

The Resilient Doctor: Pillar of Healthcare or a Commodity in the Marketplace?

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INTRODUCTION

Being a doctor is both rewarding and incredibly psychologically demanding. With doctors being no exception to human nature, they are highly susceptible to anxiety, depression and occupational burnout.¹ Medical schools introduce and expose students to the concept of “resilience” early on, which is crucial for doctors who cope with tough decisions and emotionally charged situations daily.² Resilience – partly a modifiable capacity of adapting, risk aversion, persistence, and self-compassion – is essential to manage difficult decisions and emotional challenges they face regularly.³

Resilience carries a significant role in our daily lives as medical students and doctors and is often used as a “buzzword” across various fields, ranging from natural sciences to social sciences and public policies.⁴ However, there is no universally accepted definition.⁵ It typically encompasses a range of personality traits, such as the ability to “bounce back” from failures, viewing these as beneficial feedback and to thrive under stress and pressure – traits considered to be vital to work in healthcare.^{3,5} Discussions persist over whether these are innate characteristics or are shaped by external, societal factors.^{6,7}

Defining resilience at the individual level can result in overlooking the systemic flaws in healthcare. This personalised perspective places the blame on doctors for failures due to under-resources, over-politicised and faulty systems, therefore holding them accountable for broader political and organisational deficiencies.³ Doctors are being left physically and psychologically compromised, reduced to mere cogs maintaining the status quo of a failing system.⁸

The commodification of resilience in healthcare, markets it as a valuable skill for medical professionals to mitigate shortcomings. This commodification turns resilience into a purchasable commodity, reflecting a capitalist influence in healthcare where doctors are trained to be profit-driven and detached from the human aspects of medicine.⁴ The focus on resilience as a marketable trait underpins passive approaches by institutions like mind-fulness based interventions in stress management, which have shown limited effects on making doctors feel supported and prevent burnout.¹⁰

By commodifying and using resilience as a convenient solution, the underlying issues of the institution remain unaddressed.⁴ Medical staff may internalise the failures of their institutions, feeling personally responsible for systemic errors.⁹ This misplacement of responsibility questions the concept of the doctor’s resilience and where the line should be drawn between individual and systemic accountability.

The introduction of resilience as a personal resource, emphasised through institutional programs, has shown to be ineffective in improving a doctor’s mental health.¹⁰ This leads to a dangerous oversight: the failure to address the root causes of medical professionals’ distress and burnout. It is important to differentiate what truly fosters resilience and distinguish the modifiable aspects from the unavoidable institutional influences.

This article is written by a medical student for doctors and peers, aiming to explore the challenges of medical practice within this system, advocating for a more supportive

and realistic approach to manage the demands on medical professionals. This paper will touch on how organisational failures and high rates of burnout in doctors could be addressed and prevented and be supported in their critical roles on an institutional level.

RESPONSIBILITY OF A DOCTOR

Burnout has increasingly been recognised, particularly highlighted by several reports between 2010 and 2015 that identified significant rates of burnout, depression, and suicide among doctors.¹¹ Defined by the World Health Organisation (WHO) as a result of “chronic workplace stress that has not been successfully managed” and it is characterised by physical and emotional exhaustion, a low sense of professional accomplishment and depersonalisation at work.^{12, 13} Consequently, resilience is a key part of protecting yourself from burnout and is essential for doctors to develop it during their careers.¹²

The demands of the medical profession are inherently stressful, characterised by long working days, stressful situations, and frustration and frequent exposures to traumatic situations. These conditions can erode the resilience even of the most seasoned professionals, particularly affecting junior doctors who may be much less experienced in handling such pressures. Studies by O’Dowd et al. and Garcia et al. have shown that higher burnout rates are linked to toxic work environments, poor patient safety and increased number of errors, which amplify stress and reduces job satisfaction among healthcare professionals leading to job turnover and absenteeism.^{14,15}

Resilience varies significantly among individuals due to its multifactorial influences, such as work-dynamics, socioeconomic background and personal and environmental factors. Personal and environmental factors are defined by social support available (peers and personal support), outside interests and an individual’s history of overcoming adversities.³ Even though looking after one’s mental health and well-being is necessary, and each of us is responsible for our own well-being, the question lies in whether the systemic pressures exerted by the institutions should lie within their responsibility and whether doctors can sustainably cope with such demands.

In response to the high incidence of burnout, bodies such as the General Medical Council (GMC) and British Medical Association (BMA)³ have endorsed mindfulness-based and resilience-focused programs. The aim is to enhance doctor’s productivity and bolster doctors’ skills to manage stress through workplace engagement and stress coping strategies.¹² The interventions purposes are to educate on burnout, promote work-life balance, adjust work-relationships and encourage mindful practice and acceptance of the clinical work environment.¹² The interventions aim to raise awareness about the effects of stress and develop cognitive strategies to reduce stress and avoid self-invalidation.

However, McKinley et al. suggest that while these programs address individual skills, they often fail to significantly impact resilience, as they overlook the social and organisational contexts that are crucial to a doctor’s work-life experience.³ Critically, such interventions may inadvertently

contribute to a neoliberal framing of resilience and treating it as a commodity – a skill to be acquired through organisational programs. Social Darwinism is considered to be manifested credo in our society as the reactionary forces (here patients) expect individuals (here doctors) to effectively deal with personal disasters.⁷ This perspective pressures doctors to enhance and acquire resilience as if it were the simple solution to complex problems and demonstrates the danger of the concept resilience.⁴

Clough et al.¹⁰ criticise the quality of research on the individual-based interventions for their lack of depth and failure to consider the wider picture and systemic factors impacting the doctor. This highlights the individualistic and variable nature of resilience and that the need of contextualising resilience is essential to understand the influences of one's ability to cope in the workplace. The interventions arguably commodify doctors and the underlying exploitation of these individuals becomes apparent, as they are seen as the embodiment and carriers of the responsibility for institutional failures.

More successful have been organisational-level interventions that address systemic issues within the institution, which have shown greater effects compared with individual-targeted interventions.³ These findings support the claim that resilience should not be viewed as solely dependent on a doctor's personal resources but a broader issue that encompasses the whole healthcare organisation.¹⁶

Ultimately, while doctors bear responsibility for their mental health, the role of the healthcare system in supporting or undermining their resilience is crucial without commodifying it.¹¹

RESPONSIBILITY OF THE SYSTEM

Doctors face a significant challenge with high burnout rates and continuous organisational failures, exacerbated by a low sense of control, an overwhelming sense of personal responsibility for resilience, organisation success and patient safety. The capitalist system and its commodification of resilience place doctors in a vulnerable position, forcing them to absorb negative conditions such as long working hours, limited control over daily tasks, and increasing demands on clinical time and productivity.

These factors shift the blame from systemic issues – such as underfunding, understaffing and poor organisation – to doctors, further perpetuating the cycle of stress and burnout.¹⁷ Currently, doctors are working in a system pushed to its limits, dealing with rising uncompromising demands for NHS services and workforce gaps that predispose organisations to fail their medical staff.

The paradoxical trend of higher demands from doctors alongside reduced autonomy and resources heightens anxiety and stress, major risk factors for organisational failures.¹⁸ Qualitative research has emphasised the necessity of shifting focus beyond the individual resilience to systemic organisational issues.¹⁹ The NHS, an overregulated marketplace with significant under-resourcing, exploits doctors by demanding to be more resourceful than the system itself. This work intensification carries moral implications from quality patient-centred care and increasing fears of medical malpractice.

Studies by Mache et al.²⁰ and O'Dowd et al.¹⁴ argue that resilience and work engagement positively correlate with the degree of freedom and flexibility and opportunities for career development within the workplace. Regarding interventions,

Panagioti et al.¹⁶ and Romito et al.¹¹ find that organisation-directed interventions, which include systemic changes which lead to cultivating a sense of control over one's work and improved communication and teamwork, significantly reduce burnout compared to individual based interventions. The importance of concentrating on organisational interventions when aiming to improve resilience in staff was supported by O'Dowd et al. when conducting research on resilience among firefighters and paramedics.¹⁴ Resilience needs to be understood in the context of organisational factors and how the organisation can contribute to decreasing stress and burnout efficiently.

However, the impact of the interventions is often minimal, due to the small scale and rarity of the studies conducted. Organisation-directed interventions require complex and major systematic changes, such intense interventions are not widely distributed or evaluated, reflecting a healthcare system dominated by economic concerns and the commodification of healthcare, which prioritises cost and time-effective strategies over effective solutions e.g. psychosocial interventions. This undermines the exploitation of doctors as tools in the corporate wheel of profit production.⁸

To effectively combat burnout, organisations and executive leadership roles must take responsibility for fostering and preserving resilience and mitigating risks by leveraging assets that build doctor's resilience.¹² This includes monitoring quality indicators such as teamwork, managing work time and improving communication and technology that affect overall workflow.²¹ Supportive environments and effective leadership are crucial, as they create the momentum for change and foster conditions where doctors are more likely to thrive.¹²

Institutions should be held responsible for sheltering and growing resilience and mitigating risks by capitalising on assets which build the resilience of doctors.¹⁸ This can be aided through a mutually supportive discussion about the combination of day-to-day working life and the political forces within the system.⁹

However, personal resources such as optimism and resilience are positively associated with work productivity,²⁰ aligning with the *Broaden and Build theory*, which suggests that individuals frequently experiencing positive states of mind more successful at buffering against stress and building resilience.¹⁸ While organisational change is imperative to improve doctors' well-being, the significance of building personal resilience cannot be overlooked, since these factors greatly influence work engagement.¹⁹

This theoretical framework delineates the essential links between personal resources (personality factors, optimism, and resilience) and organisational resources (social support, flexibility, and effective leadership) and work engagement.²⁰ This undermines the importance of supporting healthcare workers on an individual as well as organisational level.

SUMMARY

Resilience remains a crucial trait for doctors, impacting their performance and well-being at work. However, the current focus on commodifying resilience has led to superficial interventions addressing doctor's psychosocial factors over genuine support, subjecting them to the market forces, demanding a re-evaluation to address systemic issues contributing to doctor's exploitation. In a system such as the NHS, doctors

are predisposed to struggle with maintaining resilience due to limited resources and over-politicisation, often bearing the blame for broader systemic failures. Therefore, fostering open communication within organisations – from frontline doctors to executive leaders – is vital. Integrating understanding of political and policy influences into supportive discussions could help develop more effective interventions and improve resilience.

I have come to understand that while the system can be blamed for failures, we doctors must also take the initiative in communicating and advocating for change. Although combining individual and organisational approaches is beneficial, meaningful reforms must originate from those in leadership, as they often treat doctors' resilience as a mere commodity. Resilience needs to be contextualised to each individual need to foster a supportive and productive work environment, recognising that existing interventions often target too broad an audience to effectively nurture personal resilience.

This leads to questioning whether any interventions are the right approach. Given the capitalistic nature of the system and the need to recontextualise resilience, it is doubtful that universally applicable or deeply personalised interventions can be developed. Nonetheless, we cannot cease our efforts for our own sake, we must strive to improve wherever possible.

If interventions prove successful, we as doctors must guard against being exploited from this neoliberal society, by ensuring our traits are not seen as commodities and take care of our well-being and development of resilience. In situations where the roots of issues extend beyond the individual, the responsibility to maintain our resilience shifts to an organisational level. This collective approach is essential for protecting doctor's well-being and enhancing their resilience in the long term.

CONCLUSION

Burnout remains highly prevalent among doctors, detrimentally affecting patient care and healthcare systems. Current interventions, focusing primarily on psycho/social factors and painting resilience as a personal resource, inadequately address broader systemic issues in an organisational context. Effective resilience-building and maintenance requires a synergy between individual and organisational strategies, involving NHS and governmental policies. While doctors bear much responsibility for developing and contextualising resilience, significant systemic contributions cannot be ignored. Research should refine resilience definitions and evaluate intervention effectiveness at organisational levels to prevent doctor's exploitation and avoid reducing doctor's struggles and issues to individual well-being alone.

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