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A NEW DESCRIPTION OF A HEALTHCARE PROFESSIONAL'S RESILIENCE, INCORPORATING AN EASTERN PHILOSOPHICAL PERSPECTIVE OF SELF-DEFINITION

HOW TO BRIDGE THE GAP BETWEEN INDEPENDENT AND INTERDEPENDENT SELF-DEFINITION IN MEDICAL EDUCATION

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ABSTRACT

Teaching about resilience is one of the biggest challenges in medical education. One of the problems is that medical educators might still ascribe to the individualistic self-definition mainly promoted in the North American society. This definition includes characteristics such as "enduring ongoing hardship," "thriving on challenges," "being healthy," and "being stronger," which may raise hidden expectations that a healthcare professional's personality should be strong enough to bounce back to his or her original condition even in a psychologically demanding situation.

Psychological theorists describe two broad modes of self-definition in two different cultures: independent self-definition in North American individualism and interdependent self-definition in East Asian collectivism. Despite this seemingly stereotypical discussion on the characteristics of self-definition, a discussion of the two types of self-

definition can still encourage medical educators to propose a broader model of resilience in medical education. More specifically, a person using an independent self-definition may become be a complete, whole, autonomous entity, without others, and thus tends to achieve more and become more productive in a competitive society. In contrast, a person using an interdependent self-definition is more likely to be open to another aspect of the context and thus might be able to find and value the self in different ways even in the same context. However, these two self-definitions may not be dichotomous or mutually exclusive but occur in varying ratios in any one individual, particularly as trends of increased globalization, immigration, and technology call for changes in an individual's value systems in countries.

From this standpoint, this review proposes a new definition of resilience in medical education, which is 'a person's capacity to be aware of the aspects of the self differently identified in each context, and to consciously value oneself and others in the context'.

This is the first article that incorporates the concept of the two self-definitions into resilience education in healthcare. The proposed definition may provide a broader model of resilience in a healthcare professional for educators as well as trainees in medical education.

INTRODUCTION

Teaching about resilience is one of the biggest challenges in medical education. Recent studies around the world have consistently reported that healthcare professionals experience a high rate of psychological morbidity, manifesting as emotional exhaustion, depersonalization, and low personal accomplishment[1, 2]. A growing body of evidence suggests that burnout among healthcare workers is an unforeseen result of a demanding and continuously high-stress work environment; time pressures, workload, multiple roles, and emotional issues in a highly developed healthcare system can affect the physical and mental health of a healthcare worker[3, 4]. In addition, these persistent and excessive workloads placed on clinicians and the resulting fatigue could potentially affect patient safety[5]. Within these contexts, determining ways to effectively develop resilience in healthcare professionals has been the focus of studies to prevent burnout during training[6]. Rogers found that a combination of educational interventions with reflection, mentoring, mindfulness, and relaxation techniques were effective in developing resilient healthcare professionals[7]. However, despite efforts such as this in medical education, healthcare workers still believe that more practical definitions and instructions of resilience are necessary to help them cope with demanding situations[8, 9].

WHAT CAUSES THE SUFFERING OF MEDICAL STUDENTS AND PHYSICIANS?

The discussion of the term "resilience" in healthcare began in the 1970s–1980s. Currently, the term "resilience" in the available literature on medical education has various definitions. One of the most accepted definitions is from Walker, Gleaves, and Grey: "the capacity to endure ongoing hardship, as well as the ability to recover from difficult situations"[10]. Another definition is by Howe, Smajdor, and Stöckl : "a dynamic capability which allows people to thrive on challenges"[11]. Further, Epstein and Krasner described resilience 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"[12]. These definitions appear to be pursuing a broader sense of resilience to suit the practical conditions in healthcare; however, they might still ascribe to individualistic notions mainly promoted in North American society, such as "enduring ongoing hardship," "thriving on challenges," "being healthy," and "being stronger."

According to Wang, "resilience is a quintessentially U.S. concept. It has roots in the U.S. hero myth commemorated in books and stories by Horatio Alger in the latter half of the 19th century… [people in the society] seek to understand success in terms that magnify the agency of the striving spirit of the individual… We revere those who overcome the odds and who, through sheer determination, manage to rise above their origins to achieve personal frame and fortune"[13]. These descriptions surely appear to be extreme arguments but persistently remain anchored in the philosophy of medicine that exists primarily in North America, including the arguments of resilience education in healthcare.

Self-definition, which leads to embracing the philosophy of a "strong," "tough," "healthy," and "successful" person, may urge the expression of one's unique configuration of rights, needs, and capacities or the development of one's distinct potential, and therefore one is likely to achieve more and become more productive in a competitive society[14]. However, this individualistic self-definition can often pose a problem, especially in a situation where feelings of loss of personal control exist behind the expectation that an individual must show the ability to thrive on a hardship. With regard to the current dominant definitions of resilience in healthcare, the assumptions are that they are likely to raise hidden expectations that a healthcare professional's personality should be strong enough to bounce back to his or her original condition even in a psychologically demanding situation. Consequently, some medical students and clinicians may fail to make sense of themselves during their studies and work when they are not able to meet the expectations of society, which may then lead to burnout. From this standpoint, the discussion on resilience in healthcare that focuses on another model of self-definition allows clinicians to make sense of themselves even in a demanding situation outside of their control.

THE TWO TYPES OF SELF-DEFINITION

The theoretical approach by Markus and Kitayama assumed that the perceptions of individuals regarding their own self-other relations can lead to two broad modes of being in two different cultures[15]. The characteristics of the first mode, called independent self-definition, generally observed in North American individuals with a European ethnic background, were described as follows: "Others are less centrally implicated in one's current self-definition or identity…the self is assumed to be a complete, whole, autonomous entity, without the others… The defining features of an independent self are attributes, abilities, traits, desires, and motives that may have been social products but that have become the 'property' of the self-contained individual and that are assumed to be the source of the individual's behavior"[15]. By contrast, the characteristics of the second mode, called interdependent self-definition and usually shared among people with an East Asian cultural background, were explained as follows: "Continually adjusting to and accommodating others are often intrinsically rewarding, because they give rise to pleasant, other-focused emotions while diminishing unpleasant ones and, furthermore, because the self-restraint required in doing so forms an important basis of self-esteem. Typically, then, it is others rather than the self that serve as the referent for organizing one's experiences"[15] (Table 1).

	Independent self-definition	**Interdependent self-definition**
Stance	Individualistic	Collectivistic
Attribute	Individual	Context/Society
Intention	Conscious	Unconscious or Conscious
Goal	Achieved/Productive	Making sense
Perspective	Objective	Subjective

Table 1 Characteristics of Independent and Interdependent Self-definition*

*Adapted from 15

Nisbett and Masuda claimed that a person with an independent self-definition may "attend to some focal object, analyzing and categorizing its attributes in an effort to find out what rules govern its behavior"[16]. By contrast, a person with an interdependent self-definition may "live in a conceptual field, noticing relationships and changes and grouping objects based on intimate resemblance rather than categories membership…[the person] lives in complex social networks with prescribed role relations…[and thus] attention to context is important to effective functioning"[16]. Therefore, the person with an interdependent self-definition is more likely to realize the self as a part of the context, including one's personal roles and social responsibilities.

A large number of empirical studies that evaluate the two self-definition models in the two different cultures are available. Among them, Matsumoto[17] critically evaluated the logic underlying the theory of independent and interdependent self-definitions by reviewing more than 36 studies that directly examined the assumptions from Markus and Kitayama[15]. He concluded that differences in self-definitions might be a possible mediator that could explain various cross-cultural differences. In addition, he explored the reason behind why such seemingly stereotypical characteristics were consistently demonstrated in the studies, especially in East Asia. A possible explanation that he investigated was that East Asian collectivism may have had its roots in religion, particularly in Buddhist teachings throughout history. It is obvious that culture is not a static entity but ever-changing and dynamic, and even East Asian cultures and societies are getting less collectivistic and more individualistic than they have been in the past[17]. However, the discussion of the two types of self-definition can still encourage medical educators to propose a broader model of resilience in medical education.

As Matsumoto[17] indicated, interdependent self-definition would be grounded in Buddhist teaching[17]. Although there are, as a matter of course, thousands of arguments on Buddhist philosophy around the world, it would be a reasonable approach to review the works by Japanese philosopher Kitaro Nishida, who provided a new basis for philosophical treatments of the East Asian Buddhist thought as practiced in Western countries[18]. The objective of this review is not to promote a pure philosophical argument; however, examining Nishida's work would be beneficial in identifying the place where the meaning of the self would be constructed from the perspective of interdependent self-definition.

Nishida claimed that the individual, precisely as distinct, entails a plurality of interrelated individuals, focusing on the relation between "I and Thou"[19]. More specifically, he was drawn to the world as the mediating space of mutual formation. Nishida asserted that individual self-awareness can be described as a self-reflection of universal self-awareness; thus, "my recognition of you as not me makes me who I am, and your recognition of me as not-you makes you who you are. Each is a relative other to the self…I am one with you while not being the same as you. Not only between us does a 'continuity of absolute discontinuities' obtain, but also within each of us, insofar as our identity is in continual formation"[20]. Nishida denied the substantiality of the self and rejected both the radical alterity of other persons and the transcendence of an absolute other. He maintained that "the world is one yet many: individuals are many yet one in their mutual determination"[20]. Thus, in the model of a person with interdependent self-definition, the world defines the self, and, at the same time, the self values the world (context).

How do these descriptions work to identify and promote resilience in a healthcare professional? Remember the problem of the person with independent self-definition who would be eager to control the world even in a situation where he or she feels a lack of personal control. By contrast, a person with interdependent self-definition may simply be aware of how the world is, how the world defines the self, and then how the self

relates to the context. Furthermore, the person with interdependent self-definition could be open to another aspect of the context, and thus he or she might be able to find and value the self in a different way, even in the same situation. Thus, the person in this model may recognize the possibility of change in oneself, others, and world (context), which may result in finding a new self in that context. It is this description that could be thought of as resiliency in a person with interdependent self-definition.

A RESILIENCE MODEL COMBINED THE TWO SELF-DEFINITION CONCEPTS IN MEDICAL EDUCATION

This review identified the two types of self-definition in two different cultures in dualistic terms. However, these two self-definitions are likely not dichotomous and might not be mutually exclusive, but may occur in varying ratios in any one individual. This is particularly so as trends of increased globalization, immigration, and technology call for changes in an individual's value systems in countries with highly developed healthcare systems. In addition, the individual negotiation between autonomy and relatedness at any moment is a developmental task that spans a person's entire life. In other words, an individual may have the potential to negotiate between professional identity based on independent self-definition and self-value (personal identity) based on interdependent self-definition at a given moment, whether consciously or unconsciously. It follows that if a trainee could become consciously aware of these dynamic aspects of self-definition during his or her medical training, he or she might find a potential and flexibility of themselves within that context and then would play a new role, even in a challenging situation, without just sticking to one form of self-definition.

Based on the abovementioned discussion, this review proposes a new definition of resilience, which is "a person's capacity to be aware of the aspects of the self differently identified in each context, and to consciously value oneself and others in the context." This proposed definition can contribute to the development of a coherent educational program for medical students and healthcare professionals who are struggling with demanding situations, which might serve as a base for developing the trainees' professional identity. Further examination is necessary to obtain a more sophisticated model of the mix of independent and interdependent self-definitions in a healthcare professional.

Nevertheless, this is the first article that incorporates the concept of the two self-definitions into resilience education in healthcare. It is our hope that the proposed model of a resilient healthcare professional will assist in the teaching of resilience in medical education.■

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