Faculty Videos of Resilience Narratives at Two Institutions:
Residency Resilience Skills Program Innovation

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ABSTRACT

Burnout and mental health issues among residents are associated with adverse health consequences and suboptimal job performance, e.g. increased medical error. Given role models are key to cultivating resilience, we created faculty resilience narrative videos within resilience skill training programs, hypothesizing such videos would provide new perspectives/insights on resiliency and humanize attendings in a useful way. Child and adult neurology residents at two institutions positively rated the impact of these faculty videos. Such videos are an innovative and practical way to: 1) provide exemplar role models for learning about coping with physician challenges and gaining insights on resilience; 2) access stories of triumph over challenge for inspiration; and 3) work to achieve local culture change by reducing stigma and increase empathy/connection during training. Successful implementation of this video innovation provides good rationale for further evaluation of impact on local culture, faculty experience, and resident attitudes and behavior.

KEYWORDS

Faculty Development, Health Humanities, Narrative, Professional Identity Formation, Professionalism, Reflective Practice, Resident Wellbeing, Resilience

INTRODUCTION

Burnout and mental health issues among residents are associated with adverse health consequences and suboptimal job performance, including increased medical error (Fahrenkopf et al., 2008). International graduate medical education (GME) organizations such as the Accreditation Council for Graduate Medical Education (ACGME) and Resident Doctors of Canada have called for increased recognition that clinician well-being is crucial to deliver the safest, best possible care and improved support for healthcare professional well-being. ACGME now includes a program requirement for implementing wellness guidelines (Accreditation Council for Graduate Medical Education, 2019). Pre-emptive approaches include cultivating trainees' resilience skills to mitigate against the negative

impact of high stress and trauma (Bursch et al., 2017, 2019; Wald, Haramati, Bachner, & Urkin, 2016; Wald, 2017). Resilience, defined as "the capacity to respond to stress in a healthy way such that goals are achieved at minimal psychological and physical cost; resilient individuals "bounce back" after challenges while also growing stronger" (Epstein & Krasner, 2013, p. 301) is key to enhancing quality of care and sustainability of the healthcare workforce (Tawfik, Sexton, Adair, Kaplan, & Profit, 2017).

Given role models are key to cultivating resilience (Southwick & Charney, 2012), the authors created faculty videos for use within their respective resilience skills training programs (Bursch et al., 2017, 2019; Wald et al., 2016; Wald, 2017), hypothesizing residents would evaluate the videos to be relevant, help them learn about coping with physician challenges, humanize the featured attendings in a useful way, help them learn about coping with work related challenges, and provide them with new perspectives/insights on resiliency.

BACKGROUND

Medical Setting Culture and Help Seeking Behavior

One obstacle to effective implementation of resilience skills training is medical setting culture. Revealing a mental health or coping challenge is perceived by many trainees as negatively impacting professional advancement due to perceptions of personal weakness, devaluation, and/or discrimination (Wimsatt, Schwenk, & Sen, 2015). Personal stories of physicians experiencing and coping with and/or overcoming adversity have been successfully used to increase trainees' likelihood of seeking professional assistance when needed (Hankir, Northall, & Zaman, 2014). Likewise, hospital-wide discussion amongst caregivers from multiple disciplines about social and emotional issues health professionals face in caring for patients and families may improve resilience (Taylor, Xyrichis, Leamy, Reynolds, & Maben, 2018). However, it is unclear if exposure to the narratives of those who are not known to the observer have an impact on asking for help from supervisors or colleagues and/or resilience-promoting culture. There is thus a need for division or department-based interventions that may serve to support resilience as well as increase the likelihood that trainees will reach out for emotional support or referrals from their faculty mentors or supervisors.

Impact of Narrative Sharing on Trainees and Colleagues

Leading by example by being honest with trainees (and peers) about one's own successes and failures in resilience/wellbeing has been encouraged (Abaza & Nelson, 2018). Showing vulnerability in a safe setting with known faculty sharing stories of emotional challenge and coping efforts may help achieve local culture change and may benefit the storyteller with self-discovery, improved understanding, meaning-making, healing, and/or sharing wisdom with a learning community (Wald, 2011). The therapeutic effect of storytelling due to shared vulnerability has been described (Reisman, Hansen, & Rastegar, 2006). Sharing of story can support learning about what has happened as well as the narrator's own personhood within the work of doctoring (Greenhalgh & Hurwitz, 1998). Faculty narrative storytelling as a variant of appreciative inquiry (Cooperrider & Whitney, 2005) has been described as contributing to "deepening students' understanding and appreciation of professionalism" including "principles of humanism, accountability, altruism, and excellence" (Quaintance, Arnold, & Thompson, 2010, p. 118) and may include resilience. Vulnerability in physicians' narratives has been noted to help "create meaningful narratives that not only help to make sense of our experiences, but also profoundly affect the lives of others." (Sample, 2010, p. 494). While the phenomenon of vicarious resilience (Engstrom, Hernandez, & Gangsei, 2008) has been described in reference to mirroring resilience of patients, the term may also be relevant with mirroring of faculty resilience. The sharing of personal narratives can also foster affiliation or kinship between faculty and trainees (Charon, 2001). Mechanisms by which the videos might positively impact residents include: 1) Normalizing discussions about occupational challenges, 2)

Decreasing stigma and achieving culture change by discussing emotionally challenging situations, and 3) Sharing pearls of wisdom related to coping.

Impact of Narrative Sharing on Storyteller

The experience of sharing one's personal narrative may also potentially serve to bolster faculty members' own resilience and wellbeing through heightened awareness of strengths and triumphs (Munyikawa, 2014), receiving support or positive reinforcement from trainees and colleagues, and/ or motivating further personal and organizational cultivation of resilience/wellbeing (Shanafelt & Noseworthy, 2017). More broadly, stories "offer insight, understanding, and new perspectives" (Divinsky, 2007, p. 203), more specifically, physician stories can create a "dialogue about whether it is possible to find some kind of redemption in life's worst moments" (Frank, 2010, p. 54) and perhaps find some gratification in recognizing one's coping with adversity.

METHODS

Participants

Neurology residents participating in resilience skills training at two institutions (Bursch et al., 2019; Wald, 2017) viewed four faculty videos and rated each video. In Year Two, further data was collected from one institution using videos number one and four, which were viewed again as well as a new faculty video (number five). The number of residents who attended each resilience training session and the number who opted to complete each evaluation varied (Table 1).

The Boston Children's Hospital (BCH) program and evaluation was a quality improvement initiative. The David Geffen School of Medicine at the University of California, Los Angeles (UCLA) program and evaluation was deemed Institutional Review Board exempt.

Development of Faculty Resilience Videos

Selected faculty members, known to the residents, shared a short (five to ten minutes long) videotaped narrative of coping with a significant personal or professional challenge and what helped them cope (internal responses and/or external factors). Faculty were not expected to present about resolving a challenge given the potential value of authentically conveying stories of experiences that may not have had resolution. Filming was done by resilience course leaders, mostly in the offices of the faculty storytellers. Efforts were made to optimize the diversity of the, mostly senior, faculty participants related to gender and ethnicity. Prompts were provided for faculty who were invited to share their narratives for the videos. An example video narrative was provided for UCLA faculty. Faculty narrative sharing within all videos was free-flow and some UCLA video content was edited for length.

The prompt for the BCH videos was: Please reflect on and discuss a work-related challenge and how you coped. Aspects of what worked, what may not have worked, and anything you may have taken forward are welcome. Discussing our successes and/or failures within resilience can be helpful within 'resiliency role-modeling.' Story/narrative helping inform our trainees is of interest.

The instructions for faculty featured in the UCLA videos appears in Figure 1.

Videos were presented to neurology residents during resilience skills training. Videos were selected for inclusion during specific resilience skills sessions based on themes emerging from the video most aligned with topics of the resilience skill session at each institution. UCLA faculty videos that did not conform to the goals stated in the instructions were not utilized.

Videos at one institution (BCH, child neurology), titled "Portraits of Resilience (PR)," included a facilitated group discussion of each video without structured discussion prompts. This course was scheduled during the usual didactic time to encourage attendance. The curriculum consisted of four one-hour-long modules that introduced and facilitated the following skills: reflective narrative practices, emotion regulation, mindful awareness skills, cognitive behavioral strategies, spirituality

Figure 1. UCLA video instructions

Video Instructions
Building Resilience for Healthcare Professionals

Helpful tips to keep in mind when communicating with your video participant prior to filming:

Please prepare to present a short but **vulnerable** general description (5 minutes) of one of your worst moments related to your job (without traumatizing anyone) and a few minutes (2-3 minutes) on what did <u>and did not</u> help you cope (both external forces, such colleagues or institutional response and internal responses, such as positive self-talk or other helpful/ unhelpful coping or behaviors). The scenario does not need to end perfectly and might be better if it doesn't. **Please refrain from providing specific details that might be traumatizing to others and from revealing the identities of others.**

You were chosen because you are viewed as highly successful with excellent coping skills. It is hard for others to imagine you struggling as they do at times. You may have had intensely difficult events occur in your life. I am not asking you to discuss those events. It is entirely up to you to decide what you wish to share. I can tell you that tapping into themes of feeling inadequate, overwhelmed, shamed or scared are much appreciated by audience members.

Please **do not provide a didactic lecture** about coping/burnout or try to be an expert for this video. The idea is to tell a narrative/story that is personal to you.

The goals of the video are to:

1. Decrease stigma related to discussion of challenging personal situations.
2. Normalize discussions about the day-to-day struggles of our jobs.
3. To share pearls of wisdom related to effective coping in our setting.

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in medicine, and the identification of burnout, vicarious trauma/vicarious resilience, depression and suicidality. In addition, one individualized resilience/wellbeing coaching session was required for first year residents. Additional coaching sessions for all residents were optional.

Videos at the other institution (UCLA, adult and child neurology) titled "Stories of Professional Coping (PC)" were used as part of the introduction of each session, but not used as a discussion topic. This course was optional, but scheduled during the usual didactic time to encourage attendance. The curriculum consisted of five one-hour-long modules that taught the following skills: reflective narrative practices, emotion regulation, communication with highly distressed individuals, boundary management, and the identification of depression and trauma (Bursch et al., 2019).

Survey Instrument and Statistical Approach

The authors constructed an optional and anonymous five item, five-point Likert scale. Questions included the degree to which the residents agreed or disagreed with statements about the value of the videos for their education. (i.e. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree) (Table 1). The authors also recorded verbal or written comments that were provided to them about the videos by participating residents and faculty.

Descriptive statistics and unpaired t-tests were used to analyze the data. Review and inclusion of representative participant comments added a qualitative narrative to the data collection.

RESULTS

The percentages of residents who positively rated the videos appear in Table 1. Highest level of agreement was with the statements that the videos were relevant and that they helped the residents humanize the attending physicians.

Table 1. Percentage of residents who agreed or strongly agreed (# Responders)

Year/ Location	Video	Survey Item: This video is relevant to my personal or professional experience. (Ave=90%)	Survey Item: I learned about coping with physician challenges as a result of viewing this video (Ave=83%)	Survey Item: This video helped me humanize this attending in a useful way (Ave=90%)	Survey Item: I learned about coping with work related challenges as a result of viewing this video (Ave=83%)	Survey Item: I gained new perspectives/ insights on resiliency from viewing this video (Ave=76%)
1/ BCH	PR #1:	100% (6)	100% (6)	100% (6)	100% (6)	100% (6)
BCH	PR #2:	100% (4)	75% (4)	100% (4)	100% (4)	100% (4)
BCH	PR #3:	100% (2)	100% (2)	100% (2)	50% (2)	50% (2)
BCH	PR #4:	100% (4)	100% (4)	100% (4)	100% (4)	100% (4)
UCLA	PC #1:	92% (13)	100% (11)	100% (11)	91% (11)	82% (11)
UCLA	PC #2:	75% (12)	88% (8)	75% (8)	75% (8)	50% (8)
UCLA	PC #3:	55% (9)	44% (9)	78% (9)	55% (9)	44% (9)
UCLA	PC #4:	74% (12)	59% (12)	84% (12)	75% (12)	50% (12)
2/ BCH	PR #1	90% (10)	80% (10)	80% (10)	80% (10)	80% (10)
BCH	PR #4	100% (9)	72% (9)	78% (9)	89% (9)	78% (9)
BCH	PR #5	100% (4)	100% (4)	100% (4)	100% (4)	100% (4)

Year One data, higher scores were achieved among BCH residents for the same two items (the items related to the relevance of the video and to humanizing attendings in a useful way). See Table 2. No statistically significant differences were found between Year One and Year Two data for BCH residents.

Resident comments provided on the evaluation form included gaining increased appreciation and recognition of faculty grappling and coping with challenges:

Listening to attending stories: they were so relatable!!! And their vulnerability was helpful, I had no idea he had gone through that.

Anecdotal comments from faculty about sharing their narratives were also positive. Examples include the following comments from two different faculty members:

I've learned that one never knows what another person's struggles are as you can't see them just by looking at them. I'm very grateful to share my story. I wish I would have had someone to share their story with me back then.

I found the process of creating the video about my resilience narrative to be surprisingly affecting. While I certainly hadn't forgotten what happened (to the contrary: the challenging emotions from that time still felt quite fresh), I had not thought about or processed it from my new perspectives as a member of the teaching faculty. I felt better able to understand the viewpoints and challenges of everyone involved in the situation. That in turn has informed my approach to similar situations with trainees, in terms of how I communicate with and support the trainee while balancing the responsibilities I have as a faculty member.

Table 2. Unpaired T-tests comparing BCH vs UCLA in Year 1

Item	Two-Tailed P-Value	Intermediate Values
This video is relevant to my personal or professional experience.	0.0138*	t = 3.4388 df = 6 standard error of difference = 7.561
I learned about coping with physician challenges as a result of viewing this video.	0.1928	t = 1.4669 df = 6 standard error of difference = 14.316
This video helped me humanize this attending in a useful way.	0.0301*	t = 2.8259 df = 6 standard error of difference = 5.573
I learned about coping with work related challenges as a result of viewing this video.	0.3881	t = 0.9303 df = 6 standard error of difference = 14.511
I gained new perspectives/insights on resiliency from viewing this video.	0.0872	t = 2.0419 df = 6 standard error of difference = 15.182

*Statistically significant at 0.05 level.

DISCUSSION

The authors found it to be logistically and financially feasible to create faculty narratives for use within residency resilience training programs at their respective institutions. Faculty were provided with some guidance, and agreed to participate as storytellers. Data suggest this pilot was beneficial to neurology residents. Despite variability among the ratings of individual videos, the majority of residents indicated that the videos were relevant, helped them learn about coping with physician challenges, humanized the featured attendings in a useful way, helped them learn about coping with work related challenges, and provided them with new perspectives/insights on resiliency. While it is not known why higher ratings were achieved at BCH on items related to relevance and to humanizing the faculty member, the authors hypothesize that this difference may be due to the videos being used as a topic of group discussion at BCH, thus increasing the value derived from the video narratives. Comments provided by resident and faculty participants underscored the value they garnered from this pilot for both residents and the faculty storytellers. Thus, congruent with the observations of others, the opportunity for a medical educator to draw from both personal and professional experience to support the becoming of a physician can be gratifying (Wald & Weiss, 2018) and even result in "reciprocal illumination" (Kneebone, 2015, p. 861). As such, it expands the role model role of a teacher (Harden & Crosby, 2000) to include serving as a resilience role model. It optimizes clinical learning environments as recently called for by the American College of Physicians by "revealing what is hidden" in the development of reflective, resilient lifelong learners and clinicians as positive role models (Lehmann, Sulmasy, & Desai, 2018, p. 506).

Results should be interpreted in light of pilot study limitations including modest sample sizes, lack of a control group and no long-term follow-up to determine the behavioral impact of the videos on resident resilience and help-seeking behavior. Thus, next steps include evaluation of live resilience storytelling (Emerson & Bursch, 2018), replication of our findings, the creation of videos focusing on narratives of moral distress and moral resilience (Morley, Ives, Bradbury-Jones, & Irvine, 2019; Rushton, 2017), and further evaluation of impact on local culture, faculty experience, and resident behavior. Most notably, follow-up and comparison data is needed to determine if trainees who have heard known faculty's narratives are more likely to reach out to them for emotional support or referrals and/or derive sustained resilience/wellbeing benefit.

CONCLUSION

Videotaped narratives of known faculty are an innovative way to (1) provide personal role models for trainees' learning about coping with physician challenges and gaining insights on resilience, 2) access stories of triumph over challenge as a source of inspiration, and (3) work toward achieving local culture change by reducing stigma and increasing empathy and connection within a training program.

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