

The Impact of a Program in Mindful Communication on Primary Care Physicians

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Abstract

Purpose

In addition to structural transformations, deeper changes are needed to enhance physicians' sense of meaning and satisfaction with their work and their ability to respond creatively to a dynamically changing practice environment. The purpose of this research was to understand what aspects of a successful continuing education program in mindful communication contributed to physicians' well-being and the care they provide.

Method

In 2008, the authors conducted in-depth, semistructured interviews with primary care physicians who had

recently completed a 52-hour mindful communication program demonstrated to reduce psychological distress and burnout while improving empathy. Interviews with a random sample of 20 of the 46 physicians in the Rochester, New York, area who attended at least four of eight weekly sessions and four of eight monthly sessions were audio-recorded, transcribed, and analyzed qualitatively. The authors identified salient themes from the interviews.

Results

Participants reported three main themes: (1) sharing personal experiences from medical practice with colleagues reduced

professional isolation, (2) mindfulness skills improved the participants' ability to be attentive and listen deeply to patients' concerns, respond to patients more effectively, and develop adaptive reserve, and (3) developing greater self-awareness was positive and transformative, yet participants struggled to give themselves permission to attend to their own personal growth.

Conclusions

Interventions to improve the quality of primary care practice and practitioner well-being should promote a sense of community, specific mindfulness skills, and permission and time devoted to personal growth.

High-quality, cost-effective health care has been linked to the availability of primary care services,¹ yet primary care in the United States is at considerable risk.^{2,3} Job satisfaction for primary care physicians is strongly linked to their relationships with patients,^{4,5} which have been imperiled by increasing time and productivity pressures and administrative burdens. These factors, plus physicians' social isolation and low sense of control over their work environment, contribute to a high prevalence of burnout.⁶⁻⁹ Burnout, in turn, is related to poorer quality of care and poorer relationships with their patients.⁷⁻⁹ These dynamics likely contribute to the declining interest in primary care careers^{10,11} and an

impending shortage of primary care physicians.¹²

In response to these and other issues, a variety of efforts have been initiated to transform primary care. Structural transformations, such as the patient-centered medical home,¹³ may help but are incomplete without deeper changes. These changes should address practitioners' need for meaning and satisfaction in their work and help build adaptive reserve—practitioners' ability to respond creatively to a dynamically changing practice environment.¹⁴⁻¹⁶ Underlying all of these clinician capacities are the ability to be self-aware, curious, resilient, and fully present in an environment that supports healing relationships among clinicians, patients, and families.¹⁷⁻¹⁹

We recently described a continuing medical education program, Mindful Communication,²⁰ designed for primary care physicians, that integrated meditation,²¹ written narratives,²²⁻²⁴ appreciative inquiry,²⁵ didactic content, and discussion about common sources of meaning and stress in clinical practice.

The program significantly improved indicators of patient-centered care (e.g. empathy, psychosocial orientation) while also enhancing physicians' well-being (e.g. decreased burnout, improved mood).²⁰ These changes were mediated by changes in physicians' mindfulness.

This report describes the results of qualitative interviews we conducted with a subsample of participants in the Mindful Communication course. Our goal was to understand in greater depth what aspects of their experience contributed to their improvements in well-being and patient-centered care.

Method

We recruited primary care physicians in the Greater Rochester, New York, area who participated in the Mindful Communication study to participate in in-depth exit interviews. A detailed description of the program and participant demographics has been published previously.²⁰ Briefly, 70 primary care physicians volunteered to participate in a 52-hour continuing education course that consisted of 8 weekly sessions, a

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silent retreat, and 10 monthly sessions. The course included mindfulness meditation, self-awareness exercises, narratives about meaningful clinical experiences, appreciative interviews, didactic material, and discussion. Participants also attended a seven-hour retreat at a local retreat center; they were silent except for a 40-minute final discussion. The day included mindfulness practices such as sitting meditation, body awareness, slow walking and movement exercises, listening to short readings, and a silent meal.

We contacted participants who had attended a minimum of four weekly sessions and four monthly sessions in random order via telephone and e-mail. Participating physicians consented to audio-recorded interviews, which would be deidentified and transcribed.

The interviewers (M.W., C.M.) used a semistructured interview guide (see the Appendix) to solicit participants' experiences. The interviewers began with open-ended questions and, based on responses, followed up on clues and prompted respondents to provide additional details. We accommodated interviewees who preferred phone interviews over in-person interviews. The interviews, conducted in 2008, ranged from 30 to 145 minutes. We provided no incentives for participating.

The interviewers and another member of the research team (H.B.) reviewed transcripts for accuracy. Through an iterative process of listening, discussing, and relistening, the team identified and consensually validated emerging themes²⁶ and appended segments of dialogue supporting the proposed themes. Recruitment stopped when saturation was reached (no new themes were identified). The team systematically reviewed the themes and sorted them into content domains. The team used an analytic matrix to identify patterns and connections amongst the domains. Two of us not involved in the qualitative coding process (R.E., M.K.) audited the analytic matrix, choice of quotes, and thematic analysis.

The University of Rochester's research subjects review board determined that the study met federal and university criteria for exempt status.

Results

Of the 70 Mindful Communication program participants, 46 met the eligibility requirements to participate in the in-depth interviews. We randomly chose and then contacted 22 participants, of whom 20 agreed to be interviewed within six months of completing the program: 15 in person and 5 by telephone. Two declined for lack of time. On reaching saturation after 20 interviews, no further attempts to contact the remaining 24 participants were made.

Analysis of the audio-taped interviews revealed three major themes:

(1) professional isolation from colleagues and a desire to share their experiences, (2) acquiring skills of attentiveness, listening, honesty, and presence, and (3) taking time for professional and personal development.

Professional isolation and the desire to share experiences

For 75% (15) of the physicians, sharing personal experiences from medical practice with colleagues was one of the most meaningful outcomes of the program. When asked about initial hopes and expectations on registering, 20% explicitly stated a hope that the program would help them become better connected with peers. Many others did not anticipate the deep personal significance of sharing important professional experiences. Those interviewed noted that the groups made them more aware of the absence of meaningful peer interactions in their usual practice lives. The importance of peer-to-peer interactions is captured in the following quote.

The most meaningful part was being with other physicians, sharing and discussing some of our experiences, and being able to have the immediate understanding of peers with respect to the struggles that we all have. (Participant #16)

A nonjudgmental atmosphere helped participants feel emotionally safe enough to pause, reflect, and disclose their complex and profound experiences, which, in turn, provided reassurance that they were not alone in their feelings.

We realize that others are feeling similar in many ways, and describing very similar experiences.... That feeling that we're not alone, it validates what we're feeling, what we're experiencing. (Participant #6)

Simply gathering, especially primary physicians who tend to be isolated in their practices.... Gathering them together into a meeting place where they were invited to reflect more deeply....

Just that is tremendous, and that it happened over a year's time, I think, was very significant.... It takes time for those stories to unfold. That seemed to me, a real engine for both developing community and fostering introspection. (Participant #19)

Acquiring skills of attentiveness, listening, honesty, and presence

Stress reduction, learning mindfulness techniques, and preventing burnout were primary motives for enrolling in the program for the 13 physicians who had no prior experience in mindfulness training. The 7 physicians with previous experience in mindfulness training aspired to reinforce skills and improve their ability to bring mindfulness into their professional and personal lives. Of the 20 interviewees, 60% (12) spontaneously reported that learning mindfulness skills improved their capacity to listen more attentively and respond more effectively to others at work and home.

Physicians reported that training to focus more intently on the present moment with a sense of curiosity and openness improved their interactions with patients. For example, one participant suggested that integrating mindfulness skills in the clinical encounter gave her permission to establish clearer personal boundaries, prioritize her energy, and focus on what was most important in the patient encounter.

In general, I think that I am a pretty good listener. I will spend extra time with my patients if they need it, but I felt in some ways that it was kind of sucking me dry. I would be so empathetic, and then I would feel frustrated, like what else can I do?... I would think about patients at home, in the shower, thinking she can't get to her appointment, maybe I should pick her up and drive her.... I would empathize to the point of where I would be so in their shoes. I would start to feel the way that they felt and I mean, you know, take four of those in a row in a day, and I would be just wiped out ... and, they don't really want to hear about me and my processes.... It's not that I don't empathize with them anymore, but [now] I feel OK just to listen and be present with them ... and I think that in some ways that helps them more ... and that is a wonderful thing that you can do

for patients.... I just needed to learn that myself, I guess. (Participant # 18)

Over half of the participants acknowledged having increased self-awareness and better ability to respond nonjudgmentally during personal or professional conversations. They reported that by developing the self-awareness to appraise their own reactions, as practitioners, they became more accepting and responsive to others' needs.

One of the things that comes out of this is that when you establish a practice of thinking more honestly, thinking more clearly, speaking more honestly, that definitely leaks out into your work every day. It certainly opens you up to being more ready with patients, colleagues, and family, to have... a more intimate, more honest interaction with people.... That certainly was the case for me that came out in the rest of my work. It certainly made it much more immediate and easy to do in [my] practice. (Participant #5)

I am much more attuned to listening. I put a mental stopwatch in my head. I [now] have a heightened awareness and sensitivity to people's conversation. I look at my own communication and pay much more attention to that. I pay much more attention in general. (Participant #5)

As far as my patients go; I'm much more curious, instead of resentful. So when I'm running behind and a patient comes in with, you know, some vague sort of complaint, I try to switch my mind.... Ok, try to become more curious about it and forget about the emotions that you are feeling, just be curious, and that has really helped. (Participant #16)

For some, awareness was associated with a greater appreciation for each moment, even in unpleasant and stressful situations.

I found myself in a boring meeting that didn't have much to do with clinical patient care, and found myself looking out the window.... And there was this incredible gust of snow that blew the window off a very steep slope of roof with light behind the roof and birds flying through at the same time. I thought... this is just a beautiful moment in time and I think that perhaps I am trying to—not always successfully—note those moments even if they're infrequent.... I realize even within the course of a specific day of crazy patients and I'm feeling behind and I'm feeling like I can't give any more, that I'm trying to hold on... to those moments in a one-on-one patient interaction that provided that same kind

of meaning. [It] reminds me how lucky I am to be hearing patients' stories and to be the one with whom they're sharing intimate information. (Participant #8)

Participants realized that patients notice when the physician can be present and listening, focusing on understanding and empathy.

A couple of days ago I saw a patient for the second time... he had had a liver transplant.... I was basically just listening to what happened and his wife, she said, I just want to thank you. You're the first person who just listened to me. You know, no one else just sat there and listened. You didn't try to do anything, you just listened. (Participant #11)

Taking time for professional and personal development

The third theme from the interviews was participants' recognition of an unfulfilled need to reflect and care for themselves, and their guilt in taking the time to do so. Of the interviewees, 70% (14) placed a high value on the course having an organized, structured, and well-defined curriculum that designated time and space to pause and reflect—not something they would ordinarily consider permissible. Several of their reported experiences were profoundly transformative.

For that brief period of time, I felt more wholly me... it wasn't about anybody else.... It's just helpful to have time to reflect and I tend to just go, go, go, and I don't take a moment to pause. And when I have tried in the past to deliberately create those times I'm not, I do much better with a group. (Participant #2)

In one of the classes we had to describe a traumatic experience, realizing that this was the first time I talked about it outside of the event that it happened, probably two years later. This was the first time I really expressed anything realizing that this must really mean something, having it all bottled up. That was an enlightening moment. (Participant #1)

Forty percent (8) noted that they were more relaxed and renewed after the daylong silent retreat. For many, it was a turning point in their understanding about themselves.

I sort of laughed at first when I heard it was you're not going to be allowed to talk, but you know, you don't do that you start getting comfortable within yourself and you don't HAVE to talk.... I never really formally meditated before the class....

I left feeling so incredibly relaxed, and that was why I had done it to begin with. (Participant #11)

I think that silence isn't just the absence of noise; it's much more rich than that, and I think that that day pointed that out to me. (Participant #8)

Originally I was doing it for the stress reduction, and then as time went on.... I'm learning how to communicate... with myself as much as anybody else.... I sort of gave myself permission to start thinking. (Participant #11)

Interviewees described an overwhelming need to give to patients, family, and community even while they recognized that they felt used up or empty. This conflict sometimes was associated with guilt about taking time to participate in the program, even while recognizing that it was contributing to their greater effectiveness as physicians. For example, the most common reason for missing sessions was the perceived responsibilities of work and home. They felt that being absent from home in the evening was particularly unfair to their spouses and children. Many struggled to justify spending a weekend day on a silent retreat, even though they often described that day as the most important part of the program.

I felt this guilt about being there and not being at home, and my wife didn't even make me feel guilty. It was just me. (Participant #10)

Discussion

The themes emerging from our interviews highlight some ways by which an educational program based on cultivating intrapersonal and interpersonal mindfulness enhanced primary care physicians' ability to practice patient-centered care, improve their sense of well-being, and decrease burnout. Participants reported that the program promoted self-awareness, presence, and authenticity and promoted greater effectiveness and meaning—at work and at home. It also helped to diminish physicians' sense of isolation by helping them effectively and meaningfully share their experiences with peers in a facilitated, respectful, and supportive environment. Finally, participation in the Mindful Communication program enabled physicians to make time for self-development and to realize how

lack of attention to oneself can erode the capacity to engage more effectively with peers, family, and patients. The structured program allowed participants to experience greater joy and renewed excitement with their clinical practices.

Although participants reported important personal transformations and the power of community, they also noted some important barriers. Programs focused on personal awareness and self-development are only part of the solution. Our health care delivery systems must implement systematic change at the practice level to create an environment that supports mindful practice, encourages transparent and clear communication among clinicians, staff, patients, and families, and reduces professional isolation. In addition, medical education can better support self-awareness programs for trainees while also promoting role models—preceptors and attending physicians—who exemplify mindful practice in action.²⁷

Although self-reported empathy and psychosocial orientation correlate with observed physician practice,²⁸ it is insufficient to rely on participants' reports alone. Future research should look at the impact of mindful communication programs on physicians' actual clinical behaviors and patient outcomes; self-awareness would be expected to help physicians become better listeners and thus develop greater ability to attend to patients' needs. This training may also help physicians more effectively deal with the emotional labor,²⁹ personal distress, and "compassion fatigue" that can accompany deep connections with patients and provide appropriate venues for discussing their own reactions and experiences.

Two limitations of this study were that it was conducted with a small sample and in one geographic community. Yet, the themes of professional isolation, burnout, and difficulty making time for self-care are widely reported.³⁰ Another limitation was that participation was voluntary. In this study we were interested in whether educational programs have the potential to enhance mindfulness, patient-centered care, and well-being among individuals likely to enroll in such programs. Whether the benefits of the program would accrue to practitioners assigned to attend requires further study.

No one format for enhancing presence and self-awareness is for everyone; as with many behavioral interventions, self-selection may be necessary for effectiveness. Future studies should offer a choice of programs that focus on different ways of achieving self-awareness, self-regulation, and self-care. To begin to test generalizability of the program, we have developed and implemented required curricula in mindful practice for medical students and residents at the University of Rochester School of Medicine and Dentistry. We are currently studying the effects of an intensive, four-day residential course for physicians, using similar content and formats to the course described in this article. In addition, we offer and are studying the effects of intensive residential faculty development courses for medical educators who are interested in developing similar curricula in their home institutions. Also of note, although 20% of the participants attended less than half the sessions, our prior study results suggest that even those "part-time" participants derived substantial benefit; we know little about the right intensity of such programs.

Conclusions

In-depth interviews of physicians who completed a Mindful Communication program revealed three core themes: (1) sharing personal experiences from medical practice with colleagues reduced professional isolation, (2) mindfulness skills improved the participants' perceptions of their ability to be attentive and listen deeply to their patients' concerns and respond to them more effectively, and (3) developing greater self-awareness was positive and transformative, yet they struggled to give themselves permission to attend to their own needs and personal growth. These themes help point the way toward other individually focused trainings and systems transformations that may effectively address primary care physicians' dissatisfaction and encourage the search for additional ways to bring joy and meaning to primary care practice.

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Other disclosures: Drs. Epstein and Krasner currently present mindful communication programs such as the one reported in this paper. The other authors do not have potential conflicts to report. Dr. Beckman had full access to all of

the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Ethical approval: The University of Rochester's research subjects review board determined that the study met federal and university criteria for exempt status.

Disclaimer: The views presented here are those of the authors and should not be attributed to the Physician's Foundation or its directors, officers, or staff.

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References

- 1 Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q.* 2005;83:457–502.
- 2 Bodenheimer T. Primary care—Will it survive? *N Engl J Med.* 2006;355:861–864.
- 3 Sandy LG, Bodenheimer T, Pawlson LG, Starfield B. The political economy of U.S. primary care. *Health Aff (Millwood).* 2009;28:1136–1145.
- 4 Shanafelt TD, Sloan JA, Habermann TM. The well-being of physicians. *Am J Med.* 2003;114:513–519.
- 5 Spickard A Jr, Gabbe SG, Christensen JF. Mid-career burnout in generalist and specialist physicians. *JAMA.* 2002;288:1447–1450.
- 6 Maslach C. Job burnout. *Curr Dir Psychol Sci.* 2003;12:189–192.
- 7 Dyrbye LN, Massie FS Jr, Eacker A, et al. Relationship between burnout and professional conduct and attitudes among US medical students. *JAMA.* 2010;304:1173–1180.

- 8 Shanafelt TD, Bradley KA, Wipf JE, Back AL. Burnout and self-reported patient care in an internal medicine residency program. *Ann Intern Med.* 2002;136:358–367.
- 9 Shanafelt TD, West C, Zhao X et al. Relationship between increased personal well-being and enhanced empathy among internal medicine residents. *J Gen Intern Med.* 2005;20:559–564.
- 10 O'Connell PA, Wright SM. Declining interest in primary care careers. *J Gen Intern Med.* 2003;18:230–231.
- 11 Biola H, Green LA, Phillips RL, Guirguis-Blake J, Fryer GE. The U.S. primary care physician workforce: Persistently declining interest in primary care medical specialties. *Am Fam Physician.* 2003;68:1484.
- 12 Bodenheimer T, Pham HH. Primary care: Current problems and proposed solutions. *Health Aff (Millwood).* 2010;29:799–805.
- 13 Kellerman R, Kirk L. Principles of the patient-centered medical home. *Am Fam Physician.* 2007;76:774–775.
- 14 Epstein RM, Fiscella K, Lesser CS, Stange KC. Why the nation needs a policy push on patient-centered health care. *Health Aff (Millwood).* 2010;29:1489–1495.
- 15 Miller WL, Crabtree BF, Nutting PA, Stange KC, Jaen CR. Primary care practice development: A relationship-centered approach. *Ann Fam Med.* 2010;8(suppl 1):S68–S79.
- 16 Nutting PA, Crabtree BF, Miller WL, Stewart EE, Stange KC, Jaen CR. Journey to the patient-centered medical home: A qualitative analysis of the experiences of practices in the National Demonstration Project. *Ann Fam Med.* 2010;8(suppl 1):S45–S56.
- 17 Epstein RM. Mindful practice. *JAMA.* 1999;282:833–839.
- 18 Shapiro SL, Schwartz GE. Mindfulness in medical education: Fostering the health of physicians and medical practice. *Integr Med.* 1998;1:93–94.
- 19 Novack DH, Suchman AL, Clark W, et al. Calibrating the physician. Personal awareness and effective patient care. *JAMA.* 1997;278:502–509.
- 20 Krasner MS, Epstein RM, Beckman H, et al. Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. *JAMA.* 2009;302:1284–1293.
- 21 Kabat-Zinn J. *Wherever You Go, There You Are: Mindfulness Meditation in Everyday Life.* New York, NY: Hyperion; 1994.
- 22 Charon R. The patient–physician relationship. *Narrative medicine: A model for empathy, reflection, profession, and trust.* *JAMA.* 2001;286:1897–1902.
- 23 Connelly JE. Narrative possibilities: Using mindfulness in clinical practice. *Perspect Biol Med.* 2005;48:84–94.
- 24 DasGupta S, Charon R. Personal illness narratives: Using reflective writing to teach empathy. *Acad Med.* 2004;79:351–356.
- 25 Cooperrider D, Whitney D. *Appreciative Inquiry: A Positive Revolution in Change.* San Francisco, Calif: Berrett-Koehler; 2005.
- 26 Crabtree BF, Miller WL. *Doing Qualitative Research.* 2nd ed. Thousand Oaks, Calif: Sage Publications; 1999.
- 27 Epstein RM. Mindful practice in action (II): Cultivating habits of mind. *Fam Syst Health.* 2003;21:11–17.
- 28 Levinson W, Roter D. Physicians' psychosocial beliefs correlate with their patient communication skills. *J Gen Intern Med.* 1995;10:375–379.
- 29 Larson EB, Yao X. Clinical empathy as emotional labor in the patient–physician relationship. *JAMA.* 2005;293:1100–1106.
- 30 Linzer M, Visser MR, Oort FJ, Smets EM, McMurray JE, de Haes HC. Predicting and preventing physician burnout: Results from the United States and the Netherlands. *Am J Med.* 2001;111:170–175.

Appendix

Interview Guide

1. What led you to sign up for the Mindful Communication program?
2. What were your hopes and expectations for the program? In what ways were they met or not met?
3. What has been a meaningful part of the Mindful Communication experience for you personally?
4. In what ways did the Mindful Communication program influence how you behaved outside of the workplace, such as self-care, work–home balance, etc.?
5. In what ways did the Mindful Communication program affect how you interact or relate with patients, peers, or others?
6. If you were unable to make a number of the sessions, it would be helpful to know about the reasons that prevented you from attending more sessions ... can you talk about these?
7. Thinking back on the Mindful Communication program, what were its strengths?
8. What is something the facilitators did that was particularly helpful? Unhelpful?
9. Thinking back on the Mindful Communication program, what were its weaknesses?
10. What types of improvements, if any, would you recommend for the Mindful Communication program?
11. What surprised you about the Mindful Communication program?
12. Any further thoughts about the Mindful Communication program?

As the interviewer, please note any comments/thoughts you had about the interview.