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# Resilient Health Systems: The Imperative Need for a Paradigm Shift Especially for Pediatric Care

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## Commentary

People and systems actions are founded in paradigms that often are naturalized and become invisible and unquestioned by the actors themselves. The biomedical paradigm has prevailed in the training, ways of thinking, and strategies of health professionals for decades [1]. This paradigm focuses on disease detection, the search for accurate diagnoses and ideally, treatment of those diagnoses. This reality has allowed the health sciences to have accelerated progress, leading to understanding of the diseases affecting people and extending the life expectancy of the population. From the biomedical paradigm health professionals have become trained to think from a diagnostic hypotheses, and are comfortable acting from the certainty offered by this paradigm, which is based on the scientific method of hypothesis testing.

The advances granted by biomedicine have put us today in a different scenario, many of the diseases have already disaggregated in symptoms and there are concrete solutions to many of the health problems affecting the population. New challenges arise in front of new health problems, such as ebola or zika, and standard procedure begins to be quite similar: to understand symptoms, to evaluate risk of exposure and, ideally, to find the appropriate treatment. New studies continue to come from the biomedical paradigm, occupying logical tools that have already proven to be effective in other health crises. What happens when the health crisis cannot be overcome using the biomedical paradigm logic? What happens when the tools that I know from my own health background are not enough?

From the social sciences tradition, resilience is understood as the ability to overcome crises or unexpected events in an effective way. In a crisis, the usual tools that we use to deal with our problems are not enough, and new ways to deal with the new situation must emerge. This process requires tolerance of uncertainty and of not knowing the solution or strategy, sometimes for a prolonged period of time, so that answers could potentially emerge from a novel approach. Traditional health professional training does not tolerate such uncertainty. The usual biomedical paradigm requires the greatest certainty possible in their diagnoses and interventions. Therefore, it raises new questions: How to be resilient in a paradigm that focuses on the search for certainty? What are the necessary capabilities to be resilient?

Resilience, understood as the ability to overcome adversity and continue creating strategies to face difficulties, requires at least some characteristics related to flexibility, introspection, self-assessment, and proper use of network [2]. A resilient health system must be formed by health professionals who are able to be resilient, forming a team that is capable of: [1] adapting its strategies in a flexible way, moving out from the health system logic, going to the community, adapting to the available resources; [2] looking at themselves and recognizing their strengths and weaknesses; [3] self-assessesing their own management in front of a situation; and [4] using available social networks in the creation and implementation of new plans, considering also the users of health services.

How does this apply in the reality of health systems? Recently I had the opportunity to see a small crisis in a pediatric hospital setting. My daughter was hospitalized in a cardiac critical unit for child care. One day a child had a cardiac arrest, and all parents had to leave the unit to the waiting room so that the medical team could perform resuscitation maneuvers. All of us were in crisis in that waiting room. The mother of the child who had suffered the cardiac arrest-Sofia-was overflowing with tears. A couple of nurses came out to "try to calm" the group, but none of their technical explanations made sense and I was not even able to hear them. I was overwhelmed by Sofia crying, and terrified that something could happen to my own daughter. The level of anxiety in those few square meters seemed to only increase. At one point, someone hugged Sofia, then other parents did the same thing, and at some point we were all hugging. We started to calm ourselves, praying, and hoping together, and the crisis passed. These "small crises" happen every day in a hospital setting. How can health workers be part of these "solutions" that impact on the well-being

of families? How do we get out of the technical language and have a more human understanding of health situations?

The biomedical paradigm shift has to deal not just with the logic of thought, but also with the prioritization system, moving away from the focus on disease and risk, and towards well-being. Usually professionals with public health training have a broad approach to analyzing health crisis, however clinical staff of the formal health systems are often trapped by biomedical actions. There are frames of reference that could support a paradigmatic change: the social determinants of health [3], the social vulnerability model [4], or cultural competency in health [5]. These frames of reference are not unknown-theoretically at least-by health professionals. The issue is how to put them into practice in the daily execution of clinical tasks, and to take advantage of their potential in solving problems.

How to change a paradigm? How to change a historical health culture? From my point of view, the greatest crisis faced by health systems is the need for a re-invention. A good way to deal with this crisis is to learn to tolerate the uncertainty of not having the answers to all of the questions and together find resilient strategies to deal with them. In order to really improve health strategies in a cultural pertinent way, these efforts must be carried out involving those who are living the health problems: the users, the families, and the community.

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