Insights

Resiliency in medicine: staying connected to what matters most

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In nearly every article or presentation I've seen about burnout in health care, resiliency is lauded as one's most valuable tool, something that is critical for enduring the blows of medical education and practice. This logical move from burnout to resiliency is understandable, given the literal definition of 'resilience', which is the 'capacity to recover quickly from difficulties' or the ability to 'spring back into shape' after impact or compression.[1] Such an ability seems necessary in health care, where systemic pressures, organisational demands and interpersonal strain are ubiquitous and contribute to the existing emotional complexities of caring for people who are sick and suffering.

Resiliency, however, also lends itself to ideas about grit and toughness, an imperviousness to the vulnerability that is inherent to medical care. Resiliency rarely highlights the need for others in the journey towards well-being. Instead, the path to resiliency sounds like it's paved with stoicism and personal responsibility. It sounds onerous and even a little lonely.

Scholars have pointed to the problems that arise when resiliency and stress reduction focus too narrowly on individual interventions rather than organisational ones, and how these individual interventions may ironically exacerbate stress and ill health.[2–4] Although individual interventions like mindfulness strategies, meditation and exercise are undoubtedly beneficial, what they fail to consider is both the systemic and political contributors to burnout – especially within the US health care system – as well as the root cause of burnout, which I believe is related to a sense of meaninglessness in one's work.

In my view, what we are talking about when we describe 'burnout' is less about fatigue and the number of hours worked and more about a crisis of meaning, about losing the connection to why one chose to pursue medicine in the first place. I've seen this first hand at my own institution where I serve as both the Assistant Dean for Medical Education in our medical school and as an academic

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consultant for our resident physicians – professional roles that allow me to support students and residents academically, emotionally, personally and professionally. In working directly with trainees, I sometimes hear them say that burnout is caused by 'compassion fatigue' or feeling too much, by getting too close to patients. But, from what I've seen, things are quite the opposite. It's not connecting with others and empathising with patients that burns people out; rather, it's having to participate in routinised encounters and a kind of factory-line medical care that underplays human connection. Connecting with patients – even when it's painful and feels vulnerable – makes work meaningful, not unbearable.

Our task, then, as medical educators is to help our trainees stay connected to the things that matter most. And we can do this by acknowledging that a life in health care has just as much to do with the heart as it does with the mind, and by reminding them of the privilege they have to walk into patients' worlds and extend care to them when they need it most. I am pleased to say that there is some work that we are doing at my institution that is, at least, a step in the direction of connecting people to their work – and to each other. Not long before I started at my institution, a wellness committee had been established, which I was asked to join. The first thing we did as a committee was arrange a 'Wellness Summit', where 79 physicians, nurses, students, residents and staff got together to talk about what contributed to their wellness and what depleted them. What we heard, over and over again, was that it isn't the hours worked that burned them out, but rather engaging in work that didn't feel *meaningful* and *authentic*. The participants disagreed with the idea that there exists some kind of 'work–life balance'; rather, they saw work and life as integrated. That is, what happens at work spills over into their lives at home, and what happens at home affects who they are at work. Thus, they wanted to work in an environment that acknowledged them as whole people, not just technicians.

In response to this, our hospital is now planning to implement Schwartz Rounds®, which are monthly interdisciplinary sessions open to everyone in the hospital in order to discuss the human elements of practising medicine and caring for patients and their families.[5] Unlike other medical conferences (e.g. morbidity and mortality), the focus is not on the medical management of patients but on the lived experience of caring for another person and the trials and triumphs that come with patient care. And in our medical school, a colleague and I – along with two medical students – established our Beyond Medicine group where students voluntarily attend monthly meetings where we discuss all the things about becoming a physician that don't get addressed in their formal curriculum. We've had a session where a trauma surgeon talked about the time that he became a patient in the intensive care unit, and how it felt to be sedated, intubated, confused, and thus dependent on his nurse and physician colleagues who suddenly became his caregivers. We had a family medicine physician talk about his work at the state capitol advocating for underserved patients and the tension that he feels between his desire to do this work and the time it takes away from his wife and family. We've had residents talk about the realities of the intern year and how often they struggled with feelings of incompetence or their fear that they would hurt a patient. We've talked to students about finances and how to manage money, about burnout and depression and suicide, and we've had them reflect on what made their clinical years of training unforgettable, which for all of them was either about the distress that they felt after a patient death or their delight at connecting with a patient in a profound way. No students talked about their grades or the time that they had aced an exam.

Whether formal or informal, all of us – especially those of us in leadership roles – need to encourage opportunities to reflect on the work clinicians and trainees are engaged in every day. Intentionally reflecting with one another helps students and residents stay connected to what makes medicine so meaningful. It prevents them from giving in to the temptation to pull away from patients and from each other when they don't think there is any place to talk about what's happening to them. Those of us who are aware of the statistics about the emotional and mental suffering of clinicians and trainees know that interventions that offer moments for reflection, vulnerability, and connection – even when these interventions are transient and imperfect – are worth it. Sometimes resiliency isn't about grit; it's about having one's own suffering acknowledged. It's about being seen and known and heard as one struggles to take care of others. Sometimes clinicians and trainees need the opportunity to slow down and remember why they chose medicine in the first place. Indeed, for some, their lives depend on it.

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