

Chapter 1

BURNOUT

In your emergency room, a patient who could be your grandmother lies untended on a gurney in the corridor. There are no beds. She's been desperately trying to attract attention but now lies mutely in soiled sheets. There was nobody to take her to the toilet.

It may not be written down anywhere but the rules for health professionals are clear: Put your head down, complete your tasks as quickly as possible, get the paperwork done, and move onto the next patient.

Yesterday you took the time to really listen to a patient, holding his hand and offering your comfort and understanding. You won't make that mistake today – not after your team members snapped at you for wasting time.

**The rules are clear:
Put your head down,
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as quickly as possible,
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done, and move onto
the next patient**

After investing hard years of training to achieve the highest qualifications – probably neglecting your family along the way – you're proud of your technical skills but now the pleasure and satisfaction of using them seems dull. The work itself is routine, day-in and day-out.

And since when did patients become so ungrateful? They neglect their health and then expect you to fix them up. Then they write complaints, or sue you when things don't turn out.

At the end of the shift you go home feeling exhausted and dispirited. Today you snapped at someone. You don't know how much longer you can keep this up.

There must be more to having a job than just earning money; it's a story more and more health workers can relate to.

Healthcare is in deep peril. The relentless progression of technological medicine, the focus on disease rather than wellbeing, the rapidly escalating costs, and the corruption of healthcare by profit making and greed are taking us fast to a crisis point. In this mad scramble, the human aspects of caring, compassion and healing are being lost.

Fatigue, depression, stress and burnout are reaching epidemic proportions in the health workforce internationally. And, as health workers become more stressed, bullying and abuse do further harm to working relationships and patient care.

The term "disruptive behavior" has debuted in medical journals in recent years¹. It's the euphemism for toddler-style tantrums conducted by medical professionals – its hallmarks include yelling, throwing objects and slamming doors. Less flamboyant but equally damaging are weapons like sarcasm and derision.

Not the job we signed up for

Jill Maben is a researcher in London. Her fears about the state of the nursing profession were realized in a longitudinal study which showed how the ideals and values of nursing students clashed with the harsh reality of work in the British National Health Service².

Newly qualified nurses were exposed to a set of covert rules they were expected to adhere to, but these rules were the antithesis of their values and ideals. These four 'rules' were particularly prevalent in practice environments categorised as challenging and poor.

Rule 1: Hurried physical care prevails to the detriment of psychological care

Rule 2: No shirking! (with a need to be seen doing a fair share of the physical and 'dirty work')

Rule 3: Don't get involved with patients (keep an emotional distance at all times)

Rule 4: Fit in and don't rock the boat (don't try and introduce changes to practice)

Maben found within two years of graduation most nurses were compromised or crushed idealists. Professionally frustrated, they had a high degree of burnout leading to disillusionment, job hopping, and sometimes leaving the profession altogether.

Doctors fare no better. The Physicians' Foundation 2008 survey of 12,000 physicians in the USA painted a grim picture that could have drastic implications for the nation's healthcare ³.

The report found:

- 78% of physicians found medicine either “no longer rewarding” or “less rewarding”
- 63% of physicians said they did not always have enough time to properly treat all their patients
- 60% of doctors would not recommend medicine as a career
- 49% of physicians – more than 150,000 doctors nationwide – said that over the next three years they planned to either reduce their patient numbers or stop practicing
- 42% of physicians rated the professional morale of their colleagues as “poor” or “very low”
- Just 6% of physicians described the professional morale of their colleagues as “positive”

The chronic stress and disillusionment take their toll on staff relationships. In a survey of 50 Veterans Health Administration (VHA) community hospitals across the United States, 86% of nurses and 49% of doctors reported witnessing senior staff tantrums, which were detrimental not only to workplace relationships but ultimately to patient care ⁴.

Most VHA respondents believed the breakdown in communication led to medical errors, which impacted on patient safety – and sometimes even patient mortality.

Our healthcare systems are themselves causing so much unnecessary pain and suffering. Each day, our attitudes and actions are undoing much of the hard work we commit to the care of patients.

The most heart-rending accounts of that suffering come from health professionals who suddenly find themselves in the role of patients, feeling scared and vulnerable.

When health workers become patients

George Sweet, a retired psychotherapist and author in New Zealand, developed transverse myelitis, an acute inflammation of spinal nerves. Sweet described his personal experience of the hospital ward rounds ⁵:

“When I first arrived in hospital I inadvertently created havoc by being honest. I had suddenly lost the use of my legs. When the ward round arrived they asked ‘How are you feeling today?’ I answered quite accurately: ‘Very frightened, and deeply sad.’ Somehow however, my answer seemed inappropriate; the team staggered cognitively, then recovered by asking about symptoms: ‘Are the feet any better?’ I felt dismissed, unheard. Abandoned is not too strong a word.

“I was in hospital for several months, but it took me about nine weeks to get a focus on the vagueness and dissatisfaction that these rounds produced in me. I found them to be constantly impersonal; this was exacerbated by doctors talking not with me, but amongst themselves in response to my statements. Out of anxiety I often gave quick, partial, or even unhelpful answers to questions. I did not feel that I, George, was of the slightest importance to the round. The pathology was very important. I was overwhelmed by the numbers of people who had little desire to know George or invite him to participate in his own treatment.

“Rounds usually started with a short ‘How are you this morning?’ I quickly learned that the correct answer was ‘OK’ or ‘Good’. At worst, the focus seemed to be on getting an assurance that the patient was OK (which meant the round could move on), or, the patient had a problem so medications needed changing (then the round could move on). On questioning other patients, I found that ‘OK’ or ‘Good’ were also their preferred responses to the ward round style of consulting.”

From my perspective as a hospital specialist, this brief account accurately portrays what I have witnessed in ward rounds in every hospital in my working life. This impersonal care is not an exception – it’s the rule.

The person in the patient is quickly dissolved in the role of a patient.

Our style of medicine focuses on the disease, and standardized treatment of the pathology, not on the person with the illness. Moreover, the respective roles of practitioner and patient create a huge power imbalance.

It is much easier for patients to answer 'OK' or 'Good' in response to questions than to admit deep concerns or ask questions.

We now know this style of caring, adopted by so many health professionals, has serious consequences not only for the patient but also for the health professional.

Why we need to treat the whole person

There's growing scientific evidence of the powerful impact of emotional and psychological factors on the wellbeing and survival of our patients. For instance, in major causes of death like heart disease, the difference in death rates between pessimists and optimists is about as big as the difference between smokers and non-smokers ⁶.

Maybe you're a highly skilled surgeon doubting what relevance all this 'touchy, feely' stuff has to your surgical outcomes. Think again. There is conclusive evidence that if your patients are stressed, their healing will be delayed and they are at higher risk of wound infections and cancer recurrence ^{7,8}.

Humans have extraordinary innate powers of healing. Every doctor knows patients who completely defy expectations and continue to flourish in good health when they should be dying of incurable cancer.

So, whenever we treat patients impersonally, as 'the breast lump on ward six', we fail to tap into a powerful mechanism for healing that's at least as effective as many of our medications.

This detached, impersonal style of caring is also at the heart of so much misery among health professionals. When patients feel a lack of caring, they quickly lose trust, they are dissatisfied, they feel as if you aren't listening, and they will tend to escalate their demands or withdraw. The joy of caring becomes tarnished.

And health professions tend to be their own worst critics.

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As working conditions deteriorate and patient care is compromised, health workers who are heading for burnout suffer most from high levels of self-criticism and shame. It's a nasty vicious cycle, leading to depression and physical health problems.

Unhappy health professionals contaminate those around them.

Bad moods are contagious. People in stressed work environments lose both patience and generosity. People snap at each other. A longitudinal study of sickness absenteeism among hospital physicians showed poor teamwork was the most powerful determinant, even greater than work overload⁹.

And what happens when we run out of treatment options? Maybe the patient has chronic disease that we can't fix or cure. Worse still, incurable cancer. How do you feel when you have to tell the patient, 'I'm sorry, there's nothing more we can do'? What does that do for your sense of professional competence, your self-esteem?

Professor Keiran Sweeney was an inspirational GP and renowned medical educator in London. He died on Christmas Eve 2009, diagnosed with mesothelioma, a malignancy of the pleural lining of the lung. In a moving paper published before his death, he described his experience of learning the fateful diagnosis¹⁰.

"The biopsy was carried out competently by a surgical team who all looked disturbingly downcast after the procedure. None could address my increasing anxiety, except perhaps the most junior member of the team, who, I sense in retrospect, did not feel he had either the authority or life experience to discuss the diagnosis. The specialist nurse came to show my wife and me how to drain the pleural catheter, which was left in to promote a pleurodesis.

"If there was anything I wanted to know about mesothelioma, he said, with the best of intentions, he had lots of information available. The physical shock of his throwaway remark fractionally preceded its violent emotional impact, but smiling blandly, I went down for a check radiograph, having been invited to do so by the

nurse on duty thus: 'Could you get this young man to go down for a chest film when you're finished?' My guess is that the nurse was about 22 years old...

"While I was having the check film, my wife asked the specialist cancer nurse why everyone was so downcast. At that point, everyone around knew I had a mesothelioma, except me.

"I learnt about it by reading the discharge summary over a glass of sauvignon blanc with lunch at home: malignant mesothelioma. 'Patient is aware of the diagnosis,' said the discharge summary.

"The next 48 hours are spent talking to our four beautiful kids, aged mid-teens to early 20s, whose joyous careers are currently sprinkled through school, part time jobs, and university. I can't really convey in words the catastrophic hurt my news has inflicted on them...

"We embrace. They weep. I weep for them, for fear for myself, and for the unthinkable horror that they will continue to inhabit the world in which I will play no part. Like my wife, they are brave, selfless, and compassionate."

Sweeney went on to describe the devastating emotional impact of dealing with health professionals who were unable to acknowledge the seriousness of his illness or offer any kind of emotional support.

Sweeney's story gives insight into how much difficulty health professionals face when their treatment is directed only at the disease, or the physical symptoms of the patient. When they lack the confidence, skills, and psychological resilience to offer emotional support and understanding to a patient, they are left with a terrible failure of professional purpose.

I believe every one of Sweeney's many doctors and nurses was a caring human being, who will have suffered greatly knowing the impact of their words while feeling unable to offer comfort or hope.

But, as a health professional, if you can sit alongside patients and witness their courage, resilience, hope and forgiveness – in the face of life-threatening illness – then you feel humbled and privileged. It's a shared journey that can bring deep meaning to your work.

What happened to compassion?

Why are these practices of compassionate caring resisted so much within professional and institutional cultures? And on a personal level, what's to stop health workers from bringing their hearts to work and making an emotional connection with patients? According to the research the answers are universal:

- The sheer pace of work and multiple competing demands
- Peer pressure
- The perceived need for objectivity and clear judgment
- The de-humanizing effect of much medical technology
- Institutional rules and policies

As health professionals we are deeply immersed in a culture, which unconsciously shapes our beliefs and behaviors. These influences so powerfully inhibit compassionate, whole person care that I call them the 'tyrannies' of the system – the unconscious norms, practices, habits and beliefs we acquire in training and practice.

We seldom talk about psychological and emotional vulnerability and yet those working in healthcare witness terrible sights: horrifying injuries and mutilations (some of them in the results of treatment); disease-ridden bodies; pain and suffering; and deaths of patients who remind us of loved ones.

We're taught that the cost of emotional involvement is too high: we'd have to come to terms with our own vulnerability, brokenness, and potential mortality. How many health workers are comfortable talking with a patient about death and dying?

The first study into emotional vulnerability of health professionals was published more than fifty years ago. The classic paper is Isabel Menzies writing, *A Case-Study in the Functioning of Social Systems as a Defence against Anxiety. A Report on a Study of the Nursing Service of a General Hospital*¹¹.

Menzies' nurses were in constant contact with people who were physically ill or injured, often seriously. The recovery of patients was not certain and would not always be complete.

We seldom talk about psychological and emotional vulnerability

Nursing patients with incurable diseases was one of the nurse's most distressing tasks. Nurses were confronted with the threat and reality of suffering and death, their work involved carrying out tasks which, by ordinary standards, were distasteful, disgusting, and frightening.

Menzies reported that the nurses' intimate physical contact with patients aroused strong and mixed feelings. Emotions of pity, compassion, love, guilt, anxiety warred with those of hatred and resentment which were all aroused by patients. Such strong feelings often had their root in envy of their patients for the care being lavished on them.

Menzies documented that the nurses' coping strategies reduced anxiety by de-personalizing both themselves and the patients. The strategies included:

- A 'task-list' care system, absolving nurses from the anxiety of decision-making
- Talking of patients, not by name but by disease, the pneumonia in bed 15
- Nursing uniforms becoming a symbol of behavioral uniformity; one nurse being perfectly inter-changeable with another. There is no room for the person of the nurse
- Detachment and denial of feeling. A 'good' nurse doesn't mind being moved from one job to another

Recent reports illustrate that modern day medical students have equally challenging experiences in their early clinical attachments.

Harvard Medical student Neal Chatterjee wrote ^{12, 13}:

"There's nothing particularly natural about the hospital – ever-lit hallways, the cacophony of overhead pages, near-constant beeps and buzzes, the stale smell of hospital linens.

This unnaturalness was strikingly apparent to me when I arrived as a third-year medical student – freshly shaven, nervous, absorbent – for the first day of my surgical clerkship.

As I joined my team, my resident was describing a recent patient: "He arrived with a little twinge of abdominal pain ... and he left with a CABG, cecectomy, and two chest tubes!"

This remark was apparently funny, as I surmised from the ensuing laughter. And the resident sharing the anecdote – slouched in his chair, legs crossed and coffee in hand – seemed oddly... comfortable.

As the year – known at Harvard Medical School as the Principal Clinical Experience – proceeded, the blare of announcements dulled to a low roar, the beeps and buzzes seemed increasingly distant, and the stale smell of hospital linens became all too familiar.

Occasionally, however, there were moments that evoked a twinge of my old discomfort, some inchoate sense that what had just transpired mattered more deeply than I recognized at the time. These moments were often lost amidst morning vital signs, our next admission, or the differential diagnosis for chest pain.

At the end of the year, we were asked to reflect, in writing, on our first year in the hospital. What eventually filled my computer screen had nothing to do with vital signs or chest pain. I began to write, "I have seen a 24-hour-old child die. I saw that same child at 12 hours and had the audacity to tell her parents that she was beautiful and healthy. Apparently, at the sight of his child — blue, limp, quiet — her father vomited on the spot." I say apparently because I was at home, sleeping under my own covers, when she coded.

I have seen entirely too many people naked. I have seen 350 pounds of flesh, dead: dried red blood streaked across nude adipose, gauze, and useless EKG paper strips. I have met someone for the second time and seen them anesthetized, splayed, and filleted across an OR table within 10 minutes.

I have delivered a baby. Alone. I have sawed off a man's leg and dropped it into a metal bucket. I have seen three patients die from cancer in one night."

The remarkable thing is that *any* health professional survives the process of training and early professional experience without becoming dehumanized. Yet some health workers are like angels, they shine in their workplace, creating oases of calm, caring and compassion.

What unique emotional and psychological strengths allow them to resist the de-humanizing influences?

Maintaining our humanity

Pioneers in the new and rapidly expanding field of Positive Psychology are studying these questions about resilience, strengths and wellbeing. For too long we have focused on mental problems like anxiety and depression, say leaders like Martin Seligman^{13,14}. We need to understand what it means to be healthy, happy and resilient. What are the psychological strengths that allow people to flourish in the face of severe adversity?

People have a great tendency to believe that differences in behavior are the result of inborn personality traits. It seems that some people are just naturally happy, carefree and resilient.

Actually these traits can be quickly learned and developed. Furthermore, instead of being perpetual victims of the world around us, we can learn to re-make our environment to create a very different life experience.

When I began this long journey of learning fifteen years ago I would have scoffed at the very concept. At the time I was an anesthesiologist doing highly specialized medicine in a big teaching hospital. My source of professional identity and self-esteem was technical expertise. While I cared about my patients, I knew little about compassionate caring.

Three things changed my mind. First the great weight of scientific evidence in related fields: the links between psychological, emotional and physical health; the neuroscience of interpersonal connection and how profoundly we influence one-another; and the rapidly expanding science of Positive Psychology.

Second, was the gradual transformation in my own experience as I began to learn the attitudes and skills of compassionate caring. My clinical work has never been more joyful, satisfying and privileged. Jobs that used to be a chore, now give me great pleasure.

The final factor was the many stories I heard of other health professionals turning their lives around.

My email InBox has become a treasure of moving stories that begin with phrases like, “Robin, you saved my life...”

Anyone who studies evidence-based practice knows of the long lag between publication of clinical trials and adoption of that knowledge into practice. For instance, fibrinolytic therapy (“clot-busting” drugs) given within an hour of an acute heart attack can reduce mortality by up to 48% ¹⁵.

Although there was compelling scientific evidence of this benefit by the mid-1980’s, the practice didn’t take off until the 1990’s; well into the 2000’s many patients still missed out.

It’s the same with evidence regarding compassionate, whole-person care and the nature of the profound interconnection between human beings: the knowledge and practice has lagged far behind the evidence.

The new field of positive psychology

The explosion of knowledge in positive psychology in the last decade is beginning to revolutionize our approach to health and wellbeing. Long-regarded practices like clinical detachment must now be re-examined in the light of modern neuroscience and our new knowledge of perception, consciousness and reality.

Prior to the millennium, almost the entire focus of psychology and psychiatry was on deficits and defects in mental health, like anxiety disorders and depression. Health was perceived as the *absence* of disease, rather than a positive flourishing of physical, emotional, mental and spiritual wellbeing.

The ‘bible’ for mental health practitioners is a complex classification of mental disorders called the DSM-IV. The *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* contains thousands of entries but in effect half the book is missing. There was no description or classification of mental and emotional strengths, positive values, or sources of resilience and wellbeing. Peterson and Seligman remedied this defect by publishing *Character Strengths and Virtues: A Handbook and Classification* in 2004 ¹⁶.

TIME TO CARE draws on important new evidence from the world of positive psychology. Prominent researchers like Barbara Fredrickson, the author of the best-selling book *Positivity* teach us how we can flourish as health professionals, to become the very best version of ourselves¹⁷.

Now there is also accumulating evidence of the link between positive psychology and physical health. In one of many studies quoted by Seligman, Dutch seniors with high optimism had less than quarter the risk of dying of heart attack or stroke over the next decade, compared with pessimists¹⁴.

So it becomes clear that our focus on physical disease and biomedicine is unbalanced. We need to pay much more attention to emotional, psychological and spiritual wellbeing and the huge importance of healing relationships.

This focus on positivity, wellness, strengths and resilience – rather than disease – is foreign to health professionals. We have been so well versed in problem identification, diagnosis, treatment and risk-management that the whole character of our thinking has been unconsciously shaped.

So this new science of positive psychology is very helpful in liberating ourselves from these unconscious influences, to become fully compassionate practitioners.

Fredrickson developed a ‘broaden and build’ theory, which shows how positive thinking and emotions broaden our field of perception, increase creativity, and enhance our social contribution¹⁸.

In contrast, pessimistic, unhappy thinking – focusing on problems and risks – narrows our creativity and gets us stuck in a deep rut, rehearsing our negative thoughts again and again. Did you ever have a bad day and find yourself making lists of all the things that have gone wrong already? You are priming yourself for more disasters!

This book also draws on ancient wisdom from Eastern philosophies.

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Just as critical thinking styles can limit our repertoire of responses, many other unhelpful Western assumptions, frameworks and models handicap our approach to health and welfare. In the Western world, for instance, there's huge emphasis on self-esteem as a source of wellbeing. Recent research suggests that self-compassion is a far more stable foundation for happiness ¹⁹.

Our Western heroes tend to be men and women of action, rather than those with mindful consciousness and subtle influence. Compassion lies at the heart of Buddhist practice and philosophy. Taoist philosophy offers many counterintuitive ideas about leadership and influence that help us serve others more effectively.

In a remarkable coming together of ancient and modern, neuroscientists are starting to confirm many of the beliefs of Buddhist philosophy, which are based on more than two thousand years of meditation and internal study of the workings of the human mind.

These new findings from neuroscience dramatically challenge some of the core assumptions of Western scientific thinking, particularly separation of feelings and thoughts.

The dangers of clinical detachment

It may be that "clinical detachment" is a Western delusion – certainly as a concept it's deeply harmful to patient care and to the emotional wellbeing of health professionals. In contrast to a widely held belief, research shows that the doctors who are most empathetic, those who make the strongest emotional connections with their patients, actually have the lowest risk of burn-out ^{20, 21}.

One paper reported that those trauma therapists with "exquisite empathy" defined as being highly present, sensitively attuned, well-boundaried, with heartfelt empathic engagement, were invigorated rather than depleted by their intimate professional connections with traumatized clients and thus protected against compassion fatigue and burnout ²².

It seems clinical detachment, as a psychological defense mechanism, is flawed.

In my experience, the desire for compassionate practice is never buried deep. Most health workers come into their professions with high ideals of whole-patient, compassionate care. Although our systems of healthcare often don't encourage and nurture compassion and caring, there are simple steps health workers can take that quickly lead you to a point of greater flourishing.

When we begin to shift our attitudes and beliefs, the system begins to take on a more malleable form and we find powerful ways to shape the world around us. As Gandhi said, you need to become the change you want to see.

Those who have adopted the latest developments in neuroscience and positive psychology are demonstrating that spending time actually saves time – even in the busiest and most demanding medical environments.

Doctors who make more time for caring, learn to love even their 'difficult' patients. They actually become better doctors with more successful medical outcomes. And they're happier people.

Some will say, 'Get real. You just don't understand the kind of pressure we're under every day!'

It's true. Healthcare has become incredibly stressed, patients make too many demands, and the shortage of health workers makes it all worse.

Nevertheless, there are people at work who are happy every day. They rarely get stressed and they always find time to do the special little things that make a huge difference for patients.

Doctors who make more time for caring learn to love even their 'difficult' patients

How? It turns out that many of the things we unconsciously think and do when we are stressed actually waste time, create conflict, multiply the work, make us unhappy, reinforce our stress, and make our patients more demanding.

We can learn a new way of being.

Flourishing

By doing simple things differently, anyone can flourish even in the most challenging workplace.

Dr Stephen Beeson, a family doctor in California, is one of the happiest doctors I know. His patients love him too – his patient satisfaction ratings place him in the top 1% of family doctors in the USA.

Beeson has an unusual practice: he gives his personal mobile phone number to every one of his patients. ‘Feel free to call me,’ he says.

Insane! Who would want to do that? Doesn’t he have a family life? When I tell my colleagues to give their personal phone number to patients, they think I am mad. Patients would never let them alone.

Actually, Beeson’s phone hardly ever rings. And when it does, it’s usually something really important. For his patients, just knowing he’s there and that he cares, is enough. They’ll only bother him if it’s absolutely necessary.

Beeson is an outstanding physician leader, many of the clues to his happiness are found in his book, *Practicing Excellence – A Physician’s Manual to Exceptional Healthcare* ²³.

The secrets to being happy and fulfilled are often paradoxical. They’re hidden because the results are so unexpected. Nearly everyone imagines giving a personal phone number to patients would result in continuous calls. But the opposite happens.

Most health professionals I know spend a huge amount of time and effort every day, limiting their contact with patients. It’s exhausting, managing all this demand. When you learn to trust your patients better, it’s such a relief to put all that effort aside.

The more barriers built between doctor and the patient, the more they will demand of you. It’s as if you’re not really connecting, so patients remain unsatisfied. The more you take down your barriers and defenses, the less patients will take advantage of you. And they’ll do a better job of helping themselves.

At Crestwood Medical Center in Huntsville, Alabama, Chief Nursing Officer Martha Walls, also had a crazy idea.

'I know you're busy,' she told her staff in 2007, "but on top of all your usual duties I'm going to ask you to check on each of your patients every hour. We're going to call it 'Hourly Rounds'."

Walls insisted whenever a nurse entered a room they were to follow a script. They were instructed to ask the patient about the need for pain relief, the need to use the bathroom, whether changing position would make the patient more comfortable, and did they have all their possessions in easy reach. These patient needs were high on the list of top ten reasons patients press their call button.

At first the nurses didn't exactly embrace the new practice, thinking it would interfere with their other duties. They were flat-out busy already. Now, they say, they'd never go back to the old system.

Why? Things changed in surprising ways ²⁴. The call-bells fell silent and the nurses found their work was interrupted less frequently. An audit showed they walked nearly a mile less per shift and spent more time on direct patient care.

After hour rounding was introduced, patient care improved too. Patient falls – a major cause of accidental patient injury – declined by 58% and bedsores reduced by 39%.

Patient satisfaction scores improved, as did the reputation of the hospital. The number of patients who would definitely recommend Crestwood to their family or friends jumped from 73% to 82% since introduction of hourly rounds.

It's a paradox: if you don't have enough time to care, slow down, stop rushing, and pay more attention. Caring doesn't take any time at all, it happens in magical moments. It turns out that investing a little time up front, in the care of the patient, is one of the magical ways of making more time to care.

A subtle shift in the attitude and behavior of the doctor elicits a more positive response from the patients. As human beings, we are deeply and intuitively sensitive to the motives and attitudes of others, mostly through non-verbal clues.

Many health professionals have told me stories of a transformational patient encounter, which marked for them a day of no return.

From that moment they found themselves on a rapidly accelerating path of positive change, with increasing joy and satisfaction in their work, greater happiness, and a growing sense of positive influence in the system.

Patient satisfaction and practitioner satisfaction are closely interrelated. This positive feedback of the cared-for patient powerfully reinforces the early changes in the practitioner and builds the courage for more openness and risk-taking in the relationship.

When the relationship between the health professional and the patient warms up in this way, the rewards for both are immediate. There's a greater bond of trust, a deepening of mutual understanding, and satisfaction with the encounter increases greatly for both parties.

Thus both practitioner and patient find themselves on an upward spiral of enhanced positivity, which I image as a double-helix, expanding and opening as it rises.

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