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Perfectionism, Power, and Process: What We Must Address to Dismantle Mental Health Stigma in Medical Education

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Abstract

In this commentary, the authors draw on 2 personal accounts of mental illness published by Kirk J. Brower, MD, and Darrell G. Kirch, MD, in this issue to consider how and why mental health stigma is maintained in medical education. In particular, they explore how perfectionism, power differentials, and structural forces drive mental illness stigma in medical education. They argue that mental health stigma in medical education, while deeply embedded in the physician archetype and medical culture, is not inevitable and that dismantling it will require individual courage, interpersonal acceptance, and institutional action.

Editor's Note: This is an Invited Commentary on Brower KJ. Professional stigma of mental health issues: Physicians are both the cause and solution. Acad Med. 2021;96:635–640, and on Kirch DG. Physician mental health: My personal journey and professional plea. Acad Med. 2021;96:618–620.

In this issue of *Academic Medicine*, authors and leaders in medical education provide honest and open accountings of their experiences with mental illness over the course of medical training and practice.[1,2] Central to these experiences was the role of mental health stigma, a concept that has historically referred to a discrediting label that may be applied to an individual or group that is discrepant from the norm.[3]

Mental health stigma often relates to stereotypes about mental illness that influence how we view others and ourselves. Empirically linked with delayed treatment seeking, minimization of illness severity, and suicidality,[4] stigma can manifest at multiple levels. For example, interpersonal or social stigma exists through labeling and stereotyping, while self-stigma refers to negative biases that can be internalized and influence behavior. Meanwhile, structural or institutional stigma refers to how stigma becomes embedded in policies, practices, and society at large.[5]

As practicing physicians and researchers focusing on shame and stigma in medicine, we were moved, saddened, and not surprised by Dr. Brower's and Dr. Kirch's experiences.[1,2] We know firsthand the courage it takes to share experiences of mental illness and struggle,[6] and our research[7,8] points to the inherent risk of the shame and psychological distress that accompanies the perfectionistic nature of the culture of academic medicine.

In reflecting on the stories courageously shared by Dr. Brower and Dr. Kirch, we believe our attention must shift to a deeper understanding of how stigma is enacted and perpetuated in academic medicine. As Dr. Brower eloquently states, "if we cause and perpetuate stigma, then we control the solutions."[1] We agree and wonder: in a profession devoted to principles of acceptance, practices of empathy, and commitment to advancing health and well-being, why has mental health stigma become enculturated and how is its presence maintained?

In this commentary, we consider 3 mechanisms through which stigma is created and maintained in academic medicine: self-protection through perfectionism, maintenance of power differentials, and structural determinants embedded within health system design and regulatory processes.

A Culture of Perfection

In medicine, the high-stakes learning and practice environment and the prominent value placed on achievement drive unattainable personal expectations among physicians. Perfectionist standards are at once admirable and reckless for physicians: patients deserve perfection from us, but the realities of medical practice—derived from our inherent imperfection as humans—highlight that perfection as an unattainable goal. Yet despite our ability to think rationally and our intimate familiarity with the limitations of the human body, we often fail to accept this reality and strive for perfection anyway.

Perfectionist tendencies are built into the culture of medicine. Medical learners are products of an educational system that relies heavily on high-stakes, objective performance measures such as grades and standardized examination scores. Accordingly, many learners set and evaluate themselves against lofty standards that, while achievable in premedical and undergraduate medical education, become impossible to attain after clinical training begins and objective measures fade.[8] Meanwhile, learners' sense of worthiness can become so tightly linked to performance that high achievement drives self-worth, and self-worth becomes dependent on continued high achievement.[8,9] Thus, perfectionism may either bolster or undermine self-worth depending on the degree to which it is achieved.

As we invest increasing amounts of time, energy, and self-worth to the pursuit of perfection, we have less

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to devote to other aspects of our identities, which may begin to fade. When faced with inevitable struggle or adversity, we may self-protect by further compartmentalizing our identities, blunting our emotional responses, and leaning on high academic achievement. Through attempts to "armor up," thicken our skin, and keep our emotion from bubbling to the surface, we idealize a fantasy version of ourselves that is impossible to achieve, and we implicitly stigmatize what is an otherwise normal human response to struggle and failure.[2,7] Accordingly, we bargain with a variable we can control: our own health and well-being. Between the blurred lines of altruism to patients and service to our perfectionism, we work longer, study harder, and sleep less; we disregard life priorities; we sacrifice leisure; and we neglect relationships. The more of ourselves we invest in the profession, the more reliant our self-worth and identity become on what it gives back and how we are treated within its institutions. When faced with mental health struggles, we may be forced to reckon with an imperfect and vulnerable self that neither we—nor our learning and practice environments—are prepared or willing to accept.

The Role of Power and Hierarchy

Power—essential to the social production of stigma[10]—is unequally distributed in medical learning environments. Hierarchies of power in medical education manifest through multiple dimensions, including knowledge, vulnerability, risk taking, access to resources, and influence. The role of power in the production and maintenance of stigma has been relatively underexplored in medical education, but examples do exist. In one study, health professionals who implicitly labeled and avoided patients with mental illness caused moral distress, imprinted social stigma, and prompted avoidance behaviors in onlooking medical students, who learned to distance themselves from such patients in the future.[11] Power differentials and hierarchy also appear to fuel *self*-stigma, particularly in learners at the low end of the hierarchy. For example, in a study of female medical students, researchers found self-stigma and shame related to harassment levied from male attendings and lack of outlets for reporting it.[12]

If a medical student learns—through implicit modeling or direct mistreatment—to stigmatize people with mental illness, how will they react to the development of their own mental illness? Further, more junior medical learners must endure the tension of possessing low levels of knowledge, skill, and influence; striving for high achievement; and facing the vulnerabilities that both incur. The fact that many clinical learning environments are psychologically unsafe further escalates this tension, and, over time, the chances of distress may increase, the likelihood of perceived failure may grow, and the desire to be vulnerable may fade.[13] Not only does this precarious state leave little room for revealing personal struggle and mental illness, but it also actively dissuades us from seeking help when we need it most.

Individuals at the top of the hierarchy are not spared the risk of self-stigma associated with power. Years of training have positioned us to diagnose the deficiencies and struggles of others, including both patients and trainees, without having to reveal our own. Sitting on the "high side" of the vulnerability gap confers power, safety, and comfort, all of which are relinquished when we reveal our own deficiencies and struggles. In so doing, we yield a part of our identity we have worked tirelessly to solidify—that of care*giver*—to make room for another whose presence we may be reluctant to accept: that of care *receiver.*

Structural Stigma

Structural forms of stigma, which refer to how policy, cultural norms, and regulatory rules maintain inequities for individuals with mental illness,[14,15] are baked into the system of medicine and medical education. Consider the example of treatment seeking or self-disclosure, around which fears exist at all points along the medical education continuum. Medical students fear unwanted intervention, documentation of mental illness in their formal record,[16] and negative impacts on selection for residency[17]; residents fear jeopardization of training status[18] and adverse effects on their careers[19]; and practicing physicians fear repercussions for medical licensure.[20] These fears may be well-founded, as evidence suggests that disclosure of a mental illness influences residency selection[21] and questions about physician mental illness by medical licensing bodies violate the Americans with Disabilities Act in 32 states.[22]

If medical trainees and physicians are able to overcome fears and stigma associated with treatment seeking, what support resources will they find? Inequitable funding, inconsistent access, and poor mental health infrastructure within medical education institutions are likely both to limit treatment options and to perpetuate the stigma that those seeking help are less deserving of high-quality care. This is a particularly troubling paradox for health care providers whose distress—particularly burnout and moral injury—may be driven, in part, by futile efforts to help mentally ill patients navigate the same structural stigma.

Finally, the culture of academic medicine further perpetuates structural stigma toward mental illness in health care professionals. Students enter the profession and encounter a culture in which perfectionism is rewarded, self-sacrifice is lauded (if not demanded), and mental illness is perceived as weakness. As students navigate the processes, policies, and dynamics that propagate this culture, stigma may become internalized, reinforced, and projected. Further, as students eventually ascend the hierarchy, the growing influence and weight of this internalized stigma, which the now former students are able to direct toward those lower on the hierarchy, may set up a cycle that all but ensures this culture will perpetuate.

Dismantling Stigma and Honoring Our Shared Vulnerability

While deeply engrained in both the physician archetype and the culture of medicine, mental illness stigma in medical education is not an inevitability. Confronting and eradicating this stigma will require engaged, courageous efforts on the part of individuals and leaders in medical education. The contributions from Dr. Brower[1] and Dr. Kirch[2] are 2 such efforts.

As part of this work, we must confront the degree to which mental illness stigma has permeated the processes of personal and professional identity formation in medicine. We might start by gaining a clear understanding of the presence, nature, and manifestations of stigma

across a career in medicine, starting before medical school matriculation and continuing into professional practice. Then, we need to deconstruct the forces that allow this stigma to persist, replacing intolerance with acceptance; perfectionism with vulnerability; judgment with grace; and hiding with sharing.

Those who care for and/or work alongside physicians and trainees with mental illness should recognize the potential for profound associated self-stigma and shame when the power of diagnosis is surrendered and the vulnerability gap is reversed. We should explore the notion of "stigma-sensitive care," perhaps embedding it within the growing movement toward trauma-informed care and trauma-informed medical education.[23] Within a stigma-sensitive approach, we would explicitly honor the vulnerability required for disclosure and would help physician–patients navigate skewed power dynamics, overcome internalized mental health stigma, and manage fears associated with wider disclosure and continued treatment.

Indeed, if maintaining power and hierarchy leads us to suffer in the shadows, we must embrace the emancipatory power of disclosure. Simply talking about experiences of mental health struggle with others can be powerfully destigmatizing: 97.4% of residents who attended a panel of faculty sharing personal experiences of mental health struggle felt that such sharing destigmatizes mental health issues during training.[24] If we are going to break our culture of silence, however, we must dismantle structural forms of stigma and build systems where help seeking is celebrated and facilitated instead of punished.[25] Thus, we call on leaders in academic medicine to examine their ethical duty to fully support the vulnerable population working within their institutions' walls, to identify overt and insidious structural forces that undermine this support, and to ensure that the critical perspectives of those suffering from mental illness are included in building a better structure and co-designing a more equitable system of care.

Yes, we cause and perpetuate professional stigma in medicine, and yes, we *can* control the solution,[1] but only with individual courage and self-compassion; interpersonal love and acceptance; and institutional commitment and action.

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