VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: When “resilience” becomes a dirty word

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We need to talk about “resilience.” One dictionary definition is “the capacity to recover quickly from difficulties; toughness.”¹ Health Education England describes it as “the ability to bounce back—a capacity to absorb negative conditions, integrate them in meaningful ways, and move forward.”² The General Medical Council announced in recent years that doctors under investigation and all medical students would receive “emotional resilience” training.^{3,4}

Practising medicine has never been straightforward, and it has always required such attributes. Doctors carry responsibility, risk, uncertainty, and self doubt. We make difficult decisions and witness harrowing scenarios weekly—that’s the nature of being a doctor. And, being human, it can get to us. Support to adapt and learn from these inherent challenges, and to develop coping skills, would be welcome in any health system.

But “absorbing” any unacceptably and avoidably “negative conditions”² makes resilience a dirty word. It shifts the blame and responsibility for doctors’ struggles away from what are often over-politicised, understaffed, underfunded, badly organised systems and onto individuals.

“Absorbing negative conditions” shifts the blame for doctors’ struggles away from over-politicised, understaffed, underfunded systems and onto individuals

Physician burnout is well reported in the United Kingdom and internationally.⁵ A recent survey of 3695 doctors who had graduated from UK medical schools in 1974 and 1979 found that 44% reported adverse effects of the job on their health and wellbeing.⁶ As the Royal College of Physicians’ recent report *Being a Junior Doctor* showed,⁷ younger doctors will find the factors cited in the survey eerily familiar: long hours, excessive workload, poor work-life balance, compassion burnout, and managerial and regulatory changes are all there. As is the impact of doctors’ own ageing and the failure of their roles and work patterns to adapt.⁸

There’s nothing wrong with helping doctors build “resilience,” if we must use the word. Mentorship, access to good occupational health, and counselling—such as the new GP health service⁹—all have potential. So does support in developing the

necessary skills in time management finance or leadership to be an effective doctor-manager. Initiatives such as the Point of Care Foundation’s Schwartz Rounds,¹⁰ designed to help doctors reflect on difficult clinical situations, are welcome, as are sabbaticals or protected time for development activity.

Right now, doctors in the NHS face workforce gaps, inexorably rising demand, and struggling community care services.^{11,12} They’re working in a system on the edge, compounded by top-down target pressures and serial, politicised reorganisations. In the recent industrial relations dispute with junior doctors the health secretary deployed the combative language of blame and shame, and some sections of the mainstream media added to the mood music.¹³

It’s an understandable impulse to give reassuring platitudes and shift responsibility for wellbeing onto individual practitioners. But a resilient system is what we need: one that adequately recruits, retains, values, and supports its employees.

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