The Dissertation Committee for Stephanie Lynne Shively Certifies that this is the approved version of the following dissertation:

TRAUMATIZED THROUGH HEALING: THE STIGMATIZATION AND MISRECOGNITION OF TRAUMA AMONG AMERICAN PHYSICIANS

Committee:

Dr. Arlene MacDonald, Ph.D., Chair

Dr. Howard Brody, MD, Ph.D.

Dr. Jerome Crowder, Ph.D.

Dr. Kristen M. Peek, Ph.D.

Dr. Michael Fuller, M.D.

TRAUMATIZED THROUGH HEALING: THE STIGMATIZATION AND MISRECOGNITION OF TRAUMA AMONG AMERICAN PHYSICIANS

by

Stephanie Lynne Shively, B.A.

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Dedication

This is for those who dedicate their lives each day to helping others, yet struggle in silence, not sure of how to help themselves. You are not alone.

This is also for the girl who doubted herself. You thought the fire was consuming you, but it was only burning away that which you are not.

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At times I was uncertain whether I would ever actually finish this dissertation. The process was not quick or smooth and there were numerous obstacles and roadblocks along the path to completion. This process has taught me that there is wisdom in knowing when to let something go and power in deciding when to commit and work harder to achieve a sought-after goal. The trick comes in recognizing when it is time to do which. Like many treasured accomplishments in life, this dissertation, and the degree it will secure, was hard-fought, frequently painful (sometimes excruciatingly so), and ultimately immensely rewarding. Also like most things of value in this life, it would not have been possible without the help and support of several important people. I would like to thank a few of those individuals whose support made this work both possible, and survivable.

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role of power in any given situation. Jason Glenn is also, without question, the best *teacher* I have ever had the privilege to study under. I will forever be grateful to him for modeling those skills to me and for training me how to think in a more authentic and earnest way.

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And finally, I would like to thank my beloved partner in this life, Michael Angelo Russo. As evidenced by the following 200 pages, I usually have too many words; brevity is not my strong suit. It is therefore significant that there are no words that adequately express how grateful I am to love and to be loved by him. He held my hand, encouraged me, supported me, and moved heaven and hell to provide me with uninterrupted, protected time for writing. Not only is he one of the most brilliant people I have ever met, he is also the most gracious and loving partner and friend that I could ever ask for. Every day he encourages me to be a stronger and better person. I would not have believed in myself enough to finish this without him, his love, and his endless support. You are the partner, lover, and friend with whom I choose to travel through this life. Thank you for everything.

Traumatized Through Healing: The Stigmatization and Misrecognition of Trauma Among American Physicians

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Language shapes the way that we look at an issue and the words we choose to define a problem dictate how we address it. This dissertation focuses on the effects of trauma on physicians and analyzes how the professional identity of physicians fails to provide adequate solutions for coping with the damaging effects of trauma. It focuses on the popular concern over "physician burnout" and the implications of choosing to use that term to the exclusion of others. Over the last five years physician wellbeing has received a great deal of public attention. In 2016 the American Foundation for Suicide Prevention reported that approximately 300-400 physicians commit suicide every year. However, while suicide is frequently associated with mental health conditions such as depression, anxiety, and PTSD, most of the recent literature dealing with the issue has focused almost exclusively on "physician burnout". This dissertation suggests that defining the issue exclusively as "burnout" narrows the range of contributing factors which can be considered. Concerns about trauma are overlooked in favor of discussions about work hour restrictions, paperwork, and bureaucratic red tape. While these are important topics worth considering, choosing to use language to define the problem which directs the conversation away from other important topics, like trauma, is problematic. Moreover, the focus on "burnout"

places the responsibility upon individual suffering physicians and fails to hold institutions of power within the medical community accountable for their role in the situation. It also fails to acknowledge the role of the heroic myth of the doctor in preventing struggling physicians from seeking the help they need. This dissertation argues instead for the implementation of the broader categorization of *physician distress* in order to make space for conversations incorporating other forms of distress such as traumatization.

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List of Abbreviations

CF	Compassion Fatigue
DSM	Diagnostic and Statistical Manual of Mental Disorders
GSBS	Graduate School of Biomedical Science
IMH	Institute for the Medical Humanities
MI	Moral Injury
PTSD	Post Traumatic Stress Disorder
STS	Secondary Traumatic Stress
SVS	Secondary Victim Syndrome
UTMB	University of Texas Medical Branch
VT	Vicarious Traumatization

Chapter 1
Introduction: Identifying Distress and Revealing the Truth

> We expect the world of doctors. Out of our own need, we revere them; we imagine that their training and expertise and saintly dedication have purged them of all the uncertainty, trepidation, and disgust that we would feel in their position, seeing what they see and being asked to cure it. Blood and vomit and pus do not revolt them; senility and dementia have no terrors; it does not alarm them to plunge into the slippery tangle of internal organs, or to handle the infected and contagious. For them, the flesh and its diseases have been abstracted, rendered coolly diagrammatic and quickly subject to infallible diagnosis and effective treatment.[1]

The above lines were written by John Updike as part of his introduction to Samuel Shem's[2] seminal novel *The House of God.* It is a disturbing, gritty, and at times gruesomely humorous account of a first-year medical intern's traumatic experience discovering the brutality of medicine and what it means to be a doctor. Published in 1978, *The House of God* not only demonstrates the traumatic nature of medicine, it also openly addresses the issue of physician distress. In fact, *The House of God* received a tremendous amount of attention when it was published, for revealing many of the institutional issues that were contributing to the pervasive, but not frequently discussed problem of physician suffering.[3] *The House of God* demonstrates that medicine can be traumatizing. It also demonstrates that, despite society's desire to believe in the heroic myth of the doctor that Updike's quote describes, our collective wish to turn doctors into unshakeable heroes who can be confidently relied upon to save their patients in times of

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[1] John Updike, Introduction, *The House of God*, by Samuel Shem (New York, NY: Berkley Books, 2010), xv.

[2] Samuel Shem is the pen name for Dr. Stephen Bergman.

[3] Howard Markel, "A Book Doctors Can't Close," *New York Times* Aug. 17, 2009, https://www.nytimes.com/2009/08/18/health/18house.html.

crises, that doctors are in fact human. They are as fragile and susceptible to injury – both physical and moral – as any other human being is. They too are vulnerable to the trauma that is so prevalent in medicine.

The House of God also demonstrates that the problem of physician suffering is exacerbated by a few key characteristics of the culture of medicine. First, the structurally reinforced inability of doctors to name or openly discuss their struggles forces physicians to suffer silently and express their pain in more socially 'acceptable' ways. Second, strict adherence to rationalist principles and restrictive, unrealistic hero archetypes woven into the professional identity of physicians can lead to a caustic atmosphere in medicine that causes anything even obliquely related to mental illness (such as physician distress or traumatization) to be highly stigmatized. And finally, the ubiquitous nature and power of that stigma can instill deep fear and shame in already suffering physicians, not only forcing them to hide their struggles, but exacerbating their anguish in the process.

The Problem

More than forty years after *The House of God* was first published, physician distress is still a significant problem.[4] Recently it has become a popular topic of conversation, particularly within the medical discourse. More specifically, the topic of "physician burnout" has become a major focus, with a surge in interest over the last eight

[4] While this dissertation focuses specifically on the distress, traumatization, and burnout of physicians, it is vital to recognize that these are not issues unique to physicians. All of these issues also affect nurses, physician's assistants, nurse practitioners, and other medical professionals. The author's choice to focus narrowly on the plight of physicians was the result of the limited size and scope of this dissertation. The author wishes to underline, however, that these discussions need to be broadened to include many different groups of healthcare providers and encourages future research in that vein. The author also wishes to acknowledge that, for this reason, a valid argument could be made that instead of "physician traumatization" the term "healthcare provider traumatization" could be used in order to be more inclusive of non-physician providers suffering from traumatization.

years.[5] In 2015 the Medscape Physician Lifestyle Report identified a 6 percent increase in physicians reporting symptoms of burnout, from 40 percent to 46 percent, since their previous report in 2013.[6] This finding supported the earlier claims of Linzer et al. who reported in 2014 that physician burnout rates "range from 30-65 percent across medical specialties, with the highest rates experienced by those at the front lines of care."[7] In 2016 The American Foundation for Suicide Prevention received significant attention, especially within the medical community, when it reported that approximately 300 physicians commit suicide every year, and that suicide rates among American female physicians were 250-400 percent higher than American females in other professions.[8] The same year, the Surgeon General of the United States announced that physician burnout and suicide would be one of his major focuses for 2016.[9]

Since that time, numerous scholars have written about physician burnout. Many studies have been conducted to document its occurrence, and countless interventions have

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5 While physician distress has been written about for centuries and "burnout" specifically has been written about since the 1970s, the number of scholarly articles published on the topic of "physician burnout" has increased significantly since 2011. In 2011 and 2012 Tait Shanafelt and his colleagues published several significant articles suggesting a link between physician suicide and physician burnout. Since that time, not only has there been an increase in the number of articles published referencing physician burnout, but most of them have also cited Shanafelt's influential publications, indicating that particular work marked a shift in the discourse.

6 Carol Peckham, "Physician Burnout: It Just Keeps Getting Worse," *Medscape*, January 26, 2015, accessed October 4, 2016, http://www.medscape.com/viewarticle/838437.

7 Linzer et al, "10 Bold Steps to Prevent Burnout in General Internal Medicine," *Journal of General Internal Medicine* 29, no. 1 (2013): 18, https://doi.org/10.1007/s11606-013-2597-8.

8 "Physician and Medical Student Depression and Suicide Prevention," American Foundation for Suicide Prevention, accessed September 5, 2016, https://afsp.org/our-work/education/physician-medical-student-depression-suicide-prevention/.

9 Shannon Firth, "Surgeon General Concerned about Physician Burnout," *Medpage Today*, April 10, 2016, accessed July 23, 2016, http://www.medpagetoday.com/publichealthpolicy/generalprofessionalissues/57280.

been proposed and instituted.[10] In fact, it could be suggested that the discourse has reached something of a fevered pitch in recent years. A search for the phrase "physician burnout" in the Google Scholar search engine in February of 2019 returned 11,600 articles in total, with more than 5,600 of those articles published since 2013 and more than 4,100 of them published since 2016 alone. What is perhaps most sobering about those numbers is that they only include articles and studies published in scholarly and academic journals, and do not include any of the countless popular articles that have been written on the subject. This discussion has recently spilled out beyond the ivory halls of academia. Physician burnout has become a national topic of debate, with articles and reports appearing on CNN, NBC, and countless news stations, as well as in *The New York Times*, *TIME Magazine,* and even in *The Wall Street Journal*.[11] In other words, physician burnout has become a hugely popular topic.

More and more people are discussing physician burnout and, according to scholars like David Rothenberger, more and more doctors are identifying as being burned out.[12] Rothenberger, for instance, published an article in 2017 claiming that the

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[10] Balch and Shanafelt (2010); Bianchi et al (2016); Gunderson (2001); Rothenberger (2017); Schaufeli, Leiter, and Maslach (2009); Shanafelt, Drybye and West (2017); Shanafelt et al (2009) (2015)

[11] New York Times – https://www.nytimes.com/2017/11/13/well/family/taking-care-of-the-physician.html; NBC – www.nbcnews.com/better/health/sick-doc-cases-doctorburnouts-are-rise-it-s-serious-ncna815936; CNN – https://www.cnn.com/2012/08/23/health/time-doctor-burnout/index.html; TIME – https://time.com/3004782/burnout-in -the-hospital-whydoctors-are-set-up-for-stress/; Wall Street Journal – https://www.wsj.com/articles/hospitals-address-widespread-doctor-burnout-1528542121.

[12] David A. Rothenberger, "Physician Burnout and Well-Being: A Systematic Review and Framework for Action," *Diseases of the Colon and* Rectum 60, no. 6 (2017): 570, https://doi.org/10.1097/DCR.0000000000000844; T. D. Shanafelt et al, "Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014," *Mayo Clinic Proceedings* 90 (2015) 1600-1613, https://doi.org/10.1016/j.mayocp.2015.08.023.

prevalence of burnout among practicing physicians had exceeded 50 percent[13] and characterized the situation as a "crisis" of "epidemic proportions."[14] This sort of extreme rhetoric, coupled with shocking statistics and concerning predictions has not only caught the public's attentions, but it has instigated action. Many medical institutions have initiated burnout prevention programs, and educational courses to offer formal assistance to employees and students.[15] There have also been support movements from within the physician community in the form of blogs and subreddit threads, as well as nontraditional campaigns to completely reimagine medical practice, such as Pamela Wible's "Ideal Medical Clinic" movement.[16] All are aimed at reducing the crisis of physician burnout

This apparent increase in the incidence of burnout and clear increase in the issue's visibility have led some scholars to wonder what has happened within medicine to account for this significant increase in burnout cases. Some have argued that the apparent rise is the result of shifts in technology and the widespread adoption of electronic health

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[13] It is important to note that Rothenberger bases this claim primarily on a study published by Shanafelt et al (2015) which reports an increase in reported burnout rates (from 45.5% in 2011 to 54.4% in 2014) among their study respondents between 2011 and 2014. While the statistics suggest an increase in the rate of burnout among physicians, this author believes that it is an unfounded leap to interpret this as evidence that more than half of all physicians are burned out. Rothenberger is not the only one to make that leap however. Shanafelt, Dyrbye, and West (2017) make a similar claim, based on the same study. This author argues that there is insufficient evidence to make such a claim.

[14] Rothenberger, "Physician Burnout and Well-Being," 567.

[15] West, Dyrbye, Erwin, and Shanafelt, "Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis," *The Lancet* 388, no. 10057 (2016) 2272-2281, https:///doi.org/10.1016/S0140-6736(16)31279-X; Maria Panagioti, Efharis Panagopoulou, and Peter Bower, "Controlled Interventions to Reduce Burnout in Physicians: A Systematic Review and Meta-analysis," *JAMA Internal Medicine* 177, no. 2 (2017): 195-205, https://doi.org/10.1001/jamainternmed.2016.7674.

[16] Pamela Wible, "Why doctors kill themselves," filmed 2015, TEDMED video, 13:48. https://www.tedmed.com/speakers/show?id=526394

records systems (EHRs).[17] Others have pointed to the deterioration of patient/physician relationships as a result of assembly line medicine.[18] Still others blame fallout from major shifts in the public identity of physicians as the result of national political policies that protect the corporate interests of pharmaceutical companies, health insurance companies, and major hospital systems, over those of patients.[19]

While this dissertation acknowledges the reality and seriousness of each of these issues and supports the contention that they likely contribute to the concerning issue of physician distress, it ultimately suggests these perspectives may be overlooking an important point. Most of these explanations favor bureaucratic causes of physician suffering, virtually ignoring the endemic stressors that are part of the very nature of medical care.[20] They also assume that the increase in incidence must be the result of a recent change. In this way, they fail to adequately recognize that the increase in reported

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[17] Abraham Verghese, "How Tech Can Turn Doctors Into Clerical Workers: The Threat that Electronic Health Records and Machine Learning Pose to Physicians' Clinical Judgement – And their Well-Being," in The Health Issue, *The New York Times* May 16, 2018, https://www.nytimes.com/interactive/2018/05/16/magazine/health-issue-what-we-lose-with-data-driven-medicine.html; N. Lance Downing, David W. Bates, and Christopher A. Longhurst, "Physician Burnout in the Electronic Health Record Era: Are We Ignoring the Real Cause?" *Annals of Internal Medicine* 169, no. 1 (2018) 50-51, https://doi.org/10.7326/M18-0139; Shanafelt, Dyrbye, and West, "Addressing Physician Burnout: The Way Forward," *JAMA* 317, no. 9 (2017) 901-902, https://doi.org/10.1001/jama.2017.0076.

[18] John J. Squiers et al., "Physician Burnout: Are We Treating the Symptoms Instead of the Disease?" *The Annals of Thoracic Surgery* 104, no. 4 (2017) 1117-1122, https://doi.org/10.1016/j.athoracsur.2017.08.009; Ronald Epstein and Richard L. Street, "The Values and Value of Patient-Centered Care," *Annals of Family Medicine* 9, no. 2 (2011) 100-103, https://doi.org/10.1370/afm.1239.

[19] Liselotte Dyrbye and Tait Shanafelt, "Physician Burnout: A Potential Threat to Successful Health Care Reform," JAMA 305, no. 19 (2011): 2009-2010, https://doi.org/10.1001/jama.2011.652.

[20] This is significant because these kinds of causes require surface changes, and not major deep-structure changes within the culture of medicine or shifts in perspective regarding the identity of the physician and the traumatic nature of medical practice. These are bigger issues and not necessarily as easily addressed or blamed as time spent with patients or time spent entering data into an EMR.

incidence of physician burnout could be the result of increased public attention and/or decreased hesitation on the part of doctors to acknowledge their struggles, as a result of the increased visibility and discussion of this previously taboo subject. In other words, they fail to recognize the possibility that perhaps nothing has changed at all, except for the discourse. It is entirely possible that doctors have been struggling with burnout (and other forms of physician distress) all along and may only now be coming forward and speaking about their suffering because the public dialogue has changed, letting them know they are not alone and giving them a safe forum in which to speak out. These other studies also fail to ask important questions about why "burnout" has garnered such public attention, especially when physician distress has been studied and written about for decades but has been virtually ignored in comparison to the widespread attention received by burnout in recent ears. [21]

Applying a Rhetorical Lens

In this dissertation I argue that to truly understand what is going on one must take a step back and view the entire situation from a different perspective. I suggest taking a note from the *studia humanitatis*[22] and pausing to consider the dialogue surrounding the issue of burnout from the standpoint of rhetoric. Renaissance humanists argued that

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21 For instance, Tait Shanafelt alone has written more than two dozen articles dealing with physician wellbeing and/or burnout since 2015, and was named Chief Wellness Officer and Director of the Stanford Medicine WellMD Center at Stanford University's School of Medicine, as a result of his influential work.

22 Robert Proctor defines the *studia humanitatis* as a "cultural revolution" which initiated in fifteenth century Italy and which called for "the imitation of classical, as opposed to medieval, Latin, and for the study of Roman, and to a lesser extent Greek, literature, history, and moral philosophy as guides to individual and collective behavior." For a more extensive discussion of the humanities and the wisdom of the *studia* humanitatis, please see: Robert E. Proctor, *Defining the Humanities: How Rediscovering a Tradition Can Improve Our Schools: With A Curriculum for Today's Students*, 2nd Edition (Bloomington, IN: Indiana University Press, 1998).

rhetoric could be used as an important tool for inspiring virtuous action, and that it could also provide solutions for alleviating human suffering.[23] While there is still a great deal of uncertainty regarding the discourse surrounding physician burnout, what *is* clear from looking at the issue closely is that physicians are suffering and that virtuous action is required to assuage that anguish. This dissertation argues that by viewing the current discourse about burnout through the lens of rhetorical analysis, it becomes clear that there has been insufficient attention paid to issues of language and silence, as they relate to physician suffering, and more specifically to physician traumatization.

What is missing is a discussion about which forms of suffering are given names and which are not, as well as how those decisions are made. Additionally, there are inconsistencies in the language used around burnout that indicate a more complex problem than simple emotional exhaustion. In other words, there is more to the issue than is currently being discussed. I argue that by paying attention to the words that are being used to describe physician distress – by considering their meaning, connotation, purpose, and implied intent – it becomes evident that the current "burnout" discourse is not only failing to address the full scope of physician distress, but may actually be making it more difficult to initiate meaningful change, and in some instances may even be exacerbating that distress.

Humans use language to define our experiences and our existence; we are thought to be unique within the animal kingdom in that respect.[24] Part of the reason this ability is so unique is that language is symbolic. That means we use words to represent things,

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[23] Proctor, *Defining the Humanities,* 149.

[24] Sonja K. Foss, *Rhetorical Criticism: Explorations and Practice*, 5th ed. (Long Grove, IL: Waveland Press, 2018) 4.

thoughts, feelings, etc. We invest words with meaning in various ways (metaphors, stereotypes, archetypes) and that meaning in turn dictates not only how we use those words, but also our ability and inability to discuss, understand, and address the various events and issues in our lives.[25] Our ability to solve problems, for instance, is heavily influenced by the words we have and the words we use to talk about those problems, to describe them accurately, and to understand them. With regard to the topic at hand, this means that any efforts to help alleviate the suffering of physicians must begin by ensuring the correct words are being used to discuss the situation. It also means that those struggling doctors need to have access to the language necessary for them to accurately identify what they are experiencing and seek appropriate help.[26] The late Fred Rogers, beloved children's television host of *Mister Roger's Neighborhood,* explained the importance of being able to speak about emotional struggles when he said: "Anything that's human is mentionable, and anything that's mentionable can be more manageable. When we can talk about our feelings, they become less overwhelming, less upsetting, and less scary. The people we trust with that important talk can help us know that we're not alone."[27] Conversely, when we lack the language to talk about our problems or something in our environment renders them unmentionable, then our feelings become more overwhelming and our situation more stressful and frightening.

Ultimately, I suggest that this is an important part of the current crisis of physician suffering that is not being addressed by the current discourse. In fact, I argue

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[25] Foss, *Rhetorical Criticism*, 5 and 287.

[26] Much as an accurate diagnosis is helpful in determining appropriate treatment within the practice of medicine.

[27] Fred Rogers, *You Are Special: Neighborly Wisdom from Mister Rogers* (Philadelphia, PA: Running Press Book Publishers, 2002), 116.

that in some ways this suffering is being exacerbated by the contemporary dialogues, which focus the conversation on a narrow type of distress. I argue that there are other important forms of physician distress, specifically physician traumatization, that are contributing to the current crisis of physician suffering but are not being named. As a result, they are not adequately acknowledged, discussed, or addressed, and physicians who are suffering from such forms of distress do not have the language necessary to seek help for their problems. I suggest that this rhetorical insufficiency is at least in part the result of other terms such as "burnout" being inaccurately used in their place.

Misuse of "Burnout"

Multiple scholars have pointed out that there is problematic ambiguity and lack of clear consensus regarding the definition of "burnout."[28] More specifically, while there is general agreement about the three hallmark symptoms of physician burnout (emotional exhaustion, depersonalization, and low sense of personal accomplishment), there is less clarity regarding the boundaries between burnout and other related conditions like depression and substance abuse.[29] In fact, I argue that the term "burnout" has been used in a progressively more broad and inclusive way over the past decade and that it is now being employed to refer to more than simply the three symptoms listed above.

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[28] Renzo Bianchi et al, "Burnout and depression: Label-related stigma, help seeking, and syndrome overlap," *Psychiatry Research* 245 (2016): 91-98, https://doi.org/10.1016/j.psychres.2016.08.025; Wolfgang P. Kaschka, Dieter Korczak, and Karl Broich, "Burnout: a Fashionable Diagnosis," *Deutsches Ärzteblatt International* 108, no. 46 (2011) 781-787, https://doi.org/10.3238/arztebl.2011.0781; Jésus Montero-Marín, et al, "A new definition of burnout syndrome based on Farber's proposal," *Journal of Occupational Medicine and Toxicology* 4 (2009) 31-47, https://doi.org/10.1186/1745-6673-4-31.

[29] Ibid; also Tait Shanafelt et al, "Special Report: Suicidal Ideation Among American Surgeons," *Archives of Surgery* 146, no. 1 (2011) 54-62, https://doi.org/10.1001/archsurg.2010.292.

This author suggests that a number of different forms of physician distress, that were previously studied as distinct conditions, are now rhetorically lumped together with burnout, as "related conditions" and that as a result the boundaries between them have subsequently blurred.[30] While the exact relationship between related conditions can be difficult and confusing to pinpoint, it is important to remember that correlation does not equal causation. Evidence that conditions like depression and burnout are frequently linked,[31] or that burnout has been demonstrated to correlate with a higher frequency of suicidal ideation[32] or substance abuse, does not mean that physician depression or

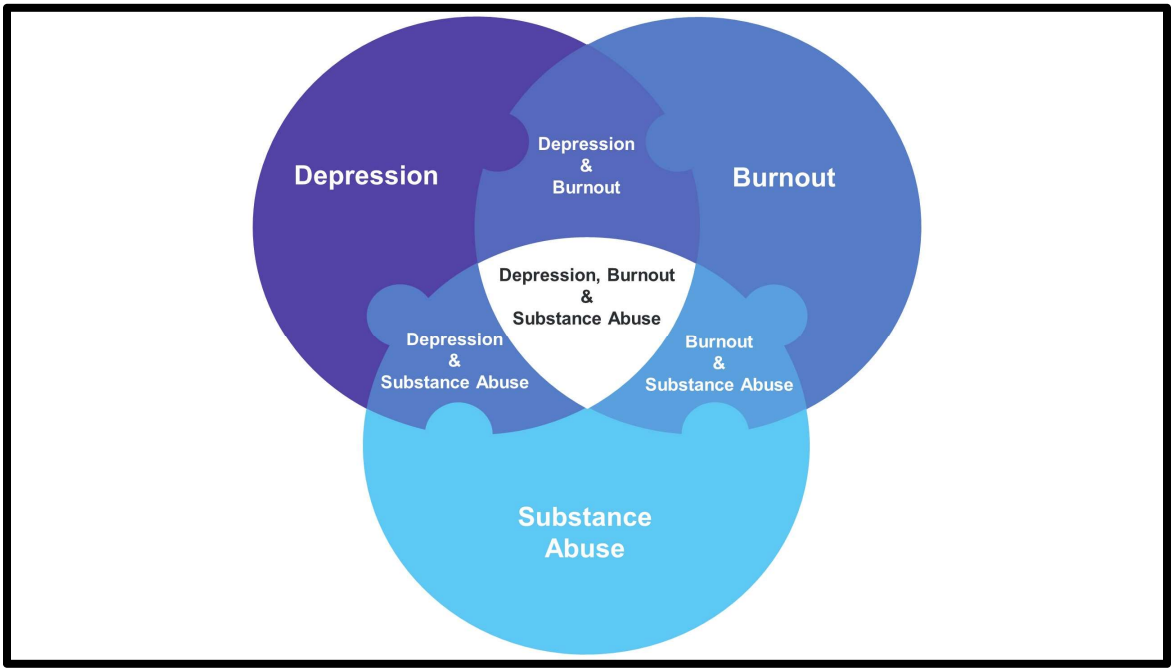

Figure 1. Potential Overlap of 3 Different Types of Physician Distress[33]

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[30] Bianchi, Schonfeld, and Laurent (2015); Bianchi et al (2016); Shanafelt et al (2011, "Special Report").

[31] Bianchi et al, 2016.

[32] Shanafelt et al., "Special Report," 54-62.

[33] This example is limited to demonstrating the potential overlap of depression, burnout, and substance abuse as the result of difficulty accurately visually representing all of the potential combinations of more than 3 conditions. It is important to recognize, however, that more than these three conditions can occur concomitantly. For instance, it is possible for a physician to

substance abuse necessarily indicate the presence of burnout. Nor does it mean that they should be assumed to be indicators of burnout.

As Figure 1 demonstrates, different forms of physician distress can occur independently or concomitantly in various combinations. For instance, in some physicians depression may develop entirely on its own, completely unrelated to burnout, substance abuse, or even to work. In others, it may develop as a result of prolonged burnout. This example shows that symptoms of one form of distress does not necessarily guarantee the presence of another. While depression, substance abuse, and burnout might frequently co-occur, they also can and do also occur independently. It is therefore logically inaccurate to presume that symptoms of one condition (such as substance abuse or suicidal ideation) in physicians are indicators of burnout.

While I do not discount any of the broad system changes mentioned above that have taken place recently within the culture of medicine, or refute the fact that those changes may have contributed to an increase in physician burnout, I suggest that there is insufficient evidence to draw definitive conclusions about the statistics regarding burnout. The high number of physicians reporting (at least one symptom of) burnout in recent studies[34] may be the result of an increase in the incidence of burnout, as is

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suffer from depression, burnout, traumatization, substance abuse, and suicidal ideation all at the same time.

[34] Shanafelt et al, "Changes in Burnout and Satisfaction With Work-Life Balance in Physicians and the General US Working Population Between 2011 and 2014," *Mayo Clinic Proceedings* 90, no. 12 (2015) 1600-1613, https://doi.org/10.1016/j.mayocp.2015.08.023. In this landmark study, the authors considered a response indicative of burnout if the physician reported at least one qualifying symptom ("a high score on either the depersonalization and/or emotional exhaustion subscale of the MBI"). As a point of reference, the DSM-5 stipulates that a patient should exhibit at least 5 of the qualifying symptoms to meet part of the diagnostic criteria for depression, while a patient must exhibit 1 symptom from Criterion B, 1 symptom from Criterion C, and 2 symptoms of Criterion D (and also meet Criterion A) in order to qualify for a diagnosis of PTSD. Reporting 1 symptom is an extremely low inclusion criteria for a designation of

frequently suggested.[35] However, it may also be the result of other factors, such as an increase in attention as mentioned previously.[36] Additionally, the large and increasing numbers could also be artificially inflated. The loose definition of the burnout condition with its fuzzy conceptual boundaries, could be resulting in multiple forms of physician distress being inaccurately labeled as a single issue. While there may be overlap and/or linkage between different types of distress, that does not mean they can all be spoken of as "burnout." This dissertation posits that the term "burnout" is being inappropriately applied as a rhetorical catch-all term to describe different, distinct, yet interconnected forms of physician distress, which may be related to, but are not the same as, physician burnout. Figure 2 depicts the popular rhetorical perception of burnout, as a catch-all category that includes many different forms of distress.

While it may be reasonable and prudent to consider all these related issues together, especially in relation to their influence on physician well-being, it is inaccurate and dangerous to refer to them all as "physician burnout" because it limits the scope of the problem that can be addressed. Physicians are not *only* experiencing burnout; they are suffering from other forms of distress as well. For some, burnout may develop into full-blown clinical depression. Others may struggle with traumatization after committing a medical error, making them more susceptible to developing burnout. Still others may

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"burnout," and leads this author to consider the findings to be ambiguous at best, since the symptom can be evidence of other, potentially unrelated conditions as well.

[35] Shanafelt et al, "Changes," 1612; Rothenberger, "Physician Burnout," 567.

[36] This refers to the process of "mutual recognition" currently being witnessed in the #metoo movement, which "makes visible and helps overcome" injustices experienced by individuals who have suffered in silence. Debra Jackson writes about this process by which groups coming forward allow others suffering in the same way to emerge "in the context of a polyphonic symphony of victims claiming their status." Debra Jackson, "'Me Too': Epistemic Injustice and the Struggle for Recognition," *Feminist Philosophy Quarterly* 4, no. 4 (2018): 1-19, https://doi.org/10.5206/fpq/2018.4.6231.

struggle with both burnout and moral injury as a result of different structural and procedural problems in their work environment. Furthermore, different forms of distress with different causes require different solutions. A clinically depressed physician may be best aided by antidepressants, while an addicted physician might be more likely

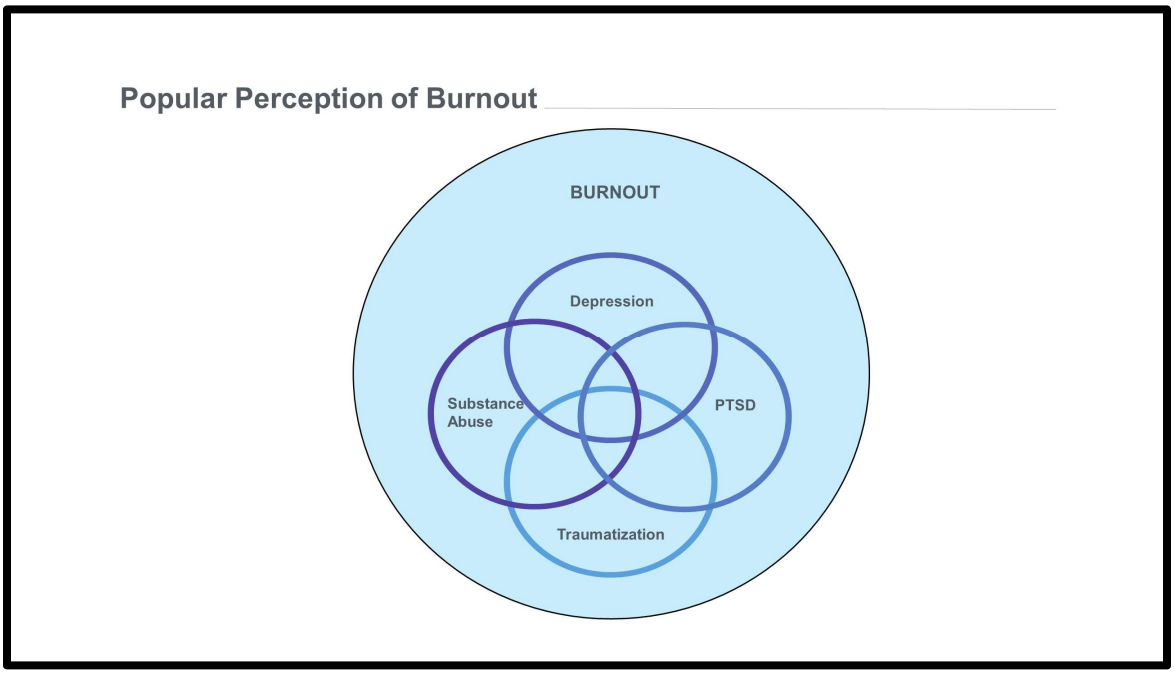

Figure 2. Popular Perception of Burnout Represented in Current Discourse

to benefit from a rehabilitation program. A burned-out physician might profit from mindfulness practices, focus on work/life balance, and goal integration, while another, who is struggling with moral injury might be better helped by a combination of narrative processing and group therapy. These are not one-size-fits-all problems. However, as long as the public discourse remains focused on burnout, solutions aimed at addressing burnout will continue to be most widely promoted. That is why the popular rhetoric needs to expand to incorporate other types of distress.

This is also not simply a theoretical problem. Actual changes and interventions are required, and in order to make them happen the discussion must expand to address all

the different factors contributing to the problem of physician distress. It is helpful to highlight the negative side effects of EHRs and their relation to physician burnout and to suggest that institutional changes need to occur to mitigate the stress they put on practicing doctors.[37] It would be more helpful, however, to also talk about how a focus on blame in the culture of medicine, or a hero archetype in the idealized role of the physician, exacerbates traumatization and distress in doctors who make medical errors.[38] All of the different forms of physician distress should be considered together as distinct yet related issues resulting in physician suffering, and then separated further into types of distress, such as physician burnout and physician traumatization (which will be defined and discussed in detail in Chapter 3). This will not only allow more broad, inclusive, and nuanced consideration of the crisis of physician suffering, but will also enable changes and interventions at the institutional level which target more of the causes and contributing factors of that distress, rather than limiting those efforts to causes related to burnout.

A Call for Change

This is a dangerous situation and the lack of clarity in relation to physician suffering is a serious enough problem that a change must be made in the discourse regarding physician distress. This dissertation addresses that problem by recommending two major rhetorical changes. The first recommended change addresses the fact that the

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[37] Downing, Bates, and Longhurst, "Physician Burnout in the Electronic Health Record Era," 50-51; Shanafelt, Dyrbye, and West, "Addressing Physician Burnout," 901-902.

[38] Jerome R. Hoffman and Hemal K. Kanzaria, "Intolerance of error and culture of blame drive medical excess," *BMJ* 349 (October 18, 2014) g5702, https://doi.org/10.1136/bmj.g5702.

term "burnout," which is not synonymous with physician distress, should not be used as though it is. Burnout is a specific type of physician distress, and though its definition has gradually changed, and its usage broadened over the years, it should be clearly and specifically defined and then consistently used. Kaschka, Korczak, and Broich suggest that one of the reasons for the lack of consensus regarding the definition of burnout is the fact that it is not a formal mental health diagnosis in either the DSM or the ICD (International Classification of Diseases).[39] Bianchi et al agree and go one step further to suggest that burnout and depression have so much conceptual and symptom overlap that burnout could (and perhaps should) be considered a subtype of depression.[40] While this is a solid argument, it is also important to recognized that the fact that burnout is *not* a formal mental health diagnosis may also make it a more appealing and less stigmatizing label (a point which will be discussed in more depth in Chapter 5). In fact, Bianchi et al suggest that burnout's lower level of perceived stigma may contribute to the term's more popular usage.[41]

Regardless of whether it becomes a formal medical diagnosis or not, however, "burnout" should no longer be used as a broad, umbrella-term, referring to multiple different types of distress. There is already an extant term that sufficiently serves that

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[39] Kaschka, Korczak, and Broich, "Burnout," 781.

[40] Bianchi, Schonfeld, and Laurent, "Burnout-depression overlap: a review," *Clinical Psychology Review* 36 (2015) 28–41, https://doi.org/10.1016/j.cpr.2015.01.004; Renzo Bianchi, Irvin S. Schonfeld, and Eric Laurent, "Is it time to consider the 'burnout syndrome' a distinct illness?" *Frontiers in Public Health* 3 (2015) 158, https://doi.org/10.3389/fpubh.2015.00158; R. Bianchi, I. S. Schonfeld, E. Laurent, "Is burnout separable from depression in cluster analysis? A longitudinal study," *Social Psychiatry & Psychiatric Epidemiology* 50 (2015) 1005–1011. https://doi.org/10.1007/s00127-014-0996-8; Bianchi et al, "Burnout and depression," 96.

[41] Bianchi et al, "Burnout and depression," 96.

function, which this dissertation has already been employing: "physician distress".[42] In an article published in 2011, Dyrbye and Shanafelt[43] identify physician distress as a major problem among medical students in the U.S., and specify that it "may manifest in a variety of ways, including burnout, stress, depression, anxiety, poor mental or physical quality of life, or fatigue."[44] This conceptualization of "distress" as a higher classificatory term is broad and inclusive enough to cover all of the various manifestations that have been discussed above, while simultaneously signaling through its lack of specificity that individual forms of distress exist within its category. In other words, it indicates a need to look closer in order to fully understand what is going on. Dyrbye and Shanafelt go on to explain that these various forms of distress "often do not occur in isolation," and that distressed individuals "frequently suffer multiple forms simultaneously, making distress a multifaceted and individualized experience."[45] This emphasizes the fact that different types of distress can be distinct, yet related, and can interact in different combinations, depending on individual physicians' circumstances.

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[42] Colin P. West and Tait D. Shanafelt, "Physician Well-being and Professionalism," *Minnesota Medicine* 90, no. 8 (2007) 44-46. ; Liselotte N. Dyrbye and Tait Shanafelt "Commentary: Medical Student Distress: A Call to Action" *Academic Medicine* 86, no.7 (2011) 801, https://doi.org/10.1097/ACM.0b013e31821da481; Dyrbye et al, "Patterns of distress if US medical students," *Medical Teacher 33* (2011) 834-839, https://doi.org/10.3109/0142159X.2010.531158.

[43] It is important to point out that, while Shanafelt co-published a number of articles focusing more broadly on physician distress earlier in his career (2011 and prior), many of his articles published after 2011 focus more and more exclusively on physician burnout. I mention this because Tait Shanafelt has been a dominant and influential voice in the physician burnout discourse, and I do not believe it is unfounded to suggest that his rhetoric (and decision to shift from speaking about "distress" to speaking about "burnout") has heavily influenced the direction of the national discourse on physician burnout.

[44] Dyrbye and Shanafelt, "Commentary," 801.

[45] ibid.

This is an important part of the equation that is lacking in the current discourse due to the narrow focus on burnout. In fact, *if* the recent literature referring to the crisis of "physician burnout" instead employed the previous rhetoric and referred to the crisis "physician distress", it would not only be more accurate, but it would point to the need for more nuanced research into the different types of physician distress. It would also illustrate that physician burnout is only one type, as is physician depression, physician suicide, physician substance abuse, and physician traumatization, as represented in Figure 3. These forms of distress can be and often are related, but it is important to remember that while they can occur concomitantly, they can also arise independently and therefore should not be conflated.

The first major rhetorical changes that this dissertation recommends, therefore, is that the current popular discourse regarding physician burnout be transformed into a discussion regarding physician distress. Once there is recognition that the current attention over physician burnout should be redirected to focus more broadly on physician distress, it is also necessary to specifically recognize and publicly discuss

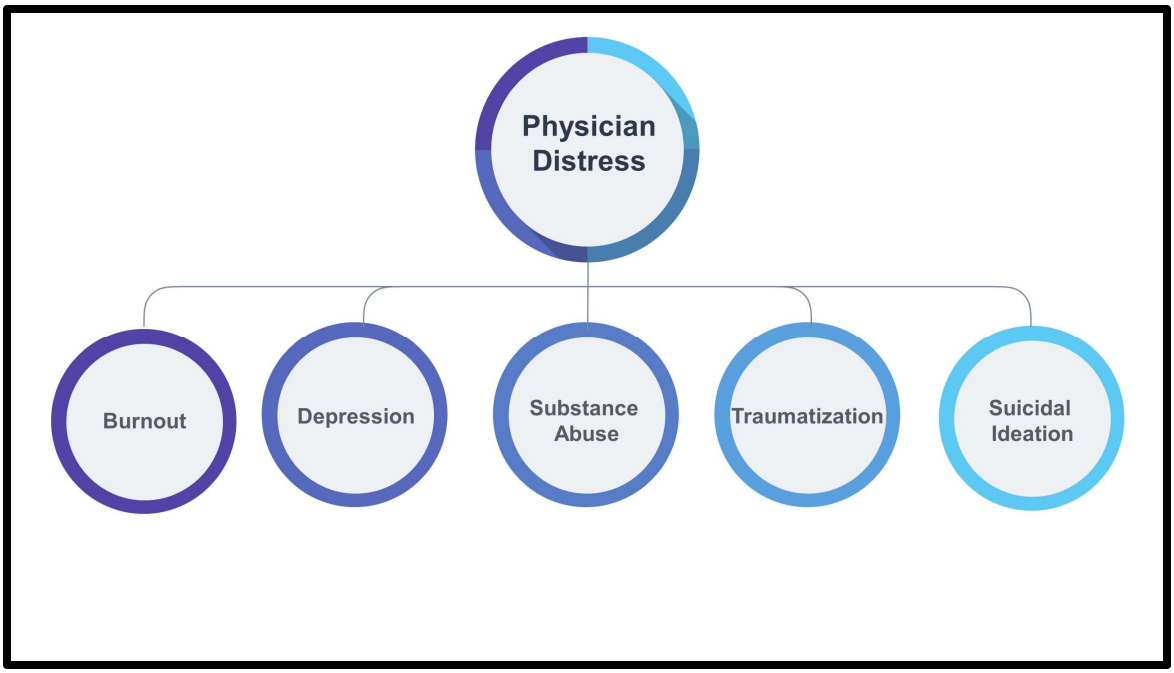

Figure 3. Recommended Rhetorical Change to Conceptualization of Physician Distress [46]

some of the other significant forms of physician distress. The second major rhetorical change that this dissertation suggests is that physician traumatization should be incorporated into the broader conversation regarding physician distress. In fact, the coining, identification, and definition of "physician traumatization" as a subcategory of physician distress is the new contribution that this dissertation makes to the literature regarding physician distress. It is this dissertation's primary aim is to bring attention specifically to the issue of physician traumatization, which it suggests is an important form of physician distress that does not currently receive adequate attention, and which is frequently conflated with burnout. It argues that medicine is frequently traumatic, and despite the hero archetype that plays such a strong part in the professional role of the physician, doctors are ultimately human. That means they are as fallible and vulnerable

[46] Even though the different forms of physician distress are represented by distinct circles in Figure 3, It is important to note that they can and often do, overlap in various ways.

as the rest of us and are not only *capable* of being traumatized by the practice of medicine, but *likely* to be.

Physicians deal with death and trauma on a daily basis. They make their living, at least in part, witnessing and attempting to help people during some of the most difficult and frightening moments of their lives, yet as illustrated in Updike's quote, they are expected to approach these situations as normal occurrences. [47]In addition, many young physicians are drilled with lessons concerning professional distance in order to ensure that patients are not burdened with their doctors' personal or emotional issues. [48] This creates a relationship that reinforces professional distance and detachment on the part of physicians, not only from their patients, but also from their emotions. Physicians frequently deal with all sorts of issues that can result in traumatization and/or depression: the emotional fallout of witnessing different types of distressing events (violence, abuse, graphic and macabre accidents), not to mention the pressures of being responsible for trying to save lives (which they may at times be unable to do), the distress of having to break devastating news to families, and the sometimes crushing burden of having to accept responsibility for mistakes that result in disability or death. These are all-natural parts of medical practice, which is why traumatization is a predictable risk of treating patients. In other words, it is endemic to medicine, which means that for some physicians it may be unavoidable.[49]These realities are important to take into consideration when

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47 Jesse Proudfoot, "Traumatic landscapes: Two geographical addictions," *Social Science & Medicine* 228 (2019): 194-201, https://doi.org/10.1016/j.socscimed.2019.03.020.

48 Harold I. Leif and Renée C. Leif, "Training for 'Detached Concern' in Medical Students," in *The Psychological Basis of Medical Practice*, ed. Harold I. Leif et al (New York, NY: Harper and Row, 1963), 12-35.

49 The author would like to clarify that she is suggesting that there are certain aspects of medicine that can be traumatizing, not that every doctor who experiences those traumatic events

looking at the complex set of issues that can lead to the traumatization of physicians.[50] They are also specifics that are lacking in most of the current discourse regarding burnout.[51]

Unfortunately, the strong stigma surrounding mental illness in medicine[52], combined with the restrictive heroic identity narrative[53] taught to and fostered in physicians creates a culture of silence regarding these forms of distress. When compounded by inaccurate use of labels like "burnout" and narrow public dialogues about permissible forms of distress, traumatized physicians are forced to either misidentify their struggles or suffer in silence because they lack the language necessary to define their pain. It is important to educate doctors, as well as the public, about other forms of distress, like traumatization, that physicians are likely to experience as a result of their work in the medical profession. In order for struggling physicians to be able to

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will become traumatized. Individual responses to traumatic stimuli can vary dramatically. Different people exposed to the same event can have dramatically different responses, due to several different personal variables. The author is simply arguing that there needs to conceptual rhetorical space to recognize that some physicians may react to the trauma endemic in the practice of medicine by developing symptoms of traumatization. The author is also suggesting that space does not exist in the current discourse.

50 West and Shanafelt, "Physician Well-being," 44.

51 Talbot and Dean (2018) and Pamela Wible (2019) mention some of these issues is their arguments that physicians are not actually suffering from burnout, but instead from moral injury; Pamela Wible, "Not "burnout," not moral injury – human rights violations," Pamela Wible MD (blog), March 18, 2019, http://www.idealmedicalcare.org/not-burnout-not-moral-injury-human-rights-violations/?inf_contact_key=3975b46ad42beb8ba2afc3cec1885323680f8914173f9191b1c0223e68310bb1.

52 The author will argue in chapters 4 and 5 that stigma surrounding mental illness is likely to be (and to a lesser extent probably already is) associated with popular conceptions of traumatization, largely as a result of the perceived link between traumatization and PTSD. For more information on the stigma of mental illness please see: Jacek Rucinski and Eva Cybulska, "Mentally ill doctors," *British Journal of Hospital Medicine* 33, no. 2 (1985) 90-94.

53 Evelyn Wilbanks, "The Doctor as Romantic Hero," *JAMA* 220, no. 1 (1972) 54-57, https://doi.org/10.1001/jama.1972.03200010040006.

recognize and identify the type or types of distress they are experiencing they need to be aware of their risk factors. The purpose of this dissertation is not to find solutions to *prevent* physician traumatization, but rather to discuss ways of identifying it and acknowledging it, in order to facilitate open discussions geared towards treating it. Avoiding or refusing to talk about a problem like traumatization will not make it cease to exist; it will simply remove one's ability to address it

Structure

This project intends to approach this discussion using an interdisciplinary approach. It will bring rhetorical analysis from the study of literature together with stigma theory and labeling theory from social science and social psychology, putting them into conversation with one another and locating as their point of intersection the words and labels used to discuss physician distress. This analysis will be split into two parts.

The first section of this dissertation will primarily engage rhetorical analysis in order to identify which words are currently being used in the discourse about physician distress and investigate their meaning and implied connotations. It will also illustrate why the meaning connected with words like "burnout" make them more rhetorically appealing and more likely to excite debate and inspire action. It will also explain why the definitions and meaning connected to words like "traumatization" render it less rhetorically appealing and lead to silence and avoidance. It will illustrate that this negative connotation not only explains why words like "traumatization" are not currently in use, but also suggests that attempts to initiate conversation about issues like "traumatization" are likely to encounter resistance for the same reason. Finally, it will

identify the negative meaning associated with the term "traumatization" as a potential obstacle to addressing the problem of physician traumatization in the future.

The second section of this dissertation will use stigma research and labeling theory to illustrate how and why words like "traumatization" are imbued with negative meaning. It will explore the ways that language becomes tied to concepts of normalcy and how the resulting negative connotation can be used as a powerful tool for maintaining the status quo. It will primarily focus on how stigmatized labels can function to dictate action and control behavior, while also considering how those labels become connected to stigma. It will specifically investigate where the stigma associated with labels used to describe different forms of physician distress, such as "traumatized," come from. In doing so, this section will also identify opportunities for change and intervention. More specifically, it will identify problematic practices, policies, and constructs that create, maintain, and perpetuate that stigma, and suggest that they are areas which any efforts to alleviate physician suffering must address.

Chapter Outline

The first section of this dissertation builds a case for the suggestion that the current dialogue concerning "physician burnout" is inaccurate and should be replaced by a dialogue concerning "physician distress." It then devotes the remainder of the section to its primary focus: arguing for the inclusion of a new subcategory of physician distress which it identifies as physician traumatization. Chapter 2 introduces the concept of physician traumatization through the use of a fictional case study. It illustrates the unique and serious nature of physician traumatization using the example of a young neurosurgical resident (Jane) struggling with traumatization. Jane's case study is used as

a reference point for the remainder of the dissertation and a way of grounding the theoretical argument in a living (though fictional) example.

Chapter 3 briefly traces the historical development and expansion of the term "burnout," identifying how its perceived meaning evolved over time. It then dissects the rhetorical implications of the meaning of the term "burnout" in order to suggest why it is an appealing term that has garnered significant public attention. The author suggests that "burnout" is being used inappropriately and should instead be replaced in the public discourse by the more accurate term "physician distress," as the less descriptive term will encourage more nuanced discussion of the different forms of physician distress. This leads to the suggestion that physician traumatization be included in the public discourse concerning physician distress. The bulk of the chapter is devoted to defining physician traumatization and distinguishing it from Post-traumatic Stress Disorder (PTSD) and "physician burnout.' It then identifies the specific group of conditions that fall under the proposed category "physician traumatization" (the constituent phenomena of suffering that make up physician traumatization), and argues that they should be considered and spoken about together under the broader term "traumatization" for the sake of rhetorical clarity and appeal.

Part II shifts focus by looking at the obstacles which have the potential to hinder the adoption and use of the proposed category "physician traumatization." Any call for change should consider the likely impediments to instituting that change. This will not only help one better understand why the proposed change has not already taken place, but it can also enable one to predict problems and objections to the implementation and address those concerns from the beginning. This dissertation suggests that the primary

obstacle to "physician traumatization" is the fear of stigma. It is with this consideration in mind that Chapter 4 engages in a theoretical and historical analysis of the concept of stigma. Integrating research and theoretical frameworks from both sociology and social psychology, Chapter 4's analysis introduces and articulates what stigma is, how it functions, its relationship to power, and the different conceptual levels on which it exists and acts. It identifies stereotypes as the foundation upon which all other forms of stigma are built. It also identifies stereotypes as the key negative beliefs which must be targeted and changed in order to bring about change.

Chapter 5 focuses on the specific negative stereotypes connected to the label "traumatized," particularly those associated with mental illness. It then looks at the strong negative relationship between those stereotypes and the profession of medicine, explaining not only why mental illness has been shown to be more strongly stigmatized by physicians than the general public[54], but also why mental illness and physician distress are perceived to be stigmatizing conditions by many physicians.[55] It contextualizes those stereotypes by contrasting them to the heroic archetype that dominates the professional role of the physician. Finally, it identifies how those negative stereotypes are strengthened and perpetuated through institutional policies and practices, as well as the "hidden curriculum."

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[54] Wulf Rössler, "The stigma of mental disorders: A millennia-long history of social exclusion and prejudices," *EMBO reports* 17, no. 9 (2016): 1251-2, https://doi.org/10.15252/embr.201643041.

[55] Claudia Center et al, "Confronting Depression and Suicide in Physicians: A Consensus Statement," JAMA 289, no. 3 (2003): 3163-4, https://doi.org/10.1001/jama.289.23.3161.

Methodology and Situating This Dissertation

This project is ultimately part of a larger discussion about the power of language to influence human suffering. More specifically, it is a theoretical analysis of how words, and particularly labels, are invested with meaning and therefore power, and how that power in turn dictates the experience of traumatization for physicians, as well as the possibility of alleviating the suffering generated by that traumatization. As mentioned above, this dissertation is situated at the crossroads of a few different scholarly discourses. This project is also ultimately a project of the medical humanities, largely because it is inspired by the humanists' views regarding rhetoric and its relationship to both virtuous action and suffering. It is therefore important to acknowledge that it is part of a larger extant literature in the medical humanities dedicated to the problem of physician suffering. It may also be helpful to take a moment to clarify how my research relates to some of the more well-known research in that field.

Many scholars in the tradition of the medical humanities have taken inspiration from the directive of the humanists, primarily by investigating the ways that narrative can function as a means of engaging with suffering in medicine. Some have suggested that narrative should be used as an outlet for processing suffering in a profession that lacks adequate methods for doing so.[56] Others have used narrative as an avenue for transforming the experience of suffering into a tool of healing.[57] Still others have argued

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[56] Rita Charon, "Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust," *JAMA* 286, no. 15 (2001) 1897-1902, https://doi.org/10.1001/jama.286.15.1897; Rita Charon, *Narrative Medicine: Honoring Stories of Illness* (New York, NY: Oxford University Press, 2006).

[57] Arthur W. Frank, *The Wounded Storyteller: Body, Illness, and Ethics*, 2nd ed. (Chicago, IL: The University of Chicago Press, 2013); Henri J. M. Nouwen, *The Wounded Healer: Ministry in Contemporary Society* (New York, NY: Image Books, 1979).

that narratives of suffering can act as teaching tools to help physicians learn to bear witness and listen to their patients' suffering with empathy and compassion, thereby expanding the healing nature of the patient/physician interaction.[58] Most of these approaches have revolved around the therapeutic and human nature of the relationship between physicians and patients. While this robust body of scholarship provides valuable approaches to addressing the issue of physician distress and suffering from the perspective of the medical humanities, I see a critical gap in their approaches.

All of the scholars listed above suggest humanist interventions that are most likely to appeal to physicians who already value the wisdom of the humanities and believe humanist approaches can offer helpful solutions that are relevant to the problems that are endemic to the practice of medicine. In other words, most of these approaches speak to physicians who are already fluent in their language (already willing to listen to them). They fail to adequately "reach across the aisle".[59] A similar critique can be launched against some of the more holistic and nontraditional solutions offered by popular figures, like Wible's "Ideal Clinic" approach.[60] While these proposed interventions offer creative solutions and significant benefits, they are also more likely to appeal to physicians who are already proponents of holistic and integrative approaches to medicine. But what about those physicians who do not share a foundational premise that the humanities are valuable? Many of those physicians may fall into a gap. They may be suffering and need

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58 Arthur Kleinman, *The Illness Narratives: Suffering, Healing & the Human Condition* (New York, NY: Basic Books, Inc., 1988).

59 Kenneth R. Howe, "Isolating Science from the Humanities: The Third Dogma of Educational Research," *Qualitative Inquiry* 15, no. 4 (2009): 766-784, https://doi.org/10.1177/1077800408318302.

60 Wible, "Why doctors kill themselves."

help, but, as the interventions that are suggested do not match up with their beliefs and worldview, they are unlikely to find them helpful. This project is an attempt to fill that gap. It uses a humanist perspective in order to identify the problem yet seeks to approach understanding it from a perspective of rationality and logic which may be more acceptable to the more traditional, science-focused and evidence-based physicians. Furthermore, this project's emphasis on clear language, concise definitions, and consistent rhetoric is intended to be reminiscent of the familiar construct of medical diagnosis. In other words, this dissertation attempts to engage in a medical humanities project that speaks to a less humanities-friendly audience.

Personal Relationship to this Project

Several aspects of my personal, as well as my academic, career make me uniquely situated to conduct this research. I have been fascinated with medicine since childhood and came very close to pursuing a medical degree several times throughout my life. In fact, it was my keen awareness of the innately traumatizing nature of medicine that repeatedly led me to decide to follow other paths. Additionally, my former spouse of eight years is a physician, meaning that I had a front-row seat to the trials and tribulations of premedical preparation, medical school, and residency. I also chose to complete my graduate education at a medical institution, which has provided me with the unique opportunity of spending many years surrounded by doctors. As a result, I have had the privilege to live with, study with, teach and learn from, mourn with, laugh and cry with many doctors over the last 10 years. Some of my closest friends are physicians, and I have spent countless hours witnessing their suffering and talking with them about their pain. As a result, the issue of physician well-being is one that is particularly near to my

heart. I have a significant personal investment in this research, which has come from years of watching people I love as they have struggled to deal with the trauma inherent in the medical profession of which they feel called to be a part. I feel called to try to find a way to help them. This is my attempt to do so.

PART I
Making a Case for Physician Traumatization

Chapter 2:
A Rhetorical Approach for a Medical Problem: The Case Study of Jane

As this is a dissertation grounded in rhetorical analysis, it may be useful to take a moment to define what rhetoric is and outline a few key components of the study of rhetoric before proceeding further. While the term "rhetoric" often carries a negative connotation in modern discourse, employed to indicate words that lack substance or proof,[1] its official and historical definition is actually quite simple and direct. Sonja Foss explains that rhetoric, in its most basic form, exists on three dimensions: " (1) humans as the creators of rhetoric; (2) symbols as the medium for rhetoric; and (3) communication as the purpose for rhetoric."[2] She goes on to identify language as the symbolic medium through which rhetoric is expressed, before elaborating the various forms of communication it can be used to achieve. Foss explains that rhetoric can be used as a method of self-discovery, as a tool for fostering mutual understanding, as a method of shaping reality, and as a way of persuading or convincing others "to change in some way".[3] This power of rhetoric to inspire action, and more specifically virtuous action, was what caused it to be considered an admirable subject of study for classical thinkers, as well as humanist philosophers and writers. Robert Proctor explains:

> The renaissance humanists… remind us that the actual practice of virtue, at least in postclassical societies, needs more than an intellectually coherent theory of virtue. It needs examples of virtuous actions capable of inspiring others' actions; and if Petrarch is right, it needs as well a rhetorical presentation of these deeds powerful enough to move us to want to undertake them.[4]

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1 Sonja Floss, *Rhetorical Criticism: Exploration and Practice, Fifth Edition* (Long Grove, Il: Waveland Press, Inc., 2018), 3.

2 ibid

3 Floss, *Rhetorical Criticism* 5-6.

4 Proctor, *Defining the Humanities*, 149.

As mentioned in the introduction, these scholars recognized the ability of rhetoric to inspire virtuous action, and the importance of acknowledging and fully exploring the various methods for doing so.

One such method or tool of rhetorical persuasion comes in the form of narratives. Stefan Iversen explains that "narrative s and narrative elements" can be used in rhetorical discourse as a tool for "persuading, convincing, uniting or otherwise moving people towards specific ends."[5] Narratives are powerful tools within the rhetorical toolbox. They not only can provide a compelling illustration of an argument, but they also have the ability to bring an issue to life, to make it embodied. Narratives also provide a shared experience, which allows people of different perspectives to come together and find common ground through the vehicle of an exemplar tale. Ideas or perspectives that previously seemed unimaginable can be brought into the realm of possibility through narrative, and the importance of an issue can be demonstrated and advocated for without the use of direct pressure.

This dissertation looks at the current discourse about burnout from the perspective of rhetorical analysis, meaning that it investigates the different rhetorical devices and tools that are currently being used concerning burnout. It also uses a rhetorical analysis to investigate why other forms of distress have not gained the same level of attention that burnout has in recent years. This dissertation is not only a rhetorical analysis, however. It is also a work of rhetoric itself, meant to persuade the reader of its

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[5] Stefan Iversen, "Narratives in Rhetorical Discourse," *the living handbook of narratology*, Interdisciplinary Center for Narratology, University of Hamburg, last revised January 31, 2014, http://www.lhn.uni-hamburg.de/node/117.html#.

argument concerning burnout and traumatization. It is for that reason that it will also employ rhetorical tools such as narrative to illustrate its point and persuade the reader of its primary contention, that physician traumatization is a problem endemic to the practice of medicine and distinct from physician burnout. It will do this through the use of a story.

It is important to be clear from the start however, that this is not a "true" story, at least in the sense that it does not describe a "real person." It is an amalgamation of many people and many personal stories that I have heard, read, or been told over the years. At the moment of this dissertation's writing I will have spent nearly a decade living with and talking to countless friends, several roommates, and one significant other, all of whom were physicians. I was a direct witness as they went through pre-med classes in college, medical school, and residency programs. I am also currently enrolled in a graduate program which is housed within a medical school, so I have had the unique opportunity to befriend, work and learn beside, and even teach many physicians, student physicians, and professionals in the medical field. Finally, through the course of my research I have read countless published narratives and blogs written by doctors and have spoken informally with many physicians over the years about their experiences with traumatization and burnout.

Background: Stories of Pain and Fear

It is perhaps important to pause at this point to recognize the poignancy of the above statement, especially as it relates to the current discussion. I have spoken informally over the years to many doctors about their experiences related to burnout and traumatization, but it never once happened "on the record". I have discovered that many physicians (as well as family members and friends of physicians, for that matter) have

been eager to share their thoughts, feelings, and experiences with me upon discovering the focus of my research. I have spent many hours curled up on sofas listening to gut-wrenching stories of friends' and have stood witness to private pain over countless cups of coffee and glasses of wine with colleagues. Perhaps most surprising of all have been the strangers who have unexpectedly opened up to me upon discovering what I study. Unfamiliar voices, hungry for the chance to be heard, for the opportunity to break the silence and share their truth with an interested, supportive, and disconnected witness. I consider it graphic evidence of how badly many physicians secretly want to speak about their pain, and how desperately many need to be heard.

What was most telling about all those experiences, however, was the thread of fear that ran through nearly all of those interactions: a reluctance or direct refusal of virtually every person I spoke with to participate in any kind of formal qualitative research. With almost universal consensus, every physician-friend or acquaintance I mentioned my topic to expressed two sentiments: first, assurance that traumatization was and is a real issue that they encouraged me to study, and second, intense reluctance to become an actual subject of research in such a study. They were adamant that if I were to choose to pursue this topic that they would not want to be quoted and were only willing to talk to me in order to inform my perspective and future subsequent research. Those early conversations not only shaped my understanding of physician traumatization, they informed the design of my research protocols, as well as the perspective and scope of my project. I realized that my initial desire to either conduct an ethnographic study or to create a survey focused on physicians' experiences of traumatization was unlikely to be successful. Too many of the physicians and students I spoke to expressed strong

skepticism about the possibility of guaranteeing anonymity in such protocols and doubted that a questionnaire could yield accurate statistics.[6] They also shared deeply held fears that their future aspirations could be hurt by coming forward about their struggles and suggested that worries such as these were likely to negatively influence other doctors' willingness to answer questions honestly on a formal survey.

The fears and concerns I heard expressed during those exchanges shaped this work in a number of significant ways. First, I became aware of the silent yet powerful stereotypes of heroism and stoicism present in the professional role of physicians as I listened to student-doctors talk. At the same time, I also recognized an undercurrent of stigma attached to all forms of physician distress, which conflicted with those heroic stereotypes in a way that inspired fear and silence in those I spoke to. This stigma was part of a larger environment in medicine that is hostile to most forms of physician distress because of their perceived relationship to mental illness, which is another issue that will be addressed more fully in chapter 5. When I voiced my theory to others, including residents, board certified physicians, and retired doctors, I found many who agreed with my analysis. They agreed that trauma is a significant and natural part of medicine. They agreed that many doctors experience traumatization. They affirmed that there is a fear of stigma that prevents many from coming forward about their own experiences with traumatization. And finally, the agreed that there are powerful stereotypes about what it means to be a "good doctor" within the culture of medicine, which keep some physicians

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[6] While I do not doubt that it may be possible to assure anonymity or structure survey questions to address these issues, I thought that the concerns being expressed were significant, especially with regard to how they might affect issues such as selection bias. These concerns caused me to pause and reevaluate what type of perspective I wanted to use to look at the issue of physician traumatization, which eventually lead me to this focus on rhetoric.

from seeking help when they are experiencing traumatization. It was enough confirmation to encourage me to write my current theoretical analysis.

A Case Study Approach

As mentioned before, the narrative that will be outlined in the remainder of this chapter and will be used to illustrate the struggle with traumatization that many physicians are facing, is not a 'true' story, describing an actual physician I spoke to or a story I heard. Instead, the narrative provided below is an archetype of sorts[7]; an example created from a combination of many anonymous tales. Perhaps, since this dissertation deals with the medical field, it would be more helpful to think of this narrative as a fictional *case study*. A case study is, as John Gerring explains in his book *Case Study Research: Principles and Practices*, an in-depth look at "a single case where the purpose of that study is – at least in part – to shed light on a larger class of cases (a population)." [8] Case studies are frequently used as teaching tools in medical education and are occasionally amalgams compiled from a number of varied 'real' cases. It therefore seems only fitting that this dissertation should employ a case study approach to better understand the problems facing traumatized physicians. [9]

The remainder of this chapter will outline the fictional case study of "Jane," a physician who is struggling with traumatization. It will provide an "in-depth look" at one young doctor whose struggle exemplifies a "class" of traumatized physician. The

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[7] This dissertation will use the word "archetype" in several different ways, as it has different meanings depending on context. This usage implies a standard or typical example.

[8] John Gerring, *Case Study Research: Principles and Practices* (New York, NY: Cambridge University Press, 2007), 20.

[9] Colleen Cheek, Richard Hays, Janie Smith, and Penny Allen, "Improving case study research in medical education: a systematized review," *Medical Education* 52, no. 5 (2017): 480-487, https://doi.org/10.1111/medu.13469.

complex discussions in the chapters that follow it will be enhanced and clarified by references to Jane's specific example. This narrative of physician suffering will not only bring to life many of the issues discussed in the remainder of the dissertation but will help to rhetorically advocate for the importance of recognizing and addressing physician traumatization.

The Case of Jane

Jane is a 32-year-old neurosurgical resident[10]. She is currently in the sixth year of a grueling seven-year residency program. Though she is a talented and capable young physician, Jane is struggling tremendously with emotional distress, which is beginning to influence her work, as well as her personal life.

Before beginning her career, Jane completed four years of undergraduate education at a respected university where she graduated with a Bachelor of Science degree in biochemistry. Jane then completed a four-year medical degree at a respected medical school, where she graduated near the top of her class. Thanks to her excellent grades and very competitive USMLE Step 1 scores[11], Jane matched at her first-choice

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[10] The reasoning behind making Jane a neurosurgeon for this example is that multiple sources identify neurosurgery as one of the most competitive specialties in terms of residency statistics. Neurosurgery is also a specialty characterized by high work hours, small residency programs, and a patient pool with frequent negative outcomes (meaning comparatively more experiences with patient death). Finally, surgical procedures within the neurosurgical specialty are often exceedingly delicate and complex. There is little room for medical errors, and when they do occur the results can be extreme and devastating. All these factors influenced the decision to portray Jane as a neurosurgeon for the sake of this case study, as it is a specialty in which traumatization is probable.

[11] USMLE stands for the United States Medical Licensing Examination, commonly known as "The Boards," and is comprised of three different licensing exams (Step 1, Step 2 and Step 3). Step 1 is generally taken at the end of the basic sciences part of the medical curriculum (typically at the end of the second year of medical school) and is meant to ensure sufficient mastery of the basic sciences, which is required in order to become a licensed physician. Scores on the Step 1 exam are typically heavily weighted in residency applications, so students with

residency program, where she is currently specializing in Neurosurgery. The program accepts 2 residents per year, meaning there are 14 residents in total and they cover service at 3 different hospitals, as well as clinic hours. As a result, Jane stays very busy and has little time outside of work during which she is not on-call.

History of Jane's Condition

Though Jane was filled with optimism and inspiration when she entered residency, and eager to save lives, she quickly discovered that she had not been prepared for certain realities about her specialty. Most significantly, she had not realized how many of her patients would die. She had not understood how many of her interventions would be, at best, stop-gaps to postpone the inevitable. Jane had not realized how many of the traumatic brain injuries she would operate on would be utterly devastating, or that she would learn a different set of metrics for determining whether or not a surgery was "successful." She discovered the grim reality that while surgeries could go flawlessly, patients might still never regain consciousness due to the reality that there was never much that could be done to save them in the first place.[12] She learned that she would frequently stop the bleeding, evacuate a clot, and remove sections of skull in order to reduce further injury caused by intracranial pressure, the whole time knowing that irreparable damage had already been done. She would save patients' lives, maintain their

higher USMLE Step 1 scores are often considered to be more competitive applicants. More information can be found at www.usmle.org.

[12] C. Schaller and M. Kessler, "On the difficulty of neurosurgical end of life decisions," *Journal of Medical Ethics* 32 (2006): 65-69, https://doi.org/10.1136/jme.2005.011767.

heartbeats, only to offer their family members the difficult decision of *when* to turn off the machines.[13]

And it ate at her. When things went well and Jane was able to help a patient it was an amazing high, but the sheer number of negative outcomes took an emotional toll. She occasionally heard friends from medical school who went into other specialties mention "hard weeks." They would be reeling because they lost more than one patient in seven days, and Jane's head would swim to think of how frequently only two deaths would equate to a "good week" in her own specialty[14]. But she knew that it was just the reality of the brain: it is so vital yet so delicate.[15]

After a few years of residency passed, Jane had begun to truly sag under the weight of it all. She decided last year, during her fifth year, however, that she would do a fellowship in pediatric neurosurgery after finishing her final year of residency. For her, it was a way of grasping at some hope. She had discovered that neuroplasticity is truly awe-inspiring, especially in the young. An injury or a radical surgery that would devastate an adult's brain, can not only be survived, but can be compensated for by the flexibility of a child's brain. Children have the ability to form new neural pathways and literally build neurologic work-arounds for broken or severed connections that would completely disable an older and less plastic brain.[16] Kids are able to survive injuries and surgeries

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[13] Jenny Kitzinger and Celia Kitzinger, "The 'window of opportunity' for death after sever brain injury: family experiences," *Sociology of Health & Illness* 35, no. 7 (2013): 1095-1112, https://doi.org/10.1111/1467-9566.12020.

[14] Laszlo B. Tamas, "How many people die during neurosurgery?" *Quora* web forum, April 4, 2017, https://www.quora.com/How-many-people-die-during-neurosurgery.

[15] Paul Kalanithi, *When Breath Becomes Air* (New York, NY: Random House, 2016)

[16] Harvey S. Levin and Jordan Grafman, eds. *Cerebral Reorganization of Function After Brain Damage* (New York, NY: Oxford University Press, 2000), 218-235.

that adults cannot, and more than that, they can thrive. To Jane that meant hope. It was a possibility of regaining inspiration from her work and rekindling the love she used to have for medicine. It was a way of feeling like she could really help people again, which was her initial motivation for entering medicine in the first place. Since making that decision, Jane had been focusing on that fellowship to help her to counter the daily drain on her emotional energy with optimism for the future.

And then Anna happened.

Anna was a 5-year-old little girl whose case, from the outside, seemed rather straight forward. She underwent surgery to remove a fairly aggressive brain tumor. Due to the location of the tumor, there was an understood risk going in that she might wake up after surgery with some speech impairment. The size and placement of the tumor however, made the surgery necessary and everyone accepted the risk as a potential outcome. When the surgery was complete Anna did in fact show signs of speech impairment. In spite of that fact, everyone was grateful that the surgery was successful, that the doctors were able to remove all of the tumor, and that Anna woke up quickly and responded well. Anna's parents hugged Jane and her attending when they came out of surgery reporting that Anna was safely in the recovery room. Even when it became apparent that Anna would need years of speech therapy to recover a portion of her previous communicative skills, her parents and her therapists were optimistic about her prognosis. Everyone was very happy. Everyone that is, except for Jane.

Jane was the surgeon who operated on Anna. As a 6th year resident Jane often operated on her own or with a junior resident. While her attending scrubbed in for the

most complicated portion of the tumor extraction, Jane took lead on the majority of Anna's surgery, with Jim, a third-year resident at her side. And Jane made a mistake.

It was a very small mistake. In fact, Jim did not even notice it, but Jane knew what had happened. Her attention drifted slightly while she was resecting the margins of the tumor and she cut ever so slightly deeper than she had meant to. There was a little more bleeding than she had expected, and it took her a couple of moments longer to stop the bleeding than she had planned. To anyone who had been observing, it was nothing: it appeared that she had chosen to cut at the depth that she did to ensure clean margins on the tumor. But Jane knew the truth. She knew that she cut deeper than she had meant to, deeper than she needed to, and she knew that as a result she would never know whether Anna's speech impairments were the result of that mistake. It was a trivial error, but it shook her to her very core.

Jane knew that she had made a mistake and a little girl might be permanently affected because of it. She desperately wished she had a better explanation for what happened than that. The simple fact was that she had been sleep-deprived and exhausted, and her eyes had become blurry - she let her attention drift for a fraction of a second and… she pressed down slightly harder than she had meant to. That was all there was to it. It was a mistake, a life-altering mistake. And it had happened to a child.

Jane had tried to talk with her attending about the situation afterward, but it had not helped. He offered her a short speech that fell somewhere between a lecture about the importance of focus and taking breaks when she needed to, and a pep talk about "taking the win." He reminded her that speech impairment was always a potential risk and

assured her that Anna's parents did not appear to be upset or litigious.[17] Jane knew he was trying to help, but his words did not come close to addressing her problem. The foundation-disrupting issue she was dealing with was that Jane was suddenly and devastatingly aware of her own fallibility. The confidence and bravado she had been building up for six years and which helped her walk into those operating rooms and slice into the brains of her fellow human beings every day, had suddenly crumbled.[18] The weight of the possible repercussions for any mistakes she might make in the future was crushing her. More than that, no matter how much logic and positive self-talk she attempted, she could not convince herself that Anna's speech impairments were *not* the result of her mistake. Because she knew that they might be. She knew too much about the brain to deny that. And she also knew that she would never know for sure, because she could not go back and un-make the mistake. She realized that she had to live with the knowledge that she might have irrevocably damaged a child because of a moment of distraction and a slip of her hand. She did not know how to reconcile that knowledge with her self-image of a competent and self-assured surgeon. She also did not know how to shake the terrible realization that it could happen again, or the guilt that was suffocating her.

Jane tried to push past her anxiety and shame, but it kept undermining all the confidence she had built up over the years. She began to dread going to work every morning, and it took all her strength to make it through each day. Whenever possible, she

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17 Wendy Levinson, "Physician-Patient Communication: A Key to Malpractice Prevention," *JAMA* 272 no. 20 (1994): 1619-1620, https://doi.org/10.1001/jama.1994.03520200075039.

18 Thomas Ranieri, "The Courage to Cut: A Journey into the Hearts and Minds of NYU Langone's Neurosurgeons," Department of Neurosurgery, NYU Langone Health, published Spring 2013, accessed April 9, 2019, https://med.nyu.edu/neurosurgery/about-us/courage-cut.

avoided the operating room where Anna's surgery took place. When she could not, she would find herself flooded with panic and frequently found her mind flashing back to that moment. She had become timid in surgery, and often encouraged the younger residents to operate in her stead, citing their need for practice. The truth was that she was constantly afraid that she would freeze, or worse yet, make another mistake. She was having trouble sleeping and woke often with nightmares. This only made her usual level of sleep deprivation even worse. On two separate occasions, weeks after Anna was discharged, Jane thought she saw the child sitting in bed crying as she passed a patient room, only to double-back and find the room empty. She kept telling herself that non-ideal patient outcomes from risky procedure was part of being a neurosurgeon and that she needed to "get over it." But still, she was floundering.

Unfortunately, things were little better outside of the operating room. Jane felt distant from her fellow residents who did not seem to be struggling in the way that she was. She was often short tempered and critical with the younger residents, annoyed that they still enjoyed what she saw as naïve confidence. She stopped talking as freely with her colleagues and often made up excuses to avoid hanging out with them after work, as she had used to. While her sense of loneliness intensified, she felt it was better than letting them see how much she was struggling. Jane was hyper-aware that surgery was already a competitive and "tough" field, and neurosurgery was even more so. A historically male-dominated specialty, Jane had always felt, as a female neurosurgeon, she needed to prove that she was not "soft," "irrational," or "overly emotional."[19] She

[19] Martina Stippler, "How Women Will Disrupt Neurosurgery," *Congress Quarterly* Fall 2018, Congress of Neurological Surgeons, https://www.cns.org/publications/congress-quarterly/congress-quarterly-fall-2018.

worried that if her colleagues saw her struggle that they might smell blood in the water. She also feared if her superiors recognized her difficulty, they might think she could not "cut it" in the program. She knew they would be unlikely to throw her out, considering how much time and energy they had put into her training (also, the optics of losing an upper-level resident is bad and it can be very difficult to fill an open spot in a neurosurgery residency program with a high-quality candidate).[20] But Jane also knew there were other ways they could show their disappointment – weak letters of reference for a fellowship program, for instance. Besides, she was frustrated because she believed she was supposed to be trained to deal with these kinds of things. Jane felt intense shame because she thought she was supposed to be strong enough to move past her mistakes and learn from them.[21] She was convinced that she was supposed to be a neurosurgeon with nerves of steel, a *doctor*; but she felt she was failing. And she was terrified by the prospect of letting anyone know.

Jane was filled with shame and hopelessness. She could not understand why this was affecting her so significantly. She kept asking herself why she was unable to move past Anna's case? Jane felt trapped in her situation. With every passing day she felt more and more convinced that she did not have what it took to be a neurosurgeon, but she did not feel like she had other options. While she considered dropping out of her residency program and switching to another specialty, she did not think that she could bare the

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[20] RothIRA, "Switching Residencies – Timing and Consequences," *General Residency Issues* forum, May 12, 2018, *The Student Doctor Network,* https://forums.studentdoctor.net/threads/switching-residencies-timing-and-consequences.1310438/.

[21] Jack Coulehan and Peter Williams write in "Vanquishing Virtue: The Impact of Medical Education," (2001) that, though medical education in North America professes a focus on traditional values and virtues such as compassion and empathy, student doctors are actually taught detachment and objectivity as methods of self-preservation.

humiliation. She was worried what people would think. Jane also insisted to herself it would be a massive waste of 6 years of residency training, especially considering that she was almost finished with her program. Worse yet, she knew it would be a huge setback to her career. She would have to complete a different residency program and start over if she left neurosurgery.

None of that even took into consideration her ballooning student debt. Jane and her husband had been counting on her very high projected salary to pay off the astronomical student loans they had accrued as the result of their choice to both complete advanced degrees simultaneously. It was a decision they made with plans for a family in mind, but after Anna, that future seemed far away and foolish. Besides, Jane knew that any branch of surgery would have similar risks. For that matter, any medical specialty would. Jane was suddenly petrifyingly aware that risk was part of the very nature of medicine – when doctors make mistakes people can die.

Ultimately however, Jane knew it would make little difference. She believed that at her core she was a neurosurgeon; it was who she was. In fact, that was the problem. Jane could not comprehend who or what she would be if not a neurosurgeon. That was what made her struggle over Anna's case so distressing.

Jane tried everything she could think of to get over her issues. She tried putting the fear out of her mind, but it came back. She tried applying a logical perspective to her experience and attempting to view it as a valuable learning situation, but she still froze in surgery. She tried refusing to acknowledge that the mistake had even happened and attempting to forget it, only to find herself flashing back to the moment at inopportune times. Jane had tried everything she could think of. When she overheard several

colleagues talking about "physician burnout," and then had had to sit through a mandatory workshop on the subject, she began to consider that burnout might be what she was experiencing. The speaker listed several common symptoms of burnout including cognitive weariness and emotional exhaustion that Jane found particularly familiar.[22] She decided to try several self-care related interventions that the speaker recommended.

Jane took up yoga and started jogging. She focused on trying to get more sleep, and even took a weekend vacation with her husband to improve her "work/life balance," like the speaker suggested.[23] The problem soon became apparent however, that none of that addressed the guilt or shame she was experiencing, or decreased her fear over making another mistake. Additionally, though she tried sleeping more, as the burnout speaker recommended, she had recurrent nightmares about the event, leaving her tired and stressed. Jane could not even enjoy the vacation due to her dread over returning to work. The speaker had also suggested talking to friends and family members about her stress, but Jane quickly discovered that she did not feel comfortable talking to her husband or sister. Jane felt that they simply did not understand the stress she was under, since if either of them made a mistake at work, no one could die as the result. Jane was also acutely aware that her husband was already worried about her, and had made repeated comments about Jane's drinking, which had increased in her attempts to dull the emotional pain. She did not want to make matters worse, or to have to deal with his worry on top of her own, so she did not feel that talking with him was an option. Finally,

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[22] Bianchi et al, "Burnout and depression," 91-98.

[23] A list of suggested "wellness strategies" for combating burnout can be found in: Charles M. Balch and Tait Shanafelt, "Combating stress and burnout in surgical practice: A review," *Advances in Surgery* 44 no. 19 (2010): 43-45, https://doi.org/10.1016/j.yasu.2010.05.018.

though Jane had attempted taking steps towards improving her "self-care" routine, as the burnout specialist had insisted all doctors should, she quickly learned that no amount of jogging or downward facing dog stretches were going to change what had happened with Anna, or stop her fear or flashbacks.

While Jane thought briefly about seeing a therapist or psychiatrist, she ultimately concluded that she could not take that risk. She did not feel she could chance it getting back to her superiors. She worried that if she were diagnosed with something or prescribed medication that it might affect her job, or at least that others might assume it would affect her job.[24] She also feared she might be placed under supervision, as she had heard could happen with certain diagnoses.[25] Worst yet, she was concerned her supervisors might think she was too unstable to continue working and put her on medical leave. Even if all that happened was her fellow residents or superiors discovered that she had needed a therapist or psychiatrist's help to deal with *work* problems, they would know that that she couldn't 'hack it' as a neurosurgeon. She believed she would be exposed as the emotionally fragile one who needed the help of a 'shrink' to be able to do her job. She was certain she would be considered weak, and that was simply not an option in her specialty.

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[24] Rothenberger (570) suggests that physicians are often hesitant about seeking help for burnout because they worry about it affecting their medical license; More discussion about the punitive role of state medical boards will be provided in Chapter 5 in relation to stereotypes about irrationality and danger.

[25] The Federation of State Physician Health Programs states on its website, under the heading "Mission, Vision and Values" that one of its roles is to provide "prevention, treatment, and monitoring of physicians experiencing substance use disorders, mental illness, physical illness and other potentially impairing conditions."

Jane knew that neurosurgery was not one of the 'touchy-feely' specialties where they sit around and talk about their emotions.[26] One of her medical school friends who went into Family Medicine had told her a about a retreat they took their residents on to address burnout. They literally sat in a circle at one point and discussed some of the cases they were each struggling with emotionally. Then they encouraged one another, validated each other's feelings, and offered support in various ways. They even hugged afterward. Jane had been floored. She was adamant that would NEVER happen in her specialty. She couldn't even imagine it; certainly not while everyone was sober. Jane had considered going out of town, paying cash, and using a pseudonym to see a therapist or a psychiatrist, as she had heard whispers of other colleagues doing.[27] In the end however, she ultimately decided that would be ridiculous and unlikely to help.

Jane chastised herself harshly, reminding herself that she was a DOCTOR for God's sake. She was convinced that a psychiatrist would be unable to tell her anything she did not already know. Jane believed she should be able to fix her problem herself if it was psychological in origin. She reminded herself sternly that she did a psych rotation back in medical school and that all she should need to do was employ a little more professional distance. She rebuked herself, insisting that she needed to stop getting so

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[26] Pamela Wible advocates for non-traditional care experiences that she believes will help to strengthen the relationship between patients and physicians. In her book *Pet Goats and Pap Smears: 101 Medical Adventures to Open Your Heart & Mind* she speaks of throwing group "pap parties," and raffling off kittens to patients who have completed their annual physical exams. These are creative ideas for reimagining traditional clinic care, but they are also more specifically aimed at private practice physicians, and more specifically primary care doctors. Few of her non-traditional approaches offer solutions that are geared towards surgical or hospital-based specialties.

[27] An anonymous physician on KevinMD.com wrote a blog post entitled "When will the stigma of mental health end in medicine?" explaining that some physicians cross state lines and use fake names when seeking mental health services in order to avoid the possibility of a paper trail that might "leave a stain on their record."

emotionally involved with her patients and remember that it was her job to save their lives, not be their friend. She engaged in tough-love self-talk, reminding herself that she knew it was going to be hard when she decided to be a doctor and that she was supposed to be trained to deal with this stuff.

Current Presentation of Issue

Jane has been on a solitary course for some time, attempting to deal with her struggles on her own. While she was experiencing emotional exhaustion and depersonalization (classic symptoms of physician burnout) earlier in her residency training, many of those feelings subsided after she reevaluated her goals and priorities and decided to pursue a fellowship in pediatric neurosurgery. Jane experienced a new and intense form of distress however, following her experience with Ana's case. She is now exhibiting increased fear and arousal, coupled with intense feelings of shame and guilt. She has had recurrent flashbacks and nightmares and goes out of her way to avoid reminders of the inciting incident. Jane has withdrawn from family and friends and she has begun drinking more heavily as a way to dull her powerful and troubling emotions. Finally, Jane is unwilling to seek help and is instead engaged in intense negative self-talk, which is only exacerbating her distress.

Summary

The above case study offers one example of a physician who is suffering from traumatization but lacks the language to speak about or identify her problem. Jane is traumatized and confused, yet so concerned about the potential of stigma and/or professional ramifications, that she does not come forward or seek help for her problems. Furthermore, Jane's struggles are exacerbated by the heroic archetype associated with the

professional role of the ideal physicians, which dictates many of her assumptions about what feelings and actions are normal and permissible.[28] Additionally, the popular rhetoric regarding burnout causes Jane to misidentify her struggles, and to attempt to treat her traumatization with fashionable burnout remedies. Unfortunately, the suggested solutions are insufficient to adequately address Janes symptoms of traumatic stress, and their failure to help only sends her deeper into a spiral of shame and self-criticism. Later chapters will illustrate the specific forms of traumatization Jane is experiencing and use her example to inform the theoretical discussion. Jane's case provides, not only a graphic example of what physician traumatization can look like, but also a compelling argument that the current status quo in medicine, as well as the popular rhetoric regarding physician burnout, both fail to provide adequate solutions for the problem of physician traumatization.

[28] This use of the term "archetype" comes from literary theory and refers to a common and recurring character type (in this case, that of the hero). This conceptualization of "archetype" is closely related to and derived from work in psychology (Carl Jung) and cultural anthropology (James Frazer and Joseph Campbell) and will be discussed further in chapter 5. For more information on the subject, please see: Irene Rima Makaryk's, ed., *Encyclopedia of Contemporary Literary Theory: Approaches, Scholars, Terms* (Buffalo, NY: University of Toronto Press, 1993), 508.

Chapter 3:
Burnout vs Traumatization: A Problem of Terminology

Jane's case demonstrates some of the traumatic elements that are common in the practice of medicine. It shows that countless large and small moments of trauma occur repeatedly while treating the wounds and sicknesses of fellow human beings, and that the effects can be devastating. This dissertation argues that Jane's case is an example of physician traumatization, and that experiences like Jane's are natural and predictable results of practicing medicine. It also suggests that traumatization is not adequately acknowledged in the current discourse. The abundant literature on both physician burnout and PTSD falls short in offering solutions, as neither of these labels sufficiently describes physician traumatization. "Traumatization" as described in this dissertation, is a set of phenomena that currently falls between the rhetorical cracks. As a result, those doctors experiencing traumatization either misrecognize what they are facing or suffer from an unnamed wound. This chapter will define the proposed label "physician traumatization," distinguish it from physician burnout and PTSD, and identify some of the most common types of physician traumatization that occur during the practice of medicine. It is the contention of this author that by naming this issue and incorporating it into the larger dialogues concerning physician distress, that physicians who are suffering from traumatization may be able to receive the help they need.

How does Traumatization differ from PTSD and Burnout?

The first question that must be answered before progressing any further in this discussion is: What is traumatization and how does it differ from PTSD and burnout? In order to answer that question, this chapter will begin by identifying why and how

instances of traumatization are *not* adequately covered by the popular extant categories of PTSD and physician burnout. In the last two decades acknowledgement and discussion of PTSD has increased dramatically, and there is a rich scholarly literature describing its causes, symptomology, and treatment.[1] As mentioned in the introduction, the past 8 years have also seen a spike in research concerning *burnout*, particularly within the medical field.[2] So the question naturally becomes: If PTSD and burnout are such recognizable and well understood conditions, why not use one of those terms to describe the problem we are identifying? Why use "traumatization" instead? The simple answer is that traumatization, burnout, and PTSD all describe related, yet different phenomena. In fact, this dissertation suggests that it has become common for scholars to refer to many of the various forms of physician distress universally as "burnout," which is not only an inaccurate characterization, but a semantic difference that allows for problematic attitudes within the culture of medicine to continue. It is therefore especially important to articulate exactly how traumatization differs from PTSD and burnout, so a as to clarify their similarities differences. In order to do that, we must first look at each categorization individually.

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[1] Sharpless and Barber (2011); Pai Suris and North (2017); Lazarus (2014); Friedman (2019).

[2] As mentioned in the introduction, there has been a shift in the discourse since around 2011 when Shanafelt et al published their special report "Suicidal Ideation Among American Surgeons" in the *Archives of Surgery*. Not only has the link they reported between suicide and burnout been repeated in much of the subsequent writing on physician burnout, but physician burnout and physician suicide have been linked in most of the literature that has been published since.

PTSD

A rhetorical consideration of PTSD must start with its definition. As mentioned in the introduction, PTSD is the acronym used to describe Post-traumatic Stress Disorder, which is an accepted diagnosis in the fifth and most recent edition of the Diagnostic Statistical Manual of Mental Health Disorders (DSM-5). This means that PTSD is not just a term; it is a medical term. It therefore has medical significance, and a carefully and meticulously constructed definition. The American Psychiatric Association defines PTSD as "a psychiatric disorder that can occur in people who have experienced or witnessed a traumatic event," and suggest that it affects approximately 3.5% of adults in the United States.[3] The APA characterizes its presentation as including a few key symptoms:

> People with PTSD have intense, disturbing thoughts and feelings related to their experience that last long after the traumatic event has ended. They may relive the event through flashbacks or nightmares; they may feel sadness, fear or anger; and they may feel detached or estranged from other people. People with PTSD may avoid situations or people that remind them of the traumatic event, and they may have strong negative reactions to something as ordinary as a loud noise or an accidental touch.[4]

PTSD first appeared in the third edition of the DSM (DSM-III) in 1980 and its definition and characterization has undergone substantial changes in each subsequent edition.[5] Arguably the most extreme changes took place between the text revision

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[3] Ranna Parekh, "What is Posttraumatic Stress Disorder?," Patients and Families, American Psychiatric Association, last revised January 2017, https://www.psychiatry.org/patients-families/ptsd/what-is-ptsd.

[4] Ibid.

[5] Anushka Pai, Alina M. Suris, and Carol S. North, "Posttraumatic Stress Disorder in the DSM-5: Controversy, Change, and Conceptual Considerations," *Behavioral Sciences* 7 (2017): 7, accessed October 28, 2018, https://doi.org/10.3390/bs7010007.

edition of the DSM-IV (DSM-IV-TR) and the fifth edition of the manual (DSM-5) which was published in 2013, after seven years of deliberation, discussion, and debate.[6] Those changes included removing PTSD from its former classification as an anxiety disorder and creating an entirely new category called "Trauma and Stressor-related Disorders," as well as severely narrowing what counts as both a traumatic event (Criterion A) and a "qualifying exposure" to said traumatic event.[7] The APA also chose to remove language that had been added to the DSM-IV which characterized Criterion A as an event that inspired "intense fear, horror, or helplessness," which was considered to be too "subjective." [8] These, and other changes will be explained in more detail later in this chapter and in chapter 5, but what is important to recognize is that the diagnostic criteria for PTSD were tightened in the most recent iteration of the DSM, and that this happened as the result of controversy and criticism claiming that the criteria in the DSM – IV and DSM-IV-TR were too inclusive and subjective.[9]

This is good moment to pause to point out the first important way that traumatization and PTSD differ, namely that PTSD is a *medical* diagnosis, while traumatization is not. That means PTSD must be diagnosed by a mental health

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6 Pai, Suris, and North, "Posttraumatic Stress Disorder," 1.

7 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Arlington, VA: American Psychiatric Association, 2013); Pai, Suris, and North, "Posttraumatic Stress Disorder," 2.

8 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders,* 4th ed. (Washington, DC: American Psychiatric Association, 1994); Pai, Suris, and North, "Posttraumatic Stress Disorder," 3.

9 Pai, Suris, and North, "Posttraumatic Stress Disorder," 1-7; Carol S. North, Alina M. Suris, Miriam Davis, and Rebecca P. Smith, "Toward Validation of the Diagnosis of Posttraumatic Stress Disorder," *American Journal of Psychiatry* 166, no. 1 (2009): 34-41, https://doi.org/10.1176/appi.ajp.2008.08050644.

professional, preferably after a thorough psychological screening.[10] It is not a classification that can be applied or removed as desired, based on perceived traits and characteristics, nor is it a diagnosis that can or should be made without a one-on-one patient interview. This means it would be inaccurate and academically irresponsible for the author to unilaterally claim that large groups of physicians are suffering from PTSD, without diagnostic proof. Not only does the author lack the requisite credentials to diagnose PTSD, this dissertation is also speaking about traumatized physicians in the abstract and from a distance. Furthermore, while it is possible that some traumatized physicians meet the diagnostic criteria for PTSD (that they exhibit condition overlap), that does not mean that *all* traumatized physicians qualify for the medical diagnosis of PTSD, especially following the narrowing of the diagnostic criteria in the DSM-5.

This brings the discussion back to the description of what qualifies as PTSD, which leads to the second and most significant way that traumatization and PTSD differ: traumatization is a more broad and inclusive condition. As mentioned above, PTSD has a very strict set of diagnostic criteria which must be met for a person to qualify for the medical diagnosis. In fact, Pai, Suris, and North explain that PTSD, and the other conditions that fit under the new category "Trauma and Stressor-related Disorders," are "distinctive among psychiatric disorders," in that they are the only disorders in the

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[10] The National Institute of Mental Health specifies that "a doctor who has experience helping people with mental illness, such as a psychiatrist or a psychologist, can diagnose PTSD." Quote from: The National Institute of Mental Health, "Post-Traumatic Stress Disorder: Signs and Symptoms," *National Institute of Mental Health*, Last Modified February 2016, Accessed October 28, 2018, https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml.

entire DSM-5 that have the "requirement of exposure to a stressful event as a precondition."[11] This means that, instead of being defined primarily by its symptoms and presentation, like other disorders in the DSM-5, PTSD requires presenting symptoms to have been precipitated by a qualifying traumatic event. Pai, Suris and North explain that, while the DSM-5 kept the historically controversial list of "exposure types," which includes direct, witnessed, and indirect exposure to the traumatic event, the classification of what types of events qualify as trauma became far more narrowly defined in the fifth edition.[12] This means that, while a person does not have to directly experience a traumatic event to develop PTSD, and can instead witness someone else experiencing trauma (such as a physician witnessing a patient experience a traumatic event), or experience the trauma indirectly (for instance, through a traumatized loved one), the events that qualify as traumatic are extremely limited and must meet very specific criteria.

The new description of PTSD in the DSM-5 explicitly defines trauma as events that pose "actual or threatened death, serious injury, or sexual violence."[13] It also goes a step further to specifically describe the types of medically-related traumatic events that qualify as this important "Criterion A," and which are particularly pertinent to this

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11 Pai, Suris, and North, "Posttraumatic Stress Disorder," 2.

12 Lourie Reichenberg, *DSM-5 Essentials: The Savvy Clinician's Guide to the Changes in Criteria* (New York, NY: John Wiley & Sons, Incorporated), 47. ProQuest Ebook Central.

13 American Psychiatric Association, *Diagnostic and Statistical Manual*, 5th ed., 309.81 (F43.10).

discussion [14] Pai, Suris and North explain just how narrow these criteria are, especially as they apply to the medical field:

> Medically based trauma is now limited to sudden catastrophe such as waking during surgery or anaphylactic shock. Non-immediate, non-catastrophic life-threatening illness, such as terminal cancer, no longer qualifies as trauma, regardless of how stressful or severe it is. Medical incidents involving natural causes, such as a heart attack, no longer qualify (with the stated exception of life-threatening hemorrhage in one's child, as described in the text accompanying the criteria).[15]

This change to what counts as a qualifying traumatic event, especially a traumatic medical event, is important, not just to the patients who experience them, but also to the physicians who witness them, since witnessing counts as a qualifying exposure type which can result in development of PTSD .[16] This means that physicians who witness one of their patients experiencing a traumatic medical event may meet the diagnostic "criterion A," which is essential to the diagnosis of PTSD. At the same time, however, the changes to what events qualify as traumatic in the DSM-5 mean that physicians who witness distressing events that do *not* meet the narrower definition of criterion A, may *not* qualify for a diagnosis of PTSD. It depends entirely on whether that event falls within this tightly defined category of what counts as "traumatic" in the DSM-5.

This is where the difference between PTSD and traumatization becomes most apparent. For instance, if a physician witnesses a patient wake up during surgery, that experience would qualify as a traumatic event according to the DSM-5, capable of

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[14] Ibid.

[15] Pai, Suris, and North, "Posttraumatic Stress Disorder," 2.

[16] American Psychiatric Association, *Diagnostic and Statistical Manual,* 4th ed.; American Psychiatric Association, *Diagnostic and Statistical Manual,* 5th ed., 309.81 (F43.10).

precipitating PTSD in either the patient of physician. If the physician watches a long-time patient die a slow and excruciating death, following a prolonged battle with cancer, however, that experience would *not* meet the criteria to qualify as a traumatic event. That means that no matter how distressing and traumatizing the physician and/or patient might find that experience, their distress could not be diagnosed as PTSD because their experience would not be considered sufficiently traumatic to precipitate PTSD.[17] Traumatization, on the other hand, does not demand such a narrow definition of trauma. This provides an excellent example of why PTSD and *traumatization* should be considered related yet different conditions. While the physician who witnesses his/her/their patient die of cancer might not meet the DSM-5's narrow criteria for a diagnosis of PTSD, if his/her/their symptoms were sufficient, that same physician could be considered traumatized. At the same time, while some physicians may be traumatized without qualifying for a diagnosis of PTSD, all physicians who are suffering from PTSD can be considered traumatized. It is therefore possible to consider traumatization to be a broader and more inclusive category, under which the medical diagnosis PTSD should fall, as demonstrated in Figure 4.

This is an appropriate time to acknowledge that there *is* a substantial body of literature that deals with physician PTSD. These studies deal primarily with doctors who

[17] This is not only true of doctors. It is also true of patients and family members. The changes to the DSM-5 severely limit the types of medical events that can be considered sufficiently traumatic to precipitate PTSD.

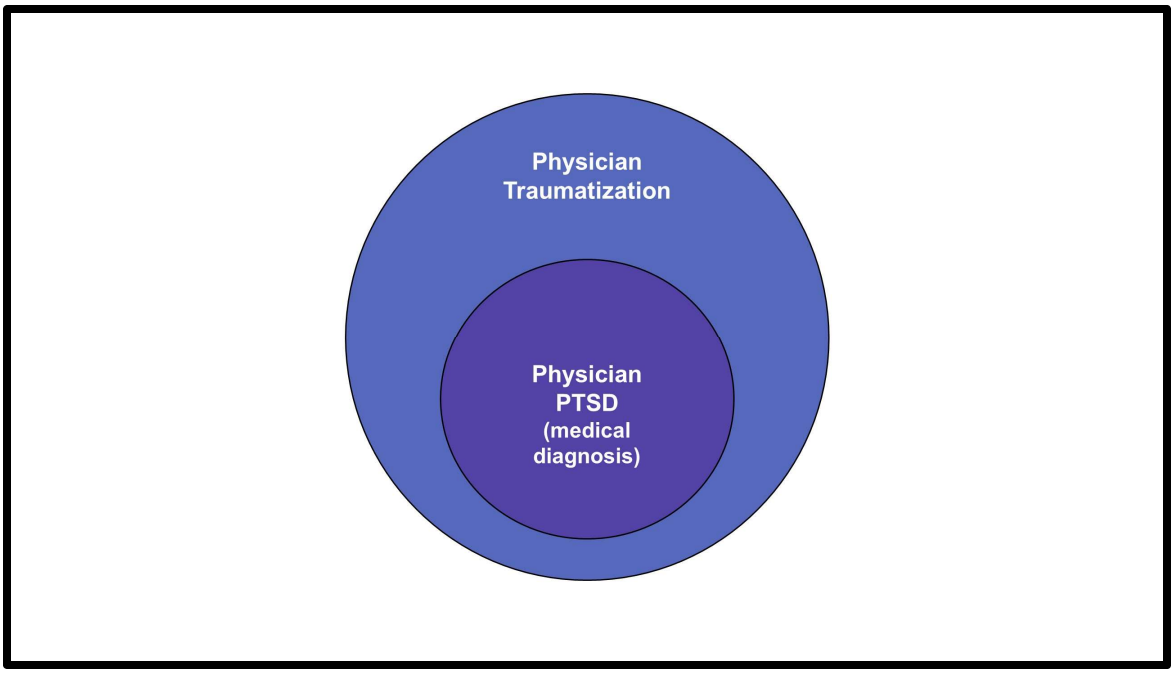

Figure 4. The relationship of PTSD to physician traumatization

experience different types of exposure to traumatic events, however, than the witnessing exposure discussed above. As mentioned earlier, there are 4 accepted types of exposure to traumatic events listed in the DSM-5: 1) "Directly experiencing the traumatic event(s);" 2) "Witnessing, in person, the event(s) as it occurred to others;" 3) "Learning that the traumatic event(s) occurred to a close family member or close friend," and finally 4) "Experiencing repeated or extreme exposure to aversive details of the traumatic event(s)," which specifically mentions first responders, among other support figures.[18] Much of the extant literature on physician PTSD deals with doctors who frequently experience exposure types 1 and 4. It primarily considers physicians who frequently treat trauma victims, as well as those who practice medicine in dangerous and potentially life-threatening conditions, such as physicians in the military, those practicing medicine in

[18] American Psychiatric Association, *Diagnostic and Statistical Manual*, 5th ed., 309.81 (F43.10).

war-torn countries, prison physicians, and emergency room doctors.[19] Such doctors are not only more likely to witness their patients experiencing qualifying traumatic events, but they are also more likely to directly experience life-threatening situations themselves.

Such studies frequently focus on first responders and emergency medical personnel and identify the need for better monitoring for symptoms of PTSD among these practitioners.[20] While it is encouraging that this form of traumatization is receiving some much-needed attention, at the same time it is also necessary to look beyond these recognized vulnerable medical specialties to look for other forms of traumatization occurring among medical providers who might not meet the criteria for a diagnosis of PTSD, or who work in specialties that are not generally thought to be traumatic. This includes a broader and more inclusive conceptualization of trauma, which could be achieved by incorporating the label "traumatization."

Burnout

While the term "PTSD" has an overly-stringent definition which excludes many forms of traumatization, the term "burnout" arguably has the opposite problem. As discussed in the introduction, it is a label with many different characterizations, and a

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19 Tonya T. Kolkow et al, "Post-Traumatic Stress Disorder and Depression in Health Care Providers Returning from Deployment to Iraq and Afghanistan," *Military Medicine* 172, no. 5 (2007): 451-455, https://doi.org/10.7205/MILMED.172.5.451; Ros Thomas, "Caring for those who care – aid worker safety and security as a source of stress and distress: a case for psychological support?," in *Workplace Violence: Issues, trends, strategies,* eds. Vaughan Bowie, Bonnie S. Fisher and Cary Cooper (New York, NY: Routledge, 2011), 121-140.; Judith M. Laposa, Lynn E. Alden and Louise M. Fullerton, "Work stress and posttraumatic stress disorder in ED nurses/personnel," *Journal of Emergency Nursing* 29, no. 1 (2003) 23-28, https://doi.org/10.1067/men.2003.7; Anne Scheck, "Special Report: Lurking Inside Every Headline, PTSD for Emergency Physicians," *EMN* (August 2013): 18-19, https://doi.org/10.1097/01.EEM.0000433389.92527.d1.

20 Scheck, "Lurking," 18-19.; Laposa, Alden and Fullerton, "Work Stress," 23-28.

lack of consensus regarding what exactly it is and is not.[21] In fact, Schufeli, Leiter, and Maslach, all experts in the field of burnout, explain in a 35-year review of the major research related to burnout, that even now there is still debate about "the dimensionality of burnout and its scope."[22] Kaschka, Korczak, and Broich go a step further to insist that "there is at present no generally valid, internationally agreed definition of burnout."[23] Despite this lack of clarity (or perhaps because of it) in order to distinguish the differences between burnout and traumatization it will first be necessary to track some of the ways that the concept and label "burnout" has been defined over the years, as well as some of the changes it has undergone.

Burnout was first introduced by psychiatrist Herbert Freudenberger in the mid-1970s, to refer to a specific phenomenon he observed among workers and volunteers in a free clinic in the East Village of New York. [24] Borrowing the term from drug use slang, Freudenberger characterized burnout as a wearing out or exhaustion of energy through repeated and/or prolonged application of empathy and care for others.[25] Interestingly, less than two years later, yet completely separately, social psychologist Christina Maslach and her colleagues also encountered the term "burnout," being used by a group

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21 Bianchi et al, "Burnout and depression," 91-98.

22 Wilmar B. Schaufeli, Michael P. Leiter and Christina Maslach, "Burnout: 35 years of research and practice," *Career Development International* 14, no. 3 (2009): 211-212, https://doi.org/10.1108/13620430910966406.

23 Kaschka, Korczak, and Broich, "Burnout," 782.

24 Herbet Freudenberger, "Staff burn-out," *Journal of Social* Issues 30 (1974): 159-165. https://doi.org/10.1111/j.1540-4560.1974.tb00706.x; Schaufeli, Leiter, and Maslach, "Burnout," 205.

25 Freudenberger, "Staff burn-out,"159-160.

of Californian workers in the human services fields to describe feelings of emotional exhaustion and cynicism and lack of professional confidence as the result of their jobs.[26]

What is significant about both of these early conceptualizations of burnout is that they identified burnout as a condition related to work in the social service fields. This is particularly salient to the current discussion because Maslach later went on to develop the Maslach Burnout Inventory (MBI), which is still considered the gold standard for measuring burnout. Maslach even explicitly stated in *Burnout: The Cost of Caring* first published in 1982 that "burnout is a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with people in some capacity."[27] This is a particularly important definition of burnout because it is almost identical to the definition of physician burnout given in many of the recent studies conducted over the last 10 years.[28]

The above statement is interesting and may rightly give the reader pause, because it seems to contradict the earlier claim this paper made that there is a lack of consensus regarding the definition of burnout. The reason for this seeming contradiction is that there is a difference between definitions used to refer to "burnout" in general and those used to

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[26] Schaufeli, Leiter, and Maslach, "Burnout," 205; Christina Maslach, "Burned-out," *Human Behavior* 9 (1976): 16-22.

[27] Christine Maslach and Philip G. Zimbardo, *Burnout: The Cost of* Caring (Palo Alto, CA: Malor Books, 2003) Kindle edition, 2.

[28] Shanafelt et al., "Burnout and Satisfaction," 1377-1385; Shanafelt et al., "Changes in burnout," 1600-1613; Shanafelt, Dyrbye, and West, "Addressing Physician Burnout," 901-902; Tait D. Shanafelt, Lotte N. Dyrbye, Christine Sinsky, Omar Hasan, Daniel Satele, Jeff Sloan, and Colin P. West, "Relationship Between Clerical Burden and Characteristics of the Electronic Environment With Physician Burnout and Professional Satisfaction," *Mayo Clinic Proceedings* 91, no. 7 (2016): 836-848, https://doi.org/10.1016/j.mayocp.2016.05.007; Alexi A. Wright and Ingrid T. Katz, "Beyond Burnout – Redesigning Care to Restore Meaning and Sanity for Physicians," *New England Journal of Medicine* 378, no. 4 (2018) 309-311, https://doi.org/10.1056/NEJMp1716845; Rothenberger, "Physician Burnout and Well-Being," 567-576; and many more.

refer to "physician burnout." More specifically, while there is a fair degree of consensus regarding the key characteristics of physician burnout (the 3 symptoms listed above, which are taken from the MBI), there is less consensus about the characteristics of burnout in scholarship dealing with non-physician populations.[29] This was particularly true in the decade following burnout's introduction. Maslach and Schaufeli describe just how broad and undefined *burnout* was historically as a classificatory term:

> [The] early burnout literature had several noteworthy characteristics, which in turn have had implications for the development of the burnout concept. First, what was meant by the term 'burnout' varied widely from one writer to the next. As a result, these writers were sometimes talking about different phenomena rather than the same one. A second, and related, characteristic is that the concept of burnout was stretched and expanded to encompass far more than did originally. Almost every personal problem that one can think of was described as 'burnout' at some point. In some cases, burnout was a somewhat superfluous addition, as in 'midlife crisis burnout.' In other cases, it was stretched to include opposite phenomena, such as overload and underload. The problem here is that a concept that has been expanded to mean everything ends up meaning nothing at all."[30]

One of the reasons for all of the variation was that many of the early writers were documenting examples of burnout more than they were engaging in scholarly analyses. In 1983 Golembiewski, Muzenrider, and Carter complained that to date, "much of the attention given to burnout has been episodic and anecdotal," which they felt had resulted in "diverse conceptual definitions of burnout, which encompass a broad – and often

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[29] Kaschka, Korczak, and Broich, "Burnout: A Fashionable Diagnosis," 782; B. A. Farber, "Symptoms and Types: Worn-Out, Frenetic, and Underchallenged Teachers," in *Crisis in Education. Stress and Burnout in the American Teacher*, ed. B. A. Farber, 72-97 (San Francisco, CA: Jossey-Bass Publishers, 1991); Montero-Marín, et al., "A new definition of burnout," 31-47; Bianchi, Schonfeld, and Laurent, "Is it time," 1-3; Bianchi, et al., "Burnout and depression," 91-98.

[30] Christina Maslach and Wilmar B Schaufeli, "Historical and Conceptual Development of Burnout," *Professional Burnout: Recent Developments in Theory and Research* eds. Wilmar S. Schaufeli, Christina Maslach, and Tadeusz Marek (Philadelphia, PA: Taylor & Francis, 1993) 4.

unclear – range of phenomena."[31] In other words, clinicians were eager to document this new phenomenon and demonstrate the many ways it could manifest, and were not particularly concerned with nailing down a solid and consistent definition.

Additionally, something about the concept of burnout resonated with workers in many different professions. As a result, its definition gradually expanded to include non-human-service jobs. For example, in 1979 M. Sasseli defined burnout as "a state of tension or energy exhaustion resulting from chronic tension and stress," a definition conspicuously lacking any mention of *emotional* energy, or human service interaction. In 1983 Golembiewski, Muzenrider, and Carter demonstrated that the MBI could be modified in order to measure burnout in non-human-service workers and created a phase-model that re-envisioned "depersonalization" and "diminished personal accomplishment" to better fit other professions such as sales and business administration.[32] These changes were significant, because they led to a proliferation of literature that focused on issues of overwork, intense stress, and administrative or bureaucratic concerns, as opposed to patient- or client-related stressors.[33]

The reason it is important to understand how this perception of generalized burnout has changed, and how its focus differs from the formal definition of "physician

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[31] Robert T. Golembiewski, Robert Munzenrider, and Diane Carter, "Phases of Progressive Burnout and Their Work Site Covariants: Critical Issues in OD Research and Praxis," *The Journal of Applied Behavioral Science* 19, no. 4 (1983): 462, https://doi.org/10.1177/002188638301900408.

[32] Golembiewski, Munzenrider, and Carter, "Phases of Progressive Burnout," 468-471.

[33] Robert T. Golembiewski and Michael Sccichitano, "Testing for demographic covariants of psychological burn-out: three sources of data rejecting robust and regular associations," *International Journal of Public Administration* 5, no. 4 (1983): 435-447, https://doi.org/10.1080/01900698308524457; *John* M. Angerer, "Job Burnout," *Journal of Employment Counseling* 40, no. 3 (2003): 98-107, https://doi.org/10.1002/j.2161-1920.2003.tb00860.x.

burnout," is that widely-held public perceptions concerning generalized burnout can influence how scholars and physicians interpret or understand physician burnout. In other words, the confusion and lack of consensus about such a closely related concept can bleed over into understandings of physician burnout. In fact, it can be difficult at times, even for those steeped in the research, to articulate the boundaries between generalized "burnout" definitions and medicalized "physician burnout" definitions. This is demonstrated by the fact that, even though most of the studies concerned with physician burnout reference the MBI's characterization of "emotional exhaustion, depersonalization, and reduced personal accomplishment," there are multiple different interpretations of what that definition actually means in modern medical publications.

For a better understanding of the range of interpretations which apply to the concept of *burnout,* specifically as it relates to physicians, the discussion will now turn to medical publications. For instance, a 2017 article published in *JAMA* (the Journal of the American Medical Association) characterizes physician burnout as "a syndrome of exhaustion, cynicism, and decreased effectiveness at work" with contributing factors including "excessive workload, clerical burden and inefficiency in the practice environment, a loss of control over work, problems with work-life integration, and erosion of meaning in work."[34] This definition is particularly interesting because it makes clear the impact of definitions of non-human-service related burnout. It characterizes *burnout* as more of a bureaucratic or even administrative issue and gives little attention to emotional complexity of physician distress, or the human component.

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[34] Shanafelt, Dyrbye and West, "Addressing Physician Burnout," 901.

A 2018 article in the Journal of Internal Medicine by West, Dyrbye and Shanafelt similarly defines *burnout* as "a work-related syndrome involving emotional exhaustion, depersonalization and a sense of reduced accomplishment," but then goes on to specify that "amongst physicians, emotional exhaustion includes feeling 'used up' at the end of the workday and having nothing left to offer patients from an emotional standpoint."[35] This definition goes a bit further in addressing the emotional and psychological components of burnout, indicating that it may go beyond issues of over-work and frustration over bureaucratic red tape. Ultimately, however, the strategies they recommend for combating burnout reveal more about their characterization of the term than their definition. The authors suggest that evidence-based strategies for reducing burnout include individual interventions such as "mindfulness, stress management training, communication skills training, exercise programs and self-care efforts," as well as organizational interventions such as "restrictions on resident duty hours," and reduction of " physician hours in intensive care units and on teaching rotations."[36] All of these interventions either directly address workload issues, or directly or indirectly address general stress and anxiety issues.

Additionally, none of the recommended interventions deal with the specific emotional distress physicians confront on a daily basis interacting intimately with a high degree of human suffering and death. Returning to the larger discussion about traumatization, this demonstrates one of the ways that burnout and traumatization differ.

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35 C. P. West, L. N. Dyrbie, and T. D. Shanafelt, "Physician burnout: contributors, consequences and solutions," *Journal of Internal Medicine* 283, no. 6 (2018): 516, https://doi.org/10.1111/joim.12752.

36 West, Dyrbye and Shanafelt, "Physician Burnout," 521.

As demonstrated in Figure 4, the characterizations of burnout that focus more specifically on bureaucratic stress and overwork as causes, completely ignore the traumatic aspects of medicine, and their potential influence over physicians' symptoms of distress. Even West, Dyrbye, and Shanafelt's additional recommendation of "participation in small-group programmes oriented around promoting community, connectedness and meaning," only obliquely touched on these issues of physician suffering and traumatization.[37] It is also worth noting that the descriptor "programmes oriented around promoting community, connectedness and meaning," is a vague recommendation, and could include a number of vastly different interventions, many of which might have nothing to do with emotional distress and may not offer ways of fortifying emotional resilience. It is also significant the fact that the suggested interventions do not include psychotherapy, or any type of formal mental health intervention.

It is worth noting that some definitions of burnout are more nuanced and do specifically include emotion, mood, and stress-related issues. An article by Linda Gundersen entitled "Physician Burnout," which appeared the *Annals of Internal Medicine* in 2001, offers a definition that arguably provides the most emotionally- inclusive characterization of physician job-related distress – including issues associated with overwork, emotional stress, and mental health-related conditions. It describes

[37] Ibid.

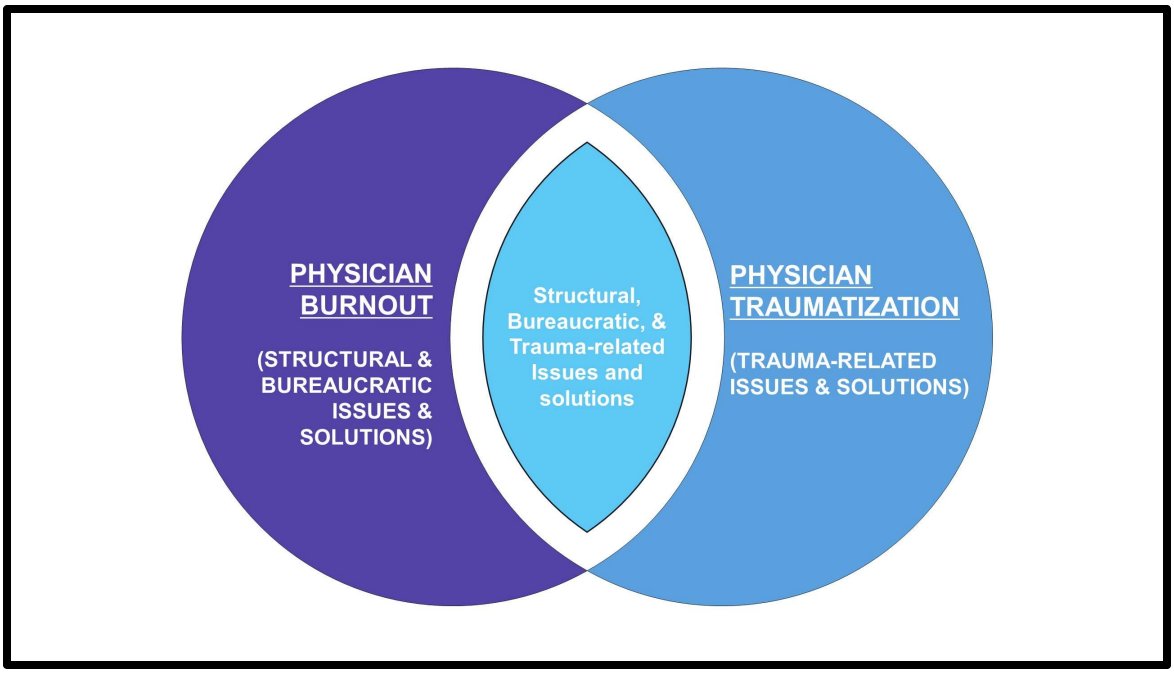

Figure 5. Conceptual Distinction and Overlap of Physician Burnout and Physician Traumatization

burnout as a condition characterized by "fatigue, exhaustion, inability to concentrate, depression, anxiety, insomnia, irritability, and sometimes increased use of alcohol or drugs. [38] Gundersen's article is significant, because it does a good job of looking at some of the emotional implications of burnout. It also considers how burnout can lead to serious mental health problems including emotional isolation, depression, substance abuse, and suicide.[39] Though, while Gundersen addresses inadequate self-care and a tendency to ignore or deny emotions as possible contributors to burnout, she fails to look at the role trauma might play in the development of this form of physician distress.

Interestingly, Gundersen's characterization of burnout is so inclusive that it might actually be possible to classify physician traumatization under this more broad and

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[38] Linda Gundersen, "Physician Burnout," *Annals of Internal Medicine* 135, no. 2 (2001): 145-148, https://doi.org/10.7326/0003-4819-135-2-200107170-00023.

[39] Gundersen, "Physician Burnout", 145.

nuanced definition. In fact, Gundersen's characterization is broad enough to cover traumatization, as well as more bureaucratic forms of burnout that result from overwork, poor work/life balance, or frustration over excess administrative red tape. In fact, if Gundersen's inclusive and emotionally complex definition of burnout were to be adopted as a universally accepted characterization, then the relationship between burnout and traumatization could essentially become the reverse of the relationship between PTSD and traumatization. Put another way, in terms of classificatory hierarchy, PTSD would fall under the classification of traumatization, while traumatization would fall under the classification of burnout, as demonstrated in Figure 5.

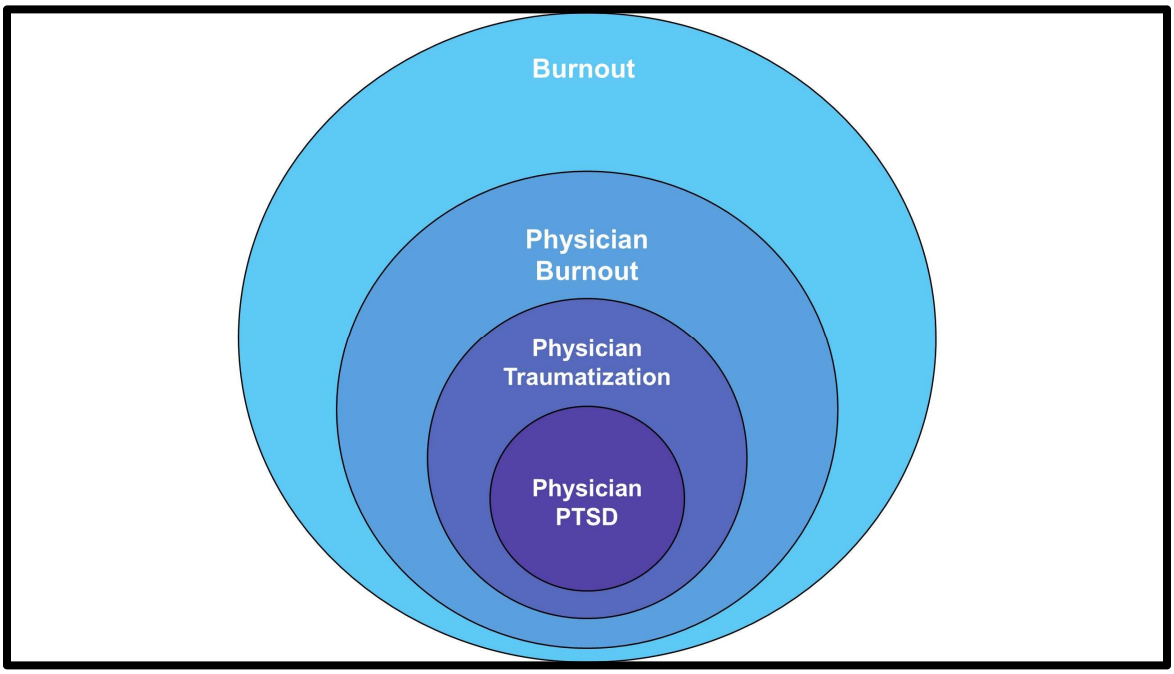

Figure 6. Classification of Physician Traumatization and PTSD using Gundersen's Framework

Under such a model, all traumatized physicians could be considered burned out, and all physicians with work-related PTSD could be considered traumatized. At the same time, however, not all traumatized physicians would necessarily qualify for a diagnosis of PTSD, and not all burned out physicians would automatically be considered traumatized.

It is a hierarchical classificatory schema which naturally leads to the question: If *burnout* is the most broad and inclusive categorization, then why not simplify things and use it to refer to all the various forms of physician distress which fall under its definition? It would technically be accurate and the broadness of the 'higher' level of classification would allow for more flexibility in the types of conditions that can be included. Is this paper's insistence upon using the more precise term *traumatization* simply a preference for using as much specificity as possible? Is it merely the most recent version of the more-than-a-century-old debate between "lumpers and splitters?"[40] The answer is somewhat complicated. While part of the reason for advocating for the use of the term *traumatization* has to do with its higher degree of specificity, the rest has to do with the semantic implications and potential dangers of using the term *burnout* to disguise issues of *traumatization.*

The Dangers of Conflating Burnout and Traumatization

The argument over which term to use has a great deal to do with the implied meaning and associated implications of each term.[41] This paper argues that a significant part of the reason many of these conditions are characterized using the less specific term *burnout,* as opposed to the more specific term *traumatization*, is that there is stigma

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40 This refers to the debate in any discipline over whether to "split" levels of classifications apart into more specific and distinct groups, or to utilize more inclusive and broad classification, there by "lumping" more categories together. It is often associated with biological taxa. For more see George G. Simpson, "The Principles of Classification and a Classification of Mammals," *Bulletin of the American Museum of Natural History* 85 (1945): 22-23, https://doi.org/10.1002/ajpa.1330040218; V. A. McKusick, "On Lumpers and splitters, or the nosology of genetic disease," *Perspectives in Biology and Medicine* 12, no. 2 (1969): 298-312, https://doi.org/10.1353/pbm.1969.0039.

41 For another thorough discussion on the difference between burnout and trauma-related conditions like secondary traumatic stress and compassion fatigue, please see: Figley, *Compassion Fatigue as Secondary Traumatic Distress*, 11-14.

associated with the word trauma. Chapter 5 will discuss where this stigma comes from and look deeper into its association with trauma, while chapter 4 will look more closely at the concept of stigma and discuss how it functions to control behavior.

For now, however, what is important to recognize is that the term *traumatization* may be associated for many physicians with a stigma connected to broader prejudices and stigmas related to mental illness, as well as historically-informed perceptions of trauma-related conditions. As a result, many consider it to be shameful to be traumatized; it may be considered a sign of weakness in a profession which values strength.[42] Michael Kauffman explains that many physicians struggling with intense feelings of distress frequently experience "a since of shame and stigma… maybe even more so for physicians, who are often trained, and regarded, to be able to rise above such problems."[43] He explains that they often "suffer in silence, successfully portraying a calm and competent outward appearance," in an attempt to maintain the illusion of strength and competence and eschew any chance of stigmatization.[44] It is therefore reasonable to conclude that the choice to label these issues as *burnout* instead of *traumatization*, may be an attempt to use a label that carries less risk of stigma.[45] The term "burnout" would function, not only because *burnout* lacks the historical negative associations linked to the

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[42] Tyler Dabel, "Why We Need to Help Doctors with PTSD Understand the Importance of Healing Their Trauma," Bridges to Recovery, last updated February 15, 2017, https://www.bridgestorecovery.com/blog/why-we-need-to-help-doctors-with-ptsd-understand-the-importance-of-healing-their-trauma/.

[43] Michael Kaufmann, "Physician Suicide: risk factors and prevention," *Ontario Medical Review* September (2000) 20-22.

[44] Ibid.

[45] Bianchi et al. make a similar argument regarding depression and burnout, suggesting that "burnout" may be used more frequently than "depression" (even though the authors demonstrate there is a good deal of condition overlap) because it carries less stigma. Please see: Bianchi, et al., "Burnout and depression," 92.

term *traumatization,* but also because *burnout* carries specific, and potentially more positive semantic implications, which could be viewed as more beneficial to physicians.

In order to better understand the semantics and implied meanings related to the term burnout, it will be most helpful to start by looking at two of the most important metaphors connected to the word. The first is the term itself: *burnout*. This expression refers to the cessation, or "burning out" of a fire, as the result of it having consumed, or "burned up" at least one of its required fuels, or necessary resources.[46] An example would be when a campfire burns out after the fire burns through all the available firewood. Once the wood (a necessary resource) is gone, the fire inevitably dies from lack of fuel. This is the quintessential metaphor which is alluded to by using the term *burnout* to identify this work-related stress condition[47].

The second, related metaphorical term we must look at is the term *exhaustion.* Most of the available definitions of burnout utilize the word *exhaustion* in at least one way, whether describing emotional, physical, psychological, or empathic depletion. It is therefore useful to understand what that term means. "Exhaustion" describes a state of being exhausted. The first two available definitions for "exhaust" provided by the online version of the Merriam-Webster dictionary are "to consume entirely" and "to tire

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46 Schaufeli, Leiter, and Maslach, "Burnout,"205.

47 The author has presented a conference paper on the rhetorical implications of this and other metaphors related to the concept of burnout and is currently working to publish this work: Stephanie Shively, "Problematic Language: How the term 'burnout' limits attempts to assist struggling physicians," Paper Presentation, *The Environment of the Health Humanities: Inquiry and Practice,* 8th International Health Humanities Meeting, Conference held at DePaul University, Chicago, TX, March 29, 2019.

extremely or completely."[48] The first version of the word mirrors the meaning of *burnout* almost exactly, while the second implies pushing one's self past one's limits.

The meaning of both these terms is important because of the resulting implications of using *burnout* and *exhaustion* to describe these conditions of work-related job distress. Their use as a label implies that whatever characteristics are described as *exhausted* in the definition of *burnout* have been exercised to the point that they are used up or consumed entirely, most likely through overuse. For example, if a burned-out physician is described as "overworked, and suffering from emotional and empathic exhaustion," then the implications are that that physician worked so hard and was so emotionally and empathetically invested in his/her/their patients that he/she/they now find those resources depleted or used up. In other words, the implication that those attributes or emotional resources are used up also indicates that they were both present and utilized. This way of looking at burnout is a method "rephrasing" burnout from a "positive-pole," or as "positively worded items that were reversed to constitute a negative scale," as Schaufeli, Leiter and Maslach explain.[49] They suggest that "changing focus in burnout research from an exclusively negative approach to the erosion of a positive psychological state" is part of the most recent conceptualizations of burnout that shifts emphasis toward the valuable lessons that burnout can teach us about what is important.[50] By defining burnout as an exhaustion or depletion of particular characteristics which are necessary for success in one's job, not only is it implied that the people in question

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48 *Merriam-Webster's Collegiate Dictionary*, 11th ed. Springfield, MA: Merriam - Webster, 2019 *s.v.* "exhaust," accessed February 16, 2019, https://www.merriam-webster.com/dictionary/exhausting.

49 Schaufeli, Leiter and Maslach, "Burnout," 214.

50 Schaufeli, Leiter and Maslach, "Burnout," 215.

possessed those characteristics, but that they also utilized those characteristics to such an extent that they exhausted them. If we look at burnout in this light, it is essentially saying "This person had the right idea. They just went too far." This positively valanced conceptualization of burnout not only frames it in a less negative way, but it simultaneously masks some of the more insidious causes of physician distress, such as traumatization.

Additionally, the tendency to describe instances of traumatization as forms of burnout functions to bolster the heroic archetype in the role of the doctor. This is an issue that will be discussed at length in Chapter 5 but can be briefly summarized here for the sake of the current argument. The use of the term *burnout* functions semantically to bolster the image of doctors as hard working, self-sacrificing, and extremely dedicated to their calling to help others. Since burnout was originally coined to describe volunteers in the helping professions, early scholars of burnout saw it as a repercussion of those idealistic and altruistic people encountering difficulty in achieving their goals as the result of roadblocks from various sources.[51] The resulting image was of frustrated idealistic individuals fighting a losing, uphill battle to hold onto their principles of compassionate care, helping others, and sacrifice for the good of others, until they eventually pushed themselves too hard and burned out. It is an image of a frustrated, burned out hero, and in applying it to physicians helps to support the heroic archetype which plays a significant role in the professional role of doctors. Furthermore, while the

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51 Freudenberger, "Staff burn-out,"; Maslach and Zimbardo, *Burnout: The Cost of Caring*; Maslach and Schaufeli, "Historical and Conceptual Development of Burnout,"; Schaufeli, Leiter, and Maslach, "Burnout: 35 years of research."

understanding of burnout has changed and evolved since its introduction in the 1970s, this association between burnout and the "helping professions" continues to this day.[52]

This perspective on the concept of burnout helps to elucidate why choosing to use the label *burnout* might have a protective function for physicians. The definition of the term *burnout* semantically bolsters the image of doctors as hard working, self-sacrificing, and extremely dedicated to their calling.[53] In a way it functions inversely to reaffirm the traits that are valued by the medical community, as well as the individuals who are likely to excel at them. T. Jock Murray, MD, a professor of neurology, Director of the Dalhousie Multiple Sclerosis Research, and Director of the Medical Humanities program at Dalhousie University explains: "we want people who are driven, who are competitive, who can excel at everything that they do," in reference to the type of students that medical schools look for.[54] He then goes on to explain that, as a result, it should not be surprising that when those people begin practicing medicine "they try to do everything, and they have this complex which also says they must succeed at everything."[55] In essence, the personality traits that medical schools look for in candidates, and the professional identity that is instilled in those individuals through training and enculturation within the medical profession, emphasizes qualities and practices which combine to frequently result in burnout. [56]

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[52] West, Dyrbye and Shanafelt, "Physician Burnout," 516-529; Newell and MacNeil, "Professional Burnout," 57-68.

[53] Richard Gunderman, "The Root of Physician Burnout," *The Atlantic* (August 27, 2012), accessed January 24, 2019, https://www.theatlantic.com/health/archive/2012/08/the-root-of-physician-burnout/261590/.

[54] This is an interview quote that appears in: Linda Gunderson, "Physician Burnout," 145.

[55] Ibid.

[56] Gunderman, "The root of Physician Burnout."

This means that the linguistic connotation almost implies that burned out individuals have been such "good" doctors and have worked so hard and been so committed to helping others that they sacrificed their own well-being; they pushed themselves past their limits. Not only does this implication reaffirm the heroic archetype of doctors within the medical community, but it forms a protective insulation around struggling physicians. It naturalizes their distress and even reframes it in a way that is arguably even slightly complimentary. It is certainly a much more positive framing of physician distress that one associated with stigma, shame, and weakness.

This is another important point to connect to the discussion concerning traumatization, because the tendency to categorize some of these situations as "burnout" instead of using potentially more accurate labels such as "traumatization" could, in addition to valorizing distressed physicians, be indicative of a desire to avoid the stigma associated with other terms such as trauma. The label "burnout" suggests working too hard, pushing oneself to the extreme, overextending, and/or choosing to deal with a high number of difficult cases to the point of mental and emotional depletion, which for many is an acceptable, even flattering characterization. On the other hand, the label "traumatized" may suggest something very different and much more negative to many physicians. It may suggest being weak, emotionally unstable, not being capable of handling one's responsibilities, and/or of having failed to learn the coping methods (professional distance, etc.) that doctors are trained to use.[57] For these physicians it is much more acceptable to be labeled or to label oneself as *burned out* as opposed to

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57 Tiffany M. Greene-Shortridge, Thomas W. Britt, and Andrew Castro, "The Stigma of Mental Health Problems in the Military," *Military Medicine* 172, no. 2 (2007): 157-161, https://doi.org/10.7205/milmed.172.2.157; Kaufman, "Physician Suicide," 21.

traumatized, because "burnout" holds a semantic change that is more positive, more reaffirming of the self-identity of many doctors, more in line with the professionalization doctrines that they praise and prize.

It is important to recognize that this negative attitude towards *traumatization* is not an overt attitude either. This stigmatization of trauma and trauma-related conditions is an undercurrent in the medical culture. It is related, as we will be discussed later in chapter 5, to medicine's intimate and negative historical relationship to the classification and 'treatment' of trauma-related conditions. It is also connected to broader, deeply-embedded cultural stigmas surrounding mental illness, both within the profession of medicine, and American culture at large. [58] This is in part because the term "traumatization" is more likely to be rhetorically associated with Post Traumatic Stress Disorder (PTSD), which is widely identified as a mental health diagnosis. There are historically informed prejudices against mental health issues (and subsequently trauma-related issues) that are prevalent within the medical culture.[59] They become evident upon examination of attitudes and behavior of physicians who are struggling with such issues. Goebert et all identify, for instance, in a study looking at depressive symptoms and suicidal ideation in medical students across the nation, that despite previous published studies[60] advocating for the utilization of mental health services by struggling physicians, "few trainees utilize psychiatric services because of issues of stigma, cost, and

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[58] Rössler, "The stigma of mental disorders," 1251-1252.

[59] Ibid.

[60] D. B. Borenstein, "Should physician training centers offer formal psychiatric assistance to house officers? A report on the major findings of a prototype program," *American Journal of Psychiatry* 142 (1985): 1053-1057, https://doi.org/10.1176/ajp.142.9.1053.

accessibility."[61] Furthermore, a consensus statement by Center et al which appeared in *JAMA* in 2003 concluded "the culture of medicine accords low priority to physician mental health despite evidence of untreated mood disorders and an increased burden of suicide." They then went on to specify that the "barriers to physicians in seeking help are often punitive, including discrimination in medical licensing, hospital privileges, and professional advancement."[62]

All of this is evidence of the stigmatization of traumatization within the culture of medicine It also speaks to why there is power in reframing the issue of physician job-related distress as *traumatization* as opposed to *burnout*. Some might argue that referring to these issues as *burnout* allows struggling physicians a level of insulation from the stigma associated with *traumatization*; that it allows them a safer and more hospitable environment for dealing with their struggles. The problem with that argument is that using the term *burnout* not only allows for complete avoidance or denial of the role trauma plays within the profession of medicine, as well as these physicians' lives, but it also re-affirms the stigma associated with the term *traumatization*. It asserts that it is better to use the term *burnout* because there is in fact something shameful about traumatization. Recall that Jane was willing to entertain the idea that she might be experiencing burnout and was even willing to attempt some of the suggested interventions. She was not, on the other hand, willing to seek mental health services and did not consider that she might be experiencing depression or traumatization.

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61 Deborah Goebert et al, "Depressive Symptoms in Medical Students and Residents: A Multischool Study," *Academic Medicine* 84, no. 2 (2009): 236-241, https://doi.org/10.1097/ACM.0b013e31819391bb.

62 Center et al, "Confronting Depression," 3165.

This dissertation argues that it is important to openly acknowledge and publicly discuss the high probability that physicians become traumatized as a result of practicing medicine. It is important to recognize that there is power in identifying those struggles having to do with trauma as forms of traumatization, precisely because doing so not only affirms that there is nothing shameful about traumatization, but also acknowledges trauma as a natural potential consequence of treating the suffering of others.

What Qualifies as Traumatization?

At this point, this chapter has distinguished between the specific medical diagnosis of PTSD and the more inclusive and general category of traumatization. It has also identified the need for more specificity within the category of physician burnout and recognized what sets traumatization apart from other forms of physician distress which are frequently lumped together under the more vague and general term *burnout*. In essence, the case has been made for the category/label "physician traumatization" to be incorporated into both the public and scholarly discourse regarding physician distress, and should be identified as distinct from, yet related to, physician burnout. Furthermore, the argument has been made that PTSD, and a handful of other trauma-related conditions, should be considered different medicalized and non-medicalized forms of traumatization.

This is an important point to reiterate because it highlights one of the potential benefits of employing higher-level classificatory terms like "physician distress" or "physician traumatization."[63] Their broad nature and lack of specificity acts as an indicator that more attention must be paid in order to gain a better understanding of exactly what is going on. Both terms trigger an additional question: What *type* of distress

63 Simpson, "The Principles of Classification."

or traumatization? This in turn triggers further investigation. This is one of the problems with the current rhetoric regarding physician burnout. As mentioned in the introduction, different forms of related physician distress (depression, traumatization, substance abuse, suicidal ideation, etc.) are frequently lumped together and spoken about collectively in the literature as symptoms of physician burnout.[64] This is problematic, however, because the term "burnout" implies a single, specific condition.[65] It's use therefor signifies that the problem has been identified, investigation can cease, and a solution or treatment can be enacted. This kind of assumption can be dangerous if, as in Jane's example, burnout is not actually the problem, but it is the label that is applied. Usage of a less specific term like "physician traumatization" not only more accurately describes what physicians like Jane are experiencing but is also vague enough that it implies there are different forms of traumatization, and more attention must be paid to determine exactly how an individual physician is suffering.

The next logical step in this discussion is then to define what exactly counts as *physician traumatization*? To begin with, it is a group of conditions characterized by at least one of the classic symptoms of traumatic stress: "intrusion, avoidance, negative alterations in cognition and mood and alterations in arousal and reactivity."[66] This list of symptoms also includes some of the symptoms of burnout, specifically emotional,

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64 Gundersen, "Physician Burnout," 145; Rothenberger, "Physician Burnout and Well-Being," 569; Please refer back to the introduction for a more thorough discussion and a list of references.

65 The author never came across a single characterization of burnout as a cluster of conditions. While Other conditions such as depression and substance abuse were frequently mentioned as either symptoms of burnout, or related consequential conditions, they were never classified as subtypes of physician burnout. Burnout was always presented as a specific type of physician distress.

66These are the defining classes of symptoms of PTSD - Pai, Suris, and North, "Posttraumatic Stress Disorder," 4.

empathic, and/or psychological fatigue. Like PTSD, these symptoms must be the result of direct or indirect exposure to a traumatic event or events, either chronic or acute. However, unlike the current definition of PTSD in the DSM-5 the criteria governing what qualifies as a "traumatic event" are much less narrow when referring to traumatization.[67] In fact, while qualifying traumatic events usually have some relation to death, injury, trauma, or suffering, ultimately a traumatic event is defined largely by whether it elicits a strong negative emotional response, followed by any of the above symptoms of traumatic stress. This means that an event that seems commonplace or innocuous to one individual may be traumatizing to another. While some may argue that this definition is too inclusive, its broad recognition of different forms of traumatic distress allows for the inclusion of forms of traumatization that are currently ignored or labeled as "subclinical," which is precisely the point. It is meant to help identify struggling, traumatized physicians, not to weed out those whose struggles were caused by events deemed "not traumatizing enough."

The final defining characteristic of *physician traumatization* is that the inciting traumatic event and the resulting symptomology are both related to the physician's role as a doctor. Typically, this means that the event happened at work, and that the

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[67] The author has chosen to incorporate the symptoms of traumatic stress into her definition of traumatization because she feels they have been shown to be accurate indicators of traumatization. In fact, the author believes that the problem with the current medical definition of PTSD is not that its symptomology is poorly described, but instead that it is too narrow and restrictive. The most recent changes to the definition of PTSD in the DSM-5 represent an attempt to make the diagnostic criteria less subjective, but the author contends that that was a mistake because traumatization is, by its very nature, inherently subjective. As a result, the author's definition of "physician traumatization" could be considered a non-medicalize, more inclusive and more subjective version of PTSD.

debilitating symptoms are hindering the affected physician's ability to perform his/her/their job.

Medical Errors and SVS

The remainder of this chapter will look at some specific conditions that the author argues should fall under the classification of physician traumatization. The first condition that will be discussed is the primary problem presented in Jane's case study. While it is possible to identify more than one traumatic condition in Jane's story, a fact that will be returned to later, her case study is primarily an example of what is known in the medical professionalism literature as *Second Victim Syndrome* (SVS).[68] SVS refers to situations in which "a healthcare provider involved in an unanticipated adverse patient occurrence experiences psychological and emotional trauma related to the event." [69] The term was coined by Albert W. Wu in an editorial published in the British Medical Journal in 2000. In that editorial Wu asserts that "although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims."[70] In other words, doctors who make devastating medical errors are often emotionally and psychologically injured as a result of those mistakes.

This is clearly what is described in Jane's case. Even though the mistake that she made was minor and she was unable to know with certainty whether it led to her patient's

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[68] Much of the scholarly literature regarding SVS appears in medical professionalism and patient safety literature, primarily in response to work concerning medical errors. It also appears in the literature regarding physician distress.

[69] Louis M. Marmon and Kurt Heiss, "Improving surgeon wellness: The second victim syndrome and quality of care," *Seminars in Pediatric Surgery* 24 (2015): 315-318, https://doi.org/10.1053/j.sempedsurg.2015.08.011.

[70] Albert W. Wu, "Medical error: the second victim," *British Medical Journal* 320, no. 7237 (2000): 726-727, https://doi.org/10.1136/bmj.320.7237.726.

deficits, Jane's resulting fear, anguish, and shame were severe and interfered with her ability to do her job. She no longer trusted in her abilities. Edrees et al explain that second victims of medical errors may "in addition to feelings of guilt, anger, fear," also experience "doubt [in] their clinical competence and even their ability to continue working as a health care provider."[71] This is precisely what we see in Jane's case. While her mistake was so small that it went entirely unnoticed by everyone except herself, it provided a graphic reminder to Jane of her own fallibility. It planted a terrible seed of self-doubt in her mind which proved crippling.

Jane's mistake also made her acutely aware of the potentially dire consequences that could occur if she were to make another mistake in the future. Edrees et all (2011) explain that "medical errors that harm patients are inevitable, and experience of these events can leave indelible impressions on health care providers."[72] This is because physicians are human, which means that they are fallible. Everyone makes mistakes and eventual job-related errors are not a possibility, they are a guarantee. The problem is that when one works in the medical field, those mistakes can be fatal. A report entitled *To Err Is Human: Building a Safer Health System, Volume 6*, compiled by the Institute of Medicine in 2000 (the same year as Wu's editorial coining the term *Secondary Victims*) reports that studies suggest as many as 98,000 deaths per year may be the result of medical errors. The authors go on to suggest that "more people die in a given year as a result of medical errors than from motor vehicle accidents (43,458), breast cancer

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71 Edrees et al, "Health care workers as second victims of medical errors," *POLSKIE ARCHIWUM MEDYCYNY WEWNĘTRZNEJ* 121, no. 4 (2011): 102.

72 Edrees et al, "Health care workers," 107.

(42,297) or AIDS (16,516).[73] While these are sobering statistics from the perspective of patient safety, they become even more disturbing when one takes into consideration the potential number of secondary victims related to those medical errors. That number represents an incredibly large number of suffering individuals.

Many physicians like Jane, also keep their struggles to themselves because they are afraid to talk about their mistakes. Not only are they embarrassed and ashamed, but many physicians also worry about what Marmon and Heiss (2015) refer to as "Enduring the Inquisition."[74] This refers to the institutional investigations and potential disciplinary actions which frequently result from medical errors. This can range from minor criticism from superiors (like stern lecture Jane received when she confided in her attending about her possible mistake), or public shaming at morbidity and mortality conferences (M+M), to being placed on administrative leave, or losing one's job.[75] In some extreme cases medical mistakes can result in losing one's medical license or facing civil or criminal charges. And of course, there is also the ever-present threat of a lawsuit[76]. It is possible that this focus on punitive repercussions for medical errors is the understandable result of public attention and activism centered around improving patient safety protocols and

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[73] Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, eds., *To Err Is Human: Building a Safer Health System*, volume 6, report by Committee on Quality of Health Care in America, Institute of Medicine (Washington, D.C.: National Academies Press, 2000), 1.

[74] Marmon and Heiss, "Improving surgeon wellness," 316.

[75] Emily L. Aronson et al., "Morbidity and Mortality Conference in emergency Medicine Residencies and the Culture of Safety," *Western Journal of Emergency Medicine* 16, no. 6 (2015): 810-817, https://doi.org/10.1016/j.jemermed.2008.09.018.

[76] Allen Kachalia et al., "Does Full Disclosure of Medical Errors Affect Malpractice Liability? The Jury Is Still Out," *The Joint Commission Journal on Quality and Safety* 29, no. 10 (2003): 503-511, https://doi.org/10.1016/S1549-3741(03)29060-2.

increasing transparency.[77] Unfortunately, this patient-centered approach often leaves the traumatized providers to struggle on their own. As Marmon and Heiss explain:

> Initially the involved healthcare organization responds to an adverse event by addressing the needs of the patient and their family members. As a "third victim," the organization will customarily also need time to evaluate and recover from the incident, make public disclosure to appropriate agencies, and to identify any root causes to understand what occurred and why it happened to improve quality of care and to prevent future harm. Many organizations do not have established response systems in place to address the emotional and psychological needs of the involved providers.[78]

In other words, while most of the attention is understandably centered around the patients (the primary victims of medical errors), and the medical establishments (the third victims) frequently scramble to understand what happened, institute procedural fixes, and protect themselves from legal ramification, the physicians who made the mistakes (the secondary victims) are often abandoned to cope on their own.[79]

There are many stories of healthcare providers whose careers and lives were destroyed as the result of unfortunate medical errors.[80] It is understandable why physicians might be terrified of the repercussions of a mistake, or why Jane might have been so worried about the possibility of making another, potentially more severe mistake.

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[77] Edrees et al, "Healthcare workers," 103; S. T. Chan, P. C. B. Khong, and W. Wang, "Psychological responses, coping and supporting needs of healthcare professionals as second victims," *International Nursing Review* 64, no. 2 (2017): 243, https://doi.org/10.1111/inr.12317; Kohn, Corrigan, and Donaldson, *To Err Is Human*.

[78] Marmon and Heiss, "Improving surgeon wellness," 316.

[79] It is important to note that this issue is not limited to physicians. SVS can and does affect nurses, support staff, and other healthcare providers as well. In fact, much of the available literature concerning SVS focuses on nurses.

[80] Matthew Grissinger, "Too Many Abandon the 'Second Victims' Of Medical Errors," *P&T* 39, no. 9 (2014): 591-592, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4159062/; Elizabeth R, "The Mistake I'll Never Forget," *Nursing* September 1990, 50-51; Mara Gordon, "When A Nurse Is Prosecuted For A Fatal Medical Mistake, Does It Make Medicine Safer?," *npr*, April 10, 2019, https://www.npr.org/sections/health-shots/2019/04/10/709971677/when-a-nurse-is-prosecuted-for-a-fatal-medical-mistake-does-it-make-medicine-saf.

This also explains why providers who have made medical errors are hesitant to talk about it with others. Edrees et al (2017) found after conducting a survey of healthcare providers that "although the large majority of respondents were able to identify a case in which they felt emotionally traumatized by their involvement in an adverse event, many had not heard of the term 'second victim'."[81] This not only points to the tendency of providers to suffer in silence and to keep their emotional struggles to themselves, but it also highlights the importance of having access to the appropriate language necessary to describe and identify unrecognized forms of distress. Many of the physicians interviewed by Edrees et al thought that they were alone in their struggles, because the discourse about SVS (like many of the other forms of traumatization) is not as popular or visible as the discourse about burnout. Edrees et al.'s study illuminates the importance of language and rhetoric in addressing less popular forms of physician distress.

Edrees et al.'s study also found that suffering providers were unlikely to seek help from existing institutional services or established infrastructure.[82] The concern over stigma was simply too great. In fact, the concern over stigmatization was so extreme that the authors provided a list of suggested responses for practitioners to use if a coworker ever confides in them about a medical error. They also provide a second list of problematic responses which reveals some of the stigma that traumatized physicians frequently face. It includes phrases such as "Didn't you realize what would happen?", "I wouldn't have done that!", and perhaps most telling of all, "You need to get over it."[83] This last comment closely resembles the advice that Jane's attending offered her after she

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81 Edrees et al, "Health care workers," 106.

82 Ibid.

83 Ibid.

told him about her mistake during Anna's surgery. He encouraged her to "take the win," and move on, which, although it was intended to help, only left Jane feeling more isolated in her distress. Because of his response, Jane not only struggled with the traumatization caused by her mistake, but also added shame over concern that her reaction was inappropriate. [84] Finally, many doctors may, like Jane feel guilty for even feeling distressed, because they are not the primary victims of the medical error, failing to recognize the validity of their own victimhood. This is where increased rhetoric regarding physician traumatization could help such struggling doctors to not only put a name to their suffering, but also recognize it as a valid form of distress.[85]

Indirect and Chronic Trauma – CF, STS, and VT

While SVS refers to a form of traumatization that results from the trauma of a medical error the next set of conditions that fall under the proposed category of physician traumatization result from more indirect or chronic interactions with traumatic events. It is also important to point out that, while there is relative consensus about the definition of SVS, there is less definitional cohesion when it comes to these conditions. It is for this reason that this chapter will clearly identify the definition that is being used for each term.

The indirect and/or chronic forms of traumatization that this dissertation argues should be classified as forms of physician traumatization are compassion fatigue (CF),

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[84] It is also important to point out that SVS can occur in response to small medical errors as well as large ones, as in Jane's case. Though much of the research regarding SVS deals with major medical errors that result in significant patient morbidity or mortality, intense feeling of stress, shame, and guilt can also arise as the result of minor mistakes, or even mistakes that the primary victims are unaware of.

[85] Edrees et al, "Health care workers," 106.

secondary traumatic stress (STS), and vicarious trauma (VT)[86] Before proceeding, it is important to acknowledge that these three conditions have a fair amount of definitional overlap, which can make them difficult, at times, to distinguish from one another. Furthermore, some scholars insist that CF, VT, and STS should be considered separate yet related constructs,[87] while others, like Charles Figley, suggest that VT and STS should be considered related subtypes of the larger phenomenon, compassion fatigue. [88] This dissertation adopts Figley's framework of these conditions, not only because it is convincing and well-articulated, but also because Figley is a formative and influential scholar in the field of Traumatology, as well as being among the first to write on the topic of indirect or secondary traumatization.[89]

It is also important to point out that much of the work concerning these issues comes from the mental-health-related fields. Psychology and Psychiatry have historically

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86 Arohaina Nimmo and Peter Huggard, "A Systematic Review of the Measurements of Compassion fatigue, Vicarious Trauma, and Secondary Traumatic Stress in Physicians," *Australian Journal of Disaster and Trauma* Studies 2013, no. 1 (2013): 37-44; Sarah C. Voss Horrell et al, "Treating Traumatized OEF/OIF Veterans: How Does Trauma Treatment Affect the Clinician?," *Professional Psychology: Research and Practice* 42, no. 1 (2011): 79-86, https://doi.org/10.1037/a0022297.

87 Nimmo and Huggard, "A Systematic Review," 38-39; Jason Newell and Gordon A. MacNeil, "Professional Burnout, Vicarious Trauma, Secondary Traumatic Stress, and Compassion Fatigue: A Review of Theoretical Terms, Risk Factors, and Preventative Methods for Clinicians and Researchers," *Best Practices in Mental Health* 6, no. 2 (2010): 57-68.

88 Jeffrey E. Barnett et al., "In Pursuit of Wellness: The Self-Care Imperative," *Professional Psychology: Research and Practice* 38, no. 6 (2007): 603-612, https://doi.org/10.1037/0735-7028.38.6.603.

89 Charles R. Figley, "Traumatization and comfort: Close relationships may be hazardous to your health," Keynote Presentation, *Families and close relationships: Individuals in social interaction,* Conference held at Texas Tech University, Lubbock, (February, 1983); Charles R. Figley, "The family as victim: Mental health implications," in *Stress and the family: Vol. 2. Coping with catastrophe*, ed. Charles R. Figley and H.I. McCubbins, 3-20 (New York, NY: Brunner/Mazel, 1983); Charles R. Figley, "Compassion stress and the family therapist," *Family Therapy News*, February 1993, 1-8; Charles R. Figley, "Compassion Fatigue as Secondary Traumatic Stress Disorder: An Overview," in *Compassion Fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* ed. Charles R. Figley (Philadelphia, PA: Brunner/Mazel, 1995).

been more open to discussing the ramifications of traumatization and *secondary distress* on providers than many other medical specialties.[90] In fact, Johnson et al (2011) argues that it is an ethical obligation of psychologists and mental healthcare providers to attend to their psychological wellbeing to ensure their competence. They argue that the psychological and emotional soundness of practitioners is "essential for rendering effective services and for protecting patients," and therefore it is imperative that practitioners monitor their emotional and psychological wellness and seek help when they are experiencing problems.[91]

As Figley identifies compassion fatigue as the broader construct under which VT and STS, it seems only logical to begin with a definition of CF. According to Newell and MacNeil, compassion fatigue is "a more general term describing the overall experience of emotional and physical fatigue that social service professionals experience due to the chronic use of empathy when treating patients who are suffering in some way."[92] Figley identifies compassion fatigue as the common result of "professional work centered on the relief of the emotional suffering of clients," and which frequently "includes absorbing that suffering itself."[93] Figley also goes on to explain that in his early years of research on

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90 Though Psychologists are not medical doctors, I will not distinguish between psychological and psychiatric literature in this dissertation because they both deal with the psychological ramifications of trauma.

91 W. Brad Johnson et al, "Psychology *in Extremis," 95.*

92 Newell and MacNeil, "Professional Burnout, Vicarious Trauma," 61. It is also worth noting that Newell and MacNeil suggest Compassion Fatigue to be an umbrella term under which burnout and STS fall, further complicating the definition. While this points to the overlap between certain forms of burnout and certain types of traumatization, it also reaffirms the larger point that the potential stress caused by these definitional confusions could be eased by looking at all of these as incrementally distinct yet related forms of physician distress.

93 Figley, "Compassion Fatigue," 2.

the subject, "I first called it a form of burnout, a kind of 'secondary victimization'."[94] Over time, however, he came to see a distinction between burnout and the traumatization he was seeing. As a result, Figley shifted his rhetoric to call the phenomena of distress "compassion fatigue," and to further specify his distinction of STS. He even explicitly distinguishes compassion fatigue (and STS) from burnout by explaining:

> In contrast to burnout, which emerges gradually and is the result of emotional exhaustion, STS (compassion stress) [which Figley uses interchangeably with compassion fatigue] can emerge suddenly with little warning. In addition to a more rapid onset of symptoms… in contrast to burnout, there is a sense of helplessness and confusion, and a sense of isolation from supporters; the symptoms are often disconnected from real causes, and yet there is faster recovery rate.[95]

Compassion fatigue in physicians then refers to the distress that results from the different forms of traumatization that result from indirectly experiencing or being exposed to details of traumatic experiences through the care of the primary victims of those experiences. This can manifest as vicarious traumatization of secondary traumatic stress.

Vicarious traumatization, or VT was originally coined by McCann and Pearlman in 1990, and describes a situation in which a provider develops psychological symptoms of traumatic stress after indirectly experiencing (listening to) the trauma that their patients experienced directly, usually as the result of the traumatic events being recounted to them in extreme detail.[96] This is a common experience for psychiatrists and psychologists, but can also occur with emergency room doctors, or even primary care physicians, especially

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[94] Ibid.

[95] Figley, "Compassion Fatigue," 12.

[96] I. Lisa McCann and Laurie Pearlman, "Vicarious Traumatization: A framework for Understanding the Psychological Effects of Working with Victims," *Journal of Traumatic Stress* 3, no. 1 (1990): 131-149, https://doi.org/10.1007/BF00975140.

considering the need for detailed patient histories. Laurie Anne Pearlman and Paula S. Mac Ian define VT as "the transformation that occurs within the therapist (or other trauma worker) as a result of empathic engagement with clients' trauma experiences and their sequelae." They go on to specify that it is often the result of "listening to graphic descriptions of horrific events, [and] bearing witness to people's cruelty to one another," and that it is "an occupational hazard for those who work with trauma survivors."[97] An example of vicarious traumatization would be if Jane's friend Sarah, a psychiatrist, began struggling after listening to multiple clients' stories about being raped, and subsequently began developing psychological symptoms of traumatic stress herself. If Sarah experienced the retelling of the events in vivid detail began having recurring visions of the attack, as well as nightmares and feelings of extreme fear or panic when in situations resembling those leading up to her patients' attacks, these would all be signs of VT. Pearlman and Mac Ian explain that vicarious traumatization "implies changes in the [provider's] enduring ways of experiencing self, others, and the world," that in turn "permeate the [provider's] inner world and relationships."[98] It is easy to underestimate the effect that another's story can have on our psyches, but some events are so horrific that they can wreak havoc even in their retelling.

Another relevant component of VT is the tendency for stories of trauma to build up and accumulate within providers. Many physicians, especially those in more trauma-related specialties, hear numerous stories of tragedy. Ted Bober, Cheryl Regehr, and

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97 Laurie Anne Pearlman and Paula S. Mac Ian, "Vicarious Traumatization: An Empirical Study of the Effects of Trauma Work on Trauma Therapists," *Professional Psychology: Research and Practice* 26, no. 6 (1995): 558, https://doi.org/10.1037/0735-7028.26.6.558.

98 Ibid.

Yanqui Zhou refer to this as the "'dosage' of exposure" and suggest that when considering vicarious traumatization it is important pay attention to "the percentage of time spent with traumatized individuals, the types of tragedy that are described… and the impact of suffering and adversity that [practitioners] witness in others."[99]While it is possible for a provider to suffer vicarious traumatization after only one experience, it is more often the result of repeated psychological exposure to brutality and trauma. Many physicians end up being traumatized as a result of their attempt to heal through bearing witness. Witnessing is an important component of healing and as such plays an important role in the practice of medicine, however, it does not come without its risks.

Secondary Traumatic Stress or STS is incredibly similar to vicarious traumatization in that it also describes an indirect experience of trauma. STS occurs in the medical field when a provider cares for someone who has experienced a traumatic event and develops symptoms of traumatic stress as the result.[100] While this sounds nearly identical to VT, the difference lies primarily in the psychological experience of the trauma. Newell et al explain that the primary distinction between VT and STS is that vicarious traumatization describes "a cognitive change process resulting from chronic direct practice with trauma populations," that affects "one's thoughts and beliefs about the world in key areas such as safety, trust, and control," whereas STS "places more emphasis on the outward behavioral symptoms rather than intrinsic cognitive changes."

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99 Ted Bober, Cheryl Regehr, and Yanqiu Rachel Zhou, "Development of the Coping Strategies Inventory for Trauma Counselors," *Journal of Loss and* Trauma 11, no. 1 (2006): 72, https://doi.org/10.1080/15325020500358225.

100 Nimmo and Huggard, "A Systematic Review, 39; Brian E. Bride, Schnavia Smith Hatcher, and Michael N. Humble, "Trauma Training, Trauma Practices, and Secondary Traumatic Stress Among Substance Abuse Counselors," *Traumatology* 15, no. 2 (2009): 96-105, https://doi.org/10.1177/1534765609336362.

[101] STS then, has more to do with the external manifestation of symptoms, than internal psychological shifts, though it is possible for both to happen. Newell and Huggard suggest that it is most helpful "to think of vicarious traumatization and secondary traumatic stress as two different disorders with similar features, which may occur either independently of each other or as co-occurring conditions."[102]

As mentioned above, in VT providers repeatedly relive the experiences of traumatic events through retelling by the primary victims, which can eventually warp their sense of normalcy and safety. In STS on the other hand, the provider may be traumatized by simply witnessing the horrific aftermath of the traumatic events, in the course of caring for the primary victims.[103] This means that the retelling or reliving of traumatic events is not necessary to precipitate STS. An example of secondary traumatic stress would be if Jane's friend John, an ER doctor, developed symptoms of traumatic stress after caring for a series of victims of horrific gang violence. If John was haunted by memories of breaking the news to the victims' families, had nightmares in which he was surrounded by their bodies, and became exceptionally jumpy and short tempered at work, these would all be signs that he might be suffering from secondary traumatic stress. Even though he would not be the primary victim of the violence, his proximity to the trauma, and his first-hand witnessing of the suffering it caused would make him vulnerable of developing STS.

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101 Newell and MacNeil, "Professional Burnout," 60-61.

102 Ibid.

103 Figley, (1995) 7-10.

Moral Injury

The final type of traumatic distress that this dissertation suggests should be included as a form of physician traumatization is moral injury (MI). Moral injury is a condition first described by Jonathan Shay in 1994 in his book *Achilles in Vietnam: Combat Trauma and the Undoing of Character*, which he coined after working intensively with combat veterans experiencing PTSD. Shay applied Homer's classical exploration of "the moral dimension of combat" in *The Odyssey* to better understand and articulate the complex nature of the traumatization he witnessed in returned combat soldiers suffering from PTSD.[104] Shay defines MI as a condition that can develop when three conditions occur simultaneously: "when there has been (a) a betrayal of 'what's right'; (b) either by a person in legitimate authority… or by one's self…; (c) in a high stakes situation."[105] Moral injury therefore deals with the intersection of trauma and betrayal and is deeply entangled with personal ethics, as well as questions of right and wrong. It is also often the result of institutional and/or structural failures and wrongdoing.

Simon Talbot and Wendy Dean demonstrate that Shay's concept of moral injury can be usefully applied to the medical field and argue that many of the cases that are currently being identified as physician burnout are in fact actually instances of moral injury among physicians. They suggest that "the moral injury of health care is not the offense of killing another human in the context of war. It is being unable to provide high-

104 Jonathan Shay, *Achilles in Vietnam: Combat Trauma and the Undoing of Character* (New York, NY: Scribner, 2003) Kindle edition, location 373.

105 Jonathan Shay, "Moral Injury," *Psychoanalytic Psychology* 31, no. 2 (2014): 182, https://doi.org/10.1037/a0036090.

quality care and healing in the context of health care."[106] Talbot and Dean's analysis points to the fact that moral injury in physicians is generally the result of larger systemic issues of structural violence or insufficiency, in the form of inadequate support, unethical pressure to focus energy away from patient welfare, and institutional prioritization of policies and procedures that are financially driven, rather than patient driven. When such conditions prevent physicians from being able to help their patients, or result in tragic outcomes, the result can be a deep moral, emotional, and psychological form of traumatization.

Talbot and Dean suggest that the recent trend of misidentifying moral injury as burnout is problematic, because burnout research not only fails to recognize the role of concepts like morality and betrayal in cases of physician traumatization, but it also tends to place more of the responsibility for change on individual physicians. They identify the flawed perspective of common burnout solutions and explain why they are unlikely to solve the problem of MI:

> The simple solution of establishing physician wellness programs or hiring corporate wellness officers won't solve the problem. Nor will pushing the solution onto providers by switching them to team-based care; creating flexible schedules and float pools for provider emergencies; getting physicians to practice mindfulness, meditation, and relaxation techniques or participate in cognitive behavior therapy and resilience training… None of these measures is geared to change the institutional patterns that inflict moral injuries.[107]

The current system does not acknowledge the traumatization or deep moral ambivalence that a doctor may feel as the result of having to provide a patient suboptimal care because

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[106] Simon Talbot and Wendy Dean, "Physicians aren't 'burning out.' They're suffering from moral injury," *Stat*, July 26, 2018, accessed January 15, 2019, https://www.statnews.com/2018/07/26/physicians-not-burning-out-they-are-suffering-moral-injury/.

[107] Ibid.

his/her/their insurance company refused to cover a treatment, or the guilt and grief another physician may feel when his/her/their indigent patients are 'fired' after their hospital decides to eliminate charity care funding.[108] These are clear violations of what is 'right' by authority figures and/or institutions, and as they have direct impact on the health of patients, they are by definition "high stakes." Such situations can create deep emotional wounds, especially in physicians who feel called to medicine as a way to help people. Not only can the resulting traumatic stress can be paralyzing, but, morally injured physicians may also feel unable to openly discuss or address their distress, for fear of retaliation from the offending institutions for which they work, as well as conflicting feelings about having been made complicit in the traumatizing event. In such situations, the physicians may feel even more isolated, afraid, and ashamed, thereby intensifying their distress. This dissertation argues that such instances of moral injury should be considered forms of physician traumatization, which, together with the other forms discussed above, should be included in the suggested revised rhetoric regarding physician distress.

Still Confusion

The above discussion identifies the different conditions that this dissertation argues should be classified under the category "physician traumatization." Its analysis is meant to demonstrate not only the different ways that traumatization can result from the practice of medicine, but also that physician traumatization is not a new or unrecognized problem that has never been written about. As established above, authors have been

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[108] Rachel Pearson, *No Apparent Distress: A Doctor's Coming-of-Age on the Front Lines of American Medicine* (New York, NY: W. W. Norton & Company, 2017), 47-58.

writing about different types of physician traumatization for decades, however, as a topic, traumatization has never received the same level of attention that is currently surrounding the issue of physician burnout. While the above analysis concerning burnout suggests that one potential reason for that difference in attention has to do with the rhetorically appealing connotation of the term, and Part II will suggest that it may also have to do with increased stigma surrounding the concepts of trauma and mental illness, there is another potential explanation for the relative lack of attention given traumatization which the above discussion reveals: The extant literature is confusing, and often contradictory.

While the author did her best to clarify the similarities and differences between Secondary Traumatic Stress (STS), Vicarious Traumatization (VT), Compassion Fatigue (CF), and Secondary Victim Syndrome (SVS), the boundaries between these different conditions are dim at best. The confusion becomes even stronger when attempts are made to draw clear dividing lines between compassion fatigue and burnout. It does not help the matter that many of the major scholars in the field contradict each other, and some of them have changed their terminology and rhetoric multiple times over the course of their careers.[109] All of this has a negative influence over the rhetorical strength of the argument that physician traumatization is an issue that deserves more attention. How are scholars and physicians, particularly suffering physicians, expected to talk about a condition obscured by so much rhetorical chaos?

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[109] For instance, Newell and MacNeil suggest that CF, VT, and STS are three distinct conditions, Nimmo and Huggard suggest that they are related constructs with definitional overlap, and Figley suggests (as mentioned above) that STS and VT are more specific types of CF; Figley also acknowledges having referred to the same phenomena as "secondary victimization" and "burnout" in the past, while at the same time using the terms "secondary traumatic stress" (STS) and "secondary traumatic stress disorder" (STSD), as well as "compassion stress" and "compassion disorder" interchangeably.

This dissertation suggests that the solution is to take a step back and, instead of getting lost in the confusion over which acronym to use, to view these together as different forms of physician traumatization. The broad nature of the term allows for the inclusion of multiple forms of traumatization (medicalized and non-medicalized), while simultaneously providing enough vagueness to encourage further specification at the individual level. It also allows all of these various forms of traumatization to be discussed together, which enables attention to be focused on what is important (physician suffering), instead of getting distracted by minute definitional differences (like between VT and STS). Figure 4 demonstrates how the various forms of traumatic distress can be viewed as different subtypes of physician traumatization and can therefore all be referred to collectively using that term.

Summary of Part I - Need for Definitional Clarity and Visible Rhetoric

So, to summarize the discussion to this point, physician traumatization is a significant problem facing many physicians. It is a predictable natural consequence of practicing medicine and should be studied as a major form of physician distress. However, physician traumatization it is relatively absent in the majority of the copious popular rhetoric regarding physician distress, which is virtually obscured by the issue of physician burnout. Furthermore, the extant scholarship that has been written about forms of physician traumatization other types of physician distress are not only less visible, they lack consensus regarding their definitions. In fact, it is difficult, even after years of

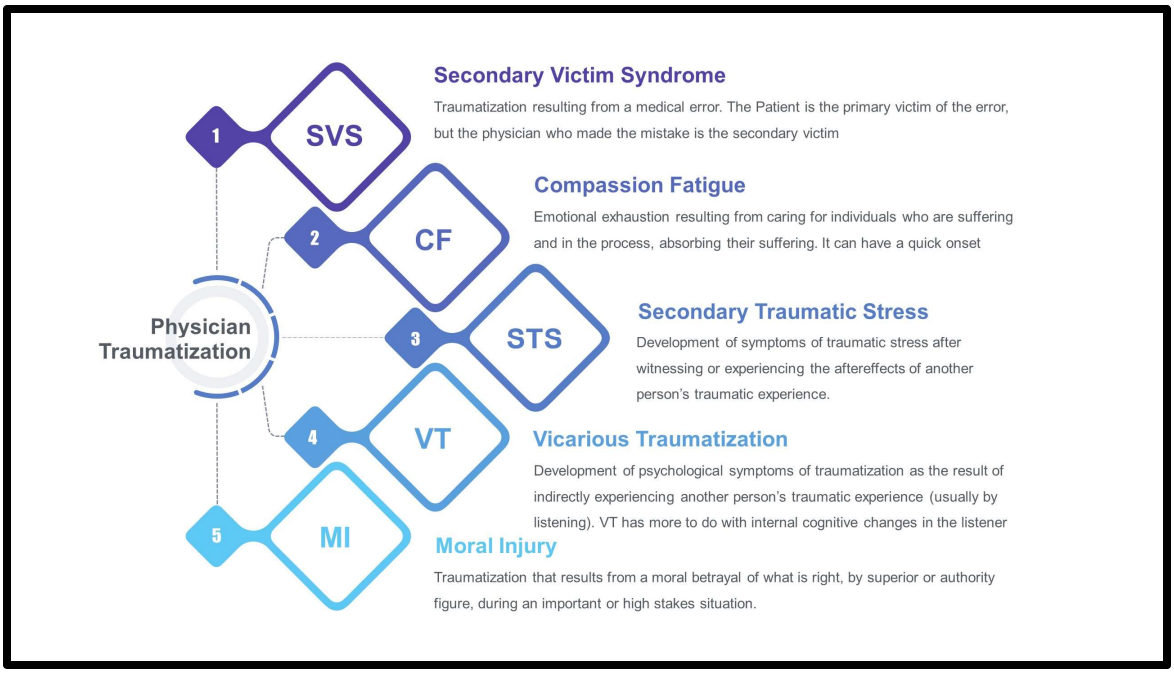

Figure 7. Types of Physician Traumatization

intensive study, for this author to clearly articulate the difference between all of the various terms and concepts related to physician traumatization. Considering this confusion, it is not surprising that such a complex topic remains relatively hidden in the shadows, and instead catchy and appealing labels like "burnout" garner public attention.

The problem is that physician traumatization is an incredibly important subject. Furthermore, simply because it is not discussed as frequently or given as much attention as burnout, does not mean that it is not still occurring. Part I of this dissertation calls for the development of clear and concise language concerning physician traumatization and argues that the above rhetoric needs to be included in the current discourse regarding physician burnout. It also suggests that the current dialogues regarding physician burnout need to be reframed as discussions regarding physician distress, of which physician burnout is one type, and physician traumatization another. The goal of this shift in rhetoric is to bring these ignored forms of suffering into the popular discourse, in the

hopes that increased attention will help some of the physicians experiencing traumatization to identify what they are feeling and seek help.

In the upcoming chapters of Part II, the discussion will shift to look at potential hurdles that might obstruct the suggested changes to the current discourses regarding physician distress.

PART II:
Understanding the Obstacles to Changing the Discourse

CHAPTER 4
Understanding Stigma and How It Works

A Shift in Perspective

The first half of this dissertation constructed an argument for the use of the term "physician traumatization" to describe a particularly devastating and largely unrecognized form of physician distress affecting doctors today. The second part of this dissertation recognizes that in order for a label like "traumatization" to be helpful for struggling physicians, first it must be used. As the last section demonstrated, many terms and labels are often suggested by scholars that never make it into to popular discourses. A term may be abandoned or may never be adopted for various reasons, but one of the primary factors influencing whether or not a label will be accepted into common use, is related to its meaning[1].

The implied meaning of labels like "traumatization" can vary, and preexisting prejudices can heavily influence what a term is understood to mean by different groups of people. Many factors, including institutional history, can dictate how an identity label is perceived and whether or not it is accepted or stigmatized.[2] If the purpose of applying this narrative institutional identity is to help these struggling physicians, it is important to be cognitive of the fact that if the label is rejected, or if it intensifies stigmatization, and thereby increases internal distress, then it will not be helpful. If that is the case, then it is important to understand how and why that is happening, in order to make appropriate

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[1] Blake E. Ashforth and Ronald H. Humphrey, "The Ubiquity and Potency of Labeling in Organizations," *Organizational Science* 8, no. 1 (1997): 1-107, https://doi.org/10.1287/orsc.8.1.43.

[2] Mary Bucholtz, and Kira Hall, "Identity and Interaction: a sociocultural linguistic approach," *Discourse Studies* 7, no. 4-5 (2005): 585-614, https://doi.org/10.1177/1461445605054407.

changes within the minds of physicians as well as the institutions of power in the culture of medicines, so that the issue can be appropriately addressed.

Traumatization is a stigmatized condition.[3] Part of the reason for this is, as mentioned previously, that traumatization is associated in most people's minds with mental illness, which is also highly stigmatized. In fact, some scholars argue that mental illnesses are the most stigmatized of all illnesses (with the possible exception of STIs, which are frequently associated with "sin").[4] This naturally raises the question: Why is mental illness, as well as other conditions associated with it, so stigmatized?

In looking for the answer, one must consider not only the conditions themselves, but also the labels: what they mean and how they are perceived. This is because words can be invested with power. In the field of social psychology "labeling bias" refers to the tendency of people to apply certain designatory terms or labels to others, which then influence people's expectations and views of those labeled individuals.[5] Part II of this dissertation looks specifically at the stigmas associated with these words, and more

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[3] Dinesh Mittal, et al., "Stigma Associated With PTSD: Perceptions of Treatment Seeking Combat Veterans," *Psychiatric Rehabilitation Journal* 36, no. 2 (2013): 86-92, https://doi.org/10.1037/h0094976.

[4] Rössler suggests that mental disorders are negatively judged and stigmatized "far more than any other type of illness." In Rössler, "The Stigma of mental disorders," 1250-1253; For information about the stigmatization of STIs, as well as the link between those stigmas and "religious teachings about STI as 'the wages of sin,'" see: Bronwen Lichtenstein, "Stigma as a barrier to treatment of sexually transmitted infection in the American deep south: issues of race, gender and poverty," *Social Science & Medicine* 57 (2003): 2435-2445, https://doi.org/10.1016/j.socscimed.2003.08.002.

[5] J.D. Fox and T. A. Stinnett, "The effects of labeling bias on prognostic outlook for children as a function of diagnostic label and profession," *Psychology in Schools* 33, no. 2 (1996): 143-152, https://doi.org/10.1002/(SICI)1520-6807(199604)33:2<143::AID-PITS7>3.0.CO;2-S; Rajiv Jhangiani and Hammond Tarry, "The Social Self: The Role of the Social Situation," in *Principles of Social Psychology – 1st International Edition* ed. Charles Stangor (Pressbooks Publishers, 2014) accessed January 2, 2019, https://opentextbc.ca/socialpsychology/chapter/the-social-self-the-role-of-the-social-situation/.

specifically at the stereotypes, prejudices, and forms of discrimination associated with these labels, since stigmas are one method of investing words with power.[6] It suggests that in order to truly help traumatized physicians, first the stigmas connected to the label "traumatized" must be understood and dismantled. The stigmas not only can prevent struggling doctors from recognizing what they are experiencing, or from seeking help if they do[7], they can also add to the stress these physicians are already experiencing from traumatization, which statistics indicate that can be a deadly combination.[8]

In order to dismantle these stigmas, this dissertation first aims to understand how they work and where they come from. The current chapter will attempt to inform this process by articulating what is known about stigma and prejudice from a theoretical perspective, how they work, and the various conceptual levels on which stigma exists. It will also identify the importance of focusing on the *cognitive* level of stigma in order to truly deconstruct existing stereotypes connected to the term "traumatization." In order to dismantle the stigma confronting traumatized physicians, it is first necessary to understand how stigma connects with the label "traumatized." To do that, this chapter will begin by unpacking what stigma is and how it works and will then move on to elucidating the complex interactions of its different components.

Understanding Stigma Theory

It is difficult to think about stigma without also considering the related concepts of prejudice, stereotypes, and discrimination. While all these concepts are clearly linked,

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6 Everymind, *National Communications Charter: A unified approach to mental health and suicide prevention* (Newcastle, Australia: 2018), https://everymind.org.au/.

7 Ibid.

8 Center et al., "Confronting Depression and Suicide," 3161-3164.

it can be challenging to articulate exactly how they relate to one another. The reason for this difficulty lies in the fact that stigma research and prejudice research developed separately and existed within parallel fields for multiple decades. While both fields of inquiry address generally the same topic, they did so from different perspectives and with relatively little interdisciplinary crossover for many years.

The concept of stigma as an object of theoretical and (later) empirical study was first developed by sociologist Erving Goffman in his seminal book *Stigma: Notes on the Management of Spoiled Identity* in 1963. Goffman and his successors in the field of Sociology focused primarily on the interactional and functional qualities of stigma, paying special attention to its relationship to concepts of normalcy and deviance. As a result, subsequent social science approaches tended to focus on the ways stigmatization of abnormal attributes functioned to govern behavior and reinforce social norms. [9] They also tended to specifically address the control of deviant identities, behaviors, and diseases by groups or by society, concentrating on how ostracism and acceptance could be used as tools for ensuring adherence to social norms and mores. [10]

The prejudice research tradition on the other hand, stems from the work of social psychologist Gordon Alport, and initiated with his classic *The Nature of Prejudice* in 1954. In it, Allport focused on the relationship between prejudice and identity,

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[9] Erving Goffman, *Stigma: Notes on the Management of Spoiled Identity* (New York, NY: Simon & Schuster Inc. , 1986); Jennifer Stuber, Ilan Meyer, and Bruce Link, "Stigma, prejudice, discrimination and health," *Social Science & Medicine* 67 (2008): 351-357, https://doi.org/10.1016/j.socscimed.2008.03.023.

[10] Jo C. Phelan, Bruce G. Link, and John F. Dovidio, "Stigma and Prejudice: One animal or two?" *Social Science & Medicine* 67 (2008): 258-367, https://doi.org/10.1016/j.socscimed.2008.03.022.

predominantly as it applied to group identification.[11] As a result, much of the social psychology work regarding prejudice written since 1954 has focused on intergroup relations, particularly ingroup biases and outgroup stereotypes, their connection to social identity, and their influence on discriminatory behaviors.[12] Additionally, while much of the work on stigma has focused on abnormal or unusual characteristics, traits, and identities, social psychologists studying prejudice have generally looked at relationships between groups within broad membership categories such as race, gender, or age.[13] Social psychologists have also paid attention to how those group prejudices manifest in individual members' thoughts, feelings, and behaviors.[14]

These two fields developed largely parallel to one another, discussing the same issues from different perspectives, but with little explicit crossover for multiple decades. In 2006 however, spurred by the US Healthy People 2010 program, the Health & Society Scholars Working Group on Stigma, Prejudice, Discrimination and Health, a group of interdisciplinary scholars interested in the effects of stigma and prejudices on health disparities, held a conference to bring together scholars from the previously separated fields.[15] To do so, they focused on their joint interest in health disparities. Many scholars

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11 Gordon Allport, *The Nature of Prejudice* (Reading, MA: Addison-Wesley, 1954).

12 Irwin Katz, "Gordon Allport's *The Nature of Prejudice*," *Political Psychology* 12, no. 1 (1991): 125-157; Stuber, Meyer, and Link, "Introduction," 351-357, https://doi.org/10.2307/3791349.

13 Phyllis A. Katz, "Attitude change in children: can the twig be straightened? "In *Towards the Elimination of Racism,* ed. Phyllis A. Katz, 213-244 (New York, NY: Pergamon Press, 1976), https://doi.org/10.1016/B978-0-08-018316-9.50015-1; H. Tajfel and J. C. Turner, "The social identity theory of intergroup behavior," in *Psychology of Intergroup Relations* ed. S. Worchel and W. G. Austin, 7-24 (Chicago, IL: Nelson-Hall, 1986); D. A. Wilder, "Perceiving persons as a group: Categorization and intergroup relations," in *Cognitive Processes in Stereotyping and Intergroup Behavior* ed. D. L. Hamilton, 213-258 (Hillsdale, NJ: Erlbaum, 1981).

14 Jhangiani and Tarry, *"The Social Self."*

15 Stuber, Meyer, and Link, "Introduction," 351-357.

from various backgrounds came together to discuss the benefits of cross-disciplinary collaboration, identifying possible roadblocks, and highlighting areas for future research. The result was a Special Issue in *Social Science & Medicine* in 2008, devoted entirely to bridging "disparate research traditions in stigma, on the one hand, and in prejudice and discrimination on the other hand." [16]

In that special issue, the authors provided a strong argument for the benefits of blending traditional stigma research approaches from the social sciences with prejudice research approaches from social psychology. They demonstrated that each field had unique contributions to add to the conversation that would help deepen the understanding of stigma and prejudice and allow for the two related concepts to be studied together. Phelan, Link, and Dovidio outlined a particularly useful framework for understanding stigma and prejudice as different parts of the same "animal," which had significant ramifications for future research.[17] It is this combined approach to stigma and prejudice that will be employed in the remainder of this discussion. Before moving on to outline that model in detail, however, it will be helpful to outline some of the important contributions from each field of inquiry.

Lessons from Stigma Research

Goffman's early work on stigma helps to identify stigma's functional ability to reinforce ideas of "normalcy" by a group or society. He explains how stigma can be used as a tool for ensuring that social norms and mores are followed and for either preventing or quashing threats to group conformity. Goffman addresses the concept of normalcy by

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16 Stuber, Meyer, and Link, "Introduction," 351.

17 Phelan, Link, and Dovidio, "Stigma and Prejudice" 358-367.

defining individuals who fit the category of "normal"[18] as "those who do not depart negatively from the particular expectations" of the group.[19] He then identifies stigmatized individuals, in contrast, as individuals who possess an attribute that is deviant or unexpected and thus "obtrude[s]… upon attention," turning those with whom they interact away and "breaking the calm that [their] other attributes have on us"[20]. Goffman goes on to clarify that this "stigma" is "an undesired differentness from what we had anticipated"[21] Normalcy is therefore essentially defined by what it is not: to be normal is to NOT differ from what is expected.

According to Goffman, stigma then not only reaffirms the norms of the group, it eliminates anyone who throws those norms into question. Furthermore, to diverge from what is deemed normal or anticipated is to pose a threat to the group and to the status quo. Goffman explains that in response to that threat "normals" develop "stigma-theory" which he defines as an ideology meant to explain the inferiority of the stigmatized person and to "account for the danger he represents," while simultaneously "rationalizing animosity" felt by those in the normal majority.[22] Goffman's work helps to frame stigmas as social and psychological constructs which develop in order to justify avoidance, mistreatment, and ostracization of deviant individuals by the "normal" majority. In doing so the stigmas in turn reaffirm group norms, mores, and (to a degree) identity, as well as

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[18] Goffman interestingly includes himself in this classification, actually using the phrase "we normals," which has understandably interesting ramifications for his following analysis.

[19] Goffman, Stigma, 5.

[20] Goffman, Stigma, 5.

[21] Goffman, Stigma, 5.

[22] Ibid.

encourage conformity and normalcy by penalizing deviance and ostracizing those who do not fit.

This is significant to the discussion of traumatized physicians because, as this dissertation will later argue, many of the norms that are taught and prioritized within the culture of medicine, and particularly those that correlate to the positive stereotypes regarding what it means to be a "good doctor," conflict with some of the features, and more importantly, with many of the stereotypes of traumatization. This means that employing the concept traumatization and the related label "traumatized" might pose the threat of casting labeled physicians as deviating from the image of the "normal" and "good" medical doctor. This might in turn then lead to them being characterized as posing a threat to either their patients or to the medical establishment for which they work.[23]

Stigma research from the social sciences also provides some unique perspectives on the stress that can be generated by stigma, while also illuminating some of the different ways stigmatized individuals may experience that stress. Much of the emphasis of both stigma and prejudice research explores the stress exerted by external forces, most commonly the community or other powerful groups, upon stigmatized individuals or marginalized groups, focusing on the influence of unequal power dynamics. In other words, both classic stigma research and classic prejudice research focus on stigma exerted upon a subject or subjects by *external* forces. Stigma researchers specifically,

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[23] A similar stigma exists concerning the "mentally ill" label among physicians, as documented in Center et al, "Confronting Depression and Suicide," 3163-3164; Rucinski and Cybulska, "Mentally ill doctors," 90-94.

however, have gone a step further, also identifying two significant forms of stigma stress which originate *internally*.[24]

The first of these internally originating stresses identified by stigma scholars is that which results from stigmatized individuals sharing the beliefs and norms of the community or group stigmatizing them. Stuber et al. describe internalized stigma as "the direction of negative societal attitudes towards the self," and demonstrate that it has been the focus of many stigma scholars over the years.[25] This is an important concept because it demonstrates that stigma does not always originate solely from outside stigmatized individuals. Additionally, internalized stigma can also lead to intense feelings of shame and self-loathing that can have especially detrimental effects on self-esteem and mental health. Furthermore, scholars like Campell, et al. demonstrate how internalized stigma complicates efforts to eliminate stigma.[26] Interventions must not only change the thoughts and actions of stigmatizers, but of everyone in the community, especially the stigmatized individuals themselves. Since shame can be a powerful cementing force, such a change can be particularly difficult to achieve in those who have internalized their own stigmatization.

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[24] Stuber, et al. explain that "A few prejudice researchers have considered internalized forms of oppression as a source of stress contributing to poor health outcomes,"(referencing Clark, Anderson, Clartk & Williams, 199 and Meyer, 2003b) but they insist that internalized stress is generally "not a main focus of inquiry" in the field of prejudice research. In Stuber, Meyer, and Link, "Introduction," 352.

[25] Stuber, Meyer, and Link, "Introduction," 352; Bruce Link, "Understanding Labeling Effects in the Area of Mental Disorders: An Assessment of the Effects of Expectations of Rejection," *American Sociological Review* 52, no. 1 (1987): 96-112, https://doi.org/10.2307/2095395; Jennifer Stuber and Mark Schlesinger, "Sources of Stigma for means-tested government programs," *Social Science & Medicine*63, no. 4 (2006): 933-945, https://doi.org/10.1016/j.socscimed.2006.01.012.

[26] Catharine Campbell, et al., "I have an evil child at my house: stigma and HIV/AIDS management in a South Africa community," *American Journal of Public Health* 95, no. 5 (2005): 808-815, https://doi.org/10.2105/AJPH.2003.037499.

This concept of internalized stigma is particularly helpful in understanding the complex issue of stigma and physician traumatization in two ways. First, it helps to explain one of the potential reasons why many of the distressed physicians who have been studied (including those reporting burnout), express hesitation over seeking help or letting their colleagues know they are struggling.[27] Their hesitation may, at least in part, be the result of shame coming from internalized stigmas related to broader cultural perceptions of distress. For instance, Center et al. suggest that a contributing factor to student physicians' increased risk of suicide, are "the professional attitudes that broadly discourage admission of health vulnerability, "and that distress is considered to be one such vulnerability.[28] This type of internalization can be seen in Jane's case. For example, when she lampooned herself for not being able to successfully employ the coping mechanisms she believed she should have mastered during medical school, and frustratedly questioned "why this was affecting her so much," Jane was internalizing stigmas that conceive of traumatization as a sign of weakness and failure.[29] Jane also castigated herself for failing to have the "nerves of steel" that she believed she was "supposed" to possess as a neurosurgeon. These were beliefs she learned and attitudes she adopted from the medical culture around her.[30] Jane's symptoms of traumatic stress were exacerbated by the internalized stigma she projected onto herself. Not only was she

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[27] Rothenberger, "Physician Burnout," 570; Rucinski and Cybulska, "Mentally ill doctors." 92; Shanafelt et al, "Special Report."59-61.

[28] Center et al., "Confronting Depression and Suicide," 3164.

[29] These perceptual connections between traumatization and weakness and failure will be discussed in more depth in chapter 5.

[30] These unofficial attitudes are often learned through the 'hidden curriculum,' which will be discussed further in Chapter 5.

struggling with traumatization, she was also punishing herself *because* she was struggling with traumatization.

The second insight that the concept of internalized brings to this discussion of physician traumatization, has to do with its implications for the recommendation this dissertation is making to increase rhetoric regarding physician traumatization. Internalization raises the possibility that, if traumatization does indeed carry increased stigma due to its perceived connection to mental illness, then that stigma would be likely to be internalized by traumatized physicians. This would mean that a label intended to help ease suffering, could potentially increase it instead. That would not only be counterproductive and potentially problematic, but it would also likely lead to avoidance of the label and therefore diminish its usefulness in terms of helping traumatized physicians.

The other form of internally generated stigma-stress that stigma researchers from the social sciences helped define and explore is that which comes from trying to hide one's stigma. Goffman first introduced this concept in his discussion of "discredited" and "discreditable" individuals, when he described the difference between individuals with known stigmatized traits, as opposed to those with stigmatized traits that are unknown to their community. He explains that the former are discredited individuals who are likely to experience stigma pressures exerted by the outside community. The later, on the other hand, he identifies as discreditable individuals, who may not experience stigmatization from the community since their stigmatized trait is unknown, but are still likely to experience internal stress from the ever-present knowledge that their discrediting attribute

might be discovered.[31] Goffman explains that if such individuals have the ability to "pass" as normal, then that stress can increase, as the possibility of their stigma being discovered requires that they "manage" their identity:

> "when his differentness is not immediately apparent and is not known beforehand (or at least known by him to be known to the others), when in fact his is a discreditable, not a discredited, person, then the second main possibility in his life is to be found. The issue is not that of managing tension generated during social contacts, but rather that of managing information about his failing."[32]

This threat of being discovered to be abnormal not only leads individuals to hide their differentness, but also to micro-manage many aspects of their lives in order to ensure that their "spoiled" identity remains a secret. Both processes can cause significant levels of internal stress.

This form of internal stress is especially significant to this discussion of traumatized physicians, because it not only identifies another possible source of stigma-related stress, it also provides another explanation for why so few distressed physicians seek help.[33] As traumatization and distress are not an immediately visible conditions, traumatized physicians fall into the category of discreditable individuals who have the ability to pass as normal. That means that many of them may feel pressure to hide their traumatization. Additionally, as traumatization is not currently an accepted or widely

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[31] Goffman, Erving. *Stigma: Notes on the Management,* 42.

[32] Ibid.

[33] Many of the studies concerning physician substance abuse, physician medical errors, and physician suicide indicate that burned out, depressed, and traumatized physicians often do not seek help for their struggles. They hide their distress, and it does not become known until a tragic occurrence (such as suicide, a devastating medical error, or extreme and obvious addiction) brings it to light. For more on this please see Center et al., "Confronting Depression and Suicide," 3163; Shanafelt et al., "Special Report," 94; Rucinski and Cybulska, "Mentally Ill Doctors," 90.

discussed condition, physicians who are struggling with it may feel the dual internal pressure of trying to hide their abnormality, while simultaneously not knowing exactly what type of abnormality they are exhibiting. This also helps explain why, as Rucinski and Cybulska and others have reported, many distressed physicians who take medication (particularly psychiatric medications) admit to treating themselves.[34] This is most likely done in an attempt to hide their struggling, and subsequently their "spoiled identity. It is also related to struggling physicians' fear of having to report psychiatric diagnoses on medical licensing applications, which would not only risk potential penalties, but also official discredited status within the medical establishment in which they work.[35]

Referring back to Jane's example, the reader will recall that she dismissed the idea of seeing a therapist or psychiatrist, for fear that it might get back to her superiors or her colleagues. She worried that they might discover that she was too "emotionally fragile" to do her job and that she would be considered weak and suffer professional ramifications as a result. Jane did not talk to her colleagues or supervisors about her symptoms of traumatic stress because she worried they might "smell blood in the water" or think "she could not 'cut it' in the program." She experienced increased loneliness as a result, as well as stress and exhaustion from the heightened vigilance she had to employ to ensure she did not "let them see how much she was struggling." This stress was further exacerbated by her confusion over why she was struggling so intensely.

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[34] Rucinski and Cybulska, "Mentally ill doctors," 90.

[35] Shanafelt et al. report that 60% of surgeons interviewed report "reluctance to seek professional help" for their struggles due to fear that doing so might negatively affect their medical licenses. Questions about psychiatric diagnoses on many state medical licensing exams, which are intended to help protect patients, unfortunately come with the added risk of outing distressed physicians, who may be desperately attempting to hide their distress. For more on this, please see: Shanafelt et al., "Special Report," 60-61.

The above are just a few important contributions from classic stigma research, traditionally carried out by scholars in the social sciences. They provide useful insights, not only into the study of stigma, but also into this discussion about traumatized physicians. Next the discussion will turn to some of the important contributions from classic prejudice research.

Lessons from Prejudice Research

Classic prejudice research from the field of social psychology also tends to deal with power relationships, marginalization, and stigma/prejudice-related stress, but it does so from a different perspective. While stigma research traditionally focuses on the interaction between stigmatized individuals and the group or groups to which they belong, prejudice research has traditionally focused on the relationship between groups, and more specifically between marginalized groups and the majority. It often deals with prejudice and discrimination related to race, gender, class, etc. In this way prejudice researchers deal with more macro level power struggles (between different groups or categories). At the same time, however, they also look at how those macro level struggles play out on a micro level, paying attention to group prejudices and how they influence members' cognition, affect, and behavior. Social psychologists consider the role of group membership in the formation of social identity, as well as how definitions of group identity subsequently influence member's thoughts and feelings about themselves and others.[36] Prejudice research also considers the tendency for groups to define themselves in relation to other groups, or perhaps more accurately in *contrast* to one another.

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36 Henri Tajfel and John Turner, "An Integrative Theory of Intergroup Conflict," in *The Social Psychology of Intergroup Relations,* ed. Williams G. Austin and Stephen Worchel (Monterey, CA: Borrks/Cole Publishing, 1979), 33-47.

One of the most significant contributions from classical prejudice research, however, is its insight concerning unconscious and indirect forms of prejudice and discrimination. Stigma research traditionally focuses on how stigma functions as a tool for achieving societal goals and reinforcing social norms. It pays little attention, however, to the psychological state or awareness of the stigmatized or the stigmatizers, especially concerning how their beliefs and/or actions contribute to discrimination. Social psychologists on the other hand, have provided valuable insight on that front, especially with relation to how cultural trends favoring political correctness have changed which expressions of prejudice that are deemed more or less acceptable.[37]

Teachman, Wilson, and Komoravoskaya, for instance, have demonstrated how prejudicial thoughts and beliefs can persist, despite cultural norms discouraging overt discrimination, manifesting instead as implicit (unconscious) biases, even among healthcare providers.[38] This means that subtle preferences for or against different groups of people may exist and influence a person without his/her/their explicit awareness. It also shines light on humans' tendency to delude ourselves into believing that we do not harbor any prejudicial beliefs when in fact we do. Teachman, Wilson, and Komarovskaya also demonstrate this point by showing that implicit biases against individuals with mental illnesses exist, not only among subjects who express explicit bias against the mentally ill, but also among those who do not, and perhaps most interestingly, among

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[37] Stuber, Meyer, and Link, "Introduction," 352

[38] B. A. Teachman and K. D. Brownell, "Implicit anti-fat bias among health professionals: is anyone immune?," *International Journal of Obesity and Related Metabolic Disorders* 25 (2001): 1525-1531, https://doi.org/10.1038/sj.ijo.0801745; B. A. Teachman, J. G. Wilson, and I. Komoravoskaya, "Implicit and explicit stigma of mental illness in diagnosed healthy samples," *Journal of Social and Clinical Psychology* 25, no. 1 (2006): 75-95, https://doi.org/10.1521/jscp.2006.25.1.75.

those who themselves have mental illness diagnoses.[39] This reveals that a lack of obvious or conscious prejudice in no way precludes internal or unconscious prejudice. This part of the findings also reinforces the previously-discussed concept of internalized stigma from social science research.

This is an important point to keep in mind when considering the expansion of the rhetoric regarding traumatization because it cautions that traumatized physicians who are labeled with that term could experience prejudice and stigmatization, even if traumatization is not overtly stigmatized in medical culture. It demonstrates that a condition need not be publicly and/or loudly stigmatized in order for people to discriminate against it. Sometimes powerful stigmas can exist without overt displays. One way in which these silent stigmas are passed forward, particularly in educational settings such as medical school, is through a process known as the "hidden curriculum". This concept will be discussed in more depth in chapter 5, but it relates directly to the concept of implicit bias. Hafferty and Franks explain that the hidden curriculum in medicine refers to the fact that:

> Only a fraction of medical culture is to be found or can be conveyed within those curriculum-based hours formally allotted to medical students' instruction. Most of what the initiates will internalize in terms of the values, attitudes, beliefs, and related behaviors deemed important within medicine takes place not within the formal curriculum but via a more latent one, a 'hidden curriculum,' with the latter being more concerned with replicating the culture of medicine than with the teaching of knowledge and techniques.[40]

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[39] Teachman, Wilson, and Komarovskaya, "Implicit and explicit stigma," 75–95.

[40] Frederic W. Hafferty and Ronald Franks, "The Hidden Curriculum, Ethics Teaching, and the Structure of Medical Education," *Acadmeic Medicine* 69, no. 11 (1994): 864-865, https://doi.org/10.1097/00001888-199411000-00001.

They go on to explain that this hidden curriculum frequently contradicts the formal curriculum; meaning that what is being covertly reinforced and fostered is not what is overtly valued.[41] In other words, implicit biases are frequently passed forward to future generations of doctors, and senior physicians keep stigma-related beliefs alive, often without conscious recognition that they are doing so.

This dissertation will argue in Chapter 5 that there are negative stereotypes and stigmas associated with the concept of traumatization, which are passed down through the hidden curriculum in medical education. This means that the problem of implicit bias poses a significant potential roadblock to open discussion and recognition of traumatization, unless steps are taken to address and combat those implicit biases, in addition to any overt forms of stigma. While there may not be overt stances against traumatization or mental illness within the medical community, there are a number of discriminatory practices which point to unexpressed, silent prejudices and stigmas.[42] Returning to the example of Jane's case study, the reader will recall, that is why Jane is afraid that she will suffer indirect penalties if her superiors find out she is suffering, such as receiving weak recommendation letters for her fellowship applications or not being asked to scrub in on unique surgeries. Since there is no formal reason to discriminate against her for her traumatization, discrimination would be more likely to manifest in more socially acceptable forms, or for different expressed reasons.

Furthermore, this perspective on implicit bias highlights the fact that cultural movements intended to ban overt expressions of prejudice may fail to eliminate them,

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41 Ibid.

42 Teachman, Wilson, and Komarovskaya, "Implicit and explicit stigma," 75-95.

and instead risk simply sending those prejudices "underground.[43]" Such actions are likely to result in prejudicial undercurrents, which are felt and acted upon, even when they are not spoken out loud. This is an incredibly valuable insight in relation to efforts to eliminate prejudice and discrimination, because it indicates that simply banning certain actions, or rendering prejudicial ideas and attitudes as unacceptable, is unlikely to be successful in eliminating unconscious or unexpressed biases. Such actions are more likely to just push those thoughts and feelings into the silent, internal realm. This research indicates that any successful efforts to combat prejudice must focus on changing the way people think through understanding, as opposed to policing what they say and do. [44]

This leads us to the issue of indirect prejudice and discrimination, another topic on which prejudice researchers have contributed valuable insight. Prejudice scholars have been particularly helpful in adding nuance to the issue of subjects' awareness of their own beliefs and feelings. Gaertner and Dovidio for instance identify the complexity of "aversive prejudice/racism" in which subjects experience dissonance between beliefs concerning equality and egalitarianism, and their negative feelings towards a particular

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[43] Many journalists have suggested that the recent rise in white nationalist rhetoric provides an example of this. Sherri Williams of CNN, for instance, reports that the recent surge in public expressions of racist and xenophobic beliefs indicates that the relative decrease in such public discourse in the preceding decades was not the result of such beliefs disappearing, but instead simply going "underground." For more, please see Sherri Williams, "With Trump in the White House, white nationalists aren't going anywhere," *CNN* August 14, 2018, https://www.cnn.com/2018/08/14/opinions/white-supremacist-rally-and-white-house-rhetoric-sherri-williams/index.html.

[44] John F. Dovidio and Kerry Kawakami, "Reducing Contemporary Prejudice: Combating Explicit and Implicit Bias at the Individual and Intergroup Level," in "The Claremont Symposium on Applied Social Psychology," *Reducing Prejudice and Discrimination*, ed. S. Oskamp, 137-163 (Mahwah, NJ: Erlbaum, 2000).

group or groups.[45] This is closely linked to the concept of implicit bias, because subjects may consciously believe that they do *not* harbor prejudicial thoughts and feelings towards a particular group, while they unconsciously *do*. In these types of situations, the conflict usually manifests not as overt forms of conscious discrimination, but instead as feelings of discomfort or fear that lead to avoidance, or other forms of indirect discrimination.[46]

This is an important component of our discussion about traumatized physicians because it speaks to the fact that people can hold prejudicial beliefs and discriminate against others without realizing they are doing so. One particularly unassuming way this can occur is through the praise and fostering of opposite characteristics or traits. For instance, instead of saying it is "bad to experience emotional distress," the medical profession may instead celebrate objectivity, rationality, and composure. Richard Gunderman characterizes how a combination of negative and positive beliefs fostered by the practice of medicine can create unconscious discrimination against physicians struggling with distress:

> The U.S. system for educating and training physicians in many ways sets young doctors up for burnout. Modeling by peers and teachers rewards always going 'the extra mile' and labeling as weak those who cannot keep pace. Individuals who ask for help are perceived as incompetent or insecure. Peers fear intimacy or constructive feedback, so social tension is high and feedback is low. Perhaps most important, physicians are routinely rewarded for not setting boundaries and failing to say 'no.'"[47]

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45 Gaertner, S. and Dovidio, J.F. "The aversive form of racism," in *Prejudice, discrimination, and racism*, ed. J. F. Dovidio and S.L. Gaertner, 61-89. (Orlando, FL: Academic, 1986).

46 ibid.

47 Richard Gunderman, "The Root of Physician Burnout," *The Atlantic* (August 27, 2012) Accessed January 24, 2019, https://www.theatlantic.com/health/archive/2012/08/the-root-of-physician-burnout/261590/.

The celebration of certain traits is, therefore, just as responsible for determining permissible behavior as the overt discrimination. This is significant because the positive valence may disguise the fact that there is still discrimination happening. This kind of positive, yet restrictive characterization of a role such as "doctor" will be discussed further in chapter 5 in relation to the hero archetype. For now, however, the important takeaway is that discrimination can play out in unconscious ways and can even be disguised as positive affirmation.

This is also an important concept in relation to the discussion about the stigmatization of traumatization and efforts to combat that stigma. By engaging in covert, socially acceptable forms of discrimination which are masked by other explanations, many of these prejudices are taught and fostered without conscious recognition. The research regarding the above mentioned hidden curriculum indicates that often these discriminatory attitudes and behaviors are unofficially taught and passed along because those teaching them do not fully realize that they harbor those negative stereotypes.[48] Off-handed comments, small jokes made to ease stress, and unconscious behaviors and attitudes can unwittingly pass along unrecognized biases from generation to generation of doctor. Jane was not afraid of her traumatization being discovered because there were official policies precluding traumatized physicians from practicing medicine. She was worried because she had heard about and seen the subtle ostracization happen to other struggling residents. Similarly, she did not learn her own bias against traumatization by being explicitly taught it in a classroom. She developed it over time by hearing other

48 Hafferty and Franks, "The Hidden Curriculum," 864.

physicians talk about those who could not "cut it" or who didn't have the "nerve" for neurosurgery. She learned it inversely when she was taught about "professionalism" and professional distance in medical school, and when she was encouraged by senior residents to maintain a protective layer of detachment and not to get "too close" to her patients. None of these practices constitute overt discrimination against traumatization, but together they encouraged Jane to view her struggles as shameful and evidence that she was an inferior physician. Any efforts to combat the stigma and prejudice surrounding traumatization in medicine must consider the role implicit biases and aversive forms of discrimination play in perpetuating the problem.

Understanding the Role of Power

Stigma research and prejudice research both offer important insights for the study of marginalized individuals and groups, and therefore for the study of traumatized physicians. Before outlining the model that this dissertation will use to combine the two perspectives, it may be useful to say a few words about the role power plays in this equation. Michel Foucault's philosophical work becomes especially useful when considering this point. Perhaps Foulcault's most significant contribution to the study of stigma, and the one that is most pertinent to the discussion of traumatized physicians, is his thorough and insightful treatment of the concept of power. Foucault suggests that, instead of thinking of power as a uni-directional force, applied from either the top down or the bottom up, power can be better understood as an omnipresent entity, which exerts its influence from every direction, and constantly reinforces itself[49]. As such, it is broad,

[49] Foucault, 1990; Michel Foucault, *The History of Sexuality: Volume 1: An Introduction,* trans. Robert Hurley, (New York, NY: Vintage Books, 1990).

diffuse, self-generating, and fluctuating. Foucault suggests that power is "produced from one moment to the next, at every point, or rather in every relation from one point to another." Conjuring the image of a large and intricate web, he insists that, "power is everywhere; not because it embraces everything, but because it comes from everywhere."[50] In short, we are not only incapable of escaping the influence of power, we are, in fact, complicit in both creating and maintaining it.

Relating back to the concept of stigma and Goffman's analysis of managing spoiled identity, this would imply that the pressure to conform, or to hide that which deviates from the norm, is a manifestation of power being exerted upon an individual. Furthermore, the power that influences an individual to attempt to hide a discreditable trait is not simply exerted by the larger society onto the individual subject (which would be considered top-down). Instead, the power relationships at play are many, varied, and multidirectional. The pressure, and therefore the power, comes from self as well as society, peers as well as superiors, and from inside as well as outside. This also means that the stress on the stigmatized subject is also multi-directional.

Additionally, Foucault's work shows that power does not just sit upon the stigmatized, but upon the stigmatizer as well. This means that one cannot simply speak of the stigmatization or subjugation of a deviant individual or marginalized group by society, or of an 'out group' by the 'normals,' to use Goffman's language. Instead, to fully understand the situation, one must look at the many different power relationships at play, the ways in which they are internalized, and the mechanisms through which they are enacted. The stigmas exerted on traumatized physicians, for instance do not simply come

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50 Michel Foucault, *The History of Sexuality: Volume 1: An Introduction*, 1990, 93.

from the supervising doctors, or the larger medical community; they also come from individual patients, from society in general, from groups of fellow doctors, and perhaps most significantly, from within the individual physicians themselves. This perspective is illustrated in Jane's example. While she is worried about discrimination and ostracization from superiors, colleagues, and even family, ultimately much of her stress originates from her own implicit biases and internalized stigma against her traumatization. Her stress is then further exacerbated by her concern over keeping her traumatization secret.

Power is being exerted upon Jane from many different directions, including from within herself, in the form of pressure to conform. At the same time, power is also being exerted upon others by Jane's attempts to conceal her traumatization, which in turn reinforces the norms and stereotypes influencing her own behavior. Stigma scholars like Holly Slay and Delmonize Smith have demonstrated that one of the ways that the detrimental effects of stigma can be reduced is through the presence of positive role models.[51] This is, in part, because these role models defy the norms that exert such pressure to conform; these role models do not reinforce the stereotypes, thereby perpetuating the established power structures. When individuals with stigmatized identities or attributes achieve success and respect without hiding their "spoiled identity," they become examples to other people struggling with that same stigma. These role models may help to diminish existing stigma. They may also be viewed as proof that success is possible, in spite of their stigmatized attribute or identity, or at the very least that the attribute need not be hidden. In Jane's example, for instance, if any of the other

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[51] Holly S. Slay and Delmonize A. Smith, "Professional identity construction: Using narrative to understand the negotiation of professional and stigmatized cultural identities," *Human Relations* 64, no. 1 (2011): 85-107, https://doi.org/10.1177/0018726710384290.

neurosurgical attendings in her program had previously come forward about their own struggles with traumatization, Jane might not feel so ashamed or isolated by her own difficulties.[52] At the same time, by hiding her own traumatization, Jane not only is *not* providing an example to others, she is also reaffirming the group norm that insinuates that distress like hers is abnormal, shameful, and something that should not be discussed. Jane is having power exerted upon her at the same time that she herself is creating it and exerting it upon others.

This is an important point to articulate in any discussion about eradicating stigma. It demonstrates why any single solution, or uni-directional approach to solving the issue of stigma, and especially any stigma related to traumatized physicians will be insufficient and destined to fail. Addressing only one source of stigma would be like clipping one of the filaments in a spider's web and expecting the entire silk lacework to collapse. Any earnest attempt to destigmatize traumatization must begin by recognizing the complexity of the problem, which means recognizing all of its different strands. Addressing one source of stigma may lessen the overall stigma burden traumatized physicians face, but it will not eliminate the pressure coming from the other forms of power which are pressing on them, particularly those coming from within.

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[52] Dr. Steven Miles became an unofficial mentor to countless struggling students after revealing to his class that he had been diagnosed with bipolar disorder. He was inspired to share his diagnosis after a student committed suicide, feeling that other students might benefit from knowing it was possible to seek help for psychiatric troubles and still practice medicine. Dr. Miles became a common referral used by various sources at the school who did not know how else to help struggling students, as there was nothing else in place and people were afraid to talk about mental illness. He was the only person who talked about it mental illness openly at his school. Unfortunately, Miles later was embroiled in a long court battle after his state medical board attempted to require access to his medical records in order to renew his medical license. For more on this story, please see: Firth, "Do Docs Deserve Mental Health Privacy."

Here Foucault offers another way of looking at power that is particularly helpful in understanding the concept of stigma. Derived from Jeremy Benthem's eighteenth century prison plan, Foucault offers the term "panopticon" in his book *Discipline and Punish: The Birth of the Prison*,[53]. Foucault uses the concept of the panopticon to refer to the ever-present self-surveilling and self-generating form of power that he believes is prevalent in our society and mirrors the purpose behind Benthem's archaic circular prison structure. In such a model, he explains, "the productive increase of power can be assured only if, on the one hand, it can be exercised continuously in the very foundation of society, in the subtlest possible way, and if, on the other hand, it functions outside" of a system of violence that is consistent to the idea of a sovereign[54]. In other words, the power structure must be internalized in order to be at its strongest. Power exerted solely from external forces will always have to fight against internal resistance, but if that structure of power is integrated into the thought patterns of those on whom it is acting, then they will ensure their own adherence to its constructs through self-surveillance. Traumatized or distressed physicians who police their own behavior and their own actions in order to ensure that they disguise their potentially spoiled identity are engaging in this form of self-surveillance. Foucault's concept of the ever-present nature of power and the self-surveillance of the "panopticon" provide a helpful way of understanding what is taking place in those situations. Pressure is exerted from all sides, especially from within, to abide by the norms of the group and appear untouched by stigma. It is a subtle,

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53 Foucault, *The History of Sexuality*, 208.

54 Ibid.

often unnoticed, yet incredibly effective form of social control, and it is exerted, not by one person or group upon another, but *by* everyone *upon* everyone at *all times*

Combining Stigma Research and Prejudice Research

Now that some of the most significant contributions from classic stigma research and classic prejudice research have been introduced, it is possible to look more closely at how the two fields joined together following the conference organized by the Health & Society Scholars Working Group on Stigma, Prejudice, Discrimination and Health. Phelan, Link, and Dovidio suggest that the question of stigma and prejudice is a "one animal" issue, meaning that classic stigma research and classic prejudice research are ultimately addressing the same subject, just from different perspectives.[55] They suggest the use of a combined perspective, like the one suggested by Dovidio, Major, and Crocker which utilizes "stigma" as an umbrella concept and incorporates "prejudice" as a specific attitudinal type of stigma.[56] Moving forward this dissertation will use a model that fits this suggested framework. It will specifically utilize the model provided by Wulf Rössler in his 2016 analysis of the stigma connected to mental disorders. In it he suggests that "stigma can be described on three conceptual levels: cognitive, emotional and behavioral, which allows us to separate mere stereotypes from prejudice and discrimination."[57]

Rössler identifies stereotypes as the cognitive level of stigma and defines them as "prefabricated opinions and attitudes towards members of certain groups," or those with

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55 Phelan, Link, and Dovidio, "Stigma and Prejudice," 365.

56 J. F. Dovidio, B. Major, and J. Crocker, "Stigma: introduction and overview," in *The social psychology of stigma*, T. F. Heathertone, R. E. Kleck, M. R. Hebl, and J. G. Hull, eds. (New York , NY: Guilford Press, 2000): 1-28.

57 Rössler, "The stigma of mental disorders," 1250.

specific stigmatized attributes.[58] These stereotypes are made of preconceived ideas pertaining to a group's identity or an attribute's cause or effect. Rössler explains that stereotypes can serve an important function because they allow people to make quick judgements and decisions, especially in the absence of additional information.[59] Stereotypes can also be positive as well as negative, and can therefore be beneficial in some situations, in addition to being damaging in others. For example, the stereotype that many doctors are altruistic and go into medicine to help people may help to put worried patients at ease or encourage them to trust their doctors' advice. The stereotype that a number of doctors go into medicine solely for money, on the other hand, might cause patients to mistrust their doctors' advice and question their motives. In terms of stigma, stereotypes are the pre-formed beliefs that lead to prejudice and discrimination. Therefore, they are in effect the cognitive foundation upon which the other levels of stigma are built

Rössler identifies prejudice as the second, emotional level of stigma and defines it as "consenting emotional reactions to a stereotype."[60] Prejudices are the resulting affective responses generated by stereotypes. Therefore, when people accept a negative stereotype and follow it up with emotional judgements they are engaging in prejudicial thinking. If, upon discovering that Jane was suffering from traumatization, her colleagues believed that her traumatization, as a doctor, was a sign of weakness and irrationality, they would be applying negative stereotypes to Jane's situation. If they then looked down on Jane as a 'bad doctor,' or a threat to her patients, as a result of those

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58 Ibid.
59 Ibid.
60 Ibid.

stereotypes, without any other corroborating reasons for feeling that way, they would be engaging in prejudice. By assigning judgements of "good" or "bad" they are enacting the emotional or prejudicial level of stigma.

Finally, Rössler suggests that when the cognitive and emotional levels of stigma combine causing "a behavioral response," then the resulting actions can be described as discrimination, the third (behavioral) level of stigma. Put differently, preconceived thoughts and feelings about a person, attribute, or group (stereotypes) can generate negative judgements about that person, attribute, or group (prejudices), that then can lead to negative behavioral responses or actions based on those thoughts, feelings, and judgements (discrimination). So, if Jane's colleagues avoided scrubbing in with her on surgeries, or her superiors allowed her fewer opportunities to operate unsupervised, as a result of their preconceived thoughts and judgements concerning traumatization, they would be discriminating against Jane. They would also be reaffirming and continuing the stigma surrounding traumatization among her fellow residents by encouraging others to accept the same stereotypes.

Now it is necessary to stop to clarify an important distinction about the above example. If Jane's colleagues had valid reasons for questioning her competency as a surgeon or worrying about the safety of her patients, then their judgements and actions would not qualify as prejudice and discrimination. If Jane was making dangerous errors, behaving erratically, or was using substances at work, for example, judgements and disciplinary actions from her colleagues and supervisors would be justified and

necessary, even if those behaviors were related to her traumatization.[61] In that situation Jane would still need help for her traumatization, but protective and/or disciplinary actions would also be required to limit her risk to others. There is a big difference between an actual threat and a perceived threat, however. Prejudice and discrimination refer to negative judgements and behaviors which are based, not on reality and specific experiences, but on stereotypes. They refer to assumptions that traumatized doctors are weak, emotionally unstable, dangerous to their patients, when there is no justification for feeling that way aside from stereotypes. When this dissertation refers to stigmas concerning traumatization and traumatized physicians in this discussion, it is referring to these types of situations; it is not talking about physicians who pose legitimate risks to their colleagues and/or patients. In fact, conflating the two scenarios is precisely where these stigmas, and more specifically the stereotypes, come from.

Rössler's combined model provides a useful framework for analyzing the complexity of the existing and also the potential future stigma confronting traumatized physicians. It also offers a helpful linguistic roadmap for discussing this complex topic with accurate terminology. Since classic stigma and prejudice research both talk about the same issue from different directions, by using a model that combines the two concepts, one is able to apply all of the useful insights from both fields. It is possible to understand the social function of the stigma of traumatization in reaffirming certain norms within the culture of medicine, while at the same time recognize how the group

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61 State Physician Health Programs (PHPs) exist in "nearly every state," exist in order to monitor and treat impaired physicians struggling with mental illness, physical illness, substance abuse or alcoholism. These programs are intended to aid physicians in need and also help improve patent safety. Physicians who are legitimately impaired and pose a threat to their patients should seek help, either from their state PHP or another source. For more information please see: "Mission, Vision and Values." Federation of State Physician Health Programs.

identity of 'good doctors' are defined largely in contrast to the out-group identity of 'bad doctors.' It also becomes possible to use understandings of implicit biases and aversive discrimination to nuance the comprehension of how internalized stigmas manifest.

The Foundation of Stigma

Perhaps the most significant benefit of this conceptualization of stigma is that it offers important insights into the foundation of stigma. Understanding the footing on which stigma is built is crucial if there is any chance of dismantling it. The best way to kill a weed in the garden is to pull it out at its roots. Mowing a weed down or cutting it back will rarely do the trick; it simply regrows. The same is true of stigma. Attempts to restrict or ban the visible forms of stigma, the discriminatory actions and behaviors, do not address the cognitive and emotional roots that lead to those behaviors in the first place. It is essentially like trimming weeds (discrimination) but leaving the roots (stereotypes and prejudices) intact. The discrimination will either rebound, or manifest in different ways (like aversive discrimination proliferating when overt discrimination is discouraged).[62] To truly combat stigma, it is necessary to begin by identifying the roots. Since prejudices are judgements based on stereotypes, the absolute point of origin for stigma is found on the cognitive level: the stereotypes. These preconceived thoughts and feelings lead to all of the other levels of stigma.

This means that in order to prevent the stigma related to the concept of traumatization from negatively effecting physicians who may be labeled with the term "traumatized," it is necessary to identify and deconstruct the stereotypes connected to traumatization (and, as will be suggested in chapter 5, mental illness). This author is not

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62 Teachman and Brownell, "Implicit anti-fat bias," 1525-1531.

the first to suggest this approach; numerous scholars have documented attempts to combat stereotypes, primarily through educational interventions.[63] The logic behind such interventions posits that stereotypes thrive among ignorance and inexperience. Therefore, by educating people about the reality of stigmatized groups and/or conditions, the hope is that incorrect stereotypes will be overturned by personal experience and facts. Research has demonstrated that educational and exposure-based interventions are often successful in reducing or combating stereotypes in individual cases.[64]

Education and exposure interventions are useful and important tools for decreasing stigma, however, they also have two significant drawbacks. First, their purpose is to reduce or eliminate *existing* stereotypes. Simple educational interventions do not necessarily prevent stereotypes' formation in the future. In order to do that, one must first determine where and how the stereotypes originate. Hafferty and Frank, for instance, suggest that educational interventions aimed at combating problematic ethics-based prejudices are "an effective remedial (as opposed to prophylactic) tool," largely due to the undermining nature of the hidden curriculum.[65] In other words, educational interventions cannot stop the formation, or reaffirmation of stereotypes through unofficial

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[63] James R. Moore, "Shattering stereotypes: A lesson plan for improving student attitudes and behavior toward minority groups," *The Social Studies* 97, no. 1 (2006): 35-39, https://doi.org/10.3200/TSSS.97.1.35-39; Zehavit Gross, "Combating stereotypes and prejudice as a moral endeavor," in *Getting Involved: Global Citizenship Development and Sources of Moral Values*, Moral Development and Citizen Education, Volume: 1, ed. Fritz K. Oser and Wiel Veugelers, 293-306 (Leiden, The Netherlands: Brill-Sense, 2008); John F. Dovidio and Samuel L Gaertner, "Reducing prejudice: Combating intergroup biases," *Current Directions in Psychological Science* 8, no. 4 (1999): 101-105, https://doi.org/10.1111/1467-8721.00024.

[64] Hafferty and Frank, "The Hidden Curriculum," 862; also, Dovidio and Gaertner, "Reducing Prejudice," 101-105 assert that educational interventions can be useful in combating more overt forms of prejudice, while they argue that intergroup contact is a better intervention for more aversive forms of prejudice.

[65] Hafferty and Frank, "The Hidden Curriculum," 862.

means. Nor can they stop their initial formation. It is necessary to identify the source of a stereotype in order to develop effective and focused methods of disproving that stereotype through education. Such efforts also enable institutional changes to be made in order to prevent continued creation and promotion of that stereotype moving forward. If the source of a stereotype is unknown, then the only way to combat it is with education after the fact, which in no way hampers its formation. It is a bit like repeatedly mopping up the water from a leaking pipe instead of locating the leak and attempting to repair it. While this dissertation supports the use of educational interventions as an important tool in decreasing the stigma surrounding traumatized physicians, it suggests that it is also necessary to identify the sources of the stereotypes that are responsible for much of that stigma in the first place.

The second drawback to educational and exposure interventions aimed at combatting stigma is that they are frequently directed towards changing the beliefs and opinions of people with limited experience and/or exposure to the stigmatized group or attribute.[66] This can be useful in helping to combat popular misconceptions, or in overturning logical fallacies founded in ignorance and unfamiliarity. It is less helpful, however, in overturning stereotypes that exist in individuals or groups with extensive education on the subject, or deep familiarity with the group or condition.[67] That is because stereotypes that exist among such individuals do not typically originate from the same sources as the stereotypes of those with limited exposure. The stereotypes found among individuals and groups who have had extensive experience with the stigmatized

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66 Dovidio and Gaertner, "Reducing prejudice," 101.

67 This will be discussed in more detail in Chapter 5. For more information please see note 7 in Chapter 5.

group or attribute are more likely to come from personal experiences or specific shared histories. That means that efforts to combat those stereotypes will require a different approach.

This is particularly true of the stereotypes that exist concerning traumatization and mental illness among physicians.[68] In fact this dissertation argues that it is precisely the intimate and problematic historical relationship between traumatization (as well as some other conceptually linked conditions) and medicine that is the source for many of the stereotypes concerning traumatization that could negatively affect distressed physicians if the suggested rhetorical changes are implemented and they are labeled as "traumatized." Unless that extant stigma is addressed, it is likely to impede the change in discourse that this dissertation recommends. As a result, in order to ultimately help traumatized physicians to recognize what they are experiencing and seek help, it is necessary to dismantle the stigma surrounding and connected to the concept of traumatization within the culture of medicine, so that they can acknowledge, discuss, and seek help for their traumatization without exacerbating their stress. To do that, it is necessary to identify the sources of the specific stereotypes confronting traumatized physicians.

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[68] Ibid.

Chapter 5:

Stereotypes Related to Physician Traumatization

Since "traumatization" is a label that this dissertation *suggests* should be introduced into the dialogue about physician distress, as a subcategory, it should not be surprising that currently "traumatization" is not a word that is used much when talking about struggling physicians. Furthermore, when anything related to trauma *is* mentioned, it is almost exclusively referencing PTSD. As mentioned in Chapter 2, much of the medical literature concerning PTSD in physicians usually focuses on the prevalence of the disorder in emergency room physicians or doctors who practice in war zones or areas of extreme conflict.[1] However, rhetoric focusing on "traumatization," among doctors, as a more general struggle, is not a common topic in the medical literature. Though, as outlined in chapter 3, there is some rhetoric about specific trauma-related conditions (SVS, STS, VT, CF, and moral injury), this author was unable to find an established discourse regarding "physician traumatization."

With that in mind, when this dissertation mentions stereotypes and stigmas associated with physician traumatization, it is important to recognize that it is not talking about explicit beliefs used in connection to the label "physician traumatization." That rhetoric either does not exist or is not used frequently or commonly enough to be widely stigmatized. Instead, it is referring to the stigmas and stereotypes that are associated with related conditions, which are likely to influence acceptance of and reactions to the label "physician traumatization." More specifically, it is referring to stereotypes concerning

[1] For a list of references, please see footnote 19 in Chapter 3.

trauma-related conditions (largely discussed in literature about non-physicians), as well as stereotypes about mental illness, specifically as they manifest within the culture of medicine, and especially as they relate to doctors. These related stereotypes not only combine to create a quiet undercurrent of stigma regarding traumatization among physicians in the present system, but they also create an atmosphere within the culture of medicine which is likely to be inhospitable to this dissertation's suggestion to expand the dialogue regarding physician distress to include physician traumatization.

As mentioned in chapter 4, these related stereotypes are likely to act as impediments to labeling what some struggling doctors are experiencing as "traumatization," even though it may be a more accurate description of what they are suffering. In fact, the realization that the words "trauma," "traumatized," and "traumatization" are so conspicuously absent from most of the literature regarding physician burnout[2] leads the author to suggest that that this may be the result of stigma already at work. In fact, this dissertation also argues that these stereotypes not only explain why so little has been written specifically about the stigma of physician traumatization, but also why many struggling physicians fail to recognize their own

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[2] There are a few scholars who link VT and STS (both trauma-related conditions) with burnout, but those authors do not usually refer to the conditions together, as forms of traumatization. Interestingly, while Figley linked burnout and STS/CF early in his career (Figley 1983), he eventually came to differentiate between the conditions based on their relation to trauma (Figley 1995), specifying that STS/CF is related to trauma, while burnout is not. Also, most of the studies looking at physician PTSD, are limited in terms of the types of physicians they consider, as discussed above. The author was unable to find studies looking at the prevalence of PTSD in physicians outside of those trauma-related specialties (for instance among family practice physicians or surgeons). Furthermore, aside from Figley's work, most of the articles cited in chapter 3 regarding SVS, VT, STS, and CF seem to be focused on distinguishing the conditions from each other, rather than underlining their shared connection to trauma. In short, the word "trauma" and anything too closely connected to it seems to generally be handled with hesitancy and caution. It is either avoided as much as possible or is only employed in a very narrow and medicalized way.

traumatization when it occurs. It posits that the dearth of information on physician traumatization is indicative of a larger avoidance of trauma-related labels within the medical culture, which unfortunately may exacerbate struggling physicians' distress.

In order to initiate change and to begin accurately recognizing instances of physician traumatization, it is necessary to take steps towards reducing the stigma surrounding traumatization, as well as reducing some of the cultural factors within medicine that exacerbate that stigma. As chapter 4 just demonstrated, that process is best achieved by identifying the negative stereotypes on which that stigma is built. Identification and recognition of the problematic negative beliefs allows better understanding of how they formed, how they are passed forward, and subsequently how they can best be dismantled.

This chapter will focus primarily upon identifying and characterizing the stigmas related to two specific conditions that are conceptually linked to traumatization: PTSD and mental illness. It will not only describe the stigmatizing beliefs surrounding each condition, but will also historically situate those beliefs, outlining how they originally developed, as well as how they are historically related to the culture of medicine. It will then shift perspectives to outline how and why those stereotypes are particularly problematic within the medical field today, leading to an increased threat of stigma. It will demonstrate the potential conflict they may create in relation to widely prioritized ideals (such as rationality and objectivity) within medicine, as well as how those stereotypes conflict with idealized traits that define popular and influential role assumptions regarding what it means to be a "good doctor". Finally, it will explore how

those stereotypes are passed down and reinforced by structural practices and policies, including the hidden curriculum.

Labeling and Identifying Related Negative Stereotypes

In order to understand what existing stigmas might inhibit the implementation of the expansion in rhetoric that this dissertation suggests, it will be helpful to consider some of the medical conditions (and the stigmas connected to them) that are rhetorically and perceptually linked to the word "traumatization." Though this dissertation is only suggesting that physician traumatization be incorporated as a category into the medical and poplar rhetoric regarding physician distress, and is not advocating for it to become a formal medical diagnosis, it is important to recognize that official medical diagnostic labels and the way they function in medicine are likely to influence the reception of this suggestion. Classification and labeling play an important role in medicine and nosology heavily influences the way that doctors perceive the world. Linda Garand, Jennifer Lingler, and Mary Amanda Dew explain that diagnostic labels are used to "classify individuals for both treatment and research purposes," and that they "allow clinicians and researchers to assume that all members of a group are generally homogenous in the underlying nature of illness."[3] They are an integral component of western medical practice and help physicians to process large amounts of information quickly, and to use groups of presenting symptoms to efficiently determine likely disease etiologies as well as potentially helpful treatments.[4] Unfortunately, however, as Garand, Lingler, and Dew

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[3] Linda Garand, Jennifer Lingler, and Mary Amanda Dew, "Diagnostic Labels, Stigma, and Participation in Research Related to Dementia and Mild Cognitive Impairment," *Research in Gerontological Nursing* 2, no. 2 (2009): 114, https://doi.org/10.3928/19404921-20090401-04.

[4] A. Frances et al, "An Introduction to DSM-IV," *Hospital and Community Psychiatry* 41, no. 5 (1990) 493-495; E. Rosch and S. Mueller, "Classification judgements: Restrictive conditions for the explanation of stereotypes," *Zeitschrift für Sozialpsychologie 55 (1978): 246-*

also explain, "despite the benefits of diagnostic labels, such labels often serve as cues to signal stereotypes." This means that certain diagnostic labels frequently become associated with stigma, and more specifically, with sets of negative stereotypes and assumptions.

While "physician traumatization" may not be an official diagnostic label, it is rhetorically linked to two well-known diagnostic labels. This is because, whenever a new word is encountered, or an old word is applied in a way that is unfamiliar, people tend to turn to other uses of that word, or to related concepts in order to determine the intended meaning.[5] This author suggests that many people, and particularly many doctors, who encounter the label "traumatization," are likely to conceptually link it to the well-known diagnostic label that already includes the word "trauma," namely Post *Traumatic* Stress Disorder. Furthermore, as PTSD is a well-known formal mental health diagnosis, people are also likely to conceptually link the label "traumatization" with mental illness. This means that stigmas and stereotypes related to both PTSD and mental illness are likely to influence physicians' reception of the label "traumatization." It is for that reason that this analysis of related stigmatized conditions will look at the stereotypes associated with both conditions, particularly as they relate to the medical community, in order to better understand what changes will need to be made in order for the suggested rhetorical expansion to be successful.

256; Patrick W. Corrigan, "How clinical diagnosis might exacerbate the stigma of mental illness," *Social Work* 52, no. 1 (2007): 31-39, https://doi.org/10.1093/sw/52.1.31. 2007; Garand, Lingler, and Dew, "Diagnostic Labels," 114.

5 Eve Sweetser, *From Etymology to Pragmatics: Metaphorical and Cultural Aspects of Semantic Structure* (New York, NY: Cambridge University Press, 1990), 1-10.

Stereotypes of Mental Illness: Irrational and Dangerous

While "traumatization" may not be a commonly used term, mental illness, as a general category, is widely recognized condition. It is also a highly stigmatized condition[6]. In fact, studies have shown that, despite increased education and exposure to mental illness through patient interaction, which is usually found to minimize acceptance of stereotypes, many doctors endorse negative stereotypes about mental illness as much as, and in some cases even more strongly than the general public.[7] This means that any condition that is even tangentially related to mental illness may by tainted by its stigma through perceptual association. This is why the current discussion will begin by considering a few of the stereotype connected to mental illness that are most problematic when applied to physicians.

Numerous studies have documented the many negative stereotypes that are frequently associated with mental illness.[8] Among them is one that is not only particularly strong, but also especially relevant to the practice of medicine, and therefore helps to explain some of the stigma surrounding mental illness in doctors. It is also therefore likely to influence physicians' perception of traumatization. The stereotype in question posits that people with mental illness are irrational and out of control, especially of their faculties, which therefore makes them dangerous.[9] This stereotype is often

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6 Teachman, Wilson, and Komarovskaya, "Implicit and explicit stigma," 75–95; Rucinski and Cybulska, "Mentally ill doctors." 90-94; Patrick W. Corrigan and Amy C. Watson, "Understanding the impact of stigma on people with mental illness," *World Psychiatry* 1, no.1 (2002): 16-20.

7 Corrigan and Watson, "Understanding," 16; Rössler, "The stigma of mental disorders," 1251-1252.

8 For lists of negative stereotypes associate with mental illness, please see: Corrigan and Watson, "Understanding," 16-20, and Rössler, "The stigma of mental disorders," 1251-1252.

9 Corrigan and Watson, "Understanding," 17.

followed by the prejudicial judgment that mentally ill people are therefore deserving of fear and ostracism.[10] Not only is this stereotype particularly detrimental to the public and personal image of the physician, as will be discussed later in this chapter, but it also has deep roots and a long historical connection to medicine. Before exploring how this particular stereotype affects physicians labeled as "mentally ill" today, it will first be helpful to look at how this stereotype developed. In order to successfully dismantle negative and inaccurate beliefs about a condition or a group of people, it can be useful to understand why and how they originated. This can be accomplished by applying a historical lens.

The Stereotype portraying mental illness and mentally ill people as dangerous and deserving of fear and ostracism is both popular and strong. It has been documented in many studies addressing the stigma surrounding mental illness[11] and frequently portrayed on television and in film.[12] Scholars such as Foucault suggest this stereotype comes from the perceived danger that mental illness seems to pose to rational thought and self-control, particularly in a culture that prizes those qualities.[13] Western culture's historical prioritization of logic, rationality, and reasoned control of the inner self helps explain

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[10] Corrigan and Watson, "Understanding," 16-17; Rössler, "The stigma of mental disorders," 1252.

[11] Corrigan and Watson, "Understanding," 17; Rössler, "The stigma of mental disorders," 1250; Bruce Link, Dorothy M. Catille, and Jennifer Stuber, "Stigma and coercion in the context of outpatient treatment for people with mental illness," *Social Science & Medicine* 67 (2008): 411, https://doi.org/10.1016/j.socscimed.2008.03.015.

[12] Ian F. Brockington et al, "The community's tolerance of the mentally ill," *British Journal of Psychiatry* 162 (1993): 93-99, https://doi.org/10.1192/bjp.162.1.93; Steven E. Hyler, Glen O. Gabbard, and Irving Schneider, "Homicidal maniacs and narcissistic parasites: Stigmatization of mentally ill persons in the movies," *Hospital & Community Psychiatry* 42 (1991): 1044-1048.

[13] Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, trans. Richard Howard (New York, NY: Vintage Books, 1988), 65-71.

why a condition which, in many ways is represented as the antithesis of those ideals, has become connected with fear, shame, and exclusion. As Sander Gilman explains:

> "Of all the models of pathology, one of the most powerful is mental illness. For the most elementally frightening possibility is loss of control over the self, and loss of control is associated with loss of language and thought perhaps even more than with physical illness. Often associated with violence (including aggressive sexual acts), the mad are perceived as the antithesis to the control and reason that define the self." [14]

"Madness" or mental illness then represents (whether a fair association or not) a potential loss of both reason and control, and therefore poses a risk, not only to the mentally ill individual, but to society at large.

Foucault argues that as reason rose to a position of prominence in Western culture, "madness" became "unreason's empirical form." It became the animalistic counterbalance for the idealized rationality that was thought to mirror God's perfection[15] Ever since the rise of rationality during the Enlightenment, madness took on important symbolism. Foucault explains that during the seventeenth century, the madman came to embody the very opposite of what Enlightenment thought valued most: reason. He explains that in the West, "until the Renaissance the sensibility to madness was linked to the presence of imaginary transcendence," but that during the Enlightenment, it became stigmatized for its "social uselessness," and more importantly, for its characterization as the antithesis of reason[16]. The mentally ill were herded together and locked away in institutions, in what Foucault refers to as "The Great Confinement."[17] He suggests that

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14 Sander L. Gilman, *Difference and Pathology: Stereotypes of Sexuality, Race, and Madness* (Ithaca, NY: Cornell University Press, 1985) 23.

15 Foucault, *Madness and Civilization*, 82-84.

16 Foucault, *Madness and Civilization*, 58.

1717 Ibid.

this locking away was meant to shield the 'rational' citizens of Europe from having to see constant reminders of their greatest fear: irrationality. Foucault explains that during that moment in time it was widely believed that "all those forms of evil that border on unreason must be thrust into secrecy," enacting the old adage "out of sight, out of mind."[18] It is also important to remember that, as previously mentioned, these early institutions were not therapeutic, and they often housed the mentally ill along with prisoners, the poor, the mentally disabled, and other groups of individuals who had violated the norms of society. Communal feelings of fear, disdain, and revulsion associated with any of these groups was likely to inevitably taint the others.

Both exclusion and exhibition of mental patients, which became common occurrences in the seventeenth and eighteenth centuries, functioned as a way of reaffirming the importance of rationality by highlighting and perpetuating the stigma surrounding the "mad". As Foucault explains, "confinement hid away unreason, and betrayed the shame it aroused; but it [also] explicitly drew attention to madness, pointed to it."[19] Societies in Western Europe (and later the United States) underlined the importance they placed on rationality by emphasizing the rejection of those who did not exhibit rationality and portraying them as dangerous and unpredictable and therefore deserving of derision, ostracism, and fear.

That same emphasis has continued into the present, and while the socially acceptable treatment of and attitudes toward the mentally ill have changed, the stigma which comes from this historically informed association between mental illness and unreason persists.

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18 Foucault, *Madness and Civilization*, 68.

19 Foucault, *Madness and Civilization*, 70.

As a result, the stereotypes that mentally ill persons are irrational and dangerous and therefore deserving of fear and exclusion have also persisted. [20] In fact, this fear has led to some popular and incredibly negative media and film representations of mental illness, which serve as both evidence of and vehicles for continuing that fear. [21] Such extreme and intensely negative depictions of mental illness inevitably influence popular assumptions about what it means to be mentally ill, and foster stereotypes that mental illness equates with danger.

Mental Illness Stereotypes and Physicians

These stereotypes become particularly detrimental when they are applied to practicing physicians. This occurs in two ways. As Peter Hadad and Isabelle Hadad explain, "two main types of stigma occur with mental health problems, social stigma and self stigma."[22] As discussed in chapter 4, social stigma refers to the negative public beliefs, judgments, and actions that exist in the broader social environment and become applied to an individual by other people (externally originating). Self-stigma refers to the internalization of those beliefs and judgments, resulting in low sense of self, increased self-criticism, and often attempts to avoid or limit labeling and expectations of discrimination.[23] This means that the consideration of how the stereotypes regarding mental illness can affect physicians labeled as mentally ill (or labeled with another related label like "traumatized) should consider both of these forms of stigma

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[20] Corrigan and Watson, "Understanding," 17.

[21] Hyler, Gabbard, and Schneider, "Homicidal Maniacs and Narcissistic Parasites," 1044-1048.

[22] Peter Hadad and Isabelle Hadad, "Mental Health Stigma," British Association for Psychopharmacology, March 3, 2015, http://ww.bap.org.uk/articles/mental-health-stigma/.

[23] Ibid.

Returning the discussion to the consideration of why the stereotype concerning irrationality is particularly stigmatizing when associated with doctors, it is first helpful to consider how this might manifest as external, social stigma. To do so, it is necessary to acknowledge a unique and defining aspect of the doctor/patient relationship. Patients often turn to physicians during moments of great fear and uncertainty and frequently find that they must place their bodies and their trust in the hands of their doctors.[24] That can be a terrifying experience and is understandably difficult for many people, especially when physicians are strangers, or specialists they have been referred to and do not know. During those moments, frightened patients may base their trust or lack of trust in their doctors on common beliefs. This is part of what some scholars refer to as "social trust," which Steven Pearson and Linda Raeke explain "is trust in collective institutions, influenced broadly by the media and by general social confidence in particular institutions."[25]

One of the factors influencing the social trust of patients is the public perception of what it means to be a "good doctor" and assumptions about the attributes that a "good doctor" would possess.[26] Chief among those beliefs are 1) that most doctors are motivated by a commitment to "first do no harm," (also characterized as "humaneness") and 2) that "good doctors" exhibit "competence/accuracy" which includes the following

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[24] Steven D. Pearson and Lisa Raeke, "Patients' Trust in Physicans: Many Theories, Few Measures, and Little Data," *Journal of General Internal Medicine* 15, no. 7 (2000) 509-513, https://doi.org/10.1046/j.1525-1497.2000.11002.x.

[25] Ibid.

[26] Kaat Marynissen and Bethan Spurrier, "Becoming the 'good doctor': Medical students' views on altruism and professional identity," *amee MedEdPublish* (June 03, 2018), https://doi.org/10.15694/mep.2018.0000052.1; Daniel E. DeSole, Philip Singer, and Samuel Aronson, "Suicide and Role Strain Among Physicians," *International Journal of Social Psychiatry* 15, no.4 (1969) 294-301, https://doi.org/10.1177/002076406901500407.

characteristics: they are smart, well-educated, rational, logical, methodical, and thoughtful.[27] In short, patients put their faith in the belief that "good doctors" are always capable of taking the evidence they are given, applying their knowledge and rationality, and logically deciding on the best course of action. These two assumptions help patients to view their doctors as "safe" figures, which in turn enable them to place their faith and trust in their "safe" saviors.

The prospect of being associated with a label like "mental illness," which carries stereotypes of irrationality and dangerousness, is likely to conflict with this important reassuring characterization of the "good doctor." In fact, the assumption that mental illness poses a threat to patient safety, as well as the stereotype that mentally ill individuals are dangerous, helps explain a few of the discriminatory practices and policies that have been built into some of the structural institutions of medicine. This is because, within the culture of medicine, physicians who are considered dangerous, unpredictable, and/or irrational, not only pose a threat to their patients, but also to the organizations and medical institutions in which they work, not to mention to the profession as a whole. As this chapter just discussed, patient trust is an integral part of the practice of medicine, and physicians who actually injure or endanger their patients damage that trust. In fact, they do not only damage the trust of their own patients, they potentially damage the trust all patients put in the medical establishment.[28] That is why

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[27] Angela Coulter, "Patients' view of the good doctor," *British Medical Journal* 325, no. 7366 (September 2002): 668-669, https://doi.org/10.1136/bmj.325.7366.668; Ami Schattner, Dan Rudin, and Navah Jellin, "Good physicians from the perspective of their patients," *BMC Health Services Research* 4, no. 26 (September 12, 2004), https://doi.org/10.1186/1472-6963-4-26.

[28] Carly Parnitzke Smith, "First, do no harm: institutional betrayal and trust in health care organizations," *Journal of Multidisciplinary Healthcare* 10 (2017): 133-144, https://doi.org/10.2147/JMDH.S125885.

physicians with mental illness labels (or related labels) are thought to pose a threat – because they are considered to be more likely to make a dangerous mistake or an irrational decision. At least, that is the rationale behind many of the policies, procedures, and organizations aimed at improving patient safety and limiting medical errors.[29]

In fact, the stereotypes that cast mentally ill individuals as irrational and dangerous have led to the inclusion of invasive questions on several state medical boards' license applications and renewal applications requiring physicians to list all psychiatric diagnoses for the previous 5 years which affected their work or school.[30] In fact, in the past, many state's licensing applications used to ask about *any* psychiatric diagnoses, regardless of impairment, but legal backlash and intense criticism over the last 10 years has led many states to change their questions to focus more on impairment, as opposed to simply diagnosis.[31] Even so, In a special report concerning suicide and burnout in surgeons, Shanafelt et al explains that "more than one-third (3046 [38.8%]) of surgeons indicated that they would be reluctant to seek help for treatment of depression, alcohol/substance use, or other mental health problems due to concern that it could affect their license to practice medicine."[32] In other words, fear of retaliation and/or

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[29] Ibid.

[30] The Texas medical license application includes the following as Question #49: "Within the past five (5) years, have you been diagnosed with or treated for any: psychotic disorder, delusional disorder, mood disorder, major depression, personality disorder, or any other mental condition which impaired or does impair your behavior, judgment, or ability to function in school or work?" http://www.tmb.state.tx.us/idl/CCCC910D-2641-4DEE-D66C-0AADB5BBDF6E

[31] Shannon Firth, "Do Docs Deserve Mental Health Privacy?: First of a three-part *MedPage Today* investigation," *MedPage* Today (July 12, 2018), Accessed February 18, 2019, https://www.medpagetoday.com/publichealthpolicy/generalprofessionalissues/73988.

[32] Shanafelt et al, "Special Report," 55-56.

discrimination leads a significant number of distressed physicians to hide their stigmatized distress.

The ramifications of such discriminatory practices can clearly be severe. While the motivation of protecting patients is an admirable one, the assumption that all mental illnesses render physicians dangerous to their patients is simply untrue. This brings up another interesting point about these damaging negative stereotypes. As mentioned in chapter 4, education and experience often help to minimize negative stereotypes, by teaching uninformed individuals about the flaws in their beliefs. It might therefore be logical to expect that these negative stereotypes would be less common within the medical community. Doctors typically have far more education concerning mental illness than the general public, as well as more exposure to mentally ill patients, even if only during their medical education.[33] As a result, a person might expect that physicians with mental illness would not need to worry about these stigmatizing beliefs influencing their colleagues and peers. It would be logical to assume that doctors with mental illnesses would only need to worry about the potential repercussions of their patients discovering their diagnosis and applying negative stereotypes to them; that fellow physicians would understand that there are many different types of mental illnesses, as well as different levels of severity, all of which should be taken into consideration before making assumptions about a mentally ill person's rationality and soundness of mind. On might also expect physicians to be cognizant of the fact that many mentally ill persons are able to manage their mental illnesses successfully with treatment, and also that some forms of

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[33] The AAMC identifies psychiatry as one of core clerkships that medical students at most schools are required to rotate through during their third year of medical education. For more information please see: James Graham, "Clerkship Length in US Medical Schools," *Curriculum Inventory in Context* 2, no. 4 (2015): 1-3.

mental illness have little to no effect on a person's cognitive ability to think rationally. [34]In other words, one might logically expect that physicians would be unlikely to adopt these negative stereotypes concerning mental illness.

Unfortunately, this has not been shown to be the case. As mentioned earlier, studies related to the stigma of mental illness have revealed that physicians often more strongly endorse the negative stereotypes associated with mental illness.[35] It is unclear why this is true. It may be the result of physicians' increased exposure to mentally ill patients (as compared with the general population) which leads to a higher chance of having more negative experiences with mentally ill patients. Higher overall exposure leading to more frequent negative exposure, could skew physicians' perception of mental illness. On the other hand, it is also possible that the negative stereotype is stronger among physicians as a result of medicine's high emphasis on rationality. In other words, mental illness may be more strongly stigmatized because rationality is more strongly prioritized.[36] This may help explain the existence of key policies and practices like the licensing questions, that discriminate against physicians with mental illnesses.

Such institutionalization of stigmas not only help to perpetuate the stereotypes on which they are founded, but they also discourage physicians from reporting or even seeking mental health services. [37] It is understandable that physicians, as a result of the

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[34] Mark Zimmerman, Thersa A. Morgan, and Kasey Stanton, "The severity of psychiatric disorders," *World Psychiatry* 17, no. 3 (2018): 258-275, https://doi.org/10.1002/wps.20569.

[35] Corrigan and Watson, 17.

[36] Bernhard Gert and K. Danner Clouser, "Rationality in Medicine: An Explication," *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine* 11, no. 2 (1986): 185-205, https://doi.org/10.1093/jmp/11.2.185.

[37] Firth, "Do Docs Deserve."

threat such stereotypes pose to fragile patient trust, would go out of their way to avoid them. Similarly, if the label traumatization is perceived to be at all associated with mental illness, it is highly likely that many physicians would avoid it for the same reason. Physicians may worry that patients' trust would be lost if their patients discover that they are traumatized. Doctors may fear that their patients would discriminate against them as a result. They may also fear that their colleagues or superiors would similarly discriminate against them. These fears may lead physicians to resist the label "traumatized" altogether, posing a potential obstacle to expanding the public discourse regarding physician distress to include it (physician traumatization)

Self-Stigma and Internalized Shame

As discussed above, social (external) stigma is only one part of this conversation. The other key element in understanding how conversations about traumatization could be affected by the negative stereotypes associated with related conditions, is self-stigma. This is an important idea because these assumptions can become deeply internalized and lead to intense shame and exacerbated distress.

Returning to the case study from chapter 2, the reader will recall that Jane expressed concern regarding a number of different forms of external stigmatization. For instance, she was hesitant about visiting a therapist or psychiatrist, for fear that it might get back to her colleagues or superiors. Jane was concerned that discovery of her traumatization might cause her to be assigned oversight and that it might also hurt her chances of getting into her desired fellowship after residency. Some of Jane's distress clearly came from external stigma sources, At the same time, however, fear of being

stigmatized by others was not the only reason for Jane's hesitancy to seek help for her traumatization. She was also deeply worried for another reason: Jane was ashamed.

While the aforementioned stereotypes connected to mental illness may account for some of this shame, they did not account for all of it. Jane was very concerned about her colleagues questioning her competency, but she was also exquisitely concerned about what her struggles indicated about her own character. Jane was concerned that, if her colleagues learned of her traumatization then they would question her strength of character and emotional and psychological fitness for the job. Not only that, but Jane questioned it as well. She felt intense shame over not being able to "get over it" or employ the professional detachment she believed she was supposed to have learned. She had internalized the stigmas leading to her feelings of shame, thereby activating the shame without needing anyone else's involvement. She was ashamed that she was struggling, and she minimizes her traumatization, even attempting to insist that it was not happening, only to feel more ashamed by her continued struggles. She castigated herself for her weakness and lack of emotional fortitude, and those feelings of shame only rendered her traumatization more isolating.

PTSD: Medicine and the Military in Context

The internalized stigmas that Jane was experiencing are indicative of self-stigma. They are also indicative of stigmas associated with the other diagnostic label, which is rhetorically linked to traumatization: PTSD. PTSD is a condition that is intimately linked with internalized stigma and intense shame.[38] It is also a condition that, like mental

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38 Tanya Saraiya and Teresa Lopez-Castro, "Ashamed and Afraid: A Scoping Review of the Role of Shame in Post-Traumatic Stress Disorder (PTSD)," *Journal of Clinical Medicine* 5, no. 11 (2016): 94, https://doi.org/10.3390/jcm5110094.

illness, is related closely enough with traumatization that the stigmas associated with it are likely to influence physicians' reception of this dissertations suggested expansion of rhetoric. PTSD is also a condition with a particularly problematic history, in which the medical institution plaid a major role. It is for all these reasons that this author argues it is important to consider the historical development of a few of the stigmas associated with PTSD in order to fully understand where they came from, how they developed, and why they might influence physicians' willingness or hesitation to accept the label "traumatized."[39]

As part of this effort to identify the specific stereotypes and stigmas associated with PTSD, it will be helpful to address the specific historical connection between PTSD, the military, medicine, and trauma.[40] This history will help provide context for why high degrees of internalized stigmas might exist among medical doctors. Many scholars have devoted extensive time and energy to the history of PTSD, however, due to the scope of this project it will only be possible to explain a few historically relevant points that are pertinent to the argument at hand.[41]

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[39] The role that medicine has repeatedly played in the perception, diagnosis, and treatment of trauma-related conditions in the military, assumes that some of the stigmatizing beliefs regarding PTSD in the military are likely to also be present in the culture of medicine. This is especially true since, as this dissertation is about to explain, during key moments in history, the stigma of certain trauma-related conditions directly influenced the medical treatment of traumatized soldiers. It is therefore justified to assume there may be some crossover in beliefs and stereotypes regarding traumatization.

[40] This is a good moment to offer an important caveat. PTSD does not only affect soldiers, and this dissertation does not mean to imply that in any way. PTSD has been well-documented in many other populations, such as victims of rape, sexual assault, domestic abuse and violent attacks, as well as first responders, survivors of natural disasters, and war refugees, to name a few. It is also important to recognize that shame is also not unique to doctors and soldiers.

[41] For a more nuanced and complete understanding of this complex issue, please see: Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Cambridge, MA: Harvard University Press, 2001).

Many scholars trace the history of PTSD back to World War I and the emergence of a condition that came to be called "Shell shock."[42] This is significant because initially, shell shock was believed to be caused by concussive blasts resulting in traumatic injuries to the brain, but that theory was eventually disproved and the exact etiology of shell shock became suspect. When physicians finally reported that shell shock appeared to be a psychological, rather than physical injury, what military leaders seems to have heard was that shell shock was not "real." As a result, they took that to mean that the soldiers were malingering. More specifically, what they heard was that shell-shocked soldiers were cowards. This was particularly unacceptable considering the danger at the front, so Allied military officials put heavy pressure upon military psychiatrists to return soldiers to the front, encouraging them to view their soldier/patients as malingering cowards and to use whatever means were necessary to "cure" that cowardice. Much of the "treatment" at that time focused on shame, fear, and diminishment or blatant denial of the soldiers' problems. Some of the treatments were extreme and have been described by some scholars as akin to torture. [43]

This history is significant because it demonstrates that during this period medicine became, in a way, the handmaid of the military. Doctors became tools, utilized by the military in order to ensure that they had as many men fighting at the front as possible. With regard to shell-shocked soldiers, physicians were directed to return as many soldiers as they could to battle as quickly as possible. In some cases, this superseded physicians'

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[42] The following is an extremely truncated history of PTSD and shell shock. For a more detailed history please see: Shephard, *War of Nerves.*

[43] Shephard, *A War of* Nerves, 76-84; For example, the novel *Regeneration* by Pat Barker depicts the disturbing use of electric shock to cure hysterical muteness in a soldier suffering from Shell Shock.

usual primary motivation to help their patients. This author suggests that this moment of ethical inversion was significant and has had long-lasting effects on the perception of trauma-related conditions in the medical community.

Eventually the perception of shell shock changed, and the emphasis shifted from a focus on malingering and cowardice to an emphasis on weak character. The assumption became that certain soldiers did not have the proper constitution for war and were more likely to develop shell shock, or "combat fatigue," as it came to be known during World War II. The United States government instituted the Selective Service System and conducted psychological screenings to attempt to weed out those soldiers who were thought to be predisposed to developing combat fatigue.[44] Those who exhibited symptoms of a weaker character and were thought to be more vulnerable to the stresses of warfare, were rejected when they enlisted[45] While this effort did not ultimately fix the problem of traumatization in soldiers, it did help to solidify a powerful stereotype that shell shock, or combat fatigue, and later PTSD, was equated with a weakness of character and constitution.

While the above analysis represents an exceptionally short and incomplete overview of the early history of PTSD, it demonstrates that over the years physicians were used multiple times to achieve politically-motivated goals of the military. It also shows that through that process, stereotypes were not just imbedded within the military,

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[44] Hans Pols and Stephanie Oak, "WAR & Military Health," *American Journal of Public Health* 97, no. 12 (2007): 2132-2142, https://doi.org/10.2105/AJPH.2006.090910.

[45] Sheena M. Eagan Chamberlain, "Emasculated by Trauma: A Social History of Post-Traumatic Stress Disorder, Stigma, and Masculinity," *The Journal of American Culture* 35, no. 4 (2012): 358-365; David H. Marlowe, *Psychological and Psychosocial Consequences of Combat and Deployment with Special Emphasis on the Gulf War* (Santa Monica, CA: Rand Publishing, 2001).

but also within medicine. Trauma-related conditions became associated with malingering, cowardice, and weakness of character and constitution. While the names associated with traumatization and the formal recognition and treatment changed over the years, those stereotypes persisted as stigmatizing undercurrents, this history is important to understand because it demonstrates that medicine not only played a central role in the development of these negative stereotypes, but that these stereotypes also dictated the treatment of traumatized patients (first soldiers, and then other non-military patients). Medicine is therefore at least partially responsible for the formation, dissemination, and legitimization of those stereotypes. It is only logical then, to presume that those stereotypes still exist in the medical culture and may influence physicians' perception of and willingness to accept the label "traumatized" themselves.

These particular stereotypes also pose a particularly strong threat to physicians and are more likely to result in internalized stigma and shame, as a result of the narrow and restrictively positive professional identity that this author suggests is common in the culture of medicine. As mentioned in earlier chapters, there are characteristics of a hero archetype present in the some of the popular conceptualizations of the professional identity of doctors. Amanda Shang explains that, "traditional heroes in literature are typically those who courageously conquer some enemy force through their mental or physical prowess. Exuding confidence, strength, bravery, and charisma, these individuals

uphold societal values, peace, and justice."[46] Shang also identifies the traditional hero as the savior who risks it all to save an individual (like a damsel in distress) in need.[47]

While this list of traits may seem a little overly idealized and prosaic to be associated with modern physicians, upon closer examination, it becomes clear that the connection isn't that far-fetched. For instance, in 1956 the British Medical Association created the *Book of Valor* in order to record "heroic deeds performed by medical practitioners." In the BMA's explanation of this compilation of heroism, they insist, "each day of their professional lives, doctors and medical practitioners demonstrate bravery and exceptional devotion to their patients."[48] Meanwhile, in their analysis of medical professionalism courses, Kyle Karches and Daniel Sulmasey argue that medical education curricula should include professionalism lessons that characterize "justice, courage, and truthfulness," as essential virtues of any good doctor.[49] The American University of Antigua's website lists as three of the "seven essential qualities of a physician," compassion, confidence, and humility.[50] Finally, Kaufman argues that many doctors are taught to "deny their own personal needs while serving those of others in medical practice," while Gunderman enthusiastically professes that "being a professional

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46 Amanda Shang, "Who Are Heroes? An Analysis of the Literary Hero and an Interpretation of the Modern Hero," Plan II Honors Thesis, Austin, TX: University of Texas (2018), 20, http://hdl.handle.net/2152/65285.

47 Ibid.

48 British Medical Association, "Hero Doctors: The BMA Book of Valor – remembering acts of heroism by doctors," British Medical Association, (2018), https://www.bma.org.uk/features/herodoctors/.

49 Kyle E. Karches and Daniel P. Sulmasy, "Justice, Courage, and Truthfulness: Virtues That Medical Trainees Can and Must Learn," *Society of Teachers of Family Medicine* 48, 7 (2016): 511-516.

50 "The 7 Essential Qualities of a physician," American University of Antigua College of Medicine, accessed February 12, 2019, https://www.auamed.org/blog/7-essential-qualities-physician-2/.

means above all professing something, declaring openly in work and life that we stand for something beyond our own narrow self-interest… At its heart, medicine is a calling."[51] So in short, the professional characteristics prized by many in the culture of medicine include bravery, devotion, courage, truthfulness, confidence, compassion, commitment to justice, self-sacrifice, altruism, and feeling of being called to help others. It should be noted that this list closely resembles the above definition of a hero.

The problem with this heroic characterization of what it means to be a doctor is that, although it is seemingly positive, it narrowly defines permissible behavior and reactions among those who want to consider themselves "good doctors." This can lead to serious problems when one factors in the negative stereotypes related to PTSD (and related conditions like traumatization). A label that is associated with stereotypes of weakness and cowardice risks conflicting diametrically with a professional identity characterized by a hero archetype. As Adam Woolf explains, individuals with identities characterized by conflicting hero and trauma narratives can experience increased distress on top of existing traumatic stress.[52] These conflicts are also likely to result in intense feelings of shame. As Kaufman warns, "A since of shame and stigma still exists for anyone experiencing these feelings – maybe even moreso for physicians, who are often trained, and regarded, to be able to rise above such problems. Perfectionistic and proud, they suffer in silence, successfully portraying a calm and competent outward appearance."[53]

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[51] Kaufmann, "Physician Suicide," 21; Gunderman, "The Root of Physician Burnout."

[52] Adam Woolf, "Competing Narrative: Hero and PTSD Stories Told by Male Veterans Returning Home," Masters Thesis, University of South Florida (2012), ii-iii, http://scholarcommons.usf.edu/etd/4260.

[53] Kaufmann, "Physician Suicide," 21.

The stereotypes associated with PTSD are not only intimately connected to issues of self-stigmatization, but they also contradict with powerful and influential hero archetypes within the professional identity of physicians. As a result of the perceptual connection between PTSD and traumatization, they are therefore also likely to negatively influence physicians' acceptance of the proposition to expand the current physician distress rhetoric to include traumatization. This means that any earnest efforts to engage in such a change would need to not only address the problematic stereotypes connected to PTSD, but also the restrictive nature of the hero archetype connected to the professional role of "doctor."

Stereotype: Not "Real"

So far, this chapter has identified a major stereotype connected to mental illness, as well as a few stereotypes associated with PTSD, all of which could become or may already be connected to the concept of traumatization within the culture of medicine. It has also identified how and why these stereotypes might influence physicians who are struggling with traumatization to *not* identify their struggles as such, for fear of having those stereotypes connected to them through the application of the label "traumatized." There is one other significant stereotype connected with both mental illness in general and PTSD specifically, which, if linked to the label "traumatized," is likely to prove dissuasive to physicians. It is a stereotype which is particularly powerful and negative within the medical community as a result of Western medicine's strong preference for physicalist explanations for diseases. The stereotype in question is a belief that the condition (whether mental illness, PTSD, or traumatization) is "all in the person's head", or essentially is not "real." This stereotype was mentioned earlier, in relation to PTSD,

during the discussion about cowardice and malingering. "Malingering" means to make up an illness or pretend to have it in order to get out of one's responsibilities, work, or punishment and we have already its connection to PTSD and the military. There is a long history of skepticism and doubt connected with mental illness, which helps to explain why the "not real" stereotype is particularly significant and powerful in medicine and especially problematic when attributed to doctors.[54]

This stigmatizing belief, while not always expressed explicitly, frequently manifests in attitudes of skepticism, particularly within the medical community. In order to fully understand the significance of this stereotype it is necessary to know a little more about Western medicine's strong and long preference for physicalist explanations for diseases. Anne Harrington refers to it in her book *The Cure Within* as "physicalist approach to illness," which she considers a dominant approach in Western medicine.[55] She explains that this mindset is dictated by a simple perspective:

> A belief that physical symptoms of illness have physical causes. If the physical causes of our illness are not immediately obvious to the unaided senses, then people expect their doctors to use X rays, ultrasound, CT scans, laboratory analysis of blood or tissue, or surgery to look more deeply for the cause of what ails. Once a doctor can 'see' what is wrong, the hope is that he or she will be able to tell the patient how to fix him- or herself: what drug to take, what kind of surgery to have, what change in diet or lifestyle to make. For many these days, this way of thinking about illness includes even that class of disorders we still call 'mental illness.'"[56]

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54 Gerald N. Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (New York, NY: The Free Press, 1994); Thomas Szasz, *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement* (Syracuse, NY: Syracuse University Press, 1997).

55 Anne Harrington, *The Cure Within: A History of Mind-Body Medicine* (New York, NY: W. W. Norton & Company, 2008): 17.

56 Anne Harrington, *The Cure Within,* 15-16.

This physicalist approach is largely based upon the philosophical dominance of "cartesian[57]" dualist thinking.

George Engel laments that "medicine's adherence to a seventeenth century paradigm predicated on the mechanism, reductionism, determinism, and dualism of Newton and Descartes," rejects all that is "distinctively human from the realm of science and the scientific."[58] According to scholars like Engel, "Cartesian Dualism" allows for the separation of mind and body in a way that allows a reductive materialist approach to illness, putting the emphasis primarily, if not solely, on the physical body and neglecting the lived experience. Irene Switankowsky, echoing this criticism, argues that "the scientific paradigm within which the physician is trained" is completely dedicated to "the materialistic framework through which the medical practitioner views illness as merely based on a bodily diagnosis and treatment." [59] Steeped in this reductive approach, practitioners learn to not only prize the observable, but to dismiss subjective experience as unimportant and even a dangerous distraction. Franz Alexander launches a particularly biting criticism of this reductive approach to medicine in his article, "Psychological Aspects of Medicine":

> The fundamental philosophical postulate of modern medicine is that the body and its function can be understood in terms of physical chemistry, that living organisms are psycho-chemical machines and the ideal of the physician is to become an engineer of the body. The recognition of psychological forces, a psychological approach to the problems of life and

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[57] I set the label "Cartesian" in quotes because, as Geir Kirkebøen explains in "Descartes' Embodied Psychology: Descartes' or Damasio's Error?," this dualist philosophy has been misattributed to Descartes for over a century. It is based on a very old misinterpretation of his writing, which has dramatically influenced the philosophy of medicine in the West.

[58] George Engel, "How Much Longer Must Medicine's Science Be Bound by a Seventeenth Century World View?" *Psychotherapy and Psychosomatics* 57 (1992): 4, https://doi.org/10.1159/000288568.

[59] Irene Switankowsky, "Dualism and Its Importance for Medicine," *Theoretical Medicine and Bioethics* 21, no. 6 (2000): 572.

> disease, appears as a relapse back to the ignorance of the dark ages in which disease was considered as the work of the evil spirit and therapy was exorcism, , the expelling of the demon from the diseased body.[60]

Not only has the body been prioritized over the mind, but the latter has, in many ways, been discounted altogether.

Such a reductive, materialistic perspective is the dominant model on which modern medicine has been based for over three hundred years, and change can be slow to take hold. Even those practitioners who realize the inadequacy of such a framework, still often continue to hold onto it. As Neeta Mehta explains in her article "Mind-body Dualism: A Critique from a Health-Perspective," there is a strong urge to "stick to the familiar dualistic thinking," not only as a way to fit in with peers and mentors, but because most doctors (and patients) have been inculcated to "feel skeptical about nonbiological explanations" for illness, viewing them instead as "unreal, illegitimate and unscientific in nature."[61]

As a result, conditions of the mind have posed a problem in relation to medicine and that is because they pose a larger philosophical question: What is the difference between the mind and the spirit? How does one distinguish between the self that is determined by the physical brain, and the self that is determined by the immaterial soul? This quandary has led to a great deal of boundary ambiguity between medicine and religion over the years, with regard to mind/body conditions. Perhaps as a result of this ambiguity, medicine has gravitated towards material, physicalist explanations for

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60 Franz Alexander, "Psychological Aspects of Medicine," *Psychosomatic Medicine* 1, no.1 (1939): 8, https://doi.org/10.1097/00006842-193901000-00002.

61 Neeta Mehta, "Mind-body Dualism: A critique from a Health Perspective," *Mens Sana Monographs* 9, no. 1 (2011): 207, https://10.4103/0973-1229.77436.

illnesses and diseases that can be touched, measured, cut, medicated, imaged, or in other words, *observed*. Medicine has prioritized objectivity, which functions well with its previously discussed prioritization of rationality and logic.

As a result, Harrington points out, the ambiguity has led to a great deal of discomfort around mind/body conditions.[62] This is apparent when considering the history of mind/body issues such as mental illness, but it is also evident in the subtle forms of prejudice and discrimination against the specialties that deal most frequently with mental illness, like psychiatry and family medicine. Both are listed as two of the least prestigious and least competitive specialties.[63] Physicians who prioritize objectivity and clear, physicalist explanations for diseases frequently approach mental health issues with an attitude of skepticism. A clear example of this skepticism and medicine's preference for objectivity can be seen in the previously discussed changes made to the diagnostic criteria in the DSM-5.

Defining "Real" PTDS

When it comes to both PTSD specifically and mental illness in general, the lack of an observable, materialist explanation engenders skepticism from many physicians who are thoroughly trained in this primarily physicalist approach to medicine. Their distaste for the less 'objective' conditions is not always overt, but can be detected in common attitudes and preferences, such as the tendency for many residents to list psychiatry as one of the less prestigious or desirable specialties. This reflects a preference

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62 Anne Harrington, *The Cure Within,* 15-30.

63 David Holmes et al, "'Bashing' of Medical Specialties: Students' Experiences and Recommendations," *Family Medicine* 40, no. 6 (2008): 400-406; Peter Creed, Judy Searle, and Mary E. Rogers, "Medical specialty prestige and lifestyle preferences for medical students," *Social Science & Medicine* 71 (2010): 1084-1088, https://doi.org/10.1016/j.socscimed.2010.06.027.

for working with illnesses that are considered more "real," and a discomfort with illnesses and diagnoses that are more varied and subjective. A particularly pertinent example of this can be seen in the most recent changes made in the DSM-5. As discussed in Chapter 3, the diagnosis of PTSD is completely dependent on the existence of Criteria A, which is the experience of a qualifying traumatic event.[64] As also discussed, between the fourth and fifth edition of the DSM, the definition of what counts as a qualifying traumatic event narrowed significantly, subsequently eliminating numerous cases that previously qualified for the diagnosis under the DSM-IV criteria.[65]

This was a significant change to the definition of PTSD, and it was the result of widespread discomfort and criticism that criterion was too broad and too subjective. Pai, Suris, and North explain:

> PTSD begins with criterion A, which requires exposure to a traumatic event. Criterion A is not only the most fundamental part of the nosology of PTSD, but also its most controversial aspect. Some trauma experts criticized criterion A in the DSM-IV as too inclusive and warned that this change had the potential to promote 'conceptual bracket creep' or criterion creep.' Some authors questioned the value of criterion A altogether, even suggesting that it should be abolished. Criterion A was retained in the DSM-5, but it was modified to restrict its inclusiveness.[66]

As a result, individuals who exhibit all of the other symptoms of PTSD, but who have experienced an event that, though it inspired those symptoms, does not meet Criteria A's narrow definition of a qualifying traumatic event, would not meet the diagnostic criteria for PTSD and would instead be given a different diagnosis. Following the logic of the

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64 Lourie W. Reichenberg, *DSM-5 Essentials: The Savvy Clinician's Guide to the Changes in Criteria* (Hoboken, NJ: John Wiley & Sons, Incorporated, 2013), 47.

65 Dean G. Kilpatrick et al, "National Estimates of Exposure to Traumatic Events and PTSD Prevalence Using DSM-IV and DSM-5 Criteria," *Journal of Traumatic Stress* 26, no. 5 (October 2013): 537-547, https://doi.org/10.1002/jts.21848.

66 Pai, Suris, and North, "Posttraumatic Stress Disorder in the DSM-5," 2.

Manual, they would most likely be diagnosed with Adjustment Disorder. This could be problematic, as it requires symptoms to resolve within six months of the end of the stressful event. If symptoms last longer than that, the diagnosis would most likely change to the vaguely named and nebulously-defined "Other Specified Trauma- and Stressor-Related Disorder," and would require a specific identification as an abnormally long-lasting case of Adjustment Disorder.[67] This is significant for two reasons. First, it downgrades the diagnosis of individuals who experience events that do not qualify as traumatizing from the more recognizable and understood label "PTSD". Instead, it employs the label "Adjustment Disorder," a diagnosis that has been sanitized of its connection to the idea of trauma. Furthermore, this happens regardless of whether or not the subject considered the event to be traumatizing. In other words, without explicitly saying so, the authors of the DSM-5 are defining what *should* and *should not* be experienced as traumatic. Through their definition of diagnoses they are passing judgement on the legitimacy of patients' experiences.

It may be helpful to note that if the argument were to be that PTSD is a specific condition and needs to be narrowly defined, that would be a justified argument. The question would then become, however, why not diagnose people who have been traumatized by events that do not fit the narrow criteria A of PTSD with a diagnostic label that still affirms their experience of traumatization, such as "generalized traumatic stress disorder?" The label "Adjustment Disorder," (as well as its definition) insinuates that their distress is the result of difficulty adjusting to a life event that is admittedly difficult, but relatively normal in comparison to trauma. Additionally, it's limited

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67 Reichenberg, *DSM-5 Essentials*, 49-50.

acceptable duration of 6 months also indicates that there is a narrow window of time in which it is tolerable for someone to struggle with such an event. Both points subtly denigrate the seriousness of these traumatizing events, as well as dismiss people's difficulty coping with them. The same judgements are not placed on recognized traumatic events, which have been acknowledged to affect people with PTSD for decades.[68]

This brings the discussion back to the other reason this change is significant. The narrowing of Criteria A was executed in an attempt to remove some of the perceived subjectivity from the diagnostic criteria of PTSD. This is due in large part to medicine's preference for objectivity and deep discomfort with the "squishy" nature of subjective experience. Pai, Suris, and North's praise-filled summary of the changes demonstrate this attitude of prejudice against subjective experience:

> The new changes in criterion A provide more conceptual clarity. Trauma exposure is objectively defined, and the subjective responses to trauma exposure (criterion A2) have been removed from criterion A, separating them from the trauma definition and confining them to symptom criteria. This separation of the subjective response to trauma from the objective definition of trauma is an important advancement in the nosology of this conditionally-based disorder. The new criteria for trauma and exposure to it further limit the types of events that qualify as trauma for consideration of this disorder and more carefully define qualifying exposures to trauma.[69]

The "subjective response to trauma exposure (A2)" that they reference in the above paragraph is a description that was included in the DSM-IV ,which defined a traumatic event in part as an event that elicited a response of "intense fear, horror, or helplessness." Critics argued that this presented a "serious conceptual error" because it conflated "the subjective experience of trauma with objective exposure to the traumatic event". [70]

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68 Reichenberg, *DSM-5 Essentials*, 47-49.

69 Pai, Suris, and North, "Posttraumatic Stress Disorder in the DSM-5," 5.

70 Pai, Suris, and North, "Posttraumatic Stress Disorder in the DSM-5," 3.

In other words, the change was made because some providers were uncomfortable with how subjective and broad the DSM-IV and DSM-IV-R criteria were, especially with relation to criterion A.[71] They were concerned that qualifying an event as traumatic by whether it elicited a response of traumatization was problematic and overly-inclusive. Two people could experience the same event and have entirely different responses to it. The changes were intended to make the new criteria more objective. The hope being that by clearly defining what qualifies as a traumatic event and then requiring that as the primary diagnostic criteria, it would enable physicians to check a clearly defined box, leading to a more objectivity and consistency in diagnoses. The irony, however, is that the definition of what counts as traumatic is still based on a subjective evaluation. The major difference between the DSM-IV the DSM-5 definitions is who decides whether an event *should* be traumatizing. While the DSM-IV relied on the experiences of each patient to explain whether an event was traumatizing to them, the DSM-5 has relied upon a set of experts, consulting a series of studies, to determine what types of events *most people* consider traumatizing, and then setting those as the norms for the diagnosis.[72] While they may be more "normal" they are not more objective; they are still based on subjective experiences.

Ultimately, the purpose of explaining this controversial change is that it occurred in response to concerns that the previous diagnostic criteria was too subjective and therefore inclusive. This translates into a concern that too many people were qualifying for the diagnosis of PTSD, and that some were receiving that diagnosis when they should

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[71] Pai, Suris, and North, "Posttraumatic Stress Disorder in the DSM-5," 2.

[72] Pai, Suris, and North, "Posttraumatic Stress Disorder in the DSM-5," 3.

not. In other words, researchers and physicians were concerned that people were either being diagnosed with PTSD or claiming to have PTSD when they did not. Essentially, they were concerned that misdiagnosis and malingering were occurring as the result of diagnostic criteria that was too subjective.[73] The expressed desire to make the diagnostic criteria for PTSD more "objective," to decrease the subjective components, and to "narrow" the number of people qualifying for the diagnosis, reveals an interesting concern that people were being diagnosed with PTSD who should not have been. In other words, a significant number of physicians and scholars were concerned that people were being diagnosed with PTSD when they did not really qualify; that their diagnosis was not justified or "real." This may seem like a minor point, but it is in fact significant because it reveals that there is still healthy skepticism towards mental health conditions like PTSD within the culture of medicine. This is evidence that the stereotype that posits these conditions are "fake" may be at least partially to blame. It is also reasonable to expect that these same stereotypes may also keep physicians from being accepting of a label like traumatization that is associated with those same stereotypes.

Conclusion

All of the above discussions regarding stereotypes connected with mental illness and PTSD help to identify some of the stereotypes that might also be associated with traumatization, and the label "traumatized." These discussions also to illuminate why these stereotypes might be particularly discouraging and unappealing to physicians, and therefore, might prevent physicians from being open to the suggested expansion of the

[73] This is also significant because PTSD is now the only diagnosis in the DSM-5 that is not diagnosed solely based upon symptomology. Some could argue that its requirement of an inciting traumatic event is indicative of the undercurrent of skepticism related to PTSD.

rhetoric regarding physician distress to incorporate physician traumatization. These stereotypes and the associated threat of stigma could prevent physicians from doing anything that might associate them with a potentially stigmatizing label. Any large-scale attempt to initiate conversations about physician traumatization and encourage traumatized doctors to come forward about their struggles and talk about and seek help for their traumatization, must be prepared to address these stigmas.

It must also be aware of the fact that most of these stereotypes are not overtly or openly expressed. Most of these stereotypes are passed along from one generation of physicians to another through casual comments by a senior resident, private advice from an attending or faculty member, or simply unofficial attitudes that "everyone knows about" and shares. As mentioned earlier, these are known in the field of education studies as the "hidden curriculum." It refers to the lessons which are not taught in any formal curriculum, but that are still passed down through other, unrecognized means of communication. Furthermore, the hidden curriculum often directly conflicts with the openly supported formal curriculum. Jack Coulehan and Peter Williams argue that "North American medical education favors an *explicit* commitment to traditional values of doctoring – empathy, compassion, and altruism among them – and a *tacit* commitment to behaviors grounded in an ethic of detachment, self-interest, and objectivity." [74] For example, none of the stereotypes discussed in this chapter are official beliefs or positions that are explicitly taught in the medical school curriculum, yet they are still learned and

74 Jack Coulehan and Peter Williams, "Vanquishing Virtue: The Impact of Medical Education," *Academic Medicine* 76 no. 6 (2001) 598.

passed down to new doctors. This happens primarily through the hidden curriculum, and it is important to recognize because it is both powerful and difficult to combat.

Any attempts to combat these negative stereotypes must recognize that interventions in the formal curriculum aimed at medical students are unlikely to succeed, unless they extend beyond the boundaries of the classroom. This is because the formal medical curriculum is not where the majority of these stereotypes are passed along. Instead, interventions would need to target prejudicial attitudes in more senior physicians, as well as discriminatory practices that reaffirm these stereotypical beliefs and prejudicial attitudes.

Chapter 6:
Conclusion

Since I began writing this dissertation, I have been struck by how many people responded to the explanation of my topic the same way: first with a look of surprise and perplexity, quickly followed by look of dawning revelation. Repeatedly I have had the opportunity to witness people with little connection to the medical field realize, often for the first time, that doctors are in fact also human and therefore fragile, and that they can obviously become traumatized by the death and suffering they witness on a daily basis. I cannot count how many times over the last few years I have heard the response "Wow! I never thought of that, but it makes a lot of sense!"

It is tempting and common for patients *not* to consider their doctors' emotions, especially when they are in the midst of frightening, painful, and/or dangerous experiences. In those moments all of the focus is typically on the patient and the patient's experience, as it should be. At the same time, however, it is also important to remember that doctors are not static and emotionless medical-provider automatons. They are human beings, just like their patients. Physicians are capable of being frightened, hurt, and exhausted; they are susceptible to emotional traumatization and intense suffering. Physicians are capable of mistakes, and of feeling suffocating shame and guilt over those mistakes. Many are also capable of intense empathy, making it exquisitely difficult to watch their patients suffer, or stand witness to their traumatizing stories. While many in the general public may not consider it often, doctors are not immune to the traumas inherent in medicine.

In order to be able to talk openly and honestly about all the different forms of distress that physicians struggle with, and in order to ensure that traumatized physicians receive the help and care that they need, it is necessary to begin by naming that suffering. Putting words to an issue like traumatization, bringing it out into the open and giving it a name, not only helps to identify and define it, but it also aids suffering individuals' attempts to regain their power in situations often characterized by feelings of intense powerlessness. Traumatization is a problem in medicine, not just for patients, but for doctors too. Referring to it as "burnout," or a similarly more palatable term, not only risks sanitizing it of its connection to trauma, but also risks glossing over the important truth that trauma is a very real and integral part of medicine.

Physician traumatization is a real phenomenon. Whether it is discussed openly, shrouded in euphemisms, or blatantly ignored, it continues to take place. It is a natural risk of practicing medicine, and it therefore is likely to be unavoidable for many physicians. The current silence on the subject must be broken in order to help those who are suffering. Those who suffer without the language or freedom to acknowledge, talk about, or seek assistance with their struggles are forced further into isolation, and deeper into pain. This dissertation provides two rhetorical strategies for breaking the silence that surrounds physician traumatization and fills the current gaps in language that prevent adequate recognition of, discussion about, and solutions for this real and dangerous problem.

Summary

In this dissertation I have suggested two important changes. First, I have argued that the current popular discourse regarding physician burnout is overly narrow and rhetorically problematic, and therefore needs to be expanded to focus on "physician

distress" more broadly. This more comprehensive category should be comprised of multiple forms of physician distress, including physician burnout, physician depression, physician suicide, and physician traumatization. Second, I have suggested that "physician traumatization" should be incorporated into the dialogue as one of those significant forms of physician distress and should be recognized and discussed openly as a natural potential consequence of practicing medicine. This dissertation has identified traumatization as one form of physician distress affecting countless doctors in the United States, Canada, and Great Britain (and potentially around the world).[1] It has defined what traumatization is and has outlined the different conditions which constitute its makeup.

This dissertation has also looked closely at how stigma can influence the acceptance and use of labels such as "traumatization". It has explored how negative stereotypes can cause people to avidly avoid being associated with certain terms and labels that are cognitively linked with stigmatized conditions such as mental illness and PTSD. It has also identified some of the common ways that those stigmas and stereotypes are perpetuated, as well as the potential ramifications of those stigmas being applied to physician traumatization. Finally, it has identified some of the most powerful linked stereotypes that are likely to impede implementation of the rhetorical changes that I am suggesting.

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[1] This dissertation has focused on literature and studies from these three countries. There have also been a few studies from other areas in western Europe that have been included, but not enough to draw any reliable conclusions about physician burnout, traumatization, or distress outside of the three countries specifically mentioned. It is important to recognize, however, that these same problems may exist in other parts of the world as well. Future research looking at the rhetoric, perception, and stigma of physician burnout and physician traumatization in other areas of the world would be helpful in determining the social and cultural dimensions of these conditions.

Call to Action – Next Steps

In short, this dissertation has articulated the need for rhetorical change to the discourse about physician burnout, suggested two rhetorical interventions that would achieve that change, and then identified the most likely roadblocks to instituting those interventions. The subsequent question then becomes: What happens next? The short answer is that steps need to be taken to expand the current rhetoric about physician burnout. The longer answer is that broad cultural and institutional changes must be made within the culture of medicine (and perhaps within the broader culture) in order to dismantle the roadblocks identified above, to make those rhetorical changes successful.

More specifically, it is necessary to engage in efforts to decrease the negative stereotypes within medical culture connected to mental illness and PTSD, as they are likely to influence physicians' perception of physician distress and traumatization. Chapter 5 identified that many of these stereotypes have deep historical roots, so it is important to recognize that change is unlikely to be quick or easy. Interventions will have to be creative and multidirectional, targeting young physicians, as well as more established senior doctors. These interventions will also need to be directed at gently countering widely-held and largely unofficial norms and stigmas within the culture of medicine, as well as changing institutional practices and policies that undergird and proliferate those norms and stereotypes. Successful efforts will most likely need to focus special attention on changing both the formal and the hidden curriculum, and will therefore need to target the popular attitudes and behaviors of not only classroom-based instructors, but also established practicing physicians who impart their wisdom through example during medical school rotations and residency training.

It is difficult to predict which types of interventions will be most successful, and which will meet resistance, so it is likely that long-term change will require trial and error. Some changes seem obvious and relatively easy to implement, such as revision of all state medical licensure applications and renewal application to include questions that focus exclusively on impairment and not on mental health diagnoses.[2] Another obvious intervention would be the inclusion of explicit information into the medical school curriculum that directly and clearly educates young physicians about the potential psychological and emotional dangers of practicing medicine and the types of physician distress that are commonly experienced, provides them with resources if they experience such distress, and emphasizes that these are not shameful or stigmatized conditions. These types of formal structural changes, while helpful, are more likely to modify the recognized and sanctioned attitudes and positions within the medical profession. They are unlikely to change the quieter, yet often stronger unofficial attitudes and beliefs that are frequently passed along through the hidden curriculum.

Implicit, unconscious, and informal perspectives and behaviors present more difficult problems to solve. Attempts to alter stereotypes and prejudices passed down by senior physicians through the hidden curriculum will most likely require a combination of traditional and nontraditional approaches. One potential solution is to offer continued education courses aimed at minimizing the stigma surrounding mental illness in medicine. Instead of providing more in-depth education about mental illness, however, it

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[2] As Jones et al explain (2018), some states have already instituted this change, either voluntarily, or as the result of court decisions. For more information on this, please see: Jones et al, "Medical Licensure Questions About Mental Illness and Compliance with the Americans With Disabilities Act," *Journal of the American Academy of Psychiatry and the Law Online* 46, no. 4 (December 2018): 458-471, https://doi.org/10.29158/JAAPL.003789-18.

might be more beneficial to focus on how the hidden curriculum works and how it relates to mental illness stereotypes. It also might be helpful to offer workshops aimed specifically at helping physicians to become aware of their implicit biases and to identify ways they may be inadvertently passing them on to younger physicians training under them. The interventions must be aimed at changing the attitudes and behaviors that are passed down informally, through advice, informal lessons, modeled behavior, etc.

This raises an important point. Interventions aimed at changing the rhetoric regarding physician distress, as well as interventions aimed at destigmatizing mental illness, PTSD, and traumatization, must target older, more established physicians as well as young physicians in training. As many of these beliefs and behaviors are learned through example, solutions must incorporate a multigenerational approach. For instance, it will do little good to teach young medical students in the classroom that physician traumatization is nothing to be ashamed of, if they learn through experience during rotations that it is actually looked down upon by their peers and superiors. What is necessary is a broad cultural shift that affects both new and established physicians. The reality is that that kind of shift will most likely take many incremental changes over a long period of time.

It will also be necessary to take steps to address the restrictive hero archetypes connected to the professional identity of many physicians. This dissertation argues that the heroic archetype is not only limiting to physicians experiencing distress but that it is also prioritized by the culture of medicine, making it difficult to combat. There need to be honest conversations about what traits are sought after in medical school applicants, and what messages are being communicated to applicants and students about what it means to

be a doctor. Medical professionalism courses should include discussions about physician distress, and they need to specifically address the fact that "good" doctors can still experience burnout, depression, or traumatization. It is also important to recognize that these myths about what it means to be a "good doctor" are often learned long before medical school. This means that it might also be helpful to target some educational interventions at the K-12 level, focusing on teaching young people a more realistic and human perspective of what it means to be a doctor.

These are only a few potential interventions that might help remove some of the current obstacles to implementing the rhetorical changes recommended in this dissertation. It is important to remember, however, that there is not just one path forward, and there is not only one way of creating the necessary corrections. What is important is that change must begin in order to facilitate the rhetorical shift that can bring these instances of physician traumatization out of the shadows and into the light.

Limitations and Proposals for Future Work

This dissertation is entirely an analytical and philosophical discussion. It brings together several different and diverse perspectives and disciplinary lenses in an attempt to bring clarity to an important, yet not fully understood issue: physician distress. It does so primarily by focusing on the issue of word choice and meaning. This work engages in critical interpretation and analysis of various qualitative and quantitative studies. It does not, however, engage in qualitative analysis itself. While that was the initial intent of the author, it was not feasible, due to a combination of circumstances, including the unwillingness of potential participants.

This work would benefit from future qualitative studies investigating physicians' subjective response to different labels such as "distressed," "burned-out," "traumatized," "depressed," "addicted," etc. It would also be useful to ask physicians about the stereotypes they associate with each label, as well as their willingness to have each label applied to them. Such a study would help to elucidate the exact stereotypes associated with each label, as well as indicate which labels are more likely and less likely to encounter resistance in physicians.

Another important question worth studying in future research is which symptoms physicians *believe* are associated with each form of physician distress. While it is possible to locate specific definitions for some conditions such as PTSD, some of the other terms, such as "burnout" have multiple definitions. Furthermore, a study looking at *perceived* symptomology would enable scholars to identify the difference between what a label means and what physicians *think* a label means. This is an important distinction, especially when it comes to questions about the relationship between rhetoric and stigmatization. Such studies would also allow scholars to better understand how the popular concept "burnout" is currently being used and applied. They would provide important insight regarding the apparent increase in cases of burnout and might help determine a more solid explanation for why an increasing number of physicians are reporting symptoms of burnout.

Perhaps even more significantly, these studies could help identify influential negative stereotypes that prevent physicians from talking about and identifying certain types of struggles. By doing so, they could help develop tailored interventions aimed at combatting those stereotypes.

Final Words

> "The Leggo was right: it had been your standard internship year.
> All across the country, at emergency lunches, terns were being allowed to be angry, to accuse and cathart and have no effect at all. Year after year, *in eternam*: cathart, then take your choice: withdraw into cynicism and find another specialty or profession; or keep on in internal medicine, becoming a Jo, then a Fish, then a Pinkus, then a Putzel, then a Leggo, each more repressed, shallow, and sadistic than the one below. Berry was wrong: repression wasn't evil, it was terrific. To stay in internal medicine, it was a lifesaver. Could any of us have endured the year in the House of God and somehow, intact, have become that rarity: a human-being doctor?"[3]

It seems appropriate to conclude this dissertation with the above quote from one of the final chapters of *The House of God*. Together with the quote from the introduction, they provide bookends of a sort to the discussion of physician distress and traumatization. While the quote in chapter 1 characterized the trauma physicians face in relation to the heroic archetype present in the idealized identity of the 'doctor,' the above quote speaks to the damage wrought by the current medical culture's ineffective mechanisms for coping with that trauma. It also demonstrates the insidiousness and the power of the hidden curriculum, as well as the ways in which problematic attitudes and behaviors are not only passed down but strengthened over time through repeated exposure to norms and stigmas.

The young doctors in *The House of God* were brutalized throughout the course of their intern year.[4] They experienced tremendous amounts of trauma which resulted in deep emotional wounds. What was perhaps most significant however, was that some of the most damaging psychological and emotional injuries they experienced came not from

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[3] Shem, *The House of God*, 343.

[4] The intern year is the first year of residency and therefore a new doctor's first year officially practicing medicine following medical school.

the natural trauma they encountered while practicing medicine, but instead from the medical system's reaction to their traumatization. The methods that they were encouraged to use to cope and deal with their traumatization, and the prejudicial attitudes and hurtful stereotypes they were exposed to in the process, arguably caused more damage than the trauma itself.

Instead of being recognized and dealt with, their traumatization was shamed, dismissed, criticized, and trivialized, and they were encouraged to toughen up and protect themselves with a thick layer of detachment, cynicism, and macabre humor. The main character's romantic partner, a clinical psychologist, put it succinctly when she said: "It's been inhuman… no wonder doctors are so distant in the face of the most poignant human dramas. The tragedy isn't the crassness, but the lack of depth. Most people have some human reaction to their daily work, but doctors don't. It's an incredible paradox that being a doctor is so degrading and yet so valued by society."[5]

Those words highlight the destructive dissonance between the idealized and heroic image of what it means to be a doctor and the stigmatizing characterization of traumatization, a natural potential consequence of practicing medicine. They reveal the terrible and isolating trap into which the current restricted discourse places traumatized doctors. Some physicians become traumatized by being good (caring, attentive, empathetic) doctors, but then cannot acknowledge their traumatization without risking being stigmatized and labeled as bad (incompetent, irrational, weak) doctors. They are forced into silence and as a result their suffering increases, sometimes tenfold.

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5 Shem, *The House of God*, 328

It is a situation that must change. In *The House of God* the main character escapes his traumatizing environment by transferring from internal medicine to psychiatry. He seeks solace and refuge in a specialty that, among other things, encourages recognition and open discourse about the trauma inherent in medicine. It Is my hope that the rhetorical changes suggested in this dissertation will allow struggling physicians to recognize, acknowledge, and seek help for their traumatization, regardless of their medical specialty; so that physicians of all types can seek the help they need without shame, secrecy, or fear of retaliation.

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Vita

Stephanie Shively was born on October 3, 1985 in Dallas Texas to Scott and Judi Shively. She is the youngest of three children. Her older sister Kristin is a high school teacher in Plano, Texas and her brother David is an architect in Jacksonville, Florida. Stephanie grew up in Plano, Texas and graduated from Plano Senior High School in 2004. She received her Bachelor of Arts degree in English and Anthropology from Texas A&M University in 2008, then moved to Galveston, Texas, where she worked for UTMB as an ethnographic researcher in the department of Community Based Mental Health Services and Policy.

Stephanie joined the Institute for the Medical Humanities as a direct-admit Ph.D. student in 2010. While enrolled at the IMH, Stephanie has presented at multiple national and international conventions, including the American Society for Bioethics and Humanities, the Annual Symposium on Medieval and Renaissance Studies, and the International Health Humanities Meeting. She has also helped to co-teach the Humanities and Ethics Practicum to second year medical students as a graduate teaching assistant.

Stephanie currently lives in Minneapolis, Minnesota with her partner Angelo and their four children. They own and operate a local coffeeshop/game store hybrid business in the bustling Uptown neighborhood of the Minneapolis. Stephanie is active in local politics and social justice movements. She testified in front of her state senate in support of the Paid Family and Medical Leave Bill in 2014 and met with state senators and representatives to help advocate for adoption of Earned Sick and Safe Time in Minneapolis. Stephanie is passionate about helping others and hopes to use her degree to help struggling providers receive the assistance they need.

Permanent address: 8513 1st Ave. S., Bloomington, Minnesota, 55420

This dissertation was typed by Stephanie Lynne Shively.