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The Calling-Cost Paradox: When Identity-Driven Motivation Becomes a Risk in Medical Training

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ABSTRACT

Physicians are often fueled by more than external rewards or professional mastery; many experience a deeply internalised sense that being a doctor is central to who they are. Self-determination theory (SDT) labels this identity-level drive 'integrated regulation'—a form of autonomous motivation typically viewed as protective and performance-enhancing. This viewpoint introduces the Calling-Cost Paradox: the proposition that the very physicians and trainees who appear most autonomously motivated may be uniquely vulnerable to burnout when learning and practice environments lack clear boundaries, reciprocal support, or psychologically need-nurturing cultures. Drawing on empirical work in motivational profiling, need-sacrifice and work–family conflict, as well as the author's dual perspective as an SDT scholar and practicing family physician, this article traces how integrated motivation can blur boundaries, amplify perfectionistic norms and lead high performers to self-sacrificial overextension. It argues that simply moving learners along the SDT continuum is insufficient. Medical programmes must also implement structural safeguards, such as duty-hour limits, reflective mentoring, team-based scheduling and boundary-setting norms, to 'protect the purposeful.' By naming and unpacking the Calling-Cost Paradox, this paper invites further research and urges educators to recognise that high engagement does not necessarily equate to low risk.

1 | Introduction

Individuals who choose medicine have traditionally been seen as deeply purpose driven. While this is often true, particularly in North America and older generations, it is important to recognise that physician values, identities and motivations are both variable and dynamic. Hafferty and Castellani [1] documented multiple forms of professionalism in contemporary society, including individualistic, altruistic and policy-oriented conceptions of what it means to be a health professional. These traditions continue to shape how identity and work are understood in different countries and institutions. Thus, this paper does not claim that all physicians or learners are identity-driven but rather calls attention to the specific risks faced by those who are, particularly in systems that glorify self-sacrifice, overwork and perfectionism.

While this may be shifting among newer generations, such as Gen Z, a strong internalised identity as a physician remains common among medical trainees and physicians [2]. This identity-based motivation—what self-determination theory (SDT) calls integrated regulation—is widely viewed as protective, fostering meaning, resilience and engagement. Yet, this same drive can, under certain conditions, backfire. This viewpoint introduces the Calling–Cost Paradox: identity-driven physicians and trainees may be uniquely vulnerable to burnout when systems offer limitless work, unclear boundaries and insufficient reciprocal support. Emerging motivational-profile and need-sacrifice studies suggest that high autonomy does not fully immunise against exhaustion. Thus, simply reducing disengagement or advancing learners along the SDT continuum is not enough. Medical programmes must pair autonomy support with structural safeguards—workload boundaries, mentoring and psychologically

safe team cultures—that protect those already highly motivated but often overlooked in wellness initiatives.

I write as a physician who has navigated the full arc of medical training and now supervises medical learners, and as a researcher whose scholarship centres on SDT and physician motivation and well-being. This dual vantage—lived experience and empirical expertise—shapes the examples, concerns and recommendations advanced here.

2 | The Drive to Serve: What Integrated Motivation Looks Like

SDT [3] frames motivation along a continuum from least to most self-determined. At one end lies amotivation—the 'why bother?' state in which, for example, a resident mechanically completes charts because the work feels pointless. Next is controlled motivation, which comes in two forms. In external regulation, behaviour is driven by carrots and sticks, such as finishing notes to avoid reprimand. In introjected regulation, the pressure comes from within: a learner might stay up late studying, not out of interest, but to silence guilt or anxiety.

Beyond these regulations lies autonomous motivation, where behaviour is more self-endorsed. In identified regulation, learners recognise and value the goal, like practising procedures to become genuinely competent. Integrated regulation goes deeper, reflecting actions that align with one's identity; for example, offering weekend follow-up calls, not because anyone asks, but because being a reliable physician feels like part of who you are. At the far end sits intrinsic motivation, where learners act out of genuine enjoyment or curiosity, such as reading an updated guideline simply to learn something new.

Integrated regulation is often treated as a good-news story, and rightfully so. It sustains persistence through long hours, emotional hardship and steep learning curves and aligns with the 'calling' narrative that draws many of us to medicine. Research also shows that it underpins high-functioning teams [4], which is critical in healthcare. Yet, this deep alignment between identity and work can carry hidden costs.

3 | When Engagement Goes Too Far

When work becomes indistinguishable from identity, boundaries blur. Rest can feel like weakness. Saying no can feel like failure. In unsupportive or unbounded systems, integrated individuals may suppress personal limits in the name of professional commitment, mistaking autonomy for invulnerability.

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Medicine often reinforces this dynamic. Rather than discouraging overextension, it sometimes celebrates it. Those who 'go above and beyond' are praised, promoted, and emulated. Yet, few ask what that devotion costs or how it is quietly enabled. LaDonna et al. [5] found that Canadian physicians feel dehumanised by an entrenched 'invincibility myth' that expects them to 'sacrifice everything'. When wellness initiatives focus narrowly on individual behaviours without addressing structural enablers of overwork, many physicians disengage, perceiving a gap between their compassion for patients and the institution's compassion for them.

To be fair, some institutions are making meaningful efforts to support learner motivation. However, without a guiding theoretical framework, these initiatives may miss the subtle ways that culture and reward structures reinforce overextension. These findings support the argument that while autonomous motivation is protective, it may be overwhelmed in environments that valorise overwork, lack structural boundaries or fail to support clinicians in return.

4 | Cultural Amplifiers: Workaholism and Perfectionism

This vulnerability is intensified by medicine's perfectionistic, workaholic culture. Trainees are immersed in stories of stoicism and self-sacrifice: sleepless nights, relentless schedules and unflagging productivity. The implicit message is that rest must be earned, fatigue is a badge of honour, and productivity is the currency of belonging.

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Psychiatrist Glen Gabbard [6] observed that many physicians display a 'compulsive triad' of doubt, guilt and an exaggerated sense of responsibility. These traits—often forged early and reinforced by training culture—can motivate admirable diligence but also make it difficult to relax, set limits or feel that one has ever done enough. Gabbard's observations resonate closely with introjected regulation [7]. His framing underscores how powerful these internalised drivers can be—not merely situational but identity-adjacent and affectively charged.

This cultural ethos is reinforced not only through informal norms but also through professional discourse. As Parker and Davies [8] emphasise, medicine encourages overwork, self-sacrifice, perfectionism and emotional detachment—traits that fuel burnout yet underpin a professional ideal of resilience. In doing so, institutions may frame self-care as an individual duty, subtly absolving themselves of responsibility for structural protection. According to their analysis, even without explicit policies, semi-formal professionalism codes and cultural expectations may be enough to imply that doctors bear a personal responsibility to remain resilient within unrelenting systems.

Consequently, many can develop introjected regulation alongside integrated motivation. They strive for excellence but fear inadequacy. They value their work yet feel guilt when not working. An inner voice insists: 'Do more'. This blend of autonomy and internal pressure is seldom acknowledged but widespread

in clinical training. It also overlaps with traits observed in the impostor phenomenon, where learners doubt their competence despite evidence of success—a pattern increasingly linked to controlled forms of motivation [9, 10]. It drives achievement but can also distort learning and threaten well-being. Motivational-profile studies [11, 12] support this picture. While informative, however, both studies used the Academic Motivation Scale, which omits integrated regulation. Future studies should adopt instruments that capture the full motivational spectrum, including identity-based drivers and their interaction with internalised pressure.

Research by St-Jacques [13] highlights how psychological-need-sacrificing—suppressing one's own autonomy, competence and relatedness—relates to introjected motivation and extrinsic goal orientations in high-demand fields like medicine. Similarly, Houlfort et al. [14] found that sacrificing psychological needs to manage conflicting work and family roles predicted lower well-being and satisfaction months later. Hence, even physicians who are generally autonomous may overextend when they deeply care and see effort as self-expression. Believing that 'more autonomy always protects' risks overlooking how identity-driven motivation can silently erode well-being, particularly in environments lacking structural boundaries and support.

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5 | Systems That Capitalise on Motivation Without Safeguarding It

Medical education often targets wellness interventions at disengaged or visibly struggling learners. These efforts are important. But a potential blind spot remains: high-performing, autonomously motivated learners are often assumed to be low risk. In reality, many overidentify with their role, quietly override their limits and avoid seeking help. Their visible success may attract recognition, but also more responsibility and strain.

Institutions may unknowingly capitalise on their motivation without safeguarding it. This is not necessarily due to malice but rather to cultural inertia, structural gaps and the absence of protective norms. Programmes should not just cultivate autonomy—they must steward it. Motivation is a resource, not a shield.

While precise estimates are lacking, emerging research suggests that this group—highly motivated yet silently strained—is both prevalent and overlooked in current wellness models. A recent study of medical students identified four impostorism profiles, each differing in their motivational characteristics [15]. Notably, the 'Fakers' subgroup combined high introjected motivation and controlled striving with an internal locus of control, indicating that learners can be driven and high-performing and still deeply susceptible to internalised pressure and emotional risk.

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6 | Protecting the Purposeful: Practical Recommendations

What can medical educators do to protect identity-driven learners?

1. **Normalise rest and build structural buffers.** Treat rest as essential, not as optional or a reward. Implement and model duty-hour limits, team-based scheduling and recovery practices that prevent overextension.
2. **Screen for identity enmeshment.** Use mentorship to explore identity language ('I am a doctor' vs. 'I work as a doctor'). This can help learners develop a more differentiated sense of self.
3. **Reinforce that excellence ≠ perfection**. Promote imperfection and vulnerability. Spotlight role models who succeed without glorifying overwork. Integrate self-compassion practices and coaching where possible.
4. **Support reflective practice and identity development.** Use narrative exercises, small-group discussions or guided journaling to help learners reflect on their values, identities and boundaries.
5. **Routinely monitor well-being and need-sacrifice.** Add brief, regular check-ins (e.g., a 2-item burnout screener or the short Need-Sacrificing Scale). Share deidentified trends and provide timely support.

Unlike many SDT-based interventions, which centre on boosting basic psychological need satisfaction directly, the present recommendations emphasise the importance of boundaries and cultural scaffolds that prevent need-sacrifice in the first place. This distinction is intentional. In high-intensity training environments, autonomy, competence and relatedness are not just supported—they are often neglected and quietly sacrificed due to cultural and structural pressures [16]. By establishing limits, modelling rest and supporting identity differentiation, programmes create the 'soil' in which these core needs can be satisfied organically, sustainably, and without overreliance on individual resilience.

7 | Limitations and Future Directions

Empirical work on identity-level motivation in medicine remains limited. Motivational-profile studies [11, 12] support person-centred approaches but did not include integrated regulation. Future studies should incorporate this regulation, along with distinctions between harmonious and obsessive passion [17]—where harmonious passion supports flexible, healthy engagement and obsessive passion may drive rigid overcommitment.

Longitudinal designs that examine how motivational profiles interact with workload, team norms, cultural messages and

supervisory style could clarify when purpose protects and when it costs too much. Interventions that embed structural boundaries, reflective practices and mentorship should also be tested.

8 | Conclusion: The 'Calling–Cost Paradox'

We invest heavily in supporting disengaged learners yet rarely examine the Calling–Cost Paradox: the hidden toll on those most committed to medicine. The same sense of calling that draws learners in can, if unchecked, drive them toward exhaustion. Integrated motivation is a tremendous asset, but without cultures and systems that recognise, reciprocate and occasionally restrain it, that drive can become a liability. Guiding learners toward purpose is only half the task. Safeguarding the purposeful is the other half.

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Data Availability Statement

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

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