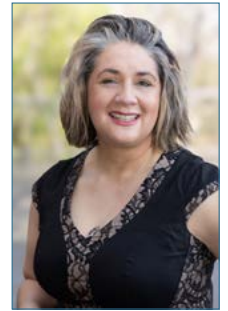


# Building resilience is not for the faint-hearted

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We seem to be in a national crisis. Healthcare workers are faced with financial constraints, increased patient loads, and reduced staff. For many of us, the greatest struggle is the sense that we cannot help our patients in the way we know they deserve. When admissions are unrelenting, the emergency board is never-ending, and theatre time is insufficient, it is demoralising. I am not responsible for a trauma firm, but I still feel the heat.

Equally, in private practice, being caught in the bureaucratic red tape of motivating for your procedure to the medical aids can cause mental distress, especially when you are met with a non-clinician on the other side of the phone. You know what you can offer the patient, but someone or something indirectly involved prevents you from doing this.

Moral distress occurs when a person knows the ethically correct action to take but is unable to act due to internal or external constraints, such as lack of resources, organisational policies, or systemic barriers. The conflict between knowing what you should do and being unable to do it produces an acute emotional reaction. It can manifest as compassion fatigue – feeling apathetic to and detached from the patient's circumstance that brought the two of you together. Moral distress can lead to sleep disruption, as you lie awake in bed ruminating, unable to sleep. You could feel emotionally exhausted. The slightest inconvenience triggers a severe emotional response (often anger) because you simply cannot cope with more obstacles to doing your job. Moral distress can finally leave you feeling a diminished sense of personal accomplishment – no longer proud of what work you do, the unit that you belong to, the fraternity at large, even.

I recall my ICU rotation, surrounded by intubated trauma patients, some of them dying. Families circled the beds, desperate for hope, while I often became the 'angel of death' delivering bad news. In my appraisal, I told my head of department that we needed trauma counselling for those situations. That was more than ten years ago, and the need has only continued to grow.

Over time, moral distress increases the risk of substance abuse. No one can function when suffering from insomnia, and thus it isn't uncommon for healthcare workers to self-medicate to ensure some hours of sleep (no matter the quality). There is also an increased risk of mental illness, such as depression, with difficulty in managing workplace stress while trying to maintain compassion for others (patients and co-workers alike).

When you are experiencing moral distress, you may struggle to find the energy for professional development.

As Locke et al. put it: 'Days felt like digging out an avalanche with a teaspoon.'<sup>1</sup>

When repeated, moral distress escalates to moral injury – deeper psychological and spiritual harm resulting from violating, or witnessing the violation of, one's core values. While often associated with war or natural disasters, in South Africa, it is all too

familiar in our overstretched healthcare sector. Moral injury erodes job satisfaction, fuels resignations and increases suicidal ideation.

The causes are numerous: unsafe patient loads, excessive paperwork, inadequate equipment, power failures, and staff shortages. Even minor, repeated frustrations, such as doing menial administrative tasks that detract from patient care, accumulate, leaving clinicians feeling guilty, helpless and devalued. I am sure all sectors of healthcare can relate to this situation.

Cultural beliefs within medicine add to the problem. In some workplaces, open discussion of distress is discouraged, as it is seen as a weakness rather than a symptom of systemic dysfunction. There persists an unrealistic sense of duty – the idea that exhaustion is a badge of honour. A friend of mine is a foreign supernumerary from Switzerland. She told me that one of their surgical programmes requires its trainees to work from 06:30 to 22:00 five days a week, plus weekends. The 'weak' are dismissed after a week. Practices like this breed self-doubt and drive further burnout.

In the private sector, where financial survival often breeds isolation and discourages collaboration, loneliness can be a significant problem. Being unable to speak about what you are experiencing fuels thoughts of 'this is only happening to me' and 'something is wrong with me'.

Generational differences add another layer. Older generations (Generation X in particular) often accepted hardship as part of their profession, priding themselves on being self-sufficient and resilient. Generation X is known for rolling up their sleeves and getting the job done. I, myself, as an elder millennial, did not question seniors and just toughed it out.<sup>2</sup> You did not question the hand dealt to you: intern placements, community service placements, and a lack of shortlisting for interviews. All of these were taken on the chin.

Today's younger doctors, by contrast, are less willing to tolerate discomfort and often question traditional structures. While some (older generations) may see this as a lack of toughness, it may also reflect a healthier resistance to toxic cultures. The real question is how we can foster resilience without glorifying suffering.

## Building resilience

Addressing moral distress requires action at individual, leadership and organisational levels.<sup>3</sup> Individuals should focus on working within their locus of control, recognising they are not responsible for systemic failures, such as load shedding or broken equipment. Techniques such as mindfulness, reflection and boundary-setting help manage stress. Leaders must listen to their staff, empower them, and remove barriers to success. Open discussion should be encouraged, stressors identified, and staff experiences acknowledged. A mindset shift is needed in leaders not to expect their subordinates to 'fix everything'.

Organisations must commit to cultural change, prioritising staff well-being as much as efficiency. Administrative buy-in and leadership support are critical.<sup>4</sup> In the private sector, perhaps a mind shift from ‘every man for himself’ to a collaborative practice consisting of subspecialties working together would make life less stressful (and more fun!).

Practical strategies include mindfulness and reflection; whether through meditation, group discussion or yoga, mindfulness encourages non-judgmental awareness and stress relief. Breathing exercises are an effective way to manage burnout.<sup>5</sup>

The GROW model is effective in building resilience within leadership. Clarifying Goals, assessing your current Reality, exploring the Options available to you, and committing to next steps (Will) builds structured resilience. A quick tool to regulate emotions in stressful moments is the STOP technique: Stop, Take a breath, Observe, Proceed.<sup>6</sup>

Listening to music has also been researched and found to help distress and build resilience. Mahler’s Fifth Movement of Symphony No. 2, ‘Resurrection’, has been shown to inspire, reduce stress, and rekindle a sense of hope.<sup>7</sup> This specific piece of music has been used due to its specific rhythm, as well as the dynamic fluctuations transitioning from darkness (tiredness and frustration) to dawn (warmth and hope). Interpersonal psychotherapy can enhance communication and relationships, reduce feelings of isolation, and improve coping mechanisms.<sup>8</sup> Lifestyle resilience, such as sleep, exercise, having hobbies and social support, and coaching all reinforce well-being.

## Conclusion

Moral distress is not a sign of weakness but a natural response to working in environments where your core values clash with your reality. Left unchecked, it erodes the very heart of healthcare – the healthcare workers. But resilience, when cultivated at every level (individual, leadership and organisational), can transform distress into growth.

Resilience is not about ‘toughing it out.’ It is about creating a workspace that enables healthcare workers to thrive, even in the face of adversity. By acknowledging moral distress, addressing systemic barriers, and equipping clinicians with tools for coping, we can, together, move from despair to hope.

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