Physician Resilience: What It Means, Why It Matters, and How to Promote It

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Abstract

Resilience is the capacity to respond to stress in a healthy way such that goals are achieved at minimal psychological and physical cost; resilient individuals "bounce back" after challenges while also growing stronger. Resilience is a key to enhancing quality of care, quality of caring, and sustainability of the health care workforce. Yet, ways of identifying and promoting resilience have been elusive. Resilience depends on individual, community, and institutional factors. The study by Zwack and Schweitzer in this issue of *Academic Medicine* illustrates that individual factors of resilience include the capacity for mindfulness, self-monitoring, limit setting, and attitudes that promote constructive and healthy engagement with (rather than withdrawal from) the often-difficult challenges at work. Cultivating these specific skills, habits, and attitudes that promote resilience is possible for medical students and practicing clinicians alike. Resilience-promoting programs should also strive to build community among clinicians and other members of the health care workforce. Just as patient safety is the responsibility of communities of practice, so is clinician well-being and support. Finally, it is in the self-interest of health care institutions to support the efforts of all members of the health care workforce to enhance their capacity for resilience; it will increase quality of care while reducing errors, burnout, and attrition. Successful organizations outside of medicine offer insight about institutional structures and values that promote individual and collective resilience. This commentary proposes methods for enhancing individuals' resilience while building community, as well as directions for future interventions, research, and institutional involvement.

Editor's Note: This is a commentary on Zwack J, Schweitzer J. If every fifth physician is affected by burnout, what about the other four? Resilience strategies of experienced physicians. Acad Med. 2013;88:382–389.

The study by Zwack and Schweitzer[1] in this issue of *Academic Medicine* identifies resilience as a central element of physician well-being. Resilience is the ability of an individual to respond to stress in a healthy, adaptive way such that personal goals are achieved at minimal psychological and physical cost; resilient individuals not only "bounce back" rapidly after challenges but also grow stronger in the process. Building on work from the past 25 years on physician stress, their qualitative study suggests that it is possible to enhance resilience. They have developed a useful taxonomy of ways in which individuals can become more resilient, drawing on a snowball sample of physicians in Germany. Their sensible descriptions of these approaches are likely to resonate with physicians worldwide.

With these findings in mind, it is now time to bring together three critical issues in health care—quality of care, health care costs, and the well-being of the clinician workforce. Descriptive studies suggest that these three areas are linked,[2] and a few interventions lend support to the idea that changes in one of these domains can affect the others. For example, our group has demonstrated that an intensive program that used mindfulness meditation, narrative medicine, and appreciative inquiry-based dialogues had a profound and synergistic effect on physician well-being and quality of relationship-centered care.[3] Measures of mindfulness, burnout, and psychological well-being improved with the intervention—factors linked to fewer (costly) errors and lower attrition. We also observed improvements in physician empathy and psychosocial orientation—important markers for quality of interpersonal care. Unexpectedly, we also saw changes in personality. Participants exhibited greater resilience ("mental stability") and conscientiousness on the NEO-5 factor personality inventory[4,5] and reported healthier ways of managing the stresses of clinical practice.[6] These changes lasted beyond the end of the intervention.

Drawing on our own experience and the work of others, we offer some further thoughts about strategies and recommendations for developing and maintaining physician resilience. These recommendations fall into three key categories: (1) self-awareness and self-monitoring, (2) self-regulation and resilience, and (3) public accountability, communities of care, and health care institutions.

Self-Awareness and Self-Monitoring

Before enacting strategies to enhance resilience, individuals must first be able to recognize when they are adversely affected by stress and understand the difference between their own adaptive and maladaptive responses to stress. All too often, busy clinicians ignore the early warning signs of stress—fatigue, irritability, and feeling outside their comfort zone—in the hope that the situation will self-correct or that their baseline adaptive skills will carry them

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forward.[7] However, this approach often does not work—stresses increase so that they are more difficult to address. Worse yet, there is a missed learning opportunity—clinicians do not become more skilled in responding and adapting before stresses get out of hand.

We and others suggest that the requisite self-awareness of one's own somatic, emotional, and cognitive experience of stress can be cultivated through both formal (e.g., mindfulness meditation) and informal practices (e.g., habits of mind and work). Zwack and Schweitzer direct our attention to the use of contemplative practices, specifically mindfulness-based stress reduction, to foster a continuous self-awareness in which individuals can observe their own reactions to stress. They also direct our attention to Balint groups,[8,9] designed to help family physicians be aware of their own emotional reactions, biases, and countertransference that might be influencing their clinical care. Balint groups are common in family medicine residency programs in the United States and the United Kingdom.

As helpful as formal practice and workshops might be, practitioners also need ways of bringing resilience-promoting activities into their daily work. Informal practices are designed to promote self-awareness during patient care; they help clinicians take stock and clear their minds at key moments, allowing them to be aware of any less-than-optimal reactions that would not serve them well for the task at hand. We call these "informal practices" because they can be done anywhere and can be conveniently applied to the work setting. These practices may be diverse. For example, Moulton and Epstein[10] describe how expert surgeons develop a tacit awareness so that they can "slow down when they should" when encountering difficult moments during surgery, allowing them to proceed more deliberatively (and safely). Some primary care clinicians have developed the habit of briefly pausing before entering a patient's room, taking a breath to clear the mind of residual thoughts and feelings from the previous interaction to help them be more present and attentive for the next patient. Using reflective questions can also promote self-awareness (e.g., "What am I/are you assuming about this situation that might not be true?" "In what ways are prior experiences influencing my/your responses to this situation?" "What might a trusted peer say about the way I/you managed this situation?").[11] When incorporated into teaching rounds, these questions can help promote habits of self-monitoring.

Self-Regulation and Resilience

It is not enough to recognize that stresses exist, that they are unavoidable, and that they can result in cognitive errors, strong feelings, and moral distress. Clinicians also need to realize the degree to which they have choices about how to address those stresses and self-regulate their own cognitive, emotional, and somatic reactions. We draw some hope in Zwack and Schweitzer's observation that resilient physicians valued owning up to their own limits, uncertainties, and errors. This is a positive sign that at least some professionals are ready to embrace greater self-awareness in the interest of sustaining their professional competence as well as their own sense of well-being.

Unfortunately, in current medical education, students, residents, and practicing clinicians are all too often left to their own devices to find means for enhancing their capacity for self-regulation. Some find help through activities outside of the health care setting, often drawing on habits that were developed prior to medical training such as exercise, relaxation techniques, or meditation. It is also important to set boundaries around one's work and have enough time to relax, sleep, and spend time with family; younger physicians may be doing better with these compared with the prior generation. However, as important as those outside-of-work activities may be, clinicians also need to find ways to engage with work in such a way that it nourishes and does not deplete resilience. Otherwise, clinicians will satisfice; they will rely on survival strategies rather than cultivating healthy habits that they can bring to future challenges. Resilience, in that sense, is about wholehearted engagement with—not withdrawal from—the often-harsh realities of the workplace.[12] Paradoxically, loss of resilience can result from the seemingly energy-saving measures of withdrawal.

Recognizing that there are very few formal opportunities for clinicians to develop greater resilience and greater moment-to-moment awareness in the health care setting itself, since 2007 all third-year medical students and several residency programs at the University of Rochester School of Medicine and Dentistry have had "mindful practice seminars" as part of the required curriculum. Developed in parallel to sessions that we created for our longitudinal program for practicing physicians[3] and multiday workshops for clinicians and educators, they focus on self-awareness and resilience. There are likely many institutions that have similar opportunities. However, these efforts have been poorly studied and are highly variable in format, content, and quality. Importantly, we distinguish sessions which promote cultivation of skills and habits of self-awareness from support groups which provide psychological support and a "friendly ear." Although support groups can be helpful and necessary in some circumstances, they may not necessarily enhance the skills and habits of mind that promote insight and resilience. Also, it is very likely that there is no one-size-fits-all approach; optimally, students, residents, and practicing clinicians would have a choice of different types of experiences that could promote resilience and self-awareness.

Several months after our mindful communication intervention, we interviewed physician participants to explore what they had learned that might be helpful for future courses.[6] Although we were not surprised that they felt that cultivation of formal and informal mindfulness practices would be helpful, we were struck with two other findings. The first and perhaps most frequently mentioned was the need for community. Physicians are increasingly isolated—physically because they work in diverse settings or emotionally because there is little time for learning about each other's stresses, discussing challenging professional situations, and developing personal connections. This sense of isolation may be exacerbated as more impersonal and publicly discoverable electronic documentation is rapidly replacing collegial face-to-face communication. We take from this observation that approaches to promoting well-being

and the consequent quality of care should serve to develop a sense of community from which physicians can draw support. The other finding was particularly compelling. Physicians needed—but found it difficult—to give themselves permission to engage in activities that would improve their self-awareness and self-care, despite recognizing that these qualities enhanced their own resilience and their capacity to provide the kind of patient care they and their patients value. They had difficulty responding to their own needs despite the supportive attitudes of their families and colleagues.

Public Accountability, Communities of Care, and Health Care Institutions

The general public may not be very sympathetic to an argument that physicians need to augment their well-being; they may see physicians as privileged and see an investment in their well-being as evidence of entitlement. But, patients want physicians who are attentive, rested, present, and caring. They want physicians with the resilience to handle stress that may be the result of their own and other patients' devastating illnesses and complex problems. They want physicians who can recognize potential errors before they happen, slow down when they should, seek advice when they are overwhelmed, and respond mindfully rather than react reflexively to complex and challenging situations. They want physicians who are sufficiently connected to other physicians to draw support, advice, information, and wisdom.

First-rate musicians and athletes know that attention to the self is a key to optimal performance. Their training explicitly includes development of skills in self-monitoring, self-awareness, and resilience. In medicine, where the stakes are arguably higher, this kind of training is lacking. Promoting mindfulness, self-awareness, and resilience is not solely the responsibility of individuals. It also depends on active support and investment from health care institutions. Explicit attention to self-awareness and self-care has been incorporated as a curricular theme at a few medical schools under the rubric of professional formation; these themes should be on the radar screen in all discussions of training, continuing education, and quality of care. It is in the public's interest, as well as in health care institutions' self-interest, to promote a more self-aware, resilient health care workforce.[13,14] Physicians who care for themselves do a better job of caring for others and are less likely to commit errors, be impaired, or leave practice, all of which are costly to the health care system. We can learn from the experience of high-reliability organizations and high-risk settings outside of medicine that devote specific attention to the resilience of their workforces. Programs should involve not only physicians and nurses; they also should include other clinicians and nonclinical staff.

Attending to the Self of the Practitioner

We are only at the beginning of serious inquiry about how to attend to the self of the practitioner. This inquiry should include qualitative and quantitative approaches so that we can learn from the experiences of those who have found ways to be more mindful, self-aware, and resilient. Intervention research is particularly important, but it is also challenging. Measuring change is difficult during times of rapid professional and personal development, and randomized trials are not always feasible or the best means for assessing change. We need creative, forward-looking intervention research using nonrandomized and randomized designs to identify the essential elements and the optimal timing and dose of such approaches.

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