but unjust or injurious. A long-call pilot program that had been highly rated by a previous residency class, for instance, was nixed when residents suggested it would lead to self-harm. And while most traineees were striving for excellence, a vocal minority could set the tone — and shape perceptions — for the majority. Each class had a group chat, and according to Dr. S., once a grievance was expressed in the group, consensus about potentially traumatizing effects quickly solidified. Such framing, with its moral overtones, was a successful strategy; her own authority dissolved in the face of it. "It becomes unconscionable not to comply," she says. "Then you are oppressing them."

Though these challenges to traditional hierarchy have distinct implications for medicine, understanding why grievance now carries such power requires a broader cultural lens. One analysis that suggests a mechanism of action actually comes from *New Yorker* book critic Parul Sehgal.[2] In "The Case Against the Trauma Plot," Sehgal describes a spate of recent fiction and television shows that seem to reduce both personality and plot to the characters' deepest wounds. Like other commentators trying to account for "trauma creep,"[3] Sehgal raises the obvious question: Are we all just more traumatized? She seems unconvinced. Instead, she wonders, "In a world infatuated with victimhood, has trauma emerged as a passport to status — our red badge of courage?" Though Sehgal anticipates readers "grumbling" about her questioning their traumas, she captures the essential danger of this preoccupation. "The enshrinement of testimony in all its guises," she writes, "elevated trauma from a sign of moral defect to a source of moral authority, even a kind of expertise."

Sometimes grievance carries moral authority because it should: medicine has long perpetrated racism and misogyny, for example, and recognition of the immorality of the structures and people perpetuating such oppression is long overdue. But when every ill feeling is labeled "trauma," distinguishing among harms of varying magnitudes becomes difficult, as does targeting interventions to root problems. Capturing this imprecision in a column describing how the language of trauma has permeated our culture, *New York Times* opinion writer Jessica Bennett asks in the headline, "If everything is 'trauma,' is anything?"[4]

As language is similarly weaponized within medicine, we must grapple with the resulting trivialization of problems that deserve more urgent and sustained attention. Experiencing daily racism, for instance, is different from being asked by your patients if you're old enough to be a doctor. Having to admit a new patient right before end of shift is not a moral injury. And burnout is not the same as depression; the substantial proportion of medical students and trainees who have debilitating mental illness[5,6] need adequate care, but we cannot help them — much less address our structural inadequacies — if differentiating between serious illness and the inevitable challenges of training is treated as a moral breach.

But beyond distracting attention from the trainees who most need support, these conflations make it difficult to enforce rigorous standards — and may thereby threaten clinical competence. At what point do exhortations to minimize our own discomfort compromise development of the skills necessary for tending to others' suffering?

EXCELLENCE AS OFFENSE

In October 2022, the *New York Times* published a feature about a renowned chemistry professor who'd been fired from New York University after students filed a petition saying his class was too hard and would keep them from getting into medical school.[7] Having struggled with chemistry as a premed, I understood the students' anxiety. After receiving a terrible grade on my first college chemistry midterm and certain I'd never get to be a doctor, I called my cardiologist mother at work, and when her answering service asked, "Is it an emergency?" I said yes, in fact, it was.

But though my mother (after ascertaining that I wasn't physically maimed) gently suggested I make use of the dorm's chemistry tutor, she would

never have blamed the problem on the class itself. She knew that the stakes of medicine left little room for mediocrity; encouraging me to shirk responsibility would have set me up for failure.

The *Times* story generated much debate: Is chemistry relevant to practicing medicine? Was the professor simply a jerk? But the students' petition, which notes that "A class with such a high percentage of withdrawals and low grades has failed to make students' learning and well-being a priority," raises an essential question for medicine as well: Does the pursuit of excellence conflict with the pursuit of well-being?

Yet many educators intuit that such questions can't be asked, much less answered. A surgeon I'll call Dr. W., who chairs a highly ranked surgical department, told me about a regularly held conference focused on problems with the culture of medicine. Recently, a presenter showed some slides from the division's Twitter account (run by the marketing department): awards won, research grants received, *U.S. News and World Report* rankings. The alleged cultural problem being illustrated was that hearing about others' successes harms trainees who work hard, are burned out, and already worry about their future. Many participants expressed similar sentiments. Dr. W. wanted to suggest that there's value in celebrating excellence, while clarifying that the tweets were merely a marketing tool, not meant as an existential threat to trainee well-being. But before he could, a resident commented that division leadership would probably "gaslight everyone" by saying exactly that.

When Dr. W. described this interaction to his executive coach, mentioning his own responsibility and commitment to creating a safe space, the coach asked: "Did you feel comfortable speaking?" Dr. W. said no. The coach replied, "Then it's not a safe space."

CONSTRUCTIVE CRITICISM

Such heightened sensitivity regarding expectations of excellence impedes our ability to give candid constructive feedback. One attending I'll call Dr. L. recalled a recent rotation during which a string of unusual errors occurred. Seeking the cause, Dr. L. discovered that the team's resident was rounding on the charts but not actually seeing the patients. Dr. L. raised the problem with the resident, who replied that Dr. L.'s expectations were too high and insufficiently cognizant of the traumas she'd experienced. She accused Dr. L., who is female, of not understanding what it's like to be a woman in medicine and suggested that the attending was essentially telling her to "smile more," a common way of objectifying women.

Though Dr. L. said it was one of the hardest moments of her professional life, she recognized the effectiveness of the resident's strategy: with the ever-present threat that such interactions will be broadcast on social media, and the "popularity contest among educators to be the most liked," Dr. L.'s fear of reputational harm (and losing her job) compromised her ability to help the resident become the best doctor she could be. "It's a perfect example," Dr. L. said, "of how far we've fallen."

Because the apprenticeship model of medical education has relied on transmitting professional values from one generation to the next, some evolution is inevitable as each generation reshapes the norms they're handed. What seems unusual now is that we aren't merely facing the expected clash of generational values, but also a threat to the transmission itself. Why has this exchange become so precarious?

PLAYING THE GAME

During an away rotation in medical school, I received feedback from a renowned attending — or more precisely, from his fellow, to whom he'd outsourced that unfun task. We were walking up the stairs when she launched into a valiant attempt at a "feedback sandwich" (my enthusiasm!) and then fumbled. "It's just…" "Just what?" I asked. After a few false starts, she indicated that I came off as too youthful, perhaps unserious, definitely naive. "Maybe you could change your hair?" she suggested. I reached back to find my hair in a ponytail, as usual. "Or your voice," she added. "My voice?" I asked self-consciously. "How can I change my voice?" She acknowledged that it was difficult. "We just want what's best for you," she said.

This interaction has stuck with me, but it didn't harm me. Though I loved parts of medical school, I disliked the way our daily lives, particularly in the clinical years, felt like a performance, a game I wasn't sure I wanted to play. The feedback was just further confirmation that success required pretending to be something I'm not. That pretense would never work for me, and

I don't see why it would work for anyone. Yet I also understood that the attending was genuinely trying to help me fit into a culture he didn't know how to change.

Though that culture has since changed, partly for the better, it sometimes seems that we're now playing another game requiring another type of performance. As online discourse infiltrates training and practice environments, so do its implicit rules for behavior. Struggle is hardly new to training. But today, the one person posting about a toxic work environment may be far more influential than the quiet majority who are learning and thriving. While these shifting power dynamics may contribute to some educators' reluctance to, for example, give critical feedback or mandate conference attendance, the subtler consequence may be the pressure social media have created to perform our allegiances. Invocations of harm thus often force a moral choice: Are you with the victim or the victimizer?

This pressure not only makes it difficult to weigh the inevitable trade-offs between the rigors of training and the pursuit of well-being — it also makes it harder to endorse the value of excellence at all. After the conference where people denounced the department's highlight reel, for instance, both trainees and faculty members told Dr. W. they had wanted to offer alternative perspectives but were afraid to speak up.

When I asked one of the residents in attendance, Dr. C., to explain this fear, he said that as soon as someone expressed feelings of inadequacy or distress, the "floodgates opened." Likening the support of someone feeling victimized in conference to the "innumerable replies of support, likes, and retweets" when a trainee posts "about a hard day in the hospital," Dr. C. described his befuddlement. He wanted to offer a counterpoint about being inspired by others' accomplishments or feeling pride in his peers, but he feared any objection would be perceived as insensitive to "others' triggers."

Given our historical insensitivity to trainees' personal struggles, some observers would argue that unquestioning deference to pain and vulnerability is a small price to pay for offering better support. Yet as the list of threats to well-being lengthens, this logic's essential flaw becomes harder to ignore. Trainees may be vulnerable. But so are our patients, many of whom are not in a position to advocate for themselves. The centrality of patient care to our educational mission may seem obvious. Yet the mounting pressure to project sensitivity to trainee well-being has made it difficult to consider the consequences of unwavering dedication to their comfort. Indeed, emphasizing how critical it is for trainees to become "comfortable with being uncomfortable," Dr. C. wondered, "If we keep going down this rabbit hole, how can we become good doctors?"

QUESTIONING THE NARRATIVE

A few years ago, when writing about whether health care is a right (I believe it is), I interviewed economist Katherine Baicker, who stopped me in my tracks. Noting that all health care has to be paid for by someone, she asked rhetorically, "*How much* health care is a right? And who is drawing that line?"[8] A morally sensitive conversation about fostering our professional values in modern training environments would require asking similar questions about well-being. How much are we entitled to? At what cost? Who decides? Because measuring well-being is challenging, answering these questions has never been easy. But now merely asking them risks being seen as opposing trainee well-being. The irony of these implicit limits on discourse is that improving well-being requires considering its meaning — and therefore talking about it.

When I asked Dr. A. what motivated him to do work his classmates considered beneath them, he said these tasks both "unambiguously advanced patient care" and helped him understand dysfunctions of a system he hoped to improve. But he also understood his peers' hesitance. As they witness an exploitative and transactional system crushing workers, a "globally perceived narrative" is reinforced: if they don't set limits, the system will break them.

In her takedown of the trauma plot, Sehgal describes the transformation of trauma into a "totalizing identity" and argues that our experiences and our cultural scripts can't be easily divided: "We will interpret one through the other." The same goes for the stories we tell ourselves about medicine. Our experiences shape these narratives, but the narratives also shape us. We can't address the factors actually compromising trainee well-being if we can't separate them

from the cultural forces rewarding declarations of being unwell. How, then, to separate the narrative from the reality?

Some details have been changed to protect the privacy of the persons quoted.

Disclosure forms provided by the author are available at NEJM.org.

Dr. Rosenbaum is a national correspondent for the *Journal*.

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