Clinical and scientific letters

Resilience: friend or foe?

Over the last decade, the parlance of resilience has become popularised within the field of medicine. Considered to be the ability of individuals to adapt, cope and transcend disruption or long term adversity,[1] a resilience model has received endorsement from the GMC with supporters believing it to be the necessary apparatus by which to address physician burnout and more extreme incidents including suicide. Subsequently, the GMC intend to integrate an obligatory resilience framework into curricula at the level of postgraduate specialty and subspecialty training. Despite this, the espoused usefulness of the resilience framework reflects outcomes of research conducted in the fields of psychology and childhood development. Presently there is little by way of academic evidence supporting the adoption of resilience initiatives in the health sector as a means to generate overall improvement in physician wellbeing. We argue that the uncritical acceptance of a resilience narrative within the field of medical training will prove problematic.

Much has been written regarding the prevalence of physician burnout, an affliction noted increasingly within the NHS. Yet despite burnout being a predictable antiphon to ongoing and worsening issues surrounding rota gaps, complaints, working hours and pressures to achieve, physicians are told to build their resilience to combat this by means of meditation, self-awareness, reflection, exercise and finding that elusive greater work–life balance. Accepting the old adage 'prevention is better than cure' the appreciable benefits of a wellbeing culture within medical discourse is evident. However, experiences of resilience are more individualised and nuanced, and as such the emphasis should be on individual responses as fundamental in both generating and sustaining personal modes of coping. The resilience paradigm in its current iteration may thus heighten burnout through the additional pressure it places on the individual to subscribe to models for the many rather than develop tailor made responses.

The implications of resilience as a binary concept, despite a lack of defined quantifiable measures, renders use of the term open to criticism. There is a complete failure to recognise the dynamic nature of resilience and the presence of an adversity 'dose-effect' or 'saturation point' after which individuals, many of whom were previously considered resilient, end up displaying adverse effects.[2] Resultantly, those considered non-resilient can find themselves ostracised, subject to blame, stigma and discrimination, further engendering additional physician stress. Therefore, one must consider if the terminology of resilience within the NHS merely reflects a means by which to divert accountability away from those involved in NHS governance, acting as a whitewash to the documented structural challenges within the system as a consequence of bed pressures, funding deficits and lack of workforce security. No more is such a conclusion as evident that in the recent case of Dr Bawa-Garba, which highlighted a chronic shortfall in accountability, reinforcing a blame culture and engendering heightened levels of isolation among NHS staff.

The application of a 'one size fits all' model of resilience for NHS staff, those operating under the most severe blanket of austerity since the organisation's inception, is an unfair abdication of responsibility by those who manage NHS governance. Greater appreciation of a number of issues, including work–life balance, and support for trainees who wish to pursue less traditional models of medical training, including the opportunity to volunteer and develop their skill set abroad, would arguably enhance morale. In acknowledging this need, the Northern Ireland Medical and Dental Training Agency (NIMDTA) recently adopted the VALUED strategy.[4] Developed with the views of trainees being paramount, this initiative highlights trainee achievements through a newsletter and seeks to promote wellbeing through the provision of external activities designed to reduce stress, subsidised local yoga classes being but one example. Although a relatively small gesture, such a change in mindset and management strategy is not to be underestimated.

Thus, as we have noted above, the uncritical promotion of a resilience 'narrative' is both counterproductive and disingenuous, and leads to 'acquiescence not resistance' to the structures in which you find yourself bound.[3] Genuine efforts to support staff and enhance wellbeing should be promoted rather than reverting to the buzzword of the day: resilience. ■

EMMA KEELAN
ST4 respiratory medicine, Belfast City Hospital, Belfast, UK

BRENDAN CIARÁN BROWNE
Assistant professor, Trinity College Dublin, The University of Dublin, Dublin, Republic of Ireland

References

1 Fleming J, Ledogar RJ. Resilience, an evolving concept: a review of literature relevant to aboriginal research. *Pimatisiwin* 2008;6:7–23.
2 Werner E. Children and war: risk, resilience, and recovery. *Dev Psychopathol* 2012;24:553–8.
3 Garrett PM. Questioning tales of 'Ordinary Magic': 'Resilience' and neo-liberal reasoning. *Br J Soc Work* 2015;46:1909–25.
4 Northern Ireland Medical and Dental Training Agency. VALUED, NIMDTA Profession support, 2018. www.nimdta.gov.uk/professional-support/valued/ [Accessed 19 May 2018].