The Resilience Paradox

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I wasn't prepared for the tears.

My foundation year doctor—the UK equivalent of an intern—approached me halfway through a busy shift in the emergency department, and asked for "a quiet word." She wanted to know if I thought she was doing a good job. I told her that she was doing very well. She gave me a weak smile and then continued tentatively, "It's just that . . . I presented my patient to the consultant (attending physician), and she basically told me . . ."—a small gulp—"she said that I hadn't . . . I hadn't done *anything right*."

These last words broke down some kind of internal barrier. Tears poured forth. She began to make little gulps, which seemed to be a suppressed, retrograde sob, punctuating her humiliating tale. "She said I hadn't *thought* about the patient (gulp), and how was I going to go back to the patient and tell him that I messed up his care? (gulp) Then she asked if I even *went* to medical school . . ."

I steered her into a quiet side room and considered my options. This was an individual in crisis. Someone who needed wise, authoritative words to empower and encourage. However, all of my verbal attempts to console her seemed to shift their meaning and become accusatory or dismissive.

> "You're doing *fine*, silly! Come on; let's dry those tears, no more of this." In other words: *Stop making a fuss*.

> "She's like that with everyone, it's nothing personal to you, she's famously horrible to junior doctors. . . ." *This is normal medical behavior: get used to it*.

> "This is really good for you, this experience, it will make you tough—you need a thick skin in this job. . . ." *You're too weak for this job*.

I eventually defaulted back to the "English Cure": a cup of tea, to be taken orally, stat.

Much has been made of "resilience" in medical education. It is generally agreed that resilience is important, and that physicians should have it, although authorities differ in their definitions of what it is. Perhaps it is a trait, or a process—or possibly a skill. For me, the most elegant definition has always been an engineering definition, which relates to the physical property of resilience in solid materials: "the ability of something to return to its original shape after it has been pulled, stretched, pressed, bent."[1] Using this analogy, I perceive psychological resilience as a person's ego—or sense of self—swaying and bending in the tornado of professional life, only to snap back to normal with an elastic *boiiiing*.

Whether resilience can be taught is contested. In 2014, the General Medical Council (GMC), the UK watchdog that polices British physicians, launched an investigation into the troubling phenomenon of physician death during a formal investigation process. Such investigations are initiated when a concern about a physician's health or probity is raised. Astonishingly, of the 96 physician deaths between 2005 and 2013, 28 were due to suicide. Physicians who were having their fitness to practice medicine investigated were killing themselves at a rate of 3 to 4 a year. Being the subject of a formal investigation is indubitably a stressful experience, but it should not be a terminal one.

One of the GMC recommendations was that "emotional resilience" should be taught in medical institutions, enabling physicians in training to protect themselves from the trials and tribulations of medical life. In other words: learn to toughen up.

As I became more interested in resilience, I began to understand that there are 3 barriers to effective resilience training for physicians in training. The first is that they tend to not want to learn about resilience, because it is not on their final examination. They don't want to put extraneous information into their fevered brains, lest it displace vital medical knowledge that they need to regurgitate in an examination in order to graduate. They perceive their brains as a computer hard drive, with a finite amount of available memory: all incoming information must be screened for relevance. The criteria for relevance are the following: Do I need this information to succeed in my academic studies? Might I be asked about this again at a later date? All other material is discarded.

The second barrier is that physicians in training do not believe that resilience, in fact, can be learned. As I probed their attitudes and perceptions, I uncovered a binary attitude toward resilience: either you have it,

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or you don't. Without buy-in from the most important stakeholder, an enterprise will die. Resilience training thus tends to not be valued by physicians in training, and they only seem to become interested in it when they desperately need it, and find that it is not there.

The third barrier, and the one that pains me the most, is that I have no idea how to teach resilience. I have, like Thomas Edison, discovered methods that do not work. I have devised simulated role-playing scenarios that test participants' abilities to cope in situations involving difficult patients, critical and complex unstable patients, and multiple simultaneous problems competing for their attention. These sessions are poorly attended. I have lectured about how mindfulness has been demonstrated to improve self-awareness and psychological well-being in medical professionals. The result is that trainees' eyes might rapidly glaze over: they do not want to learn about how to be mindful when they could be listening to an interesting heart murmur, or memorizing the causes of pancreatitis.

This is the resilience paradox: health care professionals need to be resilient, but they don't buy into resilience training methodologies, and medical educators don't know which methodologies will work.

I encountered my junior colleague again recently. She told me that she spent a lot of time reflecting on the incident, and she now works as a counselor and mentor for junior physicians who are experiencing difficulties. It seems that she has managed to draw out positives from a negative experience. I wondered whether resilience had been achieved; if a small, fortifying strut had been added to the construction of her self-confidence. I asked her if the experience had toughened her up, and how she might react if it happened again. She laughed and replied, "I would probably still cry my eyes out! But maybe not for as long."

Her story shows that resilience is not synonymous with "toughening up"—she recognized that she would experience emotional distress—but something does change. Rather than a process of returning to one's original resting state following a period of stress, like a spring or a sheet of metal, resilience develops into a new shape, a better shape. Resilience *is* adaptation. Resilience *is* evolution.

I still have not cracked the resilience paradox, but I hope that I am slightly closer to understanding how to deal with it. I must still convince physicians that resilience can be learned, and that it is not solely an inborn phenomenon. I need to persuade physicians in training that investigating their own coping mechanisms will enhance their clinical knowledge and abilities, not displace them. By publicizing my conviction that resilience is transformative rather than restorative, I hope to further our collaborative understanding of the process.

I hope that 1 day the medical community will not just say, "Physicians need to be resilient," but add "and *this* is how you do it."

References

1. Merriam-Webster Inc. Merriam-Webster's Collegiate Dictionary. 2003. Online. https://www.merriam-webster.com. Accessed July 7, 2017.

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