Withstanding the storm: On resilience

A hidden curriculum is introduced in the first week of medicine. There are well-intentioned lectures on how to receive feedback, how to report maltreatment, and how to practise self-care and recognize burnout. Why do we expect greater physical stamina of ourselves than we would ever recommend to patients?

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Modern medical education has a strong infatuation with the concept of resilience. It is the quality du jour, evidenced by resilience modules, chipper speeches on building resilience, and even residency program descriptions that ask applicants to address personal examples of resilience. It is not much of a leap to see where the impulse comes from—our culture is reiterating the messaging heard throughout society at large. And while there is immense pressure on physicians and the health care system to stand up against crushing pressures that now come with a frequency comically pronounced, there is no tinge of irony to edicts to extend hours, work harder, and be better.

I wonder how my conception of resilience measures up. My mental picture is of a brutal wind lashing at my statuesque, immobile body. While it is an evocative image, I feel deflated by the sensation of being an object accepting what comes; my resilience has no association with agency or pride. Instead, I am reminded of our sick patients who are told they are brave in their perseverance—watery, polite smiles are frequently the response. The grace of these moments, at times provoked by me (why do I act this way when I know?), is embarrassing, the commentaries stunning for their cowardice and lack of insight, or perhaps, in a kinder light, their naivete. Bravery assumes a choice, or perhaps it prescribes it—part of an unspoken agreement between victims of hardship and society, wherein the former soothes the anxieties of the latter, separating themselves as uniquely suited for hardship.

I have a close acquaintance in our class, maybe just a person to joke with, who is unflappable. Every bad preceptor experience he has is slightly hilarious to him. He is light as air. I gave him the very, very short version of how I had to move out and become independent at 18. He didn't get it. "But did you *have* to move out, or could you have, like, negotiated? Could you have offered to, like, pay some of the bills or something?" I have affection for this classmate and gently tried to explain how if you have to manipulate someone into letting you stay, the cost is going to be too high, trying to balance my truth with the knowledge that the whole truth is too much, my pain easier to flatten than to risk making someone else uncomfortable.

I am not grateful for the lashing of the wind, for what it teaches me, and I am not grateful for my resilience. I am sensitive to the suggestion that mental breakdowns in medicine or academic malfunctioning can be remedied with resilience. I am troubled that training programs are asking learners to be resilient instead of creating environments built around developing healthy stress responses or, better still, recognizing the humanity of learners, the simple fact that we are organisms whose mental well-being is strongly impacted by the withholding of basic biological needs. When we expect greater physical stamina of ourselves than we would ever recommend to patients, that is cruel. When we codify this stamina, normalize it, we entrench that those who suffer under sleep or food deprivation are weak. A case provided in one resilience-based resource for residents includes the following, apparently to describe warning signs for depression in residents:

"John has been having a harder time getting out to social activities. He feels tired all of the time, and does not feel motivated to go out. Instead, he stays home and tries to study. However, John is finding it hard to concentrate and focus on his reading. He beats himself up for wasting time, and that makes him feel worse."

It is hardly cutting-edge medicine to say that lack of sleep can lead to feeling tired

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all the time, and that the stakes are high enough in medicine that skipping social events to study is both ethical and the best way to avoid the misery of ignorance and the professional consequences that result from falling behind. Using this hypothetical resident as an example of depression, for me, smacks of a cognitive dissonance of training programs—that we can be meaningfully compared to other work environments, that John's problems are his alone to manage, that he is defective, and that he has to fix himself.

I wonder who is left out when programs ask for resilient applicants, and whether being a work-in-progress, so to speak, is unacceptable. I question whether those advocating for resilience in medical learners understand that, too often, the twin sister of resilience is grief. Residency programs state that they seek resilient residents, and while I am aware that I qualify, I feel an uneasiness, the tightrope between my truth and the discomfort of others, my desire to spare them the "ick," my desire to remain professional. I want to disclose; I don't want to disclose. Even the concept of resilience as a trait across different domains is problematic. I would like to know how the translation works, how resilience in one area may determine my reaction to new situations. Part of the issue is a lack of agreement, a slipperiness in what exactly this thing is, the *resilience* that we celebrate and ask for in others. A resilient child, according to the Organisation for Economic Co-operation and Development, is one who is in the bottom quarter of students socioeconomically but performs in the top quarter of students academically. Yes. I am this, or I was this. I am resilient—this definition has metrics. But there are other descriptions that use the words "adapt," "overcome," and "withstand." I am not sure if resilience is a character trait, a power, or simply a description of the chronology of certain unpleasant events. Those who emerge from adversity or tragedy with a self that is acceptable to others are, perhaps, the nucleus of resilience, a reflection of us taking pleasure in those who walk through fire without burning.

What does it mean that our medical community's new favorite character trait is being able to withstand anything? *Should* we withstand anything? Resilience is the distant cousin of agency and determination, which are much closer to the gifts I want to practise in my daily life. I am mostly uninterested in resilience. I am uninterested in learning from being abused or mistreated. To put it another way, it feels so good when the lighter is taken away from your hand, but first the burn hurts, and then you have the scar. There is a hollowness to resilience in practice, at least for me. I have profound sadness when tragedy or adversity strikes my life, and I immediately feel myself managing it. I don't want to manage it.

It is ironic to have the idea of a hidden curriculum introduced to us in our first week of medicine. I know that, at 28, soft alarm bells went off during those well-intentioned lectures, which also included lectures on how to receive feedback, how to report maltreatment, and how to practise self-care and recognize burnout. The irony is that the lectures are adrift, shapeless, with no associations, like lecturing to kindergarteners about taxes. They start medical education *in medias res* to poor effect. We are warned against abuse as we are primed for it. We are told to report our abusers while it is imparted that our responsibility is to receive feedback earnestly, completely poised and grateful. We are told that potential abusers will be taken for a coffee to have an informal chat. I recognize the safety this gives my future self, as I cannot pretend to have confidence that I will never hurt a learner, that I am one of the good ones. We are told that we must put our names on the report to have this chat happen.

In November 2020, Twitter erupted after a sample reference letter for family medicine was posted to the official CaRMS (Canadian Resident Matching Service) website. Screenshots are all that remain of this document, but the crucial line that caused the uproar was "Have you observed any of the following? . . . A lapse in composure (e.g., anger, tearfulness, defensiveness)." Many of the responses to the main Tweet were doctors narrating times they cried over patients. Only a few doctors, Dr Brian Goldman being one of them, said they had cried or been defensive in less flattering lights as well. I am already one of those who can admit true lapses in composure, tears for myself, not for a patient, defensiveness on my own behalf, not on another's. Perhaps it's a bad start. Perhaps resilience has an expiry date.

The biggest breaths of fresh air I experienced during my third year were when two first-year students shadowed general surgery while I was on my core rotation at St. Paul's Hospital. On two separate days, I had coffee with a student who thought I had something to know while I was just emerging from a sad period of feeling like I knew nothing at all. It was so easy to find the right words to say, to anticipate their insecurities, to reassure them that they were doing great, that it was a pleasure to have them in the operating room. Selfishly, of course, it was a break from being the most ignorant in the room. But that's not it, not really. I have opportunities to at least create a good day, a safe day, for someone else. I am as uninterested in these students' resilience as I am in my own.

I want to be clear: I think strength, tenacity, and, yes, even resilience, have value. There is some responsibility on the individual to embrace their own determination, to set themselves up for success. Railing against the system is pointless for triage: I do understand this. However, institutions pushing resilience as more than a triage tool are not meeting the minimum effort. If resilience is focused on each learner having agency, assessing what we can do in a program, then the logical conclusion should be that the institution should focus on what *it* can do. The institution's power is far greater than that of those who live under the culture of the institution. An institution cannot determine how resilient an individual is; it can only determine how to create fail-safes. I believe these fail-safes are rooted in culture, so that is where institutions should devote energy and resources.

Resilience is solitary, a drive toward

individual responsibility, a turning away from collective care. Doctors are known for our intelligence and persistence in problem-solving, especially with problems that we have no blame for, such as illness. I refuse to believe that our institutions are immune to creativity and revision. It is only impossible until it is done. We can strive to be interdependent and have the courage to accept our humanity, and accept those in our profession who are struggling, irrespective of whether their resilience has taken a pause or is nascent. Let us build resilient systems, architecture with storm-proofing, not rely on individuals to carry the load. We are each other's community. Like water, we are more magnificent in our interactions than in our constituent parts. We should encourage people both to give and to take; both are essential aspects of a collective care model, a linking of hands, a lean-to built in a windstorm. ■

Continued from page 139

the community, for your WorkSafeBC patients, case managers and return-to-work specialists at WorkSafeBC can take on this role. An ability-focused fit note lays the foundation for appropriate accommodations. If required, you may speak directly with the employer or with WorkSafeBC about return-to-work plans (there are fee codes for this).[5]

Returning to work is a healthy and important step in recovering from a work injury or illness. Worklessness not only affects a person's livelihood but is also associated with significant health risk.[6,7] Helping patients return to work is an important role for physicians.[8] Tolerance-related limitations may delay return to work. By describing tolerance in a positive, ability-focused fashion, physicians can help promote recovery. A fit note will have more impact than a sick note on your patient's livelihood and health.

If you have questions, contact a medical advisor at WorkSafeBC via the RACE app or call 604 696-2131 or 1 877 696-2131 toll-free. ■

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