The Missing Link: Connection Is the Key to Resilience in Medical Education

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Abstract

Awareness of the risks of burnout, depression, learner mistreatment, and suboptimal learning environments is increasing in academic medicine. A growing wellness and resilience movement has emerged in response to these disturbing trends; however, efforts to address threats to physician resilience have often emphasized strategies to improve life *outside* of work, with less attention paid to the role of belonging and connection *at work*. In this Commentary the authors propose that connection to colleagues, patients, and profession is fundamental to medical learners' resilience, highlighting "social resilience" as a key factor in overall well-being. They outline three specific forces that drive disconnection in medical education: the impact of shift work, the impact of the electronic medical record, and the impact of "work–life balance." Finally, the authors propose ways to overcome these forces in order to build meaningful connection and enhanced resilience in a new era of medicine.

We are in the midst of an epidemic in academic medicine, one characterized by alarming rates of burnout, depression, suicidality, mistreatment, and suboptimal learning environments. Leaders from across the field are responding to this crisis with a nascent, yet powerful, movement towards approaches that promote resilience in learning and practicing medicine. Much of the literature on wellness and resilience thus far has focused on specific, programmatic initiatives to optimize well-being and enhance the quality of time spent *outside* the hospital. Existing efforts include mindfulness exercises, yoga classes, gym access, and child care support, all of which exist alongside new duty hours restrictions.[1] When addressing burnout at work, however, solutions should be focused on how to find fulfillment *within* work and not just how to escape it. In our efforts to build resilience through these worthwhile endeavors, we may be underemphasizing our fundamental need as humans to feel connected with one another and to experience a sense of belonging among those with whom and for whom we work, as well as within the profession as a whole. These connections are foundational to our well-being. In this Commentary, we argue that *disconnection* is the single greatest threat to our efforts to foster resilience and to promote wellness in medical education. We discuss how connection enhances resilience, propose three specific forces that drive disconnection in medical education, and outline specific solutions to build resilience through connection and belonging.

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Acad Med. 2016;91:1197–1199.
First published online July 19, 2016
doi: 10.1097/ACM.0000000000001311

How Connection Fosters Resilience

Resilience is generally thought of as our long-term ability to respond to adversity in a healthy and adaptive manner, growing and thriving rather than simply enduring and surviving.[2,3] It is considered to be a dynamic construct that evolves over time and requires "wholehearted engagement with—not withdrawal from—the often harsh realities of the workplace."[2–4] Both individual and social factors contribute to resilience, and connectedness to those around us has been shown to be one such factor.[1] "Social resilience" describes the ability of a group to endure stress in an adaptive manner through mutual trust and bonding among its members.[3] In medicine, group membership, or "being part of the club," can serve as a much-needed safety net when adversity overwhelms a learner's individual resilience. On the other hand, learners who are "on the outside looking in," either with respect to a team or to the profession as a whole, may lack the benefits of social resilience and be at significant risk of impaired well-being in the face of adversity.

Three Drivers of Impaired Belonging in Medical Education

Learners' relationships with their peers, patients, and family are suffering as graduate medical education continues to evolve in response to regulatory pressures, integration of the electronic medical record (EMR), and calls for greater "work–life balance" for learners. These same pressures, often intended to improve learner wellness, may also disconnect learners from the core tenets of medicine as a profession, interfering with their need to become legitimate, engaged members of a community of practice.[5] We believe that shift work, more time with computers than patients, and a push to get trainees out of the hospital are undermining connection at the interpersonal and professional levels, thus degrading learner wellness.

The impact of shift work

New duty hours regulations have been implemented in an attempt to improve resident wellness and patient safety, but they have also led to increased emphasis on dismissing residents from the hospital at a certain time at the expense of continuity with patients and colleagues. The "revolving door" model of shiftwork in patient care has left trainees with less time to bond with coworkers and connect with patients. As trainees, we are frequently told just to "sign it out," handing over all responsibility to the next

resident in line. Although some tasks are certainly appropriate to hand off, others, such as managing a patient who becomes unstable or helping a family through a goals-of-care discussion, should be carried out by the clinician who knows the patient best. Residency training should promote personal responsibility in these situations to reinforce each individual's role on the care team, allowing meaningful care situations to become teaching opportunities that solidify the patient–doctor relationship, build a sense of connection to the profession of medicine, and instill value in the trainee's identity as a provider.

The same regulations that have generated shift work and excessive handoffs have led to a perceived, and often real, difference in training between junior and senior team members. This gap, which often spans generations, may cause hierarchical tension, variable expectations of performance, and misunderstanding among groups who trained differently. Indeed, our new model of training has fundamentally altered the shared social construct of a grueling residency as the rite of passage to becoming a physician.[6] Today's learners are met with new pressure to gain the trust of faculty who trained in a different model and may be skeptical of the skills and competence of current trainees, impairing learners' sense of belonging and perpetuating their shame and self-doubt. Ultimately, in the midst of current residency training regulations, we should continue to communicate to residents that they are indispensable members of patients' care teams and not replaceable shift workers.

The impact of the EMR

The advent and rapid uptake of the EMR is another factor that has further deepened disconnection. Residents spend a stunning amount of time in front of a computer: A recent study showed that first-year internal medicine residents spent, on average, 112 hours per month documenting in the EMR.[7] Not only do residents spend exorbitant amounts of time in the EMR, but it is increasingly difficult to escape its pervasive reach. Time pressures force the EMR into patient encounters, where we prioritize efficiency at the expense of connecting with patients through nonverbal communication, mindfulness, and shared vulnerability. After patient care duties are complete, mountains of accumulated electronic documentation await, with the added challenge that it must be completed within a limited window of time as dictated by duty hours regulations. Thus, rather than ending our days bonding with colleagues about the struggles, frustrations, and triumphs, we are often alone with a computer and an EMR that offer no hope of human connection. With the growing availability of mobile technologies and the ever-present pressure to leave the hospital, we often take this work home with us, where it invades the last place where we might reliably find connection. By the end of the day, the EMR has undermined our sense of belonging with our patients, our colleagues, and our families, leaving many of us to wonder why we signed up for this in the first place, with our overall connection to the profession, and our resilience, hanging in the balance.

The impact of "work–life balance"

Many of the efforts to combat burnout in medicine are tied to improving "work–life balance," a phrase that has now become both a lofty goal and a ubiquitous term in the medical lexicon. This term, however, emphasizes life as separate from work and pleasure as separate from profession. Residents are encouraged to get out of the hospital so they can finally enjoy life, rather than actively seeking joy and fulfillment while at work. Wellness initiatives aimed at achieving work–life balance in medical education often focus on improving personal connections and quality of life *outside* of work, suggesting that this is where wellness is best found. Although connections and wellness outside of work are very important, the key to professional resilience is to find wellness through the work we are privileged to do as physicians and the connections that we make with both our patients and our colleagues. Effective "work–life balance" initiatives should highlight the connection—not the competition—between work and life, with the goal of achieving simultaneous personal and professional satisfaction. By overly relying on wellness outside of work and failing to nurture our personal connections and well-being *at work*, efforts to achieve "work–life balance" instead may be significant barriers to resilience.

The Roadmap to Connection

The path to enhanced resilience in medical education begins by prioritizing the need for human connection and belonging. Maslow's[8] hierarchy of needs theorized that the need to achieve belonging is foundational to the more advanced need of self-actualization. Self-actualization is characterized by realizing one's potential, achieving peak goals, and finding self-fulfillment—all strong motivators for medical learners and a primary focus in medical education; however, our medical education system strives to help learners meet the hierarchically superior goal of self-actualization without first ensuring a necessary foundation in human belonging. Resilience initiatives must start with this foundation.

A simple first step is for programs to provide protected time and space for learners to congregate within the confines of the work environment and without the presence of faculty. With this protected time, learners would have the opportunity to organically share and bond over whatever is most important to them at that time, rather than what a resilience curriculum tells them they *should be* concerned about. Indeed, relationships between colleagues should be authentic and not artificially nurtured through overly contrived, mandatory bonding activities.

Programs and institutions should strive to create psychologically safe learning environments that encourage us to openly display and share our unique personality attributes, life stories, and emotions. It is through the mutual understanding of each other's histories and values that authentic human connection occurs. In the midst of extremely busy work environments and constantly changing teams, we should make deliberate and consistent efforts to acknowledge and appreciate all members. For example, upon formation of a new clinical teaching team, members might be given the opportunity to share a life story, unique characteristic, fear, or recent success about which other team members are unaware. This simple act of sharing would stimulate deeper connection among team members and explicitly highlight the diverse team assets through which mutual respect, inclusion, and belonging can thrive.

Mentoring networks offer a structured solution to building improved connectivity

among colleagues. There are many types of mentors, coaches, and advisors throughout medical education, but not all of them aim to enhance a sense of belonging among their members.[9,10] The mentoring programs that have been successful are ones in which the mentors are trained to provide both professional and psychosocial support, eliciting and integrating mentees' core values and priorities.[9] These programs encourage reciprocal exchanges that expand beyond a traditional hierarchical dyad, acknowledging that both mentor and mentee can gain by this connection. Peer mentoring programs, in particular, have been shown to be highly effective, and by creating a strong sense of collegiality, they can more specifically foster a supportive learning environment.[9] Institutions should build dynamic, bidirectional mentorship programs that engage all members of the hierarchy. Such programs have been shown to nurture professional identity formation and create a sense of supportive community, the latter of which is known to be one of the best protective factors for burnout.[10,11]

Additional initiatives to promote connection include setting reasonable expectations for EMR use that ensure sufficient documentation while prioritizing maximal engagement with the patient; providing training in efficient use of the EMR and effective management of technology in interpersonal communication; utilizing narrative medicine to reflect on the individual challenges and emotions that arise during medical training; training in identifying and addressing individual emotions that impair belonging, such as personal shame[12]; and providing maximal support for learners' family and social needs outside the work setting.

Conclusion

We all have a fundamental need to feel connected to our colleagues, patients, families, and profession. Our well-being as physicians depends on this connection, and our resilience grows from it. As we continue to build a movement of wellness and resilience in medical education, we should prioritize connecting with one another and with our patients to build a sense of belonging within our teams, programs, hospitals, and profession. We should focus less on the competition between work and life and more on making our work a functional and enjoyable part of our lives. To do so, we might draw upon the feelings we first channeled into our medical school personal statements to remember how medicine brings us together to share in the privilege of caring for others. This is where connection, and resilience, begins.

Acknowledgments: K.M. McKenna, D.A. Hashimoto, and M.S. Maguire are all members of the administrative board of the Association of American Medical Colleges Organization of Resident Representatives (ORR); W.E. Bynum IV is a former chair of the ORR. The authors acknowledge the other resident members of the ORR who have contributed to the discussion on learner wellness and resilience and provided the impetus for this Commentary.

Funding/Support: None reported.

Other disclosures: The opinions and statements in this presentation are the responsibility of the authors, and such opinions and statements do not necessarily represent the policies of the U.S. Air Force, U.S. Army, U.S. Navy, Department of Defense, the United States, or its agencies.

Ethical approval: Reported as not applicable.

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