



Clinician Burnout and Resiliency Fast Facts and Concepts

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**FAST FACTS AND CONCEPTS: CONTINUING MEDICAL EDUCATION MODULE
CLINICIAN BURNOUT AND RESILIENCY
COURSE DESCRIPTION AND LEARNING OBJECTIVES**

Course Description: Clinician burnout has been defined as a state of exhaustion caused by excessive and prolonged work-related stress. Many clinical disciplines report high rates of clinician burnout. Clinicians who are frequently exposed to distressing emotional situations and patients and families who are withstanding profound suffering are at heightened risk of burnout. Clinician burnout can have deleterious consequences for the health-care system and ultimately lead to compromised patient care. Individual and system-wide strategies are needed to sustain the delivery of responsive, compassionate, and effective care for patients with serious illnesses. This module assimilates the published medical evidence regarding clinician burnout and offers evidence-based strategies to foster clinician resiliency.

- A. Content review of 10 *Fast Facts and Concepts* covering the following topics:
 - a. Health Professional Burnout
 - b. Health Professional Boundaries in Palliative Care and Hospice
 - c. Disclosing Medical Error
 - d. Responding to a Colleague's Medicine Error
 - e. Managing Clinician Emotions
 - f. Consultation Etiquette
 - g. Utilizing Mindfulness to Foster Resiliency in Clinical Practice
- B. Score of 70% or higher on a 10-question quiz covering this content
- C. Completion of a course evaluation.

Learning Objectives: After completion of this course, the learner will be able to:

1. Describe four common features and 5 risk factors for health professional burnout.
2. Develop effective strategies for setting and maintaining effective patient-care boundaries.
3. Describe the essential components of disclosing a medical error to a patient in a manner which fosters transparency and resiliency.

FAST FACTS AND CONCEPTS #167
HEALTH PROFESSIONAL BURNOUT – PART I

Linda Blust MD

Background Compared with other American workers, health care professionals suffer more burnout (1). Amongst US physicians burnout rates range from 30% to 65% across specialties, with the highest rates of burnout incurred by physicians at the front line of care (e.g. emergency medicine and primary care) and those who are frequently exposed to distressing emotional situations and profound suffering (e.g. palliative medicine) (2,3). Lack of attention to health providers' stress responses to the witnessed suffering contributes to the high prevalence of burnout in US health professionals. This has consequences for the provider and his/her interpersonal relationships. This *Fast Fact* will describe burnout and its risk factors, and review essential research regarding health professionals and burnout. *Fast Facts* #168-170 will address symptoms, consequences, avoidance and assessment of burnout.

Definitions: Burnout is a . . .

- “Psychological syndrome in response to chronic interpersonal stressors on the job” (7).
- “State of mental and/or physical exhaustion caused by excessive and prolonged stress” (4).

Common features (adapted from Maslach 1982)

- A predominance of mental or emotional exhaustion, fatigue, and depression.
- The symptoms are more mental and behavioral than physical.
- The symptoms are work-related.
- Burnout manifests in persons with no previous history of psychopathology.
- Decreased effectiveness and work performance result from negative attitudes and behaviors.

Situational Risk Factors

- Physician Worklife Study: 2326 US physicians identified via AMA masterfile responded to a 38-item mailed questionnaire developed and validated for this study. Predictors of stress were:
 - Demands of solo practice, long work hours, time pressure, and complex patients.
 - Lack of control over schedules, pace of work, and interruptions.
 - Lack of support for work/life balance from colleagues and/or spouse.
 - Isolation due to gender or cultural differences.
- Hospital consultants in the UK: 882 gastroenterologists, radiologists, surgeons, and oncologists responded to 12-item General Health Questionnaire and Maslach Burnout Inventory. Sources of stress were:
 - Work overload and its effect on home life.
 - Feeling poorly managed and resourced.
 - Managerial responsibility.
 - Dealing with patients' suffering.

Individual Risk Factors

- At risk earlier in career
- Lack of life-partner
- Attribution of achievement to chance or others rather than one's own abilities
- Passive, defensive approach to stress
- Lack of involvement in daily activities
- Lack of sense of control over events
- Not open to change

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FAST FACTS AND CONCEPTS #168 HEALTH PROFESSIONAL BURNOUT – PART II

Linda Blust MD

Background As described in *Fast Fact* #167, burnout is a “psychological syndrome in response to chronic interpersonal stressors on the job” (Maslach 1982). This *Fast Fact* will explore symptoms of burnout and its personal and professional consequences. *Fast Facts* #169 and 170 will describe avoidance and assessment of burnout.

Symptoms of each sequential stage of burnout

- **Stress Arousal:** anxiety, irritability, hypertension, bruxism, insomnia, palpitations, forgetfulness, and headaches.
- **Energy Conservation:** Work tardiness, procrastination, resentment, morning fatigue, social withdrawal, increased alcohol or caffeine consumption, and apathy.
- **Exhaustion:** Chronic sadness, depression, chronic heartburn, diarrhea, constipation, chronic mental and physical fatigue, the desire to “drop out” of society.

Consequences

- **Personal**
 - Depletion of emotional and physical resources.
 - Negative self-image: feelings of incompetence and lack of achievement.
 - Self-neglect: 35% of Johns Hopkins’ medical graduates had no a regular source of health care.
 - Questioning of previously held spiritual beliefs.
 - Neglect of family and social obligations.
 - Mental Illness: anxiety, depression, substance abuse, suicide.
 - Substance Abuse: MD lifetime risk is 10-14%.
 - MD suicide rates similar to general population for both genders
 - Relative Risk of MD suicide versus other professionals
 - Male MDs: 1.1-3.4
 - Female MDs: 2.5-5.7
 - Female MDs complete suicide as often as male MDs
- **Professional**
 - Longer Work hours: *If I work harder, it will get better.*
 - Withdrawal, absenteeism, and reduced productivity.
 - Depersonalization: attempt to create distance between self and patients/trainees by ignoring the qualities that make them unique individuals.
 - Loss of professional boundaries leading to inappropriate relationships with patients/trainees.
 - Compromised patient care. Burnout has been linked to
 - More medical errors
 - Diminished sense of empathy for patients
 - Impaired decision-making
 - 45% of University of Washington residents who self-report burnout also report providing “suboptimal care.”

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FAST FACTS AND CONCEPTS #169 HEALTH PROFESSIONAL BURNOUT – PART III

Linda Blust MD

Background *Fast Facts* #167 and 168 described burnout, its risk factors, symptoms, and consequences. This *Fast Fact* will address strategies to avoid burnout while sustaining personal and professional health, integrity, and growth. *Fast Fact* #170 will describe assessment tools validated for burnout.

I. Individual Strategies

- Reflection upon work: journaling, discussion with colleagues.
 - Am I burned-out/healthy?
 - Why do I do this/continue to do this?
 - What inspired/moved/surprised me today?
- Attend to health: diet, exercise, rest, regular health care.
- Plan activities that rejuvenate: Play!
- Professional supervision: Regular interaction with a mental health professional with the express purpose of exploring dynamics of the provider/patient relationship.
- Make time for yourself
 - Plan vacations at regular intervals.
 - Allow for “time-out” when stressors increase.

II. Interpersonal Strategies

- Give important relationships priority – strengthen existing relationships with family and friends.
- Expand your community beyond existing relationships through activism or spiritual engagement.

III. Professional Strategies

- Debrief emotional events:
 - Reach out to colleagues.
 - Seek out or strengthen a mentor relationship.
 - Write about your work for a larger audience.
 - Utilize your institution’s *Critical Incident Response Team* if available.
 - Psychosocial rounds with colleagues to explore these issues.
 - *Schwartz Center Rounds*: interdisciplinary hospital rounds to explore emotions surrounding provider/patient interactions.
- Advocate for change in your job, organization, or profession.

Triggers for Professional Counseling

- Persistent feelings of sadness, exhaustion, anger, worthlessness, hopelessness, suicidal ideation, or anxiety interfering with work or interpersonal relationships.
- Self-prescribing sedative/hypnotic medication.
- Substance abuse: alcohol, prescription, or non-prescription drugs.
- Other ‘addictions’ interfering with work/relationships: gambling, exercise.
- Persistent sleep disturbance: nightmares, difficulty initiating or staying asleep, early morning awakening.
- Loss of professional boundaries:
 - Inappropriate relationships with patients, families, or trainees.
 - Lack of attention to patients’ rights, safety, or autonomy.

If, after careful attention to the variables within your control, you still feel burned-out and at risk for serious consequences, it may be necessary to temporarily or permanently leave your current job to regain your health.

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FAST FACTS AND CONCEPTS #170
HEALTH PROFESSIONAL BURNOUT – PART IV

Linda Blust MD

Background *Fast Facts* #167-169 described burnout, its risk factors and consequences, and coping strategies. This *Fast Fact* will briefly describe assessment tools used in health professional research. Additionally, it provides a validated screening tool utilized widely in education.

1. **Maslach Burnout Inventory** (CPP, Inc.)

- a. Designed for use in health care and other service industries.
- b. Evaluates emotional exhaustion, depersonalization, and reduced personal accomplishment.
- c. Well-validated; readily available; utilized by Physician Worklife Study.
- d. 10-15 minutes to complete.
- e. Cost: approximately \$1.25 per test, with additional fee for scoring key.

2. **General Health Questionnaire** (Bank 1980)

- a. 12-item screen for symptoms of psychiatric morbidity
- b. Reliable in community and occupational settings
- c. Utilized in conjunction with Maslach Burnout Inventory in ongoing, longitudinal UK study of burnout and psychiatric morbidity in hospital consultants

3. **Self Assessment Exercise** (Girdin 1996)

How often do you . . .

a) almost always; b) often; c) seldom; d) almost never

1. Find yourself with insufficient time to do things you really enjoy?
2. Wish you had more support/assistance?
3. Lacksufficient time to complete your work most effectively?
4. Have difficulty falling asleep because you have too much on your mind?
5. Feel people simply expect too much of you?
6. Feel overwhelmed?
7. Find yourself becoming forgetful or indecisive because you have too much on your mind?
8. Consider yourself in a high pressure situation?
9. Feel you have too much responsibility for one person?
10. Feel exhausted at the end of the day?

Calculate your total score: a) = 4, b) = 3, c) = 2, d) = 1. Your total? _____

A total of 25-40 indicates a high stress level that could be psychologically or physically debilitating.

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FAST FACTS AND CONCEPTS #172
PROFESSIONAL-PATIENT BOUNDARIES IN PALLIATIVE CARE

Lise Taylor Barbour MD

Background Boundaries in patient care are “mutually understood, unspoken, physical and emotional limits of the relationship between the trusting patient and the caring physician or provider” (Farber 1997). Health professional boundaries represent a set of culturally and professionally derived rules for how health professionals and their patients interact. Boundaries serve to establish and maintain a trusting provider-patient relationship and help clinicians maintain “justice and equity in dealing with all of their patients”, not only a special few (Spence 2005). This *Fast Fact* reviews issues in health professional-patient boundaries in palliative care.

Causes of Boundary Problems In caring for seriously ill or dying patients it is common for strong emotional bonds to develop. However, when the limits of the provider-patient/family relationship are not clear or where normal professional boundaries are not respected, problems are likely to arise. Common reasons for boundary problems include:

- Personality styles or psychiatric disorders in which normal boundaries are not recognized or respected.
- Health professional stress/burnout (see *Fast Facts* #167-170).
- Cultural misunderstandings.

Examples Warning signs and examples of potential boundary blurring include:

- Gift giving from/to patient/family.
- Patients having or wanting access to provider’s home phone number, or other personal information.
- Patient/family expectations that the provider will provide care or socialize outside of clinical care settings.
- Patient/family requests that the provider participate in prayer (See *Fast Facts* #120).
- The health care provider revealing excessive personal information with patient/family.

Self-Monitoring Not all ‘boundary issues’ are detrimental to the provider-patient relationship – some clearly enhance compassionate care and serve to reinforce a trusting therapeutic relationship. However, it is important for the provider to self-reflect when boundaries are approached.

- *Am I treating this patient or family differently than I do my other patients?*
- *What emotions of my own does this patient/family trigger and are the emotions impacting my clinical decision-making?*
- *Are my actions truly therapeutic for the patient, or am I acting in a manner to meet my personal needs?*
- *Would I be comfortable if this gift/action was known to the public or my colleagues?*
- *Could this boundary issue represent a sign that I am experiencing professional burnout?*

Managing boundary concerns

- Set clear expectations with patients and families as to your role in the context of their care, your availability and best ways to communicate with you.
- Use professional colleagues or a mental health professional as a sounding board when you are uncertain about your own or your patient/family behaviors.
- Address issues as they arise with the patient/family. Acknowledge importance of feelings, emphasize the provider-patient relationship and the importance of maintaining objectivity; emphasize that the rejection of a requested behavior does not imply a lack of caring.
- Seek professional counseling for yourself or the patient/family when boundary issues impact your ability to provide objective, compassionate care.

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FAST FACTS AND CONCEPTS #194 DISCLOSING MEDICAL ERROR

Ciarán Bradley MD and Karen Brasel MD, MPH

Background Discussing an adverse outcome related to medical error is challenging under the best of circumstances—for both the clinician and the patient or family. Errors can damage a clinician's self-esteem, confidence, and reputation, and lead to costly and unpleasant legal action. Timely disclosure of error is now considered a standard of quality patient care. An empathic, open discussion can help restore trust while respecting a patient's autonomy and right to justice. Hospice and Palliative Care clinicians may themselves be the source of medical error, or be asked to comment on other clinician's actions by patients or families concerned that medical errors have led to a dying trajectory. This *Fast Fact* will address how to disclose error with a patient/family; *Fast Fact* #195 will discuss responding to a colleague's error.

Types of Error No single definition of error exists. For practical purposes error can be thought of being due to a) an isolated or series of clinician mistakes (providing care below a reasonable professional standard such as by failing to prescribe an indicated medication or injuring the common bile duct during routine cholecystectomy), b) a system failure (inadequate checks on pharmacy medication dispensing), or c) both. Unanticipated outcomes of medical care also occur and can be perceived as errors by patients/families even if not the consequence of a 'mistake.'

Discussing Error – Preparation

- Whoever committed the error (attending physician, advance practice nurse, or resident), the attending physician has final responsibility for the patient's care and should lead the discussion. Invite trainees to attend – this is an important learning opportunity. Limit the discussion to just those healthcare professionals directly involved.
- Have the discussion in a timely manner – as soon as possible after the error is identified – but make sure the appropriate people are there (including an incapacitated patient's legal decision maker). Set aside ample time and have the meeting in a distraction-free environment.
- Review the pertinent facts of the case so that you are prepared to answer any detailed questions that the patient/family might have.
- Discourage other consultants/ancillary staff from discussing the error with the patient/family – multiple accounts of the events will likely confuse rather than clarify.
- Notify and seek the advice of your institution's risk manager. In addition to informing you of policies and procedures specific to your institution, they will then be aware of the case should legal inquiries be made. **Note:** while it is wise to seek risk management input, remember that discussing errors with patients/families is a *clinical* task – part of clinicians' obligation to openly share medical information – not a *legal* task.

Discussing Error – Content (see *Fast Facts* #6, 11 for general breaking bad news principles)

- Be clear, concise, and honest. Avoid medical jargon or lengthy explanations.
- Give the patient and family time for questions, emotional reactions, or silence.
- If you believe the adverse outcome was a result of error (either individual or system-wide), specifically apologize for the error and its outcome.
- If the outcome was unanticipated, but not clearly avoidable express regret and sorrow. Avoid blame: "*I am sorry this has happened*" is not an admission of error or liability.
- Commit yourself and your institution to investigating and remedying any individual or systematic deficiencies.
- Commit to providing ongoing, appropriate care, including comfort-oriented care for a dying patient. Involve the appropriate services as indicated such as chaplaincy, social work, and consultants including palliative care.
- Document your discussion; refer legal inquiries to your institution's risk manager.

Discussing error requires professionalism and openness, sometimes at the expense of vulnerability. In addition to being an ethical imperative, it is a requisite skill and a key to maintaining a healthy clinician-patient relationship.

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FAST FACTS AND CONCEPTS #195 RESPONDING TO A COLLEAGUE'S ERROR

Ciarán Bradley MD and Karen Brasel MD, MPH

Background When a physician makes an error that causes a patient harm, other physicians may be asked to explain the error or manage its consequences. Palliative care consultants may be involved to help provide terminal care and family support, or may be asked by families if a patient is dying as a result of error. We also have a professional duty to respond to a colleague's error if we are concerned about them personally or about patient safety. *Fast Fact #194* addressed disclosing an error to a patient or family. This *Fast Fact* will discuss responding to a colleague's error.

Case: You are the accepting trauma surgeon at a major referral center. A community surgeon who is a friend from residency transfers to you a 45-year-old man involved in a motorcycle crash for further care of a closed head injury. The patient is found to have an unrecognized lower extremity fracture and an associated vascular injury that, in your opinion, should have been recognized and treated. The resultant compartment syndrome evolves into a severe soft tissue infection, and despite amputation and serial debridements, the patient remains in septic shock with a grave prognosis. The patient's family asks you if the outcome could have been avoided.

Responding to error as a consultant

- Reassure the family that they will have an honest and prompt explanation. Contact the referring doctor to learn all the details.
- If the referring physician agrees an error was made he or she should be encouraged to tell the patient/family directly. This may be impractical if the physician is from an outside institution.
- We have a duty to answer the patient's/family's questions honestly and to the best of our ability given the information at hand. Describe the facts as you know them, but without drawing conclusions or making value judgments about specific events in which you played no part. If asked, general statements about what constitutes usual standard of care are appropriate.
- Being purposefully vague or evasive during your explanation to the patient/family in order to spare the colleague is unethical. Affirm the patient's/family's right to open disclosure and refer them to the appropriate resources such as the hospital's patient advocate.

Responding to error as a colleague, mentor, and confidant

- Approach the colleague in a non-confrontational manner away from a public forum. *"I have concerns about Mr. X's care. Can you help me understand what happened?"*
- Offer emotional support. Your colleague may feel tremendous guilt and self-doubt, and the shame from harming a patient may prevent your colleague from seeking help. Reassure them that excellent physicians can make serious errors, can have psychiatric or family problems, and can need remediation in their professional skills from time to time.
- Was this event a sign of a colleague experiencing "burn-out" (see *Fast Facts #167-170*)? Help him or her identify and address professional or personal factors that are may be contributing (such as overwhelming practice load, relationship and family issues, depression, or substance abuse), as well as needed resources to address any problems.
- If appropriate, suggest the correct course of action in the future. This may be all the colleague needs to change practice. Offer to help with remediation: literature, courses, scrubbing together for the next few surgical cases.
- If there is any concern about the ongoing quality of medical care given by a colleague, most institutions have a peer review committee that can be contacted. In the case of substance abuse, most states and professional societies mandate the reporting of impaired physicians in a timely fashion in order to protect patients (see reference 5 below). Speaking with your institution's risk manager may give you a better sense of what are your specific options as well as your specific state regulations.

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FAST FACTS AND CONCEPTS #203
MANAGING ONE'S EMOTIONS AS A CLINICIAN

Donna Posluszny PhD and Robert Arnold MD

Background It is normal for clinicians to experience an array of emotions when interacting with ill patients and their families. Although positive emotions such as joy and satisfaction are rarely problematic, negative emotions such as anger or sadness may interfere with your ability to communicate empathically or even to provide appropriate medical care. This *Fast Fact* focuses on clinicians' emotional responses to patient care. See *Fast Facts* #59, 167-170, and 172 for more on responding to anger, clinician burnout, and professional boundaries.

Sources of Emotion Some of the emotions we experience are direct reactions to what the patient is saying or doing (e.g. an angry patient may trigger our own anger). Difficult emotions may also arise when patients do not act in ways that we like (e.g. feeling frustrated when a patient is not taking medication as prescribed). We may feel sad, helpless, or even guilty when we cannot prevent a patient from further illness or death. We may also experience emotions triggered by our own past experiences, such as a patient who reminds us of a family member (e.g. grief, longing).

Strategies for managing difficult emotions *Dealing with one's emotions is a learned skill. Like all skills it takes time and practice. Be patient and keep practicing – look at each experience as a learning opportunity.*

- Prior to an interaction you anticipate will be difficult specifically identify what is causing your emotional response. Was it the patient's health behavior, their behavior towards you, their intense emotions, or your own sadness about their condition? If your emotional response is based on your past, acknowledge this and put it aside during the upcoming interaction.
- Practice the interaction ahead of time. Imagine the most likely ways that the patient will react and how you will respond.
 - Clarify your goals. It is unrealistic to expect that you can prevent or control patients from experiencing difficult emotions, especially anger and grief. Acknowledge this and focus on realistic goals: being empathic, listening, disclosing medical information, talking patients through options, and validating their emotions.
 - Don't go it alone. Bring along a colleague or team member who can help if you have trouble controlling your emotions and can give you feedback on what might work better next time.
- During the interaction recognize when your emotions are impacting your thinking/communicating:
 - Increased heart rate; feeling flushed, sweating; shallow, rapid breathing; increased muscle tension; speaking rapidly or loudly; repeating yourself; or realizing you are not listening.
- If you are experiencing intense negative emotions:
 - Give yourself and the patient time to allow emotional intensity to subside. Listen, rather than speak; allow silence.
 - Validate the patient's experience by naming their emotions ('You seem frustrated'). If you are not sure, pose it as a question ('Are you feeling frustrated?'). Besides being empathic, simply naming what is happening may attenuate your own emotional response.
 - Naming your own emotions is appropriate as long as it does not divert attention from the patient's needs or put blame on the patient. For example you might say, "I am feeling frustrated that there is not more we can do to help you."
- If you are feeling overwhelmed, it is appropriate to say, "Please excuse me for one moment" and then step outside the room; resume your interaction once composed.
 - Most patients appreciate certain displays of clinician emotion (e.g. tears), if they occur at appropriate times and are consonant with the tenor of the interaction.
 - However, losing control of one's emotions, including grief (sobbing), is never appropriate in front of patients and clinicians should excuse themselves prior to doing so.
- Afterwards, debrief with a trusted colleague or team member about what happened, how you responded, and how you might do it differently next time. A less emotionally involved person can often see things in the interaction that you cannot. Students and residents might ask faculty to come with them the next time they interact with the patient. Repeated episodes of emotional instability may be a sign of burnout and/or need for mental health counseling.

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FAST FACTS AND CONCEPTS #266
CONSULTATION ETIQUETTE IN PALLIATIVE CARE

Charles F von Gunten MD, PhD and David E Weissman MD

Background There are generally agreed upon rules for consultation (just as there are in social life) that can have profound consequences if they are breached. For those just starting to provide consultation services, it is wise to follow the rules until you develop enough familiarity to know when they can be breached. This *Fast Fact* reviews the rules of consultation etiquette for palliative care (PC) clinicians. See *Fast Fact #298* for more specific guidance on PC consultation in the Emergency Department.

1) Remember your stakeholders. Although the focus of the consultation is a patient/family issue, your primary stakeholder is the attending physician that requested the consultation. Unhappy referring physicians mean fewer palliative care consultations!

2) Make contact/clarify request. Before you see the patient, contact the referring service to acknowledge that you received the request and to clarify the nature of the request. Determine what questions the managing service wants answered. The phrasing of this is important. '*Please tell me a little about Patient X so we can be most helpful to you*' is an excellent open-ended query. Determine if there are areas that are "off-limits" and find out who the consulting team should talk with following your assessment – the referring clinicians or someone else on the care team. Remember, no matter what is written in the chart, the real story exceeds what is written, and the referring clinicians often have concerns/needs that are not evident from the chart. Particularly for palliative care consultations, this has an important secondary importance; in telling you about the patient, the service will receive emotional support in the telling the story. Be quiet and actively listen; acknowledge the underlying distress.

Cultural corollary: in *some* institutions the rank of the person calling should match or exceed the rank of the person called. Strictly applied, for instance, an attending speaks to an attending. This is not true of all institutions or physicians, but it is wise to know your local culture. When in doubt, or conflict occurs, following the cultural corollary of your institution connotes respect.

3) Negotiate roles. Many referring clinicians will want the palliative care service to play an ongoing role in the management of the patient and family. This may range from providing information and counseling, to actively managing symptoms including writing medication orders, to assuming principal care for the patient and family. Others will want the palliative care service to maintain a strictly consulting role while the primary service implements recommendations.

4) See the patient & gather your own data. This includes reviewing the medical record, pertinent laboratory and diagnostic tests, interviewing the patient and family, examining the patient, and offering information and counseling if that was part of the nature of the request.

5) Call the referring service. Before you write in the chart, call the referring service with details of your findings and recommendations. With experience and familiarity with frequent referrers, this step may not be necessary. If appropriate, contact other consultants and clinicians involved with the patient (housestaff, nurses, discharge planners, etc.).

Additional Tips

- **Brevity** (in general, try to limit your recommendations to ≤ 5) and **specificity** (e.g., exact morphine dose/route/schedule) are important to both communicate your key messages and increase the likelihood that your recommendations will be acted upon.
- **Plan ahead** – you are often in the best position to recognize likely future needs beyond the hospitalization; plan ahead to meet expected symptom control and other patient/family needs. Helping to expedite and simplify patient discharge is an easy and high-yield way of demonstrating your service's value to referring clinicians.
- **Honor turf** – you may be one of many consultants; when in doubt about the expectations and plans of the referring clinician, clarify by personal contact.

- **Be accessible** – a referring physician or service needs to know how to reach you easily. He or she will be put off if they can't reach your service. Indicate how you can be reached in your consult note.
- **Be responsive** – acknowledge receipt of the request as immediately as possible and plan to see the patient the same day or within 24 hours. If unable to do this, contact the referring clinician directly to discuss.

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FAST FACTS AND CONCEPTS #316
MINDFULNESS SELF-CARE STRATEGIES FOR CLINICIANS
Nicholas Kerr D.O.

Background: Burnout is an alarming problem affecting clinicians throughout many fields, including hospice and palliative care (1). Research suggests that comprehensive mindfulness training may correlate with improvements in emotional exhaustion, depersonalization, and a sense of accomplishment (2). This *Fast Fact* focuses on mindfulness exercises as a self-care strategy. See *Fast Facts #167-170* for more information on the risks, consequences, and definition of clinician burnout.

Mindfulness Definition: "*Paying attention on purpose, in the present moment, and nonjudgmentally, to the unfolding of experience moment to moment*" (3). Put another way, mindfulness is a focused state of awareness of one's present and changing emotions, thoughts, and physical sensations.

Supportive Evidence: Fostering mindfulness may benefit patients, trainees, physicians and nurses.

- An uncontrolled, observation study suggested that clinicians with higher self-reported mindfulness participated in more patient-centered communication and had better patient satisfaction scores (4).
- In a matched randomized trial, medical students who underwent mindfulness training had improved empathy and spirituality scores as well a reduction in self reported psychological distress (5).
- Significant improvements in emotional exhaustion, self-compassion, and a sense of personal accomplishment were reported in experimental pilot studies on Mindfulness-Based Stress Reduction education in nurses and health care professionals (6,7).

Learning Mindfulness: The best studied mindfulness educational programs have robust outcomes data to support their effectiveness, but they are time intensive and likely impractical to replicate in most institutions. For example, an uncontrolled, before and after study involving mindfulness training for primary care physicians showed significant and long-lasting improvements in emotional exhaustion, depersonalization, empathy, emotional stability, and self-reported mood (2). However, the training was more than a year long and required several follow up sessions thereafter (2). Fortunately, clinicians can be taught to employ simple mindfulness exercises effectively. There are websites and mobile applications which can be accessed anytime at home or work that help to teach and promote mindfulness (8-11). Additionally, many mindfulness stress reduction programs are available and provided through local mental health services, universities, and employer health benefit programs.

Examples of Mindfulness Exercises (2,12):

- **Body Scan:** led- or self-guided meditation focused on recognizing bodily sensations and the natural reactions without trying to alter the perceptions, but rather employing unbiased concentration.
- **Loving-Kindness Meditation:** focused attention on warm, loving feelings for close loved ones followed by redirection of those feelings towards the self and larger circles of others.
- **Walking Meditation:** relaxed, leisurely gait with direct focus on the experience and feelings associated with the movement.
- **Mindful Movement:** disciplined, relaxing movement coupled with attention centered on the physical experience and emotional response to the actions rather than focus on the activity itself.

Practical Real-Time Mindfulness Approaches:

- Concentrating on the present moment by setting aside electronic devices and avoiding the distractions of multitasking.
- In the thick of a difficult situation, complete a brief breathing exercise by taking four to five long deep breaths focusing on the relaxing effects of purposeful deep breathing.
- Take the few moments during hand washing to focus attention on the sensations of the water's temperature and scent of the soap.
- In a relaxed and comfortable position such as a desk chair in a quiet clinician workroom, mentally visualize close loved ones and the emotions associated with them. Then, perceptually transition those feelings to other family, friends, and colleagues.

- While relaxed in a chair, respite room, or in the hospital chapel, sequentially concentrate on the position and sensations of the body starting with the feet and gradually transition focus superiorly.

Summary: Stress and burnout are significant concerns within the healthcare community. While the most evidence-based mindfulness educational programs are comprehensive and time intensive, mindfulness activities made simple to learn and easy to access may mitigate the effects of burnout.

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