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Contemporary issues

Fostering compassion and reducing burnout: How can health system leaders respond in the Covid-19 pandemic and beyond?

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1. Introduction

In the book "The Help" (Stockett, 2009), an African-American nanny living in Jackson, Mississippi whispers to the small child sitting on her knee: "You is kind, You is smart, You is important". In this unprecedented time of the rapid spread of SARS-CoV-2, the virus that causes Covid-19, all nurses need to repeat that phrase to themselves and to others often.

Kindness and compassion not only benefit "those who receive it but also to those who offer it" and is the motivation why many are drawn to healthcare practice (Lown et al., 2019, p. 400). When empathic communication and compassion exists, clinical teams are more effective, morale is higher, patient safety and satisfaction is higher, and fulfilling the organizational mission is more likely (Lown et al., 2019). As Rosen (2015, p. 1) explains:

'Compassion is the foundation of good medical care. It recognises the concerns, distress and suffering of patients and families and taking action to relieve them. It is based on listening, respect, empathy, communication, interpersonal skills, and knowledge and understanding of the patient's life and preferences. At its core, it means treating patients as people, not just illnesses'.

The unprecedented Covid-19 pandemic continues to have a profound impact on nursing and healthcare services. There are media reports of hundreds of patients dying in quarantine without their family present. The need for compassionate nurses and healthcare workers is critical.

Globally, large numbers of retired healthcare workers have returned to workplaces that notably were overburdened and lacking resources prior to Covid-19. Their altruism and willingness to leave the safety of their homes to care for sick and frightened patients should be met with gratitude and assurances about safe work conditions. Governments are responsible for health policy and funding so must work with health system leaders to urgently address shortages of personal protective equipment (PPE) and structural work conditions known to cause burnout (WHO, 2019). Burnout has a destructive effect on clinicians' wellbeing and capacity to provide compassionate and quality healthcare (Lown et al., 2019).

To spark debate about these 'contemporary issues', we present a series of three papers for different audiences (i.e., nurse educators; front-line nurses; health system leaders and managers) to explain the relevance of empathic healthcare cultures and constructs such as empathy, emotion regulation, compassion, and self-care to sustain wellbeing, resilience and effectiveness in these volatile times. In this third paper in the series, we explain how health system leaders can implement relevant organizational interventions to reduce caregiver burnout and promote engagement and compassionate practice during the Covid-19 pandemic, and beyond.

First, we discuss burnout and draw links with the 2018 NHS Staff Survey results about bullying, harassment, and unsafe conditions. We then outline policy responses in the 2019 Interim NHS People Plan. Next, we present nine evidence-based strategies developed by Mayo Clinic researchers to identify areas for organizational improvement and strategies to promote engagement and reduce caregiver burnout. Finally, we explain how "The Schwartz Rounds" is an organizational strategy for staff to talk about the psychological and emotional challenges of caregiving.

2. Work-related stress - burnout

In 2018, burn-out was included in the WHO 11th Revision of the International Classification of Diseases and described as: a syndrome resulting from chronic work stress (unsuccessfully managed) and features emotional exhaustion, depersonalization (cynicism, loss of idealism, withdrawal), and feeling ineffective (WHO, 2019). Burnout is now a global workforce crisis driven by frustrations with institutional policies, clerical work (Shanafelt and Noseworthy, 2017), conflict with colleagues, inadequate staffing, unmanageable patient workloads, insufficient time to deliver healthcare, and inadequate wellbeing support (Rosen, 2015).

More than 50% of US physicians are now burned out (Shanafelt and

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Noseworthy, 2017). Despite significant research, the ongoing crisis of a burnt-out workforce continues to have adverse effects on patient safety and satisfaction, clinician productivity, increased absenteeism, turnover, higher rates of treatment errors, and the organizational bottom line (Bauer-Wu and Fontaine, 2015; Francis, 2013; Rosen, 2015). Taken together with escalating reports of bullying, depersonalization (regarding patients as objects), feeling ineffective and low morale, this negative spiral is destructive to clinicians' wellbeing and ability to care for others (Bauer-Wu and Fontaine, 2015). In a Mayo Clinic study of 7905 US surgeons over a 3 month period, the proportion of surgeons who committed a major surgical error was three times higher among those with the highest levels of depersonalization (Shanafelt and Noseworthy, 2017).

Addressing structural deficits is essential to ensure compassionate quality healthcare, patient safety and satisfaction, and retaining engaged caregivers (Shanafelt and Noseworthy, 2017). Moreover, "creating cultures and system improvements that support the workforce and diminish burnout are vital leadership skills" (Lown et al., 2019, p. 398).

2.1. NHS staff survey (2018)

The 2018 NHS Staff survey results indicated 12.8% of nurses experienced workplace discrimination and 28.3% of nurses experienced bullying or harassment from patients or the public in the past year. A further 13.2% of nurses reported managerial bullying and harassment and 19% from colleagues. Regrettably, 33% of nurses said they are unable to deliver the care they aspire to provide and 27.8% said they witnessed an unsafe event within the last month that could have harmed a patient. Of concern, 56.5% of nurses said they had reported for work in the past 3 months despite not feeling well enough to work. The highest number of nurses in the past 5 years reported feeling unwell as a result of work-related stress at some time in the past 12 months (39.8%). Moreover, 27.6% of nurses reported musculoskeletal problems due to work activities in the past year.

Almost 3 in 5 nurses (57.8%) routinely worked additional unpaid hours on a weekly basis to deliver essential patient care. Staff shortages affect nurses' wellbeing and contributes to exhaustion, burnout and low morale. Respondents indicated they want more done to support their health and wellbeing. Fewer nurses (28.7%) felt their organization took positive action to support staff health and wellbeing in 2018 than in 2017. Nearly 30% of nurses said they regularly considered resigning. Less than half of respondents (46.1%) were satisfied with the extent to which their organization valued them and their work (NHS Staff Survey, 2018).

2.2. Interim NHS People Plan (2019)

Since early 2020, health policy decisions and funding has been reprioritised to fight the Covid-19 pandemic. The adaptability of the Interim NHS People Plan (2019) in the UK government's ten-year NHS Long Term Plan will become clearer in the future. But it is likely core goals will remain relevant. The Interim Plan details how the NHS should recruit, retain and develop staff to work differently to meet the increasing demand for services (NHS, 2019, p. 2). The Interim Plan (2019) aims to address the nursing workforce shortage; create healthy, inclusive and compassionate workplace cultures; tackle bullying, harassment and violence in the workplace; prioritize education and training so staff can develop fulfilling careers; support physical and mental wellbeing, and provide flexible working. Developing compassionate leadership is key to meeting the NHS goal of being the best place to work. Leaders need the knowledge, skills and behaviours to create and sustain cultures of compassion and inclusion. Middle managers set the tone for clinical teams. Highly engaged staff typically deliver high quality patient care, so recruiting and retaining the best people is also a key goal (NHS, 2019).

3. Organizational strategies

The level of funding provided by governments impacts on the decisions administrations can make and capacity to build empathic healthcare organizations. Health care is often structured, organized and resourced in ways that diminish the ability of individuals to practice effective self-care. Leaders of successful organizations that support staff know transformation begins with empathic communication, but few leaders have the ability (Sanchez, 2018). Leaders wanting to build empathic organizations must understand the needs of staff and tackle occupational stress, foster engagement and sustain cultures of compassion. In empathic cultures, self-care will be an easier choice for staff.

Health system leaders and managers realise a burnt-out workforce negatively impacts patient and organizational outcomes (Taylor et al., 2018). Health system leaders must provide relevant evidence-based interventions at all levels of the organization (including department and units) to support workers to achieve its mission to provide quality, safe care for patients (Lown et al., 2019). Shanafelt and Noseworthy, 2017 developed nine evidence-based organizational strategies at the Mayo Clinic that health system leaders could use to assess the strengths and challenges in their organizations. These data could inform implementation of relevant strategies to promote engagement and reduce caregiver burnout. Many ideas are inexpensive, but demonstrate significant impact (see Table 1).

3.1. Strategy 1: acknowledge and assess the problem

Staff respond to sincere discussions with health system leaders and managers that reflect a genuine commitment to solve the problem of burnout and foster wellbeing. Organizations typically measure factors that are key to achieving performance targets and the mission. Evidence confirms that staff wellbeing is critical to the organizational mission, so validated instruments to measure wellbeing should be used regularly and results aggregated to the department level (see Shanafelt and Noseworthy, 2017 p. 133 for a list of instruments and research impact).

3.2. Strategy 2: harness the power of effective leadership

The impact of toxic leadership on worker burnout and wellbeing is proven. Effective leaders need to be developed and receive evaluative feedback about their leadership behaviours from those they lead. Effective leaders will develop and support staff to enact a shared organizational vision. Leaders must understand what motivates staff and what provides meaning in their work. Health Boards need to "have the courage" to make leadership changes when required (Shanafelt and Noseworthy, 2017, p. 135–6).

3.3. Strategy 3: develop and implement targeted interventions

External compliance factors can increase pressure on health system leaders, managers and practice leaders. Expectations of increased productivity, excessive documentation, and administrative burden are

Table 1
Organizational strategies.

Strategy	Organizational strategies to promote engagement and reduce burnout
1	Acknowledge and assess the problem
2	Harness the power of effective leadership
3	Develop and implement targeted interventions
4	Cultivate community at work
5	Use rewards and incentives wisely
6	Align values and strengthen culture
7	Promote flexibility and work-life integration
8	Provide resources to promote resilience and self-care
9	Facilitate and fund organizational science

drivers of burnout. These tasks deplete and prevent clinicians from achieving what they went into healthcare to do in the first place: to care for patients and families (Rosen, 2015). Factors requiring improvement must be identified in each department. Targeted interventions can then be developed and implemented to ensure maximum local impact and effectiveness (Shanafelt and Noseworthy, 2017).

3.4. Strategy 4: cultivate community at work

Formal and informal peer support is important to physicians and nurses. But structural changes such as the loss of dedicated spaces to share ideas with colleagues has resulted in a loss of relationships, connections, and eroded peer support and sense of community (Shanafelt and Noseworthy, 2017, p. 138). Health system leaders must ensure fair pay, effective training; and minimise work overload by addressing inadequate staff levels and inappropriate skill mix (Rosen, 2015). Other supports include providing debriefing opportunities with pastoral carers (non-religion affiliated) who understand nursing-related issues; formal and informal mentoring; a quiet area for reflection and refocusing (Drury et al., 2014).

Another strategy to cultivate "community at work" is The Schwartz Rounds that promotes dialogue and caring (discussed later in this article). Compassion is expressed when co-workers comfort each other (Lown et al., 2019). "The Pause" is a strategy practiced in emergency and other clinical settings to honor the caring work for patients who die. It is a minute of stillness when clinicians pause, listen to their breathing, focus, and prepare to care for the next patient with calmness and compassion (Bartels, 2014). This strategy could be a comforting balm for nurses caring for patients dying of Covid-19.

3.5. Strategy 5: use rewards and incentives wisely

Now more than ever during the Covid-19 crisis, leaders should collaborate with staff to identify ways to acknowledge and reward effort (Rosen, 2015). Productivity-based compensation can encourage overwork, over servicing, and increases burnout risk. Greater work-life flexibility (strategy 7) has been considered a valued reward, now flexibility is a necessity. Rewards and incentives convey respect, appreciation, and encourage work to fulfill organizational caring goals (Shanafelt and Noseworthy, 2017).

3.6. Strategy 6: align values and strengthen culture

The triple bottom line model evaluates alignment between "what we say we do" (mission, values); "what we do" (actions and culture); and "what others say we do" (i.e., patients, families, community stakeholders). The question is whether the values and actions are aligned to foster a healthy culture, staff wellbeing, optimal practice environments, and quality care delivery. Shanafelt and Noseworthy (2017) propose collaborative dialogue and deliberate action to address any barriers undermining this goal.

3.7. Strategy 7: promote flexibility and work-life integration

The drivers of burnout can be embedded in rigid and out-of-date policies. It is wise to promote flexible, family friendly work environments that meet the needs of a diverse workforce (Drury et al., 2014). Leaders need to be sincere about understanding what motivates their staff to do their best work and support work-life integration. Leaders need to promote flexibility so staff can adapt their work hours to accommodate personal obligations, provide coverage for vacation, studying, and important life or family events (Shanafelt and Noseworthy, 2017).

3.8. Strategy 8: provide resources to promote resilience and self-care

Leaders can work with staff to co-create essential resources to cope with work-related stress to prevent burnout, promote wellbeing and self-care. Meditation can improve emotion regulation and resilience (Singer and Klimecki, 2014). Staff committed to self-care and work-life integration are better prepared to care for patients and fulfill the organizational mission (Shanafelt and Noseworthy, 2017).

3.9. Strategy 9: facilitate and fund organizational science

Leading healthcare organizations (e.g., Mayo Clinic) have the added responsibility to contribute to oganizational science to generate robust scientific evidence to inform national benchmarks and evidence-based instruments that other organizations can implement to reduce burnout and promote staff wellbeing and engagement (Shanafelt and Noseworthy, 2017).

4. The Schwartz Rounds

Hundreds of healthcare organizations globally are Schwartz Centre members and conduct the Schwartz Rounds® to bring clinical and non-clinical staff (all considered caregivers) together to discuss the psychosocial and emotional impact of caring for patients and families (Lown and Manning, 2010; Robert et al., 2017). In 1994, Ken Schwartz, a Boston health attorney, was diagnosed with terminal lung cancer at age 40. What mattered to him most were acts of kindness from staff, which he said made "the unbearable bearable". Prior to his death in 1995, he left a legacy to establish The Schwartz Centre for Compassionate Healthcare in Boston to strengthen caregiver-patient relationships and educate caregivers and organizations to provide compassion in healthcare. The Schwartz Rounds program was launched in 1996 in response to increased physician burnout and suicide. Caregivers share their experiences and hear others do the same. More than 470 organizations in the U.S., Canada, Australia, New Zealand and over 190 sites in the U.K. and Ireland hold The Rounds (Lown and Manning, 2010).

The Point of Care Foundation led the implementation of The Schwartz Rounds in UK healthcare organizations between 2009 and 2015 (Robert et al., 2017). There was a notable increase in adoption of The Rounds following The Mid Staffordshire NHS Foundation Trust Public Inquiry. Francis (2013) noted The Rounds were a strategy to foster a sense of team and individual wellbeing and improve performance. In response, the UK government provided £600,000 to the Point of Care Foundation in 2013 to fund the implementation of The Rounds across the NHS (Robert et al., 2017).

4.1. Purpose of the Rounds

The Rounds are an education strategy to foster "shared purpose, interdisciplinary communication, teamwork, and support" (Lown and Manning, 2010, p. 1079). The Rounds take place on a monthly basis for an hour, preceded by refreshments. It begins with a brief presentation by a person who reflects upon their emotional experience/impact of caring for patients and families and working with team members (Robert et al., 2017). Then others discuss their experiences of caregiving (not clinical issues). Discussing the psychosocial and emotional experiences of caring with others who may have similar experiences can increase compassion for self, colleagues and patients.

4.2. Evaluation of interventions

Maben led the UK evaluation of The Rounds in 2018. Findings showed participation in The Rounds cut the psychological distress of attendees in half compared with non-attendees, attendees felt less isolated and stressed, and their wellbeing and relationships with colleagues and patients improved (Taylor et al., 2018). Expectations to adopt

may explain the rapid spread in the UK, although evaluation evidence was scant (Robert et al., 2017). Many institutions offered wellbeing interventions, so it was difficult to attribute improvements to any particular intervention.

Taylor et al. (2018, p. 1) reviewed eleven interventions to support staff in the emotional work of caring, namely: "action learning sets; after action reviews; Balint groups; caregiver support program; clinical supervision; critical incident stress debriefing; mindfulness-based stress reduction; peer-supported storytelling; psychosocial intervention training; reflective practice groups; and resilience training". The Rounds were then compared and contrasted with the eleven interventions (see review by Taylor et al., 2018). Quality evidence for the effectiveness of all interventions, including The Rounds was sparse, so attributing improvements in staff outcomes to any intervention is contentious. However, Taylor et al. (2018, p. 12) argued, "given the high rates of work-related stress and mental health issues among healthcare staff, it is not acceptable for employers not to act, despite a weak evidence base for most approaches and interventions." In the current reality of Covid-19, nurses need regular opportunities to talk about the psychosocial and emotional impact of caring for patients with Covid-19. The Rounds is a proven institutional strategy to bring us together to debrief and care for others and ourselves.

5. Conclusion

As the Covid-19 pandemic continues to escalate at the time of writing, nurses struggle to obtain suitable and sufficient supplies of PPE from their employers. The lag in the provision of PPE leaves nurses and other health workers vulnerable, and shows an utter disregard for their health and safety. Moreover, the rise of infections and deaths among these groups further strains health systems and compromises the response. It is the responsibility of Governments worldwide to develop policies and to provide adequate funding for health system leaders so they can meet their statutory obligations to provide essential resources to fight the Covid-19 pandemic and provide healthcare services. On 1 April 2020, RCN general secretary Dame Donna Kinnair demanded action over the "unconscionable" lack of PPE.

That said, we conclude with four tips for health system leaders and managers in these turbulent and grief-stricken times so they remain well and can lead the repair and revitalization of their organizations into a post-Covid-19 world, namely:

1. We are told to put on our own oxygen "mask" before helping others during a flight emergency. What self-care strategies constitute your "mask" so you can live more bravely and stay well in the months ahead so you can be there for others? Do remember: You is kind, You is smart, You is important.
2. Respond to staff grief, sadness and burnout with patience, kindness, empathy and compassion as we try to do the best we can each day.
3. Advise your staff to access public health and professional websites for trusted updates about self-protection and information to maintain wellbeing.
4. Implement relevant organizational interventions to reduce caregiver burnout and promote engagement and compassionate practice during the Covid-19 pandemic, and beyond. ICN chief executive Howard Catton said the fears and anxieties that front-line nurses experience during the pandemic, and the risk of post-traumatic stress disorder in the aftermath, must be met with appropriate support and compassion.

Credit author statement

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