Teaching and learning resilience: a new agenda in medical education

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Reading the article on resilience by Howe et al. brings to mind a picture of palm trees curving in the wind and returning to their original positions. Palm trees face adversity over time without deforming, an image that seems to depict the meaning of resilience. Just like palm trees, we need resilience to face the challenges with which life confronts us.

The term ‘resilience’ has been imported from the language of physics and is used to designate the capacity of a material or body to suffer stress or the imposition of external pressure and return to its original state without becoming deformed after the stimulus of the stressor is withdrawn. In a transdisciplinary context, this term is also used in physiology and psychology to refer to a person’s capacity to resist adversity without developing physical, psychological or social disabilities.

Resilience is an emotional competence and can be considered as a virtue or behaviour to be acquired and improved. It consists of cognitive processes that encompass at least four dimensions: self-efficacy; planning; self-control, and commitment and perseverance.

Being resilient does not mean being indestructible, but being able to deal with life events, meet problems as opportunities for personal growth, and recognise problems, limitations, and personal and collective resources. It also means being able to organise strategies through self-reflection, creativity, optimism and humour, being flexible and able to act with responsibility and ethical awareness.

In recent years, the term ‘resilience’ (from the psychological perspective mentioned by Howe et al.) has been assimilated by the health sciences and associated with better outcomes in health promotion, well-being and quality of life. In this context, resilience may be potentially linked to improved academic and professional performance.

As we know, professional competence extends beyond technical knowledge. It encompasses abilities and attitudes that allow one to show effective team-working abilities, leadership, communication skills, empathy, self-control and metacognition. These emotional competences are considered essential within the international agenda of professionalism because they represent an attempt to rescue values and humanism in medical practice.

In this context, medical schools should seek to provide students with a holistic education and should focus on providing opportunities for the development of emotional competences within their curricula.

Although Howe et al. observe that interventions to develop resilience are ‘best delivered as a managed process’, we might ask ourselves how we teach (and learn) emotional competences such as resilience. What are the most appropriate learning strategies? Are we evaluating our strategies with appropriate measures? Are we using these resilience measures for ‘formative reflection and discussion’ of the construct with our students? What are the impacts of our strategies in the academic community?

How do we teach (and learn) emotional competences such as resilience?

We strongly believe the answers to some of these questions lie in transformative education. During medical training, we all (students and professors!) learn, acquire and improve emotional competences. If we understand education as a process with cognitive, ethical, historical and socio-cultural dimensions that emerge in a dialectic and dialogic relationship between learner and teacher, both can be considered as unfinished beings under continuing individual and collective development. Within the sociological and ethical dimensions of resilience, education may be transformative for both students and professors: the one who learns also has something to teach.
During medical training, we all learn, acquire and improve emotional competences

There may be different ways to teach and learn emotional competences during medical training. Accordingly, different students learn different things, at different times and for different reasons. The literature presents a wide range of learner-centred and reflective experiences (pedagogic theatre, role-play, simulations, positive role modelling, video feedback, portfolios and mentoring) as means of developing students’ emotional competences. These strategies seek reflection on practice as alternatives to students’ change in (or acquisition of) attitudes.

All these strategies and techniques will only be effective if we precisely establish how opportunities for learning are planned, managed and evaluated. In this context, validated resilience measures such as the Resilience Scale\(^1\,^8\) may be useful evaluation tools for future research. Providing an effective learning environment for the development of resilience is a challenge upon which we must focus the medical education agenda; otherwise our strategies will be nothing but intentions.

At this point, we might examine ourselves as models of resilience and even reflect upon whether we really are concerned about this educational objective. In addition, we might ask whether our practices favour the development of resilience or other emotional competences in our students.

Providing an effective learning environment is a challenge upon which we must focus the education agenda

Discussion about resilience in medical education refers not only to professional development, but also to human growth. We understand the article by Howe et al.\(^1\) as a starting point to stimulate discussion in medical education that seeks to establish a new dialectic synthesis in our educational practice. By fostering transformative educational approaches in medical school, we will certainly achieve competent and humanistic professionals. After all, we need doctors who are able to transform reality.

REFERENCES


Shining light on competence

Brian Jolly

The competency-based medical education movement has generated intense controversy over the last 15–20 years. For example, in Australia in the 1990s, the word ‘competency’ was an unwelcome utterance in the corridors of the established universities. Its use was seen as a threat to the integrity of disciplines steeped in reverence for academic self-determination. It also challenged academics’ respect for freedom of thought and action. Finally, many thought that by reducing academic and professional expertise to a set of behavioural specifications, they would capitulate to the techno-rationality appropriate to vocational institutions that train, for example, electricians, builders and surveyors.