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How healthcare team build Resilience to Stress

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Abstract

Introduction:

This study explores how the interaction theory of stress and coping, the expansion and construction theory of positive emotions, and the conservation of resources theory can help healthcare teams resist stress. Community resilience has been overlooked in health research on individual resilience. This study examines the resilience of teams to overcome knowledge gaps.

Methodology:

A snowballing method was used to select 10 members of the oral and maxillofacial surgery team for the study. Zoom was used to conduct 10 semi-structured interviews with three study participants. What causes team stress? How is stress tolerance defined? What strategies does the team use to build resilience? Interviews were coded using thematic analysis.

Results:

Research has found that patient care, long working hours, conflicting work commitments and a lack of control contribute to employee stress. Transactional theories of stress and coping suggest that a problem- and meaning-centered approach can help people cope with a variety of stressors. Teams also leverage social capital, constructive criticism, and positive emotions. It turns out that people have different definitions of resilience. Resilience is defined as a quality, characteristic, or strategy for coping with stress.

Conclusion:

The paper concludes with recommendations for implementation. Research shows that unpleasant emotions are expressed in difficult, low-stress work situations. It supports the non-suppression of unpleasant feelings, their resolution, and solutions. Management needs to step in and teach team members to express uncomfortable feelings in a constructive way.

Keywords: healthcare, doctor, dentist, stress, anxiety, treatment.

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Introduction:

Numerous researches have shown that healthcare job is stressful (1). Managing difficult patient situations, coordinating clinical and administrative duties, and witnessing medical disasters causes

everyday stress for healthcare practitioners. If untreated, they cause mental and physical decline, absenteeism, medical mistakes, and poor patient care (2). In 2015 research found that many healthcare workers who helped parents grieving a sudden child death had trouble separating their own feelings from those of the parents (3). Due to their intense emotions, their job performance was often compromised.

Due of stress's devastating effects, healthcare resilience research has increased. Most research is done at the individual or organizational level, in my opinion. Team resilience research is sparse. The first of 18 peer-reviewed team resilience studies was published in 2009 (4). There is little empirical data on how healthcare teams build resilience. This does not diminish resilience or healthcare collaboration's rarity. A recent UK research found that shifting work practices need staff with a broad variety of knowledge and abilities to cooperate to improve patient care (5).

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Numerous studies have revealed healthcare team stress. Qualitative and quantitative stress was found in 73 primary healthcare teams from 1200 Israeli hospitals (6). According to 29.2% of respondents, difficult patient situations cause stress, while 30.8% mention administrative difficulty. French public hospital physician teams must conduct administrative activities in addition to therapeutic ones owing to changing government laws and fiscal restrictions (Grima et al., 2020).

Methodology

Research Philosophy and Design

This study is based on interpretive philosophy. The interpretive philosophy implies that reality and knowledge is not something that exists out there and waiting to be discovered but rather, is constructed and reproduced through human experiences, communications, interactions and practices (7). It also, implies that what is classified as knowledge and reality varies from person to person depending upon differences in their understanding, beliefs, and thought processes. Hence this study attempts to understand stress and resilience from participants' points of view rather than investigating facts of reality. Special attention is paid to differences in perception among participants.

Since this study is interested in developing an understanding of how participants perceive stress and about the complexities of developing team level resilience, the qualitative research design was judged to be most appropriate. In contrast, quantitative research would have been preferred, if the research focused on examining the relationship between variables which could be measured numerically and

analysed using statistical or graphical techniques (8). The qualitative data is collected through semi-structured interviews. Firstly, these are more flexible in comparison to structured interviews. For instance, when conducting semi-structured interviews, it is possible to change the order of the questions and even add additional questions depending upon the responses gathered.

Secondly, many researchers have defined resilience to stress as a complex research topic. For example, resilience-building strategies are different depending upon the type of stressors, how long ago the team was formed and how the stressors are appraised. I believe that we can uncover these complexities better using semi-structured interviews. Moving on, alongside studying about its numerous advantages, I also attempted to make myself aware of the weakness of semi-structured interviews. For one, there is a possibility of getting off-topic. For a novice researcher like myself, steering participants attention back to the main topic might be difficult. Second, there could be an issue of response bias. That is, while participants have agreed to partake in this study, they might still be hesitant about the exploration of some themes (8). Thus, they might choose to provide partial, false or no information at all for some interview questions.

The semi-structured interview questions used in this study are adapted from the interview schedule from O'Dowd et al. (2018) study on psychological resilience among physicians. All the interview questions were open-ended and were guided by "what" and "how". "What does the statement "coping with stress" means to you?" "What are the stressors your team faces?", and "what coping strategies are adopted by your team to deal with stress?" Before conducting the interviews, all participants were given a consent form and information sheet. The information sheet contained all the information regarding the research; research objective, how will it be conducted, how will the collected data used and stored, who will be involved and what will be the rights of the participants. The participants were meant to read the information sheet and then read and sign the consent form. Once, signed consent forms were returned only then, were interviews conducted.

All the interviews were conducted via Zoom, in light of Covid-19. Zoom provided the same advantages as face-to-face interviews while at the same time being less costly and more convenient (7). For instance, while conducting Zoom interviews, it is still possible to read facial expressions and body language. Zoom also offers the option of recording meeting video and audio and save them either locally to a computer or online. This option, hence, eliminates the need to have a separate recorder. Alongside the benefits of using Zoom, weaknesses were also, considered. First, there was a possibility that the participants might not have the technical expertise or access to the internet. Second, there was an issue with differing time zones; Karachi is four hours ahead of London. While there was nothing which could have

been done about the lack of access to the internet, something could still be done about technological expertise, and time zone issue. In regards, to not knowing how to use Zoom, a few days before the scheduled interview, each participant was sent an email which contained thorough instructions on how to download and use Zoom. Furthermore, the problem of differing time zones was dealt with by allowing the participants to determine the date and time of the interview themselves.

Each interview began by firstly, thanking participants for agreeing to take part in the research. And secondly, by quickly going over the contents of the information sheet. Participants were reminded of the research objectives and their rights during the interview. For instance, if they did not wish to answer any question or set of questions, they were under no obligation to do so. Similarly, if they wanted to stop the interview at any point, they could do so, without having to give any reasons. I made sure to point out that all the interview responses will be kept anonymous and that all the data including the audio recordings, consent forms, and transcripts will be stored in an online file protected by passwords. Once, satisfied that I covered all the essential contents from the information sheet, only then did I proceed with the actual interview.

Each interview was conducted in English and took about 30-45 minutes. Participants were encouraged to provide examples of stressors faced and strategies used. Each interview was closed with a summary of what was discussed and two questions: "What behaviours might your teams do better or more frequently in stressful period?" and "Is there anything else you would like to add?" Finally, all the interviews were audio and video-recorded and later transcribed and analysed using the thematic analysis approach.

Sampling Design

A method of snowballing sampling was employed to identify participants for the research. This sampling is adopted when it is difficult to identify or obtain access to members of the desired population (7). Researchers begin by identifying several participants who fit the study's criteria and then ask these people to suggest a colleague, a friend, or a family member (Saunders, et al., 2015). In terms of sample size, there is no fixed rule for how many participants to interview. The sample size is dependent upon research objectives, research questions, and finally, the availability of resources (8). However, one can still benefit from available guidance to ensure sufficient interviews are conducted. Many textbooks have recommended continuing with the interviewing process until the saturation point is reached (9). Alternatively, Saunders et al. (2012) have identified that for a semi-structured interview, the sample size could be anywhere around 5-25. In my case, I did not have the option of choosing participants, but instead, they were endorsed. Hence, I had little control over the sample size.

Method of Data Analysis

The data collected from the interviews were studied using thematic analysis method. Thematic analysis is a method for identifying, exploring, and reporting patterns or themes within a data (10). Braun and Clarke's (2006) step-by-step guidance on how to conduct thematic

analysis, was consulted. I began by acquainting myself with the data I collected from the interviews. I repeatedly listened to recorded interviews to look for patterns and meanings, after which I started to transcribe them into written documents. The second step in the analysis was to generate initial codes. It involved, reading the transcripts to find interesting points which may have been repeated by serval participants (11).

Findings and Discussion

Theme 1: Team stressors

This subject concerned healthcare worker stress. Detailed participant conversations highlighted four sub-themes. The first sub-theme is "Patient Care". Most participants highlighted challenging patient case stress and managing patient expectations. A senior assistant professor who struggles with patient expectations identified the most common stressor as meeting patient expectations for treatment results. Pakistan, notably Karachi, has numerous oral cancer sufferers. To tell them that we will fix your jaw, tongue, face, or neck, but it will appear different, is difficult. Despite our tough expectations before therapy, patients cannot completely understand reality.

Some resident trainees said conveying bad news to patients with life-threatening diseases is distressing. Some resident trainees noted the burden of managing such individuals. According to the third resident trainee questioned, severe sickness patients need regular observation and more difficult therapy. Many of us are emotionally and physically exhausted. We are worried by the possibility that we may not have adequate personal resources to meet patient needs. The second sub-theme was "Competing Work Responsibilities". Managing various job duties stressed participants. All participants have clinical, administrative, and academic duties. If a team member is absent, others must take over their duties.

"Perceived Lack of Control" and "Long Working Hours" were less often stated sub-themes. Participants were stressed since they had little influence over treatment results. The third resident trainee cited a cancer patient who needed a unit of blood after surgery and the hospital running out. Recently, most participants felt powerless due to Covid-19. Asymptotic patients were mentioned by the final two resident trainees. A fifth resident trainee said that COVID-19 has caused a sense of helplessness among healthcare personnel, leading to increased stress. No matter how many measures we take for ourselves, our families, and coworkers, we must treat patients at the hospital. These patients are often asymptotic". Finally, participants acknowledged the challenge of working long hours without breaks, even for lunch. The fourth resident trainee said that they must work daily from 8:30 am to 4 pm. After each day, we're exhausted and lose concentration. We seldom have time for lunch or tea breaks since we're so busy at work.

Theme 2: Defining Resilience

This topic shows participants' definitions of "Resilience to Stress". Participants interpreted the phrase differently. Seven interviews found that stress-management coping methods were most often known. These included problem-solving, acceptance, repression, and diversion. Acceptance and problem-solving were chosen by the third and sixth resident trainees. Acceptance means acknowledging that they cannot control everything in healthcare, no matter how well they prepare. The sooner people realise this, the sooner they can actively design remedies for planning failures (12).

Many participants also described stress resilience as stable personality qualities and talents. For instance, the fifth resident trainee I questioned said, "I think stress resilience depends on personality. I'm not afraid to ask work-related questions, unlike others. I also build connections effortlessly. Both features have traditionally enhanced stress management. Being resilient included being cool and seeing pressures as manageable, according to most participants. According to the senior assistant professor I met, resistance to stress involves maintaining calmness. More particularly, managing nerves and unpleasant emotions like wrath and irritation.

The last sub-theme, "Resilience Developing with Time or Experience," shows how some individuals gain resilience from their surroundings and others. The third resident trainee says, "When we enter the medical field, initially we do not know how to deal with patients and stressful work situations, but over time with the guidance of our supervisors and their expertise we learn". The different sub-themes within this subject disclose an intriguing point. This study's participants define stress resilience in numerous ways. In the discussion with the senior assistant professor, she said stress resilience can be developed.

Theme 3: Resilience Strategies

Team members are willing to help emotionally and behaviourally. Most interviewees mention this strategy. This method focuses on patient care stress. A team member assisted the third resident trainee I met with a tough patient case at the outset of her residency: "I got a gunshot wound patient in the emergency department on my first night shift. Patient was quickly worsening. I was nervous seeing the patient. My anxiety increased since I had no notion what to do. Panicked, I phoned a senior team member. He soothed me and gave me detailed instructions to relax. His phone presence encouraged me as I followed his suggestions. He intended to get to the hospital to aid me. We were treating the patient when he arrived.

The fourth resident trainee praised her colleagues for helping the newcomers. Relocating may be difficult, she explains. She says they seldom know team rules and, most crucially, team members' personalities. The aid of other members lessens newbie stress. Just after joining, she had to organise blood transfusions for an anaemic patient. I was inept at blood organisation. I requested assistance from coworkers. They provided detailed blood arranging instructions without making me feel incompetent. Serval players described team compensation. Compensatory behaviour is member support for those

who cannot perform. Top resident trainee adds, "I requested one of them to stand in for me in the ER since we had an interview this afternoon; she instantly consented. “If necessary, I would do the same for her."

The quote emphasises reciprocity. Reciprocity tends to improve social resource cooperation by creating a sense of duty. The sixth resident trainee I met recalls when Covid-19 was unknown in Pakistan. He praises the bosses' pre-event briefings for preparing everyone for the cases' apex. "Because the Covid-19 was so novel and information was scarce, there was a great deal of anxiety regarding how to protect our families, patients, and ourselves," says. Senior members of our team held seminars and training sessions, spoke via Zoom and the hospital auditorium, and wrote frightening articles to raise Covid-19 awareness.

The problem-solving technique concludes with team communication adjustments. The second senior registrant stated staff adjusted after becoming weary of misinformation. Everyone decided to start a WhatsApp group to discuss work-related information and updates on their commitments for everyone. This strategy builds team resilience via emotions. Positive reinforcement, encouragement, social support, and appreciation foster pride, confidence, gratitude, and optimism, culminating in calmness and teamwork. Previous study shows that group effectiveness and composure improve resilience.

Most participants utilised thankfulness and nice remarks to feel good in this research. "One positive event has the capacity to eradicate feelings of stress and convince individuals that stress never existed," said the help. Staff appreciation is essential. When my members appreciate me, I'm motivated to overcome challenges.

"I think I had two lectures and clinical duties on Monday," remarked the fourth resident trainee. Social assistance was rare yet important. My mother was unwell, so I took the day off. I texted my residents and teammates for backup. I was happy when they agreed and helped. I sent multiple love emoticons to express my gratitude, happiness, and appreciation for their support. I was pleased to be on my team and more likely to seek for assistance. Social support among team members reduces the consequences of prior subtheme strains. It only produces nice sentiments in rare circumstances like the one above.

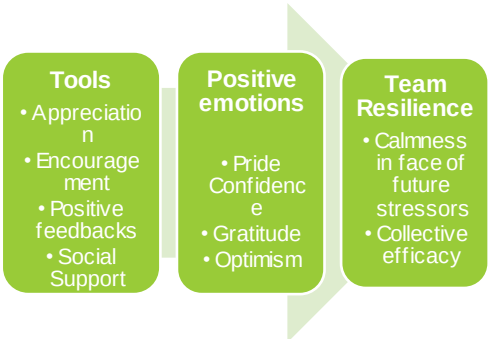

Figure 1: Building Team Resilience Through Positive Emotions

Theme 4: The need for improvement

This theme emerged in response to the question asked at the end of the interview; “What behaviours might your teams do better or more frequently

in a stressful period?" In four interviews, participants reported the need to change the negative team culture. They discussed how power politics and conflicts within the team made the team environment toxic and full of negative energy. For instance, the second resident trainee shared how the senior members of the team are often not willing to share their knowledge and expertise with junior members. Instead, they judge and make remarks which makes the juniors feel incompetent. She believed that this occurs because senior residents might feel insecure.

The second senior registrar made a similar comment recalling the time when she first joined the team:

"When I first started, I made friends very easily. I shared all my stress with them. However, what I said in confidentiality was misused, distorted, and communicated to others. Senior residents were also very rude to me; they often used to go to my supervisors and wrongly complained about me".

Discussion

This research examined how a small oral and maxillofacial surgical team increases stress resilience to address gaps in the literature. This research examined resilience-requiring team stresses. Stress from patient care and conflicting job tasks was more common than from long hours and perceived lack of control. Some of these stresses were previously identified in studies of nursing, midwifery, and clinical psychology practitioners' resilience. Grima et al. (2020) highlight how French doctors are burdened by clinical and administrative tasks (12).

The results showed that individuals define stress resilience differently. Participants mostly saw resilience as a way to handle professional issues. Participants also characterised resilience by personality and skills. This fit Alliger et al. (2015) input-based resilience definition. They defined resilience "as the capacity to withstand and recover from challenges, pressure, or stressors". Both definitions appear to define capacity, qualities, and talents similarly. Another less-mentioned definition of resilience is growing with time or experience (13).

I showed that the team utilises five stress-coping methods using three theoretical frameworks from resilience and stress literature. Participants often share team resources to promote resilience, as shown in the conservation of resources hypothesis. This research shows that members share social resources by offering emotional support during uncertain times, assisting one other with work, and sharing information and skills. Teamwork was essential for resilience, according to participants (14). All but a handful said their teammates are helpful and cooperative. In contrast to earlier research, social resources were mostly employed for problem-solving rather than emotional expressiveness. This suggests the team values showing emotions less. Some individuals said they repress emotions when anxious. Although this works, long-term emotional unfulfilled demands lead to disengagement and denial (15).

The transactional theory of stress and coping was supported by this research. The most common coping mechanisms were problem-focused and meaning-based. When dealing with patient care

stress, problem-focused solutions like proactive planning stand out in the interviews. Participants who struggle to accept their stresses utilise meaning-based solutions. One participant said stresses improved performance (16).

One method, constructive criticism, illuminated team-level coping expertise. The study found that constructive criticism increases social resource sharing. This study supports the conservation of resources theory's recommendation that teams create the optimal circumstances for social resource sharing (17). The emotional strain and anxieties created by errors are reduced when members get respectful comments on both good and negative parts of work. They may be certain that no matter how many errors they make, they will be allowed to learn and not humiliated. The participants said constructive criticism helped them acknowledge their faults and resolve them via team talks and informal and formal inquiries with particular members (18,19).

Finally, the broaden-and-build explanation of happy emotions was supported. The team gives gratitude, praise, feedback, and social support to induce happy feelings in work life. Positive emotions have helped individuals recover from stress and create psychological resources. Pride, empathy, thankfulness, and optimism have helped improve team resilience by fostering collective effectiveness, belonging, and capacity to stay. Many participants also said that being commended made them feel like the tension never existed (20,21).

The topic “the need for improvement” illuminates an intriguing aspect. Participants gave inconsistent answers. Resilience techniques showed a good team atmosphere with constructive criticism, collaborative problem-solving, and social resource sharing. However, final question replies imply bad team culture. In four interviews, participants described a hostile team climate. Juniors said seniors are insecure about their skills and sabotage them (22).

Conclusion

To conclude, this study, explored some of the stressors faced by the oral and maxillofacial team along with their understanding of resilience and strategies used to build resilience to various stressors. It began with the review of literature on stress and resilience; discussed different concepts and theoretical frameworks and explored the empirical findings on resilience strategies implemented by teams in healthcare. That was, followed by the data collection process. Semi-structured interviews were considered suitable for this study. Hence, these were conducted, via Zoom. Once, all the data was collected, it was examined and coded using thematic analysis approach. Four themes emerged with each having four to five subthemes.

The research findings reveal that patient care, long working hours, competing work responsibilities and perceived lack of control are some of the stressors the team faces. It also found, support for the coping strategies discussed in the literature. For instance, the participants reported using problem-focused,

meaning-based strategies and strategies of using the team's social resources and inducing positive emotions (22). Furthermore, this study is in agreement with previous researchers who reported difficulties in adopting a fixed definition of resilience. In this study, particularly the subtheme of "defining resilience" offers insight on how for different participants meaning of resilience varies. Finally, this study found the existing theoretical frameworks applicable to real world work settings. The conservation of resources of theory stresses the importance of developing the right team conditions for encouraging the practice of sharing resources to build resilience. The findings support this; the practice of constructive criticisms leads to an environment of trust, confidence, and respect which then encourages participants to make an effort to seek and offer social support in the form of behavioural and emotional assistance (23,24).

This study makes serval contributions. First, to my knowledge, there is very little attention paid to team-level resilience in comparison to individual-level resilience. Therefore, this study fills in the gaps in the literature. I believe that it is crucial to focus on team-level resilience because most teams in healthcare settings will face stressors which will drain their resources, disturbs team process and effect goal achievements. And without understanding how teams develop resilience or what resilient teams look like, it would be difficult for management to develop future programs to facilitate optimal mental and physical well-being and coping strategies among teams in healthcare. Second, the research findings revealed strategies, not previously discussed in the literature: constructive criticism. Therefore, it successfully extends the existing knowledge on resilience strategies. Finally, this study shed light on varying ways resilience and stress is, conceptualised in the literature. I believe that this the right step in the direction to ensuring enhanced conceptual clarity of stress and resilience.

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Sara Mayet: Concept, design, analysis and interpretation of the data.
Aisha Mayet: Drafting the work and revising it critically for intellectual content.
Yousuf Ahmed Qureshi: Final approval of the version to be published.
Faiza Siddiqui: Proof Reading and revisions