I was prepared for medicine to be academically challenging; the high entrance requirements, competitive application process, and long course of study had set my expectations for an intellectually laborious five years. What I was not prepared for was the emotional toll of medicine; the effects of witnessing pain and suffering on a daily basis, being belittled by senior doctors and integrating myself into a workplace functioning under increasing pressure and low morale. Resilience can be broadly defined as an individual’s capacity to respond and adapt to extreme stress or adversity. In this essay I will give an individual account of personal and professional resilience, and suggest how the medical profession can support a culture more amenable to the development of resilience through self-management and mindfulness for the benefit of patients.

In order to show resilience one must first face adversity, which can occur in all shapes and guises. During the first year of medical school, I remember vividly an occasion where two colleagues and I were asked to talk to a chemotherapy patient. Mr X was a friendly and articulate man, who after five minutes openly shared that his cancer was terminal. I could see my two colleagues begin to grapple for words, and the conversation between them suddenly became stilted where it had once been flowing. For the remainder of our time with Mr X, I was the only one to continue to ask him about his experiences. Afterwards, my colleagues asked me how I appeared to be unaffected by his disclosure, and although shaken were determined that next time they encountered a similar situation they would act in a more professional manner.

This vignette is not dramatic. However, it demonstrates that something as simple as having a conversation can require personal and professional resilience. The adversity that healthcare professionals (HCPs) face is multifocal; from...
working in an environment ingrained with pain and suffering and facing the external pressures of bureaucracy, to dealing with the personal responsibility that another human’s life potentially lies in your hands. Despite this, HCPs strive to remain positive and provide high-quality patient care. I consider my colleagues and I to have all demonstrated resilience. My colleagues faced a stressful situation and from it were motivated to improve their performance, whereas I possessed the ability to adapt to the change in the conversation and react accordingly.

I consider personal resilience the ability to maintain personal identity and safeguard well-being in the face of extreme stress. Linked to the need to safeguard one’s own well-being is the necessity to protect the inspiration and motivation that led the individual to pick the medical profession in the first place. Professional resilience, to me, is not only the ability to thrive in a workplace facing adversity but also to provide a compassionate and consistent professional performance when faced with internal and external stressors. Although personal and professional resilience are considered to be separate entities, in the context of the medical profession I deem them to be inextricably linked.

WHY RESILIENCE MATTERS

HCPs are expected to possess clinical knowledge and emotional intelligence in order to holistically support a patient through their illness. This dynamic process is both intellectually and emotionally taxing, and requires HCPs to invest personal resources in their professional life. The health of HCPs matters, directly affecting personal well-being and the care they are able to provide to their patients, with open recognition of the link between the well-being of HCPs and the quality of care that they provide. Resilience is considered to be the antidote to burnout, which Maslach and Leither describe as ‘the index of dislocation between what people are and what they have to do. It represents an erosion in values, dignity, spirit, and will – an erosion of the human soul’. Those in a caring profession are considered to be particularly susceptible to burnout; working in an occupation exposed to high ideals and prolonged periods of stress. Burnout impacts the cognitive abilities and emotional intelligence of HCPs. This can result in serious medical errors, low job satisfaction and early retirement amongst HCPs, accompanied by decreased empathy towards patients causing lower patient satisfaction with medical care as well as reduced adherence to treatment regimens. The crux of the matter is that improving the resilience of HCPs increases their ability to maximise patient safety and dignity, whilst preventing absences and illnesses associated with stress in the workforce.

SUPPORTING RESILIENCE

Not all HCPs experience burnout, and research into the foundations of resilience has been conducted in both the physical and psychological sciences. The genetic make-up, neurobiology, environmental experiences and trained behaviour of individuals are thought to fuse together to confer resilience on the individual, resulting in the acquisition of ‘stress inoculation’. Discussing genetics and neurobiology are beyond the remit of this essay, and therefore discussion will focus on combating the contributory factors to burnout and cultivating resilience for the benefit of HCPs and patients.

In light of the detrimental effects burnout has on HCPs and on their ability to provide high quality, compassionate care, it is important that individual HCPs take responsibility to cultivate personal and professional resilience. A Cochrane Review conducted by Ruotsalainen et al. concluded that organisational interventions and changes of work schedules had little effect on the stress experienced by HCPs. Rather than taking an institution-wide approach, the review recommended a focus on the ability to manage individual stressors.

My definitions of resilience require the individual to consciously recognise their well-being and the consistency of the care they provide.
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For this to occur, the individual must reflect upon their past and present experiences. From the first year of medical school written personal reflections are incorporated into the curriculum, encouraging students to analyse and meditate on their interactions with patients. However, these are completed at set points throughout the year rather than when such situations occur. I propose that the early integration of mindfulness techniques and the adoption of ‘hot debriefing’ or Balint groups (a confidential meeting of HCPs to share experiences) into the medical curriculum could cultivate resilience from the first year of medical school to consultancy. It is for these reasons that techniques of mindfulness are now integrated into the curriculum at Brighton and Sussex Medical School.

Mindfulness is a key tool in increasing self-awareness and self-monitoring of how one is coping with stressors experienced, and can help combat stress. Beckman et al. reported that holding classes and programmes not only increased well-being and self-management, but fostered a sense of community amongst HCPs – combatting feelings of isolation and cultivating relationships and support amongst colleagues. Fostering self-management and self-awareness is a key tool in supporting resilience, and recognising the signs of detrimental coping mechanisms. This therefore increases the ability of HCPs to successfully safeguard their personal well-being and recognise when it may be prudent to seek external support. Mindfulness encourages reflection rather than rumination, which can be a destructive mind-set leading to psychological distress and an inability to separate personal and professional life. By adopting strategies such as mindfulness from the first year of training, students can use experiences such as my conversation with Mr X to start to recognise their behavioural patterns and responses to stress.

Ultimately, this will help students to foster resilience to safeguard their well-being and enhance their ability to provide high quality care to patients.

Debriefing is a valuable tool in medical education, however little is known about the use and delivery of ‘hot debriefing’ as a strategy in clinical practice. After a traumatic incident has occurred, at the next possible moment the team comes together to discuss the events that unfolded. This allows clinicians to analyse and evaluate their strengths, weaknesses, the emotional impact of the event and ways to improve their clinical practice, giving a sense of closure to the experience. Additionally, Balint groups have been used as a tool to foster resilience by allowing clinicians to talk through difficult encounters in a safe, non-judgmental place. I believe my colleagues who spoke to Mr X would have benefited from such approaches to reflect upon their experience and foster a resilient approach to future encounters. I consider the adoption of hot debriefs and Balint groups to be undervalued tools in building camaraderie, acknowledging professional boundaries and encouraging healthcare innovation, and should be researched further as a way to increase personal and professional resilience.

CONCLUSION

Resilience allows HCPs to respond and adapt to adversity whilst maintaining personal well-being and desire to improve patient care. Reflecting on workplace events and incidents at work can aid the recognition of personal and professional limits, however in the world of modern medicine reflection has become a tick box exercise rather than a mental exploration. Developing and maintaining resilience requires a journey of personal and professional reflection, which in itself aids clinicians to identify and self-manage stressors and increases their capacity to care for patients competently and compassionately.

References


The personal well-being of health practitioners can affect the care given to patients.