MEDICINE AND SOCIETY

MEDICAL TRAINING TODAY
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On Calling — From Privileged Professionals to Cogs of Capitalism?

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Growing up in Oliver Springs, Tennessee, Austin Witt — who recently finished his family medicine residency at Duke — became keenly aware of the mistreatment of American workers. He watched his coal-miner relatives endure occupational hazards such as mesothelioma, afraid to seek better working conditions in light of past retribution against their coworkers. He observed large corporations coming and going with little concern for the impoverished communities they left behind. Witt, part of the first generation in his family to attend college, chose a different career path from his coal-mining ancestors, but he's no more likely than they were to describe his job as a "calling." That term, he argues, "is weaponized against trainees as a means of subjugation — a way to force them to accept poor working conditions."

Though Witt's reasons for rejecting the notion of medicine-as-calling reflect his particular experiences, he's hardly alone in thinking critically about the role of work in our lives. As society's reckoning with work's centrality converges with medicine's corporatization, the sacrifices that once brought physicians spiritual fulfillment have increasingly been replaced by a sense that we're simply cogs in a wheel. For trainees in particular, whose work may feel distinctly like a job, medicine's demands may conflict with evolving ideas about what makes for a good life.

As personal as these considerations may be, they collectively have vast implications for training the next generation and, ultimately, for patient care. There's an opportunity to harness a generational critique to improve both clinicians' lives and our struggling system, yet there's also a risk of using our frustrations to justify abdicating our professional responsibilities and damaging our system further. Avoiding that spiral requires understanding what forces outside medicine are reshaping attitudes about work and why medicine is particularly vulnerable to these critiques.

FROM CALLING TO JOB?

The pandemic catalyzed a national conversation about work, but worker discontent predated Covid. Writing in February 2019 about a century-long evolution in Americans' conceptualization of work from "jobs to careers to callings," the *Atlantic*'s Derek Thompson explored "workism" — the belief, common among the educated elite, that work is "the centerpiece of one's identity and life purpose."[1] Workism's rise is multifaceted, but Thompson emphasizes that it's "among the most potent" of the "new atheisms" that have been replacing traditional faith among Americans.

Arguing that this sanctification of work was inadvisable generally, Thompson describes the specific fallout for millennials (born between 1981 and 1996). Though encouraged by baby-boomer parents to find work pursuing their passions, millennials graduated with enormous debt into an unstable labor market. Forced into unfulfilling work, they experienced both exhaustion and the demoralizing realization that work doesn't necessarily love them back. Many became skeptical about capitalism altogether. Whereas traditional faith offered "an intangible and unfalsifiable force of goodness," writes Thompson, to people harmed by the market's whims, capitalism's goodness was eminently falsifiable.

Corporatized medicine seems ripe for this critique. Joel Katz, who recently stepped down as the internal medicine residency program director of Brigham and Women's Hospital after 22 years,

notes that historically the missions of trainees and hospitals were better aligned. Hospitals were invested in residents' education, and there was a shared commitment to serve vulnerable people. Today, Katz notes, most hospital boards and leaders — even at so-called not-for-profit hospitals — increasingly prioritize financial success. Some hospitals view trainees more as an "inexpensive labor force with a short memory" than as doctors vested with medicine's future. As educational missions are increasingly subordinated to corporate priorities (such as early discharges and billing documentation), sacrifice becomes far less appealing.

Heightening the disillusionment is a growing sense of workforce exploitation, supercharged by the pandemic: while trainees worked longer hours and assumed significant personal risk, their friends in tech and finance worked from home, often cashing in on the crisis. Though medical training always meant delayed financial gratification, the pandemic amplified perceived unfairness: if you were barely making rent, saddled with debt, and scrolling through Instagram pictures of friends' exotic "working from home" destinations while fielding requests to cover ICU shifts for coresidents out with Covid, why wouldn't you have questioned the fairness of your working conditions? This sense of injustice persists despite the pandemic's retreat. Referring to medicine as a calling, some residents have concluded, is a way of saying "Suck it up."

Insofar as workism also arose from the belief that work should be meaningful, medicine still holds the promise of spiritual fulfillment. But for people for whom that promise proved hollow, medicine had farther to fall than other professions. And to some trainees — who describe pervasive inequities, trainee mistreatment, and unwillingness of faculty to confront social injustices — medicine is a "violent" system that elicits rage. For them, the word "calling" suggests a moral superiority that medicine hasn't earned. As Nali Gillespie, a second-year medicine-pediatrics resident at Louisiana State University, asked rhetorically, "What do people actually mean when they say medicine is a 'calling'? What do they feel called to?"

In medical school, Gillespie was disheartened by what she saw as medicine's dismissal of people's pain, poor treatment of marginalized populations, and tendency to assume the worst about patients. During her medicine clerkship, a patient who'd been sent from prison died suddenly, shackled to his bed and cut off from his family because of institutional rules. His death made Gillespie question the essence of medicine. Citing our focus on biomedical issues rather than suffering, she said, "I don't want to be part of that calling."

Above all, many trainees echo Thompson's objection to the notion that work should define one's identity. As Witt explained, the false sanctity in the term "calling" tricks people into thinking work is the most important aspect of their lives. Not only does that claim diminish many other meaningful aspects of life, but work can be a precarious source of identity. Witt's father, for instance, is a union electrician who, despite excelling at his job, has been unemployed for 8 of the past 11 years owing to the vagaries of federal funding. "The American worker is largely the forgotten worker," Witt told me. "I see medicine as no exception to the cogs of capitalism."

Though I agree that corporatization is medicine's root ill, we still must figure out how to care for patients, as well as train the next generation, within the system we have. And as much as Americans may reject workism, those same Americans no doubt want well-trained physicians who are readily available to them when they or their families fall ill. What does it mean, then, to treat medicine as a job?

QUIET QUITTING

During residency, Witt cared for a relatively young woman who, like many of his patients, was underinsured and trying to manage several chronic conditions. She was frequently hospitalized, and after one admission for bilateral deep-vein thromboses and pulmonary embolism, she was discharged with a 1-month supply of apixaban. Witt, having seen many patients burned by inadequate insurance, was skeptical when she said her pharmacy had promised that a manufacturer's coupon would let her receive uninterrupted anticoagulation. He scheduled three visits with her over the next 2 weeks, outside his allotted clinic time, hoping to keep her out of the hospital.

Nevertheless, 30 days after discharge, she messaged Witt saying she'd run out of apixaban; the pharmacy now told her a refill would cost $750, which she couldn't afford. Alternative anticoag-

ulation strategies were equally unaffordable, so he hospitalized her to bridge her to Coumadin, knowing he was just kicking the financial can down the road. When the patient apologized for "being a nuisance," Witt replied, "Please don't apologize for my trying to help you. If there is a frustration, it's that this system is failing you so miserably that I can't even do my job well."

Witt's view of medicine as a job rather than a calling clearly hasn't diminished his willingness to go above and beyond for his patients. But my interviews with trainees, educational leaders, and clinicians suggested that efforts to keep work from consuming life have unintentionally increased resistance to medical education's demands.

Several educators described a pervasive "on the clock" mentality, with growing intolerance of educational requirements. Some preclinical students aren't attending mandatory small groups, and those on clerkships sometimes refuse to preround. Some trainees insist that expectations to read up on patients or prepare for conferences violate duty hours. Faculty are quitting voluntary educational activities as students stop showing up. And sometimes when educators address absenteeism, they're met with shamelessness. One program director told me that some residents seem to see their absences from mandatory clinic as no big deal. "I would have been so horrified," she said, "but they don't see it as a professionalism issue or a missed learning opportunity."

But while many educators recognize changing norms, few want to comment publicly. Most asked me to maintain their anonymity. And many worried that they were guilty of the generational fallacy — a tendency sociologists call "kids these days" — of thinking their own training was superior to the next generation's.[2] Yet for every acknowledgment that trainees may recognize essential boundaries previous generations failed to understand, there was a countervailing perception that the shifting mindset threatens the professional ethic. One education dean described a sense of student disengagement, noting that even after returning to the classroom, some students continue to behave as if they're in the virtual world. "They want to turn the camera off and blank out the screen," she said. "Hello," she longs to say, "you're no longer on Zoom."

One of my fears as a writer, particularly in a data-free zone like this one, is that I may be cherry-picking anecdotes to suit my bias. And I'm hardly dispassionate about this topic: as a third-generation physician, I saw as I was growing up that the people I loved treated medicine less as a job than a way of life. And I still view doctoring as sacred work. But I don't think the current challenges reflect individual trainees' lack of devotion or potential. Participating in our annual cardiology fellowship recruitment, for instance, always leaves me awed by the brilliance and talent of the trainees (and certain that I'd never get a fellowship today). But even if our challenges are more cultural than individual, the question remains: Are the perceived shifts in workplace attitudes real?

It's hard to know. In the pandemic's wake, countless think pieces have detailed the end of ambition,[3,4] the rejection of "hustle culture,"[5] and the rise of "quiet quitting,"[6] which essentially means refusing to go above and beyond at work. And some data from the broader labor market hint at these trends. One study, for instance, showed a relative decline in work hours among high-earning, educated men during the pandemic, though this group had tended to work the longest hours to begin with.[7] The authors conjecture that the quiet-quitting phenomenon and quest for work–life balance may have contributed to these trends, but neither a causal link nor the implications have been established. Partly that's because it's difficult to use science to capture a mood.

What might quiet quitting, for instance, mean for clinicians, trainees, and their patients? Is it poor form to leave a night float to tell a patient that a CT report, returned at 4 p.m., indicates probable metastatic cancer? I think so. Will such lack of commitment shorten the patient's lifespan? Unlikely. Do work habits acquired during training shape our practice? Of course. But given that many factors affecting clinical outcomes change over time, it's nearly impossible to establish causal relationships between workplace attitudes now and future care quality.

PEER PRESSURE

There is, however, an extensive literature documenting our sensitivity to our peers' work behaviors. One study examined how introducing a highly productive worker onto a shift affects productivity among salaried grocery cashiers.[8] Because customers often switch out of slow-moving lines, introducing an efficient worker risks a "free

rider" problem: other workers might respond by doing less. But the researchers found the opposite: other workers' productivity actually increased when the efficient worker was introduced, but only if they could see that worker's line. Moreover, the effect was greater among cashiers who knew they'd work with that worker again. As Enrico Moretti, one of the researchers, told me, the underlying mechanism is probably social pressure: cashiers care about peers' perceptions and don't want to be judged negatively for slacking off.

As much as I loved residency, I complained throughout its entirety. And writing on this topic made me remember — with burning shame — a situation in which I played my chiefs off against one another to try to get out of work. But whereas, back then, they appropriately put me in my place, several senior trainees I interviewed for this series described how new norms emphasizing individual well-being are compromising work ethic more globally — a corollary to Moretti's findings. One trainee, for instance, acknowledging the need for "personal" or "mental health" days, nevertheless noted that medicine's high stakes necessarily raises the bar for requesting a day off. Recalling having to cover a long ICU shift for someone who wasn't sick, she described the contagion of such behavior, which influenced her own threshold for taking personal days. The result is a "race to the bottom," she said, driven by a few selfish people.

In one of our early conversations, Joel Katz enumerated the many ways we are failing current trainees, concluding, "We are robbing young doctors of meaning." I was skeptical. Given broader societal rejection of work-as-calling, it seemed people were intentionally seeking meaning elsewhere. But over time, I came to think that Katz had hit on the essential chicken-and-egg dynamic that we need to unravel. Has medical training been so stripped of meaning that the only natural response is to see it as a job? Or when you treat medicine like a job, does it become one?

WHOM DO WE SERVE?

When I asked Witt what distinguishes his commitment to patients from that of someone who considers medicine a calling, he told me a story about his grandfather, who was a union electrician in eastern Tennessee. When his grandfather was in his 30s, a large machine he was working on in a coal-powered energy-production plant exploded. Another electrician was stuck inside the plant, so Witt's grandfather ran into the flames to save him. Both men survived, but Witt's grandfather suffered from smoke inhalation. Yet rather than focusing on his grandfather's heroism, Witt emphasized that had his grandfather died, energy production in eastern Tennessee wouldn't have missed a beat. To the company, his grandfather's life was expendable. In Witt's telling, his grandfather ran into the fire not because it was his job nor because he felt "called" to be an electrician, but "because there was a human in need."

Witt sees his role as a physician similarly. "God forbid I were struck by lightning," he said, "the entire world of medicine would spin madly on." Witt's sense of duty, like his grandfather's, is independent of institutional loyalty or terms of employment. Metaphorically speaking, he notes, there are people all around him in burning buildings who need help. "My commitment is to those people," he says, "not to the institutions that keep us down."

The tension between Witt's sense of institutional betrayal and his commitment to patients reflects a moral quandary. Medicine may seem morally corrupt, particularly to a generation that is highly attuned to systemic failures. But our patients may suffer even more if we respond to institutional wrongs by relegating medicine to the margins of our lives. Doctoring was once considered worthy of sacrifice because lives were at stake. Our institutions have changed the nature of our work — but not the stakes for patients. Deeming the present inferior to the "good ol' days" may be the most cliché generational bias. But automatic dismissal of such nostalgia risks an equally problematic extreme: believing that nothing about the past is worth holding onto. I don't think that's true in medicine.

Training my generation at the dawn of the 80-hour workweek, some of our attendings thought we'd never live up to their standards. I knew their views, of course, because they voiced them publicly and fiercely. What seems crucially different about today's intergenerational tension is that it's become significantly harder to openly discuss our educational challenges. Indeed, that silencing is what drew me to this topic. I understand that physicians' beliefs about work are personal; whether medicine is a job or a calling has no "right" answer. What I don't fully understand is the fear I felt, while writing this essay, about

saying what I actually think. Why does believing that the sacrifices trainees and physicians make are worthwhile feel increasingly taboo?

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

This article was published on January 10, 2024, at NEJM.org.

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DOI: 10.1056/NEJMms2308226