deserved. Recipients who attribute the mistreatment to a non-
internal cause (ie, an ineffective teacher or suboptimal learn-
ing environment) may feel guilt or humiliation but do not
necessarily experience shame.2 Thus, the emotional outcome
of the mistreatment must be analyzed to determine if particu-
lar treatment is “shaming.”

The ability to receive mistreatment and not experience
shame may actually constitute a form of emotional resilience.
In the study by McMains et al,1 residents’ responses to the
mistreatment suggest the presence of constructive responses
to mistreatment. Over half of residents reported self-improve-
ment and reaching out to others in response to the mistreat-
ment, both of which are associated with constructive,
prosocial guilt responses.3 Conversely, respondents also
reported keeping the event a secret, reaching out to colleagues
less frequently, feeling professionally isolated, and experi-
encing depression, each of which implies a damaging shame
response.

Thus, the data that McMains et al collected suggest the pres-
ence of both damaging shame responses and constructive guilt
responses in the face of mistreatment. As such, it is both bleak
and encouraging. It is bleak because of the high rate of reported
mistreatment, which is consistent with rates previously
reported,4,5 and its tendency to cause shame. However, the emo-
tional resilience woven into the results is encouraging.

Research is needed to further characterize how learners
experience shame, what influences its occurrence, and the out-
comes with which it is associated. This should be accompa-
nied by equally important research into what constitutes and
influences emotional resilience in the face of learner mistreat-
ment. Eradicating mistreatment in medical education will take
time, but characterizing the underlying emotions and promot-
ing resilient responses can and should begin immediately.

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We sincerely appreciate the interest of Drs Bynum and Durning and their thoughtful consideration. They highlight several important aspects of this topic. First, the emotional response experienced by the learner does depend to a degree on his or her own emotional makeup. Tangey and Dearing provide a book-length treatment of features of “guilt-prone” and “shame-prone” personalities.1 Generally speaking “guilt-
proneness” tends toward more adaptive and resilient responses than does “shame-proneness.” The second impor-
tant aspect is that emotional resilience can be cultivated. The importance of this has been recognized by the US Army, which has initiated the Comprehensive Soldier Fitness pro-
gram in an effort to maximize resilience among soldiers.2 These techniques can and should be adopted throughout medical and surgical training to maximize learner experience during residency training.

The work of this research group has aimed to extend the conversation about educational best practices, looking criti-
cally at how we, as a community of educators, do business.3,4 We serve in a leadership capacity with respect to our trainees.
It is clear that there are many behaviors associated with suc-
cessful leadership.5 Increasing exposure to and training in effective leadership behaviors represent an opportunity to improve learning environments and unlock potential among
our trainees.

For the benefit of our trainees and the strength of our pro-
fession, it is incumbent upon each of us to build resilience in
our trainees and model professionalism in teaching both for
ourselves and for our colleagues.

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