In this issue of Medical Education, Luong and colleagues describe the effects of the pandemic on the personal and professional roles of the medical education community.¹ The effects of the health crisis on the roles and responsibilities in clinical clerkships are described by Noerholk and colleagues.² Together, these well-executed qualitative studies work as an invitation to reflect on the effects of the pandemic on our personal and professional identities. To that end, I start with this commentary.

In the beginning of 2020, the COVID-19 virus quickly spreads around the world. Images of flooded hospitals are etched in our memories whether they were seen on TV or as the harsh reality of one who had to deal with the situation on a daily basis. United, the pandemic was fought to everyone's best abilities and COVID-19 exposed the necessity, flexibility and sense of community in our health care system. However, the pandemic also exposed something else: dormant tensions between different identities held by members...
of the medical education community. To deal with the unstable situation, one had to be adaptive. Adaptation and self-regulation are closely connected and both depend heavily on one's reflectivity; it is increased reflectivity that made members of the medical education community aware of dormant tensions they experienced between their roles and identities.

Both Luong et al. and Noerholk et al. discuss the exacerbation of an already existing tension. The latter group report on the tension between clerkship students and physicians. Both are trying to survive the pandemic to the best of their abilities, struggling to combine education and healthcare. The tension between the two is shown to exist at both a personal and an organisational level. Similarly, Luong and colleagues report the tension between work and private life and, thereby, between organisational expectations and personal norms. Interviewed members of the medical education community consistently verbalised a personal search for their role, their norms and their identity. The clerkship students interviewed struggled to legitimise their presence in the hospital during the health care crisis. They viewed themselves as doctors-to-be but felt consistently treated as students-to-be-managed, leading to conflicts in their identity. For those working from home due to the pandemic, opportunities arose to rebalance one's work and private life. Interviewees experienced relief for a waned pressure they had not noticed to its full extent until it had been lifted. They furthermore expressed gratitude that they could organise their lives differently. After mourning the negative effects of the pandemic, they embraced the positive effects and had no intention of returning to the status quo.

Interviewed members of the medical education community consistently verbalised a personal search for their role, their norms and their identity.

This reappraisal of personal norms and identities feels inconclusive. Some interviewees indicated to them that there is no way back, but they expressed uncertainty about how to align their transformation with their organisations. That seems especially challenging considering that the organisations they are a part of, as well as society as a whole, are on their way back to the status quo. Empathy and sensitivity for each others' well-being are waning, and expectations are rising quickly to pre-pandemic levels. Organisational changes have not been nearly as drastic as the personal changes that have occurred. The conflict between individuals' identities and organisational expectations has always been evident, but it was previously easily ignored or pushed aside. Now it has been awakened and intensified by COVID-19 and continues to impose on individuals in the medical education community. Such conflict between identities can lead to feelings of stress and efforts to reduce the conflict by integrating one's identities.

Organisational changes have not been nearly as drastic as the personal changes that have occurred.

In fact, basically speaking, conflicts like these are generally resolved in one of two ways: (1) individuals leave or (2) organisations change. Amidst the rising tension between personal and organisational norms, it is intriguing to note that interviewees still expressed a desire to belong. They do not want to leave. Organisational change must, however, occur as individuals cannot endure conflict between identities in the long run. In traditional organisations, organisational change occurs in three phases: unfreeze, change and freeze. The members of the medical education community featured in these articles are clearly unfreezed: They are actively reflecting and open to change. The organisations in which they act are, however, still in their freeze state. At first, it may seem remarkable that individuals appear open to change, while organisations do not. Often, the reverse occurs. However, the reflections of individuals that have unfolded during the pandemic meant more individuals became open to change during a time in which one was not allowed to mingle and interaction was kept to a minimum. Health care organisations, in contrast, had something else on their mind rather than unfreezing.

Organisational change must, however, occur as individuals cannot endure conflict between identities in the long run.

As the pandemic appears to fade, the moment has come for organisational reflection. I echo the appeal for organisational transformation made in both articles by challenging you to wonder: How has the pandemic transformed my norms? How has the pandemic transformed the norms of those around me? and What can I do to make sure my organisation transforms accordingly? I hope we can make sure that personal transformation is followed by organisational transformation. The members of the medical education community cited in both articles give clear
directions on how our field could change for the better. While the COVID-19 pandemic has led to loss, sadness and grief, beautiful things have emerged as well. Let us make sure that increased reflectivity, and its consequences, is among these beautiful things.

I echo the appeal for organisational transformation made in both articles.

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Mental health self-disclosure: From stigma to empowerment

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Physicians, other health care providers and medical trainees have experienced an exhausting 2 years as the public face of efforts to care for patients with COVID-19. Long work hours, high patient volumes, personal risk for providers and inadequate staff support yielded high rates of stress, burnout and onset or exacerbation of other mental health conditions. In this context, Sukhera and colleagues studied discourses about mental health stigma to understand how stigma and help-seeking for mental health challenges drive members of the medical education community to respond to their own and their colleagues’ distress.1 A compelling tweet from an emergency medicine physician, revealing that she sees a therapist and takes antidepressants, constituted an index case for which the authors followed subsequent Twitter conversations and analysed news articles, academic literature and interviews with medical trainees and faculty. Critical discourse analysis,2 which uncovers how power relations among individuals and within institutions perpetuate inequities, revealed how