8-4-2020

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NURS 501: Theoretical Foundations of Advanced Nursing

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August 4, 2020

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The problem of burnout in the healthcare setting was first introduced in the 1960s when the term was used to refer to clinicians experiencing emotional and psychological distress while caring for vulnerable populations in free clinics (Rotenstein et al., 2018). Since being introduced, decades of seemingly strong research has poured into defining, measuring, and treating clinician burnout – but without success (Dean et al., 2020). A meta-analysis of 182 quantitative and qualitative research trials looking at the prevalence of physician burnout among 109,628 physicians uncovered, "at least 142 unique definitions" of physician burnout (Rotenstein et al., 2018, p. 1131). Additionally, there was no commonly accepted instrument to measure burnout, even though the majority (85.7%) of the studies employed some derivation of the Maslach Burnout Inventory (Rotenstein et al., 2018). Out of the 182 reviews, 67% (n=122) measured overall burnout (some studies only measured subcomponents of burnout). Of these, "overall burnout prevalence ranged from 0% to 80.5%" (Rotenstein et al., 2018, p. 1131). After reviewing their data, Rotenstein et al. felt compelled to abandon their research question, concluding that there was too much variability to draw any meaning from the heterogeneous data meant to illuminate the prevalence of physician burnout.

Part 1: Rethinking the Description of Clinician Burnout

Dean et al. (2020) believe that without an agreed-upon definition of the concept of burnout, one which accurately reflects clinician experience, it is impossible to diagnose or treat it. They propose a total of four concepts (moral dilemmas, moral distress, moral injury, and burnout) that are spread along a continuum of increasingly severe symptoms to quantify and define the problem previously called burnout. Moral dilemmas are relatively common and expected in healthcare, and they encompass the decisions clinicians must make when there is no

ideal choice. Moral distress happens when a clinician is prevented from doing what is in the best interest of the patient, because of outside influences, such as a fear of lawsuits or insurance constraints. Moral injury is a wound to one's emotional wellbeing caused when an individual perpetrates or witnesses a violation of their morally held beliefs (Talbot & Dean, 2018). Moral injury can also be caused by a buildup of unresolved moral distress (Dean et al., 2020). Lastly, burnout would be the equivalent to learned helplessness, using extreme coping strategies like depersonalization, or just giving up (Dean et al., 2020).

Resilience is often deployed to tackle the problem of clinician burnout. However, just as burnout is a complex and multidimensional problem, resilience is as well. Finding the means necessary to overcome a problem like burnout will require a comprehensive theory of resilience such as Polk's.

Part 2: Polk's Theory of Resilience

The theory of resilience is a middle-range nursing theory first developed by Laura Polk and published in the journal of Advances in Nursing Science when she was a doctoral nursing student in Washington, D.C. in 1997. Polk was interested in developing a nursing theory that explained how nurses could promote wellness through rehabilitation and psychosocial change. She thought that in order for nurses to do so, they first needed to understand how people overcame adversity and challenges in life, and how they used these experiences as growth opportunities. She felt that the term "resilience" captured these concepts broadly, but that the term needed clarification for the purpose of being integrated into a nursing theory. She reviewed the literature, but she did not find either a concept of resilience that captured the full depth and range of meaning she wanted nor a nursing theory that adequately reflected the notion of

resiliency that she was looking for. So, Polk developed her own concepts and a middle-range nursing theory of resilience.

In order to create her theory, she first needed to define the concept of resilience. To do so, she searched the literature from various disciplines to determine the basic traits that other scholars had defined as resilience. She identified 26 attributes of resilience that she then categorized into four patterns or clusters. One cluster was made up of both physical and psychosocial attributes. A second cluster included roles and relationships. A third group dealt with problem-solving. And the fourth cluster was the philosophical component.

Physical aspects of resilience include attributes such as a person's intelligence, their level of health, their ability to care for others, and their personality. Psychosocial aspects would include feelings of worth, confidence, self-esteem, and autonomy. These attributes were combined under the heading of *dispositional pattern* of resilience.

The roles and relationship attributes were also combined, and they were given the heading of *relational pattern*. These attributes are thought to include intrinsic and extrinsic factors. Intrinsic aspects of role and relationship attributes include having a confidant, choosing positive role-models, and seeking comfort from another person. Extrinsic aspects are interacting positively in social settings, being part of a community that is supportive, being committed to school or work, and being interested in hobbies.

Polk expanded the problem-solving cluster into what she called the *situational pattern*. In addition to being able to recognize and act as a problem solver, this cluster of attributes includes the ability to be flexible, resourceful, inquisitive, and to persevere.

The final attribute cluster is the *philosophical pattern*. This cluster includes hopes for better times, finding the positive side to situations, using reflection, contributing to a greater

good, and believing that all beings are unique and worthwhile. Polk believed that these clusters of attributes stood alone as well as interacted together in a synergistic manner through time.

She embedded these four patterns into a nursing science paradigm that included interactions that take place between the environment and the individual. The paradigm she used is called the simultaneity paradigm, and it views humans and the environment as open energy fields that act on each other to create diversity and meaning. One assumption of this paradigm is that a situation can have multiple meanings depending on the human-environment dynamic. Other assumptions include the belief that a whole person is greater than the sum of his parts, and that people can change their environments while simultaneously being changed by their environments.

To create her theory of resilience, Polk (1997) melded the simultaneity paradigm of the environment and human energy flow together with the four dimensional patterns of resilience (dispositional, relational, situational, and philosophical) that she had developed earlier (see Figure 1). She noted that when a stressor is introduced into this dynamic system, the person and environment experience a state of disorder, or chaos, while undergoing change in an attempt to create a higher state of equilibrium, or negentropy. This stressor is filtered through the open exchange of energy fields of the environment-individual dynamic and the four patterns of resilience. These four patterns interact and combine in a synergistic manner that moves the situation away from chaos and disorder to negentropy and higher order. This entire process is called resilience.

Resilience

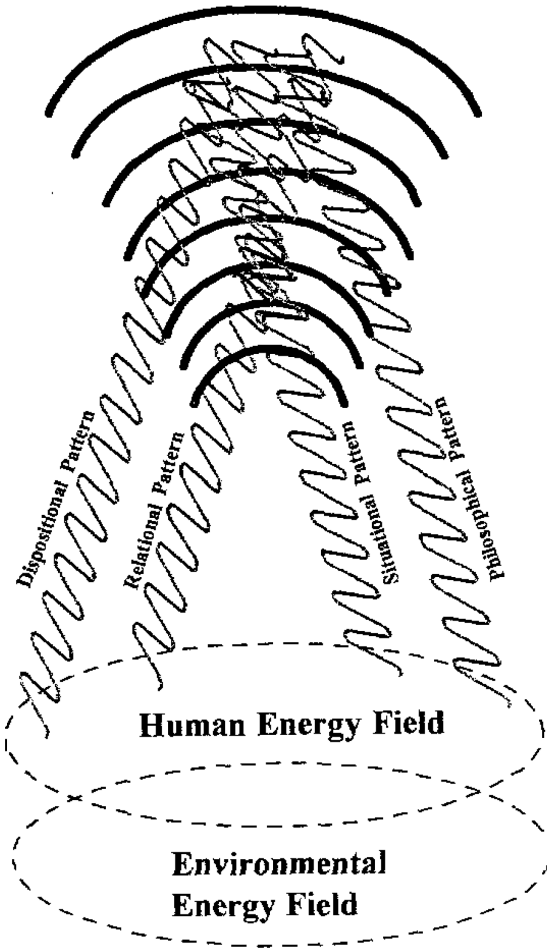

Figure 1. Toward a middle-range theory of resilience by Laura Polk, 1997, retrieved from *Advances in Nursing Science,* https://doi.org/10.1097/00012272-199703000-00002

Polk's theory of resilience asserts that the more diverse the four patterns of resilience (dispositional, relational, situational, and philosophical) are, the greater an individual's resilience. Such that the more attributes one has in each of the four patterns, and the more attributes in total across all four dimensions, the greater the diversity and the higher the likelihood that resilience will be manifested. By understanding this multidimensional pattern, nurses can recognize the processes necessary to increase diversity and, therefore, resilience in themselves and others.

Part 3: Applying Polk's Theory of Resilience to Clinician Burnout

In applying this theory to clinician burnout, one can observe that a stressor has disturbed the balance in the energy fields of the clinician and her environment. This stressor has put the clinician and her environment into a state of chaos and disorder. The four patterns of resilience with their multiple and diverse attributes are necessary to gain strength to overcome clinician burnout. By utilizing the energy that is free flowing from her environment through her, she can call upon her many attributes that make up resilience to propel her towards a higher level of functionality and order in her life.

Recalling Dean et al.'s (2020) four stages of clinician burnout (moral dilemmas, moral distress, moral injury, and burnout), one can see that the meaning of each stage depends on the dynamic between the individual and the environment presented in Polk's simultaneity paradigm. One person's experience of moral distress will differ from another's based on her attributes (e.g., history of marginalization, violence, or trauma) and her perception of environmental characteristics (e.g., social and administrative support or the ability to talk to a real person at an insurance carrier). One can break down each stage of clinician burnout using examples from Polk's theory of resilience to better understand the theory's applicability to the issue.

Moral dilemmas happen when an ideal choice does not exist, such as electronic charting while taking a patient's history. The ideal situation would be fully interacting face to face with the patient while taking his medical history, but the reality is typing while looking at the computer. The stressor is computer charting versus patient focus. The environment is a physical barrier (the computer and desk) between the clinician and the patient. The human dynamic is focusing on a screen rather than engaging in a face to face interaction. Resiliency patterns that the clinician is using could include intelligence, confidence, autonomy, being committed to

work, being flexible, and finding the positive side of the situation. Resilience patterns that are being dismissed could include one's real personality, giving comfort, looking interested, and problem-solving. By applying the theory of resilience, one can see how it contributes to understanding the energy of the problem or situation and determining which resiliency patterns are present and which are absent in each moral dilemma.

Moral distress happens when one is prevented from acting in the best interest of the patient. Moral injury is a buildup of moral distress that can come about because one witnesses or perpetuates acts that violate one's beliefs. An example of moral distress would be a hospitalized patient being close to dying from an untreatable brain tumor, but his family insisting that all measures be taken to prolong his life, even though they cause the patient unnecessary suffering. Moral injury would be an amplification of this situation. Such as when a clinician has a similar experience only multiple times, or when she causes her patient to suffer by performing unnecessary surgeries or even coding her dying patient. This stressor is characterized by doing harm rather than good. The energy of this environment supports the family's right to make health care decisions when the patient is not able. The clinician's contributing energy is her desire to minimize her patient's suffering and for him to have a good death. Polk's patterns of resilience that are helpful for the clinician through these stages could include her health level, her personality, her feelings of worth, having a confidant, seeking comfort from another person, being interested in her patient, using reflection, and her knowledge that all beings (including herself, the patient, and the patient's family members) are equal and worthwhile. Resilience patterns that are absent and are not of help to the clinician in this case, could include autonomy, confidence, being able to persevere, being a part of a hospital community that is supportive, and situational problem-solving. Once again, the theory of resilience could contribute to

understanding how the clinician could move this situation from one of disharmony to one of order to benefit her and her patient.

Lastly, clinician burnout is exemplified by learned helplessness, giving up, and depersonalization. This stage can come about when a clinician consistently fails to meet the needs of his patients. An example of this stage would be the breast radiologist who unnecessarily physically harms hundreds of patients every year by performing expensive and painful breast biopsies on patients who have benign-looking cysts, masses, or calcifications. Even though there is a low probability of him finding a malignancy, he is so worried about lawsuits, that he doesn't question the practice. The stressor here is giving up one's moral belief to do no harm. The energy field of his environment is characterized by high-stress, anxiety, distrust, and suspicion. His individual energy is marked by his robotic behavior, a lack of identity, and a willingness to harm others without questioning it. Polk's patterns of resiliency could include one's health and ability to care for oneself, seeking comfort from others, having hobbies outside of work, and being part of a community. Patterns of resilience that are lacking in this situation could include self-esteem, accomplishing goals, choosing positive role models, being committed to the type of work, problem-solving, being inquisitive, contributing to the greater good, hoping for better times, and finding the positive side to situations. Even though this clinician seems unmotivated to self-reflect and change his practice, the theory of resilience is still useful as it sheds light on the issue in a systematic process.

Three major strengths of the theory of resilience are as follows. 1) The ability for a person to define the stressor, the characteristics of the environmental energy, the characteristics of the individual energy, the patterns of resilience that are present, and those that are lacking. 2) That upon recognizing the attributes in the first strength, one can gain a perspective to see the issue or

problem in a different way. For example, frequently, when a person is faced with a problem, they lose outside perspective. By using this theory and looking at the patterns of resilience, one can gain insight into what is needed to move the situation from a state of chaos to one of order. 3) The theory forces one to look at the positives and not just the negatives. When things are bad, it is easy to see the negative side, but this theory lets a person see the positives too, which makes it easier to create positive changes.

Two major weaknesses of this theory's ability to address clinician burnout is that 1) it requires fairly extensive self-reflection on the part of the clinician and 2) that significant institutional changes are probably necessary to resolve clinician burnout on a massive scale. To grow and move from a situation that is in chaos to one that is in harmony, an individual has to be willing to self-reflect. However, self-reflection can be overwhelming when one is in the throes of apathy, burnout, depersonalization, or has given up. Because of this, the application of the theory would be easier to accomplish during the earlier stages of moral dilemmas to moral injury. Once a person has crossed into burnout, it is unlikely that they can start on the path towards resilience without an outside push. Additionally, this theory would benefit from a discussion regarding the implementation of organizational and structural systems that are designed to recognize and manage clinician distress and burnout. These systems must be proactive and seek out clinicians who are dealing with known stressors. Suggestions for institutions interested in building resiliency include mentorship programs, incorporating professional organizations into the workplace, and adding resiliency-building skills to the curricula of medical and nursing schools (Jackson et al., 2007).

Part 4: Summary

Clinician burnout is an alarming problem in the United States. Physicians are twice as likely to take their own lives than active-duty military (Talbot & Dean, 2018). On average, 300-400 physicians commit suicide every year, which is 2.5 times the suicide rate of any other profession (Shepherd et al., 2020). Studies of physician suicide reveal that it is more likely related to job burnout and stress at work than it is to the death of a loved one or another life tragedy (Shepherd et al., 2020). Nurses are also more likely to commit suicide than other professions, with female nurses more likely than the female population, generally, to die by suicide, and male nurses are significantly more likely than the general male population to commit suicide (Davidson et al., 2020). Researchers found that, "one of the strongest characteristics associated with nurse suicide was the presence of known job problems" (Davidson et al., 2020, p. 14). Building personal resilience to workplace adversity has been shown to reduce clinician burnout and lead to thriving at work (Jackson et al., 2007).

Applying Polk's theory of resilience is one method that clinicians can use to deal with stressors at work. Through utilizing the relational, dispositional, situational, and philosophical patterns, one can move from a state of disorder in workplace difficulty to a higher order and even thrive at work. Polk's theory provides a framework to evaluate both the attributes that are present and the elements that are lacking or absent within the patterns of resilience. Applying this knowledge can illuminate a solution that can help to propel an individual towards resilience and thriving. Understanding gained through reflection on this theory means that clinicians can ask for help that is specific to their needs, instead of merely vaguely knowing something is wrong but not understanding what is needed to change the situation. The theory does require self-reflection

to do this, and it would greatly benefit from institutionalized assistance that automatically kicks in when known stressors are identified.

As organizations move forward in addressing clinician burnout, professional organizations and health care companies should consider implementing programs specifically tasked with identifying and treating workplace adversity, stressors, and early signs and symptoms related to clinician distress. As these programs are executed, research can be conducted to determine their effectiveness at reducing stress and suicides and increasing satisfaction and retention.

Finally, one idea to increase the relevance of the theory of resilience to clinician burnout would be to expand the theory to include organizational and institutional patterns of resilience and energy. As of now, it only comprises individual patterns and individual energy flow and environmental energy. The addition of a focus on institutional energy would be helpful. When health care institutions make it a goal to provide positive energy and patterns of resilience to their staff, healthier work communities will blossom, and the incidence of clinician burnout would diminish.

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